

3.2.7.1 RFP Forms

Release of Information Form

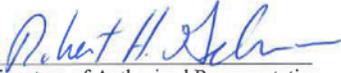
MED-16-009
Iowa High Quality Healthcare Initiative

Exhibit A: Release of Information
(Return this completed form behind Tab 6 of the Bid Proposal.)

AmeriHealth Caritas Iowa, Inc. 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.

AmeriHealth Caritas Iowa, Inc.
Printed Name of Bidder Organization


Signature of Authorized Representative

May 12, 2015
Date

Robert H. Gilman
Printed Name

Exhibit B: Primary Bidder Detail Form & Certification

(Return this completed form behind Tab 6 of the Proposal. If a section does not apply, label it “not applicable”.)

Primary Contact Information (individual who can address issues re: this Bid Proposal)	
Name:	Mary Pat Sherry
Address:	AmeriHealth Caritas, 200 Stevens Dr., Philadelphia, PA 19113
Tel:	(215) 937-8756
Fax:	(215) 937-5344
E-mail:	msherry@amerihealthcaritas.com

Primary Bidder Detail			
Business Legal Name (“Bidder”):	AmeriHealth Caritas Iowa, Inc.		
“Doing Business As” names, assumed names, or other operating names:	N/A		
NAIC Number:	Pending (HMO license application pending before Iowa Insurance Division)		
Parent Corporation, if any:	AmeriHealth Caritas Health Plan (direct parent)		
Form of Business Entity (i.e., corp., partnership, LLC, etc.):	Corporation		
State of Incorporation/organization:	Iowa		
Primary Address:	200 Stevens Dr. Philadelphia, PA 19113		
Tel:	(215) 937-8000		
Fax:	N/A		
Local Address (if any):	N/A		
Addresses of Major Offices and other facilities that may contribute to performance under this RFP/Contract:	<table border="0"> <tr> <td>AmeriHealth Caritas (corporate) 200 Stevens Dr. Philadelphia, PA 19113</td> <td>AmeriHealth Caritas (service operations) Cambridge West 8171 Baymeadows Way West Jacksonville, FL 32256</td> </tr> </table>	AmeriHealth Caritas (corporate) 200 Stevens Dr. Philadelphia, PA 19113	AmeriHealth Caritas (service operations) Cambridge West 8171 Baymeadows Way West Jacksonville, FL 32256
AmeriHealth Caritas (corporate) 200 Stevens Dr. Philadelphia, PA 19113	AmeriHealth Caritas (service operations) Cambridge West 8171 Baymeadows Way West Jacksonville, FL 32256		

Primary Bidder Detail	
Number of Employees:	0
Number of Years in Business:	Less than 1
Primary Focus of Business:	Managed health care
Federal Tax ID:	47-3923267
Bidder's Accounting Firm:	KPMG
If Bidder is currently registered to do business in Iowa, provide the Date of Registration:	May 5, 2015
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
<p>AmeriHealth Caritas Iowa makes the general assertion that the information specified in this table is exempt from public disclosure by application of Iowa Code §22.7 and IAC Ch. 9 (describing DHS' Public Records and Fair Information Practices). AmeriHealth Caritas Iowa further considers certain of the information to be protected by the Iowa Uniform Trade Secrets Act codified at Iowa Code Ch. 500, in that we: (1) derive economic value from its not being generally known to, and not being readily ascertainable by proper means by a person able to obtain economic value from its disclosure or use; and (2) take reasonable efforts to maintain the secrecy of the information.</p>		
Tab 3 Pages 68	Iowa Uniform Trade Secrets Act	Specific financial performance indicators have been redacted. AmeriHealth Caritas Iowa and its owners and affiliates are privately-held companies; line items from its financial statements are not subject to public disclosure.
Tab 3 Page 923	Iowa Uniform Trade Secrets Act	Specific payment amounts to AmeriHealth Caritas Iowa's affiliate have been redacted. AmeriHealth Caritas Iowa and its owners and affiliates are privately-held companies, and Select Health's compensation from the State of South Carolina is confidential.
Tab 4 Pages 954, 956, 958, 960	Iowa Code §22.7	AmeriHealth Caritas Iowa has redacted the home addresses and phone numbers of its directors and officers.
Tab 6 Page 987-1088	Iowa Uniform Trade Secrets Act Iowa Code §22.7	Certain identifying information of individual owners and managing employees of AmeriHealth Caritas Iowa and its subcontractors has been redacted from ownership disclosure forms. These are private data of a sensitive nature that could potentially cause great harm to the subject individuals if publicly disclosed.
Financial Statements Binder	Iowa Uniform Trade Secrets Act Iowa Code §22.7	The financial statements of BMH LLC and Subsidiaries have been redacted. All of these companies are privately-held companies whose audited financial statements are not publicly reported. The companies would be competitively disadvantaged by their disclosure, and they take reasonable measures to prevent their public disclosure in the normal course of business.

Request for Confidential Treatment (See Section 3.1)

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Request for Confidential Treatment (See Section 3.1)

Intentionally Left Blank

Request for Confidential Treatment (See Section 3.1)

Intentionally Left Blank

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:	Steven H. Bohner, Vice President & Treasurer
Date:	5/11/15

Subcontractor Disclosure Form (one for each proposed subcontractor)

The following subcontractors' disclosure forms are attached:

- Access2Care, LLC.
- AmeriHealth Caritas Iowa, LLC
- Avesis Third party Administrators, Inc.
- Discovery Health Partners.
- Health Management Systems, Inc. (HMS).
- Medical Transportation Management, Inc. (MTM).
- PerformRx
- SironaHealth, Inc.

Ownership Disclosure Forms

For the sake of uniformity and consistency, and to ensure that the information called for under 42 CFR 455.104 is disclosed, AmeriHealth Caritas Iowa had its subcontractors complete the Department's "Iowa Medicaid Ownership and Disclosure Form" (form 470-5186 Rev. 3/15). These are included along with each subcontractor's "Subcontractor Disclosure Form" within Tab 6.

The ownership disclosure forms are substantially complete, but in certain instances our identified subcontractors have either redacted or withheld certain sensitive personally identifiable information such as dates of birth and social security numbers of their managing employees. We have determined this is primarily due to a lack of understanding of the safeguards available to protect such information. AmeriHealth Caritas Iowa understands the requirement to furnish complete subcontractor information; and we will work with each of our subcontractors in order to provide complete and updated information on or before Contract execution, in accordance with the SOW.

Exhibit C: Subcontractor Disclosure Form

(Return this completed form behind Tab 3 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"):	AmeriHealth Caritas Iowa, Inc.
Subcontractor Contact Information (individual who can address issues re: this RFP)	
Name:	Enid Krasner
Address:	6200 South Syracuse Way, Suite 200, Greenwood Village, CO
Tel:	303-495-1214
Fax:	303-495-1295
E-mail:	Enid.Krasner@amr.net

Subcontractor Detail	
Subcontractor Legal Name ("Subcontractor"):	Access2Care, LLC
"Doing Business As" names, assumed names, or other operating names:	Previously known as TMS Management Group Inc.
Form of Business Entity (i.e., corp., partnership, LLC, etc.)	LLC
State of Incorporation/organization:	Missouri
Primary Address:	6200 South Syracuse Way, Suite 200, Greenwood Village, CO
Tel:	303-495-1214
Fax:	303-495-1295
Local Address (if any):	Des Moines Airport, 5800 Fleur Drive, Suite 231, Des Moines, IA 50321
Addresses of Major Offices and other facilities that may contribute to performance under this RFP/Contract:	16331 Bay Vista Drive, Clearwater, FL 33760 Abbot Place, St. Louis, MO 63143
Number of Employees:	297 employees, 20 in Iowa
Number of Years in Business:	11 (date of organization: January 31, 2006)
Primary Focus of Business:	Non-emergency medical transportation and related technologies
Federal Tax ID:	01-0876348
Subcontractor's Accounting Firm:	Ernst & Young LLP, Independent registered public accounting firm
If Subcontractor is currently registered to do business in Iowa, provide the Date of Registration:	TMS Management Group Inc. was registered in Iowa on 6/11/13.
Percentage of Total Work to be performed by this Subcontractor pursuant to this RFP/Contract.	<5%
General Scope of Work to be performed by this Subcontractor	
Non-emergency medical transportation and related technologies	
Detail the Subcontractor's qualifications for performing this scope of work	
Access2Care is the only transportation management program operating in Iowa. We serve Medicaid recipients in all 99 Iowa counties, every day, since 2010. We currently maintain a 99.9% COMPLAINT-FREE transportation program. We have the only EXISTING, CREDENTIALLED and PROVEN transportation network in Iowa, covering the entire State with an extensive and satisfied provider network. We have knowledge of the rural landscape and proven strategy for effective statewide transportation coverage. Access2Care optimizes all area resources, including public transportation and mileage reimbursement to ensure that the most appropriate and cost efficient mode of transportation is used for every trip. Our Iowa-based staff is experienced and knowledgeable in Iowa's regulatory requirements and our Iowa toll-free number are already well known and available in medical centers and facilities across Iowa. We have established relationships with Iowa healthcare facilities and providers.	

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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:	Steven G. Murphy, President
Date:	May 8, 2015



Iowa Department of Human Services

Iowa Medicaid Ownership and Control Disclosure

Provider Name Access2Care, LLC	Federal Tax ID or SSN FEIN# 01-0876348
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Pursuant to 42 C.F.R. sections 455.104 through 455.106, providers applying for Medicaid must disclose certain information about those who have a sufficient ownership interest in the provider as well as those who act as managers or agents of the provider. The following series of questions seeks the necessary information to comply with these regulations.

It is the provider's responsibility to ensure all information is accurate and to report any changes immediately by completing a new Ownership and Disclosure form. See Section 1.6 and Section 3 of the Provider Agreement. Only one form is required per Tax Identification Number (TIN) or Social Security Number (SSN).

In the questions that follow, the provider listed above is referred to as "You" or "Your."

Section 1: Provider Type

Are you an individual practitioner or a group of practitioners?

Individual Practitioner: Yes or No

Group of Individual Practitioners Yes or No

If you answered "Yes" and you are an individual practitioner or a group of individual practitioners, please skip to Section 5. The ownership disclosure requirements do not apply to these entities that generally do not have owners, such as individual practitioner or groups of practitioners.

If you answered "No" because your entity is some form of business other than an individual practitioner or a group of practitioners, please complete all sections.

Section 2: Ownership

Individual Ownership

Please list in the following table all **individuals** with an ownership or control interest in you. Include each person's name, address, date of birth (DOB), and SSN, title (e.g., chief executive office, owner, board member, etc.) and if an owner, the percent of ownership.

"Persons with an ownership or control interest" means:

- has an ownership interest totaling five percent or more in you;
- has an indirect ownership interest equal to five percent or more in you;
- has a combination of direct and indirect ownership interest equal to five percent or more in you;
- owns an interest of five percent or more in any mortgage, deed of trust note, or other obligation secured by the disclosing entity if that interest equals at least five percent of the value of the property or assets of you;
- is an officer or director of your organization if you are organized as a corporation; or
- is a partner in your organization if organized as a partnership.

Table 1: Individual Owners

Name of Individual	Title	Ownership Percentage (if applicable)	Address	Date of Birth	Social Security Number
N/A					

Non-individual Ownership

Please list all corporations or other form of business entity with an ownership or control interest in you. Include the TIN, the percent of ownership, the primary address, all business locations, and the P.O. Box address.

A corporation or other form of business entity is deemed to have an ownership or control interest in you if it:

- a) has an ownership interest totaling five percent or more in you;
- b) has an indirect ownership interest equal to five percent or more in you;
- c) has a combination of direct and indirect ownership interest equal to five percent or more in you;
- d) owns an interest of five percent or more in any mortgage, deed of trust note, or other obligation secured by you if that interest equals at least five percent of the value of the property or assets of you;
- e) is an officer or director of you if organized as a corporation; or
- f) is a partner in you if organized as a partnership.

Table 2: Non-individual Owners

Name of Business Entity	TIN	Ownership Percentage	Primary Business Address	All Business Addresses	All P.O. Box Addresses
Mission Care Services, LLC	42-1644377	100%	221 Bolivar Jefferson City, MO 65101	221 Bolivar Jefferson City, MO 65101	221 Bolivar Jefferson City, MO 65101

Please copy this page if additional space is needed.

Your Ownership of Subcontractors

Please list all subcontractors in which you have an ownership interest of five percent or more. Include the TIN or SSN, the percent of ownership, the primary address, all business locations, and all P.O. Box addresses.

Table 3: Subcontractors

Name of Subcontractor	TIN/SSN	Ownership Percentage	Primary Business Address	All Business Addresses	All P.O. Box Addresses
N/A					

Section 3: Individual Relationships

If you listed in Table 1 any individual owners of you, are any of the individual owners related to each other as a spouse, parent, child or sibling? Yes or No

If you answered Yes, please provide all of the following information about each individual owner in the table below.

Table 4:

Social Security Number	Person Name	Relationship	Date of Birth

If you listed in Table 1 any individual owners of you and also listed in Table 3 subcontractors in which you have an ownership interest, are any of the individual owners listed in Table 1 related to any owner of any subcontractors listed in Table 3 as a spouse, parent, child or sibling?

Yes or No

If you answered Yes, please provide all of the following information about each individual owner in the following table.

Table 5:

Social Security Number	Person Name	Relationship	Date of Birth

Please copy this page if additional space is needed.

Section 4: Other Disclosing Entities

Do any owners of you have an ownership or control interest in any “other disclosing entity”? This question is asking if any of your owners have an ownership or control interest in any other organization that would qualify as a “disclosing entity.” “Other disclosing entity” means any other Medicaid disclosing entity and any entity that does not participate in Medicaid, but is required to disclose certain ownership and control information because of participation in any of the programs established under Title V, XVIII or XX or the Act. This includes:

- a) Any hospital, skilled nursing facility, home health agency, independent clinical laboratory, renal disease facility, rural health clinic, or health maintenance organization that participates in Medicare (Title XVIII);
- b) Any Medicare intermediary or carrier; and
- c) Any entity (other than an individual practitioner or group of practitioners) that furnishes, or arranges for the furnishing of, health-related services for which it claims payment under any plan or program established under Title V or Title XX of the Act.

Whereas “disclosing entity” is limited to Medicaid provider, “other disclosing entity” can include entities that are not enrolled in a Medicaid program.

List in the following table the name of each owner of you who has such interest and the name of other disclosing entity in which the owner has an ownership or control interest in:

Table 6:

Name of Owner	Name of Other Disclosing Entity
Mission Care Services, LLC	Mission Care of Missouri, LLC; Mission Care of Illinois, LLC

Please copy this page if additional space is needed.

Section 5: Managing Employees

Federal regulations require that Medicaid agencies require providers to submit information about managing employees. The term “managing employees” means a general manager, business manager, administrator, director, or other individuals who exercise operational or managerial control over, or who directly or indirectly conduct the day-to-day operation of an institution, organization, or agency. The term “managing employees” includes any “agent” of the provider, which would include any person who has been delegated the authority to obligate or act on behalf of the provider. All managing employees of the provider at any of the provider’s practice locations must be reported in this section.

Please provide the following information in the table below; the name of all managing employees, title, address, DOB, and SSN.

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Table 7:

Name	Title	Address	DOB	SSN
Matt McCormick	Vice President	Confidential & Not for Public Disclosure		
Enid Krasner	Director Business Development			
Chris Morris	Director Network Management			
George White	Director Business Integration			
Jade Warren	Director Public Transit Operations			

Please copy this page if additional space is needed. [This list continues on the following page 5a.](#)

Section 6: Final Adverse Actions

This section captures information on “Final Adverse Actions,” such as convictions, exclusions, revocations, and suspensions. All applicable final adverse actions must be reported, regardless of whether any records were expunged or any appeals are pending. Enrolled providers are required to report all Final Adverse Actions/Convictions within 30 days of the reportable event.

Final Adverse Actions That Must Be Reported:

Criminal Conduct:

The provider, supplier, or any owner of the provider or supplier must report any convictions of criminal offenses related to that person’s involvement in any program under Medicare, Medicaid, or Title XX service program since the inception of those programs. Criminal offenses include:

- Felony convictions, guilty pleas and adjudicated pre-trial diversions; financial crimes, such as extortion, embezzlement, income tax evasion, insurance fraud, and other similar crimes for which the individual was convicted, including guilty pleas and adjudicated pre-trial diversions; any felony that placed the Medicaid program or its beneficiaries at immediate risk (such as a malpractice suit that results in a conviction of criminal neglect or misconduct); and any felonies that would result in a mandatory exclusion under Section 1128(a) of the Social Security Act.
- Misdemeanor conviction, under federal or state law, related to: (1) the delivery of an item or service under Medicare or a state health care program, or (2) the abuse or neglect of a patient in connection with the delivery of a health care item or service.
- Misdemeanor conviction, under federal or state law, related to theft, fraud, embezzlement, breach of fiduciary duty, or other financial misconduct in connection with the delivery of a health care item or service.
- Felony or misdemeanor conviction, under federal or state law, relating to the interference with or obstruction of any investigation into any criminal offense described in 42 C.F.R. Section 1001.101 or 1001.201.
- Felony or misdemeanor conviction, under federal or state law, relating to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance.

CONFIDENTIAL

Table 7:

Name	Title	Address	DOB	SSN
Scott Anderson	Director Operations	Confidential & Not for Public Disclosure		
Tom Bowen	Director Customer Service			
Dan Cyr	Director Operations			
Rich Eberle	Director Operations			

Please copy this page if additional space is needed. [This list is a continuation from page 5.](#)

Section 6: Final Adverse Actions

This section captures information on “Final Adverse Actions,” such as convictions, exclusions, revocations, and suspensions. All applicable final adverse actions must be reported, regardless of whether any records were expunged or any appeals are pending. Enrolled providers are required to report all Final Adverse Actions/Convictions within 30 days of the reportable event.

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- Felony convictions, guilty pleas and adjudicated pre-trial diversions; financial crimes, such as extortion, embezzlement, income tax evasion, insurance fraud, and other similar crimes for which the individual was convicted, including guilty pleas and adjudicated pre-trial diversions; any felony that placed the Medicaid program or its beneficiaries at immediate risk (such as a malpractice suit that results in a conviction of criminal neglect or misconduct); and any felonies that would result in a mandatory exclusion under Section 1128(a) of the Social Security Act.
- Misdemeanor conviction, under federal or state law, related to: (1) the delivery of an item or service under Medicare or a state health care program, or (2) the abuse or neglect of a patient in connection with the delivery of a health care item or service.
- Misdemeanor conviction, under federal or state law, related to theft, fraud, embezzlement, breach of fiduciary duty, or other financial misconduct in connection with the delivery of a health care item or service.
- Felony or misdemeanor conviction, under federal or state law, relating to the interference with or obstruction of any investigation into any criminal offense described in 42 C.F.R. Section 1001.101 or 1001.201.
- Felony or misdemeanor conviction, under federal or state law, relating to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance.

Exclusions, Revocations, or Suspensions:

Providers must also report any:

- Revocation or suspension of a license to provide health care by any state licensing authority. This includes the surrender of such a license while a formal disciplinary proceeding was pending before a state licensing authority.
- Revocation or suspension of accreditation.
- Suspension or exclusion from participation in, or any sanction imposed by, a federal or state health care program, or any debarment from participation in any federal executive branch procurement or non-procurement program.
- Current Medicare or a state health care program payment suspension under any Medicare or a state health care program billing number.
- Medicare or a state health care program revocation of any Medicare or a state health care program billing number.

Final Adverse Action Reporting:

For all individuals or entities listed in any of the previous tables, as well as the provider submitting this application, provide all information required below for any individual or entity that has been the subject of a Final Adverse Action.

Have you, under any current or former name or business identity, ever had a final adverse action? Yes or No

Report each final adverse action, when it occurred, the federal or state agency or the court/administrative body that imposed the action, and attach the resolution, if any.

Table 8:

Organization or Person Name	Final Adverse Action Taken By	Date of Final Adverse Action

Please copy this page if additional space is needed.

Section 7: Patient Protection and Affordable Care Act

Please answer all five questions:

Does the provider applicant have any current or previous direct or indirect affiliation (as defined below) with a present or former Medicaid provider?

The term "affiliation" includes, but is not limited to, relationships between individuals, business entities, or a combination of the two. The term includes direct or indirect business relationships that involve:

1. a compensation arrangement,
2. an ownership arrangement,
3. managerial authority over either member of the affiliation,
4. the ability of one member of the affiliation to control the other, or
5. the ability of a third party to control both members of the affiliation.

1. For all individuals or entities listed in any of the previous tables, list all that have uncollected debt owed to Medicaid or any other health program funded by any governmental entity, including, but not limited to, the federal and Iowa governments or mark none.

None

Name:

2. For all individuals or entities listed in any of the previous tables, list all that have been or is subject to a payment suspension under a federally-funded health care program or mark none.

None

Name:

3. For all individuals or entities listed in any of the previous tables that have had its billing privileges denied or revoked or mark none.

None

Name:

Please copy this page if additional space is needed.

4. For all individuals or entities listed in any of the previous tables that have been excluded from participation under Medicaid, Medicare or any other federally-funded health care program or mark none.

None

Name:

5. For all individuals or entities listed in any of the previous tables that have shared a National Provider Identifier (NPI) number or Federal Tax Identification number with another provider who has uncollected debt or mark none.

None

Name:

Please copy this page if additional space is needed.

The provider certifies that the information submitted on this form is, to the best of the provider's knowledge, true, accurate, and complete and that the provider has read this entire form before signing. The provider also understands that payment of claims will be from federal and state funds and that any falsification or concealment of a material fact may be prosecuted under federal and state law.

Printed Name of Legal Entity Signatory Steven G. Murphy, President	
Signature of Authorized Signatory 	Date May 8, 2015



Iowa Department of Human Services

Iowa Medicaid Ownership and Control Disclosure

Provider Name AmeriHealth Caritas Iowa, Inc.	Federal Tax ID or SSN 45-3923267
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Pursuant to 42 C.F.R. sections 455.104 through 455.106, providers applying for Medicaid must disclose certain information about those who have a sufficient ownership interest in the provider as well as those who act as managers or agents of the provider. The following series of questions seeks the necessary information to comply with these regulations.

It is the provider's responsibility to ensure all information is accurate and to report any changes immediately by completing a new Ownership and Disclosure form. See Section 1.6 and Section 3 of the Provider Agreement. Only one form is required per Tax Identification Number (TIN) or Social Security Number (SSN).

In the questions that follow, the provider listed above is referred to as "You" or "Your."

Section 1: Provider Type

Are you an individual practitioner or a group of practitioners?

Individual Practitioner: Yes or No

Group of Individual Practitioners Yes or No

If you answered "Yes" and you are an individual practitioner or a group of individual practitioners, please skip to Section 5. The ownership disclosure requirements do not apply to these entities that generally do not have owners, such as individual practitioner or groups of practitioners.

If you answered "No" because your entity is some form of business other than an individual practitioner or a group of practitioners, please complete all sections.

Section 2: Ownership

Individual Ownership

Please list in the following table all **individuals** with an ownership or control interest in you. Include each person's name, address, date of birth (DOB), and SSN, title (e.g., chief executive officer, owner, board member, etc.) and if an owner, the percent of ownership.

"Persons with an ownership or control interest" means:

- has an ownership interest totaling five percent or more in you;
- has an indirect ownership interest equal to five percent or more in you;
- has a combination of direct and indirect ownership interest equal to five percent or more in you;
- owns an interest of five percent or more in any mortgage, deed of trust note, or other obligation secured by the disclosing entity if that interest equals at least five percent of the value of the property or assets of you;
- is an officer or director of your organization if you are organized as a corporation; or
- is a partner in your organization if organized as a partnership.

Table 1: Individual Owners

Name of Individual	Title	Ownership Percentage (if applicable)	Address	Date of Birth	Social Security Number
Russell Gianforcaro	Director; President	0%	Confidential & Not for Public Disclosure		
James Michael Jernigan	Director	0%			
Steven H. Bohner	Director; VP & Treasurer	0%			
Robert H. Gilman	VP & Secretary	0%			

Non-individual Ownership

Please list all corporations or other form of business entity with an ownership or control interest in you. Include the TIN, the percent of ownership, the primary address, all business locations, and the P.O. Box address.

A corporation or other form of business entity is deemed to have an ownership or control interest in you if it:

- a) has an ownership interest totaling five percent or more in you;
- b) has an indirect ownership interest equal to five percent or more in you;
- c) has a combination of direct and indirect ownership interest equal to five percent or more in you;
- d) owns an interest of five percent or more in any mortgage, deed of trust note, or other obligation secured by you if that interest equals at least five percent of the value of the property or assets of you;
- e) is an officer or director of you if organized as a corporation; or
- f) is a partner in you if organized as a partnership.

Table 2: Non-individual Owners

Name of Business Entity	TIN	Ownership Percentage	Primary Business Address	All Business Addresses	All P.O. Box Addresses
AmeriHealth Caritas Health Plan	23-2859523	100% (direct)	200 Stevens Dr., Philadelphia, PA 19113	8040 Carlisle Rd., Harrisburg, PA 17112	
BMH Subco I LLC	38-36946080	50% (indirect)	200 Stevens Dr., Philadelphia, PA 19113		
BMH Subco II LLC	80-0768643	50% (indirect)	200 Stevens Dr., Philadelphia, PA 19113		
BMH LLC	30-0703311	100% (indirect)	200 Stevens Dr., Philadelphia, PA 19113		

Please copy this page if additional space is needed.

Your Ownership of Subcontractors

Please list all subcontractors in which you have an ownership interest of five percent or more. Include the TIN or SSN, the percent of ownership, the primary address, all business locations, and all P.O. Box addresses.

Table 3: Subcontractors

Name of Subcontractor	TIN/SSN	Ownership Percentage	Primary Business Address	All Business Addresses	All P.O. Box Addresses
N/A					

Section 3: Individual Relationships

If you listed in Table 1 any individual owners of you, are any of the individual owners related to each other as a spouse, parent, child or sibling? Yes or No

If you answered Yes, please provide all of the following information about each individual owner in the table below.

Table 4:

Social Security Number	Person Name	Relationship	Date of Birth

If you listed in Table 1 any individual owners of you and also listed in Table 3 subcontractors in which you have an ownership interest, are any of the individual owners listed in Table 1 related to any owner of any subcontractors listed in Table 3 as a spouse, parent, child or sibling?

Yes or No

If you answered Yes, please provide all of the following information about each individual owner in the following table.

Table 5:

Social Security Number	Person Name	Relationship	Date of Birth

Please copy this page if additional space is needed.

Section 4: Other Disclosing Entities

Do any owners of you have an ownership or control interest in any “other disclosing entity”? This question is asking if any of your owners have an ownership or control interest in any other organization that would qualify as a “disclosing entity.” “Other disclosing entity” means any other Medicaid disclosing entity and any entity that does not participate in Medicaid, but is required to disclose certain ownership and control information because of participation in any of the programs established under Title V, XVIII or XX or the Act. This includes:

- a) Any hospital, skilled nursing facility, home health agency, independent clinical laboratory, renal disease facility, rural health clinic, or health maintenance organization that participates in Medicare (Title XVIII);
- b) Any Medicare intermediary or carrier; and
- c) Any entity (other than an individual practitioner or group of practitioners) that furnishes, or arranges for the furnishing of, health-related services for which it claims payment under any plan or program established under Title V or Title XX of the Act.

Whereas “disclosing entity” is limited to Medicaid provider, “other disclosing entity” can include entities that are not enrolled in a Medicaid program.

List in the following table the name of each owner of you who has such interest and the name of other disclosing entity in which the owner has an ownership or control interest in:

Table 6:

Name of Owner	Name of Other Disclosing Entity
Mission Care Services, LLC	Mission Care of Missouri, LLC; Mission Care of Illinois, LLC

Please copy this page if additional space is needed.

Section 5: Managing Employees

Federal regulations require that Medicaid agencies require providers to submit information about managing employees. The term “managing employees” means a general manager, business manager, administrator, director, or other individuals who exercise operational or managerial control over, or who directly or indirectly conduct the day-to-day operation of an institution, organization, or agency. The term “managing employees” includes any “agent” of the provider, which would include any person who has been delegated the authority to obligate or act on behalf of the provider. All managing employees of the provider at any of the provider’s practice locations must be reported in this section.

Please provide the following information in the table below; the name of all managing employees, title, address, DOB, and SSN.

CONFIDENTIAL

Table 7:

Name	Title	Address	DOB	SSN
Matt McCormick	Vice President	Confidential & Not for Public Disclosure		
Enid Krasner	Director Business Development			
Chris Morris	Director Network Management			
George White	Director Business Integration			
Jade Warren	Director Public Transit Operations			

Please copy this page if additional space is needed. [This list continues on the following page 5a.](#)

Section 6: Final Adverse Actions

This section captures information on “Final Adverse Actions,” such as convictions, exclusions, revocations, and suspensions. All applicable final adverse actions must be reported, regardless of whether any records were expunged or any appeals are pending. Enrolled providers are required to report all Final Adverse Actions/Convictions within 30 days of the reportable event.

Final Adverse Actions That Must Be Reported:

Criminal Conduct:

The provider, supplier, or any owner of the provider or supplier must report any convictions of criminal offenses related to that person’s involvement in any program under Medicare, Medicaid, or Title XX service program since the inception of those programs. Criminal offenses include:

- Felony convictions, guilty pleas and adjudicated pre-trial diversions; financial crimes, such as extortion, embezzlement, income tax evasion, insurance fraud, and other similar crimes for which the individual was convicted, including guilty pleas and adjudicated pre-trial diversions; any felony that placed the Medicaid program or its beneficiaries at immediate risk (such as a malpractice suit that results in a conviction of criminal neglect or misconduct); and any felonies that would result in a mandatory exclusion under Section 1128(a) of the Social Security Act.
- Misdemeanor conviction, under federal or state law, related to: (1) the delivery of an item or service under Medicare or a state health care program, or (2) the abuse or neglect of a patient in connection with the delivery of a health care item or service.
- Misdemeanor conviction, under federal or state law, related to theft, fraud, embezzlement, breach of fiduciary duty, or other financial misconduct in connection with the delivery of a health care item or service.
- Felony or misdemeanor conviction, under federal or state law, relating to the interference with or obstruction of any investigation into any criminal offense described in 42 C.F.R. Section 1001.101 or 1001.201.
- Felony or misdemeanor conviction, under federal or state law, relating to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance.

CONFIDENTIAL

Table 7:

Name	Title	Address	DOB	SSN
Scott Anderson	Director Operations	Confidential & Not for Public Disclosure		
Tom Bowen	Director Customer Service			
Dan Cyr	Director Operations			
Rich Eberle	Director Operations			

Please copy this page if additional space is needed. [This list is a continuation from page 5.](#)

Section 6: Final Adverse Actions

This section captures information on “Final Adverse Actions,” such as convictions, exclusions, revocations, and suspensions. All applicable final adverse actions must be reported, regardless of whether any records were expunged or any appeals are pending. Enrolled providers are required to report all Final Adverse Actions/Convictions within 30 days of the reportable event.

Final Adverse Actions That Must Be Reported:

Criminal Conduct:

The provider, supplier, or any owner of the provider or supplier must report any convictions of criminal offenses related to that person’s involvement in any program under Medicare, Medicaid, or Title XX service program since the inception of those programs. Criminal offenses include:

- Felony convictions, guilty pleas and adjudicated pre-trial diversions; financial crimes, such as extortion, embezzlement, income tax evasion, insurance fraud, and other similar crimes for which the individual was convicted, including guilty pleas and adjudicated pre-trial diversions; any felony that placed the Medicaid program or its beneficiaries at immediate risk (such as a malpractice suit that results in a conviction of criminal neglect or misconduct); and any felonies that would result in a mandatory exclusion under Section 1128(a) of the Social Security Act.
- Misdemeanor conviction, under federal or state law, related to: (1) the delivery of an item or service under Medicare or a state health care program, or (2) the abuse or neglect of a patient in connection with the delivery of a health care item or service.
- Misdemeanor conviction, under federal or state law, related to theft, fraud, embezzlement, breach of fiduciary duty, or other financial misconduct in connection with the delivery of a health care item or service.
- Felony or misdemeanor conviction, under federal or state law, relating to the interference with or obstruction of any investigation into any criminal offense described in 42 C.F.R. Section 1001.101 or 1001.201.
- Felony or misdemeanor conviction, under federal or state law, relating to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance.

Exclusions, Revocations, or Suspensions:

Providers must also report any:

- Revocation or suspension of a license to provide health care by any state licensing authority. This includes the surrender of such a license while a formal disciplinary proceeding was pending before a state licensing authority.
- Revocation or suspension of accreditation.
- Suspension or exclusion from participation in, or any sanction imposed by, a federal or state health care program, or any debarment from participation in any federal executive branch procurement or non-procurement program.
- Current Medicare or a state health care program payment suspension under any Medicare or a state health care program billing number.
- Medicare or a state health care program revocation of any Medicare or a state health care program billing number.

Final Adverse Action Reporting:

For all individuals or entities listed in any of the previous tables, as well as the provider submitting this application, provide all information required below for any individual or entity that has been the subject of a Final Adverse Action.

Have you, under any current or former name or business identity, ever had a final adverse action? Yes or No

Report each final adverse action, when it occurred, the federal or state agency or the court/administrative body that imposed the action, and attach the resolution, if any.

Table 8:

Organization or Person Name	Final Adverse Action Taken By	Date of Final Adverse Action

Please copy this page if additional space is needed.

Section 7: Patient Protection and Affordable Care Act

Please answer all five questions:

Does the provider applicant have any current or previous direct or indirect affiliation (as defined below) with a present or former Medicaid provider?

The term "affiliation" includes, but is not limited to, relationships between individuals, business entities, or a combination of the two. The term includes direct or indirect business relationships that involve:

1. a compensation arrangement,
2. an ownership arrangement,
3. managerial authority over either member of the affiliation,
4. the ability of one member of the affiliation to control the other, or
5. the ability of a third party to control both members of the affiliation.

1. For all individuals or entities listed in any of the previous tables, list all that have uncollected debt owed to Medicaid or any other health program funded by any governmental entity, including, but not limited to, the federal and Iowa governments or mark none.

None

Name:

2. For all individuals or entities listed in any of the previous tables, list all that have been or is subject to a payment suspension under a federally-funded health care program or mark none.

None

Name:

3. For all individuals or entities listed in any of the previous tables that have had its billing privileges denied or revoked or mark none.

None

Name:

Please copy this page if additional space is needed.

4. For all individuals or entities listed in any of the previous tables that have been excluded from participation under Medicaid, Medicare or any other federally-funded health care program or mark none.

None

Name:

5. For all individuals or entities listed in any of the previous tables that have shared a National Provider Identifier (NPI) number or Federal Tax Identification number with another provider who has uncollected debt or mark none.

None

Name:

Please copy this page if additional space is needed.

The provider certifies that the information submitted on this form is, to the best of the provider's knowledge, true, accurate, and complete and that the provider has read this entire form before signing. The provider also understands that payment of claims will be from federal and state funds and that any falsification or concealment of a material fact may be prosecuted under federal and state law.

Printed Name of Legal Entity Signatory Steven G. Murphy, President	
Signature of Authorized Signatory 	Date May 8, 2015

Exhibit C: Subcontractor Disclosure Form

(Return this completed form behind Tab 3 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"):	AmeriHealth Caritas Iowa, Inc.
Subcontractor Contact Information (individual who can address issues re: this RFP)	
Name:	Mary Pat Sherry
Address:	AmeriHealth Caritas, 200 Stevens Dr., Philadelphia, PA, 19113
Tel:	(215) 937-8756
Fax:	(215) 937-5344
E-mail:	msherry@amerihealthcaritas.com

Subcontractor Detail	
Subcontractor Legal Name ("Subcontractor"):	AmeriHealth Caritas Services, LLC
"Doing Business As" names, assumed names, or other operating names:	N/A
Form of Business Entity (i.e., corp., partnership, LLC, etc.)	Limited liability company
State of Incorporation/organization:	DE
Primary Address:	200 Stevens Dr. Philadelphia, PA 19113
Tel:	(215) 937-8000
Fax:	N/A
Local Address (if any):	N/A
Addresses of Major Offices and other facilities that may contribute to performance under this RFP/Contract:	200 Stevens Dr. Philadelphia, PA 19113
Number of Employees:	4,500
Number of Years in Business:	AmeriHealth Caritas Services has been in existence since 2012. It is part of a family of companies that has been in business since 1996.
Primary Focus of Business:	Managed care management & administrative services
Federal Tax ID:	45-5415725
Subcontractor's Accounting Firm:	KPMG
If Subcontractor is currently registered to do business in Iowa, provide the Date of Registration:	N/A – business registration is in process.
Percentage of Total Work to be performed by this Subcontractor pursuant to this RFP/Contract.	Based upon the State capitation rates released on April 23, 2015, AmeriHealth Caritas Services' compensation for services furnished under its subcontract with AmeriHealth Caritas Iowa is estimated to be approximately 4.5% of AmeriHealth Caritas Iowa's anticipated capitation payment from DHS.

General Scope of Work to be performed by this Subcontractor

AmeriHealth Caritas Services (ACS) will provide comprehensive management and administrative services to AmeriHealth Caritas Iowa in the operation of its managed care plan.

Detail the Subcontractor's qualifications for performing this scope of work

AmeriHealth Caritas Services (ACS) was formed in 2012 in order to provide staffing and management & administrative services to companies within the AmeriHealth Caritas Family of Companies ("AmeriHealth Caritas"). AmeriHealth Caritas is an enterprise of managed care and related organizations that has been providing services under the Medicaid and Medicare programs since its inception in 1983. Over the years, AmeriHealth Caritas has developed significant experience in providing Medicaid managed care services, and has developed the systems and infrastructure necessary to support the Iowa High Quality Healthcare Initiative.

From our roots as a small managed care organization serving low-income residents of West Philadelphia, AmeriHealth Caritas has grown to become an industry leader with over 4,500 employees. Providing health care coverage and services to more than 6 million members nationwide, our partnerships and commitment to excellence ensure that our members have the best possible health outcomes through an integrated, cost-effective approach that coordinates physical health, behavioral health and pharmacy benefits. For decades, AmeriHealth Caritas has provided managed care to Medicaid recipients and other low-income populations throughout the country. This longstanding experience includes managing health care service delivery for TANF, dual eligible, and ABD populations, under programs that include Medicaid risk and non-risk, Medicare Advantage Dual-Eligible Special Needs Plans (D-SNPs), Medicare Part D, Medicaid risk and non-risk Behavioral Health Organizations (BHOs), Medicaid/Medicare Dual Eligible demonstrations, and State Children's Health Insurance Programs (SCHIP).

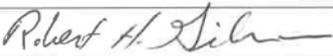
ACS is currently in the process of registering to conduct business in Iowa, including securing its TPA certification as required under Iowa Code Chapter 510.

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:	Robert H. Gilman, Vice President & Secretary
Date:	May 11, 2015



Iowa Department of Human Services

Iowa Medicaid Ownership and Control Disclosure

Provider Name AmeriHealth Caritas Iowa, Inc.	Federal Tax ID or SSN 45-3923267
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Pursuant to 42 C.F.R. sections 455.104 through 455.106, providers applying for Medicaid must disclose certain information about those who have a sufficient ownership interest in the provider as well as those who act as managers or agents of the provider. The following series of questions seeks the necessary information to comply with these regulations.

It is the provider's responsibility to ensure all information is accurate and to report any changes immediately by completing a new Ownership and Disclosure form. See Section 1.6 and Section 3 of the Provider Agreement. Only one form is required per Tax Identification Number (TIN) or Social Security Number (SSN).

In the questions that follow, the provider listed above is referred to as "You" or "Your."

Section 1: Provider Type

Are you an individual practitioner or a group of practitioners?

Individual Practitioner: Yes or No

Group of Individual Practitioners Yes or No

If you answered "Yes" and you are an individual practitioner or a group of individual practitioners, please skip to Section 5. The ownership disclosure requirements do not apply to these entities that generally do not have owners, such as individual practitioner or groups of practitioners.

If you answered "No" because your entity is some form of business other than an individual practitioner or a group of practitioners, please complete all sections.

Section 2: Ownership

Individual Ownership

Please list in the following table all **individuals** with an ownership or control interest in you. Include each person's name, address, date of birth (DOB), and SSN, title (e.g., chief executive office, owner, board member, etc.) and if an owner, the percent of ownership.

"Persons with an ownership or control interest" means:

- a) has an ownership interest totaling five percent or more in you;
- b) has an indirect ownership interest equal to five percent or more in you;
- c) has a combination of direct and indirect ownership interest equal to five percent or more in you;
- d) owns an interest of five percent or more in any mortgage, deed of trust note, or other obligation secured by the disclosing entity if that interest equals at least five percent of the value of the property or assets of you;
- e) is an officer or director of your organization if you are organized as a corporation; or
- f) is a partner in your organization if organized as a partnership.

Table 1: Individual Owners

Name of Individual	Title	Ownership Percentage (if applicable)	Address	Date of Birth	Social Security Number
Russell Gianforcaro	Director; President	0%	Confidential & Not for Public Disclosure		
James Michael Jernigan	Director	0%			
Steven H. Bohner	Director; VP & Treasurer	0%			
Robert H. Gilman	VP & Secretary	0%			

Non-individual Ownership

Please list all corporations or other form of business entity with an ownership or control interest in you. Include the TIN, the percent of ownership, the primary address, all business locations, and the P.O. Box address.

A corporation or other form of business entity is deemed to have an ownership or control interest in you if it:

- a) has an ownership interest totaling five percent or more in you;
- b) has an indirect ownership interest equal to five percent or more in you;
- c) has a combination of direct and indirect ownership interest equal to five percent or more in you;
- d) owns an interest of five percent or more in any mortgage, deed of trust note, or other obligation secured by you if that interest equals at least five percent of the value of the property or assets of you;
- e) is an officer or director of you if organized as a corporation; or
- f) is a partner in you if organized as a partnership.

Table 2: Non-individual Owners

Name of Business Entity	TIN	Ownership Percentage	Primary Business Address	All Business Addresses	All P.O. Box Addresses
AmeriHealth Caritas Health Plan	23-2859523	100% (direct)	200 Stevens Dr., Philadelphia, PA 19113	8040 Carlson Rd., Harrisburg, PA 17112	
BMH Subco I LLC	38-36946080	50% (indirect)	200 Stevens Dr., Philadelphia, PA 19113		
BMH Subco II LLC	80-0768643	50% (indirect)	200 Stevens Dr., Philadelphia, PA 19113		
BMH LLC	30-0703311	100% (indirect)	200 Stevens Dr., Philadelphia, PA 19113		

Please copy this page if additional space is needed.

Your Ownership of Subcontractors

Please list all subcontractors in which you have an ownership interest of five percent or more. Include the TIN or SSN, the percent of ownership, the primary address, all business locations, and all P.O. Box addresses.

Table 1: Individual Owners

Name of Individual	Title	Ownership Percentage (if applicable)	Address	Date of Birth	Social Security Number

Non-individual Ownership

Please list all corporations or other form of business entity with an ownership or control interest in you. Include the TIN, the percent of ownership, the primary address, all business locations, and the P.O. Box address.

A corporation or other form of business entity is deemed to have an ownership or control interest in you if it:

- a) has an ownership interest totaling five percent or more in you;
- b) has an indirect ownership interest equal to five percent or more in you;
- c) has a combination of direct and indirect ownership interest equal to five percent or more in you;
- d) owns an interest of five percent or more in any mortgage, deed of trust note, or other obligation secured by you if that interest equals at least five percent of the value of the property or assets of you;
- e) is an officer or director of you if organized as a corporation; or
- f) is a partner in you if organized as a partnership.

Table 2: Non-individual Owners

Name of Business Entity	TIN	Ownership Percentage	Primary Business Address	All Business Addresses	All P.O. Box Addresses
Blue Cross Blue Shield of Michigan	38-2069753	38.7% (indirect)	800 E. Lafayette Blvd., Detroit, MI 48226		
IBC MH LLC	45-3672640	61.3% (indirect)	1901 Market St., Philadelphia, PA 19103		
AmeriHealth, Inc.	23-2425461	58.2% (indirect)	1901 Market St., Philadelphia, PA 19103		
Independence Health Group, Inc.	47-1233198	61.3% (indirect)	1901 Market St., Philadelphia, PA 19103		

Please copy this page if additional space is needed.

Your Ownership of Subcontractors

Please list all subcontractors in which you have an ownership interest of five percent or more. Include the TIN or SSN, the percent of ownership, the primary address, all business locations, and all P.O. Box addresses.

Table 3: Subcontractors

Name of Subcontractor	TIN/SSN	Ownership Percentage	Primary Business Address	All Business Addresses	All P.O. Box Addresses
None					

Section 3: Individual Relationships

If you listed in Table 1 any individual owners of you, are any of the individual owners related to each other as a spouse, parent, child or sibling? Yes or No

If you answered Yes, please provide all of the following information about each individual owner in the table below.

Table 4:

Social Security Number	Person Name	Relationship	Date of Birth
N/A			

If you listed in Table 1 any individual owners of you and also listed in Table 3 subcontractors in which you have an ownership interest, are any of the individual owners listed in Table 1 related to any owner of any subcontractors listed in Table 3 as a spouse, parent, child or sibling?

Yes or No

If you answered Yes, please provide all of the following information about each individual owner in the following table.

Table 5:

Social Security Number	Person Name	Relationship	Date of Birth
N/A			

Please copy this page if additional space is needed.

Section 4: Other Disclosing Entities

Do any owners of you have an ownership or control interest in any "other disclosing entity"? This question is asking if any of your owners have an ownership or control interest in any other organization that would qualify as a "disclosing entity." "Other disclosing entity" means any other Medicaid disclosing entity and any entity that does not participate in Medicaid, but is required to disclose certain ownership and control information because of participation in any of the programs established under Title V, XVIII or XX or the Act. This includes:

- a) Any hospital, skilled nursing facility, home health agency, independent clinical laboratory, renal disease facility, rural health clinic, or health maintenance organization that participates in Medicare (Title XVIII);
- b) Any Medicare intermediary or carrier; and
- c) Any entity (other than an individual practitioner or group of practitioners) that furnishes, or arranges for the furnishing of, health-related services for which it claims payment under any plan or program established under Title V or Title XX of the Act.

Whereas "disclosing entity" is limited to Medicaid provider, "other disclosing entity" can include entities that are not enrolled in a Medicaid program.

List in the following table the name of each owner of you who has such interest and the name of other disclosing entity in which the owner has an ownership or control interest in:

Table 6:

Name of Owner	Name of Other Disclosing Entity
See Attached	

Please copy this page if additional space is needed.

Section 5: Managing Employees

Federal regulations require that Medicaid agencies require providers to submit information about managing employees. The term "managing employees" means a general manager, business manager, administrator, director, or other individuals who exercise operational or managerial control over, or who directly or indirectly conduct the day-to-day operation of an institution, organization, or agency. The term "managing employees" includes any "agent" of the provider, which would include any person who has been delegated the authority to obligate or act on behalf of the provider. All managing employees of the provider at any of the provider's practice locations must be reported in this section.

Please provide the following information in the table below; the name of all managing employees, title, address, DOB, and SSN.

**AmeriHealth Caritas Iowa, Inc.
 Iowa Medicaid Ownership and Disclosure**

Table 6 (Other Disclosing Entities)

Name of Owner	Name of Other Disclosing Entity
AmeriHealth Caritas Health Plan	AmeriHealth Caritas Louisiana, Inc.
	Florida True Health, Inc.
	AmeriHealth Nebraska, Inc.
	AmeriHealth Michigan, Inc.
	Select Health of South Carolina, Inc.
	AmeriHealth District of Columbia, Inc.
	Prestige Health Choice, L.L.C.
	PerformSpecialty, LLC
Blue Cross Blue Shield of Michigan	Blue Care Network of Michigan
	Blue Cross Complete of Michigan
IBC MH LLC	Vista Health Plan, Inc. (including CMS contract H4227)
AmeriHealth, Inc.	AmeriHealth HMO, Inc.
	Keystone Health Plan East, Inc.

Table 7:

Name	Title	Address	DOB	SSN
See Table 1				
(No other managing employees at this time)				

Please copy this page if additional space is needed.

Section 6: Final Adverse Actions

This section captures information on "Final Adverse Actions," such as convictions, exclusions, revocations, and suspensions. All applicable final adverse actions must be reported, regardless of whether any records were expunged or any appeals are pending. Enrolled providers are required to report all Final Adverse Actions/Convictions within 30 days of the reportable event.

Final Adverse Actions That Must Be Reported:

Criminal Conduct:

The provider, supplier, or any owner of the provider or supplier must report any convictions of criminal offenses related to that person's involvement in any program under Medicare, Medicaid, or Title XX service program since the inception of those programs. Criminal offenses include:

- Felony convictions, guilty pleas and adjudicated pre-trial diversions; financial crimes, such as extortion, embezzlement, income tax evasion, insurance fraud, and other similar crimes for which the individual was convicted, including guilty pleas and adjudicated pre-trial diversions; any felony that placed the Medicaid program or its beneficiaries at immediate risk (such as a malpractice suit that results in a conviction of criminal neglect or misconduct); and any felonies that would result in a mandatory exclusion under Section 1128(a) of the Social Security Act.
- Misdemeanor conviction, under federal or state law, related to: (1) the delivery of an item or service under Medicare or a state health care program, or (2) the abuse or neglect of a patient in connection with the delivery of a health care item or service.
- Misdemeanor conviction, under federal or state law, related to theft, fraud, embezzlement, breach of fiduciary duty, or other financial misconduct in connection with the delivery of a health care item or service.
- Felony or misdemeanor conviction, under federal or state law, relating to the interference with or obstruction of any investigation into any criminal offense described in 42 C.F.R. Section 1001.101 or 1001.201.
- Felony or misdemeanor conviction, under federal or state law, relating to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance.

Exclusions, Revocations, or Suspensions:

Providers must also report any:

- Revocation or suspension of a license to provide health care by any state licensing authority. This includes the surrender of such a license while a formal disciplinary proceeding was pending before a state licensing authority.
- Revocation or suspension of accreditation.
- Suspension or exclusion from participation in, or any sanction imposed by, a federal or state health care program, or any debarment from participation in any federal executive branch procurement or non-procurement program.
- Current Medicare or a state health care program payment suspension under any Medicare or a state health care program billing number.
- Medicare or a state health care program revocation of any Medicare or a state health care program billing number.

Final Adverse Action Reporting:

For all individuals or entities listed in any of the previous tables, as well as the provider submitting this application, provide all information required below for any individual or entity that has been the subject of a Final Adverse Action.

Have you, under any current or former name or business identity, ever had a final adverse action? Yes or No

Report each final adverse action, when it occurred, the federal or state agency or the court/administrative body that imposed the action, and attach the resolution, if any.

Table 8:

Organization or Person Name	Final Adverse Action Taken By	Date of Final Adverse Action

Please copy this page if additional space is needed.

Section 7: Patient Protection and Affordable Care Act

Please answer all five questions:

Does the provider applicant have any current or previous direct or indirect affiliation (as defined below) with a present or former Medicaid provider?

The term "affiliation" includes, but is not limited to, relationships between individuals, business entities, or a combination of the two. The term includes direct or indirect business relationships that involve:

1. a compensation arrangement,
2. an ownership arrangement,
3. managerial authority over either member of the affiliation,
4. the ability of one member of the affiliation to control the other, or
5. the ability of a third party to control both members of the affiliation.

1. For all individuals or entities listed in any of the previous tables, list all that have uncollected debt owed to Medicaid or any other health program funded by any governmental entity, including, but not limited to, the federal and Iowa governments or mark none.

None

Name:

2. For all individuals or entities listed in any of the previous tables, list all that have been or is subject to a payment suspension under a federally-funded health care program or mark none.

None

Name:

3. For all individuals or entities listed in any of the previous tables that have had its billing privileges denied or revoked or mark none.

None

Name:

Please copy this page if additional space is needed.

4. For all individuals or entities listed in any of the previous tables that have been excluded from participation under Medicaid, Medicare or any other federally-funded health care program or mark none.

None

Name:

5. For all individuals or entities listed in any of the previous tables that have shared a National Provider Identifier (NPI) number or Federal Tax Identification number with another provider who has uncollected debt or mark none.

None

Name:

Please copy this page if additional space is needed.

The provider certifies that the information submitted on this form is, to the best of the provider's knowledge, true, accurate, and complete and that the provider has read this entire form before signing. The provider also understands that payment of claims will be from federal and state funds and that any falsification of concealment of a material fact may be prosecuted under federal and state law.

Printed Name of Legal Entity Signatory Robert H. Gilman	
Signature of Authorized Signatory <i>Robert H. Gilman</i>	Date <i>5/8/15</i>

MED-16-009
Iowa High Quality Healthcare Initiative

Exhibit C: Subcontractor Disclosure Form

(Return this completed form behind Tab 3 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"):	Avesis Third Party Administrators, Inc.
Subcontractor Contact Information (individual who can address issues re: this RFP)	
Name:	Joshua Cohn
Address:	10324 S Dolfield Rd, Owings Mills MD 21117
Tel:	(800) 643-1132, ext. 12410
Fax:	(410) 654-1145
E-mail:	jcohn@avesis.com

Subcontractor Detail	
Subcontractor Legal Name ("Subcontractor"):	Avesis Third Party Administrators, Inc.
"Doing Business As" names, assumed names, or other operating names:	NA
Form of Business Entity (i.e., corp., partnership, LLC, etc.):	corporation
State of Incorporation/organization:	Arizona
Primary Address:	10324 S Dolfield Rd, Owings Mills MD
Tel:	(800) 643-1132 ext. 12410 21117
Fax:	(410) 654-1145
Local Address (if any):	NA
Addresses of Major Offices and other facilities that may contribute to performance under this RFP/Contract:	Please see attached.
Number of Employees:	Avesis Incorporated: 384
Number of Years in Business:	15
Primary Focus of Business:	eye care, dental and hearing programs
Federal Tax ID:	86-0986927
Subcontractor's Accounting Firm:	KPMG
If Subcontractor is currently registered to do business in Iowa, provide the Date of Registration:	3/1/2002
Percentage of Total Work to be performed by this Subcontractor pursuant to this RFP/Contract.	100%
General Scope of Work to be performed by this Subcontractor	
Please see attached.	
Detail the Subcontractor's qualifications for performing this scope of work	
Please see attached.	

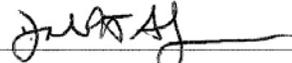
MED-16-009
Iowa High Quality Healthcare Initiative

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:	Joel H. Alperstein President
Date:	3/27/2015

AVESIS THIRD PARTY ADMINISTRATORS, INC.
Additional Information to Exhibit C: Subcontractor Disclosure Form

OFFICE ADDRESSES

In addition to the primary office location in Owings Mills, Maryland, services are provided at the facilities noted below:

CLAIMS DEPARTMENT

3030 North Central Avenue, Suite 300
Phoenix, Arizona 85012

CALL CENTER

4451 East Oak Street
Phoenix, Arizona 85008

UTILIZATION REVIEW/UTILIZATION MANAGEMENT

2300 Lake Park Drive SE
Smyrna, Georgia 30080

NUMBER OF EMPLOYEES

Avesis Third Party Administrators, Inc. is a wholly owned subsidiary of Avesis Incorporated. Avesis Incorporated, in business since 1978, employs 100% of the personnel involved with all aspects of our program administration services.

SCOPE OF WORK TO BE PERFORMED

As the third party administrator for AmeriHealth for the Iowa Medicaid eye care program, Avesis Third Party Administrators, Inc. will provide comprehensive eye care program administration services including but not limited to: claims processing, adjudication and payment; customer service for members, providers, and the health plan; network development and management; provider contracting; credentialing; utilization review/utilization management; provider appeals; quality assurance; encounter submissions; and reporting.

QUALIFICATIONS FOR PERFORMING THE SCOPE OF WORK

Avesis Third Party Administrators, Inc. has been providing administration services for managed eye care, dental and hearing care programs since 2000. Today, our programs cover nearly 8.5 million members. We have extensive experience working with government-sponsored programs throughout the country. Furthermore, we have been working with AmeriHealth in several other markets. This experience makes us uniquely qualified as we understand and have addressed the various special requirements that AmeriHealth may have for their programs and appreciate the importance of doing everything possible to ensure that the members are 100% satisfied with the services that are provided.



Iowa Department of Human Services

Iowa Medicaid Ownership and Control Disclosure

Provider Name Avesis Third Party Administrators, Inc.	Federal Tax ID or SSN 86-0986927
--	-------------------------------------

Pursuant to 42 C.F.R. sections 455.104 through 455.106, providers applying for Medicaid must disclose certain information about those who have a sufficient ownership interest in the provider as well as those who act as managers or agents of the provider. The following series of questions seeks the necessary information to comply with these regulations.

It is the provider's responsibility to ensure all information is accurate and to report any changes immediately by completing a new Ownership and Disclosure form. See Section 1.6 and Section 3 of the Provider Agreement. Only one form is required per Tax Identification Number (TIN) or Social Security Number (SSN).

In the questions that follow, the provider listed above is referred to as "You" or "Your."

Section 1: Provider Type

Are you an individual practitioner or a group of practitioners?

Individual Practitioner: Yes or No

Group of Individual Practitioners Yes or No

If you answered "Yes" and you are an individual practitioner or a group of individual practitioners, please skip to Section 5. The ownership disclosure requirements do not apply to these entities that generally do not have owners, such as individual practitioner or groups of practitioners.

If you answered "No" because your entity is some form of business other than an individual practitioner or a group of practitioners, please complete all sections.

Section 2: Ownership

Individual Ownership

Please list in the following table all **individuals** with an ownership or control interest in you. Include each person's name, address, date of birth (DOB), and SSN, title (e.g., chief executive office, owner, board member, etc.) and if an owner, the percent of ownership.

"Persons with an ownership or control interest" means:

- has an ownership interest totaling five percent or more in you;
- has an indirect ownership interest equal to five percent or more in you;
- has a combination of direct and indirect ownership interest equal to five percent or more in you;
- owns an interest of five percent or more in any mortgage, deed of trust note, or other obligation secured by the disclosing entity if that interest equals at least five percent of the value of the property or assets of you;
- is an officer or director of your organization if you are organized as a corporation; or
- is a partner in your organization if organized as a partnership.

Table 1: Individual Owners

Name of Individual	Title	Ownership Percentage (if applicable)	Address	Date of Birth	Social Security Number
Joel H. Alperstein	Pres/Treas	NA	Confidential & Not for Public Disclosure		
Michael P. Reamer	Secretary	NA			

Non-individual Ownership

Please list all corporations or other form of business entity with an ownership or control interest in you. Include the TIN, the percent of ownership, the primary address, all business locations, and the P.O. Box address.

A corporation or other form of business entity is deemed to have an ownership or control interest in you if it:

- a) has an ownership interest totaling five percent or more in you;
- b) has an indirect ownership interest equal to five percent or more in you;
- c) has a combination of direct and indirect ownership interest equal to five percent or more in you;
- d) owns an interest of five percent or more in any mortgage, deed of trust note, or other obligation secured by you if that interest equals at least five percent of the value of the property or assets of you;
- e) is an officer or director of you if organized as a corporation; or
- f) is a partner in you if organized as a partnership.

Table 2: Non-individual Owners

Name of Business Entity	TIN	Ownership Percentage	Primary Business Address	All Business Addresses	All P.O. Box Addresses
Avesis Incorporated	86-0349350	100%	10324 S Dolfield Road Owings Mills, MD 21117	3030 N Central Avenue Phoenix, AZ 85012	

Please copy this page if additional space is needed.

Your Ownership of Subcontractors

Please list all subcontractors in which you have an ownership interest of five percent or more. Include the TIN or SSN, the percent of ownership, the primary address, all business locations, and all P.O. Box addresses.

Table 3: Subcontractors

Name of Subcontractor	TIN/SSN	Ownership Percentage	Primary Business Address	All Business Addresses	All P.O. Box Addresses
None					

Section 3: Individual Relationships

If you listed in Table 1 any individual owners of you, are any of the individual owners related to each other as a spouse, parent, child or sibling? Yes or No

If you answered Yes, please provide all of the following information about each individual owner in the table below.

Table 4:

Social Security Number	Person Name	Relationship	Date of Birth
None			

If you listed in Table 1 any individual owners of you and also listed in Table 3 subcontractors in which you have an ownership interest, are any of the individual owners listed in Table 1 related to any owner of any subcontractors listed in Table 3 as a spouse, parent, child or sibling?

Yes or No Not applicable.

If you answered Yes, please provide all of the following information about each individual owner in the following table.

Table 5:

Social Security Number	Person Name	Relationship	Date of Birth
Not applicable			

Please copy this page if additional space is needed.

Section 4: Other Disclosing Entities

Do any owners of you have an ownership or control interest in any "other disclosing entity"? This question is asking if any of your owners have an ownership or control interest in any other organization that would qualify as a "disclosing entity." "Other disclosing entity" means any other Medicaid disclosing entity and any entity that does not participate in Medicaid, but is required to disclose certain ownership and control information because of participation in any of the programs established under Title V, XVIII or XX or the Act. This includes:

- a) Any hospital, skilled nursing facility, home health agency, independent clinical laboratory, renal disease facility, rural health clinic, or health maintenance organization that participates in Medicare (Title XVIII);
- b) Any Medicare intermediary or carrier; and
- c) Any entity (other than an individual practitioner or group of practitioners) that furnishes, or arranges for the furnishing of, health-related services for which it claims payment under any plan or program established under Title V or Title XX of the Act.

Whereas "disclosing entity" is limited to Medicaid provider, "other disclosing entity" can include entities that are not enrolled in a Medicaid program.

List in the following table the name of each owner of you who has such interest and the name of other disclosing entity in which the owner has an ownership or control interest in:

Table 6:

Name of Owner	Name of Other Disclosing Entity
None.	

Please copy this page if additional space is needed.

Section 5: Managing Employees

Federal regulations require that Medicaid agencies require providers to submit information about managing employees. The term "managing employees" means a general manager, business manager, administrator, director, or other individuals who exercise operational or managerial control over, or who directly or indirectly conduct the day-to-day operation of an institution, organization, or agency. The term "managing employees" includes any "agent" of the provider, which would include any person who has been delegated the authority to obligate or act on behalf of the provider. All managing employees of the provider at any of the provider's practice locations must be reported in this section.

Please provide the following information in the table below; the name of all managing employees, title, address, DOB, and SSN.

Table 7:

Name	Title	Address	DOB	SSN
Joel H. Alperstein	President	Confidential & Not for Public Disclosure		
Mark Babbitt	Senior VP			

Please copy this page if additional space is needed.

Section 6: Final Adverse Actions

This section captures information on “Final Adverse Actions,” such as convictions, exclusions, revocations, and suspensions. All applicable final adverse actions must be reported, regardless of whether any records were expunged or any appeals are pending. Enrolled providers are required to report all Final Adverse Actions/Convictions within 30 days of the reportable event.

Final Adverse Actions That Must Be Reported:

Criminal Conduct:

The provider, supplier, or any owner of the provider or supplier must report any convictions of criminal offenses related to that person’s involvement in any program under Medicare, Medicaid, or Title XX service program since the inception of those programs. Criminal offenses include:

- Felony convictions, guilty pleas and adjudicated pre-trial diversions; financial crimes, such as extortion, embezzlement, income tax evasion, insurance fraud, and other similar crimes for which the individual was convicted, including guilty pleas and adjudicated pre-trial diversions; any felony that placed the Medicaid program or its beneficiaries at immediate risk (such as a malpractice suit that results in a conviction of criminal neglect or misconduct); and any felonies that would result in a mandatory exclusion under Section 1128(a) of the Social Security Act.
- Misdemeanor conviction, under federal or state law, related to: (1) the delivery of an item or service under Medicare or a state health care program, or (2) the abuse or neglect of a patient in connection with the delivery of a health care item or service.
- Misdemeanor conviction, under federal or state law, related to theft, fraud, embezzlement, breach of fiduciary duty, or other financial misconduct in connection with the delivery of a health care item or service.
- Felony or misdemeanor conviction, under federal or state law, relating to the interference with or obstruction of any investigation into any criminal offense described in 42 C.F.R. Section 1001.101 or 1001.201.
- Felony or misdemeanor conviction, under federal or state law, relating to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance.

Exclusions, Revocations, or Suspensions:

Providers must also report any:

- Revocation or suspension of a license to provide health care by any state licensing authority. This includes the surrender of such a license while a formal disciplinary proceeding was pending before a state licensing authority.
- Revocation or suspension of accreditation.
- Suspension or exclusion from participation in, or any sanction imposed by, a federal or state health care program, or any debarment from participation in any federal executive branch procurement or non-procurement program.
- Current Medicare or a state health care program payment suspension under any Medicare or a state health care program billing number.
- Medicare or a state health care program revocation of any Medicare or a state health care program billing number.

Final Adverse Action Reporting:

For all individuals or entities listed in any of the previous tables, as well as the provider submitting this application, provide all information required below for any individual or entity that has been the subject of a Final Adverse Action.

Have you, under any current or former name or business identity, ever had a final adverse action? Yes or No

Report each final adverse action, when it occurred, the federal or state agency or the court/administrative body that imposed the action, and attach the resolution, if any.

Table 8:

Organization or Person Name	Final Adverse Action Taken By	Date of Final Adverse Action

Please copy this page if additional space is needed.

Section 7: Patient Protection and Affordable Care Act

Please answer all five questions:

Does the provider applicant have any current or previous direct or indirect affiliation (as defined below) with a present or former Medicaid provider?

The term "affiliation" includes, but is not limited to, relationships between individuals, business entities, or a combination of the two. The term includes direct or indirect business relationships that involve:

1. a compensation arrangement,
2. an ownership arrangement,
3. managerial authority over either member of the affiliation,
4. the ability of one member of the affiliation to control the other, or
5. the ability of a third party to control both members of the affiliation.

1. For all individuals or entities listed in any of the previous tables, list all that have uncollected debt owed to Medicaid or any other health program funded by any governmental entity, including, but not limited to, the federal and Iowa governments or mark none.

None

Name:

2. For all individuals or entities listed in any of the previous tables, list all that have been or is subject to a payment suspension under a federally-funded health care program or mark none.

None

Name:

3. For all individuals or entities listed in any of the previous tables that have had its billing privileges denied or revoked or mark none.

None

Name:

Please copy this page if additional space is needed.

4. For all individuals or entities listed in any of the previous tables that have been excluded from participation under Medicaid, Medicare or any other federally-funded health care program or mark none.

None

Name:

5. For all individuals or entities listed in any of the previous tables that have shared a National Provider Identifier (NPI) number or Federal Tax Identification number with another provider who has uncollected debt or mark none.

None

Name:

Please copy this page if additional space is needed.

The provider certifies that the information submitted on this form is, to the best of the provider's knowledge, true, accurate, and complete and that the provider has read this entire form before signing. The provider also understands that payment of claims will be from federal and state funds and that any falsification of concealment of a material fact may be prosecuted under federal and state law.

Printed Name of Legal Entity Signatory	
Joel H. Alperstein	
Signature of Authorized Signatory	Date
	4/14/2015

MED-16-009
Iowa High Quality Healthcare Initiative

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"):	AMERIHEALTH CARITAS	
Subcontractor Contact Information (individual who can address issues re: this RFP)		
Name:	Laura Cohen	
Address:	2 Pierce Place, Ste 1900, Itasca, IL 60143	
Tel:	224-366-0373	
Fax:	224-220-5035	
E-mail:	lcohen@discoveryhealthpartners.com	
Subcontractor Detail		
Subcontractor Legal Name ("Subcontractor"):	LaunchPoint Ventures, LLC	
"Doing Business As" names, assumed names, or other operating names:	Discovery Health Partners	
Form of Business Entity (i.e., corp., partnership, LLC, etc.):	LLC	
State of Incorporation/organization:	Delaware	
Primary Address:	2 Pierce Place, Ste 1900, Itasca, IL 60143	
Tel:	224-265-0015	
Fax:	224-265-0016	
Local Address (if any):		
Addresses of Major Offices and other facilities that may contribute to performance under this RFP/Contract:		
Number of Employees:	125	
Number of Years in Business:	7	
Primary Focus of Business:	Payment Integrity, Subrogation & COB	
Federal Tax ID:	26-3000153	
Subcontractor's Accounting Firm:	Grant Thornton	
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 pursuant to this RFP/Contract.		
General Scope of Work to be performed by this Subcontractor		
Subrogation and reimbursement services		
Detail the Subcontractor's qualifications for performing this scope of work		
our team of highly skilled paralegals, legal assistants and attorneys provide subrogation services for medicaid, medicare and commercial plans throughout the country, including one of the largest National health plans.		

MED-16-009
Iowa High Quality Healthcare Initiative

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:	<i>Elizabeth A. Long</i>
Printed Name/Title:	Elizabeth A. Long / General Counsel
Date:	4/30/2015



Iowa Department of Human Services

Iowa Medicaid Ownership and Control Disclosure

Provider Name LAUNCHPOINT VENTURES, LLC	Federal Tax ID or SSN 26-3000153
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Pursuant to 42 C.F.R. sections 455.104 through 455.106, providers applying for Medicaid must disclose certain information about those who have a sufficient ownership interest in the provider as well as those who act as managers or agents of the provider. The following series of questions seeks the necessary information to comply with these regulations.

It is the provider's responsibility to ensure all information is accurate and to report any changes immediately by completing a new Ownership and Disclosure form. See Section 1.6 and Section 3 of the Provider Agreement. Only one form is required per Tax Identification Number (TIN) or Social Security Number (SSN).

In the questions that follow, the provider listed above is referred to as "You" or "Your."

Section 1: Provider Type

Are you an individual practitioner or a group of practitioners?

Individual Practitioner: Yes or No

Group of Individual Practitioners Yes or No

If you answered "Yes" and you are an individual practitioner or a group of individual practitioners, please skip to Section 5. The ownership disclosure requirements do not apply to these entities that generally do not have owners, such as individual practitioner or groups of practitioners.

If you answered "No" because your entity is some form of business other than an individual practitioner or a group of practitioners, please complete all sections.

Section 2: Ownership

Individual Ownership

Please list in the following table all *individuals* with an ownership or control interest in you. Include each person's name, address, date of birth (DOB), and SSN, title (e.g., chief executive office, owner, board member, etc.) and if an owner, the percent of ownership.

"Persons with an ownership or control interest" means:

- a) has an ownership interest totaling five percent or more in you;
- b) has an indirect ownership interest equal to five percent or more in you;
- c) has a combination of direct and indirect ownership interest equal to five percent or more in you;
- d) owns an interest of five percent or more in any mortgage, deed of trust note, or other obligation secured by the disclosing entity if that interest equals at least five percent of the value of the property or assets of you;
- e) is an officer or director of your organization if you are organized as a corporation; or
- f) is a partner in your organization if organized as a partnership.

Table 1: Individual Owners

Name of Individual	Title	Ownership Percentage (if applicable)	Address	Date of Birth	Social Security Number
TERRENCE RYAN	CEO	29.92%	Confidential & Not for Public Disclosure		
JOHN BAIR	CTO	5.41%			
PAUL VOSTERS	PRESIDENT, COO	9.72%			

Non-individual Ownership

Please list all corporations or other form of business entity with an ownership or control interest in you. Include the TIN, the percent of ownership, the primary address, all business locations, and the P.O. Box address.

A corporation or other form of business entity is deemed to have an ownership or control interest in you if it:

- a) has an ownership interest totaling five percent or more in you;
- b) has an indirect ownership interest equal to five percent or more in you;
- c) has a combination of direct and indirect ownership interest equal to five percent or more in you;
- d) owns an interest of five percent or more in any mortgage, deed of trust note, or other obligation secured by you if that interest equals at least five percent of the value of the property or assets of you;
- e) is an officer or director of you if organized as a corporation; or
- f) is a partner in you if organized as a partnership.

Table 2: Non-individual Owners

Name of Business Entity	TIN	Ownership Percentage	Primary Business Address	All Business Addresses	All P.O. Box Addresses
N/A					

Please copy this page if additional space is needed.

Your Ownership of Subcontractors

Please list all subcontractors in which you have an ownership interest of five percent or more. Include the TIN or SSN, the percent of ownership, the primary address, all business locations, and all P.O. Box addresses.

Table 3: Subcontractors

Name of Subcontractor	TIN/SSN	Ownership Percentage	Primary Business Address	All Business Addresses	All P.O. Box Addresses
N/A.					

Section 3: Individual Relationships

If you listed in Table 1 any individual owners of you, are any of the individual owners related to each other as a spouse, parent, child or sibling? Yes or No

If you answered Yes, please provide all of the following information about each individual owner in the table below.

Table 4:

Social Security Number	Person Name	Relationship	Date of Birth

If you listed in Table 1 any individual owners of you and also listed in Table 3 subcontractors in which you have an ownership interest, are any of the individual owners listed in Table 1 related to any owner of any subcontractors listed in Table 3 as a spouse, parent, child or sibling?

Yes or No

If you answered Yes, please provide all of the following information about each individual owner in the following table.

Table 5:

Social Security Number	Person Name	Relationship	Date of Birth

Please copy this page if additional space is needed.

Section 4: Other Disclosing Entities

Do any owners of you have an ownership or control interest in any “other disclosing entity”? This question is asking if any of your owners have an ownership or control interest in any other organization that would qualify as a “disclosing entity.” “Other disclosing entity” means any other Medicaid disclosing entity and any entity that does not participate in Medicaid, but is required to disclose certain ownership and control information because of participation in any of the programs established under Title V, XVIII or XX or the Act. This includes:

- a) Any hospital, skilled nursing facility, home health agency, independent clinical laboratory, renal disease facility, rural health clinic, or health maintenance organization that participates in Medicare (Title XVIII);
- b) Any Medicare intermediary or carrier; and
- c) Any entity (other than an individual practitioner or group of practitioners) that furnishes, or arranges for the furnishing of, health-related services for which it claims payment under any plan or program established under Title V or Title XX of the Act.

Whereas “disclosing entity” is limited to Medicaid provider, “other disclosing entity” can include entities that are not enrolled in a Medicaid program.

List in the following table the name of each owner of you who has such interest and the name of other disclosing entity in which the owner has an ownership or control interest in:

Table 6:

Name of Owner	Name of Other Disclosing Entity
N/A.	

Please copy this page if additional space is needed.

Section 5: Managing Employees

Federal regulations require that Medicaid agencies require providers to submit information about managing employees. The term “managing employees” means a general manager, business manager, administrator, director, or other individuals who exercise operational or managerial control over, or who directly or indirectly conduct the day-to-day operation of an institution, organization, or agency. The term “managing employees” includes any “agent” of the provider, which would include any person who has been delegated the authority to obligate or act on behalf of the provider. All managing employees of the provider at any of the provider’s practice locations must be reported in this section.

Please provide the following information in the table below; the name of all managing employees, title, address, DOB, and SSN.

Table 7:

Name	Title	Address	DOB	SSN
Laura Cohen	VP, OPERATIONS	Confidential & Not for Public Disclosure		
Jeremy Arthur	DIRECTOR, OPERATIONS			
Paul Vosters	PRESIDENT, COO			

Please copy this page if additional space is needed.

Section 6: Final Adverse Actions

This section captures information on "Final Adverse Actions," such as convictions, exclusions, revocations, and suspensions. All applicable final adverse actions must be reported, regardless of whether any records were expunged or any appeals are pending. Enrolled providers are required to report all Final Adverse Actions/Convictions within 30 days of the reportable event.

Final Adverse Actions That Must Be Reported:

Criminal Conduct:

The provider, supplier, or any owner of the provider or supplier must report any convictions of criminal offenses related to that person's involvement in any program under Medicare, Medicaid, or Title XX service program since the inception of those programs. Criminal offenses include:

- Felony convictions, guilty pleas and adjudicated pre-trial diversions; financial crimes, such as extortion, embezzlement, income tax evasion, insurance fraud, and other similar crimes for which the individual was convicted, including guilty pleas and adjudicated pre-trial diversions; any felony that placed the Medicaid program or its beneficiaries at immediate risk (such as a malpractice suit that results in a conviction of criminal neglect or misconduct); and any felonies that would result in a mandatory exclusion under Section 1128(a) of the Social Security Act.
- Misdemeanor conviction, under federal or state law, related to: (1) the delivery of an item or service under Medicare or a state health care program, or (2) the abuse or neglect of a patient in connection with the delivery of a health care item or service.
- Misdemeanor conviction, under federal or state law, related to theft, fraud, embezzlement, breach of fiduciary duty, or other financial misconduct in connection with the delivery of a health care item or service.
- Felony or misdemeanor conviction, under federal or state law, relating to the interference with or obstruction of any investigation into any criminal offense described in 42 C.F.R. Section 1001.101 or 1001.201.
- Felony or misdemeanor conviction, under federal or state law, relating to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance.

Exclusions, Revocations, or Suspensions:

Providers must also report any:

- Revocation or suspension of a license to provide health care by any state licensing authority. This includes the surrender of such a license while a formal disciplinary proceeding was pending before a state licensing authority.
- Revocation or suspension of accreditation.
- Suspension or exclusion from participation in, or any sanction imposed by, a federal or state health care program, or any debarment from participation in any federal executive branch procurement or non-procurement program.
- Current Medicare or a state health care program payment suspension under any Medicare or a state health care program billing number.
- Medicare or a state health care program revocation of any Medicare or a state health care program billing number.

Final Adverse Action Reporting:

For all individuals or entities listed in any of the previous tables, as well as the provider submitting this application, provide all information required below for any individual or entity that has been the subject of a Final Adverse Action.

Have you, under any current or former name or business identity, ever had a final adverse action? Yes or No

Report each final adverse action, when it occurred, the federal or state agency or the court/administrative body that imposed the action, and attach the resolution, if any.

Table 8:

Organization or Person Name	Final Adverse Action Taken By	Date of Final Adverse Action

Please copy this page if additional space is needed.

Section 7: Patient Protection and Affordable Care Act

Please answer all five questions:

Does the provider applicant have any current or previous direct or indirect affiliation (as defined below) with a present or former Medicaid provider?

The term "affiliation" includes, but is not limited to, relationships between individuals, business entities, or a combination of the two. The term includes direct or indirect business relationships that involve:

1. a compensation arrangement,
2. an ownership arrangement,
3. managerial authority over either member of the affiliation,
4. the ability of one member of the affiliation to control the other, or
5. the ability of a third party to control both members of the affiliation.

1. For all individuals or entities listed in any of the previous tables, list all that have uncollected debt owed to Medicaid or any other health program funded by any governmental entity, including, but not limited to, the federal and Iowa governments or mark none.

None

Name:

2. For all individuals or entities listed in any of the previous tables, list all that have been or is subject to a payment suspension under a federally-funded health care program or mark none.

None

Name:

3. For all individuals or entities listed in any of the previous tables that have had its billing privileges denied or revoked or mark none.

None

Name:

Please copy this page if additional space is needed.

4. For all individuals or entities listed in any of the previous tables that have been excluded from participation under Medicaid, Medicare or any other federally-funded health care program or mark none.

None

Name:

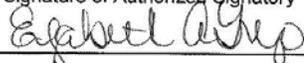
5. For all individuals or entities listed in any of the previous tables that have shared a National Provider Identifier (NPI) number or Federal Tax Identification number with another provider who has uncollected debt or mark none.

None

Name:

Please copy this page if additional space is needed.

The provider certifies that the information submitted on this form is, to the best of the provider's knowledge, true, accurate, and complete and that the provider has read this entire form before signing. The provider also understands that payment of claims will be from federal and state funds and that any falsification or concealment of a material fact may be prosecuted under federal and state law.

Printed Name of Legal Entity Signatory Elizabeth A. Longo	
Signature of Authorized Signatory 	Date 5/3/2015

MED-16-009
Iowa High Quality Healthcare Initiative

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"):	AmeriHealth
Subcontractor Contact Information (individual who can address issues re: this RFP)	
Name:	Robert Dickerson
Address:	360 Park Ave South NY, NY 10010
Tel:	212 857-5270
Fax:	212 857-5010
E-mail:	rdickerson@hms.com

Subcontractor Detail	
Subcontractor Legal Name ("Subcontractor"):	Health Management Systems, Inc.
"Doing Business As" names, assumed names, or other operating names:	N.A.
Form of Business Entity (i.e., corp., partnership, LLC, etc.)	Corporation
State of Incorporation organization:	New York
Primary Address:	360 Park Ave South NY, NY 10010
Tel:	214 453-3000
Fax:	214 453-3023
Local Address (if any):	N.A.
Addresses of Major Offices and other facilities that may contribute to performance under this RFP/Contract:	5615 Highpoint Drive Irving, TX 75038
Number of Employees:	2,700
Number of Years in Business:	41
Primary Focus of Business:	Cost Containment and Data Analytics
Federal Tax ID:	132770433
Subcontractor's Accounting Firm:	KPMG
If Subcontractor is currently registered to do business in Iowa, provide the Date of Registration:	August 21, 2014
Percentage of Total Work to be performed by this Subcontractor pursuant to this RFP/Contract.	50%

General Scope of Work to be performed by this Subcontractor

Payment Integrity

Detail the Subcontractor's qualifications for performing this scope of work

HMS has over 40 years of experience. As a result of the company's services, clients recover billions of dollars every year and save billions more through the prevention of erroneous payments.

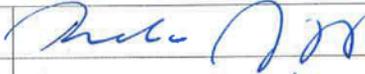
MED-16-009
Iowa High Quality Healthcare Initiative

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:	Rohan Singh - EOP Commercial Mktg
Date:	5/5/2015



Iowa Department of Human Services

Iowa Medicaid Ownership and Control Disclosure

Provider Name HMS	Federal Tax ID or SSN 132770433
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Pursuant to 42 C.F.R. sections 455.104 through 455.106, providers applying for Medicaid must disclose certain information about those who have a sufficient ownership interest in the provider as well as those who act as managers or agents of the provider. The following series of questions seeks the necessary information to comply with these regulations.

It is the provider's responsibility to ensure all information is accurate and to report any changes immediately by completing a new Ownership and Disclosure form. See Section 1.6 and Section 3 of the Provider Agreement. Only one form is required per Tax Identification Number (TIN) or Social Security Number (SSN).

In the questions that follow, the provider listed above is referred to as "You" or "Your."

Section 1: Provider Type

Are you an individual practitioner or a group of practitioners?

Individual Practitioner: Yes or **No**

Group of Individual Practitioners Yes or **No**

If you answered "Yes" and you are an individual practitioner or a group of individual practitioners, please skip to Section 5. The ownership disclosure requirements do not apply to these entities that generally do not have owners, such as individual practitioner or groups of practitioners.

If you answered "No" because your entity is some form of business other than an individual practitioner or a group of practitioners, please complete all sections.

Section 2: Ownership

Individual Ownership

Please list in the following table all **individuals** with an ownership or control interest in you. Include each person's name, address, date of birth (DOB), and SSN, title (e.g., chief executive officer, owner, board member, etc.) and if an owner, the percent of ownership.

"Persons with an ownership or control interest" means:

- a) has an ownership interest totaling five percent or more in you;
- b) has an indirect ownership interest equal to five percent or more in you;
- c) has a combination of direct and indirect ownership interest equal to five percent or more in you;
- d) owns an interest of five percent or more in any mortgage, deed of trust note, or other obligation secured by the disclosing entity if that interest equals at least five percent of the value of the property or assets of you;
- e) is an officer or director of your organization if you are organized as a corporation; or
- f) is a partner in your organization if organized as a partnership.

Table 1: Individual Owners

Name of Individual	Title	Ownership Percentage (if applicable)	Address	Date of Birth	Social Security Number
N.A.					

Non-individual Ownership

Please list all corporations or other form of business entity with an ownership or control interest in you. Include the TIN, the percent of ownership, the primary address, all business locations, and the P.O. Box address.

A corporation or other form of business entity is deemed to have an ownership or control interest in you if it:

- a) has an ownership interest totaling five percent or more in you;
- b) has an indirect ownership interest equal to five percent or more in you;
- c) has a combination of direct and indirect ownership interest equal to five percent or more in you;
- d) owns an interest of five percent or more in any mortgage, deed of trust note, or other obligation secured by you if that interest equals at least five percent of the value of the property or assets of you;
- e) is an officer or director of you if organized as a corporation; or
- f) is a partner in you if organized as a partnership.

Table 2: Non-individual Owners

Name of Business Entity	TIN	Ownership Percentage	Primary Business Address	All Business Addresses	All P.O. Box Addresses
HMS Holdings	1327704333	100%	5615 Highpoint Drive Irving, TX 75038		

Please copy this page if additional space is needed.

Your Ownership of Subcontractors

Please list all subcontractors in which you have an ownership interest of five percent or more. Include the TIN or SSN, the percent of ownership, the primary address, all business locations, and all P.O. Box addresses.

Table 3: Subcontractors

Name of Subcontractor	TIN/SSN	Ownership Percentage	Primary Business Address	All Business Addresses	All P.O. Box Addresses
N.A.					

Section 3: Individual Relationships

If you listed in Table 1 any individual owners of you, are any of the individual owners related to each other as a spouse, parent, child or sibling? Yes or No

If you answered Yes, please provide all of the following information about each individual owner in the table below.

Table 4:

Social Security Number	Person Name	Relationship	Date of Birth
N.A.			

If you listed in Table 1 any individual owners of you and also listed in Table 3 subcontractors in which you have an ownership interest, are any of the individual owners listed in Table 1 related to any owner of any subcontractors listed in Table 3 as a spouse, parent, child or sibling?

Yes or No

If you answered Yes, please provide all of the following information about each individual owner in the following table.

Table 5:

Social Security Number	Person Name	Relationship	Date of Birth
N.A.			

Please copy this page if additional space is needed.

Section 4: Other Disclosing Entities

Do any owners of you have an ownership or control interest in any "other disclosing entity"? This question is asking if any of your owners have an ownership or control interest in any other organization that would qualify as a "disclosing entity." "Other disclosing entity" means any other Medicaid disclosing entity and any entity that does not participate in Medicaid, but is required to disclose certain ownership and control information because of participation in any of the programs established under Title V, XVIII or XX or the Act. This includes:

- a) Any hospital, skilled nursing facility, home health agency, independent clinical laboratory, renal disease facility, rural health clinic, or health maintenance organization that participates in Medicare (Title XVIII);
- b) Any Medicare intermediary or carrier; and
- c) Any entity (other than an individual practitioner or group of practitioners) that furnishes, or arranges for the furnishing of, health-related services for which it claims payment under any plan or program established under Title V or Title XX of the Act.

Whereas "disclosing entity" is limited to Medicaid provider, "other disclosing entity" can include entities that are not enrolled in a Medicaid program.

List in the following table the name of each owner of you who has such interest and the name of other disclosing entity in which the owner has an ownership or control interest in:

Table 6:

Name of Owner	Name of Other Disclosing Entity
N.A.	

Please copy this page if additional space is needed.

Section 5: Managing Employees

Federal regulations require that Medicaid agencies require providers to submit information about managing employees. The term "managing employees" means a general manager, business manager, administrator, director, or other individuals who exercise operational or managerial control over, or who directly or indirectly conduct the day-to-day operation of an institution, organization, or agency. The term "managing employees" includes any "agent" of the provider, which would include any person who has been delegated the authority to obligate or act on behalf of the provider. All managing employees of the provider at any of the provider's practice locations must be reported in this section.

Please provide the following information in the table below; the name of all managing employees, title, address, DOB, and SSN.

Table 7:

Name	Title	Address	DOB	SSN
Bill Lucia	CEO	5615 Highpoint Drive Irving, TX 75038		
Jeffrey Sherman	CFO	5615 Highpoint Drive Irving, TX 75038		
Cynthia Nustad	CIO	5615 Highpoint Drive Irving, TX 75038		
Gene DeFelice	General Counsel	5615 Highpoint Drive Irving, TX 75038		
Doug Williams	Division President	5615 Highpoint Drive Irving, TX 75038		

Please copy this page if additional space is needed.

Section 6: Final Adverse Actions

This section captures information on "Final Adverse Actions," such as convictions, exclusions, revocations, and suspensions. All applicable final adverse actions must be reported, regardless of whether any records were expunged or any appeals are pending. Enrolled providers are required to report all Final Adverse Actions/Convictions within 30 days of the reportable event.

Final Adverse Actions That Must Be Reported:

Criminal Conduct:

The provider, supplier, or any owner of the provider or supplier must report any convictions of criminal offenses related to that person's involvement in any program under Medicare, Medicaid, or Title XX service program since the inception of those programs. Criminal offenses include:

- Felony convictions, guilty pleas and adjudicated pre-trial diversions; financial crimes, such as extortion, embezzlement, income tax evasion, insurance fraud, and other similar crimes for which the individual was convicted, including guilty pleas and adjudicated pre-trial diversions; any felony that placed the Medicaid program or its beneficiaries at immediate risk (such as a malpractice suit that results in a conviction of criminal neglect or misconduct); and any felonies that would result in a mandatory exclusion under Section 1128(a) of the Social Security Act.
- Misdemeanor conviction, under federal or state law, related to: (1) the delivery of an item or service under Medicare or a state health care program, or (2) the abuse or neglect of a patient in connection with the delivery of a health care item or service.
- Misdemeanor conviction, under federal or state law, related to theft, fraud, embezzlement, breach of fiduciary duty, or other financial misconduct in connection with the delivery of a health care item or service.
- Felony or misdemeanor conviction, under federal or state law, relating to the interference with or obstruction of any investigation into any criminal offense described in 42 C.F.R. Section 1001.101 or 1001.201.

- Felony or misdemeanor conviction, under federal or state law, relating to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance.

Exclusions, Revocations, or Suspensions:

Providers must also report any:

- Revocation or suspension of a license to provide health care by any state licensing authority. This includes the surrender of such a license while a formal disciplinary proceeding was pending before a state licensing authority.
- Revocation or suspension of accreditation.
- Suspension or exclusion from participation in, or any sanction imposed by, a federal or state health care program, or any debarment from participation in any federal executive branch procurement or non-procurement program.
- Current Medicare or a state health care program payment suspension under any Medicare or a state health care program billing number.
- Medicare or a state health care program revocation of any Medicare or a state health care program billing number.

Final Adverse Action Reporting:

For all individuals or entities listed in any of the previous tables, as well as the provider submitting this application, provide all information required below for any individual or entity that has been the subject of a Final Adverse Action.

Have you, under any current or former name or business identity, ever had a final adverse action? Yes or No

Report each final adverse action, when it occurred, the federal or state agency or the court/administrative body that imposed the action, and attach the resolution, if any.

Table 8:

Organization or Person Name	Final Adverse Action Taken By	Date of Final Adverse Action
N.A.		

Please copy this page if additional space is needed.

Section 7: Patient Protection and Affordable Care Act

Please answer all five questions:

Does the provider applicant have any current or previous direct or indirect affiliation (as defined below) with a present or former Medicaid provider?

The term "affiliation" includes, but is not limited to, relationships between individuals, business entities, or a combination of the two. The term includes direct or indirect business relationships that involve:

1. a compensation arrangement,
2. an ownership arrangement,
3. managerial authority over either member of the affiliation,
4. the ability of one member of the affiliation to control the other, or
5. the ability of a third party to control both members of the affiliation.

1. For all individuals or entities listed in any of the previous tables, list all that have uncollected debt owed to Medicaid or any other health program funded by any governmental entity, including, but not limited to, the federal and Iowa governments or mark none.

None

Name:

2. For all individuals or entities listed in any of the previous tables, list all that have been or is subject to a payment suspension under a federally-funded health care program or mark none.

None

Name:

3. For all individuals or entities listed in any of the previous tables that have had its billing privileges denied or revoked or mark none.

None

Name:

Please copy this page if additional space is needed.

4. For all individuals or entities listed in any of the previous tables that have been excluded from participation under Medicaid, Medicare or any other federally-funded health care program or mark none.

None

Name:

5. For all individuals or entities listed in any of the previous tables that have shared a National Provider Identifier (NPI) number or Federal Tax Identification number with another provider who has uncollected debt or mark none.

None

Name:

Please copy this page if additional space is needed.

The provider certifies that the information submitted on this form is, to the best of the provider's knowledge, true, accurate, and complete and that the provider has read this entire form before signing. The provider also understands that payment of claims will be from federal and state funds and that any falsification or concealment of a material fact may be prosecuted under federal and state law.

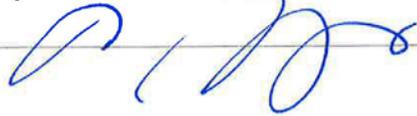
Printed Name of Legal Entity Signatory	
RONALD SINGH	
Signature of Authorized Signatory	Date
	4/20/2015

Exhibit C: Subcontractor Disclosure Form

*(Return this completed form behind Tab 3 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"):	AmeriHealth Caritas
Subcontractor Contact Information (individual who can address issues re: this RFP)	
Name:	Duane Williams, Director, Account Management
Address:	16 Hawk Ridge Drive, Lake St. Louis, MO
Tel:	636-695-5706
Fax:	636-561-2962
E-mail:	dwilliams@mtm-inc.net

Subcontractor Detail	
Subcontractor Legal Name ("Subcontractor"):	Medical Transportation Management, Inc. (MTM)
"Doing Business As" names, assumed names, or other operating names:	Not applicable
Form of Business Entity (i.e., corp., partnership, LLC, etc.)	S-Corporation
State of Incorporation/organization:	Missouri
Primary Address:	16 Hawk Ridge Drive, Lake St. Louis, MO 63367
Tel:	636-561-5686
Fax:	636-561-2962
Local Address (if any):	Not applicable
Addresses of Major Offices and other facilities that may contribute to performance under this RFP/Contract:	16 Hawk Ridge Drive, Lake St. Louis, MO 63367
Number of Employees:	928
Number of Years in Business:	20
Primary Focus of Business:	Non-emergency transportation (NEMT) services
Federal Tax ID:	43-1719762
Subcontractor's Accounting Firm:	Internal (MTM)
If Subcontractor is currently registered to do business in Iowa, provide the Date of Registration:	December 9, 2005
Percentage of Total Work to be performed by this Subcontractor pursuant to this RFP/Contract.	4%
General Scope of Work to be performed by this Subcontractor	
Non-emergency medical transportation (NEMT)	
Detail the Subcontractor's qualifications for performing this scope of work	
20 years experience providing NEMT. Currently operating in 24 states and the District of Columbia, including providing ten million trips, managing eight million calls, and serving over six million members annually.	

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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:	Alaina Maciá, President and CEO
Date:	3/27/15



Iowa Department of Human Services

Iowa Medicaid Ownership and Control Disclosure

Provider Name Medical Transportation Management, Inc.	Federal Tax ID or SSN 43-1719762
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Pursuant to 42 C.F.R. sections 455.104 through 455.106, providers applying for Medicaid must disclose certain information about those who have a sufficient ownership interest in the provider as well as those who act as managers or agents of the provider. The following series of questions seeks the necessary information to comply with these regulations.

It is the provider's responsibility to ensure all information is accurate and to report any changes immediately by completing a new Ownership and Disclosure form. See Section 1.6 and Section 3 of the Provider Agreement. Only one form is required per Tax Identification Number (TIN) or Social Security Number (SSN).

In the questions that follow, the provider listed above is referred to as "You" or "Your."

Section 1: Provider Type

Are you an individual practitioner or a group of practitioners?

Individual Practitioner: Yes or No

Group of Individual Practitioners Yes or No

If you answered "Yes" and you are an individual practitioner or a group of individual practitioners, please skip to Section 5. The ownership disclosure requirements do not apply to these entities that generally do not have owners, such as individual practitioner or groups of practitioners.

If you answered "No" because your entity is some form of business other than an individual practitioner or a group of practitioners, please complete all sections.

Section 2: Ownership

Individual Ownership

Please list in the following table all **individuals** with an ownership or control interest in you. Include each person's name, address, date of birth (DOB), and SSN, title (e.g., chief executive officer, owner, board member, etc.) and if an owner, the percent of ownership.

"Persons with an ownership or control interest" means:

- a) has an ownership interest totaling five percent or more in you;
- b) has an indirect ownership interest equal to five percent or more in you;
- c) has a combination of direct and indirect ownership interest equal to five percent or more in you;
- d) owns an interest of five percent or more in any mortgage, deed of trust note, or other obligation secured by the disclosing entity if that interest equals at least five percent of the value of the property or assets of you;
- e) is an officer or director of your organization if you are organized as a corporation; or
- f) is a partner in your organization if organized as a partnership.

Table 1: Individual Owners

Name of Individual	Title	Ownership Percentage (if applicable)	Address	Date of Birth	Social Security Number
Peg Griswold	Chairwoman of the Board	51%	Confidential & Not for Public Disclosure		
JB Bowers	Director	13%			
Alaina Macia	President & CEO Director	9%			
Lynn Griswold	Exec. VP, Director	5%			

Non-individual Ownership

Please list all corporations or other form of business entity with an ownership or control interest in you. Include the TIN, the percent of ownership, the primary address, all business locations, and the P.O. Box address.

A corporation or other form of business entity is deemed to have an ownership or control interest in you if it:

- a) has an ownership interest totaling five percent or more in you;
- b) has an indirect ownership interest equal to five percent or more in you;
- c) has a combination of direct and indirect ownership interest equal to five percent or more in you;
- d) owns an interest of five percent or more in any mortgage, deed of trust note, or other obligation secured by you if that interest equals at least five percent of the value of the property or assets of you;
- e) is an officer or director of you if organized as a corporation; or
- f) is a partner in you if organized as a partnership.

Table 2: Non-individual Owners

Name of Business Entity	TIN	Ownership Percentage	Primary Business Address	All Business Addresses	All P.O. Box Addresses
N/A					

Please copy this page if additional space is needed.

Your Ownership of Subcontractors

Please list all subcontractors in which you have an ownership interest of five percent or more. Include the TIN or SSN, the percent of ownership, the primary address, all business locations, and all P.O. Box addresses.

Table 3: Subcontractors

Name of Subcontractor	TIN/SSN	Ownership Percentage	Primary Business Address	All Business Addresses	All P.O. Box Addresses
N/A					

Section 3: Individual Relationships

If you listed in Table 1 any individual owners of you, are any of the individual owners related to each other as a spouse, parent, child or sibling? Yes or No

If you answered Yes, please provide all of the following information about each individual owner in the table below.

Table 4:

Social Security Number	Person Name	Relationship	Date of Birth
Confidential & Not for Public Disclosure	Peg Griswold	Spouse of Lynn Griswold; Step-Mother of Alaina	Confidential & Not for Public Disclosure
	Lynn Griswold	Spouse of Peg Griswold; Father of Alaina Macia	
	Alaina Macia	Step-Daughter of Peg Griswold; Daughter of Lynn Griswold	

If you listed in Table 1 any individual owners of you and also listed in Table 3 subcontractors in which you have an ownership interest, are any of the individual owners listed in Table 1 related to any owner of any subcontractors listed in Table 3 as a spouse, parent, child or sibling?

N/A Yes or No

If you answered Yes, please provide all of the following information about each individual owner in the following table.

Table 5:

Social Security Number	Person Name	Relationship	Date of Birth
N/A			

Please copy this page if additional space is needed.

Section 4: Other Disclosing Entities

Do any owners of you have an ownership or control interest in any “other disclosing entity”? This question is asking if any of your owners have an ownership or control interest in any other organization that would qualify as a “disclosing entity.” “Other disclosing entity” means any other Medicaid disclosing entity and any entity that does not participate in Medicaid, but is required to disclose certain ownership and control information because of participation in any of the programs established under Title V, XVIII or XX or the Act. This includes:

- a) Any hospital, skilled nursing facility, home health agency, independent clinical laboratory, renal disease facility, rural health clinic, or health maintenance organization that participates in Medicare (Title XVIII);
- b) Any Medicare intermediary or carrier; and
- c) Any entity (other than an individual practitioner or group of practitioners) that furnishes, or arranges for the furnishing of, health-related services for which it claims payment under any plan or program established under Title V or Title XX of the Act.

Whereas “disclosing entity” is limited to Medicaid provider, “other disclosing entity” can include entities that are not enrolled in a Medicaid program.

List in the following table the name of each owner of you who has such interest and the name of other disclosing entity in which the owner has an ownership or control interest in:

Table 6:

Name of Owner	Name of Other Disclosing Entity
N/A	

Please copy this page if additional space is needed.

Section 5: Managing Employees

Federal regulations require that Medicaid agencies require providers to submit information about managing employees. The term “managing employees” means a general manager, business manager, administrator, director, or other individuals who exercise operational or managerial control over, or who directly or indirectly conduct the day-to-day operation of an institution, organization, or agency. The term “managing employees” includes any “agent” of the provider, which would include any person who has been delegated the authority to obligate or act on behalf of the provider. All managing employees of the provider at any of the provider’s practice locations must be reported in this section.

Please provide the following information in the table below; the name of all managing employees, title, address, DOB, and SSN.

Table 7:

Name	Title	Address	DOB	SSN
See Attachment				

Please copy this page if additional space is needed.

Section 6: Final Adverse Actions

This section captures information on “Final Adverse Actions,” such as convictions, exclusions, revocations, and suspensions. All applicable final adverse actions must be reported, regardless of whether any records were expunged or any appeals are pending. Enrolled providers are required to report all Final Adverse Actions/Convictions within 30 days of the reportable event.

Final Adverse Actions That Must Be Reported:

Criminal Conduct:

The provider, supplier, or any owner of the provider or supplier must report any convictions of criminal offenses related to that person’s involvement in any program under Medicare, Medicaid, or Title XX service program since the inception of those programs. Criminal offenses include:

- Felony convictions, guilty pleas and adjudicated pre-trial diversions; financial crimes, such as extortion, embezzlement, income tax evasion, insurance fraud, and other similar crimes for which the individual was convicted, including guilty pleas and adjudicated pre-trial diversions; any felony that placed the Medicaid program or its beneficiaries at immediate risk (such as a malpractice suit that results in a conviction of criminal neglect or misconduct); and any felonies that would result in a mandatory exclusion under Section 1128(a) of the Social Security Act.
- Misdemeanor conviction, under federal or state law, related to: (1) the delivery of an item or service under Medicare or a state health care program, or (2) the abuse or neglect of a patient in connection with the delivery of a health care item or service.
- Misdemeanor conviction, under federal or state law, related to theft, fraud, embezzlement, breach of fiduciary duty, or other financial misconduct in connection with the delivery of a health care item or service.
- Felony or misdemeanor conviction, under federal or state law, relating to the interference with or obstruction of any investigation into any criminal offense described in 42 C.F.R. Section 1001.101 or 1001.201.
- Felony or misdemeanor conviction, under federal or state law, relating to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance.

Exclusions, Revocations, or Suspensions:

Providers must also report any:

- Revocation or suspension of a license to provide health care by any state licensing authority. This includes the surrender of such a license while a formal disciplinary proceeding was pending before a state licensing authority.
- Revocation or suspension of accreditation.
- Suspension or exclusion from participation in, or any sanction imposed by, a federal or state health care program, or any debarment from participation in any federal executive branch procurement or non-procurement program.
- Current Medicare or a state health care program payment suspension under any Medicare or a state health care program billing number.
- Medicare or a state health care program revocation of any Medicare or a state health care program billing number.

Final Adverse Action Reporting:

For all individuals or entities listed in any of the previous tables, as well as the provider submitting this application, provide all information required below for any individual or entity that has been the subject of a Final Adverse Action.

Have you, under any current or former name or business identity, ever had a final adverse action? Yes or No

Report each final adverse action, when it occurred, the federal or state agency or the court/administrative body that imposed the action, and attach the resolution, if any.

Table 8:

Organization or Person Name	Final Adverse Action Taken By	Date of Final Adverse Action
N/A		

Please copy this page if additional space is needed.

Section 7: Patient Protection and Affordable Care Act

Please answer all five questions:

Does the provider applicant have any current or previous direct or indirect affiliation (as defined below) with a present or former Medicaid provider?

The term "affiliation" includes, but is not limited to, relationships between individuals, business entities, or a combination of the two. The term includes direct or indirect business relationships that involve:

1. a compensation arrangement,
2. an ownership arrangement,
3. managerial authority over either member of the affiliation,
4. the ability of one member of the affiliation to control the other, or
5. the ability of a third party to control both members of the affiliation.

1. For all individuals or entities listed in any of the previous tables, list all that have uncollected debt owed to Medicaid or any other health program funded by any governmental entity, including, but not limited to, the federal and Iowa governments or mark none.

None

Name:

2. For all individuals or entities listed in any of the previous tables, list all that have been or is subject to a payment suspension under a federally-funded health care program or mark none.

None

Name:

3. For all individuals or entities listed in any of the previous tables that have had its billing privileges denied or revoked or mark none.

None

Name:

Please copy this page if additional space is needed.

4. For all individuals or entities listed in any of the previous tables that have been excluded from participation under Medicaid, Medicare or any other federally-funded health care program or mark none.

None

Name:

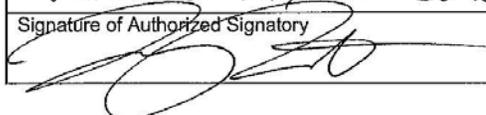
5. For all individuals or entities listed in any of the previous tables that have shared a National Provider Identifier (NPI) number or Federal Tax Identification number with another provider who has uncollected debt or mark none.

None

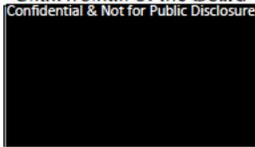
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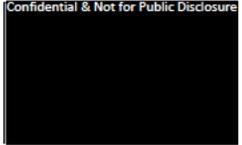
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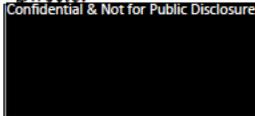
The provider certifies that the information submitted on this form is, to the best of the provider's knowledge, true, accurate, and complete and that the provider has read this entire form before signing. The provider also understands that payment of claims will be from federal and state funds and that any falsification of concealment of a material fact may be prosecuted under federal and state law.

Printed Name of Legal Entity Signatory <i>William Bennett, Staff Counsel</i>	
Signature of Authorized Signatory 	Date <i>4/13/15</i>

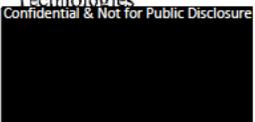
Section 5: Managing Employees: Table 7

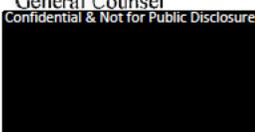
Peggy A. Griswold
Chairwoman of the Board
Confidential & Not for Public Disclosure


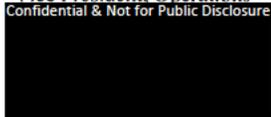
Lynn C. Griswold
Executive Vice President
Confidential & Not for Public Disclosure


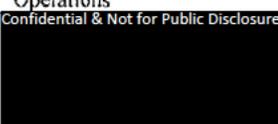
J B Bowers
Director
Confidential & Not for Public Disclosure


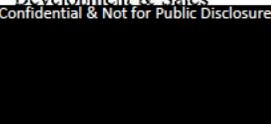
Alaina Macia
CEO
Confidential & Not for Public Disclosure

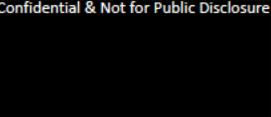

Heather Pekar
Vice President, RSD
Technologies
Confidential & Not for Public Disclosure


Donald C. Tiemeyer
Executive Vice President,
General Counsel
Confidential & Not for Public Disclosure


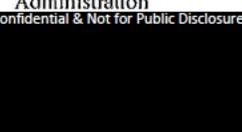
Natasha Boekholt
Vice President, Operations
Confidential & Not for Public Disclosure


Patrick McNiff
Vice President, Paratransit
Operations
Confidential & Not for Public Disclosure


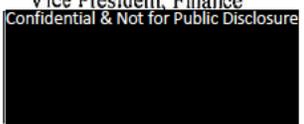
Aaron Crowell
Vice President, Business
Development & Sales
Confidential & Not for Public Disclosure


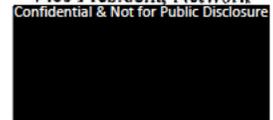
Michele Lucas
Vice President, Marketing
Confidential & Not for Public Disclosure


Kimberly Clark
Regional Vice President,
MidAtlantic Operations
Confidential & Not for Public Disclosure


Kerri Schewe
Vice President,
Administration
Confidential & Not for Public Disclosure


Philip G. Stalboerger
Vice President, Public
Affairs
Confidential & Not for Public Disclosure


Stephanie Klaas
Vice President, Finance
Confidential & Not for Public Disclosure


Carrie Seeler
Vice President, Network
Confidential & Not for Public Disclosure


Valorie Williams
Regional Vice President
Confidential & Not for Public Disclosure


Exhibit C: Subcontractor Disclosure Form

(Return this completed form behind Tab 3 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"):	AmeriHealth Caritas Iowa, Inc.
Subcontractor Contact Information (individual who can address issues re: this RFP)	
Name:	Michael Draine
Address:	Vice President, Sales Marketing & Proposals PerformRx 200 Stevens Dr. Philadelphia, PA 19113
Tel:	(215) 863-5829
Fax:	(215) 863-5100
E-mail:	mdraine@performrx.com

Subcontractor Detail	
Subcontractor Legal Name ("Subcontractor"):	PerformRx, LLC
"Doing Business As" names, assumed names, or other operating names:	N/A
Form of Business Entity (i.e., corp., partnership, LLC, etc.)	Limited liability company
State of Incorporation/organization:	PA
Primary Address:	200 Stevens Dr. Philadelphia, PA 19113
Tel:	1-866-533-5492
Fax:	1-215-937-8776
Local Address (if any):	N/A
Addresses of Major Offices and other facilities that may contribute to performance under this RFP/Contract:	200 Stevens Dr. Philadelphia, PA 19113
Number of Employees:	276 (as of March 31, 2015)
Number of Years in Business:	16
Primary Focus of Business:	Pharmacy benefits management
Federal Tax ID:	27-0863878
Subcontractor's Accounting Firm:	KPMG
If Subcontractor is currently registered to do business in Iowa, provide the Date of Registration:	While company registrations are in process, PerformRx is not yet registered to do business in Iowa; PerformRx will be registered as a foreign limited liability company.
Percentage of Total Work to be performed by this Subcontractor pursuant to this RFP/Contract.	Based upon the State capitation rates released on April 23, 2015, PerformRx's compensation for services furnished under its subcontract with AmeriHealth Caritas Iowa is estimated to be less than 5% of AmeriHealth Caritas Iowa's anticipated capitation payment from DHS.

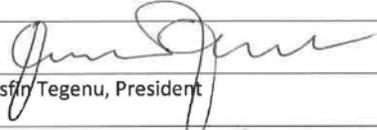
General Scope of Work to be performed by this Subcontractor
PerformRx will administer the pharmacy benefit of AmeriHealth Caritas Iowa members, providing full service pharmacy benefit management (PBM) services that includes pharmacy contracting, clinical programs, claims administration and rebate administration (where permitted).
Detail the Subcontractor's qualifications for performing this scope of work
PerformRx has more than fifteen (15) years of experience in furnishing PBM services to support Medicaid managed care plans. PerformRx began as an operating division of AmeriHealth Caritas Health Plan (then known as AmeriHealth Mercy Health Plan) in 1999, providing PBM services to AmeriHealth Caritas Health Plan and its sister company Keystone Family Health Plan (then known as Keystone Mercy Health Plan). PerformRx's client base began expanding to include government-sponsored health plans in South Carolina, Rhode Island and California; and in 2006, PerformRx began providing PBM services to plan sponsors under the Medicare Part D program. Most recently, PerformRx launched its specialty pharmacy (PerformSpecialty), with operations located in Orlando, Florida. Today PerformRx serves more than 4.5 million lives across 14 states and the District of Columbia, providing PBM services for Medicare, Medicaid, Medi-Cal and other state-funded plans, and commercial and exchange clients. PerformRx is currently in the process of registering to conduct business in Iowa, including securing its TPA certification as required under Iowa Code Chapter 510B.

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:	Mesfin Tegenu, President
Date:	4-29-2015



Iowa Department of Human Services

Iowa Medicaid Ownership and Control Disclosure

Provider Name PerformRx, LLC	Federal Tax ID or SSN 27-0863878
-------------------------------------	---

Pursuant to 42 C.F.R. sections 455.104 through 455.106, providers applying for Medicaid must disclose certain information about those who have a sufficient ownership interest in the provider as well as those who act as managers or agents of the provider. The following series of questions seeks the necessary information to comply with these regulations.

It is the provider's responsibility to ensure all information is accurate and to report any changes immediately by completing a new Ownership and Disclosure form. See Section 1.6 and Section 3 of the Provider Agreement. Only one form is required per Tax Identification Number (TIN) or Social Security Number (SSN).

In the questions that follow, the provider listed above is referred to as "You" or "Your."

Section 1: Provider Type

Are you an individual practitioner or a group of practitioners?

Individual Practitioner: Yes or No

Group of Individual Practitioners Yes or No

If you answered "Yes" and you are an individual practitioner or a group of individual practitioners, please skip to Section 5. The ownership disclosure requirements do not apply to these entities that generally do not have owners, such as individual practitioner or groups of practitioners.

If you answered "No" because your entity is some form of business other than an individual practitioner or a group of practitioners, please complete all sections.

Section 2: Ownership

Individual Ownership

Please list in the following table all **individuals** with an ownership or control interest in you. Include each person's name, address, date of birth (DOB), and SSN, title (e.g., chief executive officer, owner, board member, etc.) and if an owner, the percent of ownership.

"Persons with an ownership or control interest" means:

- has an ownership interest totaling five percent or more in you;
- has an indirect ownership interest equal to five percent or more in you;
- has a combination of direct and indirect ownership interest equal to five percent or more in you;
- owns an interest of five percent or more in any mortgage, deed of trust note, or other obligation secured by the disclosing entity if that interest equals at least five percent of the value of the property or assets of you;
- is an officer or director of your organization if you are organized as a corporation; or
- is a partner in your organization if organized as a partnership.

Table 1: Individual Owners

Name of Individual	Title	Ownership Percentage (if applicable)	Address	Date of Birth	Social Security Number
Paul A. Tufano	Chairman	0%	Confidential & Not for Public Disclosure		
Mesfin Tegenu	President	0%			
Steven H. Bohner	Director, VP & Treasurer	0%			
Robert H. Gilman	VP & Secretary	0%			

Non-individual Ownership

Please list all corporations or other form of business entity with an ownership or control interest in you. Include the TIN, the percent of ownership, the primary address, all business locations, and the P.O. Box address.

A corporation or other form of business entity is deemed to have an ownership or control interest in you if it:

- a) has an ownership interest totaling five percent or more in you;
- b) has an indirect ownership interest equal to five percent or more in you;
- c) has a combination of direct and indirect ownership interest equal to five percent or more in you;
- d) owns an interest of five percent or more in any mortgage, deed of trust note, or other obligation secured by you if that interest equals at least five percent of the value of the property or assets of you;
- e) is an officer or director of you if organized as a corporation; or
- f) is a partner in you if organized as a partnership.

Table 2: Non-individual Owners

Name of Business Entity	TIN	Ownership Percentage	Primary Business Address	All Business Addresses	All P.O. Box Addresses
AmeriHealth Caritas Health Plan	23-2859523	100% (direct)	200 Stevens Dr., Philadelphia, PA 19113	8040 Carleton Rd., Harrisburg, PA 17112	
BMH Subco I LLC	38-36946080	50% (indirect)	200 Stevens Dr., Philadelphia, PA 19113		
BMH Subco II LLC	80-0768643	50% (indirect)	200 Stevens Dr., Philadelphia, PA 19113		
BMH LLC	30-0703311	100% (indirect)	200 Stevens Dr., Philadelphia, PA 19113		

Please copy this page if additional space is needed.

Your Ownership of Subcontractors

Please list all subcontractors in which you have an ownership interest of five percent or more. Include the TIN or SSN, the percent of ownership, the primary address, all business locations, and all P.O. Box addresses.

Table 1: Individual Owners

Name of Individual	Title	Ownership Percentage (if applicable)	Address	Date of Birth	Social Security Number
Robert E. Tootle	Assistant Secretary	0%	Confidential & Not for Public Disclosure		
Marie A. Savard	Chief Medical Officer	0%			

Non-individual Ownership

Please list all corporations or other form of business entity with an ownership or control interest in you. Include the TIN, the percent of ownership, the primary address, all business locations, and the P.O. Box address.

A corporation or other form of business entity is deemed to have an ownership or control interest in you if it:

- a) has an ownership interest totaling five percent or more in you;
- b) has an indirect ownership interest equal to five percent or more in you;
- c) has a combination of direct and indirect ownership interest equal to five percent or more in you;
- d) owns an interest of five percent or more in any mortgage, deed of trust note, or other obligation secured by you if that interest equals at least five percent of the value of the property or assets of you;
- e) is an officer or director of you if organized as a corporation; or
- f) is a partner in you if organized as a partnership.

Table 2: Non-individual Owners

Name of Business Entity	TIN	Ownership Percentage	Primary Business Address	All Business Addresses	All P.O. Box Addresses
Blue Cross Blue Shield of Michigan	38-2069753	38.7% (indirect)	600 E. Lafayette Blvd., Detroit, MI 48226		
IBC MH LLC	45-3672640	61.3% (indirect)	1901 Market St. Philadelphia, PA 19103		
AmeriHealth, Inc.	23-2425461	58.2% (Indirect)	1901 Market St. Philadelphia, PA 19103		
Independence Health Group, Inc.	47-1233198	61.3% (indirect)	1901 Market St. Philadelphia, PA 19103		

Please copy this page if additional space is needed.

Your Ownership of Subcontractors

Please list all subcontractors in which you have an ownership interest of five percent or more. Include the TIN or SSN, the percent of ownership, the primary address, all business locations, and all P.O. Box addresses.

Table 3: Subcontractors

Name of Subcontractor	TIN/SSN	Ownership Percentage	Primary Business Address	All Business Addresses	All P.O. Box Addresses
None					

Section 3: Individual Relationships

If you listed in Table 1 any individual owners of you, are any of the individual owners related to each other as a spouse, parent, child or sibling? Yes or No

If you answered Yes, please provide all of the following information about each individual owner in the table below.

Table 4:

Social Security Number	Person Name	Relationship	Date of Birth
N/A			

If you listed in Table 1 any individual owners of you and also listed in Table 3 subcontractors in which you have an ownership interest, are any of the individual owners listed in Table 1 related to any owner of any subcontractors listed in Table 3 as a spouse, parent, child or sibling?

Yes or No

If you answered Yes, please provide all of the following information about each individual owner in the following table.

Table 5:

Social Security Number	Person Name	Relationship	Date of Birth
N/A			

Please copy this page if additional space is needed.

Section 4: Other Disclosing Entities

Do any owners of you have an ownership or control interest in any "other disclosing entity"? This question is asking if any of your owners have an ownership or control interest in any other organization that would qualify as a "disclosing entity." "Other disclosing entity" means any other Medicaid disclosing entity and any entity that does not participate in Medicaid, but is required to disclose certain ownership and control information because of participation in any of the programs established under Title V, XVIII or XX or the Act. This includes:

- a) Any hospital, skilled nursing facility, home health agency, independent clinical laboratory, renal disease facility, rural health clinic, or health maintenance organization that participates in Medicare (Title XVIII);
- b) Any Medicare intermediary or carrier; and
- c) Any entity (other than an individual practitioner or group of practitioners) that furnishes, or arranges for the furnishing of, health-related services for which it claims payment under any plan or program established under Title V or Title XX of the Act.

Whereas "disclosing entity" is limited to Medicaid provider, "other disclosing entity" can include entities that are not enrolled in a Medicaid program.
List in the following table the name of each owner of you who has such interest and the name of other disclosing entity in which the owner has an ownership or control interest in:

Table 6:

Name of Owner	Name of Other Disclosing Entity
See Attached	

Please copy this page if additional space is needed.

Section 5: Managing Employees

Federal regulations require that Medicaid agencies require providers to submit information about managing employees. The term "managing employees" means a general manager, business manager, administrator, director, or other individuals who exercise operational or managerial control over, or who directly or indirectly conduct the day-to-day operation of an institution, organization, or agency. The term "managing employees" includes any "agent" of the provider, which would include any person who has been delegated the authority to obligate or act on behalf of the provider. All managing employees of the provider at any of the provider's practice locations must be reported in this section.

Please provide the following information in the table below; the name of all managing employees, title, address, DOB, and SSN.

**PerformRx, LLC
Iowa Medicaid Ownership and Disclosure**

Table 6 (Other Disclosing Entities)

Name of Owner	Name of Other Disclosing Entity
AmeriHealth Caritas Health Plan	AmeriHealth Caritas Louisiana, Inc.
	Florida True Health, Inc.
	AmeriHealth Nebraska, Inc.
	AmeriHealth Michigan, Inc.
	Select Health of South Carolina, Inc.
	AmeriHealth District of Columbia, Inc.
	Prestige Health Choice, L.L.C.
	PerformSpecialty, LLC
Blue Cross Blue Shield of Michigan	Blue Care Network of Michigan
	Blue Cross Complete of Michigan
IBC MH LLC	Vista Health Plan, Inc. (including CMS contract H4227)
AmeriHealth, Inc.	AmeriHealth HMO, Inc.
	Keystone Health Plan East, Inc.

Table 7:

Name	Title	Address	DOB	SSN
Michael W. Reilley	Vice President & CFO	Confidential & Not for Public Disclosure		
Andrew F. Maiorini	Vice President, Clinical Programs			
Patrick M. Gallagher	Vice President, Operations			

Please copy this page if additional space is needed.

Section 6: Final Adverse Actions

This section captures information on "Final Adverse Actions," such as convictions, exclusions, revocations, and suspensions. All applicable final adverse actions must be reported, regardless of whether any records were expunged or any appeals are pending. Enrolled providers are required to report all Final Adverse Actions/Convictions within 30 days of the reportable event.

Final Adverse Actions That Must Be Reported:

Criminal Conduct:

The provider, supplier, or any owner of the provider or supplier must report any convictions of criminal offenses related to that person's involvement in any program under Medicare, Medicaid, or Title XX service program since the inception of those programs. Criminal offenses include:

- Felony convictions, guilty pleas and adjudicated pre-trial diversions; financial crimes, such as extortion, embezzlement, income tax evasion, insurance fraud, and other similar crimes for which the individual was convicted, including guilty pleas and adjudicated pre-trial diversions; any felony that placed the Medicaid program or its beneficiaries at immediate risk (such as a malpractice suit that results in a conviction of criminal neglect or misconduct); and any felonies that would result in a mandatory exclusion under Section 1128(a) of the Social Security Act.
- Misdemeanor conviction, under federal or state law, related to: (1) the delivery of an item or service under Medicare or a state health care program, or (2) the abuse or neglect of a patient in connection with the delivery of a health care item or service.
- Misdemeanor conviction, under federal or state law, related to theft, fraud, embezzlement, breach of fiduciary duty, or other financial misconduct in connection with the delivery of a health care item or service.
- Felony or misdemeanor conviction, under federal or state law, relating to the interference with or obstruction of any investigation into any criminal offense described in 42 C.F.R. Section 1001.101 or 1001.201.
- Felony or misdemeanor conviction, under federal or state law, relating to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance.

Exclusions, Revocations, or Suspensions:

Providers must also report any:

- Revocation or suspension of a license to provide health care by any state licensing authority. This includes the surrender of such a license while a formal disciplinary proceeding was pending before a state licensing authority.
- Revocation or suspension of accreditation.
- Suspension or exclusion from participation in, or any sanction imposed by, a federal or state health care program, or any debarment from participation in any federal executive branch procurement or non-procurement program.
- Current Medicare or a state health care program payment suspension under any Medicare or a state health care program billing number.
- Medicare or a state health care program revocation of any Medicare or a state health care program billing number.

Final Adverse Action Reporting:

For all individuals or entities listed in any of the previous tables, as well as the provider submitting this application, provide all information required below for any individual or entity that has been the subject of a Final Adverse Action.

Have you, under any current or former name or business identity, ever had a final adverse action? Yes or No

Report each final adverse action, when it occurred, the federal or state agency or the court/administrative body that imposed the action, and attach the resolution, if any.

Table 8:

Organization or Person Name	Final Adverse Action Taken By	Date of Final Adverse Action

Please copy this page if additional space is needed.

Section 7: Patient Protection and Affordable Care Act

Please answer all five questions:

Does the provider applicant have any current or previous direct or indirect affiliation (as defined below) with a present or former Medicaid provider?

The term "affiliation" includes, but is not limited to, relationships between individuals, business entities, or a combination of the two. The term includes direct or indirect business relationships that involve:

1. a compensation arrangement,
2. an ownership arrangement,
3. managerial authority over either member of the affiliation,
4. the ability of one member of the affiliation to control the other, or
5. the ability of a third party to control both members of the affiliation.

1. For all individuals or entities listed in any of the previous tables, list all that have uncollected debt owed to Medicaid or any other health program funded by any governmental entity, including, but not limited to, the federal and Iowa governments or mark none.

None

Name:

2. For all individuals or entities listed in any of the previous tables, list all that have been or is subject to a payment suspension under a federally-funded health care program or mark none.

None

Name:

3. For all individuals or entities listed in any of the previous tables that have had its billing privileges denied or revoked or mark none.

None

Name:

Please copy this page if additional space is needed.

4. For all individuals or entities listed in any of the previous tables that have been excluded from participation under Medicaid, Medicare or any other federally-funded health care program or mark none.

None

Name:

5. For all individuals or entities listed in any of the previous tables that have shared a National Provider Identifier (NPI) number or Federal Tax Identification number with another provider who has uncollected debt or mark none.

None

Name:

Please copy this page if additional space is needed.

The provider certifies that the information submitted on this form is, to the best of the provider's knowledge, true, accurate, and complete and that the provider has read this entire form before signing. The provider also understands that payment of claims will be from federal and state funds and that any falsification or concealment of a material fact may be prosecuted under federal and state law.

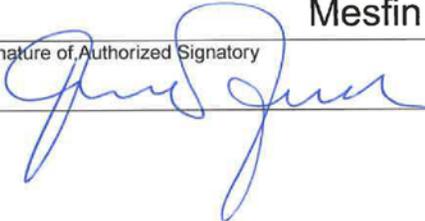
Printed Name of Legal Entity Signatory Mesfin Tegenu	
Signature of Authorized Signatory 	Date 4/20/15

Exhibit C: Subcontractor Disclosure Form

(Return this completed form behind Tab 3 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"):	AmeriHealth Caritas
Subcontractor Contact Information (individual who can address issues re: this RFP)	
Name:	Richard Walker
Address:	500 Southborough Dr, South Portland, Maine 04106
Tel:	207-822-3001
Fax:	207-773-1857
E-mail:	rwalker@sironahealth.com

Subcontractor Detail	
Subcontractor Legal Name ("Subcontractor"):	SironaHealth, Inc.
"Doing Business As" names, assumed names, or other operating names:	NA
Form of Business Entity (i.e., corp., partnership, LLC, etc.)	S corporation
State of Incorporation/organization:	Delaware
Primary Address:	500 Southborough Dr, South Portland, Maine 04106
Tel:	207-775-2600
Fax:	207-773-1857
Local Address (if any):	NA
Addresses of Major Offices and other facilities that may contribute to performance under this RFP/Contract:	NA
Number of Employees:	170
Number of Years in Business:	7
Primary Focus of Business:	Medical Contact Center
Federal Tax ID:	26-3734240
Subcontractor's Accounting Firm:	Baker, Newman, Noyes
If Subcontractor is currently registered to do business in Iowa, provide the Date of Registration:	No
Percentage of Total Work to be performed by this Subcontractor pursuant to this RFP/Contract.	1%
General Scope of Work to be performed by this Subcontractor	
See attached A	
Detail the Subcontractor's qualifications for performing this scope of work	
See attached B	

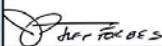
MED-16-009
Iowa High Quality Healthcare Initiative

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:	Jeff Forbes, President SironaHealth
Date:	3/31/2015

Attachment A: General Scope of Work to be performed by this Subcontractor

SIRONAHEALTH'S NURSE TRIAGE SERVICE

SironaHealth's Nurse Triage service provides client members with access to a Registered Nurse (RN) over the telephone at any time, night or day. Our purpose is to ensure patient safety and satisfaction by facilitating the next level of appropriate care with compassion and speed.

During a Nurse Triage call, a SironaHealth RN answers general health questions and evaluates any current symptoms the caller (or a member of their family) is experiencing. Based on the caller's reported symptoms, the RN then provides guidance on the next appropriate course of action.

In addition to the RN's expertise, physician-authored clinical guidelines—created by Dr. Barton Schmitt (Pediatric) and Dr. David Thompson (Adult)—enable RNs to provide consistent health information during every call. SironaHealth RN's also have access to the Healthwise medical content database, providing them with information on over 5,500 topics relating to health conditions, medical tests, procedures, medications, and everyday health and wellness issues.

Attachment B: Detail the Subcontractor's qualifications for performing this scope of work

SironaHealth has been providing nurse triage services for over a decade to healthcare providers and payers. SironaHealth is a URAC accredited center, maintains PCI certification, and is an NCQA delegate. In 2015, SironaHealth is applying for an NCQA certificate as a health information center.

URAC accreditation, with its extensive audit every three years, ensures SironaHealth has the management, privacy, and quality controls needed to perform its duties. Additionally, URAC audits guarantee SironaHealth has annual quality improvement plans in place that produce results.

SironaHealth's quality infrastructure, QCare is the means by which we achieve our stated mission, which is to guarantee patient safety and satisfaction through compassionate and competent care and a relentless focus on quality improvement.



Iowa Department of Human Services

Iowa Medicaid Ownership and Control Disclosure

Provider Name SironaHealth, Inc	Federal Tax ID or SSN 26-37374240
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Pursuant to 42 C.F.R. sections 455.104 through 455.106, providers applying for Medicaid must disclose certain information about those who have a sufficient ownership interest in the provider as well as those who act as managers or agents of the provider. The following series of questions seeks the necessary information to comply with these regulations.

It is the provider's responsibility to ensure all information is accurate and to report any changes immediately by completing a new Ownership and Disclosure form. See Section 1.6 and Section 3 of the Provider Agreement. Only one form is required per Tax Identification Number (TIN) or Social Security Number (SSN).

In the questions that follow, the provider listed above is referred to as "You" or "Your."

Section 1: Provider Type

Are you an individual practitioner or a group of practitioners?

Individual Practitioner: Yes or No

Group of Individual Practitioners Yes or No

If you answered "Yes" and you are an individual practitioner or a group of individual practitioners, please skip to Section 5. The ownership disclosure requirements do not apply to these entities that generally do not have owners, such as individual practitioner or groups of practitioners.

If you answered "No" because your entity is some form of business other than an individual practitioner or a group of practitioners, please complete all sections.

Section 2: Ownership

Individual Ownership

Please list in the following table all **individuals** with an ownership or control interest in you. Include each person's name, address, date of birth (DOB), and SSN, title (e.g., chief executive office, owner, board member, etc.) and if an owner, the percent of ownership.

"Persons with an ownership or control interest" means:

- has an ownership interest totaling five percent or more in you;
- has an indirect ownership interest equal to five percent or more in you;
- has a combination of direct and indirect ownership interest equal to five percent or more in you;
- owns an interest of five percent or more in any mortgage, deed of trust note, or other obligation secured by the disclosing entity if that interest equals at least five percent of the value of the property or assets of you;
- is an officer or director of your organization if you are organized as a corporation; or
- is a partner in your organization if organized as a partnership.

Table 1: Individual Owners

Name of Individual	Title	Ownership Percentage (if applicable)	Address	Date of Birth	Social Security Number
Jeff Forbes	President	76.0%	Confidential & Not for Public Disclosure		
Richard Walker	CFO	10.1%			
Travis Hersom	VP Technology	8.5%			

Non-individual Ownership

Please list all corporations or other form of business entity with an ownership or control interest in you. Include the TIN, the percent of ownership, the primary address, all business locations, and the P.O. Box address.

A corporation or other form of business entity is deemed to have an ownership or control interest in you if it:

- a) has an ownership interest totaling five percent or more in you;
- b) has an indirect ownership interest equal to five percent or more in you;
- c) has a combination of direct and indirect ownership interest equal to five percent or more in you;
- d) owns an interest of five percent or more in any mortgage, deed of trust note, or other obligation secured by you if that interest equals at least five percent of the value of the property or assets of you;
- e) is an officer or director of you if organized as a corporation; or
- f) is a partner in you if organized as a partnership.

Table 2: Non-individual Owners

Name of Business Entity	TIN	Ownership Percentage	Primary Business Address	All Business Addresses	All P.O. Box Addresses

Please copy this page if additional space is needed.

Your Ownership of Subcontractors

Please list all subcontractors in which you have an ownership interest of five percent or more. Include the TIN or SSN, the percent of ownership, the primary address, all business locations, and all P.O. Box addresses.

Table 3: Subcontractors

Name of Subcontractor	TIN/SSN	Ownership Percentage	Primary Business Address	All Business Addresses	All P.O. Box Addresses

Section 3: Individual Relationships

If you listed in Table 1 any individual owners of you, are any of the individual owners related to each other as a spouse, parent, child or sibling? Yes or No

If you answered Yes, please provide all of the following information about each individual owner in the table below.

Table 4:

Social Security Number	Person Name	Relationship	Date of Birth

If you listed in Table 1 any individual owners of you and also listed in Table 3 subcontractors in which you have an ownership interest, are any of the individual owners listed in Table 1 related to any owner of any subcontractors listed in Table 3 as a spouse, parent, child or sibling?

Yes or No

If you answered Yes, please provide all of the following information about each individual owner in the following table.

Table 5:

Social Security Number	Person Name	Relationship	Date of Birth

Please copy this page if additional space is needed.

Section 4: Other Disclosing Entities

Do any owners of you have an ownership or control interest in any "other disclosing entity"? This question is asking if any of your owners have an ownership or control interest in any other organization that would qualify as a "disclosing entity." "Other disclosing entity" means any other Medicaid disclosing entity and any entity that does not participate in Medicaid, but is required to disclose certain ownership and control information because of participation in any of the programs established under Title V, XVIII or XX or the Act. This includes:

- a) Any hospital, skilled nursing facility, home health agency, independent clinical laboratory, renal disease facility, rural health clinic, or health maintenance organization that participates in Medicare (Title XVIII);
- b) Any Medicare intermediary or carrier; and
- c) Any entity (other than an individual practitioner or group of practitioners) that furnishes, or arranges for the furnishing of, health-related services for which it claims payment under any plan or program established under Title V or Title XX of the Act.

Whereas "disclosing entity" is limited to Medicaid provider, "other disclosing entity" can include entities that are not enrolled in a Medicaid program.

List in the following table the name of each owner of you who has such interest and the name of other disclosing entity in which the owner has an ownership or control interest in:

Table 6:

Name of Owner	Name of Other Disclosing Entity

Please copy this page if additional space is needed.

Section 5: Managing Employees

Federal regulations require that Medicaid agencies require providers to submit information about managing employees. The term "managing employees" means a general manager, business manager, administrator, director, or other individuals who exercise operational or managerial control over, or who directly or indirectly conduct the day-to-day operation of an institution, organization, or agency. The term "managing employees" includes any "agent" of the provider, which would include any person who has been delegated the authority to obligate or act on behalf of the provider. All managing employees of the provider at any of the provider's practice locations must be reported in this section.

Please provide the following information in the table below; the name of all managing employees, title, address, DOB, and SSN.

Table 7:

Name	Title	Address	DOB	SSN
Jeff Forbes	President	Confidential & Not for Public Disclosure		
Richard Walker	CFO			
Travis Hersom	VP Technology			
Dan Roy	VP Operations			
Lorie Whittemore	VP Quality			

Please copy this page if additional space is needed.

Section 6: Final Adverse Actions

This section captures information on “Final Adverse Actions,” such as convictions, exclusions, revocations, and suspensions. All applicable final adverse actions must be reported, regardless of whether any records were expunged or any appeals are pending. Enrolled providers are required to report all Final Adverse Actions/Convictions within 30 days of the reportable event.

Final Adverse Actions That Must Be Reported:

Criminal Conduct:

The provider, supplier, or any owner of the provider or supplier must report any convictions of criminal offenses related to that person's involvement in any program under Medicare, Medicaid, or Title XX service program since the inception of those programs. Criminal offenses include:

- Felony convictions, guilty pleas and adjudicated pre-trial diversions; financial crimes, such as extortion, embezzlement, income tax evasion, insurance fraud, and other similar crimes for which the individual was convicted, including guilty pleas and adjudicated pre-trial diversions; any felony that placed the Medicaid program or its beneficiaries at immediate risk (such as a malpractice suit that results in a conviction of criminal neglect or misconduct); and any felonies that would result in a mandatory exclusion under Section 1128(a) of the Social Security Act.
- Misdemeanor conviction, under federal or state law, related to: (1) the delivery of an item or service under Medicare or a state health care program, or (2) the abuse or neglect of a patient in connection with the delivery of a health care item or service.
- Misdemeanor conviction, under federal or state law, related to theft, fraud, embezzlement, breach of fiduciary duty, or other financial misconduct in connection with the delivery of a health care item or service.
- Felony or misdemeanor conviction, under federal or state law, relating to the interference with or obstruction of any investigation into any criminal offense described in 42 C.F.R. Section 1001.101 or 1001.201.
- Felony or misdemeanor conviction, under federal or state law, relating to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance.

Exclusions, Revocations, or Suspensions:

Providers must also report any:

- Revocation or suspension of a license to provide health care by any state licensing authority. This includes the surrender of such a license while a formal disciplinary proceeding was pending before a state licensing authority.
- Revocation or suspension of accreditation.
- Suspension or exclusion from participation in, or any sanction imposed by, a federal or state health care program, or any debarment from participation in any federal executive branch procurement or non-procurement program.
- Current Medicare or a state health care program payment suspension under any Medicare or a state health care program billing number.
- Medicare or a state health care program revocation of any Medicare or a state health care program billing number.

Final Adverse Action Reporting:

For all individuals or entities listed in any of the previous tables, as well as the provider submitting this application, provide all information required below for any individual or entity that has been the subject of a Final Adverse Action.

Have you, under any current or former name or business identity, ever had a final adverse action? Yes or No

Report each final adverse action, when it occurred, the federal or state agency or the court/administrative body that imposed the action, and attach the resolution, if any.

Table 8:

Organization or Person Name	Final Adverse Action Taken By	Date of Final Adverse Action

Please copy this page if additional space is needed.

Section 7: Patient Protection and Affordable Care Act

Please answer all five questions:

Does the provider applicant have any current or previous direct or indirect affiliation (as defined below) with a present or former Medicaid provider?

The term "affiliation" includes, but is not limited to, relationships between individuals, business entities, or a combination of the two. The term includes direct or indirect business relationships that involve:

1. a compensation arrangement,
2. an ownership arrangement,
3. managerial authority over either member of the affiliation,
4. the ability of one member of the affiliation to control the other, or
5. the ability of a third party to control both members of the affiliation.

1. For all individuals or entities listed in any of the previous tables, list all that have uncollected debt owed to Medicaid or any other health program funded by any governmental entity, including, but not limited to, the federal and Iowa governments or mark none.

None

Name:

2. For all individuals or entities listed in any of the previous tables, list all that have been or is subject to a payment suspension under a federally-funded health care program or mark none.

None

Name:

3. For all individuals or entities listed in any of the previous tables that have had its billing privileges denied or revoked or mark none.

None

Name:

Please copy this page if additional space is needed.

4. For all individuals or entities listed in any of the previous tables that have been excluded from participation under Medicaid, Medicare or any other federally-funded health care program or mark none.

None

Name:

5. For all individuals or entities listed in any of the previous tables that have shared a National Provider Identifier (NPI) number or Federal Tax Identification number with another provider who has uncollected debt or mark none.

None

Name:

Please copy this page if additional space is needed.

The provider certifies that the information submitted on this form is, to the best of the provider's knowledge, true, accurate, and complete and that the provider has read this entire form before signing. The provider also understands that payment of claims will be from federal and state funds and that any falsification or concealment of a material fact may be prosecuted under federal and state law.

Printed Name of Legal Entity Signatory	
Richard Walker	
Signature of Authorized Signatory	Date
	4/13/15

4. For all individuals or entities listed in any of the previous tables that have been excluded from participation under Medicaid, Medicare or any other federally-funded health care program or mark none.

None

Name:

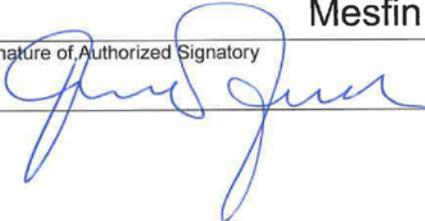
5. For all individuals or entities listed in any of the previous tables that have shared a National Provider Identifier (NPI) number or Federal Tax Identification number with another provider who has uncollected debt or mark none.

None

Name:

Please copy this page if additional space is needed.

The provider certifies that the information submitted on this form is, to the best of the provider's knowledge, true, accurate, and complete and that the provider has read this entire form before signing. The provider also understands that payment of claims will be from federal and state funds and that any falsification or concealment of a material fact may be prosecuted under federal and state law.

Printed Name of Legal Entity Signatory	
Mesfin Tegenu	
Signature of Authorized Signatory	Date
	4/20/15

3.2.7.2 Financial Statements

All necessary financial statements have been provided and are bound separately.

3.2.7.3 Resumes

AmeriHealth Caritas has engaged recruitment agencies to build a talent pipeline of highly-skilled, qualified candidates for key roles, which positions the organization to hire candidates quickly once the award is announced. AmeriHealth Caritas Iowa will submit the resumes to DHS within 10 calendar days of the execution of the contract.

3.2.7.4 Contract Lists

3.2.7.4.2 Table

Table of publically-funded managed care contracts for Medicaid, CHIP, and other low-income populations within the last five years.

AmeriHealth Caritas Pennsylvania, Pennsylvania	
Contract Duration	1997 to present
Contact Name / Phone Number / Email	Margaret Angello, Market President 717-651-3552 mangelo@amerihealthcaritaspa.com
# Members Served by Population Type	More than 143,000 serving: <ul style="list-style-type: none"> • Medicaid managed care. • Temporary Assistance for Needy Families (TANF). • Supplemental Security Income (SSI) with and without Medicare. • State and Federal General Assistance and Medically Needy.
Annual Contract Payment & Description if payment was capitated	Primarily capitation \$684,599,411
Improvements in Utilization Trends and Quality Indicators - Examples*	<ul style="list-style-type: none"> • The health plan achieved a 10 percent decrease in 30-day hospital readmissions for members with targeted chronic conditions in 2014. • Focused program on asthma medication adherence yielded a 13 percent decline in asthma-related hospital admissions. • Members engaged in telephonic care management: 36 percent decrease in emergency room (ER) visits, 27 percent decrease in ER costs and 30 percent decrease in inpatient costs.

AmeriHealth Caritas Pennsylvania, Pennsylvania	
How Contract Emphasizes Member Choice **	<ul style="list-style-type: none"> Members proactively choose their primary care provider (PCP) to serve as their medical homes. Members are able to choose from available network providers without referral. The health plan provides broad spectrum of providers rather than limited networks for all services.
How Contract Emphasizes Access **	<ul style="list-style-type: none"> The Rapid Response team is available to help members in need of assistance with specialty needs. Supports are available through discharge planning to identify resources for preventative care in community setting. We closely monitor availability of provider network and report out through consolidated registry that can be compared across plans.
How Contract Emphasizes Safety **	<ul style="list-style-type: none"> Member newsletters are published quarterly with focused areas targeting member safety. Community Education representatives meet members at community events to educate about availability of services from plan and other resources. The health plan connects members with resources from the Care Management team resources to assist families with more intense healthcare needs to navigate the system.
How Contract Emphasizes Independence & Responsibility **	<ul style="list-style-type: none"> The healthy rewards program provides gift cards to members who access key preventative care. The Web-based Member Portal allows for access to key plan information such as the member's PCP, ID card and medication history. The health plan is currently implementing smart phone technology to make such resources more readily available for members.
Role of Subcontractors, if any	<ul style="list-style-type: none"> Administration of pharmacy, dental, and routine vision and eye wear benefits. Utilization management for radiology services. Nurse triage line. Payment Integrity services include retrospective data mining and complex medical record reviews, TPL cost avoidance, carrier recoveries of retroactive TPL (pharmacy only) and subrogation.

AmeriHealth District of Columbia, District of Columbia	
Contract Duration	2013 to present
Contact Name / Phone Number / Email	Karen Dale, Market President 202-326-8741 kdale@amerihealthdc.com
# Members Served by Population Type	More than 108,000 serving: <ul style="list-style-type: none"> • Medicaid managed care. • TANF. • Children’s Health Insurance Program (CHIP). • Previously uninsured adults.
Annual Contract Payment & Description if payment was capitated	Primarily capitation \$445,412,466
Improvements in Utilization Trends and Quality Indicators - Examples *	<ul style="list-style-type: none"> • Focusing on members with dominant chronic conditions, the health plan achieved a 57 percent decrease in potentially preventable events, driven by a 63 percent decrease in potentially preventable admissions. • The health plan achieved the following results for members participating in Integrated Care Management: 60 percent decline in inpatient (IP) costs; 50 percent in IP admissions; 47 percent decline in IP Days; and 66 percent decline in potentially preventable admissions, six months post-engagement.
How Contract Emphasizes Member Choice **	<ul style="list-style-type: none"> • Members proactively choose their PCPs to serve as their medical homes. • Members are able to choose from available network providers without referral. • The health plan provides broad spectrum of providers rather than limited networks for all services. • The health plan solicits information regarding language and cultural preferences regarding providers.
How Contract Emphasizes Access **	<ul style="list-style-type: none"> • The Rapid Response Team is available to assist members in need of assistance with specialty needs. • Supports are available through discharge planning to identify resources for preventive care in community setting. • We closely monitor availability of provider network and report out through consolidated registry that can be compared across plans. • The health plan offers a telepsych program for access to behavioral health services at medical provider offices.

AmeriHealth District of Columbia, District of Columbia	
How Contract Emphasizes Safety**	<ul style="list-style-type: none"> Member newsletters are published quarterly with focused areas targeting member safety. Community Education representatives meet members at community events to educate about availability of services from plan and other resources. The health plan connects members with Care Management team resources to assist families with more intense healthcare needs to navigate the system.
How Contract Emphasizes Independence & Responsibility**	<ul style="list-style-type: none"> The healthy rewards program provides gift cards to members who access key preventative care. The Web-based Member Portal allows for access to key plan information such as the member's PCP, ID card and medication history. The health plan is currently implementing smart phone technology to make such resources more readily available for members. The "I am Healthy" campaign takes a holistic approach to providing members with small steps they can take to be healthy.
Role of Subcontractors, if any	<ul style="list-style-type: none"> Administration of pharmacy, dental, and routine vision and eye wear benefits. Utilization management for radiology services. Nurse triage line. Payment Integrity services include retrospective data mining and complex medical record reviews, TPL cost avoidance, carrier recoveries of retroactive TPL and subrogation.

AmeriHealth Caritas Louisiana, Louisiana	
Contract Duration	2012 to present
Contact Name / Phone Number / Email	Kyle Viator, Market President 225-300-9238 kviator@amerihealthcaritasla.com
# Members Served by Population Type	More than 153,000 serving: <ul style="list-style-type: none"> • Medicaid managed care. • SSI. • FITAP (TANF). • Home and community-based services (HCBS) Waiver population. • Foster children. • Breast and cervical cancer. • LaCHIP (LAP).
Annual Contract Payment & Description if payment was capitated	Primarily capitation \$536,886,831
Improvements in Utilization Trends and Quality Indicators - Examples*	<ul style="list-style-type: none"> • The health plan achieved an 18 percent decrease in 30-day hospital readmissions for members with targeted chronic conditions in 2014. • The health plan's focused program on diabetes management yielded a 17 percent decline in hospital admissions for diabetic members. • Focusing on members with dominant chronic conditions achieved a 37 percent decrease in potentially preventable events, driven by a 52 percent decrease in potentially preventable admissions • Year-over-year decreases in NICU utilization, primarily related to overall decrease in births and slight reduction in C-section rates. The health plan is aggressively promoting the use of 17-P to reduce pre-term births in both.
How Contract Emphasizes Member Choice**	<ul style="list-style-type: none"> • Members proactively choose their PCPs to serve as their medical homes. • Members are able to choose from available network providers without referral. • The health plan provides broad spectrum of providers rather than limited networks for all services.
How Contract Emphasizes Access**	<ul style="list-style-type: none"> • The Rapid Response Team is available to assist members in need of assistance with specialty needs. • Supports are available through discharge planning to identify resources for preventive care in community setting.

AmeriHealth Caritas Louisiana, Louisiana	
	<ul style="list-style-type: none"> The health plan closely monitors availability of provider network and report out through consolidated registry that can be compared across plans.
How Contract Emphasizes Safety **	<ul style="list-style-type: none"> Member newsletters are published quarterly with focused areas targeting member safety. Community Education representatives meet members at community events to educate about availability of services from plan and other resources. The health plan connects members with Care Management team resources to assist families with more intense healthcare needs to navigate the system.
How Contract Emphasizes Independence & Responsibility **	<ul style="list-style-type: none"> The healthy rewards program provides gift cards to members who access key preventative care. The Web-based Member Portal allows for access to key plan information such as the member's PCP, ID card and medication history. The health plan is currently implementing smart phone technology to make such resources more readily available for members.
Role of Subcontractors, if any	<ul style="list-style-type: none"> Administration of pharmacy, dental, non-emergency medical transportation and routine vision and eye wear benefits. Utilization management for radiology services. Nurse triage line. Payment Integrity services include retrospective data mining and complex medical record reviews, TPL cost avoidance, carrier recoveries of retroactive TPL and subrogation.

AmeriHealth Northeast, Pennsylvania	
Contract Duration	1997 to present
Contact Name / Phone Number / Email	Margaret Angello, Market President 717-651-3552 mangelo@amerihealthcaritaspa.com
# Members Served by Population Type	More than 55,000 serving: <ul style="list-style-type: none"> • Medicaid managed care. • TANF. • SSI with and without Medicare. • State and federal GA and Medically Needy.
Annual Contract Payment & Description if payment was capitated	Primarily capitation \$276,799,706
Improvements in Utilization Trends and Quality Indicators - Examples *	The health plan focused on reducing 30-day hospital readmissions for members with targeted chronic conditions in 2014, and yielded a 13 percent reduction.
How Contract Emphasizes Member Choice **	<ul style="list-style-type: none"> • Members proactively choose their PCPs to serve as their medical homes. • Members are able to choose from available network providers without referral. • The health plan provides broad spectrum of providers rather than limited networks for all services.
How Contract Emphasizes Access **	<ul style="list-style-type: none"> • The Rapid Response Team is available to assist members in need of assistance with specialty needs. • Supports are available through discharge planning to identify resources for preventive care in community setting. • We closely monitor availability of provider network and report out through consolidated registry that can be compared across plans.
How Contract Emphasizes Safety **	<ul style="list-style-type: none"> • Member newsletters are published quarterly with focused areas targeting member safety. • Community Education representatives meet members at community events to educate about availability of services from plan and other resources. • The health plan connects members with Care Management team resources to assist families with more intense healthcare needs to navigate the system

AmeriHealth Northeast, Pennsylvania	
How Contract Emphasizes Independence & Responsibility**	<ul style="list-style-type: none"> • The healthy rewards program provides gift cards to members who access key preventative care. • The Web-based Member Portal allows for access to key plan information such as the member's PCP, ID card and medication history. • The health plan is currently implementing smart phone technology to make such resources more readily available for members.
Role of Subcontractors, if any	<ul style="list-style-type: none"> • Administration of pharmacy, dental, and routine vision and eye wear benefits. • Utilization management for radiology services. • Nurse triage line. • Payment Integrity services include retrospective data mining and complex medical record reviews, TPL cost avoidance, carrier recoveries of retroactive TPL and subrogation.

Arbor Health Plan, Nebraska	
Contract Duration	2012 to present
Contact Name / Phone Number / Email	Thomas Smith, Market President 402-507-5995 tpsmith@arborhealthplan.com
# Members Served by Population Type	More than 24,000 serving: <ul style="list-style-type: none"> • Medicaid managed care. • TANF. • SSI with and without Medicare. • State and federal GA and Medically Needy.
Annual Contract Payment & Description if payment was capitated	Primarily capitation \$69,007,000
Improvements in Utilization Trends and Quality Indicators - Examples *	<ul style="list-style-type: none"> • The health plan achieved a 29 percent decrease in 30-day hospital readmissions for members with targeted chronic conditions in 2014. • The health plan focused members with dominant chronic conditions and achieved a 48 percent decrease in potentially preventable events, driven by a 69 percent decrease in potentially preventable Admissions.
How Contract Emphasizes Member Choice **	<ul style="list-style-type: none"> • Members proactively choose their PCPs to serve as their medical homes. • Members are able to choose from available network providers without referral. • The health plan provides broad spectrum of providers rather than limited networks for all services. • The health plan has a fully contracted network both statewide in Nebraska and also in all of the contiguous state for referral purposes.
How Contract Emphasizes Access **	<ul style="list-style-type: none"> • The Rapid Response Team is available to assist members in need of assistance with specialty needs. • Supports are available through discharge planning to identify resources for preventive care in community setting. • We closely monitor availability of provider network and report out through consolidated registry that can be compared across plans.
How Contract Emphasizes Safety **	<ul style="list-style-type: none"> • Member newsletters are published quarterly with focused areas targeting member safety. • Community Education representatives meet members at community events to educate about availability of services from plan and other resources. • The health plan connects members with Care Management team resources to assist families with more intense healthcare needs to navigate the system.

Arbor Health Plan, Nebraska	
How Contract Emphasizes Independence & Responsibility**	<ul style="list-style-type: none">• The healthy rewards program provides gift cards to members who access key preventative care.• The Web-based Member Portal allows for access to key plan information such as the member's PCP, ID card and medication history.• The health plan is currently implementing smart phone technology to make such resources more readily available for members.
Role of Subcontractors, if any	<ul style="list-style-type: none">• Administration of dental as well as routine vision and eye wear benefits.• Utilization management for radiology services.• Nurse triage line.• Payment Integrity services include retrospective data mining and complex medical record reviews, TPL cost avoidance, carrier recoveries of retroactive TPL and subrogation.

First Choice by Select Health, South Carolina	
Contract Duration	1996 - present
Contact Name / Phone Number / Email	Rebecca Engelman, Market President 843-569-4606 rengelman@selecthealthofsc.com
# Members Served by Population Type	More than 340,000 serving: <ul style="list-style-type: none"> • Medicaid managed care. • SSI without Medicare. • TANF. • OCWI. • Foster children.
Annual Contract Payment & Description if payment was capitated	Primarily capitation \$1,127,423,370
Improvements in Utilization Trends and Quality Indicators - Examples *	<ul style="list-style-type: none"> • The health plan is a statewide sponsor of the Premature Birth Campaign in South Carolina. Recent data on C-Section deliveries indicate a 10 percent decrease for the health plan. • Members participating in integrated healthcare management (IHM) yielded a 40 percent decrease in inpatient admissions, statistically significantly greater than the experience of a control group of non-enrolled members. • Community Care Hubs targeting Super Utilizers achieved a 28 percent decline in IP dollars, 40 percent decline in IP admissions, and 15 percent decline in total dollars (excluding prescriptions). • YOY decreases in NICU utilization, primarily related to overall decrease in births and slight reduction in C-section rates. The health plan is aggressively promoting the use of 17-P to reduce pre-term births in both.
How Contract Emphasizes Member Choice **	<ul style="list-style-type: none"> • Members proactively choose their PCPs to serve as their medical homes. • Members are able to choose from available network providers without referral. • The health plan provides broad spectrum of providers rather than limited networks for all services

First Choice by Select Health, South Carolina	
How Contract Emphasizes Access**	<ul style="list-style-type: none"> The Rapid Response Team is available to assist members in need of assistance with specialty needs. Supports are available through discharge planning to identify resources for preventive care in community setting. We closely monitor availability of provider network and report out through consolidated registry that can be compared across plans. The health plan monitors member gaps in care and outreach to encourage services and evaluate barriers to access (i.e., transportation).
How Contract Emphasizes Safety**	<ul style="list-style-type: none"> Continual monitoring of pharmacy utilization data for drug interactions, drug utilization review (DUR) edits, recalls, and drug/diagnosis conditions. Member newsletters are published quarterly with focused areas targeting member safety. Community Education representatives meet members at community events to educate about availability of services from plan and other resources. The health plan connects members with Care Management team resources to assist families with more intense healthcare needs to navigate the system.
How Contract Emphasizes Independence & Responsibility**	<ul style="list-style-type: none"> The healthy rewards program provides gift cards to members who access key preventative care. The Web-based Member Portal allows for access to key plan information such as the member's PCP, ID card and medication history.
Role of Subcontractors, if any	<ul style="list-style-type: none"> Administration of pharmacy benefit. Utilization management for radiology services. Payment Integrity services include retrospective data mining and complex medical record reviews, TPL cost avoidance, carrier recoveries of retroactive TPL and subrogation.

Keystone First, Pennsylvania	
Contract Duration	1996 –to present
Contact Name / Phone Number / Email	Joanne McFall, Market President 215-863-6467 JMcFall@amerihealthcaritas.com
# Members Served by Population Type	More than 318,000 serving: <ul style="list-style-type: none"> • Medicaid managed care. • TANF. • SSI with and without Medicare. • State and federal GA and Medically Needy.
Annual Contract Payment & Description if payment was capitated	<ul style="list-style-type: none"> • Primarily capitation \$2,088,513,546
Improvements in Utilization Trends and Quality Indicators - Examples *	<ul style="list-style-type: none"> • The “For Your Kids” community education program on how to care for sick children, effective home treatments, and when to seek medical or emergency care. The average number of non-urgent ER visits decreased - 46.3 percent for members participating in the class versus a -14.6 percent reduction for a control group of non-participants. • The focused program on diabetes management yielded a 22 percent decline in hospital admissions for diabetic members. • There was a 21 percent decline in hospital admissions for members with heart failure. • Community Care Hubs targeting Super Utilizers achieved 14 percent decline in IP dollars, 18 percent decline in IP admissions and 12 percent decline in total dollars (excluding prescriptions).
How Contract Emphasizes Member Choice **	<ul style="list-style-type: none"> • Members proactively choose their PCPs to serve as their medical homes. • Members are able to choose from available network providers without referral. • The health plan provides broad spectrum of providers rather than limited networks for all services.
How Contract Emphasizes Access **	<ul style="list-style-type: none"> • The Rapid Response Team is available to assist members in need of assistance with specialty needs. • Supports are available through discharge planning to identify resources for preventive care in community setting. • We closely monitor availability of provider network and report out through consolidated registry that can be compared across plans.

Keystone First, Pennsylvania	
How Contract Emphasizes Safety**	<ul style="list-style-type: none"> Member newsletters are published quarterly with focused areas targeting member safety. Community Education representatives meet members at community events to educate about availability of services from plan and other resources. The health plan connects members with Care Management team resources to assist families with more intense healthcare needs to navigate the system.
How Contract Emphasizes Independence & Responsibility**	<ul style="list-style-type: none"> The healthy rewards program provides gift cards to members who access key preventative care. The Web-based Member Portal allows for access to key plan information such as the member's PCP, ID card and medication history. The health plan is currently implementing smart phone technology to make such resources more readily available for members.
Role of Subcontractors, if any	<ul style="list-style-type: none"> Administration of pharmacy, dental, and routine vision and eye wear benefits. Utilization management for radiology services. Nurse triage line. Payment Integrity services include retrospective data mining and complex medical record reviews, TPL cost avoidance, carrier recoveries of retroactive TPL and subrogation.

MDwise Hoosier Alliance, Indiana	
Contract Duration	2007 to June 2015
Contact Name / Phone Number / Email	Susan Overton, Interim Market President 317-412-6463 soverto@hoosieralliance.org
# Members Served by Population Type	More than 127,000 serving: <ul style="list-style-type: none"> • Medicaid managed care and Healthy Indiana Uninsured Program. • TANF. • CHIP. • State and federal GA and Medically Needy. • Previously uninsured adults.
Annual Contract Payment & Description if payment was capitated	<ul style="list-style-type: none"> • Primarily capitation \$238,808,625
Improvements in Utilization Trends and Quality Indicators - Examples *	<ul style="list-style-type: none"> • The focused program on asthma medication adherence yielded a 13 percent decline in asthma-related hospital admissions. • Our overall integrated healthcare management program was independently evaluated by the Milliman, Inc. The evaluation showed a 4.3 percent reduction over the expected cost trend, estimated to amount to over \$20 million in savings for the Indiana Aged-Blind-Disabled (ABD) population.
How Contract Emphasizes Member Choice **	<ul style="list-style-type: none"> • Freedom of MCE selection at annual redetermination period. • Unlimited PCP selections made available to member. • Members are allowed to visit any physician extender if MCE does not have adequate availability.
How Contract Emphasizes Access **	<ul style="list-style-type: none"> • Members may self-refer to certain providers. • The health plan offers open access to all federally qualified health center (FQHC) and rural health center (RHC) providers throughout the state. • The health plan has strict Geo-Access standards for providers. • PCP 24/7 accessibility requirements.
How Contract Emphasizes Safety **	<ul style="list-style-type: none"> • MCE must maintain strict monitoring of provider network for exclusions and disbarments. • MCE must make available electronic means for member to submit an IQ (Internet Quorum) inquiry about provider fraud/abuse, PQI (Potential Quality Incident). • The health plan is required to refer all suspected member abuse or child abuse cases to DOH (Department of Health).

MDwise Hoosier Alliance, Indiana	
How Contract Emphasizes Independence & Responsibility**	<ul style="list-style-type: none">• MCEs are required to develop member incentive program to encourage members to be personally accountable for preventive care.• Behavioral health drug therapy• Well-child visits.• Member cost-sharing requirements for HIP (Healthy Indiana Plan) based on income.• Prescription co-pays for some Medicaid membership.
Role of Subcontractors, if any	<ul style="list-style-type: none">• Pharmacy, 24-hour nurse triage line, and transportation are subcontracted.• Payment Integrity services include data mining and subrogation.

PerformCare Pennsylvania - Capital Area HealthChoices (Cumberland, Dauphin, Lancaster, Lebanon, Perry counties)	
Contract Duration	October 2001 to present
Contact Name / Phone Number / Email	Jim Laughman, Executive Director 717-909-2171 jlaughman@performcare.org
# Members Served by Population Type	155,312 (February 2015) All Medicaid rating groups including ABD.
Annual Contract Payment & Description if payment was capitated	ASO \$15,955,975
Improvements in Utilization Trends and Quality Indicators - Examples*	<ul style="list-style-type: none"> • The health plan saw a significant increase in overall access evidenced by penetration rates for behavioral health services. • The health plan saw significant utilization reduction of out-of-home placements for children and adolescents (RTF). • The health plan achieved decreased wait times for children's wraparound services. • Over 70 percent of routine behavioral health services were offered within seven days. • There were multiple implementations of evidence-based and supplemental programs including ACT, DBT, FFT, MST, PCIT, Incredible Years, Certified Peer Support.
How Contract Emphasizes Member Choice**	<ul style="list-style-type: none"> • The contract requires freedom of choice of multiple provider options. • The "no wrong door" policy includes access directly to a provider, County-based Case Management units, crisis intervention units or emergency room, or telephonically through the plan's 24/7 Member Services.
How Contract Emphasizes Access**	<ul style="list-style-type: none"> • The contract contains stringent requirements and measurement for timely access, including emergent, urgent, and routine access measures. • The contract specifies clear requirements and annual measurement and action plans for geographic access, both urban and rural.
How Contract Emphasizes Safety**	<ul style="list-style-type: none"> • Safety initiatives include: • Critical Incident reporting required of all providers. • Multi-year restraint reduction initiative. • Ongoing treatment quality of care and complaint monitoring.

PerformCare Pennsylvania - Capital Area HealthChoices (Cumberland, Dauphin, Lancaster, Lebanon, Perry counties)	
How Contract Emphasizes Independence & Responsibility**	<ul style="list-style-type: none"> Recovery-oriented services including certified peer support, clubhouses, and psychiatric rehabilitation services. Consumer/family satisfaction teams are run by consumer organizations who complete face-to-face and telephonic surveys and interviews regarding the member's experience of care and treatment satisfaction. .
Role of Subcontractors, if any	<ul style="list-style-type: none"> Allan Collautt Associates, Inc. (IS services related to file transfers and encounter reporting). Emdeon (AmeriHealth Caritas corporate contract for electronic claims clearinghouse services). Xerox (terminated) and SourceHOV (current) (AmeriHealth Caritas corporate contract for paper claim intake services).

PerformCare Pennsylvania - Franklin-Fulton HealthChoices	
Contract Duration	July 2007 to present
Contact Name / Phone Number / Email	Jim Laughman, Executive Director 717-909-2171 jlaughman@performcare.org
# Members Served by Population Type	20,740 (February 2015) All Medicaid rating groups including ABD
Annual Contract Payment & Description if payment was capitated	ASO \$2,271,397
Improvements in Utilization Trends and Quality Indicators - Examples*	<ul style="list-style-type: none"> • The health plan saw a significant increase in overall access evidenced by penetration rates for behavioral health services. • The health plan saw significant utilization reduction of out-of-home placements for children and adolescents (RTF). • The health plan achieved decreased wait times for children's wraparound services. • Over 70 percent of routine behavioral health services were offered within seven days. • There were multiple implementations of evidence-based and supplemental programs including ACT, DBT, FFT, MST, PCIT, Incredible Years, Certified Peer Support.
How Contract Emphasizes Member Choice**	<ul style="list-style-type: none"> • The contract requires freedom of choice of multiple provider options. • The "no wrong door" policy includes access directly to a provider, County-based Case Management units, crisis intervention units or emergency room, or telephonically through the plan's 24/7 Member Services.
How Contract Emphasizes Access**	<ul style="list-style-type: none"> • The contract contains stringent requirements and measurement for timely access, including emergent, urgent, and routine access measures. • The contract specifies clear requirements and annual measurement and action plans for geographic access, both urban and rural.
How Contract Emphasizes Safety**	<ul style="list-style-type: none"> • Safety initiatives include: • Critical Incident reporting required of all providers. • Multi-year restraint reduction initiative. • Ongoing treatment quality of care and complaint monitoring.
How Contract Emphasizes Independence & Responsibility**	<ul style="list-style-type: none"> • Recovery-oriented services including certified peer support, clubhouses, and psychiatric rehabilitation services. • Consumer/family satisfaction teams are run by consumer organizations who complete face-to-face and telephonic surveys and interviews regarding the member's experience of care and treatment satisfaction.

PerformCare Pennsylvania - Franklin-Fulton HealthChoices

Role of Subcontractors, if any

- Allan Collaunt Associates, Inc. (IS services related to file transfers and encounter reporting).
- Emdeon (AmeriHealth Caritas corporate contract for electronic claims clearinghouse services).
- Xerox (terminated) and SourceHOV (current) (AmeriHealth Caritas corporate contract for paper claim intake services).

PerformCare Pennsylvania - Bedford-Somerset HealthChoices	
Contract Duration	July 2007 to present
Contact Name / Phone Number / Email	Jim Laughman, Executive Director 717-909-2171 jlaughman@performcare.org
# Members Served by Population Type	18,119 (February 2015) All Medicaid rating groups including ABD.
Annual Contract Payment & Description if payment was capitated	ASO \$2,015,236
Improvements in Utilization Trends and Quality Indicators - Examples*	<ul style="list-style-type: none"> • The health plan saw a significant increase in overall access evidenced by penetration rates for behavioral health services. • The health plan saw significant utilization reduction of out-of-home placements for children and adolescents (RTF). • The health plan achieved decreased wait times for children's wraparound services. • Over 70 percent of routine behavioral health services were offered within seven days. • There were multiple implementations of evidence-based and supplemental programs including ACT, DBT, FFT, MST, PCIT, Incredible Years, and Certified Peer Support.
How Contract Emphasizes Member Choice**	<ul style="list-style-type: none"> • The contract requires freedom of choice of multiple provider options. • The "no wrong door" policy includes access directly to a provider, County-based Case Management units, crisis intervention units or emergency room, or telephonically through the plan's 24/7 Member Services.
How Contract Emphasizes Access**	<ul style="list-style-type: none"> • The contract contains stringent requirements and measurement for timely access, including emergent, urgent, and routine access measures. • The contract specifies clear requirements and annual measurement and action plans for geographic access, both urban and rural.
How Contract Emphasizes Safety**	<ul style="list-style-type: none"> • Safety initiatives include: • Critical Incident reporting required of all providers. • Multi-year restraint reduction initiative. • Ongoing treatment quality of care and complaint monitoring.

PerformCare Pennsylvania - Bedford-Somerset HealthChoices	
How Contract Emphasizes Independence & Responsibility**	<ul style="list-style-type: none">• Recovery-oriented services including certified peer support, clubhouses, and psychiatric rehabilitation services.• Consumer/family satisfaction teams are run by consumer organizations who completes face-to-face and telephonic surveys and interviews regarding the member's experience of care and treatment satisfaction.
Role of Subcontractors, if any	<ul style="list-style-type: none">• Allan Collautt Associates, Inc. (IS services related to file transfers and encounter reporting).• Emdeon (AmeriHealth Caritas corporate contract for electronic claims clearinghouse services).• Xerox (terminated) and SourceHOV (current) (AmeriHealth Caritas corporate contract for paper claim intake services).

PerformCare Pennsylvania - Blair HealthChoices	
Contract Duration	July 2007 to June 2013
Contact Name / Phone Number / Email	Jim Laughman, Executive Director 717-909-2171 jlaughman@performcare.org
# Members Served by Population Type	22,018 (June 2013) All Medicaid rating groups including aged, blind and disabled (ABD)
Annual Contract Payment & Description if payment was capitated	At-Risk Capitation \$30,647,680
Improvements in Utilization Trends and Quality Indicators - Examples*	<ul style="list-style-type: none"> • The health plan saw a significant increase in overall access evidenced by penetration rates for behavioral health services. • The health plan saw significant utilization reduction of out-of-home placements for children and adolescents (RTF). • The health plan achieved decreased wait times for children's wraparound services. • Over 70 percent of routine behavioral health services were offered within seven days. • There were multiple implementations of evidence-based and supplemental programs including ACT, DBT, FFT, MST, PCIT, Incredible Years, and Certified Peer Support.
How Contract Emphasizes Member Choice**	<ul style="list-style-type: none"> • The contract requires freedom of choice of multiple provider options. • The "no wrong door" policy includes access directly to a provider, County-based Case Management units, crisis intervention units or emergency room, or telephonically through the plan's 24/7 Member Services.
How Contract Emphasizes Access**	<ul style="list-style-type: none"> • The contract contains stringent requirements and measurement for timely access, including emergent, urgent, and routine access measures. • The contract specifies clear requirements and annual measurement and action plans for geographic access, both urban and rural.
How Contract Emphasizes Safety**	<ul style="list-style-type: none"> • Safety initiatives include: • Critical Incident reporting required of all providers. • Multi-year restraint reduction initiative. • Ongoing treatment quality of care and complaint monitoring.

PerformCare Pennsylvania - Blair HealthChoices	
How Contract Emphasizes Independence & Responsibility**	<ul style="list-style-type: none"> Recovery-oriented services including certified peer support, clubhouses, and psychiatric rehabilitation services. Consumer/family satisfaction teams are run by consumer organizations The health plan completes face-to-face and telephonic surveys and interviews regarding the member’s experience of care and treatment satisfaction.
Role of Subcontractors, if any	<ul style="list-style-type: none"> Allan Collaunt Associates, Inc. (IS services related to file transfers and encounter reporting). Emdeon (AmeriHealth Caritas corporate contract for electronic claims clearinghouse services). Xerox (terminated) and SourceHOV (current) (AmeriHealth Caritas corporate contract for paper claim intake services).

PerformCare Pennsylvania - Lycoming-Clinton HealthChoices	
Contract Duration	July 2007 to June 2013
Contact Name / Phone Number / Email	Jim Laughman, Executive Director 717-909-2171 jlaughman@performcare.org
# Members Served by Population Type	22,554 (June 2013) All Medicaid rating groups including ABD
Annual Contract Payment & Description if payment was capitated	At-Risk Capitation \$22,849,886
Improvements in Utilization Trends and Quality Indicators - Examples*	<ul style="list-style-type: none"> • The health plan saw a significant increase in overall access evidenced by penetration rates for behavioral health services. • The health plan saw significant utilization reduction of out-of-home placements for children and adolescents (RTF). • The health plan achieved decreased wait times for children's wraparound services. • Over 70 percent of routine behavioral health services were offered within seven days. • There were multiple implementations of evidence-based and supplemental programs including ACT, DBT, FFT, MST, PCIT, Incredible Years and Certified Peer Support.
How Contract Emphasizes Member Choice**	<ul style="list-style-type: none"> • The contract requires freedom of choice of multiple provider options. • The "no wrong door" policy includes access directly to a provider, County-based Case Management units, crisis intervention units or emergency room, or telephonically through the plan's 24/7 Member Services.
How Contract Emphasizes Access**	<ul style="list-style-type: none"> • The contract contains stringent requirements and measurement for timely access, including emergent, urgent, and routine access measures. • The contract specifies clear requirements and annual measurement and action plans for geographic access, both urban and rural.
How Contract Emphasizes Safety**	<ul style="list-style-type: none"> • Safety initiatives include: • Critical Incident reporting required of all providers. • Multi-year restraint reduction initiative. • Ongoing treatment quality of care and complaint monitoring.

PerformCare Pennsylvania - Lycoming-Clinton HealthChoices	
How Contract Emphasizes Independence & Responsibility**	<ul style="list-style-type: none">• Recovery-oriented services including certified peer support, clubhouses, and psychiatric rehabilitation services.• Consumer/family satisfaction teams are run by consumer organizations. These teams complete face-to-face and telephonic surveys and interviews regarding the member's experience of care and treatment satisfaction.
Role of Subcontractors, if any	<ul style="list-style-type: none">• Allan Collautt Associates, Inc. (IS services related to file transfers and encounter reporting).• Emdeon (AmeriHealth Caritas corporate contract for electronic claims clearinghouse services).• Xerox (terminated) and SourceHOV (current) (AmeriHealth Caritas corporate contract for paper claim intake services).

PerformCare New Jersey- Children's System of Care	
Contract Duration	September 2009 to present
Contact Name / Phone Number / Email	Kathleen Enerlich, Executive Director 609-689-5401 KEnerlich@performcarenj.org
# Members Served by Population Type	61,809 (calendar year 2014)
Annual Contract Payment & Description if payment was capitated	\$12,976,404
Improvements in Utilization Trends and Quality Indicators - Examples *	Utilization Trends: <ul style="list-style-type: none"> • The average length of stay in residential programs decreased by 28 percent from 2012 to 2014. • The number of child welfare foster families calling for services increased by percent. • Ninety-six percent of 17,028 youth receiving Mobile Response Services remained at home, not requiring hospitalization (2014).
How Contract Emphasizes Member Choice **	<ul style="list-style-type: none"> • Members have a choice of providers (i.e., family support services, outpatient services, in-home intensive community services and in-home habilitation services.
How Contract Emphasizes Access **	<ul style="list-style-type: none"> • The health plan has a 24/7/365 call center. • Members have access to Mobile Response and Care Management 24/7/365. • Clinical criteria are used to authorize right intensity of service. Reviews are expedited as needed.
How Contract Emphasizes Safety **	<ul style="list-style-type: none"> • The health plan provides regular screening for life threatening emergencies and rapid triage of calls. • Referral to psychiatric screening services and request for police dispatch for youth presenting a danger for self or others. • Referral to child welfare Central Registry for potential neglect or abuse. • Utilization management review is provided for: Suicide ideation or attempt; self-injury requiring medical intervention; physically assaultive to a parent or other authority figure; psychiatric hospitalization; mental health screening; victim of human trafficking; threat to harm others; victim of bullying.

PerformCare New Jersey- Children's System of Care	
How Contract Emphasizes Independence & Responsibility**	<ul style="list-style-type: none">• Values and principles driving the system of care:• Child-centered and family-driven care.• Strength-based.• Individualized care based on need.• Culturally competent.• Promotes independence.• Collaborative.
Role of Subcontractors, if any	<ul style="list-style-type: none">• The health plan uses Tidgewell Associates Inc. for information technology services.

PerformRx, Pennsylvania	
Contract Duration	September 2010 to August 2015
Contact Name / Phone Number / Email	Mesfin Tegenu, President 215-937-5013 MTegenu@performrx.com
# Members Served by Population Type	15,364 California Department of Corrections and Rehabilitation Parolees including Juveniles and Adult Parolees.
Annual Contract Payment & Description if payment was capitated	ASO \$289,811
Improvements in Utilization Trends and Quality Indicators - Examples *	The health plan provides clinical and cost containment programs including: <ul style="list-style-type: none"> • Concurrent drug utilization review (DUR). • Retrospective DUR. • Physician profiling. • Prior authorization. • Step therapy. • Dose optimization/efficiency. • Quality/dosing limitations.
How Contract Emphasizes Member Choice **	<ul style="list-style-type: none"> • The health plan works with Department of Government Services and participating entity to develop an enrollment report detailing the patients eligible to receive pharmacy benefits.
How Contract Emphasizes Access **	<ul style="list-style-type: none"> • Provide patients access to two (2) pharmacies within a five (5) mile radius for each California zip code or a reasonable travel distance for rural areas. • Provide mail order pharmacy services if requested by participating entity. • Work with participating entity to identify pharmacies that will be accessed for emergency fill agreements, which require 24-hour services.
How Contract Emphasizes Safety **	<ul style="list-style-type: none"> • The health plan develops, implements and administers DURs. • Work with DGS and participating entity to develop DUR edits (i.e., drug-drug interactions, poly-pharmacy, dosing level, etc.). • Conduct prospective and retrospective DURs to reduce the cost of medication treatment to the state and prevent significant medication interactions and complications for patients of participating entities.

PerformRx, Pennsylvania	
How Contract Emphasizes Independence & Responsibility**	<ul style="list-style-type: none">• The health plan provides a dedicated toll-free telephone line with live caller support 24/7 for at least 360 days per year.• Interactive Voice Response (IVR) and Web support 24/7 for at least 360 days per year.• Customer Service Representatives will have access to a pharmacist in the event the call requires the attention of a clinician.
Role of Subcontractors, if any	<ul style="list-style-type: none">• Pharmacy claims processing is subcontracted to Argus Health Systems, Inc. to process claims and reporting associated with claims processing systems.

AmeriHealth Caritas VIP, Pennsylvania (Dual Eligible Special Need Medicare Advantage Plan)	
Contract Duration	January 2013 to present
Contact Name / Phone Number / Email	Tonya Moody, Vice President Medicare 215-863-5700 tmoody@amerihealthcaritas.com
# Members Served by Population Type	Projected 161
Annual Contract Payment & Description if payment was capitated	Projected \$1,720 Capitated
Improvements in Utilization Trends and Quality Indicators - Examples*	<ul style="list-style-type: none"> As a newer plan with small enrollment, there were fluctuations in utilization and quality data is not yet available. But in 2014, the health plan's efforts to engage members resulted in a 65 percent engagement rate. Gaps in care were identified and an outreach program was performed. This outreach included a home visit initiative for members with a gap in care and the need for hemoglobin A1C or BMI level measurement.
How Contract Emphasizes Member Choice**	<ul style="list-style-type: none"> Members proactively choose their PCPs to serve as their medical homes. Members are able to choose from available network providers without referral. The health plan provides broad spectrum of providers rather than limited networks for all services.
How Contract Emphasizes Access**	<ul style="list-style-type: none"> The Rapid Response Team is available to assist members in need of assistance with specialty needs. Supports are available through discharge planning to identify resources for preventive care in community setting. We closely monitor availability of provider network and report out through consolidated registry that can be compared across plans.
How Contract Emphasizes Safety**	<ul style="list-style-type: none"> Member newsletters are published quarterly with focused areas targeting member safety. Community Education representatives meet members at community events to educate about availability of services from plan and other resources. The health plan connects members with Care Management team resources to assist families with more intense healthcare needs to navigate the system

AmeriHealth Caritas VIP, Pennsylvania (Dual Eligible Special Need Medicare Advantage Plan)	
How Contract Emphasizes Independence & Responsibility**	<ul style="list-style-type: none">• The healthy rewards program provides gift cards to members who access key preventative care.• The Web-based Member Portal allows for access to key plan information such as the member's PCP, ID card and medication history.• The health plan is currently implementing smart phone technology to make such resources more readily available for members.
Role of Subcontractors, if any	<ul style="list-style-type: none">• Administration of pharmacy, dental, non-emergency medical transportation and routine vision and eye wear benefits.• Utilization management for radiology services.• Nurse triage line.• Payment Integrity services include data mining and subrogation.

Keystone VIP Choice, Pennsylvania (Dual Eligible Special Need Medicare Advantage Plan)	
Contract Duration	January 2013 to present
Contact Name / Phone Number / Email	Tonya Moody, Vice President Medicare 215-863-5700 tmoody@amerihealthcaritas.com
# Members Served by Population Type	Project 3,569
Annual Contract Payment & Description if payment was capitated	Projected \$54,012 Yes
Improvements in Utilization Trends and Quality Indicators - Examples*	<ul style="list-style-type: none"> As a newer plan with small enrollment, there were fluctuations in utilization and quality data is not yet available. But in 2014, the health plan's efforts to engage members resulted in a 65 percent engagement. Gaps in care were identified and an outreach program was performed. This outreach included a home visit initiative for members with a gap in care and the need for hemoglobin A1C or BMI level measurement.
How Contract Emphasizes Member Choice**	<ul style="list-style-type: none"> Members proactively choose their PCPs to serve as their medical homes. Members are able to choose from available network providers without referral. The health plan provides broad spectrum of providers rather than limited networks for all services.
How Contract Emphasizes Access**	<ul style="list-style-type: none"> The Rapid Response Team is available to assist members in need of assistance with specialty needs. Supports are available through discharge planning to identify resources for preventive care in community setting. We closely monitor availability of provider network and report out through consolidated registry that can be compared across plans.
How Contract Emphasizes Safety**	<ul style="list-style-type: none"> Member newsletters are published quarterly with focused areas targeting member safety. Community Education representatives meet members at community events to educate about availability of services from plan and other resources. The health plan connects members with Care Management team resources to assist families with more intense healthcare needs to navigate the system.
How Contract	<ul style="list-style-type: none"> The healthy rewards program provides gift cards to members who access

Keystone VIP Choice, Pennsylvania (Dual Eligible Special Need Medicare Advantage Plan)	
Emphasizes Independence & Responsibility**	<p>key preventative care.</p> <ul style="list-style-type: none">• The Web-based Member Portal allows for access to key plan information such as the member's PCP, ID card and medication history.• The health plan is currently implementing smart phone technology to make such resources more readily available for members.
Role of Subcontractors, if any	<ul style="list-style-type: none">• Administration of pharmacy, dental, non-emergency medical transportation and routine vision and eye wear benefits.• Fulfillment of the over-the-counter benefit.• Nurse triage line.• Payment Integrity services include data mining, complex medical record reviews, and subrogation.

AmeriHealth VIP Care Plus, Michigan (Medicare Medicaid Plan)	
Contract Duration	May 2015 to present
Contact Name / Phone Number / Email	Marcia Laleman, Market President 215-817-4521 mlaleman@amerihealthcaritas.com
# Members Served by Population Type	Projected 7,750
Annual Contract Payment & Description if payment was capitated	Projected \$83,879 Capitated
Improvements in Utilization Trends and Quality Indicators - Examples*	This is a new Medicare-Medicaid Plan with the goal to assess and actively engage in care planning each member who enrolls.
How Contract Emphasizes Member Choice**	<ul style="list-style-type: none"> • Integrated care plans are developed with member input and agreement and supported by the integrated care team with a primary focus on person-centered planning and self-determination. • All Members proactively chose their PCP to serve as medical home and who are included in the Integrated Care Team. • Provide broad spectrum of providers rather than limited networks for all services.
How Contract Emphasizes Access**	<ul style="list-style-type: none"> • Personal Care Connectors are embedded in the care coordination team and available via phone 8:00 am - 8:00 pm Monday through Friday • The Rapid Response team available 24-7 Monday through Friday to assist members in need of assistance with specialty needs. • Community Health Navigators are assigned caseload stratified by acuity and assist member in accessing all care. • Care Coordinators support discharge planning and transition to community through in-home support and identification of resources for preventative care in community setting. • Closely monitor availability of provider network and report out through consolidated registry that can be compared across plans.
How Contract Emphasizes Safety**	<ul style="list-style-type: none"> • Community Health Navigators and Care Coordinators assess home safety needs during home visits scheduled according to risk stratification. • Community based services brought to home to modify unsafe conditions. Member newsletters published quarterly with focused areas targeting member safety. • Community Education representatives meeting members at community events to educate about availability of services from plan and other resources.

AmeriHealth VIP Care Plus, Michigan (Medicare Medicaid Plan)	
How Contract Emphasizes Independence & Responsibility**	<ul style="list-style-type: none"> Care coordination program guided by person-centered planning and self-determination. The healthy rewards program provides gift cards to members who access key preventative care. The Web-based Member Portal allows for access to key plan information such as the member's PCP, ID card and medication history. The health plan is currently implementing smart phone technology to make such resources more readily available for members.
Role of Subcontractors, if any	<ul style="list-style-type: none"> Administration of pharmacy, dental, routine vision and eye wear, and non-emergency medical transportation benefits. Administration of behavioral health and LTSS benefits. Nurse triage line. Payment Integrity Services include retrospective data mining and complex medical record reviews and subrogation.

First Choice VIP Care Plus, South Carolina (Medicare Medicaid Plan)	
Contract Duration	February 2015 to present
Contact Name / Phone Number / Email	Jay Powell, Market President 843-414-5135 JPowell@FirstChoiceVIPCarePlus.com
# Members Served by Population Type	Projected 4,500
Annual Contract Payment & Description if payment was capitated	Projected \$26,150 Capitated
Improvements in Utilization Trends and Quality Indicators - Examples *	This is a new Medicare-Medicaid Plan with the goal to assess and actively engage in care planning each member who enrolls.
How Contract Emphasizes Member Choice **	<ul style="list-style-type: none"> • Members proactively choose their PCPs to serve as their medical homes. • Members are able to choose from available network providers without referral. • The health plan provides broad spectrum of providers rather than limited networks for all services.
How Contract Emphasizes Access **	<ul style="list-style-type: none"> • Community Health Navigator team available to assist members in need of assistance with specialty needs. • Supports available through discharge planning to identify resources for preventative care in community setting. • Closely monitor availability of provider network and report out through consolidated registry that can be compared across plans.
How Contract Emphasizes Safety **	<ul style="list-style-type: none"> • Member newsletters are published quarterly with focused areas targeting member safety. • Community Education representatives meet members at community events to educate about availability of services from plan and other resources. • The health plan connects members with Care Management team resources to assist families with more intense healthcare needs to navigate the system.
How Contract Emphasizes Independence & Responsibility **	<ul style="list-style-type: none"> • The healthy rewards program provides gift cards to members who access key preventative care. • The Web-based Member Portal allows for access to key plan information such as the member's PCP, ID card and medication history. • The health plan is currently implementing smart phone technology to make such resources more readily available for members.

First Choice VIP Care Plus, South Carolina (Medicare Medicaid Plan)	
Role of Subcontractors, if any	<ul style="list-style-type: none"> Administration of pharmacy, dental, routine vision and eye wear, and non-emergency medical transportation benefits. Administration of behavioral health and LTSS benefits. Nurse triage line. Payment Integrity Services include retrospective data mining and complex medical records reviews and subrogation.

Notes:

*The Plan Quality Assessment and Performance Improvement (QAPI) program provides a framework for the evaluation of the delivery of healthcare, behavioral health and long term services and supports provided to members. The QAPI Program description defines the quality improvement structure, function, scope and goals defined for the health plan. The Board of Directors approves the QAPI program annually. All AmeriHealth Caritas VIP plans utilize a local advisory committee consisting of the health plan’s medical director, a behavioral health professional and licensed practitioners participating in the health plan’s network to provide oversight and direction to the QAPI Program for use in the delivery of health care services to the health plans. The goal of the QAPI Program is to link together knowledge, structure and processes as well as to assess and improve quality of care, safety and service. The QAPI Program, in conjunction with the medical director and director of Quality Management, are responsible for addressing and correcting any problems identified through internal surveillance, complaints or other mechanisms. Each year the QAPI Program establishes quality improvement goals. These may be regionally established and/or may tie in to a national quality improvement goal such as readmission reduction. The quality programs are data driven and Medical Economics provides reports to highlight any variance from national or plan established standards. The following is a list of some of the data reviewed:

- Access and availability.
- Membership demographics and utilization of services (including assessment for ambulatory care sensitive services for follow up).
- Appeal categories and timeliness of processing.
- Decision making timeliness for utilization management.
- Member, practitioner and provider satisfaction surveys.
- PCP change trends and practitioner/provider complaints.
- Review, approval and monitoring of subcontractor and delegate activities associated with service. standards, access and availability;
- Member communication.
- Quality of care review based upon member concerns or sentinel events.
- Service standard compliance.
- Language services utilization, access/availability and timeliness.

**The QAPI Program is helps to engage and improve the health of members, stratify members according to their conditions and needs, identify members with potential future avoidable health care needs and

develop a comprehensive risk-specific plan of care with the member to optimize care of their chronic conditions, prevent adverse outcomes and avoidable episodes of care.

The goals of the Program are:

- To improve member's access to PCP, specialists and other medically necessary services through collaboration with providers.
- To reduce preventable inpatient hospital admissions and inappropriate emergency room visits.
- To delay or avoid nursing home admissions, when the beneficiary prefers a community-based option.
- To empower the member to accept responsibility for their ongoing health care needs including: self-managed and informed medical decision making.
- To improve clinical outcomes, including HEDIS rates, and increase the quality of life for our members.
- To improve care coordination and access to appropriate care and reduce unnecessary or duplicative services and improve health outcomes

Parent Guarantee

We have used the experience of our parent company and its affiliates. We are therefore including the following Parent Guarantee.

PERFORMANCE GUARANTEE

The undersigned, AmeriHealth Caritas Health Plan, as the parent company of AmeriHealth Caritas Iowa, Inc., hereby unconditionally guarantees AmeriHealth Caritas Iowa, Inc.'s performance of each and every obligation, covenant, term and condition arising under the contract executed by AmeriHealth Caritas Iowa, Inc. and the Iowa Department of Human Services pursuant to the Iowa High Quality Healthcare Initiative RFP #MED-16-009, for as long as AmeriHealth Caritas Health Plan is the parent company of AmeriHealth Caritas Iowa, Inc.

Dated this 8th day of May, 2015



Signature

Steven H. Bohner
Print Name

Senior Vice President & Chief Financial Officer
Title

Debarment or suspension, regulatory action, or sanction

The following describes instances where AmeriHealth Caritas Iowa, Inc., its parent organization, affiliates or subsidiaries were notified of being non-compliant with a publicly funded managed care contract.

Organization Trade Name: AmeriHealth Caritas Pennsylvania /AmeriHealth Northeast AmeriHealth Northeast/Keystone First (KF)

AmeriHealth Caritas operates its Pennsylvania Medicaid plans (AmeriHealth Caritas Health Plan, AmeriHealth Northeast and Keystone First) pursuant to the contract between the Pennsylvania Department of Human Services (PADHS) and Vista Health Plan, Inc. (Vista). Vista is an indirect subsidiary of Independence Health Group, Inc., which is AmeriHealth Caritas' parent company. Vista is also subject to regulatory oversight by the Pennsylvania Department of Health for these Pennsylvania Medicaid plans.

Regulatory Agency: Pennsylvania Department of Human Services (PADHS) / Pennsylvania Department of Health (PADOH), Medicaid

Sanctions

1. For the months of May 2010 to November 2010, AmeriHealth Caritas Pennsylvania and Keystone First were each sanctioned a total of \$9,000 by the PADHS for non-compliance with the timeframe for mailing provider claim checks after the checks were printed. The operational issues leading to this sanction were corrected by both AmeriHealth Caritas Pennsylvania and Keystone First. These sanctions did not result in an administrative proceeding or litigation.
2. For the month of December 2012, AmeriHealth Caritas Pennsylvania incurred sanctions from the PADHS totaling \$13,333, and Keystone First incurred sanctions totaling \$8,000 for failure to comply the HealthChoices contract requirement pertaining to provider claims adjudication timeliness standards. These sanctions did not result in an administrative proceeding or litigation.
3. For the month of December 2013, AmeriHealth Caritas Pennsylvania incurred sanctions from the PADHS totaling \$10,000, AmeriHealth Northeast incurred sanctions totaling \$6,000, and Keystone First incurred sanctions totaling \$8,000 for failure to comply with the HealthChoices contract requirements pertaining to provider claims adjudication timeliness standards. These sanctions did not result in an administrative proceeding or litigation.
4. For the month of August 2014, AmeriHealth Northeast and Keystone First were each sanctioned \$1,000 for failure to comply with the HealthChoices contract requirements pertaining to provider claims adjudication timeliness standards. For the month of September 2013, AmeriHealth Caritas Pennsylvania incurred sanctions from the PADHS totaling \$1,333. These sanctions did not result in an administrative proceeding or litigation.

Organization: Florida True Health

Regulatory Agency: Florida Agency for Health Care Administration (AHCA), Medicaid

Sanctions

1. In January 2014, liquidated damages in the amount of \$500 were imposed on Florida True Health by AHCA for failure to timely file an unaudited Child Health Check-Up Program (CHCUP) report with AHCA. It was later determined that the CHCUP was in fact filed on time, but the report file was incorrectly named. The sanction did not result in an administrative proceeding or litigation.

2. In February 2014, liquidated damages in the amount of \$25,000 were imposed on Florida True Health by AHCA for failure to comply with the federal 80 percent participation rate requirement. Florida True Health submitted a CAP addressing the participation ratio, which AHCA accepted on February 20, 2014. The sanction did not result in an administrative proceeding or litigation.

Organization: AmeriHealth Caritas of Louisiana

Regulatory Agency: Louisiana Department of Health and Hospitals (LADHH), Medicaid

Sanctions

1. In May 2013, monetary penalties were assessed against AmeriHealth Caritas Louisiana by the LADHH for non-compliance with contract requirements. A total of \$170,000 was assessed for failure to meet pharmacy encounter claims submission requirements and \$240,000 was assessed for failure to meet encounter data submission requirements. These sanctions did not result in an administrative proceeding or litigation.

Letters of deficiency issued by or corrective actions requested or required by any federal or state regulatory entity within the last five years

The following describes instances where AmeriHealth Caritas Iowa, Inc., its parent organization, affiliates, or subsidiaries were notified of being non-compliant with a publicly funded managed care contract.

Medicaid/CHIP

Organization Trade Name: AmeriHealth Caritas Pennsylvania (AmeriHealth Caritas Pennsylvania) / AmeriHealth Northeast (AmeriHealth Northeast) / Keystone First (Keystone First)

AmeriHealth Caritas operates its Pennsylvania Medicaid plans (AmeriHealth Caritas Health Plan, AmeriHealth Northeast and Keystone First) pursuant to the contract between the Pennsylvania Department of Human Services (PADHS) and Vista Health Plan, Inc. (Vista). Vista is an indirect subsidiary of Independence Health Group, Inc., which is AmeriHealth Caritas' parent company. Vista is also subject to regulatory oversight by the Pennsylvania Department of Health for these Pennsylvania Medicaid plans.

Regulatory Agency: Pennsylvania Department of Human Services (PADHS) / Pennsylvania Department of Health (PADOH), Medicaid

Letters of Deficiency / Corrective Action Plans (CAP)

1. February 2010. PADHS issued a CAP related to ensuring that expedited Member Grievance decisions are consistently made within required timeframes. The plans identified and addressed weekend and holiday staffing issues and implemented an on-call system to ensure weekend and holiday staffing for expedited grievances. PADHS approved the plans' response and closed the CAP on February 23, 2011, without imposing sanctions.
2. In November 2010, the PADHS requested a CAP as a result of a reportable privacy breach that occurred earlier in the year when a thumb drive containing protected health information (PHI) of members was lost. The CAP required AmeriHealth Caritas Pennsylvania and Keystone First to address the following areas: 1) implementation of encryption software; 2) information security protocols; 3) policies and procedures regarding the use of removable media, the collection of PHI at community events, and notification of PHI breaches; 4) HIPAA training; 5) monitoring of utilization by affected members to detect fraud, waste, and abuse; and 6) the logistics of member notifications, call center processes, and the handling of complaints stemming from the breach.

AmeriHealth Caritas Pennsylvania and Keystone First comprehensively responded to all items addressed in the CAP. This CAP was closed by the PADHS as of June 23, 2011. No financial sanctions were imposed.

3. August 19, 2013. PADHS requested a CAP stemming from an October 2012 on-site review of the plans' Program Integrity efforts. On October 3, 2013, AmeriHealth Caritas Pennsylvania and Keystone First submitted a response to items that scored below standard; and PADHS closed the CAP on March 20, 2014, indicating that all requests had been satisfied. No financial sanctions were imposed and the CAP did not result in an administrative proceeding or litigation.
4. On October 1, 2013, PADHS requested a CAP regarding timeliness, accuracy, and completeness of encounter data. AmeriHealth Caritas Pennsylvania and Keystone First submitted the response on October 31, 2013, which was accepted by PADHS on November 21, 2013. This CAP was closed on July 1, 2014. No financial sanctions were imposed and the CAP did not result in an administrative proceeding or litigation.
5. February 6, 2014. PADHS issued a CAP arising from issues related to the health plans' dental subcontractor. The issues identified included inaccurate eligibility and MCO membership information; unclear, incomplete, unpublished, or not appropriately reviewed and approved denial standards and criteria; inappropriate denials; insufficient access to specialty dental care; and insufficient education and outreach regarding the denial notification and appeals process. The CAP responses were timely submitted and accepted by PADHS, who closed this CAP on September 9, 2014. No financial sanctions were imposed and the CAP did not result in an administrative proceeding or litigation.
6. In April 2014, the PADOH issued a CAP stemming from the plans' missing PADOH regulatory timeframes for the external Grievance process. PADOH requested that AmeriHealth Caritas Pennsylvania and Keystone First review the processes involved to ensure timely notification to PADOH of all external Grievance requests. PADOH continues to monitor performance on a quarterly basis. No financial sanctions were imposed and the CAP did not result in an administrative proceeding or litigation.

Organization: Florida True Health

Regulatory Agency: Florida Agency for Health Care Administration (AHCA), Medicaid

Letters of Deficiency / Corrective Action Plans (CAP)

1. April 2014. This CAP stemmed from the inaccurate submission of encounter data. The plan's corrective actions, which resulted from a cross-functional problem-solving approach, resulted in improved statistics in encounter submission statistics. While the CAP remains open, AHCA did not impose financial sanctions, and the CAP did not result in an administrative proceeding or litigation.

Organization: AmeriHealth Nebraska d.b.a. Arbor Health Plan

Regulatory Agency: Nebraska Department of Health & Human Services (NEDHHS), Medicaid

Letters of Deficiency / Corrective Action Plans (CAP)

1. In January 2014, NEDHHS issued a corrective action plan (CAP) in response to AmeriHealth Nebraska's negative net income for state fiscal year 2013. AmeriHealth Nebraska received a capital contribution from AmeriHealth Caritas to reinforce its financial position, and addressed other elements contributing to financial under-performance; and NEDHHS approved closure of the CAP in September 2014.
2. In April 2015, NEDHHS issued a CAP to Arbor Health Plan in response to issues related to the encounter submission process. AmeriHealth Nebraska submitted a response to the CAP on May 1,

2015. AmeriHealth Nebraska does not expect the CAP to result in an administrative proceeding or litigation.

Organization: AmeriHealth Caritas of Louisiana

Regulatory Agency: Louisiana Department of Health and Hospitals (LADHH), Medicaid

Letters of Deficiency / Corrective Action Plans (CAP)

1. In January 2013, AmeriHealth Caritas Louisiana received a Notice of Deficiency for failure to timely submit a TPL batch file submission. The deficiency was cured within the timeframe requested by the LADHH and no sanctions were imposed. The notice did not result in an administrative proceeding or litigation.
2. In October 2013, AmeriHealth Caritas Louisiana received a request for a CAP outlining the process AmeriHealth Caritas Louisiana would follow to improve the quality and completeness of its Cash Disbursement Journal (CDJ) and Supplemental Paid Date (SPD) files. AmeriHealth Caritas Louisiana submitted a CAP, and the steps outlined within were completed by the agreed upon due date; therefore, the CAP was closed with no monetary penalties imposed. It did not result in an administrative proceeding or litigation.
3. In February 2015, AmeriHealth Caritas Louisiana, and all health plans within the Bayou Health System, received a CAP regarding non-compliance with the Wells stipulation for a denial/partial denial notice issued by a contractor. In March, AmeriHealth Caritas Louisiana submitted a CAP and timeline to address the deficiencies found in its sample denial notices.

Medicare

Regulatory Agency: Centers for Medicare & Medicaid Services (CMS)

Sanctions

QCC Insurance Company ("QCC"), Keystone Health Plan East, Inc. and AmeriHealth HMO, Inc. ("AmeriHealth"). In 2014, QCC, Keystone Health Plan East, and AmeriHealth paid to CMS a combined civil monetary penalty in the amount of \$50,000, imposed on QCC, Keystone Health Plan East, and AmeriHealth as a result of incorrect processing of enrollments and dis-enrollments in accordance with CMS requirements.

KHPE. Keystone Health Plan East. In October 2013, KHPE paid to CMS a civil monetary penalty of \$47,945 as a result of listing the incorrect Part D prescription drug deductible on a 2013 Annual Notice of Change sent to certain Medicare Advantage Members.

QCC, AmeriHealth and KHPE are all subsidiaries of AmeriHealth Caritas Iowa's parent company Independence Health Group. AmeriHealth Caritas has not been the subject of a CMS sanction; but certain of AmeriHealth Caritas Iowa's affiliates have received CMS notices of non-compliance as detailed in the following:

CMS Notice of Non-Compliance

None of the following resulted in an administrative proceeding or litigation by CMS; nor did CMS impose a corrective action plan or financial sanctions for any of the following.

1. **Vista Health Plan, Inc.** (Vista is the plan sponsor of the Medicare dual-eligible special needs plans (D-SNPs) operated as Keystone VIP Choice and AmeriHealth VIP Care in Pennsylvania.)
 - A. 2/4/13 - failure to adhere to upload requirements for scheduled marketing events.
 - B. 7/3/13 - Inaccurate annual notice of change/evidence of coverage (ANOC/EOC) for calendar year 2013 (errata sheet to correct a typographical error).
 - C. 2/14/14 - Prompt pay violation (network pharmacies paid late).
 - D. 2/18/14 - failure to comply with the less than 5 percent Part C disconnect rate requirement.
 - E. 8/8/14 - late submission of agent/broker compensation data.
 - F. 12/11/14 - Part D drug coverage non-compliance (Cialis).
2. **Select Health of South Carolina, Inc.** (plan sponsor of the Medicare dual-eligible special needs plan (D-SNP) operated as First Choice VIP Care in South Carolina).
 - A. 2/4/13 - failure to adhere to upload requirements for scheduled marketing events.
 - B. 7/3/13 - Inaccurate annual notice of change/evidence of coverage (ANOC/EOC) for calendar year 2013 (errata sheet to correct a typographical error).
 - C. 12/3/13 - Incomplete/inaccurate bid submission, related to incorrect pre-authorization requirements for outpatient diagnostic/therapeutic radiologic services).
 - D. 2/14/14 - Prompt pay violation (network pharmacies paid late).
 - E. 2/18/14 - failure to comply with the less than 5 percent Part C disconnect rate requirement.
 - F. 8/8/14 - late submission of agent/broker compensation data.
3. **AmeriHealth Caritas Louisiana, Inc.** (plan sponsor of the Medicare Advantage plan and the Medicare dual-eligible special needs plan (D-SNP) operated, respectively, as AmeriHealth VIP Care and AmeriHealth VIP Select in Louisiana).
 - A. 2/3/13 - Incomplete/inaccurate bid submission regarding preferred DME vendors/manufacturers.
 - B. 2/19/14 - Incorrect formulary filed with CMS prior to bid submission, deemed by CMS to be non-compliance with bid instructions.
4. **AmeriHealth District of Columbia, Inc.** (plan sponsor of the Medicare Advantage plan and the Medicare dual-eligible special needs plan (D-SNP) operated, respectively, as AmeriHealth VIP Care and AmeriHealth VIP Select in the District of Columbia).
 - A. 2/19/14 - Incorrect formulary filed with CMS prior to bid submission, deemed by CMS to be non-compliance with bid instructions.
5. **AmeriHealth Michigan, Inc.** (plan sponsor of the Medicare-Medicaid Plan under the dual demonstration program, operated as AmeriHealth Caritas VIP Care Plus, in Michigan).
 - A. 8/8/14 - late submission of agent/broker compensation data.

3.2.7.4.3 Description of all contracts and projects currently undertaken by the bidder

There are no active contracts currently undertaken by AmeriHealth Caritas Iowa, Inc. The full list of contracts and descriptions currently undertaken by AmeriHealth Caritas is provided in the table in 3.2.7.4.2. The active contracts and projects are:

- AmeriHealth Caritas Pennsylvania.
- AmeriHealth District of Columbia.

- AmeriHealth Caritas Louisiana.
- AmeriHealth Northeast (Pennsylvania).
- Arbor Health Plan (Nebraska).
- Select Health of South Carolina.
- Keystone First (Pennsylvania).
- PerformCare Pennsylvania
 - Capital Area HealthChoices.
 - Franklin-Fulton HealthChoices.
 - Bedford-Somerset HealthChoices.
- PerformCare New Jersey (Children’s System of Care).
- AmeriHealth Caritas VIP (Pennsylvania): Dual Eligible Special Need Medicare Advantage plan.
- Keystone VIP Choice (Pennsylvania): Dual Eligible Special Need Medicare Advantage plan.
- AmeriHealth VIP Care Plus (Michigan): Medicare-Medicaid plan.
- First Choice VIP Care Plus (South Carolina): Medicare-Medicaid plan.

3.2.7.5 Select Attachments

The following are attached to support our response:

- EQRO Report: Select Health of South Carolina.
- Implementation plan.
- HEDIS scores.
- Provider contract agreement templates
 - Hospital,
 - Physician.
 - Ancillary services.

EQRO Report: Select Health of South Carolina



The State of South Carolina
Department of Health and Human Services

Select Health of South Carolina

2013 External Quality Review

FEBRUARY 28, 2014



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Executive Summary

The Balanced Budget Act of 1997 (BBA) requires State Medicaid Agencies that contract with Managed Care Organizations to evaluate their compliance with the state and federal regulations in accordance with 42 Code of Federal Regulations (CFR) 438.358. The following report contains a description of the process and the results of the 2013 External Quality Review (EQR) conducted by The Carolinas Center for Medical Excellence (CCME) on behalf of the South Carolina Department of Health and Human Services (SCDHHS). The purpose of this review was to determine the level of performance demonstrated by Select Health of South Carolina (Select Health) since the EQR was completed in 2012.

Goals of the review were:

- To determine if Select Health was in compliance with service delivery as mandated in the Managed Care Organization (MCO) contract with SCDHHS.
- To evaluate the status of deficiencies identified during the 2012 annual review and any ongoing actions taken to remedy those deficiencies.
- To provide feedback for potential areas of further improvement. The overriding goal of the annual EQR process is to assure that contracted health care services are actually being delivered and are of good quality.

The process used for the EQR was based on the protocols developed by the Centers for Medicare & Medicaid Services (CMS) for the external quality review of a Medicaid Managed Care Organization. The review included a desk review of documents, a three-day onsite visit to the Select Health office, validation of performance improvement projects, and validation of performance improvement measures.

Findings

The findings of the 2013 EQR showed an overall reduction in Met scores of 7.69 percent and Partially Met scores increased by 8.25 percent over the prior year. Some of the deficiencies were in the areas of credentialing and recredentialing, utilization decisions, delegation, and timeliness of grievance resolutions. Also, Select Health did not fully implement the quality improvement plan which addressed the deficiencies identified during the previous EQR. As a result, the standard for addressing or correcting any of the previously identified deficiencies received a Not Met score.

STRENGTHS

Strengths of Select Health's performance at the time of this review include the following:

- Select Health is currently staffing a new Regulatory Affairs and Compliance department that will be located in SC.
- Select Health has a solid disaster recovery plan and testing regimen.

- AmeriHealth has contracted with a third party firm to conduct ethical hacking of its systems. This is an excellent practice and should be continued.
- Select Health measures specialty care providers as within 30 miles for urban/suburban areas and within 50 miles for rural areas. The state only requires specialists to be available within 50 miles.
- The Credentialing Committee has four network providers that have been long-standing members of the committee.
- Select Health has extensive training available for providers. A provider education consultant conducts educational seminars in various regions of the state. Provider-specific HEDIS trainings are conducted and account executives frequently visit provider offices to conduct ongoing education.
- The Call Center is responsible for contacting new members for telephone orientation. The call script for this process is comprehensive and includes an explanation of benefits and services provided by Select Health.
- Call Center statistics continually meet or exceed goals for abandonment rate and speed of answer.
- Preventive health guidelines are communicated to members in the Member Handbook, the First Choice website, member newsletters, and targeted mailings. These guidelines are reviewed and approved annually, measured for compliance, and the results conveyed to providers in meaningful ways.
- The grievance process is well documented, acknowledged, and investigated as required. The newly created Member Advocate role supports and assists members through the grievance process as needed. Select Health evaluates grievances twice a year, which enables early identification of trends or issues.
- Select Health has committed to multiple performance improvement projects and has identified member satisfaction as a concern. They are currently tracking progress through a member satisfaction performance improvement project.
- NCQA-certified software is used for HEDIS[®] calculations.
- Documentation indicates that very detailed explanations are given to members when a verbal request for an appeal is received, including basic appeal requirements, processes, and timelines; offers of assistance; and explanation that a written appeal will be mailed for the member to complete and return to the plan.
- Select Health demonstrates excellent turnaround times when processing authorization and appeal requests.
- The appeals information in the annual Grievances and Appeal Summary is thorough and includes a detailed appeals analysis, including the percentage of change in the number of appeals as well as specific opportunities for improvement and interventions.

WEAKNESSES

Weaknesses identified included:

- The credentialing policy file names received in the desk materials and the Master List of Policies Index did not include the new policy number prefix naming convention (QI 210).
- Some policies still referred to the old policy number prefix naming convention when making references to a policy (e.g., Policy NM 159.101 references policy QI (CR) 205.100.)
- Policy CR 210.100, Health Care Professional Credentialing and Re-credentialing, references ownership disclosure form 1513 on page 11 but should reference form 1514.
- All of the credentialing/recredentialing policies, the 2013 Credentials Program document, and the Provider Manual have the following issues:

- References the Healthcare Integrity Protection Data Bank (HIPDB) which was merged into the National Practitioner Data Bank (NPDB) on May 6, 2013. The HIPDB references should be removed.
- References to the Excluded Parties List System (EPLS) should be replaced with the System for Award Management (SAM). The EPLS records were moved to SAM and the old EPLS was phased out in 2012.
- The 2013 Credentials Program document had some information that should be corrected.
- Credentialing and/or recredentialing files reviewed onsite lacked the following information:
 - The SCDHHS specified ownership disclosure form.
 - A copy of the original signed attestation statement. The CAQH electronic signature page that shows the provider re-attested is acceptable to use as long as a copy of the original signed attestation is in the file.
 - Proof that queries of the SAM, formerly EPLS, and the SC Excluded Providers List have been performed.
 - A copy of the CLIA certificate or waiver when the application indicates that laboratory services are being performed.
 - Proof of an office site visit was not in the credentialing files.
- Policy CR 210.107, Actions and Reporting Against Health Care Professional/Provider for Quality, references a retired policy and mentions the HIPDB in several places.
- The Total Quality Management Committee which is now called the Quality Assessment Performance Improvement Committee was incorrectly referenced in policies NM 159.204, Availability of Services, and NM 159.203, Accessibility of Services, and the Provider Manual, page 10.
- Several issues were identified in the Provider Manual that should be corrected or updated.
- Policy PNO 170.406, Informal Provider Disputes, does not state a timeframe for filing informal disputes, but the Provider Manual and the Provider Kit state a 90 calendar day timeframe.
- Select Health does not address in policy MED (UM) 150.314, Continuity of Care, or any other policy, how they monitor continuity and coordination of care between PCPs and other providers.
- The Member Handbook does not include complete coverage information or inform the member that materials are available in alternate formats, upon request.
- Correct the language on page 15 of the Member Handbook removing the requirement for a member, relative, or friend to call the plan following an emergency room visit that results in hospitalization.
- Coverage information in the Member Services Training Manual is not correct.
- The websites co-payment grid for outpatient hospital services (Spanish version) contains an error.
- No policy was found which explains how members and providers obtain specialty and referral care.
- The member is not informed of Select Health's service area.
- Several grievance files reviewed were not completed in a timely fashion.
- One possible Quality of Care grievance was not reviewed by a physician.
- Items with a status of "ongoing" were not carried over to the new Quality Improvement work plan.
- Discrepancies were noted in documentation of the number of members of the QAPI Committee and in which members of the QAPI Committee have voting rights.

- Attendance is not accurately documented in the minutes for QAPI Committee meetings and several members of the QAPI Committee were listed as guests in the attendance documentation.
- Although the frequency of QAPI meetings held in 2013 was compliant, the 2013 QAPI Program Description lists a possible frequency for meetings that falls short of the quarterly requirement.
- Two of the performance improvement projects validated did not demonstrate sustained improvement.
- Inconsistencies were noted in the documentation of criteria used for medical necessity determinations.
- Multiple issues were identified with Select Health's documentation of processes and requirements for timeliness of UM determinations, notifications, and use of extensions.
- Onsite review of denial files confirmed that in some instances, incorrect criteria was used for medical necessity review. Also, denial rationales documented in notice of action letters were inappropriate and inconsistent with the clinical information submitted and/or the type of request received.
- Select Health no longer operates under the ethical limitations section of the SCDHHS MCO Contract, yet they have no policy/procedure regarding coverage of and claims filing requirements for hysterectomies, sterilizations, and abortions.
- Incorrect and/or inadequate documentation of Select Health's inter-rater reliability (IRR) auditing processes were noted.
- Issues were noted with the appeals processes, including discrepancies in whether consent is needed for a representative to act on a member's behalf for a plan-level appeal, and documentation of incorrect timeframes for requesting a State Fair Hearing and continuation of benefits pending an appeal or State Fair Hearing.
- The sample delegated contract received in the desk materials was dated 8-24-11 and credentialing/recredentialing responsibilities did not appear to address South Carolina specific requirements such as collecting the ownership disclosure form 1514, query of the SC Excluded Provider's List, CLIA certificate/waiver when laboratory services are being performed, or guidelines for NPs acting as PCPs. In addition, the contract specifies verification of sanctions by Medicare/Medicaid but does not spell out what queries are to be performed.
- Evidence of oversight monitoring was presented for the delegated entities; however, the monitoring tool does not appear to address the SC specific credentialing/recredentialing criteria and all the required queries.
- Several issues identified as deficiencies on the previous EQR were not corrected.

Comparative Data

A comparison review of the scored standards by review category for the previous EQR conducted by CCME in 2012 with the current review results is shown in the table that follows.

TABLE 1

	MET	PARTIALLY MET	NOT MET	NOT EVALUATED	TOTAL STANDARDS
Administration					
2012	17	0	0	0	17
2013	17	0	0	0	17
Provider Services					
2012	62	1	4	0	67
2013	51	13	3	0	67
Member Services					
2012	36	1	0	0	37
2013	34	3	0	0	37
Quality Improvement					
2012	15	0	0	0	15
2013	12	3	0	0	15
Utilization Management					
2012	31	7	1	0	39
2013	32	5	2	0	39
Delegation					
2012	0	2	0	0	2
2013	0	2	0	0	2
State-Mandated Services					
2012	3	0	2	0	5
2013	4	0	1	0	5

Recommendations for Improvement

CCME made the following recommendations that Select Health should implement to improve their processes and comply with state and federal requirements.

- Update the Master List of Policies Index and credentialing file names to reflect the updated naming convention (QI 210) that is listed in each credentialing policy. Also, update any policies

that reference other policies using the old naming convention (e.g., Policy NM 159.101 references policy QI (CR) 205.100).

- Update all the credentialing/recredentialing policies, the 2013 Credentials Program document, and the Provider Manual to remove references to the Healthcare Integrity Protection Data Bank (HIPDB), and references to the Excluded Parties List System (EPLS) should be replaced with the System for Award Management (SAM).
- Correct page 11 of policy CR 210.100, Health Care Professional Credentialing and Re-credentialing, to reflect the correct ownership disclosure form (#1514).
- Correct the issues identified in the 2013 Credentials Program document.
- Add Dr. Kirt Caton (new member) to the list of Credentialing Committee members and also designate who has voting privileges on that list.
- Ensure that credentialing/recredentialing files include the following:
 - The SCDHHS specified ownership disclosure form.
 - A copy of the original signed attestation statement. The CAQH electronic signature page that shows the provider re-attested is acceptable to use as long as a copy of the original signed attestation is in the file.
 - Proof that queries of the SAM, formerly EPLS, and the SC Excluded Providers List have been performed.
 - A copy of the CLIA certificate or waiver when the application indicates that laboratory services are being performed.
- Credentialing files for PCPs and OB/GYNs acting as PCPs must contain a copy of the office site visit and made available for the credentialing committee decision, if applicable. Correct the issues identified in policy CR 210.107, Actions and Reporting Against Health Care Professional/Provider for Quality.
- Update policy CR 210.103, Hospital & Ancillary Provider Credentialing and Recredentialing, to remove references to the HIPDB and change the EPLS references to reflect the SAM.
- Update policies NM 159.204, Availability of Services, and NM 159.203, Accessibility of Services, as well as the Provider Manual to include the correct committee reference.
- Correct the Provider Manual to address the other identified issues.
- Address the discrepancy between policy PNO 170.406, the Provider Manual, and the Provider Kit regarding whether providers have 90 days to file an informal dispute. Update documents to reflect consistent information.
- Update the Provider Manual to include all medical record documentation standards that are specified in policy QI 205.009.
- Update policy MED (UM) 150.314, Continuity of Care, or another policy to address how Select Health monitors continuity and coordination of care between PCPs and other providers.
- Update the Member Handbook as follows:
 - Include coverage information for members regarding non-elective, medically necessary hysterectomies; outpatient pediatric aids clinics, and preventive and rehabilitative services for primary care.
 - Correct the language on page 15 of the Member Handbook regarding hospital admissions following an emergency room visit. Select Health should receive notification from the hospital and cannot require a member, relative, or friend to call.
- Update the Member Services Training Manual as follows:
 - Remove the requirement for prior authorization for family planning services found on page 53.
 - Clarify your coverage for hysterectomies, abortions, mental health and substance abuse treatment.

- Correct the co-payment amount listed on the FirstChoice website for outpatient hospital services, (Spanish version) from \$3.30 to \$ 3.40.
- Create a policy and procedure, or add to an existing policy, the process members and providers use to obtain specialty/referral care, including when a prior authorization is needed.
- Include a map or description of Select Health's service area in member materials, the Member Handbook, or Provider Directory.
- Inform the member in the Member Handbook that materials can be provided in alternate formats, such as Braille, upon request.
- Remove the reference to an appeals process for grievances from the member grievance and appeals policy.
- Develop a process to monitor the timely resolution of grievances.
- Ensure that any questionable quality of care issues are reviewed by a Select Health physician that has the appropriate clinical expertise in accordance with Select Health's policy 154.300, Review of Potential Quality of Care Concerns and *Federal Regulation § 438.406 (a) (3) (ii) (C)*.
- Ensure that newly-created work plans contain all applicable "ongoing" items from the previous year's work plans.
- Update the Quality Assurance Performance Improvement (QAPI) Program Description to reflect a correct listing of members for the QAPI Committee. Update all applicable documents to indicate which members of the committee have voting rights.
- Update the QAPI Committee meeting frequency requirement in the 2013 QAPI Program Description to be compliant with the *SCDHHS MCO P&P Guide, Section 13.0*.
- Develop a process to accurately document QAPI Committee member attendance. Non-voting members of the committee should not be listed as guests in the attendance documentation.
- Update the UM Program Description and Provider Manual to include all criteria used for utilization review determinations.
- Update the Determination of Timeliness policy, MED 153.308, with the following:
 - Clarify the policy to indicate that approval notification will not exceed the standard or expedited timeframe allowed by federal and state regulations.
 - Add information to the policy that unless an extension is requested by the member or provider, Select Health must justify the need for the extension to SCDHHS upon request.
 - Add information regarding the two-day extension that can be granted for determinations for inpatient services if requested information is not received.
- Correct the number of days allowed for extensions of expedited authorization determinations in the Member Grievances and Appeals Process policy, MEM 129.101.
- Document the timeframe for notification of adverse determinations in either the Adverse Determinations policy, MED 153.303, or the Determination of Timeliness policy, MED 153.308.
- Correct all applicable documents to indicate that timeframes for determinations of authorization requests begin on the day of the request and not on the day all necessary information is received.
- Include approval information on the approval page of the Integrated UM Program Description.
- Re-educate staff and continue to reinforce the importance of selecting appropriate criteria sets when performing medical necessity reviews.
- Ensure that rationales for denial decisions are appropriate to the patient's condition and the type of request.
- Create a policy and procedure which details the requirements for medical necessity review of, and the requirements for filing claims for, hysterectomies, sterilizations, and abortions.

- Update the UM Inter-rater Reliability Auditing policy, MED 153.306, to contain clear and complete information on the IRR process used for physician reviewers. The benchmark for physician reviewers should be included also.
- Correct the frequency of IRR auditing for non-physician reviewers in the UM Program Description.
- Correct the Provider Manual to indicate that written consent is not required for a representative to act on a member's behalf for an expedited appeal.
- Correct the timeframes for requesting State Fair Hearings and continuation of benefits pending the outcomes of a State Fair Hearing in all the appeal determination letters.
- The delegated contract should include the SC specific credentialing/recredentialing criteria and the plan should ensure all required queries are being performed.
- Update the delegation monitoring tools to reflect the SC specific credentialing/ recredentialing criteria and all the required queries.
- Implement a process to ensure that all deficiencies identified during the EQR are addressed and corrections made.

Background

The Balanced Budget Act of 1997 (BBA) requires that a state which contracts with a Managed Care Organization (MCO) or Prepaid Inpatient Health Plan (PIHP) conduct an External Quality Review (EQR) of each entity. In January 2003, the Centers for Medicare & Medicaid Services (CMS) issued a final rule to specify the requirement for external quality reviews of a Medicaid MCO/PIHP. In this final rule, federal regulation requires that external quality reviews include three mandatory activities: validation of performance improvement projects, validation of performance measures, and compliance monitoring. In addition, federal regulations allow states to require optional activities which may include validation of encounter data, administration and validation of member and provider surveys, calculation of additional performance measures, and conduct performance improvement projects and quality of care studies. After completing the required activities, a detailed technical report is submitted to the state. This report describes the data aggregation and analysis and the way in which conclusions were drawn as to the quality, timeliness, and access to care furnished by the plans. The report also contains the plan's strengths and weaknesses; comparative information from previous reviews; recommendations for improvement; and the degree to which the plan has addressed the quality improvement recommendations made during the prior year's review.

Introduction

In July 2009, the South Carolina Department of Health and Human Services (SCDHHS) contracted with The Carolinas Center for Medical Excellence (CCME), an external quality review organization (EQRO), to conduct External Quality Review (EQR) for all Managed Care Organizations and Medical Home Networks participating in the Medicaid Managed Care Program. The purpose of this review was to determine the level of performance demonstrated by Select Health of South Carolina (Select Health) since the EQR completed in 2012.

Goals of the review were:

1. To determine Select Health's compliance with service delivery as mandated in the contract with SCDHHS.
2. To evaluate the status of deficiencies identified during the 2012 EQR.
3. To provide feedback on potential areas for further improvement.

The overriding goal of the annual EQR process is to ensure that contracted health care services are actually being delivered and are of good quality.

Process

The process used by CCME for the EQR activities was based on the protocols developed by the Centers for Medicare & Medicaid Services (CMS) for the external quality review of a Medicaid MCO/PIHP and focuses on the three federally mandated EQR activities of compliance determination, validation of performance measures, and validation of performance improvement projects. On November 18, 2013, CCME sent notification to Select Health that the annual EQR was being initiated (see Attachment 1). This notification included a list of materials required for a desk review

and an invitation for a teleconference to allow Select Health to ask questions regarding the EQR process and the desk materials being requested. On November 19th, CCME received an email from Select Health requesting the dates for the annual review be changed. With SCDHHS' approval, the dates were changed.

The review consisted of two segments. The first was a desk review of materials and documents received from Select Health on December 16, 2013 and reviewed in the offices of CCME (see Attachment 1). These items focused on administrative functions, committee minutes, member and provider demographics, member and provider educational materials, and the Quality Improvement and Medical Management Programs.

The second segment was an onsite review conducted on February 5th, 6th, and 7th, at the Select Health office located in Charleston, South Carolina. The onsite visit focused on areas not covered in the desk review or needing clarification. See Attachment 2 for a list of items requested for the onsite visit. Onsite activities included an entrance conference; interviews with Select Health's administration and staff; and a review of denial, appeal, utilization approval, case management, credentialing, recredentialing, and grievance files. At the conclusion of the onsite review, an exit conference was held to discuss preliminary evaluation results and to address areas of concern. All interested parties were invited to the entrance and exit conferences.

Findings

The findings of the EQR are summarized below and are based on the regulations set forth in title 42 of the Code of Federal Regulations (CFR), part 438, and the contract requirements between Select Health and SCDHHS. Strengths and weaknesses are identified where applicable. Areas of review were identified as meeting a standard (Met), acceptable but needing improvement (Partially Met), or failing a standard (Not Met), and are recorded on the tabular spreadsheet. (Attachment 4)

I. ADMINISTRATION

The Administration review focused on the health plan's policies and procedures, staffing, information system, compliance, and confidentiality. Select Health is a part of the AmeriHealth Caritas family of companies which administers benefits for SC Medicaid members under a contract with the SCDHHS. Select Health has developed a comprehensive list of policies which are written and organized in a consistent manner. Policies are reviewed annually and revised as needed.

Organizational charts demonstrate sufficient staff is in place to meet the needs of Select Health members. The Director of Regulatory Affairs and the Compliance Coordinator were noted as open positions on the organizational chart. Onsite discussion revealed that the Director of Regulatory Affairs is a new position that will be located in SC and will report to their Corporate Compliance Officer, Barbara Jones. In the interim, Cindy Helling is functioning as the Director of Regulatory Affairs until staffing for this new department is completed. A compliance committee is in place and meets at regular intervals.

In meeting the contractual standard for claims processing, Select Health has opted to exceed the standard by shortening the timeframe, rather than increasing the processing percentage. This speaks to their confidence in their claims processing operation; specifically, that they can beat the time requirements significantly and regularly. They also do an excellent job of tracking enrollment and demographic data. Select Health has the systems and processes in place to ensure that they can

SECTION	STANDARD	2012 REVIEW	2013 REVIEW
Credentialing and Recredentialing	Formal application with attestation statement delineating any physical or mental health problem affecting ability to provide health care, any history of chemical dependency/ substance abuse, prior loss of license, prior felony convictions, loss or limitation of practice privileges or disciplinary action, the accuracy and completeness of the application, and (for PCPs only) statement of the total active patient load	Met	Not Met
	Query of the National Practitioner Data Bank (NPDB); Health Integrity and Protection Databank (HIPDB); State Board of Examiners by the MCO (for the specific discipline); GSA Excluded Parties List Service	Not Met	Partially Met
	Query for state sanctions and/or license or DEA limitations; State Excluded Provider's Report	Met	Partially Met
	Site assessment, including but not limited to adequacy of the waiting room and bathroom, handicapped accessibility, treatment room privacy, infection control practices, appointment availability, office waiting time, record keeping methods, and confidentiality measures	Met	Not Met
	Requery the National Practitioner Data Bank; Health Integrity and Protection Databank; State Board of Examiners; GSA Excluded Parties List Service	Not Met	Met
	Requery for state sanctions and/or license limitations since the previous credentialing event; State Excluded Provider's Report	Met	Partially Met
	The MCO formulates and acts within written policies and procedures for suspending or terminating a practitioner's affiliation with the MCO for serious quality of care or service issues	Met	Partially Met
	Organizational providers with which the MCO contracts are accredited and/or licensed by appropriate authorities	Met	Partially Met
Adequacy of the Provider Network	The MCO formulates and insures that practitioners act within written policies and procedures that define acceptable access to practitioners and that are consistent with contract requirements	Met	Partially Met
Provider Education	Medical record documentation requirements	Met	Partially Met
	Member benefits, including covered services, excluded services, and services provided under fee-for-service payment by SCDHHS	Met	Partially Met

SECTION	STANDARD	2012 REVIEW	2013 REVIEW
Provider Education	Provider and member grievance and appeal procedures	Met	Partially Met
Continuity of Care	The MCO monitors continuity and coordination of care between the PCPs and other providers	Met	Partially Met

The standards reflected in the table are only the standards that showed a change in score from 2012 to 2013.

PROVIDER ACCESS AND AVAILABILITY STUDY

As a part of the annual EQR process for Select Health, a provider access study was performed focusing on primary care physicians as described in the SCDHHS MCO Policy and Procedure Guide. A list of current providers was given to CCME by the plan, from which a population of 1917 unique PCPs was found. A sample of 325 providers was randomly selected from this population for the access study. Attempts were made to contact these providers to ask a series of questions regarding the access that Select Health members have with the contracted providers.

Calls were successfully answered 51 percent of the time by personnel at the correct practice, which estimates to between 49 and 54 percent for the entire population. For those not answered successfully, 37 percent of the time (estimates to 34 and 39 percent for the entire population) the caller was informed that the physician was no longer at the practice or phone number provided by the plan. Of the successful calls, 73 percent (70, 76) of the providers indicated they specifically accept Select Health. Of those that accept Select Health, 82 percent (78, 85) responded they are accepting new Medicaid patients. When asked about the process for new patients, 46 percent (39, 52) indicated that an application or prescreen was necessary. Twenty-four percent (15, 32) of those with a prescreening process require a medical record review prior to accepting the patient. When the office was asked about the next available routine appointment, 60 percent (56, 65) of the appointment answers met within contract requirements.

STRENGTHS

- Select Health measures specialty care providers as within 30 miles for urban/suburban areas and within 50 miles for rural areas. The state only requires specialists to be available within 50 miles.
- The Credentialing Committee has four network providers that have been long-standing members of the committee.
- Select Health has extensive training available for providers. A provider education consultant conducts educational seminars in various regions of the state. Provider-specific HEDIS trainings are conducted and account executives frequently visit provider offices to conduct ongoing education.

WEAKNESSES

- The policy naming convention for the credentialing policies has been changed since the last EQR. The file names listed in the credentialing folder and the Master List of Policies Index did not match the updated policy numbers. The credentialing policies file name and the Master

List of Policies Index listed the prefix as CR 205. The prefix listed on the policies was CR 210. Also, some policies still referred to the old policy naming convention when making references to other policies (e.g., Policy NM 159.101 references policy QI (CR) 205.100.)

- Policy CR 210.100, Health Care Professional Credentialing and Re-credentialing, references ownership disclosure form 1513 on page 11. It should reference form 1514.
- The following issues were found in the credentialing/recredentialing policies, the 2013 Credentials Program document, and the Provider Manual:
 - References the HIPDB which was merged into the NPDB on May 6, 2013.
 - References to the EPLS. The EPLS records were moved to the SAM and the old EPLS was phased out in 2012.
- The 2013 Credentials Program document had the following issues:
 - Page 8 references ownership disclosure form 1415 when it should reference 1514.
 - Page 22 (#4, 1st bullet) has an incomplete sentence. It should include the wording defined in policy CR 210.102 (page 2, #5) that states, "or may choose to be represented by legal counsel or another person of his/her choice." This is also an issue in the Provider Manual, page 10.
 - Page 24 has outdated information in the delegated entities section as follows: Partners Health Network is no longer a delegated entity; Med-Advantage (CVO) is incorrectly included as a delegate; and the Medical College of Georgia's name has changed to Georgia Health Services University.
- Credentialing and recredentialing files reviewed had the following issues:
 - Two credentialing files reviewed onsite did not contain an ownership disclosure form.
 - The majority of the credentialing and recredentialing files reviewed did not have a copy of the original signed attestation in the file. The files did have the CAQH electronic signature page that shows the provider re-attested; however, the file must also contain a copy of the original attestation statement with the provider's signature.
 - Two credentialing files reviewed onsite did not contain proof that the SAM, formerly EPLS, had been queried.
 - Credentialing and recredentialing files reviewed did not contain evidence that the SC Excluded Providers List was queried. During the onsite visit, Select Health provided a screen print of their system to show that the query is included in their process.
 - Three credentialing files reviewed onsite did not contain the CLIA certificate or waiver even though the application indicated laboratory services were being performed.
- Select Health's policy (NM 159.107) states that office site visits will be conducted for PCPs and OB/GYNs; however, the credentialing files did not contain proof that a site visit had been performed.
- Policy CR 210.107, Actions and Reporting Against Health Care Professional/Provider for Quality, had the following issues:
 - Page 2 references policy QI 205.007, Review of Potential Quality of Care Concerns, which is a retired policy. Onsite discussion confirmed that policy 154-300, Review of Potential Quality of Care Concerns, is the correct policy to reference.
 - Mentions the HIPDB in several places.
- Policy CR 210.103, Hospital & Ancillary Provider Credentialing and Recredentialing, had the following issues:
 - References the HIPDB which was merged into the NPDB on May 6, 2013.
 - References the EPLS. The EPLS records were moved to SAM and the data base was phased out in 2012.

- The Total Quality Management Committee, which is now called the Quality Assessment Performance Improvement Committee, was incorrectly referenced in policies NM 159.204, Availability of Services, and NM 159.203, Accessibility of Services, as well as in the Provider Manual, page 10.
- The following issues were identified in the Provider Manual:
 - Page 34 does not include Substance Abuse Services in the list of covered benefits as specified in the *SCDHHS MCO P&P Guide, Section 10.27*.
 - The Home and Community Based Waiver Services section does not address all of the special needs populations that are specified in the *SCDHHS MCO P&P Guide Section 11.6*. Missing are "Persons enrolled in the Medically Complex Children's waiver" and "Women at or below 185% of federal poverty level for Family Planning Services only".
 - Page 51, Mental Health and Alcohol/Drug Services, is missing "inpatient psychiatric hospital" which is specified in the *SCDHHS MCO P&P Guide, Section 11.1*.
 - Vision Services listed on pages 50 and 52 need to be updated.
 - The Provider Manual specifies the medical record documentation standards but does not include signed and dates consent forms, if applicable as mentioned in policy QI 205.009.
- The Provider Manual, page 21, and the Provider Kit listed on the website state that providers can register an informal dispute either verbally or in writing within 90 calendar days from original denial notification or action; however, policy PNO 170.406, Informal Provider Disputes, does not state a timeframe for filing informal disputes.
- Policy MED (UM) 150.314, Continuity of Care, defines the process for continuity of care for members continuing treatment with a practitioner that has terminated for up to ninety days. Onsite discussion confirmed that Select Health monitors continuity and coordination of care between PCPs and other providers through medical record audits and various processes; however, they are not addressed in this policy.

III. MEMBER SERVICES

The review of Member Services included all policies and procedures; member rights; member training and educational materials; and the handling of grievances, disenrollments and practitioner changes. The Member Services department is available Monday-Friday 8:00 am to 9:00 pm; Saturday and Sunday 8:00 am to 6:00 pm. The Nurse Help Line is available 24/7 and provides support for Member Services after hours. Members have direct access to a representative at PerformCare for behavioral health issues when calling after hours.

Select Health provides a comprehensive training program for their member services staff. The member services department is responsible for new member orientation calls, and successfully reaches 58 percent of new members to provide an introduction to Select Health services and benefits. In addition, they consistently meet or exceed call center goals for call abandonment rate and average speed of answer.

The First Choice website is easily navigated and provides valuable health information for Select Health members. Members can securely access their personal health information and receive notifications about recommended preventive health screenings.

The grievance logs submitted with the desk materials contained the required elements and sufficient detail about the nature of grievances, investigations, and resolutions. The grievance files reviewed onsite reflected appropriate acknowledgement and investigation; however, some grievances were not resolved within the 90 day timeframe. Resolution letters provide sufficient detail for the member to

understand the steps taken to resolve their grievance. Select Health has taken a proactive approach to grievances by creating a Member Advocate position, whose role is to assist and support members who ask for help with the grievance process.

The charts below show 91.89 percent of the standards received a Met score for Member Services. The Partially Met scores were in the areas of member program education and grievances.

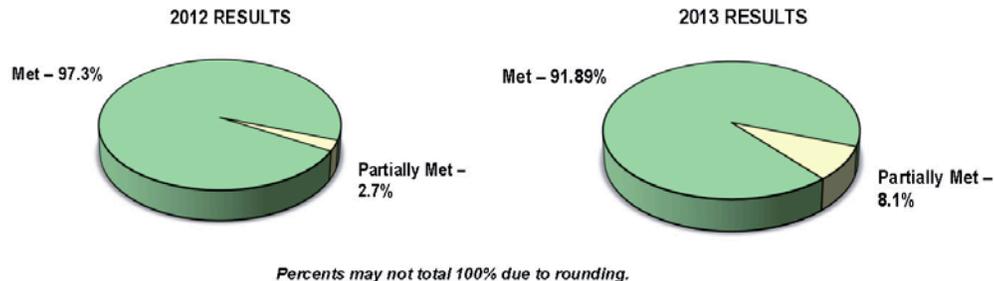


TABLE 3: MEMBER SERVICES COMPARATIVE DATA

SECTION	STANDARD	2012 REVIEW	2013 REVIEW
Member MCO Program Education	Members are informed in writing within 14 business days of enrollment of all benefits to which they are contractually entitled	Met	Partially Met
Grievances	The procedure for filing and handling a grievance	Met	Partially Met

The standards reflected in the table are only the standards that showed a change in score from 2012 to 2013.

STRENGTHS

- The Call Center is responsible for contacting new members for telephone orientation. The call script for this process is comprehensive and includes an explanation of benefits and services provided by Select Health.
- Call Center statistics continually meet or exceed goals for abandonment rate and speed of answer.
- Preventive health guidelines are communicated to members in the Member Handbook, the First Choice website, member newsletters, and targeted mailings. These guidelines are reviewed and approved annually, measured for compliance, and the results conveyed to providers in meaningful ways.
- The grievance process is well documented, acknowledged, and investigated as required. The newly created Member Advocate role supports and assists members through the grievance process as needed. Select Health evaluates grievances twice a year, which enables early identification of trends or issues.

WEAKNESSES

- Issues identified in the Member Handbook are as follows:
 - There is no coverage information for members regarding non-elective, medically necessary hysterectomies; outpatient pediatric aids clinics, or preventive and rehabilitative services for primary care.
 - Page 15 of the Member Handbook regarding a hospital admission following an emergency room visit states the member, a relative, or a friend must call First Choice by the next business day. Select Health should receive notification from the hospital and cannot require a member, relative, or friend to call.
 - Policy COM 220.105, The Production of Vital Documents in Alternative Formats, states that alternate formats available include Braille, large font, and audio tape, among others. This information is not conveyed to the member in the Member Handbook as required by *Federal Regulation § 438.10 (d) (1) (ii) and (2)*.
- The following issues were identified in the Member Services Training Manual:
 - Page 53 states non-participating providers must obtain prior authorization for family planning services; however, the Member Handbook page 10 states prior approval is not required.
 - Page 54 describes elective therapeutic abortions in two places on the same page: one paragraph says they are not covered by First Choice and in another paragraph it states they are a covered benefit.
 - Pages 45 and 58 state that mental health, alcohol, and substance abuse treatment services are provided by Medicaid outside of the health plan; however, these services are the responsibility of the health plan.
- A discrepancy was noted in the copayment for outpatient hospital services in the English and Spanish versions of the copayment guide on the First Choice website. The copayment is listed as \$3.40 on the English version and \$3.30 on the Spanish version.
- No policy and procedure was found that explains the process members or providers use to obtain referrals to in or out of network specialists.
- Member materials do not inform the member of Select Health's service area.
- Several grievance files reviewed onsite were not resolved within the 90 day timeframe. In addition, one grievance file had a questionable quality of care (QOC) issue for care received in a hospital. Select Health forwarded this grievance to the hospital and no review by a medical director or evidence that Select Health followed-up on this grievance was found.

IV. QUALITY IMPROVEMENT

Select Health's Quality Improvement Program provides the infrastructure for continuous monitoring, evaluation, and improvement of care and services rendered to members. The 2013 program description outlines the goals, strategies and processes for the program, and includes a number of data collection activities. Clinical and Service Improvement Goals for 2013 are included in the program description. The Quality Assurance Performance Improvement (QAPI) Committee has the responsibility for planning, designing, implementing, and coordinating all quality improvement activities.

The 2013 Quality Improvement Work Plan includes all required elements. It was noted that some items listed with a status of "ongoing" on the 2012 Quality Improvement Work Plan were not carried over to the 2013 work plan. This was discussed onsite and plan staff indicated this was an oversight. CCME recommended that the work plan be updated to include all quality improvement activities.

Select Health met 80 percent of the standards in the Quality Improvement section. The standards receiving Partially Met scores were related to the QI work plan, the composition of the QAPI Committee, and documentation of the QAPI Committee meeting minutes.

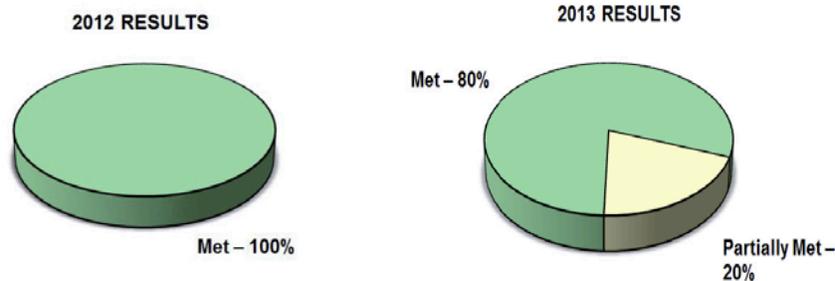


TABLE 4: QUALITY IMPROVEMENT COMPARATIVE DATA

SECTION	STANDARD	2012 REVIEW	2013 REVIEW
The Quality Improvement (QI) Program	An annual plan of QI activities is in place which includes areas to be studied, follow up of previous projects where appropriate, timeframe for implementation and completion, and the person(s) responsible for the project(s)	Met	Partially Met
Quality Improvement Committee	The composition of the QI Committee reflects the membership required by the contract	Met	Partially Met
	Minutes are maintained that document proceedings of the QI Committee	Met	Partially Met

The standards reflected in the table are only the standards that showed a change in score from 2012 to 2013.

CCME conducted a validation review of the performance measures and performance improvement projects (PIP) following the protocols developed by CMS. The health plan received a validation score of *Fully Compliant* for their performance measures and met the CMS validation requirements.

The performance improvement projects included topics for Coordination of Inpatient Care to Postpartum Visit, Follow Up for Children Prescribed ADHD Medication, Appropriate Testing of Children with Pharyngitis, Use of Appropriate Medications for People with Asthma, Post Discharge Follow-up for Members with Asthma Exacerbation, CAHPS QIA for Adults, CAHPS QIA for Child, Comprehensive Diabetes Care, Improving Women’s Health, Prenatal /Postpartum Care and Prenatal Outcomes, Well Child Visits, and Performance Measurement for Heart Failure. CCME conducted a validation review for three of the projects submitted. The following table is a summary of the validation scores.

PERFORMANCE IMPROVEMENT PROJECT VALIDATION SCORES

PROJECT	VALIDATION SCORE
Follow Up for Children Prescribed ADHD Medication	72 / 77 = 94% HIGH CONFIDENCE
Improving Women's Health	84 / 96 = 86% CONFIDENCE
Well Child Visits	91 / 96 = 95% HIGH CONFIDENCE

All of the validated projects met the CMS validation protocol requirements. Two received a score within the *High Confidence* range and one received a score within the *Confidence* range. Some of the recommendations for improving the documentation of these studies are listed in the table that follows.

Follow Up for Children Prescribed ADHD Medications		
Section	Reasoning	Recommendation
Results Presentation	For the Continuation and Maintenance Phase measure, the baseline numerator and denominator do not return the rate presented. The rate, numerator, and/or denominator are incorrect. Correct the numerator and/or denominator for the Continuation and Maintenance Phase measure and update the presented results.	The rate, numerator, and/or denominator are incorrect. Correct the numerator and/or denominator for the Continuation and Maintenance Phase measure and update the presented results.
Improving Women's Health		
Section	Reasoning	Recommendation
Measure Definition	This project uses three HEDIS measures to track women's health screenings [BCS, CCS, CHL]. BCS has the age range documented differently than the HEDIS Specifications list (42-64 versus 42-69 in the specifications).	For consistency with the HEDIS specifications these references should be fixed.
Results Presentation	For the Cervical Cancer Screening measure – Re-measurement 6, the numerator and denominator do not return the rate presented in the documentation.	Correct the numerator and/or denominator for re-measurement 6 and update the presented results.

Sustained Improvement	Two out of the three measures showed sustained improvement during the time periods documented.	The plan should continue to work on the Chlamydia screening measure to ensure consistent improvement over multiple re-measurement periods.
Well Child Visit		
Section	Reasoning	Recommendation
Sustained Improvement	None of the project's three measures are showing sustained improvement. This was discussed during the onsite and the interventions were changed for 2013. The plan is now awaiting the 2013 HEDIS results to see if any improvements have been made. CCME recommends that work continue on these measures to see consistent improvement over multiple re-measurement periods.	Work should continue on these measures to see consistent improvement over multiple re-measurement periods.

Details of the validation of the performance measures and performance improvement projects may be found in the *CCME EQR Performance Validation Worksheets, Attachment 3*.

STRENGTHS

- Select Health has committed to multiple performance improvement projects and has identified member satisfaction as a concern. They are currently tracking progress through a member satisfaction performance improvement project.
- NCQA-certified software is used for HEDIS® calculations.

WEAKNESSES

- Items with a status of “ongoing” on the 2012 Quality Work Plan were not carried over to the 2013 Quality Work Plan.
- Documents contained discrepancies in the number of members on the QAPI Committee and inconsistent information on which members have voting rights.
- Attendance is not accurately documented in the minutes for QAPI Committee meetings and several members of the committee were listed as guests in the attendance documentation.
- It was noted that page 11 of the 2013 QAPI Program Description states that the QAPI Committee meets quarterly or at a minimum of 3 times a year. The *SCDHHS MCO P&P Guide, Section 13.0 (2) (g)* requires these meetings to be held at least quarterly.
- Two of the performance improvement projects validated did not demonstrate sustained improvement.

V. UTILIZATION MANAGEMENT

The Utilization Management review included a review of policies, program descriptions, utilization management approval and denial files, case management files, and appeal files. Select Health's Utilization Management (UM) program functions include intake, prior authorization, concurrent review, discharge planning, retrospective review, provider disputes, and member appeals. The Utilization Management Program Description for 2013 details the scope and structure of the UM Program, as well as processes used to evaluate the medical necessity of covered benefits. There were several deficiencies identified in the description, and they are discussed in the weaknesses section that follows.

Files reviewed during the onsite visit were well-documented and demonstrated that utilization and case management activities occur as required. Some of the resolution letters in the appeal files reviewed onsite incorrectly documented the timeframes allowed for requesting State Fair Hearings and for requesting continuation of benefits pending the outcome of an appeal. Requirements for the timeframe for requesting a State Fair Hearing can be found in the *SCDHHS MCO Contract, Section 9.6.5.1*. Requirements for the timeframe for requesting continuation of benefits can be found in *Federal Regulation § 438.420* and in the *SCDHHS MCO Contract, Sections 9.8.1.1 and 9.8.1.2*.

The charts below show that 82.05 percent of the Utilization Management standards were scored as Met. The Partially Met and Not Met scores were related to Select Health's process for timely utilization decisions medical necessity determinations, and appeals

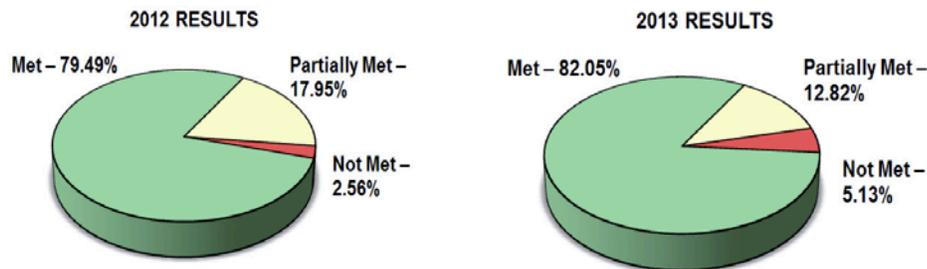


TABLE 5: UTILIZATION MANAGEMENT COMPARATIVE DATA

SECTION	STANDARD	2012 REVIEW	2013 REVIEW
The Utilization Management (UM) Program	The MCO formulates and acts within policies and procedures that describe its utilization management program	Partially Met	Met
	Guidelines / standards to be used in making utilization management decisions	Met	Partially Met

SECTION	STANDARD	2012 REVIEW	2013 REVIEW
The Utilization Management (UM) Program	Timeliness of UM decisions, initial notification, and written (or electronic) verification	Partially Met	Not Met
Medical Necessity Determinations	Utilization management standards/criteria used are in place for determining medical necessity for all covered benefit situations	Partially Met	Met
	Coverage of hysterectomies, sterilizations and abortions is consistent with state and federal regulations.	Met	Partially Met
	Utilization management standards/criteria are consistently applied to all members across all reviewers	Partially Met	Not Met
	Denial decisions are promptly communicated to the provider and member and include the basis for the denial of service and the procedure for appeal	Met	Partially Met
Appeals	The definitions of an action and an appeal and who may file an appeal	Met	Partially Met
	The procedure for filing an appeal	Not Met	Met
	Written notice of the appeal resolution as required by the contract	Partially Met	Met
	Other requirements as specified in the contract	Partially Met	Met

The standards reflected in the table are only the standards that showed a change in score from 2012 to 2013.

STRENGTHS

- Documentation indicates that very detailed explanations are given to members when a verbal request for an appeal is received, including basic appeal requirements, processes, and timelines; offers of assistance; and explanation that a written appeal will be mailed for the member to complete and return to the plan.
- Select Health demonstrates excellent turnaround times when processing authorization and appeal requests.
- The appeals information in the annual Grievances and Appeal Summary is thorough and includes a detailed appeals analysis, including the percentage of change in the number of appeals as well as specific opportunities for improvement and interventions.

MCO Contract, Section 9.5.3.3 and Section 9.5.3.7, the timeframe for determinations begins on the day the request is received, not the date of receipt of all information.

- The Integrated UM Program Description 2013 has an approval page (page 2) for documentation of approvals along with corresponding signatures and dates; however, none of the approvals were documented on this page.
- Onsite Utilization Management denial file reviews revealed the following:
 - Several initial medical necessity reviews were performed using incorrect InterQual criteria sets.
 - Some denial rationales documented in the notice of action letters didn't match the patient's clinical information and/or the criteria used for the medical necessity review.
- Select Health has no policy and procedure that addresses requirements for medical necessity review of, or claims filing requirements for, hysterectomies, sterilizations, and abortions. SCDHHS has very specific requirements for these services as defined in the *SCDHHS MCO P&P Guide, Section 10.12*.
- Incorrect and/or inadequate documentation of Select Health's inter-rater reliability (IRR) auditing processes were noted in the following:
 - The Integrated UM Program Description states on pages 17 and 19 that UM staff (non-physician) involved in medical necessity decisions are assessed for consistent application of criteria twice a year. Policy MED 153.306, Utilization Management Inter-rater Reliability Auditing, documents that IRR auditing is performed on clinical care reviewers on a quarterly basis. Onsite discussion confirmed that IRR auditing is performed on non-physician reviewers quarterly. Incorrect documentation of the frequency of IRR auditing was identified as a deficiency on the previous EQR and has not been corrected.
 - Policy MED 153.306, Utilization Management Inter-rater Reliability Auditing, does not provide adequate information on the IRR auditing process for physician reviewers, and no benchmark for physician reviewers is documented.
- Issues identified regarding Select Health's appeals processes include:
 - The Provider Manual states that for expedited appeals, written consent to act as a member's representative is required. Onsite discussion confirmed that as of August, 2013, no written consent is required for another person to act as a member's representative for plan-level appeals.
 - The timeframes for requesting a State Fair Hearing and for requesting that benefits continue pending the outcome of a State Fair Hearing were documented incorrectly in some of the appeal determination letters found in files reviewed onsite.

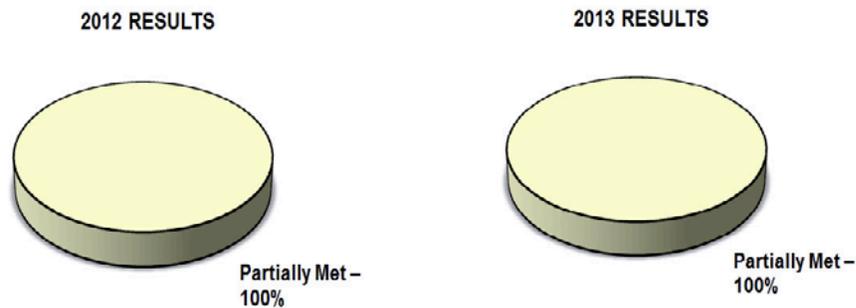
VI. DELEGATION

Select Health has delegated contracts with the following entities for credentialing and recredentialing: Health Network Solutions (HNS), Medical University of South Carolina (MUSC), St. Francis Physician Services (SFPS), Regional Health Plus (RHP), Memorial Health Partners (MHP), Georgia Health Sciences University and Greenville Hospital System (GHS). The sample delegated contract received in the desk materials was dated 8-24-11 and credentialing/recredentialing responsibilities did not appear to address South Carolina specific requirements such as collecting the ownership disclosure form 1514, query of the SC Excluded Provider's List, CLIA certificate/waiver when laboratory services are being performed, or guidelines for NPs acting as PCPs. In addition, the contract specifies verification of sanctions by Medicare/Medicaid but does not spell out what queries are to be performed.

Evidence of oversight monitoring was presented for the delegated entities; however, the monitoring tool does not appear to address the SC specific credentialing/recredentialing criteria. Oversight monitoring is performed on an annual basis. In the previous EQR it was noted that both MUSC and MHP have sub-delegates that are not accredited as required by the State. This issue is being held as "tabled with no action required" in the Credentialing Committee minutes. Onsite discussion confirmed that Select Health is awaiting clarification from the State regarding this issue.

Select Health contracts with Med-Advantage, an NCQA certified credentialing verification organization (CVO). While Select Health has a delegated contract with Med-Advantage, onsite discussion confirmed that no credentialing functions are delegated to this company. Med-Advantage provides access to a database that Select Health utilizes to verify education. Select Health has indicated they are considering changing the delegated contract with Med-Advantage to one that does not indicate the services they are providing are delegated.

The two standards in the Delegation section received Partially Met scores due to the aforementioned issues.



WEAKNESSES

- The sample delegated contract received in the desk materials was dated 8-24-11 and credentialing/recredentialing responsibilities did not appear to address South Carolina specific requirements such as collecting the ownership disclosure form 1514, query of the SC Excluded Provider's List, CLIA certificate/waiver when laboratory services are being performed, or guidelines for NPs acting as PCPs. In addition, the contract specifies verification of sanctions by Medicare/Medicaid but does not spell out what queries are to be performed.
- Evidence of oversight monitoring was presented for the delegated entities; however, the monitoring tool does not appear to address the SC specific credentialing/recredentialing criteria and all the required queries.

VII. STATE-MANDATED

Select Health tracks compliance with Well Child/EPSTD visits and immunizations, and provides a summary of the results to providers.

Several deficiencies identified in prior external quality reviews (EQR) have not been corrected. Select Health was informed they needed to include at least the date a site visit was performed

in the credentialing and recredentialing files, if applicable; however, this was not implemented. The timeframes for inter-rater reliability testing in the UM Program Description have not been corrected. In addition, the review of Policy MED 153.308 for the current EQR still lacks the documentation of an extension of the timeframe for initial inpatient authorization review and determination.

One standard is scored as Not Met in the State-Mandated Services section, and is due to uncorrected deficiencies identified in the previous external quality review.

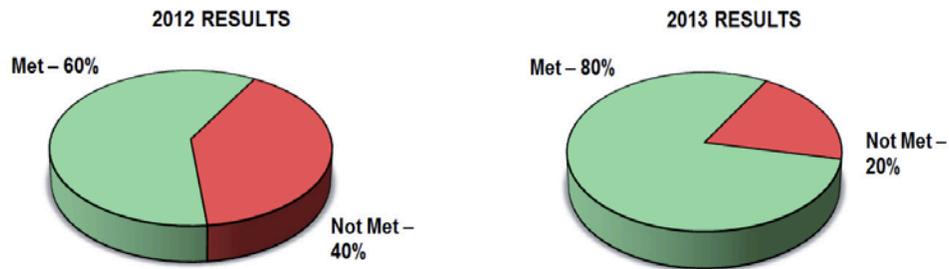


TABLE 6: STATE – MANDATED SERVICES COMPARATIVE DATA

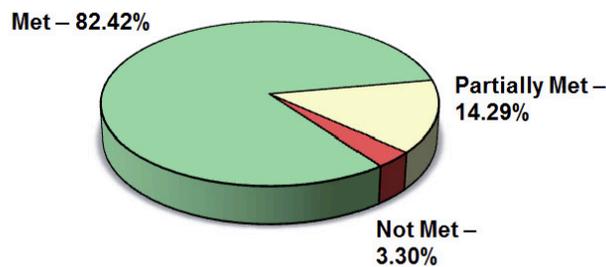
SECTION	STANDARD	2012 REVIEW	2013 REVIEW
Core benefits provided by the MCO include all those specified by the contract.	Core benefits provided by the MCO include all those specified by the contract	Not Met	Met

The standards reflected in the table are only the standards that showed a change in score from 2012 to 2013.

Summary and Recommendations

The findings of the 2013 EQR showed an overall reduction in Met scores of 7.69 percent and Partially Met scores increased by 8.25 percent over the prior year. Deficiencies were in the areas of credentialing and recredentialing, utilization decisions, delegation, and timeliness of grievance resolutions. Select Health did not fully implement the quality improvement plan which addressed the deficiencies identified during the previous EQR. As a result, the standard for addressing or correcting any of the previously identified deficiencies received a Not Met score.

Select Health of South Carolina 2013 Annual Review



Percents may not total 100% due to rounding

CCME recommends that Select Health implement the following recommendations to improve their processes and comply with all federal regulations and contract requirements.

1. Update the Master List of Policies Index and credentialing file names to reflect the updated naming convention (QI 210) that is listed in each credentialing policy. Also, update any policies that reference other policies using the old naming convention (e.g., Policy NM 159.101 references policy QI (CR) 205.100).
2. Update all the credentialing/recredentialing policies, the 2013 Credentials Program document, and the Provider Manual to remove references to the Healthcare Integrity Protection Data Bank (HIPDB), and references to the Excluded Parties List System (EPLS) should be replaced with the System for Award Management (SAM).
3. Correct page 11 of policy CR 210.100, Health Care Professional Credentialing and Re-credentialing, to reflect the correct ownership disclosure form (#1514).
4. Correct the issues identified in the 2013 Credentials Program document.
5. Add Dr. Kirt Caton (new member) to the list of Credentialing Committee members and also designate who has voting privileges on that list.
6. Ensure that credentialing/recredentialing files include the following:
 - a. The SCDHHS specified ownership disclosure form.

- b. A copy of the original signed attestation statement. The CAQH electronic signature page that shows the provider re-attested is acceptable to use as long as a copy of the original signed attestation is in the file.
 - c. Proof that queries of the SAM, formerly EPLS, and the SC Excluded Providers List have been performed.
 - d. A copy of the CLIA certificate or waiver when the application indicates that laboratory services are being performed.
7. Credentialing files for PCPs and OB/GYNs acting as PCPs must contain a copy of the office site visit and made available for the credentialing committee decision, if applicable.
8. Correct the issues identified in policy CR 210.107, Actions and Reporting Against Health Care Professional/Provider for Quality.
9. Update policy CR 210.103, Hospital & Ancillary Provider Credentialing and Recredentialing, to remove references to the HIPDB and change the EPLS references to reflect the SAM.
10. Update policies NM 159.204, Availability of Services, and NM 159.203, Accessibility of Services, as well as the Provider Manual to include the correct committee reference.
11. Correct the Provider Manual to address the other identified issues.
12. Address the discrepancy between policy PNO 170.406, the Provider Manual, and the Provider Kit regarding whether providers have 90 days to file an informal dispute. Update documents to reflect consistent information.
13. Update the Provider Manual to include all medical record documentation standards that are specified in policy QI 205.009.
14. Update policy MED (UM) 150.314, Continuity of Care, or another policy to address how Select Health monitors continuity and coordination of care between PCPs and other providers.
15. Update the Member Handbook as follows:
 - a. Include coverage information for members regarding non-elective, medically necessary hysterectomies; outpatient pediatric aids clinics, and preventive and rehabilitative services for primary care.
 - b. Correct the language on page 15 of the Member Handbook regarding hospital admissions following an emergency room visit. Select Health should receive notification from the hospital and cannot require a member, relative, or friend to call.
16. Update the Member Services Training Manual as follows:
 - a. Remove the requirement for prior authorization for family planning services found on page 53.
 - b. Clarify your coverage for hysterectomies, abortions, mental health and substance abuse treatment.
17. Correct the co-payment amount listed on the FirstChoice website for outpatient hospital services, (Spanish version) from \$3.30 to \$ 3.40.

18. Create a policy and procedure, or add to an existing policy, the process members and providers use to obtain specialty/referral care, including when a prior authorization is needed.
19. Include a map or description of Select Health's service area in member materials, the Member Handbook, or Provider Directory.
20. Inform the member in the Member Handbook that materials can be provided in alternate formats, such as Braille, upon request.
21. Remove the reference to an appeals process for grievances from the member grievance and appeals policy.
22. Develop a process to monitor the timely resolution of grievances.
23. Ensure that any questionable quality of care issues are reviewed by a Select Health physician that has the appropriate clinical expertise in accordance with Select Health's policy 154.300, Review of Potential Quality of Care Concerns and *Federal Regulation § 438.406 (a) (3) (ii) (C)*.
24. Ensure that newly-created work plans contain all applicable "ongoing" items from the previous year's work plans.
25. Update the Quality Assurance Performance Improvement (QAPI) Program Description to reflect a correct listing of members for the QAPI Committee. Update all applicable documents to indicate which members of the committee have voting rights.
26. Update the QAPI Committee meeting frequency requirement in the 2013 QAPI Program Description to be compliant with the *SCDHHS MCO P&P Guide, Section 13.0*.
27. Develop a process to accurately document QAPI Committee member attendance. Non-voting members of the committee should not be listed as guests in the attendance documentation.
28. Update the UM Program Description and Provider Manual to include all criteria used for utilization review determinations.
29. Update the Determination of Timeliness policy, MED 153.308, with the following:
 - a. Clarify the policy to indicate that approval notification will not exceed the standard or expedited timeframe allowed by federal and state regulations.
 - b. Add information to the policy that unless an extension is requested by the member or provider, Select Health must justify the need for the extension to SCDHHS upon request.
 - c. Add information regarding the two-day extension that can be granted for determinations for inpatient services if requested information is not received.
30. Correct the number of days allowed for extensions of expedited authorization determinations in the Member Grievances and Appeals Process policy, MEM 129.101.
31. Document the timeframe for notification of adverse determinations in either the Adverse Determinations policy, MED 153.303, or the Determination of Timeliness policy, MED 153.308.

32. Correct all applicable documents to indicate that timeframes for determinations of authorization requests begin on the day of the request and not on the day all necessary information is received.
33. Include approval information on the approval page of the Integrated UM Program Description.
34. Re-educate staff and continue to reinforce the importance of selecting appropriate criteria sets when performing medical necessity reviews.
35. Ensure that rationales for denial decisions are appropriate to the patient's condition and the type of request.
36. Create a policy and procedure which details the requirements for medical necessity review of, and the requirements for filing claims for, hysterectomies, sterilizations, and abortions.
37. Update the UM Inter-rater Reliability Auditing policy, MED 153.306, to contain clear and complete information on the IRR process used for physician reviewers. The benchmark for physician reviewers should be included also.
38. Correct the frequency of IRR auditing for non-physician reviewers in the UM Program Description.
39. Correct the Provider Manual to indicate that written consent is not required for a representative to act on a member's behalf for an expedited appeal.
40. Correct the timeframes for requesting State Fair Hearings and continuation of benefits pending the outcomes of a State Fair Hearing in all the appeal determination letters.
41. The delegated contract should include the SC specific credentialing/recredentialing criteria and the plan should ensure all required queries are being performed.
42. Update the delegation monitoring tools to reflect the SC specific credentialing/ recredentialing criteria and all the required queries.
43. Implement a process to ensure that all deficiencies identified during the EQR are addressed and corrections made.



Select Health of South Carolina

2013 External Quality Review

Attachment 1

Initial Notice

February 28, 2014

SCEQR_SelectHealthFinalReport201402.pdf

 CCME February 28, 2014 33



The Carolinas Center *for* Medical Excellence

246 Stoneridge Drive, Suite 200, Columbia, SC 29210 • 803.212.7500 • 800.922.3089 • www.thecarolinascenter.org

November 18, 2013

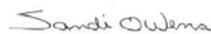
Ms. Cindy Helling
Chief Operations Officer
Select Health of South Carolina, Inc.
4390 Belle Oaks Drive, Suite 400
North Charleston, South Carolina 29405

Dear Ms. Helling:

This letter serves as your notification that the annual external quality review of Select Health of South Carolina for 2013 is being initiated. An external quality review (EQR) conducted by The Carolinas Center for Medical Excellence (CCME) is required by your contract with the South Carolina Department of Health and Human Services (SCDHHS) in relation to your organization's administration of a managed care program for Medicaid recipients. The annual EQR is being initiated at this time at the request of SCDHHS. It will include both a desk review at CCME and a multi-day onsite review at the Select Health office in Charleston SC, and will address all contractually required services as well as follow up of any areas of weakness identified during the annual review in 2012. Please note that CCME's review methodology will include the protocols required by the Centers for Medicare and Medicaid Services for the external quality review of Medicaid managed care organizations.

In preparation for the desk review, the items on the enclosed list are due at CCME no later than December 2, 2013. The CCME EQR team plans to conduct the onsite visit on January 15th, 16th, and 17th. To prepare your organization for the upcoming review, we would like to schedule a conference call with your management staff, in conjunction with SCDHHS, to describe our process and answer any questions you may have. Please contact me at (803) 212-7582 with dates your staff will be available for this conference call.

Sincerely,



Sandi Owens, LPN
Manager, External Quality Review

Enclosure

cc: SCDHHS



Select Health of South Carolina

2013 External Quality Review

Attachment 1

Materials Requested for Desk Review

February 28, 2014

SCEQR_SelectHealthFinalReport201402.pdf

 CCME February 28, 2014 35

Select Health of South Carolina

External Quality Review 2013

MATERIALS REQUESTED FOR DESK REVIEW

1. Copies of all current policies and procedures, as well as a complete index which includes policy name, number and department owner. The date of the addition/review/revision should be identifiable on each policy.
2. Organizational chart of all staff members including names of individuals in each position, and any current vacancies.
3. Current membership demographics including total enrollment and distribution by age ranges, sex, and county of residence.
4. Documentation of all service planning and provider network planning activities (e.g., geographic assessments, provider network assessments, enrollee demographic studies, population needs assessments) that support the adequacy of the provider base. Please include the maximum allowed and the current member-to-PCP ratios and member-to-specialist ratios.
5. A complete list of network providers for the Healthy Connections Choices (HCC) members. The list should be submitted as an excel spreadsheet and include the practitioner's name, title (MD, NP, PA etc.), specialty, practice name, address, phone number, counties served, if the provider is accepting new patients, and any age restrictions. Specialty codes and county codes may be used however please provide an explanation of the codes used by your organization.
6. The total number of unique specialty providers as well as the total number of unique primary care providers currently in the network.
7. A current provider list/directory as supplied to members.
8. A copy of the current Compliance plan.
9. A description of the Quality Improvement, Medical/Utilization Management, Disease/Case Management, and Pharmacy Programs.
10. The Quality Improvement work plans for 2012 and 2013.
11. The most recent reports summarizing the effectiveness of the Quality Improvement, Medical/Utilization Management, and Disease/Case Management Programs.
12. Documentation of all Performance Improvement Projects (PIPs) completed or planned since the 2012 annual review, and any interim information available for those projects currently in progress. This documentation should include information from the project that explains and documents all aspects of the project cycle (i.e. analytic plans, reasons for choosing the topic, measurement definitions, interventions planned or implemented, calculated results, barriers to improvement, results, etc...).

13. Reports of any Quality of Care Studies completed or planned since the 2012 annual review, if not included in #12 above.
14. Minutes of all committee meetings since the 2012 annual review for all committees reviewing or taking action on Select Health-related activities. All relevant attachments (e.g., reports presented, materials reviewed) should be included. If attachments are provided as part of another portion of this request, a cross-reference is satisfactory, rather than sending duplicate materials.
15. Membership lists and a committee matrix for all committees in #14 above, including the professional specialty of any non-staff members. Please indicate which members are voting members.
16. Any data collected for the purposes of monitoring the utilization (over and under) of health care services.
17. Copies of the most recent physician profiling activities conducted to measure contracted provider performance.
18. Results of the most recent medical office site reviews, medical record reviews and a copy of the tools used to complete these reviews.
19. A complete list of all members enrolled in the case management program from January 2013 through September 2013. Please include open and closed case management files, the member's name, Medicaid ID number, and condition or diagnosis which triggered the need for case management.
20. A copy of staff handbooks/training manuals, orientation and educational materials and scripts used by Member Services Representatives and/or Call Center personnel.
21. A copy of the member handbook and any statement of the member bill of rights and responsibilities if not included in the handbook.
22. A report of findings from the most recent member and provider satisfaction survey, a copy of the tool and methodology used. If the survey was performed by a subcontractor, please include a copy of the contract or other documentation of the requested scope of work.
23. A copy of any member and provider newsletters, educational materials and/or other mailings.
24. A copy of the Grievance, Complaint and Appeal logs for the months of October 2012 through October 2013.
25. Copies of all letter templates for documenting approvals, denials, appeals, grievances and acknowledgements.
26. Service availability and accessibility standards and expectations, and reports of any assessments made of provider and/or internal MCO compliance with these standards.

27. Preventive health practice guidelines recommended by the MCO for use by practitioners, including references used in their development, when they were last updated, how they are disseminated and how consistency with other MCO services and covered benefits is assessed.
28. Clinical practice guidelines for disease and chronic illness management recommended by the MCO for use by practitioners, including references used in their development, when they were last updated, how they are disseminated and how consistency with other MCO services and covered benefits is assessed.
29. A list of physicians currently available for utilization consultation/review and their specialty.
30. A copy of the provider handbook or manual.
31. A sample provider contract.
32. Documentation supporting requirements included in the Information Systems Capabilities Assessment for Managed Care Organizations (ISCAs). Please provide the following:
 - a. A completed ISCA. *(Not a summarized ISCA or a document that contains ISCA-like information, but the ISCA itself.)*
 - b. A network diagram showing (at a minimum) the relevant components in the information gathering, storage, and analysis processes. *(We are interested in the processing of claims and data in South Carolina, so if the health plan in South Carolina is part of a larger organization, the emphasis or focus should be on the network resources that are used in handling South Carolina data.)*
 - c. A flow diagram or textual description of how data moves through the system. *(Please see the comment on b. above.)*
 - d. A copy of the IT Disaster Recovery Plan.
 - e. A copy of the most recent disaster recovery or business continuity plan test results.
 - f. An organizational chart for the IT/IS department and a corporate organizational chart that shows the location of the IT organization within the corporation.
 - g. A description of the data security policy with respect to email and PHI.
33. A listing of all delegated activities, the name of the subcontractor(s), methods for oversight of the delegated activities by the MCO, and any reports of activities submitted by the subcontractor to the MCO.
34. Sample contract used for delegated entities. Specific written agreements with subcontractors may be requested at the onsite review at CCME's discretion.
35. Results of the most recent monitoring activities for all delegated activities. Include a full description of the procedure and/or methodology used and a copy of any tools used.
36. All HEDIS data and other performance and quality measures collected or planned. Required data and information include the following:
 - a. data collection methodology used (e.g., administrative data, including sources; medical record review, including how records were identified and how the sample was chosen; hybrid methodology, including data sources and how the sample was chosen; or survey, including a copy of the tool, how the sample was chosen and how the data was input), including a full description of the procedures;
 - b. reporting frequency and format;
 - c. specifications for all components used to identify the eligible population (e.g., member ID, age, sex, continuous enrollment calculation, clinical ICD-9/CPT-4 codes, member months/years calculation, other specified parameters);

- d. programming specifications that include data sources such as files/databases and fields with definitions, programming logic and computer source codes;
- e. denominator calculations methodology, including:
 - 1) data sources used to calculate the denominator (e.g., claims files, medical records, provider files, pharmacy files, enrollment files, etc.);
 - 2) specifications for all components used to identify the population for the denominator;
- f. numerator calculations methodology, including:
 - 1) data sources used to calculate the numerator (e.g., claims files, medical records, provider files, pharmacy files, enrollment files, etc.);
 - 2) specifications for all components used to identify the population for the numerator;
- g. calculated and reported rates.

These materials:

- **should be organized and submitted on a CD or flash drive (any material not available electronically maybe submitted hardcopy);**
- **should be submitted in the categories listed.**



Select Health of South Carolina

2013 External Quality Review

Attachment 2

Materials Requested for Onsite Review

February 28, 2014

Attachment 2

Select Health of South Carolina

External Quality Review 2013

MATERIALS REQUESTED FOR ONSITE REVIEW

Items with an * should be provided as copies that can be retained by CCME.

1. *Copies of all committee minutes for committees that have met since the desk materials were copied.
2. Credentialing files (including signed Ownership Disclosure Forms) for:
 - a. Ten PCP's (Include two NP's acting as PCP's, if applicable);
 - b. Two OB/GYNs;
 - c. Two specialists;
 - d. Two network hospitals; and
 - e. One file for each additional type of facility in the network.
3. Recredentialing (including signed Ownership Disclosure Forms) files for:
 - a. Ten PCP's (Include two NP's acting as PCP's, if applicable);
 - b. Two OB/GYNs;
 - c. Two specialists;
 - d. Two network hospitals; and
 - e. One file for each additional type of facility in the network.
4. Grievance and Case Management files for members on the attached list.
5. Documentation of any involuntary disenrollments for cause, including documentation of counseling provided and notices issued.
6. Appeal files for members on the attached list. Please include all information related to the initial denial.
7. All files for requests for State Fair Hearings.
8. Twenty medical necessity denial files made in the months of October 2012 through December 2013. Include any medical information and physician review documentations used in making the denial determination. Please include two behavioral health files and 2 acute inpatient rehabilitation files.
9. Twenty-five utilization approval files (acute care and behavioral health) made in the months of October 2012 through December 2013, including any medical information and approval criteria used in the decision. Please include prior authorizations for surgery and/or hospital admissions, concurrent stay, and retrospective review of admissions and of emergency care.

10. *QAPI Committee minutes for 09/10/13 and 11/14/13.
11. *Copy of the 2013 Credentials Program for Select Health of South Carolina.
12. *Copy of information provided to members about advance directives.
13. *Copy of all new member materials mailed to members. (No need for Provider List or Member Handbook already provided.)
14. *Example of marketing materials for potential members.
15. *Pharmacy Program Description, if available.
16. *Copy of policy QI 205.007, Review of Potential Quality of Care (mentioned in policy CR 210.107)



Select Health of South Carolina

2013 External Quality Review

Attachment 3

EQR Validation Worksheets

February 28, 2014

Attachment 3

EQR PIP Validation Worksheets

CCME EQR PIP VALIDATION WORKSHEET

Plan Name	Select Health
Name of PIP	FOLLOW UP FOR CHILDREN PRESCRIBED ADHD MEDICATION
Validation Period	2013
Review Performed	12/2013

ACTIVITY 1

ASSESS THE STUDY METHODOLOGY		
STEP 1: Review the Selected Study Topic(s)		
Component / Standard (Total Points)	Score	Comments
1.1 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services? (5)	MET	Topic was selected based on research and analysis of enrollee care needs.
1.2 Did the MCO's/PIHP's PIPs, over time, address a broad spectrum of key aspects of enrollee care and services? (1)	MET	A broad spectrum of enrollee care and services are addressed.
1.3 Did the MCO's/PIHP's PIPs, over time, include all enrolled populations (i.e., did not exclude certain enrollees such as those with special health care needs)? (1)	MET	All relevant populations are included.

STEP 2: Review the Study Question(s)		
Component / Standard (Total Points)	Score	Comments
2.1 Was/were the study question(s) stated clearly in writing? (10)	MET	An appropriate study question was noted in the project documentation.
STEP 3: Review Selected Study Indicator(s)		
Component / Standard (Total Points)	Score	Comments
3.1 Did the study use objective, clearly defined, measurable indicators? (10)	MET	Project uses both parts of the HEDIS® ADD measure.
3.2 Did the indicators measure changes in health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes? (1)	MET	Measure tracks how successful members are being followed up after being prescribed ADHD medications.
STEP 4: Review the Identified Study Population		
Component / Standard (Total Points)	Score	Comments
4.1 Did the MCO/PIHP clearly define all Medicaid enrollees to whom the study question and indicators are relevant? (5)	MET	Study population was clearly defined.
4.2 If the MCO/PIHP studied the entire population, did its data collection approach truly capture all enrollees to whom the study question applied? (1)	MET	Administrative HEDIS measure captured the relevant population.
STEP 5: Review Sampling Methods		
Component / Standard (Total Score)	Score	Comments
5.1 Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the margin of error that will be acceptable? (5)	NA	No sampling used.
5.2 Did the MCO/PIHP employ valid sampling techniques that protected against bias? (10) <i>Specify the type of sampling or census used:</i>	NA	No sampling used.
5.3 Did the sample contain a sufficient number of enrollees? (5)	NA	No sampling used.
STEP 6: Review Data Collection Procedures		
Component / Standard (Total Score)	Score	Comments
6.1 Did the study design clearly specify the data to be collected? (5)	MET	Study design clearly specifies data.
6.2 Did the study design clearly specify the sources of data? (1)	MET	Study design describes the sources of the data.

6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply? (1)	MET	Systematic method of collecting data is being used.
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? (5)	MET	Data collection is consistent.
6.5 Did the study design prospectively specify a data analysis plan? (1)	MET	Data analysis plan is provided.
6.6 Were qualified staff and personnel used to collect the data? (5)	MET	Qualified staff was used.
STEP 7: Assess Improvement Strategies		
Component / Standard (Total Score)	Score	Comments
7.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? (10)	MET	While just beginning, reasonable interventions are in place for this project's start.
STEP 8: Review Data Analysis and Interpretation of Study Results		
Component / Standard (Total Score)	Score	Comments
8.1 Was an analysis of the findings performed according to the data analysis plan? (5)	MET	Analysis was performed according to plan.
8.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? (10)	PARTIALLY MET	For the Continuation and Maintenance Phase measure, the baseline numerator and denominator do not return the rate presented. The rate, numerator, and / or denominator are incorrect. RECOMMENDATION Please update the presented results with the correct information.
8.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? (1)	NA	Project too young to judge at the time of this review.
8.4 Did the analysis of study data include an interpretation of the extent to which its PIP was successful and what follow-up activities were planned as a result? (1)	NA	Project too young to judge at the time of this review.

STEP 9: Assess Whether Improvement Is "Real" Improvement		
Component / Standard (Total Score)	Score	Comments
9.1 Was the same methodology as the baseline measurement, used, when measurement was repeated? (5)	NA	Project too young to judge at the time of this review.
9.2 Was there any documented, quantitative improvement in processes or outcomes of care? (1)	NA	Project too young to judge at the time of this review.
9.3 Does the reported improvement in performance have "face" validity (i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention)? (5)	NA	Project too young to judge at the time of this review.
9.4 Is there any statistical evidence that any observed performance improvement is true improvement? (1)	NA	Project too young to judge at the time of this review.
STEP 10: Assess Sustained Improvement		
Component / Standard (Total Score)	Score	Comments
10.1 Was sustained improvement demonstrated through repeated measurements over comparable time periods? (5)	NA	Project too young to judge at the time of this review.

ACTIVITY 2

VERIFYING STUDY FINDINGS		
Component / Standard (Total Score)	Score	Comments
Were the initial study findings verified upon repeat measurement? (20)	NA	NA

ACTIVITY 3

EVALUATE OVERALL VALIDITY AND RELIABILITY OF STUDY RESULTS					
Summary of Aggregate Validation Findings and Summary					
	Possible Score	Score		Possible Score	Score
Step 1			Step 6		
1.1	5	5	6.4	5	5
1.2	1	1	6.5	1	1
1.3	1	1	6.6	5	5
Step 2			Step 7		
2.1	10	10	7.1	10	10
Step 3			Step 8		
3.1	10	10	8.1	5	5
3.2	1	1	8.2	10	5
Step 4			8.3	0	NA
4.1	5	5	8.4	0	NA
4.2	1	1	Step 9		
Step 5			9.1	0	NA
5.1	0	NA	9.2	0	NA
5.2	0	NA	9.3	0	NA
5.3	0	NA	9.4	0	NA
Step 6			Step 10		
6.1	5	5	10.1	0	NA
6.2	1	1			
6.3	1	1			

Project Score	72
Project Possible Score	77
Validation Findings	94%

AUDIT DESIGNATION
HIGH CONFIDENCE

AUDIT DESIGNATION POSSIBILITIES	
High Confidence in Reported Results	Little to no minor documentation problems or issues that do not lower the confidence in what the plan reports. <i>Validation findings must be 90%–100%.</i>
Confidence in Reported Results	Minor documentation or procedural problems that could impose a small bias on the results of the project. <i>Validation findings must be 70%–89%.</i>
Low Confidence in Reported Results	Plan deviated from or failed to follow their documented procedure in a way that data was misused or misreported, thus introducing major bias in results reported. <i>Validation findings between 60%–69% are classified here.</i>
Reported Results NOT Credible	Major errors that put the results of the entire project in question. <i>Validation findings below 60% are classified here.</i>

CCME EQR PIP VALIDATION WORKSHEET

Plan Name	Select Health
Name of PIP	IMPROVING WOMEN'S HEALTH
Validation Period	2013
Review Performed	12/2013

ACTIVITY 1

ASSESS THE STUDY METHODOLOGY		
STEP 1: Review the Selected Study Topic(s)		
Component / Standard (Total Points)	Score	Comments
1.1 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services? (5)	MET	Topic was selected based on research and analysis of enrollee needs.
1.2 Did the MCO's/PIHP's PIPs, over time, address a broad spectrum of key aspects of enrollee care and services? (1)	MET	A broad spectrum of enrollee care and services are addressed.
1.3 Did the MCO's/PIHP's PIPs, over time, include all enrolled populations (i.e., did not exclude certain enrollees such as those with special health care needs)? (1)	MET	All relevant populations are included.

STEP 2: Review the Study Question(s)		
Component / Standard (Total Points)	Score	Comments
2.1 Was/were the study question(s) stated clearly in writing? (10)	MET	An appropriate study question was noted in the project documentation.
STEP 3: Review Selected Study Indicator(s)		
Component / Standard (Total Points)	Score	Comments
3.1 Did the study use objective, clearly defined, measurable indicators? (10)	PARTIALY MET	This project uses three HEDIS measures to track women's health screenings [BCS, CCS, CHL]. BCS has the age range documented differently than the HEDIS Specifications (42-64 vs 42-69 in the specifications). For consistency with the HEDIS specifications these references should be fixed. RECOMMENDATION Update documentation to reflect the correct HEDIS age groups for the breast cancer screening measure.
3.2 Did the indicators measure changes in health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes? (1)	MET	Project is tracking three health screenings for women.
STEP 4: Review the Identified Study Population		
Component / Standard (Total Points)	Score	Comments
4.1 Did the MCO/PIHP clearly define all Medicaid enrollees to whom the study question and indicators are relevant? (5)	MET	Study population was clearly defined.
4.2 If the MCO/PIHP studied the entire population, did its data collection approach truly capture all enrollees to whom the study question applied? (1)	MET	HEDIS measures captured relevant population.
STEP 5: Review Sampling Methods		
Component / Standard (Total Score)	Score	Comments
5.1 Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the margin of error that will be acceptable? (5)	NA	No sampling used.
5.2 Did the MCO/PIHP employ valid sampling techniques that protected against bias? (10) <i>Specify the type of sampling or census used:</i>	NA	No sampling used.

5.3 Did the sample contain a sufficient number of enrollees? (5)	NA	No sampling used.
STEP 6: Review Data Collection Procedures		
Component / Standard (Total Score)	Score	Comments
6.1 Did the study design clearly specify the data to be collected? (5)	MET	Study design clearly specifies data.
6.2 Did the study design clearly specify the sources of data? (1)	MET	Study design describes the sources of the data.
6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply? (1)	MET	Systematic method of collecting data is being used.
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? (5)	MET	Data collection is consistent.
6.5 Did the study design prospectively specify a data analysis plan? (1)	MET	Data analysis plan is provided.
6.6 Were qualified staff and personnel used to collect the data? (5)	MET	Qualified staff was used.
STEP 7: Assess Improvement Strategies		
Component / Standard (Total Score)	Score	Comments
7.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? (10)	MET	Reasonable interventions are in place.
STEP 8: Review Data Analysis and Interpretation of Study Results		
Component / Standard (Total Score)	Score	Comments
8.1 Was an analysis of the findings performed according to the data analysis plan? (5)	MET	Analysis was performed according to analysis plan.
8.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? (10)	PARTIALLY MET	For the Cervical Cancer Screening measure – Remeasurement 6, the numerator and denominator do not return the rate presented in the documentation. RECOMMENDATION Please update the presented results with the correct information.

8.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? (1)	MET	Plan documented the changes in guidelines that could impact those that receive the screenings.
8.4 Did the analysis of study data include an interpretation of the extent to which its PIP was successful and what follow-up activities were planned as a result? (1)	MET	An interpretation of the projects interventions was included in the documentation along with future planned interventions.
STEP 9: Assess Whether Improvement Is “Real” Improvement		
Component / Standard (Total Score)	Score	Comments
9.1 Was the same methodology as the baseline measurement, used, when measurement was repeated? (5)	MET	Same methodology was used.
9.2 Was there any documented, quantitative improvement in processes or outcomes of care? (1)	MET	Both the breast cancer and cervical cancer screening measures showed improvement from last measurement.
9.3 Does the reported improvement in performance have “face” validity (i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention)? (5)	MET	Reported improvement is deemed valid.
9.4 Is there any statistical evidence that any observed performance improvement is true improvement? (1)	MET	Project is measuring the plans entire eligible population. Observed improvement is deemed true improvement.
STEP 10: Assess Sustained Improvement		
Component / Standard (Total Score)	Score	Comments
10.1 Was sustained improvement demonstrated through repeated measurements over comparable time periods? (5)	PARTIALLY MET	Two out of the three measures in the project are showing sustained improvement during the time periods documented. RECOMMENDATION Continue working on the Chlamydia screening to have consistent improvement over multiple remeasurements.

ACTIVITY 2

VERIFYING STUDY FINDINGS		
Component / Standard (Total Score)	Score	Comments
Were the initial study findings verified upon repeat measurement? (20)	NA	NA

ACTIVITY 3

EVALUATE OVERALL VALIDITY AND RELIABILITY OF STUDY RESULTS					
Summary of Aggregate Validation Findings and Summary					
	Possible Score	Score		Possible Score	Score
Step 1			Step 6		
1.1	5	5	6.4	5	5
1.2	1	1	6.5	1	1
1.3	1	1	6.6	5	5
Step 2			Step 7		
2.1	10	10	7.1	10	10
Step 3			Step 8		
3.1	10	5	8.1	5	5
3.2	1	1	8.2	10	5
Step 4			8.3	1	1
4.1	5	5	8.4	1	1
4.2	1	1	Step 9		
Step 5			9.1	5	5
5.1	0	NA	9.2	1	1
5.2	0	NA	9.3	5	5
5.3	0	NA	9.4	1	1
Step 6			Step 10		
6.1	5	5	10.1	5	3
6.2	1	1			
6.3	1	1			
Project Score	84				
Project Possible Score	96				
Validation Findings	88%				

AUDIT DESIGNATION
CONFIDENCE

AUDIT DESIGNATION POSSIBILITIES	
High Confidence in Reported Results	Little to no minor documentation problems or issues that do not lower the confidence in what the plan reports. <i>Validation findings must be 90%–100%.</i>
Confidence in Reported Results	Minor documentation or procedural problems that could impose a small bias on the results of the project. <i>Validation findings must be 70%–89%.</i>
Low Confidence in Reported Results	Plan deviated from or failed to follow their documented procedure in a way that data was misused or misreported, thus introducing major bias in results reported. <i>Validation findings between 60%–69% are classified here.</i>
Reported Results NOT Credible	Major errors that put the results of the entire project in question. <i>Validation findings below 60% are classified here.</i>

CCME EQR PIP VALIDATION WORKSHEET

Plan Name	Select Health
Name of PIP	WELL CHILD VISITS
Validation Period	2013
Review Performed	12/2013

ACTIVITY 1

ASSESS THE STUDY METHODOLOGY		
STEP 1: Review the Selected Study Topic(s)		
Component / Standard (Total Points)	Score	Comments
1.1 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services? (5)	MET	Topic was selected based on research and analysis of enrollee needs.
1.2 Did the MCO's/PIHP's PIPs, over time, address a broad spectrum of key aspects of enrollee care and services? (1)	MET	A broad spectrum of enrollee care and services are addressed.
1.3 Did the MCO's/PIHP's PIPs, over time, include all enrolled populations (i.e., did not exclude certain enrollees such as those with special health care needs)? (1)	MET	All relevant populations are included.
STEP 2: Review the Study Question(s)		
Component / Standard (Total Points)	Line Score	Comments
2.1 Was/were the study question(s) stated clearly in writing? (10)	MET	An appropriate study question was noted in the project documentation.
STEP 3: Review Selected Study Indicator(s)		
Component / Standard (Total Points)	Score	Comments
3.1 Did the study use objective, clearly defined, measurable indicators? (10)	MET	Project is using three HEDIS measures (W15, W34, AWC) to track and improve the rate of Well Child visits among its members.
3.2 Did the indicators measure changes in health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes? (1)	MET	Project is tracking well child visit rates among three age groups.

STEP 4: Review the Identified Study Population		
Component / Standard (Total Points)	Score	Comments
4.1 Did the MCO/PIHP clearly define all Medicaid enrollees to whom the study question and indicators are relevant? (5)	MET	Study population was clearly defined.
4.2 If the MCO/PIHP studied the entire population, did its data collection approach truly capture all enrollees to whom the study question applied? (1)	MET	HEDIS measures captured relevant population.
STEP 5: Review Sampling Methods		
Component / Standard (Total Score)	Score	Comments
5.1 Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the margin of error that will be acceptable? (5)	NA	No sampling used.
5.2 Did the MCO/PIHP employ valid sampling techniques that protected against bias? (10) <i>Specify the type of sampling or census used.</i>	NA	No sampling used.
5.3 Did the sample contain a sufficient number of enrollees? (5)	NA	No sampling used.
STEP 6: Review Data Collection Procedures		
Component / Standard (Total Score)	Score	Comments
6.1 Did the study design clearly specify the data to be collected? (5)	MET	Study design clearly specifies data.
6.2 Did the study design clearly specify the sources of data? (1)	MET	Study design describes the sources of the data.
6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply? (1)	MET	Systematic method of collecting data is being used.
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? (5)	MET	Data collection is consistent.
6.5 Did the study design prospectively specify a data analysis plan? (1)	MET	Data analysis plan is provided.
6.6 Were qualified staff and personnel used to collect the data? (5)	MET	Qualified staff was used.

STEP 7: Assess Improvement Strategies		
Component / Standard (Total Score)	Score	Comments
7.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? (10)	MET	Reasonable interventions are in place.
STEP 8: Review Data Analysis and Interpretation of Study Results		
Component / Standard (Total Score)	Score	Comments
8.1 Was an analysis of the findings performed according to the data analysis plan? (5)	MET	Analysis was performed according to analysis plan.
8.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? (10)	MET	Numerical results are presented clearly and accurately.
8.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? (1)	MET	Plan has noted changes in the accepted guidelines that may impact the measures they are tracking.
8.4 Did the analysis of study data include an interpretation of the extent to which its PIP was successful and what follow-up activities were planned as a result? (1)	MET	An interpretation of the projects interventions was included in the documentation along with future planned interventions.
STEP 9: Assess Whether Improvement Is “Real” Improvement		
Component / Standard (Total Score)	Score	Comments
9.1 Was the same methodology as the baseline measurement, used, when measurement was repeated? (5)	MET	Same methodology was used.
9.2 Was there any documented, quantitative improvement in processes or outcomes of care? (1)	MET	Plan saw a slight increase from the previous remeasurement for the Adolescent Well Child Visits.
9.3 Does the reported improvement in performance have “face” validity (i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention)? (5)	MET	Reported improvement is deemed valid.
9.4 Is there any statistical evidence that any observed performance improvement is true improvement? (1)	MET	Project is measuring the plans entire eligible population. Observed improvement is deemed true improvement.

STEP 10: Assess Sustained Improvement		
Component / Standard (Total Score)	Score	Comments
10.1 Was sustained improvement demonstrated through repeated measurements over comparable time periods? (5)	NOT MET	<p>None of the projects three measures are showing sustained improvement during the time periods reported in the documentation. Plan is aware of this and had some major initiatives in place for 2013.</p> <p>RECOMMENDATION Plan is now awaiting the 2013 results to see if those planned initiatives were successful. Continue to work on these measures to see consistent improvement over multiple remeasurement periods.</p>

ACTIVITY 2

VERIFYING STUDY FINDINGS		
Component / Standard (Total Score)	Score	Comments
Were the initial study findings verified upon repeat measurement? (20)	NA	NA

ACTIVITY 3

EVALUATE OVERALL VALIDITY AND RELIABILITY OF STUDY RESULTS					
Summary of Aggregate Validation Findings and Summary					
	Possible Score	Score		Possible Score	Score
Step 1			Step 6		
1.1	5	5	6.4	5	5
1.2	1	1	6.5	1	1
1.3	1	1	6.6	5	5
Step 2			Step 7		
2.1	10	10	7.1	10	10
Step 3			Step 8		
3.1	10	10	8.1	5	5
3.2	1	1	8.2	10	10
Step 4			8.3	1	1
4.1	5	5	8.4	1	1
4.2	1	1	Step 9		
Step 5			9.1	5	5
5.1	0	NA	9.2	1	1
5.2	0	NA	9.3	5	5
5.3	0	NA	9.4	1	1
Step 6			Step 10		
6.1	5	5	10.1	5	0
6.2	1	1			
6.3	1	1			

Project Score	91
Project Possible Score	96
Validation Findings	95%

AUDIT DESIGNATION
HIGH CONFIDENCE

AUDIT DESIGNATION POSSIBILITIES	
High Confidence in Reported Results	Little to no minor documentation problems or issues that do not lower the confidence in what the plan reports. <i>Validation findings must be 90%–100%.</i>
Confidence in Reported Results	Minor documentation or procedural problems that could impose a small bias on the results of the project. <i>Validation findings must be 70%–89%.</i>
Low Confidence in Reported Results	Plan deviated from or failed to follow their documented procedure in a way that data was misused or misreported, thus introducing major bias in results reported. <i>Validation findings between 60%–69% are classified here.</i>
Reported Results NOT Credible	Major errors that put the results of the entire project in question. <i>Validation findings below 60% are classified here.</i>

EQR PM Validation Worksheets

CCME EQR PM VALIDATION WORKSHEET

Plan Name	Select Health
Name of PM	ALL HEDIS MEASURES
Reporting Year	2013
Review Performed	12/2013

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
HEDIS 2013

GENERAL MEASURE ELEMENTS			
Audit Elements	Audit Specifications	Validation	Comments
G1. Documentation	Appropriate and complete measurement plans and programming specifications exist that include data sources, programming logic, and computer source codes.	MET	Plan uses NCQA certified software Quality Spectrum Insight™. Review requirements have been met.

DENOMINATOR ELEMENTS			
Audit Elements	Audit Specifications	Validation	Comments
D1. Denominator	Data sources used to calculate the denominator (e.g., claims files, medical records, provider files, pharmacy records) were complete and accurate.	MET	Plan uses NCQA certified software Quality Spectrum Insight™. Review requirements have been met.
D2. Denominator	Calculation of the performance measure denominator adhered to all denominator specifications for the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	MET	Plan uses NCQA certified software Quality Spectrum Insight™. Review requirements have been met.

NUMERATOR ELEMENTS			
Audit Elements	Audit Specifications	Validation	Comments
N1. Numerator	Data sources used to calculate the numerator (e.g., member ID, claims files, medical records, provider files, pharmacy records, including those for members who received the services outside the MCO/PIHP's network) are complete and accurate.	MET	Plan uses NCQA certified software Quality Spectrum Insight™. Review requirements have been met.
N2. Numerator	Calculation of the performance measure numerator adhered to all numerator specifications of the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	MET	Plan uses NCQA certified software Quality Spectrum Insight™. Review requirements have been met.
N3. Numerator– Medical Record Abstraction Only	If medical record abstraction was used, documentation/tools were adequate.	NA	Abstraction was not used.
N4. Numerator– Hybrid Only	If the hybrid method was used, the integration of administrative and medical record data was adequate.	MET	Plan uses NCQA certified software Quality Spectrum Insight™. Review requirements have been met.
N5. Numerator Medical Record Abstraction or Hybrid	If the hybrid method or solely medical record review was used, the results of the medical record review validation substantiate the reported numerator.	MET	Plan uses NCQA certified software Quality Spectrum Insight™. Review requirements have been met.

SAMPLING ELEMENTS (if Administrative Measure then N/A for section)			
Audit Elements	Audit Specifications	Validation	Comments
S1. Sampling	Sample was unbiased.	MET	Plan uses NCQA certified software Quality Spectrum Insight™. Review requirements have been met.
S2. Sampling	Sample treated all measures independently.	MET	Plan uses NCQA certified software Quality Spectrum Insight™. Review requirements have been met.
S3. Sampling	Sample size and replacement methodologies met specifications.	MET	Plan uses NCQA certified software Quality Spectrum Insight™. Review requirements have been met.

REPORTING ELEMENTS			
Audit Elements	Audit Specifications	Validation	Comments
R1. Reporting	Was the measure reported accurately?	MET	Plan uses NCQA certified software Quality Spectrum Insight™. Review requirements have been met.
R2. Reporting	Was the measure reported according to State specifications?	NA	NA

VALIDATION SUMMARY			
Element	Standard Weight	Validation Result	Score
G1	10	MET	10
D1	10	MET	10
D2	5	MET	5
N1	10	MET	10
N2	5	MET	5
N3	0	NA	NA
N4	5	MET	5
N5	5	MET	5
S1	5	MET	5
S2	5	MET	5
S3	5	MET	5
R1	10	MET	10
R2	0	NA	NA

Elements with higher weights are elements that, should they have problems, could result in more issues with data validity and / or accuracy.

Plan's Measure Score	75
Measure Weight Score	75
Validation Findings	100%

AUDIT DESIGNATION
FULLY COMPLIANT

AUDIT DESIGNATION POSSIBILITIES	
Fully Compliant	Measure was fully compliant with State specifications. <i>Validation findings must be 86%–100%.</i>
Substantially Compliant	Measure was substantially compliant with State specifications and had only minor deviations that did not significantly bias the reported rate. <i>Validation findings must be 70%–85%.</i>
Not Valid	Measure deviated from State specifications such that the reported rate was significantly biased. This designation is also assigned to measures for which no rate was reported, although reporting of the rate was required. <i>Validation findings below 70% receive this mark.</i>
Not Applicable	Measure was not reported because MCO/PIHP did not have any Medicaid enrollees that qualified for the denominator.



Select Health of South Carolina

2013 External Quality Review

Attachment 4

Tabular Spreadsheet

February 28, 2014

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
I. ADMINISTRATION						
I A. General Approach to Policies and Procedures						
1. The MCO has in place policies and procedures that impact the quality of care provided to members, both directly and indirectly.	X					Select Health has developed a comprehensive list of policies which are written and organized in a consistent manner. Policies are reviewed annually and revised as needed.
I B. Organizational Chart / Staffing						
1. The MCO's resources are sufficient to ensure that all health care products and services required by the State of South Carolina are provided to members. At a minimum, this includes designated staff performing in the following roles:						Organizational charts demonstrate sufficient staff is in place to meet the needs of Select Health members.
1.1 A full time administrator of day-to-day business activities;	X					Cindy Helling, Executive Director, is responsible for the day-to-day business activities. She reports to Mike Jernigan, the Southern Region President in the AmeriHealth Caritas Family of Companies.
1.2 Information Systems personnel;	X					Several staff members provide IT support in the Charleston office, but the overall IT support for Select Health is managed out of the Pennsylvania office which is a part of the AmeriHealth Caritas Family of Companies.
1.3 Intake, investigation, resolution, and reporting of member and provider grievances;	X					The call center located in Charleston, SC is responsible for the intake of member and provider grievances.

Select Health of South Carolina
February 28, 2014
MCO ANNUAL EXTERNAL QUALITY REVIEW STANDARDS
Attachment 4

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.4 Utilization management functions;	X					There is sufficient staff to carry out utilization management functions including intake, prior authorization, concurrent and behavioral health authorizations and appeals. The Medical Directors' responsibilities include, but are not limited to, review for medical necessity, denials, educating staff and providers, and coordinating external review activities.
1.5 Quality assurance activities;	X					Quality Improvement staff is located in SC. Cindy Capps is the Director of Quality Management and reports to Tina Morton, Director Corporate Clinical Quality.
1.6 Provider credentialing and education;	X					Provider credentialing is conducted in SC within the Quality Management department.
1.7 Member service and education;	X					Kevin Vaughan is the Director of Member Services.
1.8 A physician licensed in the state where operations are based who serves as Medical Director, providing substantial oversight of the medical aspects of operation, including quality assurance activities.	X					Dr. Fred Volkman is the Regional Chief Medical Officer and Dr. William Burnham is the Senior Medical Director. Dr. Greg Barabell is the SC plan-specific Medical Director.
1.9 A designated compliance officer and a compliance committee that are accountable to senior management and that have effective lines of communication with all the MCO's employees.	X					Barbara Jones is the designated corporate compliance officer. Onsite discussion revealed that Select Health is in the process of staffing a new Regulatory Affairs and Compliance department that will be located in SC. Cindy Helling is currently functioning in the role of the Director of Regulatory Affairs until staffing for this new department is completed. A compliance committee is in place and meets at regular intervals.
2. Operational relationships of MCO staff are clearly delineated.	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
3. Operational responsibilities and appropriate minimum education and training requirements are identified for all MCO staff positions.	X					
I C. Management Information Systems						
1. The MCO processes provider claims in an accurate and timely fashion.	X					In meeting the contractual standard for claims processing, Select Health has opted to exceed the standard by shortening the timeframe, rather than increasing the processing percentage. This speaks to their confidence in their claims processing operation; specifically, that they can surpass the time requirements significantly and regularly.
2. The MCO tracks enrollment and demographic data and links it to the provider base.	X					Select Health does an excellent job of tracking enrollment and demographic data. They have plotted – for all of the major medical specialties – the locations of the providers and overlaid that with the locations of their members. They can show the driving distance to each type of provider and thus ensure that the members have at least one provider of each type within a 50 mile radius.
3. The MCO management information system is sufficient to support data reporting to the State and internally for MCO quality improvement and utilization monitoring activities.	X					Select Health has the systems and processes in place to ensure that they can meet state requirements for reporting, quality improvement, and utilization monitoring. They maintain a well-documented system, monitor its performance consistently, and have disaster recovery plans in place to ensure its continued operation.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
4. The MCO has a disaster recovery and/or business continuity plan, such plan has been tested, and the testing has been documented.	X					Select Health, as part of the AmeriHealth Caritas Family of Companies, is able to take advantage of the disaster recovery (DR) capabilities of the parent company, which has a very solid DR plan in place. The plan covers all the key elements needed, lays out requirements for participants in the plan, and specifies the duties each team member is responsible for addressing. The DR plan has been tested in a meaningful way (i.e., the testing has simulated the type of situation that might be encountered in an actual disaster), and perhaps most importantly, the failure of individual aspects of the test have each been examined, investigated, and addressed. Stated another way, they have learned from the exercise – exactly what should happen in a DR test.
I D. Confidentiality						
1. The MCO formulates and acts within written confidentiality policies and procedures that are consistent with state and federal regulations regarding health information privacy.	X					Select Health has policies and procedures in place that address confidentiality and privacy. Members receive the notice of privacy practices with their enrollment materials and the notice is posted to the Select Health/First Choice website. Employees receive compliance and HIPAA training annually.
II. PROVIDER SERVICES						
II A. Credentialing and Recredentialing						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
<p>1. The MCO formulates and acts within policies and procedures related to the credentialing and credentialing of health care providers in manner consistent with contractual requirements.</p>		X				<p>The 2013 Credentials Program document and several policies define the procedures for credentialing and recertifying. The policy number naming convention prefix has been changed on the policies from the previous EQQR. The file names for the policies received in the desk materials and the Master List of Policies Index (CR 205) did not match the updated policy numbers on the actual policies (CR 210). Also, some policies still referred to the old policy naming convention when making references to a policy (e.g., Policy NM 159.101 references policy QI (CR) 205.100).</p> <p>Additional issues were identified as follows:</p> <ul style="list-style-type: none"> • Policy CR 210.100 references ownership disclosure form 1513 on page 11 but should reference form 1514. • All of the credentialing/recertifying policies, the 2013 Credentials Program document, and the Provider Manual have the following issues: <ul style="list-style-type: none"> › References the Healthcare Integrity Protection Data Bank (HIPDB), which was merged into the National Practitioner Data Bank (NPDB) on May 6, 2013. The HIPDB references should be removed. › References to the Excluded Parties List System (EPLS) should be replaced with the System for Award Management (SAM). The EPLS records were moved to SAM and the old EPLS was phased out in 2012. • The 2013 Credentials Program document had the following issues: <ul style="list-style-type: none"> › Page 8 references ownership disclosure form 1415, but should reference 1514. › Page 22 (#4, 1st bullet) has an incomplete sentence. It should include the wording defined in policy CR 210.102 (page 2, #5) that states, "or may choose to

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						<p>be represented by legal counsel or another person of his/her choice." This is also an issue in the Provider Manual, page 10.</p> <p>Page 24 has outdated information in the delegated entities section as follows: PHIN is no longer a delegated entity; Med-Advantage (CVO) is incorrectly included as a delegate; and the Medical College of Georgia's name has changed to Georgia Health Services University.</p> <p><i>Quality Improvement Plan: Update the issues identified in this standard.</i></p>
2. Decisions regarding credentialing and recredentialing are made by a committee meeting at specified intervals and including peers of the applicant. Such decisions, if delegated, may be overridden by the MCO.	X					<p>Dr. James G. Baldwin is the chair of the Credentialing Committee. The committee also includes eight additional voting members: Dr. Fred Volkman, Regional Chief Medical Director; Dr. William Burnham, Regional Medical Director; Dr. Greg Barabell, Medical Director; Dr. Kirt Caton, Medical Director; and four contracted providers that specialize in Pediatrics, OB/GYN and Family Practice. Committee minutes reflect the quorum of 50% was met at each meeting and only physicians have voting privileges.</p> <p><i>Recommendation: Add Dr. Kirt Caton (new member) to the list of Credentialing Committee members and designate who has voting privileges on that list.</i></p>
3. The credentialing process includes all elements required by the contract and by the MCO's internal policies.		X				<p>Credentialing files reviewed onsite were organized but several files lacked appropriate documentation.</p> <p>Two credentialing files reviewed onsite did not contain the ownership disclosure form. Additional issues are discussed below.</p>

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
3.1 Verification of information on the applicant, including: 3.1.1 Current valid license to practice in each state where the practitioner will treat members; 3.1.2 Valid DEA certificate and/or CDS Certificate; 3.1.3 Professional education and training, or board certification if claimed by the applicant; 3.1.4 Work history; 3.1.5 Malpractice claims history;	X					
3.1.6 Formal application with attestation statement delineating any physical or mental health problem affecting ability to provide health care, any history of chemical dependency/ substance abuse, prior loss of license, prior felony convictions, loss or limitation of practice privileges or disciplinary action, the accuracy and completeness of the application, and (for PCPs only) statement of the total active patient load;			X			The majority of the credentialing files reviewed did not have a copy of the original signed attestation in the file. The files did have the CAQH electronic signature page that shows the provider re-attested; however, the file must also contain a copy of the original attestation statement with the provider's signature. <i>Quality Improvement Plan: Credentialing files must include a copy of the original signed attestation statement. The CAQH electronic signature page that shows the provider re-attested is acceptable to use as long as a copy of the original signed attestation is in the file.</i>

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Attachment 4

MCO ANNUAL EXTERNAL QUALITY REVIEW STANDARDS

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
3.1.7 Query of the National Practitioner Data Bank (NPDB); Health Integrity and Protection Databank (HIPDB); State Board of Examiners by the MCO (for the specific discipline); GSA Excluded Parties List Service;		X				Two credentialing files reviewed onsite did not contain proof of the SAM, formerly EPLS, had been queried. <i>Quality Improvement Plan: Credentialing files should include proof that a query of the SAM (formerly EPLS) has been performed.</i>
3.1.8 Query for state sanctions and/or license or DEA limitations; State Excluded Provider's Report;		X				Credentialing files reviewed did not contain evidence that the SC Excluded Providers List was queried. During the onsite Select Health provided a screen print of their system to show that queries of the SC Excluded Providers List is included in their process. <i>Quality Improvement Plan: Credentialing files must contain proof that a query of the SC Excluded Providers List has been performed.</i>
3.1.9 Query for Medicare and/or Medicaid sanctions; OIG List of Excluded Individuals and Entities;	X					
3.1.10 In good standing at the hospital designated by the provider as the primary admitting facility.	X					
3.1.11 Clinical Laboratory Improvement Amendment (CLIA) Certificate for providers billing laboratory procedures.		X				Three credentialing files reviewed onsite did not contain the CLIA certificate or waiver even though the application indicated laboratory services were being performed. <i>Quality Improvement Plan: Credentialing files must contain a copy of the CLIA certificate or waiver when the application indicates that laboratory services are being performed.</i>

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
3.2 Site assessment, including but not limited to adequacy of the waiting room and bathroom, handicapped accessibility, treatment room privacy, infection control practices, appointment availability, office waiting time, record keeping methods, and confidentiality measures.			X			<p>Policy NM 159.107, Site Visit, states that site visits are performed in the credentialing of new physician office sites for PCPs and OB/GYNs and when a participating OB/GYN or PCP opens a new office site. Site visits are also performed when a complaint has been lodged against a specific provider for concerns regarding office environment, as explained in policy NM 159.108, Member Quality Of Service Grievance Against a Provider/Practitioner.</p> <p>PCP and OB/GYN credentialing files reviewed onsite did not contain proof that a site visit had been performed. The site visits are conducted and maintained in another department and when the proof of onsite visits was requested, Select Health was only able to provide a few of the site visits. Discussion revealed that the site visit process is not integrated with the credentialing process. A recommendation was made in the previous EQR that the credentialing files should indicate the date a site visit had been performed.</p> <p><i>Quality Improvement Plan: Credentialing files for PCPs and OB/GYNs acting as PCPs must contain a copy of the office site visit and made available for the credentialing committee decision, if applicable.</i></p>
3.3 Receipt of all elements prior to the credentialing decision, with no element older than 180 days.	X					
4. The credentialing process includes all elements required by the contract and by the MCO's internal policies.	X					<p>Recredentialing files reviewed onsite were organized but several files lacked appropriate documentation as explained below.</p>

Select Health of South Carolina
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MCO ANNUAL EXTERNAL QUALITY REVIEW STANDARDS

Attachment 4

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
4.1 Recredentialing every three years;	X					
4.2 Verification of information on the applicant, including:						
4.2.1 Current valid license to practice in each state where the practitioner will treat members;	X					
4.2.2 Valid DEA certificate and/or CDS Certificate;	X					
4.2.3 Board certification if claimed by the applicant;	X					
4.2.4 Malpractice claims since the previous credentialing event;	X					
4.2.5 Practitioner attestation statement;			X			The majority of the recredentialing files reviewed did not have a copy of the original signed attestation in the file. The files did have the CAQH electronic signature page that shows the provider re-attested; however, the file must also contain a copy of the original attestation statement with the provider's signature. <i>Quality Improvement Plan: Recredentialing files must contain a copy of the original signed attestation. The CAQH electronic signature page that shows the provider re-attested is acceptable as long as a copy of the original signed attestation is in the file.</i>
4.2.6 Query the National Practitioner Data Bank; Health Integrity and Protection Databank; State Board of Examiners; GSA Excluded Parties List Service;	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
4.2.7. Requery for state sanctions and/or license limitations since the previous credentialing event; State Excluded Provider's Report;		X				<p>Recredentialing files reviewed did not contain evidence that the SC Excluded Providers List was queried. During the onsite, Select Health provided a screen print of their system to show that a query of the SC Excluded Providers List is included in their process.</p> <p><i>Quality Improvement Plan: Recredentialing files should contain at least the date of the SC Excluded Providers List search to show the query has been performed.</i></p>
4.2.8. Requery for Medicare and/or Medicaid sanctions since the previous credentialing event; OIG List of Excluded Individuals and Entities;	X					
4.2.9. Clinical Laboratory Improvement Amendment (CLIA) Certificate for providers billing laboratory procedures.	X					
4.3. Site reassessment if the provider location has changed since the previous credentialing activity.	X					<p>Policy NM 159.107, Site Visit, states that site visits are performed in the credentialing of new physician office sites for PCPs and OB/GYNs and when a participating OB/GYN or PCP opens a new office site. Site visits are also performed when a complaint has been lodged against a specific provider for concerns regarding office environment as explained in policy NM 159.108, Member Quality Of Service Grievance Against a Provider/Practitioner.</p> <p>There was no indication in the PCP and OB/GYN recredentialing files reviewed onsite that a site visit was needed.</p>
4.4. Review of practitioner profiling activities.	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
5. The MCO formulates and acts within written policies and procedures for suspending or terminating a practitioner's affiliation with the MCO for serious quality of care or service issues.		X				<p>Policy CR 210.107, Actions and Reporting Against Health Care Professional/Provider for Quality, defines Select Health's sanctioning process that could include dismissal from the network. The following issues were identified:</p> <ul style="list-style-type: none"> • Page 2 references policy QI 205.007, Review of Potential Quality of Care Concerns, which is a retired policy. Onsite discussion confirmed that policy 154-300, Review of Potential Quality of Care Concerns, is the correct policy to reference. • Mentions the HIPDB in several places. <p><i>Quality Improvement Plan: Correct the issues identified in policy CR 210.107, Actions and Reporting Against Health Care Professional/Provider for Quality.</i></p>
6. Organizational providers with which the MCO contracts are accredited and/or licensed by appropriate authorities.		X				<p>Policy CR 210.103, Hospital & Ancillary Provider Credentialing and Recredentialing, had the following issues:</p> <ul style="list-style-type: none"> • References the HIPDB which was merged into the NPDB on May 6, 2013. The HIPDB references should be removed from the policies. • References to the EPLS should be replaced with the SAM. The EPLS records were moved to SAM and the old EPLS was phased out in 2012. <p><i>Quality Improvement Plan: Update policy CR 210.103, Hospital & Ancillary Provider Credentialing and Recredentialing, to remove references to the HIPDB and change the EPLS references to reflect the SAM.</i></p>
II B. Adequacy of the Provider Network						

MCO ANNUAL EXTERNAL QUALITY REVIEW STANDARDS

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1. The MCO maintains a network of providers that is sufficient to meet the health care needs of members and is consistent with contract requirements.						
1.1 Members have a primary care physician located within a 30-mile radius of their residence.	X					Policy NM 159.104, Provider/Practitioner Geographic Access Policy, states that Select Health measures Family Practice/General Practice and Pediatric types of providers as two PCPs within 20 miles in urban/suburban areas and one within 30 miles for rural areas. Internal medicine providers are measured as one within 30 miles for both urban/suburban and rural. OB/GYNs are measured as one OB/GYN within 20 miles in urban/suburban and within 30 miles in rural areas. Results of the 2013 Geographic Accessibility Report show 100 percent of members have access to providers within these standards.
1.2 Members have access to specialty consultation from a network provider located within reasonable traveling distance of their homes. If a network specialist is not available, the member may utilize an out-of-network specialist with no benefit penalty.	X					Policy NM 159.104 states that specialists are measured as one specialist of each identified specialty type within 30 miles for urban/suburban and within 50 miles for rural areas. Results of the 2013 Geographic Accessibility Report show that for dermatology and rheumatology, Select Health does not meet their 95 percent goal for specialists. Onsite discussion confirmed a lack of available providers in some areas and lack of providers willing to contract in other counties. Select Health continues efforts to negotiate with identified specialists in counties not meeting the standards, where available.
1.3 The sufficiency of the provider network in meeting membership demand is formally assessed at least biennially.	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.4 Providers are available who can serve members with special needs such as hearing or vision impairment, foreign language/cultural requirements, and complex medical needs.	X					
1.5 The MCO demonstrates significant efforts to increase the provider network when it is identified as not meeting membership demand.	X					
2. Practitioner Accessibility						
2.1 The MCO formulates and insures that practitioners act within written policies and procedures that define acceptable access to practitioners and that are consistent with contract requirements.	X					<p>The provider access standards comply with contract requirements and are defined in policy NM 159.204, Availability of Services. The policy incorrectly references the Total Quality Management Committee (TQM), which is now called the Quality Assessment Performance Improvement Committee. The TQM committee is also incorrectly referenced in policy NM 159.203, Accessibility of Services and the Provider Manual, page 10.</p> <p>An after- hours study was completed in March and April 2013 to determine if the plan goal of 90 percent compliance was being met by providers. One hundred percent of the PCP locations (918) were called and 97.2 percent of the providers met the standards for after- hours availability. Twenty-five provider locations (2.8 percent) did not meet the standards and the report indicated some follow up steps were taken.</p> <p>Two reports were received for Behavioral Healthcare Access. Emergent/Urgent care and routine care were measured and of the 210 BH providers, 86 providers were contacted to determine if members could access routine care. Only 56.98 percent provided a routine office visit</p>

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
II C. Provider Education						within 10 business days. Barriers were identified with interventions to improve the results. <i>Quality Improvement Plan: Update policies NM 159.204, Availability of Services, and NM 159.203, Accessibility of Services, as well as the Provider Manual to include the correct committee reference.</i>
1. The MCO formulates and acts within policies and procedures related to initial education of providers.	X					Policy 159.105, Provider Orientation, states that orientations will be conducted for all new physician providers groups and that participation of all office staff and providers is encouraged. The Provider Manual is utilized as the basis for the orientations. The Provider Manual is updated on annual basis, or as necessary, per policy PR 170.203, Provider Manual Policy. Select Health has a provider education consultant that conducts training seminars in various regions across the state. They have very good attendance at these meetings. They also do HEDIS® specific training to providers, and deliver and explain the Provider Report Cards. Account Executives visit the provider offices on a regular basis.
2. Initial provider education includes:						The Provider Manual is very detailed and contains sufficient information for a provider to navigate the plan; however, the following issues were noted:
2.1 MCO health care program goals;	X					
2.2 Billing and reimbursement practices;	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2.3 Member benefits, including covered services, excluded services, and services provided under fee-for-service payment by SCDHHS;		X				<ul style="list-style-type: none"> • Page 34 does not list Substance Abuse Services in the list of covered benefits as specified in the <i>SCDHHS P&P Guide, Section 10.27</i>. • The Home and Community Based Waiver Services section does not address all of the special needs populations that are specified in the <i>SCDHHS P&P Guide Section 11.6</i>. Missing are the following: <ul style="list-style-type: none"> > Persons enrolled in the Medically Complex Children's waiver > Women at or below 185% of federal poverty level for Family Planning Services only. • Page 51, Section Mental Health and Alcohol/Drug Services, is missing "inpatient psychiatric hospital" which is specified in the <i>SCDHHS P&P Guide, Section 11.1</i>. • Vision Services listed on pages 50 and 52 need to be updated. <p><i>Quality Improvement Plan: Correct the Provider Manual to address the identified issues.</i></p>
2.4 Procedure for referral to a specialist;	X					
2.5 Accessibility standards, including 24/7 access;	X					
2.6 Recommended standards of care;	X					
2.7 Medical record handling, availability, retention and confidentiality;	X					
2.8 Provider and member grievance and appeal procedures;		X				The Provider Manual, page 21, and the Provider Kit listed on the website state that providers can register an informal dispute either verbally or in writing within 90 calendar days from original denial notification or action; however, policy PNO 170.406, Informal Provider

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Disputes, does not state a timeframe for filing informal disputes. <i>Quality Improvement Plan: Address the discrepancy between policy PNO 170.406, the Provider Manual, and Provider Kit regarding whether providers have 90 days to file an informal dispute. Update documents to reflect consistent information.</i>
2.9 Pharmacy policies and procedures necessary for making informed prescription choices;	X					
2.10 Reassignment of a member to another PCP;	X					
2.11 Medical record documentation requirements.		X				The Provider Manual specifies the medical record documentation standards, but the following standard mentioned in policy QI 205.009 is not listed: "Signed and dated consent forms, if applicable". <i>Quality Improvement Plan: Update the Provider Manual to include all medical record documentation standards that are specified in policy QI 205.009.</i>
3. The MCO provides ongoing education to providers regarding changes and/or additions to its programs, practices, member benefits, standards, policies and procedures.	X					Ongoing training is provided in the form of site visits, letters, newsletters, Provider Manual updates, and/or Corrective Action Plan per policy NM 159.102, Ongoing Training.
II D. Primary and Secondary Preventive Health Guidelines						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1. The MCO develops preventive health guidelines for the care of its members that are consistent with national standards and covered benefits and that are periodically reviewed and/or updated.	X					Policy QI 205 004, Preventive Health Guidelines, defines the process for developing and maintaining preventative guidelines for children, adults and obstetrical care. Guidelines are developed utilizing criteria established by nationally recognized professional organizations and with input from network PCPs and specialists. Clinical practice and preventive guidelines are developed based on demographic composition of the population. All guidelines are reviewed and approved by the Quality of Clinical Care Committee annually and more frequently if national guidelines change.
2. The MCO communicates the preventive health guidelines and the expectation that they will be followed for MCO members to providers.	X					Guidelines are distributed to practitioners via the Provider Manual, the web and through direct mailings.
3. The preventive health guidelines include, at a minimum, the following if relevant to member demographics:						
3.1 Well child care at specified intervals, including EPSDTs at State-mandated intervals;	X					
3.2 Recommended childhood immunizations;	X					
3.3 Pregnancy care;	X					
3.4 Adult screening recommendations at specified intervals;	X					
3.5 Elderly screening recommendations at specified intervals;	X					
3.6 Recommendations specific to member high-risk groups.	X					

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MCO ANNUAL EXTERNAL QUALITY REVIEW STANDARDS

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STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
4. The MCO assesses practitioner compliance with preventive health guidelines through direct medical record audit and/or review of utilization data.	X					
II E. Clinical Practice Guidelines for Disease and Chronic Illness Management						
1. The MCO develops clinical practice guidelines for disease and chronic illness management of its members that are consistent with national or professional standards and covered benefits, are periodically reviewed and/or updated and are developed in conjunction with pertinent network specialists.	X					Select Health has developed and maintains clinical practice guidelines for asthma, diabetes, heart failure, pharyngitis, sickle cell disease, hypertension, upper respiratory tract infection, ADHD, depression, overweight and obesity. This is defined in policy MED (CM) 150.210.
2. The MCO communicates the clinical practice guidelines for disease and chronic illness management and the expectation that they will be followed for MCO members to providers.	X					Information is listed in the Provider Manual and the clinical practice guidelines are listed on the website. Annually, providers are reminded through the website and the provider newsletter.
3. The MCO assesses practitioner compliance with clinical practice guidelines for disease and chronic illness management through direct medical record audit and/or review of utilization data.	X					
II F. Continuity of Care						
1. The MCO monitors continuity and coordination of care between the PCPs and other providers.		X				Policy MED (UM) 150.314, Continuity of Care, defines the process for continuity of care for members continuing treatment for up to 90 days with a practitioner that has terminated. Onsite discussion confirmed that Select Health monitors continuity and coordination of care between PCPs and other providers through medical record audits and various processes; however, they are not

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						addressed in this policy. <i>Quality Improvement Plan: Update policy MED (UM) 150.314, Continuity of Care, or another policy to address how Select Health monitors continuity and coordination of care between PCPs and other providers.</i>
II G. Practitioner Medical Records						
1. The MCO formulates policies and procedures outlining standards for acceptable documentation in the member medical records maintained by primary care physicians.	X					Policy QI 205.009, Medical Record Review, defines this standard.
2. Standards for acceptable documentation in member medical records are consistent with contract requirements.	X					Medical record standards defined in policy QI 205.009, Medical Record Review, comply with contract guidelines.
3. Medical Record Audit						
3.1 The MCO monitors compliance with medical record documentation standards through periodic medical record audit and addresses any deficiencies with the providers.	X					Select Health's Medical Record Review was completed in May 2013. The audit was completed in coordination with the annual HEDIS® survey. The overall 2013 Medical Record Review compliance rate was 99.70 percent, exceeding the plan's goal of 90 percent. Results in 2013 demonstrated an increase of 0.66 percent from the 2012 measure of 99.05 percent.
4. Accessibility to member medical records by the MCO for the purposes of quality improvement, utilization management, and/or other studies is contractually assured for a period of 5 years following expiration of the contract.	X					
III. MEMBER SERVICES						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
III A. Member Rights and Responsibilities						
1. The MCO formulates and implements policies outlining member rights and responsibilities and procedures for informing members of these rights and responsibilities.	X					Member rights and responsibilities are present in the Member Handbook, the Provider Manual, and policy MEM 129.100, Member Rights and Responsibilities. Select Health publishes member rights and responsibilities annually in the member newsletter and they can be found on the website.
2. Member rights include, but are not limited to, the right:	X					All member rights and responsibilities are present as found in the <i>SCDHHS MCO Policy and Procedure (P&P) Guide, Appendix 1.</i>
2.1 To be treated with respect and dignity;						The Privacy Notice is mailed as an insert with Member Handbook.
2.2 To privacy and confidentiality, both in their person and in their medical information;						Member Services is available by phone Monday-Friday 8 am to 9 pm and Saturday/Sunday 8 am to 6 pm. The Nurse Help Line is available 24/7 and supports member services after hours. The TTY number is well documented. Phone calls received in member services regarding behavioral health are routed to PerformCare during regular business hours. After hours calls are handled by the behavioral health team located in Harrisburg, Pennsylvania. Member service representatives have policies that guide their handling of crisis calls. The Provider Directory contains the required information.
2.3 To be provided with full information concerning the MCO, its services, and the providers who participate in their care;						

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STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2.4 Receive information on available treatment options and alternatives, presented in a manner appropriate to the member's condition and ability to understand;						
2.5 To participate in decision-making regarding their health care without prohibitions or restrictions on the clinical dialogue between patient and provider;						
2.6 To full disclosure of all treatment options;						
2.7 To receive services that are appropriate and are not denied or reduced solely because of diagnosis, type of illness, or medical condition;						
2.8 To voice grievances about the MCO or about the medical care and/or services they receive;						
2.9 To appeal decisions adversely affecting coverage, benefits, services, or their relationship with the MCO;						
2.10 To formulate advance directives;						
2.11 To access their medical records in accordance with applicable state and federal laws including the ability to request the record be amended or corrected;						
2.12 To receive oral interpretation services free of charge;						
2.13 To refuse treatment;						
2.14 To be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation, in accordance with Federal regulations.						

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	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
<p>III B. Member MCO Program Education</p> <p>1. Members are informed in writing within 14 business days of enrollment of all benefits to which they are contractually entitled, including:</p> <p>1.1 Full disclosure of benefits and services included and excluded in their coverage;</p>		X				<p>Policy MEM 129.107, New Member Orientation, confirms that members will be mailed the Member Handbook, the Provider Directory, and other new member materials within 14 calendar days of the plans receipt of enrollment data. The Select Health Member Services department makes welcome calls to all new members to provide an orientation to Select Health services and benefits. The goal is to reach 60% of new members while the actual percentage achieved is 58 percent. Issues identified in this section are noted below.</p> <p>The following deficiencies were identified in the Member Handbook:</p> <ul style="list-style-type: none"> • There is no coverage information provided for members about non-elective hysterectomies. • There is no mention of coverage for Outpatient Pediatric Aids Clinics (OPAC). • There is no information on PSPCE/RSPCE - Preventive and Rehabilitative Services for Primary Care Enhancement which is addressed in the <i>SCDHHS MCO P&P Guide, Section 10.22.</i> <p>The following issues were identified in the Member Services Training Manual:</p> <ul style="list-style-type: none"> • Page 53 states non-participating providers <u>must</u> obtain prior authorization for family planning services; however, the Member Handbook page 10 states prior approval is not required. • Page 54 describes elective therapeutic abortions in two places on the same page: one paragraph says they are <u>not</u> covered by First Choice and in another paragraph it states they are a covered benefit

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						<ul style="list-style-type: none"> • Pages 45 and 58 state that mental health, alcohol, and substance abuse treatment services are provided by Medicaid outside of the health plan; however, these services are the responsibility of the MCO per the SCDHHS MCO P&P Guide, Sections 10.23 and 10.27. <p><i>Quality Improvement Plan:</i></p> <ul style="list-style-type: none"> • Include coverage for non-elective, medically necessary hysterectomies in the Member Handbook, as found in the SCDHHS MCO P&P Guide, Section 10.12. • Include visits to an OPAC (Outpatient Pediatric Aids Clinics) in benefit information as found in the SCDHHS MCO P&P Guide, Section 10.18. • Include a brief description of PSPCE/RSPCE services, Preventive and Rehabilitative Services for Primary Care Enhancement as found in the SCDHHS MCO P&P Guide, Section 10.22. • Remove the requirement for prior authorization for family planning services, found on page 53 of the Member Services Training Manual. • Clarify your coverage of hysterectomies, abortions, mental health, and substance abuse treatment in the member services training manual.
1.1.1 Benefits include direct access for female members to a women's health specialist in addition to a PCP.						
1.1.2 Benefits include access to 2 nd opinions at no cost including use of an out-of-network provider if necessary.						

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	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.2 Any applicable deductibles, copayments, limits of coverage, maximum allowable benefits and claim submission procedures;						Services that may require a copayment are listed in the Member Handbook. Members are directed to a copayment reference guide supplied with new member materials. The First Choice website contains both English and Spanish versions of the copayment guide; however the copayment for outpatient hospital services is listed as \$3.40 on the English version and \$3.30 on the Spanish version. <i>Quality Improvement Plan: Correct the co-payment for outpatient hospital services in the Spanish-version copayment guide on the FirstChoice website.</i>
1.3 Any requirements for prior approval of medical care including elective procedures, surgeries, and/or hospitalizations;						Documented in Select Health's Member Handbook and the Provider Manual.
1.4 Procedures for and restrictions on obtaining out-of-network medical care;						Page 15 of the Member Handbook regarding hospital admissions following an emergency room visit states the member, relative or friend must call First Choice by the next business day following a hospital admission. Select Health should receive notification of the admission from the hospital and cannot require a member, relative or friend to call. <i>Quality Improvement Plan: Correct the wording on page 15 of the Member Handbook to reflect that Select Health requests, but does not require notification by a member, friend or relative, following an ER visit that results in hospitalization.</i>
1.5 Procedures for and restrictions on 24-hour access to care, including elective, urgent, and emergency medical services;						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.6 Policies and procedures for accessing specialty/referral care;						The Provider Manual, page 16, and the Member Handbook, page 9, state that no prior authorizations from Select Health is required for referrals to participating plan specialists. However, no policy or procedure was found that explains Select Health's process for members and providers to obtain referrals for in network or out of network specialists. <i>Recommendation: Create a policy and procedure, or add to an existing policy, the process members and providers use to obtain specialty/referral care, including when prior authorization is needed.</i>
1.7 Policies and procedures for obtaining prescription medications and medical equipment, including applicable copayments and formulary restrictions;						Select Health uses PerformRx as their Pharmacy Benefit Manager. The Member Handbook provides information on prescription medications, and pharmacy limitations, restrictions and copayments.
1.8 Policies and procedures for notifying members affected by changes in benefits, services, and/or the provider network, and providing assistance in obtaining alternate providers;						
1.9 Procedures for selecting and changing a primary care provider and for using the PCP as the initial contact for care;						
1.10 Procedures for disenrolling from the MCO;						Located in policy MEM 129.102, Disenrollment-Voluntary and Involuntary.
1.11 Procedures for filing grievances and appeals, including the right to request a Fair Hearing through DHHHS;						Located in policy MEM 129.101, Member Grievances and Appeals Process.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.12 Procedure for obtaining the names, qualifications, and titles of the professionals providing and/or responsible for their care and of alternate languages spoken by the provider's office;						
1.13 Additional information as required by the contract and by federal regulation.						The service area for Select Health includes all counties in South Carolina according to the Member Services Training Manual, page 45; however, this information is not communicated to members in the Member Handbook, the Provider Directory or other materials submitted for review. The <i>SCDHHS MCO P&P Guide, Section 14.3</i> , states that the MCO's written materials shall include a map or description of the MCO's service area. <i>Recommendation: Include a map or description of the Select Health service area in member materials, the Member Handbook or the Provider Directory.</i>
2. Members are informed promptly in writing of changes in benefits on an ongoing basis, including changes to the provider network.	X					
3. Member program education materials are written in a clear and understandable manner, including reading level and availability of alternate language translation for prevalent non-English languages as required by the contract.	X					Policy COM 220.105, The Production of Vital Documents in Alternative Formats, states alternate formats available include Braille, large font, and audio tape, among others. This information is not conveyed to the member in the Member Handbook as required by <i>Federal Regulation § 438.10 (d) (ii) (2)</i> . <i>Recommendation: Inform the member in the Member Handbook that materials can be provided in alternate format, such as Braille, upon request.</i>

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
4. The MCO maintains and informs members of how to access a toll-free vehicle for 24-hour member access to coverage information from the MCO, including the availability of free oral translation services for all languages.	X					Toll free numbers are on the member ID cards and throughout the Member Handbook, and are available 24 hours a day. Members are informed in the Member Handbook that translation services are available at no cost. Select Health's Member Services has a dedicated Spanish queue available for Spanish speaking members.
5. Member grievances, denials, and appeals are reviewed to identify potential member misunderstanding of the MCO program, with reeducation occurring as needed.	X					There is evidence of provider and member education in the grievance logs.
6. Materials used in marketing to potential members are consistent with the state and federal requirements applicable to enrollees and members.	X					
III C. Member Disenrollment						
1. Member disenrollment is conducted in a manner consistent with contract requirements.	X					
III D. Preventive Health and Chronic Disease Management Education						
1. The MCO enables each member to choose a PCP upon enrollment and provides assistance as needed.	X					
2. The MCO informs members about the preventive health and chronic disease management services that are available to them and encourages members to utilize these benefits.	X					The Member Handbook, the Select Health website, member newsletters, and targeted mailings contain information on preventive health guidelines and disease management services.

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	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
3. The MCO identifies pregnant members; provides educational information related to pregnancy, prepared childbirth, and parenting; and tracks the participation of pregnant members in their recommended care, including participation in the WIC program.	X					Select Health provides prenatal outreach as defined in policy MED 150.104, Prenatal Outreach Services.
4. The MCO tracks children eligible for recommended EPSDTs and immunizations and encourages members to utilize these benefits.	X					Policy QI 205 006, EPSDT/Prevention and Screening Outreach, describes the many ways Select Health educates members about well child visits and preventive health guidelines.
5. The MCO provides educational opportunities to members regarding health risk factors and wellness promotion.	X					Educating members includes now due postcards, past due automated reminders, non-established with PCP reminder, and birthday cards. Outreach phone calls, Journey to Wellness magazine for women and flu shot reminders are others ways Select Health educates and informs its members.
III E. Member Satisfaction Survey						
1. The MCO conducts a formal annual assessment of member satisfaction with MCO benefits and services. Such assessment includes, but is not limited to:	X					Select Health used an NCQA® certified survey vendor (MORPACE) to perform their 2013 CAHPS Adult and Child surveys.
1.1 Statistically sound methodology, including probability sampling to insure that it is representative of the total membership;	X					
1.2 The availability and accessibility of health care practitioners and services;	X					
1.3 The quality of health care received from MCO providers;	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.4 The scope of benefits and services;	X					
1.5 Claim processing procedures;	X					
1.6 Adverse decisions regarding MCO claim decisions.	X					
2. The MCO analyzes data obtained from the member satisfaction survey to identify quality problems.	X					
3. The MCO implements significant measures to address quality problems identified through the member satisfaction survey.	X					
4. The MCO reports the results of the member satisfaction survey to providers.	X					Summarized results of both the CAHPS and the HEDIS measures were published in the provider newsletter and available to the provider on Select Health's website.
5. The MCO reports to the Quality Improvement Committee on the results of the member satisfaction survey and the impact of measures taken to address those quality problems that were identified.	X					
III F. Grievances						
1. The MCO formulates reasonable policies and procedures for registering and responding to member grievances in a manner consistent with contract requirements, including, but not limited to:	X					Policy MEM 129.101, Member Grievances and Appeals Process, details the grievance and appeals processes. Select Health has created a position called a Member Advocate whose role is to assist members, upon request, with more complex grievance issues and monitor the grievance process.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.1 Definition of a grievance and who may file a grievance;	X					
1.2 The procedure for filing and handling a grievance;		X				Per page 8 of policy MEM 129.101, Member Grievances and Appeals Process, Select Health acknowledges grievances with a letter within 1 business day of the receipt of a grievance. Grievance files reviewed onsite confirmed adherence to this policy. Page 8, item 12 of this policy states that a member services representative will attempt to notify a member of the resolution by phone if the notification is urgent and advise of their right to file an appeal if dissatisfied with the resolution. Per onsite discussion, an appeal of a grievance is no longer part of the process. <i>Quality Improvement Plan: Remove the reference to appeals related to grievances from the member grievance and appeals policy.</i>
1.3 Timeliness guidelines for resolution of the grievance as specified in the contract;	X					Select Health utilizes a 90 day timeframe for resolution of grievances which complies with contract guidelines.
1.4 Review of all grievances related to the delivery of medical care by the Medical Director or a physician designee as part of the resolution process;	X					
1.5 Notification to the member of the right to request a Fair Hearing from SCDHHS when a covered service is denied, reduced, and/or terminated.	X					

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	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.6 Maintenance of a log for oral grievances and retention of this log and written records of disposition for the period specified in the contract.	X					The grievance logs document ample detail of grievance investigation and resolution.
2. The MCO applies the grievance policy and procedure as formulated.		X				<p>Per policy MEM 129.101, Member Grievances and Appeals, page 3 and defined in the <i>SCDHHS MCO Contract, Section 9.6.1.1</i>, standard disposition of grievances is 90 days from the day Select Health received the grievance.</p> <ul style="list-style-type: none"> • Several grievance files reviewed onsite were <u>not</u> resolved within the 90 day timeframe. • One grievance file had a questionable quality of care (QOC) issue for care received in a hospital. Select Health forwarded this grievance to the hospital and no review by a medical director or evidence that Select Health followed-up on this grievance was found. <p><i>Quality Improvement Plan:</i></p> <ul style="list-style-type: none"> • <i>Develop a process to monitor the timely resolution of grievances.</i> • <i>Ensure that any questionable quality of care issues are reviewed by a Select Health physician that has the appropriate clinical expertise in accordance with Select Health's policy 154.300, Review of Potential Quality of Care Concerns and Federal Regulation § 438.406 (a) (3) (ii) (C).</i>
3. Grievances are tallied, categorized, analyzed for patterns and potential quality improvement opportunities, and reported to the Quality Improvement Committee.	X					
4. Grievances are managed in accordance with the MCO confidentiality policies and procedures.	X					

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	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
III G. Practitioner Changes						
1. The MCO investigates all member requests for PCP change in order to determine if such change is due to dissatisfaction.	X					The reason for changing a PCP is documented in the grievance logs. The Manager of Member Services tracks PCP changes due to dissatisfaction and reports them to the Quality of Service Committee.
2. Practitioner changes due to dissatisfaction are recorded as grievances and included in grievance tallies, categorization, analysis, and reporting to the Quality Improvement Committee.	X					
IV. QUALITY IMPROVEMENT						
IV A. The Quality Improvement (QI) Program						
1. The MCO formulates and implements a formal quality improvement program with clearly defined goals, structure, scope and methodology directed at improving the quality of health care delivered to members.	X					The 2013 Quality Assurance and Performance Improvement (QAPI) Program Description details the purpose, goals, objectives, scope and structure of the QAPI Program. Lines of responsibility and accountability are included in the program description.
2. The scope of the QI program includes monitoring of provider compliance with MCO wellness care and disease management guidelines.	X					
3. The scope of the QI program includes investigation of trends noted through utilization data collection and analysis that demonstrate potential health care delivery problems.	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
4. An annual plan of QI activities is in place which includes areas to be studied, follow up of previous projects where appropriate, timeframe for implementation and completion, and the person(s) responsible for the project(s).		X				<p>The 2012 and 2013 Quality Work Plans were submitted for review and contain all required elements. The 2012 work plan (pages 9 and 18) had two items with a status of "ongoing," that were not carried over to the 2013 work plan. The items are:</p> <ul style="list-style-type: none"> • Collect, analyze, and implement activities as necessary in response to identified trends from formal Provider Disputes. • Identify and implement member and practitioner outreach activities to increase immunization rates for children. <p><i>Quality Improvement Plan: Update the 2013 Quality Work Plan with the missing items. Check newly-created work plans to make sure that all applicable "ongoing" items are carried over from previous work plans.</i></p>
IV B. Quality Improvement Committee						
1. The MCO has established a committee charged with oversight of the QI program, with clearly delineated responsibilities.	X					<p>The Quality Assurance and Performance Improvement (QAPI) Committee oversees all aspects of Select Health's quality activities.</p>
2. The composition of the QI Committee reflects the membership required by the contract.		X				<p>An inconsistency in the number of members on the QAPI Committee was noted when comparing the 2013 QAPI Program Description, page 10, and the Select Health Committee Listing – 2013. Onsite discussion confirmed that the 2013 QAPI Program Description is incorrect.</p> <p>Also, the Select Health Committee Listing – 2013 document indicates that all members of the QAPI Committee have voting rights. Minutes from the QAPI Meeting held on 09/10/13 indicate, and onsite discussion</p>

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STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
3. The QI Committee meets at regular quarterly intervals.	X					<p>confirmed, that some members do not have voting rights.</p> <p><i>Quality Improvement Plan: Update the QAPI Program Description to reflect a correct listing of members for the QAPI Committee. Update all applicable documents to indicate which members have voting rights.</i></p> <p>Review of meeting minutes confirmed that meetings are held at least quarterly. All meetings for which minutes were submitted had a quorum present.</p> <p>It was noted that page 11 of the 2013 QAPI Program Description states that the QAPI Committee meets quarterly or at a minimum of 3 times a year. The SCDHHS MCO P&P Guide, Section 13.0 (2) (g) requires these meetings to be held at least quarterly.</p> <p><i>Recommendation: Update the QAPI Committee meeting frequency requirement in the 2013 QAPI Program Description to be compliant with the SCDHHS MCO P&P Guide, Section 13.0.</i></p>
4. Minutes are maintained that document proceedings of the QI Committee.		X				<p>QAPI meeting minutes from 8/30/12, 11/8/12, 3/28/13, and 05/28/13 were reviewed prior to the onsite visit. Minutes for 09/10/19 and 12/16/13 were presented and reviewed onsite.</p> <p>Issues identified with documentation on the minutes include:</p> <ul style="list-style-type: none"> • Attendance is not accurately documented in the minutes for QAPI Committee meetings. • The minutes for 09/10/13 contain symbolic designations for voting members (A) and non-voting members (O). Several members who were indicated to be non-voting

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
IV C. Performance Measures						members of the committee were listed as guests in the attendance documentation for this meeting. This is confusing as guests are typically non-members who are attending the meeting. <i>Quality Improvement Plan: Develop a process to accurately document QAPI Committee member attendance. Non-voting members of the committee should not be listed as guests in the attendance documentation.</i>
1. Performance measures required by the contract are consistent with the requirements of the CMS protocol "Validation of Performance Measures".	X					Plan uses Quality Spectrum Insight™ for their HEDIS® measure calculations.
IV D. Quality Improvement Projects						
1. Topics selected for study under the QI program are chosen from problems and/or needs pertinent to the member population.	X					
2. The study design for QI projects meets the requirements of the CMS protocol "Validating Performance Improvement Projects".	X					All of the projects reviewed met the CMS validation protocol requirements. CCME chose to validate the Follow-up for Children Prescribed Asthma Medication, Improving Women's Health, and Well Child Visits projects. Two of the projects scored within the High Confidence range, and one scored within the Confidence range. For further details, see CCME's <i>EQR Validation Worksheet, Attachment 3.</i>

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
IV E. Provider Participation in Quality Improvement Activities						
1. The MCO requires its providers to actively participate in QI activities.	X					Providers are required to participate in QI activities, including record-keeping, inspections, and audits, etc.
2. Providers receive interpretation of their QI performance data and feedback regarding QI activities.	X					Providers are sent an annual Provider Performance Report that contains HEDIS® data and goals with the provider's rating.
IV F. Annual Evaluation of the Quality Improvement Program						
1. A written summary and assessment of the effectiveness of the QI program for the year is prepared annually.	X					The 2012 Quality Assessment Performance Improvement Evaluation was approved by the QAPI Committee on 03/28/13. It contains detailed information on all aspects of Select Health's quality program resources, structure, accreditations, service initiatives and indicators, member and provider satisfaction, clinical performance goals and initiatives, strengths, challenges and opportunities, and goals for the next year. QAPI activities are reported throughout the year to the QAPI Committee, and updates are provided quarterly to Select Health's Board of Directors. The QAPI Program is evaluated at least annually and as needed to measure effectiveness and to formulate recommendations for improvement, goals, and objectives for the next year.
2. The annual report of the QI program is submitted to the QI Committee and to the MCO Board of Directors.	X					QAPI activities are reported throughout the year to the QAPI Committee, and updates are provided quarterly to Select Health's Board of Directors.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
V. Utilization Management						
V.A. The Utilization Management (UM) Program						
1. The MCO formulates and acts within policies and procedures that describe its utilization management program, including but not limited to:	X					Select Health's Integrated Utilization Management 2013 Program Description provides a detailed description of Select Health's Utilization Management (UM) program.
1.1 structure of the program;	X					
1.2 lines of responsibility and accountability;	X					
1.3 guidelines / standards to be used in making utilization management decisions;		X				Guidelines and criteria used for UM decisions are discussed in the UM Program Description and in policies and procedures. Onsite discussion confirmed that in addition to InterQual® criteria and South Carolina State Medicaid guidelines, internal criteria have been developed and are used for 17-hydroxyprogesterone, Zofran pump, apnea monitors, cardiac rehabilitation, and pulmonary rehabilitation. Inconsistencies in the documentation of criteria used by Select Health were noted as follows: •The UM Program Description, page 12, fails to list that internal criteria is used for pulmonary rehabilitation. •The Provider Manual lists InterQual criteria and South Carolina State Medicaid guidelines but does not inform providers that some internal criteria are used. <i>Quality Improvement Plan: Update the UM Program</i>

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.4 timeliness of UM decisions, initial notification, and written (or electronic) verification;			X			<p><i>Description and Provider Manual to include all criteria used for utilization review determinations.</i></p> <p>Many issues were identified with Select Health's processes for UM determination timeliness and notification.</p> <p>Policy MED 153.308, Determination of Timeliness, discusses processes for approval decisions. Issues identified include:</p> <ul style="list-style-type: none"> • Page 2 indicates that faxes received after 5:00 pm will be logged as received on the next business day. However, there are no Federal or State Medicaid regulations that allow this. Therefore, the timeframe for review of all authorization requests begins on the date the request was actually received. • Page 2 states that approval notification is provided within 1 calendar day of making a decision, but does not include information that the notification date will not exceed the standard timeframe allowed. Refer to <i>Federal Regulation § 438.210 (d) (1) and (2)</i>, as well as the <i>SCDHHS MCO P&P Guide, Section 9</i> to view the requirements. • Page 2 states that determination timeframes may be extended by 14 calendar days if the member or provider request the extension or if matters arise beyond Select Health's control. This fails to mention that unless the extension is requested by the member or provider, the plan must justify the need for the extension to SCDHHS upon request. See the <i>SCDHHS MCO Contract, Section 9.5.3.3.2</i>. • The policy does not address that for determinations for inpatient services, a two-calendar-day extension can be granted if requested clinical information is not received.

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						<p>The extension is mentioned in the UM Program Description, page 22. <u>This issue was identified as a deficiency on the previous EQR and has not been corrected.</u></p> <p>There is a discrepancy in documentation of the number of days allowed for expedited authorization decisions. The Member Grievances and Appeals Process policy, MEM 129.101, page 4, documents that the allowable extension for expedited authorization decisions is 14 calendar days. Policy MED 153.308, Determination of Timeliness, states the allowable extension as only two calendar days. Onsite discussion confirmed that the plan allows only 2 calendar days for extensions of expedited pre-service authorization requests.</p> <p>Policy MED 153.303, Adverse Determinations lists no timeframe for notification of adverse determinations of authorization requests. Policy MED 153.308, Determination of Timeliness, lists the timeframe for notifications of approvals only.</p> <p>The Provider Manual, page 20, states that prior authorization of non-urgent care will be made within 14 calendar days of receiving all necessary information, and concurrent review determinations will be made within 24-72 hours, depending on the expiration of the certified concurrent period, of receiving all information. The PerformCare/Select Health Behavioral Health Medical Management Program Evaluation states on page 8 that determinations are made within either 1 or 14 days (depending on the type of request) of receiving all the information to support the request. The timeframe for determinations begins on the day the request is received.</p>

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						not the date of receipt of all information. See <i>Federal Regulation 438.210 (d) (1) and (2)</i> as well as the <i>SCDHHS MCO Contract, Section 9.5.3.3 and Section 9.5.3.7.</i>
1.5 consideration of new technology;	X					<i>Quality Improvement Plan: Correct the deficiencies identified in the processes for UM determination timeliness and notifications.</i>
1.6 the appeal process, including a mechanism for expedited appeal;	X					Addressed in the Evaluation of New Medical Technologies, MED 153.316.
1.7 the absence of direct financial incentives to provider or UM staff for denials of coverage or services;	X					
1.8 the absence of quotas establishing a number or percentage of claims to be denied.	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2. Utilization management activities occur within significant oversight by the Medical Director or the Medical Director's physician designee.	X					The QAPI Committee provides direction for all aspects of clinical and service quality assurance processes, including those related to utilization management. Dr. Fred Volkman, the Regional Chief Medical Officer (CMO), facilitates communication between regional and local leadership and the board of directors. He and Select Health's medical directors are responsible for the development, implementation and oversight of all aspects of the Select Health Integrated UM program.
3. The UM program design is periodically reevaluated, including practitioner input on medical necessity determination guidelines and grievances and/or appeals related to medical necessity and coverage decisions.	X					The Integrated UM Program Description 2013 confirms that the UM program is reviewed and updated annually and approved by the QAPI Committee. Recommendations are made to improve the effectiveness of the program and ability to reach established goals and objectives. Note: The Integrated UM Program Description 2013 has an approval page (page 2) for documentation of approvals along with corresponding signatures and dates; however, this page contains no documentation of any approvals. The 2012 Utilization Management Summary document contains an overview of the UM program, documentation of staffing, call metrics and timeliness of decision-making, inter-rater reliability, appeals data, utilization monitoring, and member/provider satisfaction data. All areas contain analysis of barriers, opportunities for improvement, and interventions and resources that will be used. <i>Recommendation: Include approval information on the approval page of the UM Program Description document.</i>
V B. Medical Necessity Determinations						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1. Utilization management standards/criteria used are in place for determining medical necessity for all covered benefit situations.	X					
2. Utilization management decisions are made using predetermined standards/criteria and all available medical information.	X					It was noted during reviews of demial file that several initial medical necessity reviews were performed using incorrect InterQual criteria sets. Onsite discussion confirmed that staff receive yearly training on InterQual. <i>Recommendation: Re-educate staff and continue to reinforce the importance of selecting appropriate criteria when performing reviews.</i>
3. Coverage of hysterectomies, sterilizations and abortions is consistent with state and federal regulations.		X				Appropriate information is provided in the Provider Manual. During onsite discussion, it was confirmed that Select Health has no specific policy and procedure that addresses the requirements for coverage hysterectomies, sterilizations, and abortions. Requirements can be found in the <i>SCDHHS MCO P & P Guide, Section 10.12.</i> <i>Quality Improvement Plan: Create a policy and procedure which details the requirements and processes for reviewing and covering hysterectomies, sterilizations, and abortions.</i>
4. Utilization management standards/criteria are reasonable and allow for unique individual patient decisions.	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
5. Utilization management standards/criteria are consistently applied to all members across all reviewers.			X			<p>Policy MED 153.306, Utilization Management Inter-rater Reliability Auditing, indicates on page two that quarterly inter-rater reliability (IRR) audits will be performed on each clinical care reviewer. A passing score is 90%. The process for IRR for the clinical care reviewers (non-physician) is well-documented. This policy doesn't provide detailed information on the IRR process for physician reviewers, and no benchmark for physician reviewers is documented. Onsite discussion confirmed that physicians do participate in IRR twice yearly, that there is a benchmark for performance, and follow-up testing, training, and corrective action as needed.</p> <p>By stating that IRR testing is performed twice yearly, the UM Program Description, pages 17 and 19, contradicts the IRR frequency that is listed in the MED 153.306 policy. Onsite discussion confirmed that IRR is performed quarterly. This issue was identified as a deficiency on the previous EQR and has not been corrected.</p> <p><i>Quality Improvement Plan: Update the UM Inter-rater Reliability Auditing policy to contain clear and complete information on the IRR process used for physician reviewers. The benchmark for physician reviewers should be included also. Correct the frequency of IRR auditing in the UM Program Description.</i></p>
6. Pharmacy Requirements						

MCO ANNUAL EXTERNAL QUALITY REVIEW STANDARDS

Select Health of South Carolina
February 28, 2014

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
6.1 Any pharmacy formulary restrictions are reasonable and are made in consultation with pharmaceutical experts.	X					The online (printable) preferred drug list was last updated in December 2013. The Pharmacy Benefits and Management policy, MED (PA) 150-400, describes the pharmacy benefits coverage and management. Formulary restrictions are reasonable and include quantity limits, generic substitutions, and limits on the number of prescriptions per month (with available overrides in certain circumstances).
6.2 If the MCO uses a closed formulary, there is a mechanism for making exceptions based on medical necessity.	X					
7. Emergency and post stabilization care are provided in a manner consistent with the contract and federal regulations.	X					
8. Utilization management standards/criteria are available to providers.	X					
9. Utilization management decisions are made by appropriately trained reviewers.	X					
10. Initial utilization decisions are made promptly after all necessary information is received.	X					
11. Denials						
11.1 A reasonable effort that is not burdensome on the member or the provider is made to obtain all pertinent information prior to making the decision to deny services.	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
11.2 All decisions to deny services based on medical necessity are reviewed by an appropriate physician specialist.	X					
11.3 Denial decisions are promptly communicated to the provider and member and include the basis for the denial of service and the procedure for appeal.		X				It was noted during onsite file review that some of the denial rationales placed in the notice of action letters didn't match the patient, the clinical information, and/or the criteria used for the review. <i>Quality Improvement Plan: Ensure that rationales for denial decisions are appropriate to the patient's condition and the type of request.</i>
V C. Appeals						
1. The MCO formulates and acts within policies and procedures for registering and responding to member and/or provider appeals of an action by the MCO in a manner consistent with contract requirements, including:	X					Appeals processes are detailed in policy MEM 129.101, Member Grievances and Appeals Process.
1.1 The definitions of an action and an appeal and who may file an appeal;		X				Onsite discussion confirmed that as of August, 2013, members are not required to sign authorization for a representative to act on their behalf for plan-level appeals. However, the Provider Manual states that written consent to act as a member's representative is required for expedited appeals. <i>Quality Improvement Plan: Correct the Provider Manual to indicate that written consent is not required for a representative to act on a member's behalf for an expedited appeal.</i>
1.2 The procedure for filing an appeal;	X					

Select Health of South Carolina
February 28, 2014

MCO ANNUAL EXTERNAL QUALITY REVIEW STANDARDS

Attachment 4

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.3 Review of any appeal involving medical necessity or clinical issues, including examination of all original medical information as well as any new information, by a practitioner with the appropriate medical expertise who has not previously reviewed the case;	X					
1.4 A mechanism for expedited appeal where the life or health of the member would be jeopardized by delay;	X					
1.5 Timeliness guidelines for resolution of the appeal as specified in the contract;	X					The Member Grievances and Appeals policy, MEM 129.101, includes correct timeliness guidelines for appeal resolutions and notifications.
1.6 Written notice of the appeal resolution as required by the contract;	X					
1.7 Other requirements as specified in the contract.	X					
2. The MCO applies the appeal policies and procedures as formulated.		X				Onsite review of appeals files revealed several issues: • The timeframe for requesting a State Fair Hearing is incorrect in the appeal determination letters. The letters state that the timeframe is 30 calendar days, but the correct timeframe is 30 calendar days from the date the member receives the notice of appeal resolution. See the <u>SCDHHS MCO Contract, Section 9.6.5.1.</u> • The timeframe for requesting continuation of benefits was incorrect in the appeal determination letters. Some of the letters stated that members must request continuation of benefits within 20 calendar days from the date of the letter or 20 calendar days from when services are stopped. Others indicated that continuation of benefits must be requested within 10 days of the date of the letter or within 10 calendar days from when services are stopped. The <u>SCDHHS MCO Contract, Sections 9.8.1.1 and 9.8.1.2,</u>

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						specifies that benefit continuation must be requested within ten (10) calendar days of the Contractor mailing the notice of Action or within 10 calendar days of the intended effective date of the Contractor's proposed Action. <i>Quality Improvement Plan: Correct the timeframes for requesting a State Fair Hearing and for requesting continuation of benefits in all the appeal determination letters.</i>
3. Appeals are tallied, categorized, analyzed for patterns and potential quality improvement opportunities, and reported to the Quality Improvement Committee.	X					The 2012 Grievances and Appeals Summary was presented in the desk materials, and contains a detailed analysis of the appeals and grievances for the year 2012, including identification of interventions used in 2012 and documentation of opportunities for the year 2013. The report was submitted to the Administrative Appeal and Grievance Committee on 3/22/13, and subsequently to the QAPI Committee on 05/30/13.
4. Appeals are managed in accordance with the MCO confidentiality policies and procedures.	X					
V. D Case Management						
1. The MCO utilizes case management techniques to insure comprehensive, coordinated care for members with complex health needs or high-risk health conditions, including populations specified in the contract.	X					
V.E. Evaluation of Over/ Underutilization						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1. The MCO monitors and analyzes utilization data for over/underutilization as required by the contract.	X					
2. Tracking of emergency room utilization and the authorizations/denials for such services occurs, as required by the contract.	X					
V I. DELEGATION						
1. The MCO has written agreements with all contractors or agencies performing delegated functions that outline responsibilities of the contractor or agency in performing those delegated functions.		X				Select Health has delegated contracts with the following entities for credentialing/recredentialing: Health Network Solutions (HNS), Medical University of South Carolina (MUSC), St. Francis Physician Services (SFPS), Regional Health Plus (RHP), Memorial Health Partners (MHP), Georgia Health Sciences University, and Greenville Hospital System (GHS). The sample delegated contract received in the desk materials was dated 8-24-11 and credentialing/recredentialing responsibilities did not appear to address South Carolina (SC) specific credentialing/recredentialing requirements such as collecting the ownership disclosure form 1514, query of the SC Excluded Provider's List, CLIA certificate/waiver when laboratory services are performed, or guidelines for NPs acting as PCPs. In addition, the contract specifies verification of sanctions by Medicare/Medicaid but does not spell out what queries are to be performed. <i>Quality Improvement Plan: The delegated contract should include the SC specific credentialing/recredentialing criteria and the plan should ensure all required queries are being performed.</i>

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
<p>2. The MCO conducts oversight of all delegated functions sufficient to insure that such functions are performed using those standards that would apply to the MCO if the MCO were directly performing the delegated functions.</p>		X				<p>Corporate policy 277.010, Delegation Oversight, defines the procedures for pre-delegation assessment and annual oversight.</p> <p>Evidence of oversight monitoring was presented for the delegated entities; however, the monitoring tool does not appear to address the SC credentialing/recredentialing criteria. Also, the monitoring tool does not specify which queries are required for Medicare/Medicaid sanctions. Oversight monitoring is performed on an annual basis. In the previous EQR it was noted that both MUSC and MEHP have sub-delegates that are not accredited as required by the State. This issue is being held as "tabled with no action required" in the Credentialing Committee minutes. Onsite discussion confirmed that Select Health is awaiting clarification from the State regarding this issue.</p> <p><i>Quality Improvement Plan: Update the delegation monitoring tools to reflect the SC specific credentialing/recredentialing criteria and all the required queries.</i></p>
V II. STATE-MANDATED SERVICES						
A. The MCO tracks provider compliance with:						
1. administering required immunizations;	X					
2. performing EPSDTs/Well Care	X					Select Health tracks Well Child visits annually as a HEDIS measure.
B. Core benefits provided by the MCO include all those specified by the contract.	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
C. The MCO tracks and submits service reports to the State in compliance with contract requirements.	X					The following deficiencies identified in the previous external quality review have not been corrected: <ul style="list-style-type: none"> During the 2012 external quality review, it was noted that there was a lack of documentation of extension of timeframes for authorization requests for inpatient services. A quality improvement plan (QIP) was submitted by Select Health that included adding the following statement to policy MED (UM) 153.308, "A two-calendar-day extension can be granted if requested clinical information is not received". Upon review of policy MED 153.308 for the current EQR, it is noted that the policy still contains no mention of an extension of the timeframe for initial inpatient review and determination. It was noted on the previous EQR that incorrect timeframes were listed in the UM Program Description for inter-rater reliability audits. Incorrect timeframes are still found in the UM Program Description. A recommendation was made in the previous EQR for Select Health to include at least the date a site visit was performed in the credentialing files and recredentialing files, if applicable. This was not implemented. <p><i>Quality Improvement Plan: Implement a process to ensure that all deficiencies identified during the EQR are addressed and corrections made.</i></p>
D. The MCO addresses deficiencies identified in previous independent external quality reviews.			X			

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HEDIS Scores

Keystone First

HEDIS Measure	Sub Measure	MY 2013 Ranking	MY 2013 Accred.	HEDIS 2010 Final	HEDIS 2011 Final	HEDIS 2012 Final	HEDIS 2013 Final	HEDIS 2013 QC Percentile*	HEDIS 2014 Final	Denom	Num Total	Num Admin	Num MR Hits	Point Change	Statistical Significance	2013 QC Percentile*	2014 NCQA Percentile Accred.
Preventive Screenings																	
Adult BMI Assessment (ABA)		R	A	29.93	40.18	58.85	70.68	25th	78.44	450	289	61	228	7.76	Y	50th	50th
Weight Assessment and Counseling (WCC)	BMI Screening - Total	R	A	36.01	45.13	61.59	62.07	50th	69.78	450	285	31	254	7.71	Y	75th	50th
	Counseling on Nutrition - Total	R	A	55.96	59.29	71.52	68.28	75th	69.56	450	265	16	249	1.28	N	75th	75th
	Counseling on Physical Activity - Total	R	A	41.12	48.67	60.49	54.25	50th	63.56	450	234	6	228	9.31	Y	75th	75th
Childhood Immunization Status (CIS)	Combination 2 Immunizations	R	A	73.97	79.76	82.63	82.12	75th	81.90	453	344	278	66	-0.22	N	75th	50th
Immunizations for Adolescents (IMA)	Combination 1 Immunizations	R		49.39	75.50	81.45	87.06	90th	86.73	226	196	182	14	-0.33	N	90th	NA
HPV for Female Ad 13 (HPV)		R		NA	NA	15.85	22.74	NA	24.28	453	102	88	14	1.54	N	NA	NA
Lead Screening (LSC)		R		67.15	69.03	74.39	73.51	50th	74.61	453	331	325	6	1.10	N	50th	NA
Breast Cancer (BCS)		R	A	57.87	58.03	58.31	59.42	75th	66.19					6.77	Y	90th	75th
Cervical Cancer (CCS)**				70.98	70.10	69.79	71.46	50th	70.95	453	317	297	20	-0.51	N	NA	NA
Chlamydia Screening (CHL)		R	A	58.36	66.25	67.94	59.23	50th	63.27					4.04	Y	50th	50th
Respiratory Conditions																	
Appropriate Testing for Children with Pharyngitis (CWP)		R	A	56.75	58.51	63.30	66.16	25th	64.60					-1.56	N	25th	25th

HEDIS Measure	Sub Measure	MY 2013 Ranking	MY 2013 Accred.	HEDIS 2010 Final	HEDIS 2011 Final	HEDIS 2012 Final	HEDIS 2013 Final	HEDIS 2013 QC Percentile*	HEDIS 2014 Final	Denom	Num Total	Num Admin	Num MR Hits	Point Change	Statistical Significance	2013 QC Percentile*	2014 NCQA Percentile Accred.
Appropriate Treatment for Children with URI (URI)		R	A	86.70	87.13	87.38	88.86	50th	89.20					0.34	N	50th	50th
Avoidance of Antibiotic Treatment in Adults with Bronchitis (AAB)		R	A	25.32	26.14	25.70	25.26	50th	27.03					1.77	N	50th	50th
Use of Spirometry Testing in Assessment and Diagnosis of COPD (SPR)		R	A	22.32	24.84	26.00	29.33	25th	25.82					-3.51	N	<25th	<25th
Pharmacotherapy Management of COPD Exacerbation (PCE)	Systemic Corticosteroid	R	A	62.56	69.62	73.00	76.36	75th	78.30					1.94	N	90th	90th
	Bronchodilator	R	A	88.44	88.56	89.89	89.99	75th	91.39					1.40	N	90th	90th
Use of Appropriate Medications with People with Asthma (ASM)	Total		A	91.62	91.11	87.72	87.37	50th	86.91					-0.46	N	50th	50th
Medication Management for People with Asthma (MMA)	75% Compliance	R		NA	NA	35.17	29.11	50th	37.59					8.48	Y	75th	NA
Asthma Medication Ratio (AMR)	Total Population Ratio > 50%	R		NA	NA	ND	55.87	NA	63.12					7.25	Y	NA	NA
Cardiovascular																	
Cholesterol Mgmt (CMC) ✓	LDL-C Screening ✓	R	A	82.97	84.26	82.52	81.68	25th	79.20	453	353	344	9	-2.48	N	25th	25th
	LDL-C Level < 100 ✓	R		46.23	48.56	44.47	44.59	50th	43.14	453	168	151	17	-1.45	N	50th	NA
Controlling High BP (CBP)	Total	R	A	66.58	63.12	64.01	64.41	75th	60.44	414	148	0	148	-3.97	N	50th	50th
Diabetes																	

HEDIS Measure	Sub Measure	MY 2013 Ranking	MY 2013 Accred.	HEDIS 2010 Final	HEDIS 2011 Final	HEDIS 2012 Final	HEDIS 2013 Final	HEDIS 2013 QC Percentile*	HEDIS 2014 Final	Denom	Num Total	Num Admin	Num MR Hits	Point Change	Statistical Significance	2013 QC Percentile*	2014 NCQA Percentile Accred.
Comp Diabetes Care (CDC)	HbA1c Testing	R	A	82.26	83.79	80.59	83.09	25th	82.51	630	516	503	13	-0.58	N	25th	50th
	HbA1c Poor Control (>9)*** √		A	36.29	36.14	40.91	33.97	75th	36.72	630	279	266	13	2.75	N	50th	50th
	HbA1c Adequate Control (<8)	R		54.52	55.92	51.22	53.59	50th	55.17	630	308	291	17	1.58	N	75th	NA
	LDL-C Screening	R	A	80.00	81.04	78.32	80.54	75th	79.81	630	496	479	17	-0.73	N	50th	50th
	LDL-C Level < 100 √	R		41.45	44.57	38.99	40.99	75th	37.68	630	209	189	20	-3.31	N	50th	NA
	Monitoring for Nephropathy	R	A	79.35	83.79	80.24	81.34	50th	80.92	630	508	498	10	-0.42	N	50th	50th
	Eye Exam	R	A	49.03	54.13	52.45	54.55	50th	51.67	630	287	253	34	-2.88	N	25th	25th
	Blood Pressure Control (<140/80)	R		NA	33.06	35.84	39.23	50th	40.22	630	163	2	161	0.99	N	50th	NA
	Blood Pressure Control (<140/90)	R		62.74	59.16	63.29	64.27	50th	66.93	630	267	2	265	2.66	N	50th	NA
Musculoskeletal Conditions																	
Use of Imaging for Low Back Pain (LBP)		R	A	78.49	77.73	79.63	78.87	50th	78.53					-0.34	N	50th	50th
Disease-Modifying Anti-Rheumatic Drug Therapy (DRT)		R		71.84	68.82	70.25	71.82	50th	73.94					2.12	N	50th	NA
Behavioral Health																	
Antidepressant Medication Management (AMM)	Acute Phase	R	A	NB	NB	NB	54.12	50th	54.75					0.63	N	50th	75th
	Continuation	R	A	NB	NB	NB	43.06	75th	41.25					-1.81	N	75th	75th
Follow-up with Children Prescribed ADHD Medication (ADD)	Initiation	R	A	18.72	17.51	17.59	18.21	<25th	15.68					-2.53	Y	<25th	<25th
	Continuation	R	A	16.34	14.09	12.68	15.51	<25th	14.58					-0.93	N	<25th	<25th

HEDIS Measure	Sub Measure	MY 2013 Ranking	MY 2013 Accred.	HEDIS 2010 Final	HEDIS 2011 Final	HEDIS 2012 Final	HEDIS 2013 Final	HEDIS 2013 QC Percentile*	HEDIS 2014 Final	Denom	Num Total	Num Admin	Num MR Hits	Point Change	Statistical Significance	2013 QC Percentile*	2014 NCQA Percentile Accred.
Diabetes Screening for People with Schizophrenia or Bi-Polar Disorder Who Are Using Antipsychotic Medications (SSD)		R		NA	NA	NB	83.03	NA	67.12					-15.91	Y	NA	NA
Diabetes Monitoring for People with Diabetes and Schizophrenia (SMD)		R		NA	NA	NB	72.83	NA	67.04					-5.79	N	NA	NA
Follow-up Care for Hospitalization for Mental Illness (FUH)	7 Day	R	A	NB	NB	NB	NB	NB	NB	NB	NB	NB	NB	NA	NA	NB	NB
	30 Day			NB	NB	NB	NB	NB	NB	NB	NB	NB	NB	NA	NA	NB	NB
CVD Monitoring for People with CVD and Schizophrenia (SMC)		R		NA	NA	NB	64.44	NA	74.49					10.05	N	NA	NA
Adherence to Antipsychotic Medications for People with Schizophrenia (SAA)	80% Coverage	R		NA	NA	NB	68.04	NA	75.35					7.31	Y	NA	NA
Access/Availability of Care																	
Prenatal Postpart Care (PPC)	Timeliness of Prenatal Care (Hybrid) v	R	A	81.08	78.67	81.66	82.96	25th	84.00	453	327	323	4	1.04	N	25th	25th
	Postpartum Care	R	A	61.43	54.03	62.19	62.11	25th	58.67	453	220	217	3	-3.44	N	25th	<25th
Adults Access to Preventative/Ambulatory Health Services (AAP)	Total			84.25	84.26	84.80	81.75	25th	85.57					3.82	Y	50th	NA

HEDIS Measure	Sub Measure	MY 2013 Ranking	MY 2013 Accred.	HEDIS 2010 Final	HEDIS 2011 Final	HEDIS 2012 Final	HEDIS 2013 Final	HEDIS 2013 QC Percentile*	HEDIS 2014 Final	Denom	Num Total	Num Admin	Num MR Hits	Point Change	Statistical Significance	2013 QC Percentile*	2014 NCQA Percentile Accred.
Children and Adolescents' Access to Primary Care Practitioners (CAP)	7-11 years	R		89.29	90.43	91.19	92.07	50th	92.29					0.22	N	50th	NA
Alcohol/Drug Dependence (IET)	Initiation of Treatment			NB	NB	NB	NB	NB	NB	NB	NB	NB	NB	NB	NA	NB	NB
	Initiation of Engagement			NB	NB	NB	NB	NB	NB	NB	NB	NB	NB	NB	NA	NB	NB
Utilization																	
Annual Monitoring for Patients with Persistent Medications (MPM)	Combined Rate	R		83.27	84.23	84.42	83.00	25th	79.75					-3.25	Y	<25th	NA
Freq of Ongoing PNC (FPC) ✓	81+ Percent of Expected Visits (Hybrid)			67.08	54.50	64.65	68.39	50th	63.11	453	201	199	2	-5.28	N	25th	NA
Well Child 15 Months (W15)	6+ Well Child Visits	R		57.04	63.43	63.83	63.36	25th	68.10	442	284	248	36	4.74	N	50th	NA
Well Child 3-6 Years (W34)		R		74.77	73.16	74.52	77.57	50th	80.80	427	334	321	13	3.23	N	75th	NA
Adolescent Well Care (AWC) ✓		R		57.47	61.26	61.34	62.31	75th	62.42	447	260	243	17	0.11	N	75th	NA
Annual Dental Visit (ADV) ✓	Total ✓			50.75	54.91	58.34	61.23	75th	62.73					1.50	Y	75th	NA
Ambulatory Care (AMB) ✓	ER Visits/1000 ✓***			69.21	64.52	67.88	67.05	50th	68.60					1.55	Y	50th	NA
***lower rate is better																	

AmeriHealth Caritas Pennsylvania

HEDIS Measure	Sub Measure	MY 2013 Ranking	MY 2013 Accred.	HEDIS 2010 Final	HEDIS 2011 Final	HEDIS 2012 Final	HEDIS 2013 Final	HEDIS 2013 QC Percentile	HEDIS 2014 Final	Denom	Num Total	Num Admin	Num MR Hits	Point Change	Statistical Significance	2013 QC Percentile*	2014 NCQA Percentile Accred.
Preventive Screenings																	
Adult BMI Assessment (ABA)		R	A	36.74	60.34	72.41	77.61	50th	87.08					9.47	Y	90th	90th
Weight Assessment and Counseling (WCC)	BMI Screening - Total	R	A	37.71	50.85	67.77	71.90	75th	74.54					2.64	N	75th	75th
	Counseling on Nutrition - Total	R	A	44.77	57.42	65.34	68.35	75th	69.91					1.56	N	75th	75th
	Counseling on Physical Activity - Total	R	A	40.15	54.26	60.26	61.27	50th	63.43					2.16	N	50th	50th
Childhood Immunization Status (CIS)	Combination 2 Immunizations	R	A	75.43	77.13	83.44	79.32	50th	79.91					0.59	N	75th	25th
Immunizations for Adolescents (IMA)	Combination 1 Immunizations	R		41.40	69.34	67.95	77.05	75th	81.96					4.91	N	75th	NA
HPV for Female Ad 13 (HPV)		R		NA	NA	24.29	31.87	NA	32.96					1.09	N	NA	NA
Lead Screening (LSC)		R		72.02	73.72	73.29	72.02	25th	70.42					-1.60	N	25th	NA
Breast Cancer (BCS)		R	A	61.49	61.39	59.92	62.53	75th	68.72					6.19	Y	90th	75th
Cervical Cancer (CCS)**				70.43	71.84	71.35	70.18	50th	69.04					-1.14	N	NA	NA
Chlamydia Screening (CHL)	Total	R	A	46.58	49.14	47.10	52.58	25th	53.45					0.87	N	25th	25th
Respiratory Conditions																	
Appropriate Testing for Children with Pharyngitis (CWP)		R	A	53.09	47.24	57.35	55.78	<25th	58.28					2.50	N	<25th	<25th
Appropriate Treatment for Children with URI (URI)		R	A	84.72	86.58	85.27	85.47	25th	85.90					0.43	N	50th	25th

HEDIS Measure	Sub Measure	MY 2013 Ranking	MY 2013 Accred.	HEDIS 2010 Final	HEDIS 2011 Final	HEDIS 2012 Final	HEDIS 2013 Final	HEDIS 2013 QC Percentile	HEDIS 2014 Final	Denom	Num Total	Num Admin	Num MR Hits	Point Change	Statistical Significance	2013 QC Percentile* Ranking	2014 NCQA Percentile Accred.
Avoidance of Antibiotic Treatment in Adults with Bronchitis (AAB)		R	A	16.79	19.52	20.99	21.31	25th	21.48					0.17	N	25th	25th
Use of Spirometry Testing in Assessment and Diagnosis of COPD (SPR)		R	A	27.27	31.30	29.61	23.05	<25th	28.52					5.47	N	25th	25th
Pharmacotherapy Management of COPD Exacerbation (PCE)	Systemic Corticosteroid	R	A	67.83	73.29	67.74	81.94	90th	78.76					-3.18	N	90th	90th
	Bronchodilator	R	A	82.52	82.88	81.29	87.50	75th	89.87					2.37	N	75th	75th
Use of Appropriate Medications with People with Asthma (ASM)	Total		A	90.08	89.55	86.97	84.81	50th	84.05					-0.76	N	25th	25th
Medication Management for People with Asthma (MMA)	Total 75% Compliance	R		NA	NA	39.27	33.21	75th	44.99					11.78	Y	90th	NA
Asthma Medication Ratio (AMR)	Total Population Ratio > 50%	R		NA	NA	ND	55.70	NA	64.88					9.18	Y	NA	NA
Cardiovascular																	
Cholesterol Mgmt (CMC) ✓	LDL-C Screening ✓	R	A	88.34	85.60	86.30	87.10	75th	86.77					-0.33	N	75th	75th
	LDL-C Level < 100 ✓	R		53.35	52.00	50.00	52.31	75th	52.67					0.36	N	75th	NA
Controlling High BP (CBP)	Total	R	A	64.84	66.58	67.66	66.39	75th	65.59					-0.80	N	75th	<25th
Diabetes																	
Comp Diabetes Care (CDC)	HbA1c Testing	R	A	86.31	88.87	88.54	85.04	50th	84.83					-0.21	N	50th	50th
	HbA1c Poor Control (>9)*** ✓		A	35.40	33.03	31.92	38.32	50th	33.33					-4.99	N	75th	75th
	HbA1c Adequate Control (<8)	R		52.74	55.29	56.08	50.36	50th	56.17					5.81	Y	75th	NA
	LDL-C Screening	R	A	82.48	84.85	81.83	81.02	75th	77.83					-3.19	N	50th	50th
	LDL-C Level < 100 ✓	R		40.15	42.15	40.74	41.97	75th	39.00					-2.97	N	50th	NA

HEDIS Measure	Sub Measure	MY 2013 Ranking	MY 2013 Accred.	HEDIS 2010 Final	HEDIS 2011 Final	HEDIS 2012 Final	HEDIS 2013 Final	HEDIS 2013 QC Percentile	HEDIS 2014 Final	Denom	Num Total	Num Admin	Num MR Hits	Point Change	Statistical Significance	2013 QC Percentile*	2014 NCQA Percentile Accred.
	Monitoring for Nephropathy	R	A	81.93	86.50	81.31	79.56	50th	80.50					0.94	N	50th	50th
	Eye Exam	R	A	69.53	70.26	68.78	65.15	75th	65.50					0.35	N	75th	75th
	Blood Pressure Control (<140/80)	R		NA	48.36	45.86	44.53	75th	45.50					0.97	N	75th	<25th
	Blood Pressure Control (<140/90)	R		66.79	71.53	70.9	71.35	75th	69.50					-1.85	N	75th	<25th
Musculoskeletal Conditions																	
	Use of Imaging for Low Back Pain (LBP)	R	A	70.76	73.64	72.04	71.84	25th	73.43					1.59	N	25th	<25th
	Disease-Modifying Anti-Rheumatic Drug Therapy (DRT)	R		78.22	81.82	72.28	77.27	75th	77.69					0.42	N	75th	NA
Behavioral Health																	
	Antidepressant Medication Management (AMM)																
	Acute Phase	R	A	NB	NB	ND	NB	NB	53.63					NA	NA	50th	50th
	Continuation	R	A	NB	NB	ND	NB	NB	40.73					NA	NA	75th	75th
	Follow-up with Children Prescribed ADHD Medication (ADD)																
	Initiation	R	A	25.68	24.38	22.02	26.41	<25th	19.54					-6.87	Y	<25th	<25th
	Continuation	R	A	22.96	22.04	21.56	22.12	<25th	20.25					-1.87	N	<25th	<25th
	Diabetes Screening for People with Schizophrenia or Bi-Polar Disorder Who Are Using Antipsychotic Medications (SSD)	R		NA	NA	NB	88.00	NA	85.12					-2.88	N	NA	NA
	Diabetes Monitoring for People with Diabetes and Schizophrenia (SMD)	R		NA	NA	NB	66.33	NA	74.77					8.44	N	NA	NA

HEDIS Measure	Sub Measure	MY 2013 Ranking	MY 2013 Accred.	HEDIS 2010 Final	HEDIS 2011 Final	HEDIS 2012 Final	HEDIS 2013 Final	HEDIS 2013 QC Percentile	HEDIS 2014 Final	Denom	Num Total	Num Admin	Num MR Hits	Point Change	Statistical Significance	2013 QC Percentile*	2014 NCQA Percentile Accred.
Follow-up Care for Hospitalization for Mental Illness (FUH)	7 Day	R	A	NB	NB	NB	NB	NB	NB					NA	NA	NA	NA
	30 Day			NB	NB	NB	NB	NB	NB					NA	NA	NA	NA
CVD Monitoring for People with CVD and Schizophrenia (SMC)		R		NA	NA	NB	NB	NB	NA					NA	NA	NA	NA
Adherence to Antipsychotic Medications for People with Schizophrenia (SAA)	80% Coverage	R		NA	NA	NB	70.43	NA	72.04					1.61	N	NA	NA
Access/Availability of Care																	
Prenatal Postpart Care (PPC)	Timeliness of Prenatal Care ✓	R	A	89.89	90.28	92.84	90.51	75th	92.22					1.71	N	75th	75th
	Postpartum Care	R	A	68.58	68.61	67.26	65.94	50th	68.00					2.06	N	50th	50th
Adults Access to Preventative/Ambulatory Health Services (AAP)	Total			83.27	82.81	83.83	87.04	75th	86.55					-0.49	N	50th	NA
Children and Adolescents' Access to Primary Care Practitioners (CAP)	7-11 years	R		89.83	89.00	89.28	90.32	25th	91.94					1.62	Y	50th	NA
Alcohol/Drug Dependence (IET)	Initiation of Treatment			NB	NB	NB	NB	NB	NB					NA	NA	NA	NA
	Engagement of Treatment			NB	NB	NB	NB	NB	NB					NA	NA	NA	NA
Utilization																	
Annual Monitoring for Patients on Persistent Medications (MPM)	Combined Rate	R		85.63	87.27	86.23	85.87	50th	86.11					0.24	N	50th	NA

HEDIS Measure	Sub Measure	MY 2013 Ranking	MY 2013 Accred.	HEDIS 2010 Final	HEDIS 2011 Final	HEDIS 2012 Final	HEDIS 2013 Final	HEDIS 2013 QC Percentile	HEDIS 2014 Final	Denom	Num Total	Num Admin	Num MR Hits	Point Change	Statistical Significance	2013 QC Percentile*	2014 NCQA Percentile Accred.
Freq of Ongoing PNC (FPC) ✓	81+ Percent of Expected Visits ✓			78.96	83.06	87.60	84.91	90th	82.67					-2.24	N	90th	NA
Well Child 15 Months (W15)	6+ Well Child Visits	R		70.73	72.70	73.71	77.44	90th	71.52					-5.92	N	75th	NA
Well Child 3-6 Years (W34)		R		78.05	74.65	72.88	78.51	50th	76.50					-2.01	N	50th	NA
Adolescent Well Care (AWC) ✓		R		57.78	56.08	57.40	64.76	75th	62.70					-2.06	N	75th	NA
Annual Dental Visit (ADV) ✓	Total ✓			44.96	50.27	52.50	55.59	50th	54.80					-0.79	Y	50th	NA
Ambulatory Care (AMB) ✓	ER Visits/1000 ✓***			86.68	80.85	83.28	83.43	75th	85.21					1.78	Y	75th	NA
***lower rate is better																	

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HEDIS Measure	Sub Measure	MY 2013 Ranking	MY 2013 Accred.	HEDIS 2010 Final	HEDIS 2011 Final	HEDIS 2012 Final	HEDIS 2013 Final	HEDIS 2013 Percentile	HEDIS 2014 Admin Rate	Point Change	Statistical Significance	2013 QC Percentile* Ranking	2014 NCQA Percentile Accred.
Preventive Screenings													
Adult BMI Assessment (ABA)		R	A	3.35	3.65	4.26	58.28	<25th	65.84	7.56	Y	25th	25th
Weight Assessment and Counseling (WCC)	BMI Screening - Total	R	A	0.30	20.09	0.07	15.67	<25th	25.06	9.39	Y	<25th	<25th
	Counseling on Nutrition - Total	R	A	0.22	31.13	0.33	40.40	<25th	39.90	-0.50	N	<25th	<25th
	Counseling on Physical Activity - Total	R	A	0.00	21.41	0.05	30.68	<25th	34.06	3.38	N	<25th	<25th
Childhood Immunization Status (CIS)	Combination 2 Immunizations	R	A	61.81	75.06	78.37	78.37	50th	74.45	-3.92	N	25th	25th
Immunizations for Adolescents (IMA)	Combination 1 Immunizations	R		2.73	11.65	50.99	51.88	<25th	60.83	8.95	Y	25th	NA
HPV for Female Ad 13 (HPV)		R		NA	NA	5.76	9.80	NA	13.18	3.38	Y	NA	NA
Lead Screening (LSC) ✓		R		53.69	55.28	59.12	60.61	25th	61.31	0.70	N	25th	NA
Breast Cancer (BCS) ✓		R	A	53.61	52.89	56.94	57.05	50th	63.81	6.76	Y	90th	50th
Cervical Cancer (CCS)**				60.40	70.86	70.86	68.75	50th	65.31	-3.44	Y	NA	NA
Chlamydia Screenings (CHL)	CHL Screening - Total	R	A	49.95	57.13	55.72	53.15	25th	54.48	1.33	N	25th	25th

HEDIS Measure	Sub Measure	MY 2013 Ranking	MY 2013 Accred.	HEDIS 2010 Final	HEDIS 2011 Final	HEDIS 2012 Final	HEDIS 2013 Final	HEDIS 2013 Percentile	HEDIS 2014 Admin Rate	Point Change	Statistical Significance	2013 QC Percentile* Ranking	2014 NCQA Percentile Accred.
Respiratory Conditions													
Appropriate Testing for Children with Pharyngitis (CWP)		R	A	67.83	71.69	74.15	73.59	50th	73.87	0.28	N	50th	50th
Appropriate Treatment for Children with URI (URI)		R	A	84.67	84.24	82.49	79.54	<25th	79.72	0.18	N	<25th	<25th
Avoidance of Antibiotic Treatment in Adults with Bronchitis (AAB)		R	A	24.95	21.09	24.32	19.50	25th	18.39	-1.11	N	25th	<25th
Use of Spirometry Testing in Assessment and Diagnosis of COPD (SPR)		R	A	32.84	48.05	34.29	35.24	50th	32.16	-3.08	N	50th	50th
Pharmacotherapy Management of COPD Exacerbation (PCE)	Systemic Corticosteroid	R	A	55.05	58.74	48.92	54.67	<25th	57.14	2.47	N	<25th	<25th
	Bronchodilator	R	A	80.30	77.18	71.43	77.75	<25th	81.51	3.76	N	25th	25th
Use of Appropriate Medications with People with Asthma (ASM) ✓	Combined Rate ✓		A	92.38	88.03	90.50	88.25	75th	90.53	2.28	Y	90th	75th
Medication Management for People with Asthma (MMA)	MMA - 75% Compliance	R		NA	NA	30.59	27.34	25th	31.06	3.72	Y	50th	NA
Asthma Medication Ratio (AMR)	Total Population Ratio > 50%	R		NA	NA	ND	60.32	NA	72.67	12.35	Y	NA	NA
Cardiovascular													
Cholesterol Mgmt (CMC)	LDL-C Screening	R	A	85.47	85.47	78.61	79.19	25th	80.54	1.35	N	25th	25th
	LDL-C Level < 100	R		31.62	31.62	37.43	34.84	<25th	31.39	-3.45	N	<25th	NA

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Controlling High BP (CBP)	Total	R	A	35.21	41.72	53.98	54.20	25th	42.05	-12.15	Y	<25th	<25th
Diabetes													
Comp Diabetes Care (CDC)	HbA1c Testing	R	A	80.78	83.33	82.11	82.11	25th	82.85	0.74	N	25th	50th
	HbA1c Poor Control (>9)***		A	57.65	47.13	44.97	44.97	25th	56.39	11.42	Y	<25th	<25th
	HbA1c Adequate Control (<8)	R		34.89	45.02	55.03	55.03	75th	35.77	-19.26	Y	<25th	NA
	LDL-C Screening	R	A	70.15	72.61	74.11	74.11	25th	70.62	-3.49	N	<25th	25th
	LDL-C Level < 100	R		20.71	28.16	34.24	34.24	25th	27.74	-6.50	Y	<25th	NA
	Monitoring for Nephropathy	R	A	76.87	78.93	78.71	78.71	25th	79.56	0.85	N	50th	50th
	Eye Exam	R	A	55.22	61.69	56.05	56.05	50th	50.73	-5.32	N	25th	25th
	Blood Pressure Control (<140/80)	R		NA	26.05	27.94	27.94	<25th	27.55	-0.39	N	<25th	NA
	Blood Pressure Control (<140/90)	R		37.13	42.72	47.02	47.02	<25th	46.17	-0.85	N	<25th	NA
Musculoskeletal Conditions													
Use of Imaging for Low Back Pain (LBP)		R	A	71.77	72.11	72.92	72.63	25th	74.77	2.14	N	25th	<25th
Disease-Modifying Anti-Rheumatic Drug Therapy (DRT)		R		71.08	69.47	68.18	68.88	25th	68.67	-0.21	N	<25th	NA
Behavioral Health													
Antidepressant Medication Management (AMM)	Acute Phase	R	A	NB	NR	NB	48.67	25th	45.65	-3.02	N	<25th	25th
	Continuation	R	A	NB	NR	NB	33.71	25th	30.53	-3.18	N	<25th	25th
Follow-up with Children	Initiation	R	A	45.10	50.27	45.50	42.64	50th	41.59	-1.05	N	50th	50th

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Prescribed ADHD Medication (ADD)	Continuation	R	A	57.25	61.27	59.21	54.17	50th	54.39	0.22	N	50th	50th
Diabetes Screening for People with Schizophrenia or Bi-Polar Disorder Who Are Using Antipsychotic Medications (SSD)		R		NA	NA	NB	73.04	NA	84.21	11.17	Y	NA	NA
Diabetes Monitoring for People with Diabetes and Schizophrenia (SMD)		R		NA	NA	NB	68.56	NA	73.45	4.89	N	NA	NA
Follow-up Care for Hospitalization for Mental Illness (FUH)	7 Day	R	A	NB	NR	NB	NB	NB	46.23	NA	NA	50th	50th
	30 Day			NB	NR	NB	NB	NB	66.32	NA	NA	25th	NA
CVD Monitoring for People with CVD and Schizophrenia (SMC)		R		NA	NA	NB	NA	NA	NA	NA	NA	NA	NA
Adherence to Antipsychotic Medications for People with Schizophrenia (SAA)	80% Coverage	R		NA	NA	NB	72.58	NA	73.15	0.57	N	NA	NA
Access/Availability of Care													
Prenatal Postpart Care (PPC) ✓	Timeliness of Prenatal Care ✓	R	A	90.04	91.13	92.04	85.09	25th	91.04	5.95	N	75th	75th
	Postpartum Care ✓	R	A	69.03	71.62	71.24	66.82	75th	74.63	7.81	N	90th	75th
Adults Access to Preventative/Ambulatory Health Services (AAP) ✓	Total ✓			87.40	87.89	86.87	87.00	75th	87.70	0.70	Y	75th	NA
Children and Adolescents' Access to Primary Care Practitioners (CAP)	7-11 years	R		92.86	94.44	93.54	92.93	50th	92.96	0.03	N	50th	NA

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Alcohol/Drug Dependence (IET)	Initiation of Treatment			NB	NR	NB	NB	NB	NB	NB	NA	NB	NA
	Engagement of Treatment			NB	NR	NB	NB	NB	NB	NB	NA	NB	NA
Utilization													
Annual Monitoring for Patients with Persistent Medications (MPM)	Combined Rate	R		86.72	86.70	87.02	86.21	50th	87.57	1.36	Y	75th	NA
Freq of Ongoing PNC (FPC)	81+ Percent of Expected Visits			66.46	70.10	69.23	72.93	50th	67.44	-5.49	Y	50th	NA
Well Child 15 Months (W15) ✓	6+ Well Child Visits ✓	R		56.62	56.42	60.60	59.68	25th	63.82	4.14	N	25th	NA
Well Child 3-6 Years (W34) ✓		R		62.49	66.03	62.58	60.52	<25th	64.05	3.53	N	<25th	NA
Adolescent Well Care (AWC) ✓		R		36.24	40.62	38.27	39.97	<25th	48.66	8.69	N	50th	NA
Annual Dental Visit (ADV)	Total			NB	NB	NB	NB	NA	NB	NA	NA	NA	NA
Ambulatory Care (AMB)	ER Visits/1000***			NA	56.83	56.23	58.61	25th	59.42	0.81	Y	25th	NA
***lower rate is better													

MDWise Hoosier Alliance

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Preventive Screenings													
Adult BMI Assessment (ABA)		R	A	NA	NA	4.45	5.47	<25th	NA	NA	NA	NA	NA
Weight Assessment and Counseling (WCC)	BMI Screening - Total	R	A	0.00	0.20	0.43	0.00	<25th	NA	NA	NA	NA	NA
	Counseling on Nutrition - Total	R	A	0.00	0.40	0.32	50.36	25th	NA	NA	NA	NA	NA
	Counseling on Physical Activity - Total	R	A	0.00	0.00	0.01	37.47	25th	NA	NA	NA	NA	NA
Childhood Immunization Status (CIS)	Combination 2 Immunizations	R	A	17.40	12.42	69.59	69.59	<25th	NA	NA	NA	NA	NA
Immunizations for Adolescents (IMA)	Combination 1 Immunizations	R		22.70	32.30	90.75	88.44	90th	NA	NA	NA	NA	NA
HPV for Female Ad 13 (HPV)		R		NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
Lead Screening (LSC)		R		41.60	35.19	49.64	49.64	<25th	48.53	-1.11	NA	<25th	<25th
Breast Cancer (BCS)		R	A	41.30	38.03	35.68	35.25	<25th	40.94	5.69	NA	<25th	<25th
Cervical Cancer (CCS)**				63.50	64.92	57.53	61.57	25th	60.48	-1.09	NA	NA	NA
Chlamydia Screenings (CHL)	CHL Screening - Total	R	A	48.10	46.80	42.54	42.71	<25th	45.04	2.33	NA	<25th	<25th
Respiratory Conditions													
Appropriate Testing for Children with Pharyngitis (CWP)		R	A	52.70	51.43	54.42	57.07	<25th	54.56	-2.51	NA	<25th	<25th

HEDIS Measure	Sub Measure	MY 2013 Ranking	MY 2013 Accred.	HEDIS 2010 Final	HEDIS 2011 Final	HEDIS 2012 Final	HEDIS 2013 Final	HEDIS 2013 Percentile	HEDIS 2014 Final	Point Change	Statistical Significance	2013 QC Percentile* Ranking	2014 NCQA Percentile Accred.
Appropriate Treatment for Children with URI (URI)		R	A	73.90	75.26	73.86	73.70	<25th	75.45	1.75	NA	<25th	<25th
Avoidance of Antibiotic Treatment in Adults with Bronchitis (AAB)		R	A	24.00	21.45	19.48	18.72	25th	25.09	6.37	NA	25th	25th
Use of Spirometry Testing in Assessment and Diagnosis of COPD (SPR)		R	A	NA	NA	24.32	27.78	<25th	NA	NA	NA	NA	NA
Pharmacotherapy Management of COPD Exacerbation (PCE)	Systemic Corticosteroid	R	A	NA	NA	66.67	80.00	90th	NA	NA	NA	NA	NA
	Bronchodilator	R	A	NA	NA	78.57	91.43	90th	NA	NA	NA	NA	NA
Use of Appropriate Medications with People with Asthma (ASM)	Combined Rate		A	87.90	90.70	85.30	84.96	50th	84.44	-0.52	NA	<25th	25th
Medication Management for People with Asthma (MMA)	MMA - 75% Compliance	R		NA	NA	32.14	37.13	75th	31.47	-5.66	NA	50th	NA
Asthma Medication Ratio (AMR)	Total Population Ratio > 50%	R		NA	NA	NA	NA	NA	68.27	NA	NA	NA	NA
Cardiovascular													
Cholesterol Mgmt (CMC)	LDL-C Screening	R	A	78.40	61.36	63.64	68.25	<25th	NA	NA	NA	NA	NA
	LDL-C Level < 100	R		NA	0.00	0.00	38.10	25th	NA	NA	NA	NA	NA
Controlling High BP (CBP)	Total	R	A	NA	0.00	0.00	54.07	25th	NA	NA	NA	NA	NA
Diabetes													
Comp Diabetes Care (CDC)	HbA1c Testing	R	A	74.20	74.58	81.57	83.03	25th	77.33	-5.70	NA	<25th	<25th
	HbA1c Poor Control (>9)*		A	NA	95.15	44.53	42.70	<25th	NA	NA	NA	NA	NA
	HbA1c Adequate Control (<8)	R		NA	14.56	47.08	48.18	25th	NA	NA	NA	NA	NA

HEDIS Measure	Sub Measure	MY 2013 Ranking	MY 2013 Accred.	HEDIS 2010 Final	HEDIS 2011 Final	HEDIS 2012 Final	HEDIS 2013 Final	HEDIS 2013 Percentile	HEDIS 2014 Final	Point Change	Statistical Significance	2013 QC Percentile* Ranking	2014 NCQA Percentile Accred.
	LDL-C Screening	R	A	72.50	63.86	66.97	66.24	<25th	64.68	-1.56	NA	<25th	<25th
	LDL-C Level < 100	R		NA	8.17	24.50	23.91	<25th	NA	NA	NA	NA	NA
	Monitoring for Nephropathy	R	A	81.60	55.17	58.88	67.15	<25th	61.15	-6.00	NA	<25th	<25th
	Eye Exam	R	A	40.70	40.74	59.49	59.49	50th	39.85	-19.64	NA	<25th	<25th
	Blood Pressure Control (<140/80)	R		NA	0.13	40.88	41.79	50th	NA	NA	NA	NA	NA
	Blood Pressure Control (<140/90)	R		NA	0.13	67.88	71.35	75th	NA	NA	NA	NA	NA
Musculoskeletal Conditions													
Use of Imaging for Low Back Pain (LBP)		R	A	71.20	72.95	68.02	71.69	25th	NA	NA	NA	NA	NA
Disease-Modifying Anti-Rheumatic Drug Therapy (DRT)		R		NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
Behavioral Health													
Antidepressant Medication Management (AMM)	Acute Phase	R	A	44.70	45.84	NB	NB	NB	49.26	NA	NA	25th	25th
	Continuation	R	A	27.60	30.18	NB	NB	NB	30.21	NA	NA	<25th	<25th
Follow-up with Children Prescribed ADHD Medication (ADD)	Initiation	R	A	46.60	55.02	42.17	55.77	90th	NA	NA	NA	NA	NA
	Continuation	R	A	69.20	62.36	52.01	66.67	90th	NA	NA	NA	NA	NA
Diabetes Screening for People with Schizophrenia or Bi-Polar Disorder Who Are Using Antipsychotic Medications (SSD)		R		NA	NA	NB	NB	NB	NA	NA	NA	NA	NA
Diabetes Monitoring for People with Diabetes and Schizophrenia (SMD)		R		NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
Follow-up Care for	7 Day	R	A	50.10	43.85	NB	NB	NB	44.52	NA	NA	25th	25th

HEDIS Measure	Sub Measure	MY 2013 Ranking	MY 2013 Accred.	HEDIS 2010 Final	HEDIS 2011 Final	HEDIS 2012 Final	HEDIS 2013 Final	HEDIS 2013 Percentile	HEDIS 2014 Final	Point Change	Statistical Significance	2013 QC Percentile* Ranking	2014 NCQA Percentile Accred.
Hospitalization for Mental Illness (FUH)	30 Day			74.80	71.83	NB	NB	NB	NA	NA	NA	NA	NA
CVD Monitoring for People with CVD and Schizophrenia (SMC)		R		NA	NA	NB	NB	NB	NA	NA	NA	NA	NA
Adherence to Antipsychotic Medications for People with Schizophrenia (SAA)	80% Coverage	R		NA	NA	NB	NB	NB	NA	NA	NA	NA	NA
Access/Availability of Care													
Prenatal Postpart Care (PPC)	Timeliness of Prenatal Care	R	A	84.30	80.79	93.19	89.78	75th	75.11	-14.67	NA	<25th	<25th
	Postpartum Care	R	A	63.33	61.88	71.53	73.24	75th	59.64	-13.60	NA	25th	<25th
Adults Access to Preventative/Ambulatory Health Services (AAP)	Total			NA	NA	83.43	88.02	75th	NA	NA	NA	NA	NA
Children and Adolescents' Access to Primary Care Practitioners (CAP)	7-11 years	R		91.40	92.60	91.68	91.74	50th	NA	NA	NA	NA	NA
Alcohol/Drug Dependence (IET)	Initiation of Treatment			NA	NA	NB	NB	NB	NA	NA	NA	NA	NA
	Engagement of Treatment			NA	NA	NB	NB	NB	NA	NA	NA	NA	NA
Utilization													
Annual Monitoring for Patients with Persistent Medications (MPM)	Combined Rate	R		84.20	82.90	78.43	76.28	<25th	NA	NA	NA	NA	NA
Freq of Ongoing PNC (FPC)	81+ Percent of Expected Visits			68.70	67.19	59.04	83.21	90th	57.72	NA	NA	NA	NA
Well Child 15 Months (W15)	6+ Well Child Visits	R		48.40	54.08	62.77	65.21	50th	60.98	NA	NA	NA	NA

HEDIS Measure	Sub Measure	MY 2013 Ranking	MY 2013 Accred.	HEDIS 2010 Final	HEDIS 2011 Final	HEDIS 2012 Final	HEDIS 2013 Final	HEDIS 2013 Percentile	HEDIS 2014 Final	Point Change	Statistical Significance	2013 QC Percentile* Ranking	2014 NCQA Percentile Accred.
Well Child 3-6 Years (W34)		R		69.30	68.43	63.45	69.34	25th	68.78	NA	NA	NA	NA
Adolescent Well Care (AWC)		R		52.00	59.22	47.17	50.85	50th	49.40	NA	NA	NA	NA
Ambulatory Care	ER Visits/1000***			NA	NA	67.45	66.58	50th	NA	NA	NA	NA	NA
	Outpatient/1000			NA	NA	NA	NA	NA	NA	NA	NA	NA	NA

AmeriHealth Caritas Louisiana

HEDIS Measure	Sub Measure	MY 2013 Ranking	MY 2013 Accred.	HEDIS 2013 Final	HEDIS 2013 Percentile	HEDIS 2014 Final	Point Change	Statistical Significance	2013 QC Percentile* Ranking	2014 NCQA Percentile Accred.
Preventive Screenings										
Adult BMI Assessment (ABA)		R	A	NA	NA	10.11	NA	NA	<25th	<25th
Weight Assessment and Counseling (WCC)	BMI Screening - Total	R	A	0.47	<25th	1.43	0.96	Y	<25th	<25th
	Counseling on Nutrition - Total	R	A	1.20	<25th	2.86	1.66	Y	<25th	<25th
	Counseling on Physical Activity - Total	R	A	0.01	<25th	0.26	0.25	Y	<25th	<25th
Childhood Immunization Status (CIS)	Combination 2 Immunizations	R	A	NA	NA	43.71	NA	NA	<25th	<25th
Immunizations for Adolescents (IMA)	Combination 1 Immunizations	R		73.68	50th	84.99	11.31	N	75th	NA
HPV for Female Ad 13 (HPV)		R		NA	NA	18.48	NA	NA	NA	NA
Lead Screening (LSC)		R		NA	NA	66.61	NA	NA	50th	NA
Breast Cancer (BCS)		R	A	NA	NA	NA	NA	NA	NA	NA
Cervical Cancer (CCS)**				44.49	<25th	49.93	5.44	Y	NA	NA
Chlamydia Screenings (CHL) ✓	CHL Screening - Total ✓	R	A	57.35	50th	55.84	-1.51	NA	25th	25th
Respiratory Conditions										
Appropriate Testing for Children with Pharyngitis (CWP)		R	A	NB	NB	50.57	NA	NA	<25th	<25th
Appropriate Treatment for Children with URI (URI)		R	A	NB	NB	71.43	NA	NA	<25th	<25th
Avoidance of Antibiotic Treatment in Adults with Bronchitis (AAB)		R	A	NB	NB	25.52	NA	NA	50th	50th
Use of Spirometry Testing in Assessment and Diagnosis of COPD (SPR)		R	A	NA	NA	NA	NA	NA	NA	NA
Pharmacotherapy Management of COPD Exacerbation (PCE)	Systemic Corticosteroid	R	A	NB	NB	65.22	NA	NA	25th	25th
	Bronchodilator	R	A	NB	NB	85.77	NA	NA	75th	50th
Use of Appropriate Medications with People with Asthma (ASM)	Combined Rate		A	NB	NB	81.75	NA	NA	25th	25th
Medication Management for People with Asthma (MMA)	MMA - 75% Compliance	R		NB	NB	31.53	NA	NA	50th	NA

HEDIS Measure	Sub Measure	MY 2013 Ranking	MY 2013 Accred.	HEDIS 2013 Final	HEDIS 2013 Percentile	HEDIS 2014 Final	Point Change	Statistical Significance	2013 QC Percentile* Ranking	2014 NCQA Percentile Accred.
Asthma Medication Ratio (AMR)	Total Population Ratio > 50%	R		NB	NB	54.20	NA	NA	NA	NA
Cardiovascular										
Cholesterol Mgmt (CMC)	LDL-C Screening	R	A	NA	NA	78.95	NA	NA	25th	25th
	LDL-C Level < 100	R		NA	NA	6.02	NA	NA	<25th	<25th
Controlling High BP (CBP)	Total	R	A	NR	NR	0.00	NA	NA	<25th	<25th
Diabetes										
Comp Diabetes Care (CDC)	HbA1c Testing ▼	R	A	73.50	<25th	79.87	6.37	Y	25th	25th
	HbA1c Poor Control (>9)***		A	99.61	<25th	64.70	-34.91	Y	<25th	<25th
	HbA1c Adequate Control (<8)	R		0.39	<25th	30.51	30.12	Y	<25th	NA
	LDL-C Screening	R	A	66.63	<25th	73.96	7.33	Y	25th	25th
	LDL-C Level < 100	R		0.19	<25th	19.81	19.62	Y	<25th	<25th
	Monitoring for Nephropathy	R	A	79.79	50th	81.47	1.68	N	50th	50th
	Eye Exam	R	A	27.18	<25th	37.86	10.68	Y	<25th	<25th
	Blood Pressure Control (<140/80)	R		0.00	<25th	27.16	27.16	Y	<25th	<25th
	Blood Pressure Control (<140/90)	R		0.19	<25th	42.65	42.46	Y	<25th	<25th
Musculoskeletal Conditions										
Use of Imaging for Low Back Pain (LBP)		R	A	64.94	<25th	77.94	13.00	Y	50th	25th
Disease-Modifying Anti-Rheumatic Drug Therapy (DRT)		R		NB	NB	70.00	NA	NA	50th	NA
Behavioral Health										
Antidepressant Medication Management (AMM)	Acute Phase	R	A	NB	NB	41.87	NA	NA	<25th	<25th
	Continuation	R	A	NB	NB	31.82	NA	NA	<25th	<25th
Follow-up with Children Prescribed ADHD Medication (ADD)	Initiation	R	A	NB	NB	31.85	NA	NA	25th	<25th
	Continuation	R	A	NB	NB	35.49	NA	NA	25th	<25th
Diabetes Screening for People with Schizophrenia or Bi-Polar Disorder Who Are Using Antipsychotic Medications (SSD)		R		NB	NB	81.24	NA	NA	NA	NA

HEDIS Measure	Sub Measure	MY 2013 Ranking	MY 2013 Accred.	HEDIS 2013 Final	HEDIS 2013 Percentile	HEDIS 2014 Final	Point Change	Statistical Significance	2013 QC Percentile* Ranking	2014 NCQA Percentile Accred.
Diabetes Monitoring for People with Diabetes and Schizophrenia (SMD)		R		68.09	NA	60.74	-7.35	N	NA	NA
Follow-up Care for Hospitalization for Mental Illness (FUH)	7 Day	R	A	NB	NB	NB	NA	NA	NA	NA
	30 Day			NB	NB	NB	NA	NA	NA	NA
CVD Monitoring for People with CVD and Schizophrenia (SMC)		R		NA	NA	NA	NA	NA	NA	NA
Adherence to Antipsychotic Medications for People with Schizophrenia (SAA)	80% Coverage	R		NB	NB	58.41	NA	NA	NA	NA
Access/Availability of Care										
Prenatal Postpart Care (PPC)	Timeliness of Prenatal Care	R	A	85.09	25th	77.83	-7.26	Y	<25th	<25th
	Postpartum Care	R	A	32.58	<25th	32.44	-0.14	N	<25th	<25th
Adults Access to Preventative/Ambulatory Health Services (AAP) ✓	Total ✓			77.71	<25th	83.16	5.45	Y	25th	NA
Children and Adolescents' Access to Primary Care Practitioners (CAP)	7-11 years	R		NA	NA	83.57	NA	NA	<25th	NA
Alcohol/Drug Dependence (IET)	Initiation of Treatment			NB	NB	NB	NA	NA	NA	NA
	Engagement of Treatment			NB	NB	NB	NA	NA	NA	NA
Utilization										
Annual Monitoring for Patients with Persistent Medications (MPM)	Combined Rate	R		NB	NB	86.48	NA	NA	50th	NA
Freq of Ongoing PNC (FPC)	81+ Percent of Expected Visits			58.14	25th	57.75	-0.39	N	25th	NA
Well Child 15 Months (W15)	6+ Well Child Visits	R		NA	NA	36.92	NA	NA	<25th	NA
Well Child 3-6 Years (W34) ✓		R		47.50	<25th	57.17	9.67	Y	<25th	NA
Adolescent Well Care (AWC) ✓		R		29.08	<25th	43.49	14.41	Y	25th	NA
Annual Dental Visit (ADV)	Total			NB	NA	51.95	NA	NA	50th	NA
Ambulatory Care (AMB)	ER Visits/1000***			NA	NA	76.85	NA	NA	75th	NA
***lower rate is better										

AmeriHealth District of Columbia

HEDIS Measure	Sub Measure	MY 2013 Ranking	MY 2013 Accred.	HEDIS 2014 Final (Admin)	2013 QC Percentile* Ranking	2014 NCQA Percentile Accred.
Preventive Screenings						
Adult BMI Assessment (ABA)		R	A	NA	NA	NA
Weight Assessment and Counseling (WCC)	BMI Screening - Total	R	A	NA	NA	NA
	Counseling on Nutrition - Total	R	A	NA	NA	NA
	Counseling on Physical Activity - Total	R	A	NA	NA	NA
Childhood Immunization Status (CIS)	Combination 2 Immunizations	R	A	NA	NA	NA
Immunizations for Adolescents (IMA)	Combination 1 Immunizations	R		NA	NA	NA
HPV for Female Ad 13 (HPV)		R		NA	NA	NA
Lead Screening (LSC)		R		NA	NA	NA
Breast Cancer (BCS)		R	A	NA	NA	NA
Cervical Cancer (CCS)*				NA	NA	NA
Chlamydia Screenings (CHL)	CHL Screening - Total	R	A	NA	NA	NA
Respiratory Conditions						
Appropriate Testing for Children with Pharyngitis (CWP)		R	A	86.96	90th	90th
Appropriate Treatment for Children with URI (URI)		R	A	98.99	90th	90th
Avoidance of Antibiotic Treatment in Adults with Bronchitis (AAB)		R	A	NA	NA	NA
Use of Spirometry Testing in Assessment and Diagnosis of COPD (SPR)		R	A	NA	NA	NA
Pharmacotherapy Management of COPD Exacerbation (PCE)	Systemic Corticosteroid	R	A	75.90	75th	75th
	Bronchodilator	R	A	93.98	90th	90th
Use of Appropriate Medications with People with Asthma (ASM)	Combined Rate		A	NA	NA	NA
Medication Management for People with Asthma (MMA)	MMA - 75% Compliance	R		NA	NA	NA
Asthma Medication Ratio (AMR)	Total Population Ratio > 50%	R		NA	NA	NA
Cardiovascular						
Cholesterol Mgmt (CMC)	LDL-C Screening	R	A	NA	NA	NA

HEDIS Measure	Sub Measure	MY 2013 Ranking	MY 2013 Accred.	HEDIS 2014 Final (Admin)	2013 QC Percentile* Ranking	2014 NCQA Percentile Accred.
	LDL-C Level < 100	R		NA	NA	NA
Controlling High BP (CBP)	Total	R	A	NA	NA	NA
Diabetes						
Comp Diabetes Care (CDC)	HbA1c Testing	R	A	NA	NA	NA
	HbA1c Poor Control (>9)*		A	NA	NA	NA
	HbA1c Adequate Control (<8)	R		NA	NA	NA
	LDL-C Screening	R	A	NA	NA	NA
	LDL-C Level < 100	R		NA	NA	NA
	Monitoring for Nephropathy	R	A	NA	NA	NA
	Eye Exam	R	A	NA	NA	NA
	Blood Pressure Control (<140/80)	R		NA	NA	NA
	Blood Pressure Control (<140/90)	R		NA	NA	NA
Musculoskeletal Conditions						
Use of Imaging for Low Back Pain (LBP)		R	A	85.83	90th	90th
Disease-Modifying Anti-Rheumatic Drug Therapy (DRT)		R		NA	NA	NA
Behavioral Health						
Antidepressant Medication Management (AMM)	Acute Phase	R	A	NA	NA	NA
	Continuation	R	A	NA	NA	NA
Follow-up with Children Prescribed ADHD Medication (ADD)	Initiation	R	A	NA	NA	NA
	Continuation	R	A	NA	NA	NA
Diabetes Screening for People with Schizophrenia or Bi-Polar Disorder Who Are Using Antipsychotic Medications (SSD)		R		NA	NA	NA
Diabetes Monitoring for People with Diabetes and Schizophrenia (SMD)		R		NA	NA	NA
Follow-up Care for Hospitalization for Mental Illness (FUH)	7 Day	R	A	NA	NA	NA
	30 Day			NA	NA	NA
CVD Monitoring for People with CVD and Schizophrenia (SMC)		R		NA	NA	NA
Adherence to Antipsychotic Medications for People with Schizophrenia (SAA)	80% Coverage	R		NA	NA	NA

HEDIS Measure	Sub Measure	MY 2013 Ranking	MY 2013 Accred.	HEDIS 2014 Final (Admin)	2013 QC Percentile* Ranking	2014 NCQA Percentile Accred.
Access/Availability of Care						
Prenatal Postpart Care (PPC)	Timeliness of Prenatal Care	R	A	78.50	<25th	<25th
	Postpartum Care	R	A	42.14	<25th	<25th
Adults Access to Preventative/Ambulatory Health Services (AAP)	Total			NA	NA	NA
Children and Adolescents' Access to Primary Care Practitioners (CAP)	7-11 years	R		NA	NA	NA
Alcohol/Drug Dependence (IET)	Initiation of Treatment			NB	NB	NB
	Engagement of Treatment			NB	NB	NB
Utilization						
Annual Monitoring for Patients with Persistent Medications (MPM)	Combined Rate	R		NA	NA	NA
Freq of Ongoing PNC (FPC)	81+ Percent of Expected Visits			36.36	<25th	<25th
Well Child 15 Months (W15)	6+ Well Child Visits	R		NA	NA	NA
Well Child 3-6 Years (W34)		R		NA	NA	NA
Adolescent Well Care (AWC)		R		NA	NA	NA
Ambulatory Care (AMB)	ER Visits/1000***			69.18	50th	NA
Annual Dental Visit (ADV)	Total			NA	NA	NA
*lower is better						

Implementation Plan

ID	Task Name	Duration	Start	Finish	Staff Responsibilities
1	New Business Activation (NBA) Implementation	330 days	Mon 2/9/15	Wed 5/25/16	ALL
2	Request For Proposal (RFP) - Contract	64 days	Mon 2/9/15	Fri 5/8/15	Opportunity
3	Proposal and Applications	64 days	Mon 2/9/15	Fri 5/8/15	Opportunity
45	RFP Contract: Proposal and Application - Complete	0 days	Fri 5/8/15	Fri 5/8/15	Opportunity
46	Pre-Implementation Phase	33 days	Tue 4/7/15	Fri 5/22/15	PMO
47	Project Management Office (PMO) Activities	33 days	Tue 4/7/15	Fri 5/22/15	PMO
57	Upfront Deliverables	0 days	Fri 5/8/15	Fri 5/8/15	PMO, Opportunity
93	Pre-Initiation Phase - Complete	0 days	Fri 5/22/15	Fri 5/22/15	PMO
94	Initiation Phase	115 days	Wed 4/8/15	Fri 9/18/15	PMO
95	New Business Activation (NBA) Activities	5 days	Fri 5/8/15	Thu 5/14/15	PMO
119	PMO Activities	115 days	Wed 4/8/15	Fri 9/18/15	PMO
189	IS Infrastructure Development Environment Build (must be competed prior to formal planning begins)	42 days	Wed 5/13/15	Mon 7/13/15	IS
215	Initiation Phase - Complete	0 days	Fri 9/18/15	Fri 9/18/15	IS
216	Planning Phase	159 days	Fri 2/20/15	Mon 10/5/15	PMO, Human Resource, Facilities, Provider Network
217	Monitoring and Controlling	82 days	Thu 5/14/15	Wed 9/9/15	PMO
276	Business Cross Functional Information	6 days	Fri 7/31/15	Fri 8/7/15	PMO, Finance
297	PMO Traceability Matrix Activities	15 days	Tue 6/30/15	Tue 7/21/15	PMO
298	Business Associate Agreement (BAA)	16 days	Wed 5/20/15	Thu 6/11/15	PMO, All
318	Human Resources	26 days	Wed 4/8/15	Wed 5/13/15	Human Resources
329	Facilities	100 days	Thu 5/14/15	Mon 10/5/15	Facilities
387	Provider Network / Management / Operations / Credentialing	123 days	Fri 2/20/15	Thu 8/13/15	Provider Network
421	Configuration	10 days	Tue 4/28/15	Mon 5/11/15	Configuration
443	Finance	70 days	Wed 5/20/15	Thu 8/27/15	Finance
463	Communications	20 days	Wed 5/20/15	Wed 6/17/15	Communication
495	Enrollment	10 days	Wed 5/20/15	Wed 6/3/15	Enrollment
532	Claims	3 days	Wed 5/20/15	Fri 5/22/15	Claims
542	Contact Center	10 days	Wed 5/20/15	Wed 6/3/15	Contact Center
598	Medical Management	5 days	Wed 5/20/15	Wed 5/27/15	Medical Management
607	Payment Integrity	5 days	Fri 8/7/15	Thu 8/13/15	Payment Integrity
630	Provider Data Management	5 days	Wed 5/20/15	Wed 5/27/15	Provider Data
640	Business Continuity / Disaster Recovery	3 days	Wed 5/20/15	Fri 5/22/15	Business Continuity

ID	Task Name	Duration	Start	Finish	Staff Responsibilities
643	Sourcing	60 days	Wed 5/20/15	Thu 8/13/15	Sourcing
655	Information Technology / Solutions	95 days	Mon 4/27/15	Wed 9/9/15	IS
674	Planning Phase - Complete	0 days	Mon 10/5/15	Mon 10/5/15	Provider Network
675	Design Phase	156 days	Wed 2/25/15	Mon 10/5/15	ALL
676	Facilities	23 days	Fri 8/21/15	Wed 9/23/15	Facilities
684	Provider Network	105 days	Wed 2/25/15	Thu 7/23/15	Provider Network
702	Communications	38 days	Thu 5/21/15	Wed 7/15/15	Communications
709	Contact Center	16 days	Thu 6/4/15	Thu 6/25/15	Contact Center
722	Configuration	17 days	Tue 5/5/15	Thu 5/28/15	Configuration
742	Payment Integrity	10 days	Fri 8/14/15	Thu 8/27/15	Payment Integrity
750	Provider Data Management	15 days	Thu 5/28/15	Wed 6/17/15	Provider Data
760	Information Solutions	46 days	Mon 5/18/15	Wed 7/22/15	IS
776	Design Phase - Complete	0 days	Mon 10/5/15	Mon 10/5/15	All
777	Development Phase	267 days	Mon 2/9/15	Fri 2/26/16	All
778	HUMAN RESOURCES	228 days	Mon 2/9/15	Mon 1/4/16	Human Resources
1252	Facilities - Phase II	43 days	Wed 9/23/15	Mon 11/23/15	Facilities
1291	Provider Network / Management/Operations/Credentialing	148 days	Tue 5/26/15	Wed 12/23/15	Provider Network
1356	Configuration	52 days	Tue 5/12/15	Fri 7/24/15	Configuration
1393	Finance	204 days	Mon 2/9/15	Tue 11/24/15	Finance
1442	Communications	190 days	Wed 5/20/15	Fri 2/19/16	Communication
1738	Enrollment & Eligibility	195 days	Wed 5/20/15	Fri 2/26/16	Enrollment
1826	Claims	195 days	Wed 5/20/15	Fri 2/26/16	Claims
1929	Contact Center	116 days	Wed 5/20/15	Mon 11/2/15	Contact Center
2094	OLH (Online Help) Development	31 days	Mon 6/29/15	Tue 8/11/15	Online Help
2106	Medical Management	137 days	Wed 5/13/15	Tue 11/24/15	Medical Management
2247	Payment Integrity	125 days	Thu 5/7/15	Mon 11/2/15	Payment Integrity
2293	Provider Data Management	38 days	Mon 6/1/15	Thu 7/23/15	Provider Data
2325	Sourcing	118 days	Thu 5/28/15	Wed 11/11/15	Sourcing
2365	Compliance	181 days	Wed 5/20/15	Mon 2/8/16	Compliance
2463	Reports	126 days	Wed 5/20/15	Mon 11/16/15	Reports
2482	Information Technology / Solutions	209 days	Wed 4/29/15	Thu 2/25/16	IS
2612	Business Continuity / Disaster Recovery	45 days	Thu 6/11/15	Thu 8/13/15	Business Continuity
2615	Transition Plan	20 days	Wed 7/22/15	Tue 8/18/15	IS

ID	Task Name	Duration	Start	Finish	Staff Responsibilities
2618	Pharmacy	136 days	Wed 4/8/15	Mon 10/19/15	Pharmacy
2636	Development Phase - Complete	0 days	Fri 2/26/16	Fri 2/26/16	IS
2637	Testing Phase	179 days	Thu 6/11/15	Fri 2/26/16	All
2638	Receive notice for all vendor BAAs	0 days	Thu 6/11/15	Thu 6/11/15	IS,Sourcing
2639	Develop Test Plans	15 days	Tue 6/30/15	Tue 7/21/15	IS
2643	System Integration Testing (SIT)	45 days	Wed 7/22/15	Wed 9/23/15	IS
2661	Quality Assurance (QA) Environment	47 days	Tue 8/25/15	Thu 10/29/15	IS
2680	User Acceptance Testing (UAT) Environment	61 days	Wed 8/26/15	Thu 11/19/15	IS
2703	Testing Phase - Complete	0 days	Fri 2/26/16	Fri 2/26/16	IS
2704	Facility Final Preparations	186 days	Wed 4/8/15	Mon 1/4/16	IS
2705	Facilities Phase 3 Activities - Equipment Order (Non-TeleComm)	10 days	Thu 9/24/15	Wed 10/7/15	Facilities
2706	Facilities Phase 4 - Equipment Installation	65 days	Tue 9/29/15	Mon 1/4/16	Facilities
2749	Facility - Temporary Location	60 days	Wed 4/8/15	Wed 7/1/15	Facilities
2754	Facility Final Preparations - Complete	0 days	Mon 1/4/16	Mon 1/4/16	Facilities
2755	Readiness Review	27 days	Mon 10/19/15	Tue 11/24/15	Readiness
2756	Receive notification from Iowa when Readiness will occur	0 days	Mon 10/19/15	Mon 10/19/15	Readiness
2757	Schedule debrief meeting for Readiness Participants	2 days	Thu 10/22/15	Fri 10/23/15	Readiness
2758	Coordinate Travel for on-site review	4 days	Mon 10/19/15	Thu 10/22/15	Readiness
2759	AmeriHealth Readiness Review	20 days	Mon 10/19/15	Fri 11/13/15	Readiness
2775	State Readiness	25 days	Wed 10/21/15	Tue 11/24/15	Readiness
2791	Post Readiness Phase	10 days	Wed 11/25/15	Thu 12/10/15	Readiness, IS
2792	Post Readiness Review follow-up to identify additional development and testing	10 days	Wed 11/25/15	Thu 12/10/15	Readiness, IS
2793	Post Readiness Phase: Complete	0 days	Thu 12/10/15	Thu 12/10/15	Readiness, IS
2794	Deployment	190 days	Thu 5/28/15	Fri 2/26/16	IS
2795	System Access Requests (ACA Form Request)	31 days	Thu 5/28/15	Fri 7/10/15	IS
2817	Training Execution - Operations	153 days	Thu 6/4/15	Wed 1/13/16	Human Resources, P
2851	Open Enrollment	2 days	Fri 12/11/15	Mon 12/14/15	Enrollment, Contact
2856	Deployment Phase - Complete	0 days	Fri 2/26/16	Fri 2/26/16	All
2857	Go-Live	54 days	Thu 12/10/15	Fri 2/26/16	IS, All
2858	Go-Live - Day 0 - Enrollment, Call Center, etc	10 days	Thu 12/10/15	Wed 12/23/15	IS, All
2868	Go-Live - Day 1 - Claims Processing	13 days	Fri 12/11/15	Fri 1/1/16	IS, All
2875	Go-Live - Day 2 - Encounter Processing	3 days	Mon 2/15/16	Wed 2/17/16	IS, All

Provider Contract Agreement Templates (Hospital)

AMERIHEALTH CARITAS IOWA, INC.

HOSPITAL SERVICES AGREEMENT

with

[PROVIDER NAME]

DRAFT - Subject to approval of Iowa Department of Human Services and Iowa Insurance Division

AMERIHEALTH CARITAS IOWA, INC.
HOSPITAL SERVICES AGREEMENT

This Hospital Services Agreement (the “Agreement”), dated as of the Effective Date (defined below), is made by and between AmeriHealth Caritas Iowa, Inc., a corporation organized under the laws of the State of Iowa, (hereinafter referred to as “ACIA”) and the Hospital provider (“Hospital”) identified on the signature page.

WHEREAS, ACIA is a managed care organization that is responsible for providing or arranging for the provision of health care services to its Members; and

WHEREAS, Hospital is duly licensed to furnish certain health care services; and

WHEREAS, Hospital and ACIA mutually desire to enter into this Agreement, whereby Hospital shall render services to Members enrolled with ACIA and be compensated by ACIA in accordance with the terms and conditions hereof.

NOW, THEREFORE, in consideration of the mutual promises made herein, it is mutually agreed by and between ACIA and Hospital as follows:

1. DEFINITIONS

As used in this Agreement, each of the following terms shall have the meaning specified herein, unless the context clearly requires otherwise.

- 1.1 **AFFILIATES.** An Affiliate is any corporation or other organization that is identified as an Affiliate in a written notice to Hospital and is owned or controlled, either directly or through parent or subsidiary corporations, by or under common control with, ACIA. ACIA shall give Hospital thirty (30) days advance written notice of the addition of Affiliates added under this provision. Unless otherwise specified in this Agreement or any other attachment hereto, references to “ACIA” shall include the Affiliates referenced in Appendix B.
- 1.2 **AGENCY.** The State and/or Federal governmental agency that administers the Program(s) under which ACIA is obligated to provide or arrange for the provision of Covered Services.
- 1.3 **AGENCY CONTRACT.** The contract or contracts between ACIA and the Agency, as in effect from time to time, pursuant to which ACIA is responsible for coordinating health care services and supplies for Program recipients enrolled with ACIA.
- 1.4 **CLEAN CLAIM.** A claim for payment for a health care service, which has been received by ACIA, has no defect or impropriety. A defect or impropriety shall include a lack of required substantiating documentation or a particular circumstance requiring special treatment that prevents timely payment from being made on the claim. Consistent with 42 CFR §447.45(b), the term shall not include a claim from a health care provider who is under investigation for fraud or abuse regarding that claim, or a claim under review for medical necessity.
- 1.5 **COVERED SERVICES.** Those Medically Necessary health care services and supplies to which Members are entitled pursuant to the Agency Contract, and which shall be provided to Members by

- Hospital, as described more specifically in **Appendix A**. Covered Services shall be furnished in the amount, duration and scope required under the Program.
- 1.6 **EFFECTIVE DATE.** The later of (i) the effective date on the signature page of this Agreement or (ii) the effective date of the Agency Contract, provided that Hospital has been successfully credentialed by ACIA and that all required regulatory approvals have been obtained by ACIA.
- 1.7 **EMERGENCY MEDICAL CONDITION.** Health care services provided to a Member after the sudden onset of a medical condition that manifests itself by acute symptoms of sufficient severity or severe pain, such 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:
- (a) Placing the health of the Member (or with respect to a pregnant woman, the health of the Member or her unborn child) in serious jeopardy;
 - (b) Serious impairment to bodily functions; or
 - (c) Serious dysfunction of any bodily organ or part.
- 1.8 **EMERGENCY SERVICES.** Covered inpatient and outpatient services that are furnished by a provider that is qualified to furnish these services under 42 C.F.R. Section 438.114(a) and 42 U.S.C. Section 1932(b)(2) and that are needed to screen, evaluate, and stabilize an Emergency Medical Condition.
- 1.9 **MEDICALLY NECESSARY.** Those Covered Services that are, under the terms and conditions of the Agency Contract, determined through ACIA utilization management to be: (1) appropriate and necessary for the symptoms, diagnosis or treatment of the condition of the Member; (2) provided for the diagnosis or direct care and treatment of the condition of Member enabling the Member to make reasonable progress in treatment; (3) within standards of professional practice and given at the appropriate time and in the appropriate setting; (4) not primarily for the convenience of the Member, the Member's physician or other provider; and (5) the most appropriate level of Covered Services which can safely be provided. (Ref. Agency Contract – Scope of Work document)
- 1.10 **MEMBER.** An individual who is eligible for the Program and who has enrolled in ACIA under the Program.
- 1.11 **MEMBER APPEAL PROCEDURES.** The written procedures describing ACIA's standards for the prompt resolution of Member problems, grievances and appeals, as described in the Provider Manual.
- 1.12 **PARTICIPATING HOSPITAL.** A duly licensed hospital which has entered into an agreement with ACIA to provide hospital-based Covered Services to Members.
- 1.13 **PARTICIPATING PROVIDER.** A physician duly licensed to practice medicine in the State of Iowa, participating in or eligible to participate in the Iowa Medicaid program, and who is a member of the medical staff of a(n) ACIA- participating hospital, or a licensed, appropriately supervised allied health professional, either of whom has entered into, or who is recognized by ACIA as a member of a group which has entered into, an agreement with ACIA to provide medical services to Members under the Program.

- 1.14 **PRIMARY CARE PROVIDER.** A duly licensed pediatrician, internist, family practitioner, or doctor of general medicine, obstetrician/gynecologist or group thereof or a licensed, appropriately supervised allied health professional, who has been successfully credentialed by, and is a Participating Provider with ACIA, and who is responsible for the supervision, coordination, and provision of primary care services to Members who have selected, or have been assigned to, that provider. The Primary Care Provider also is responsible for initiating any required referrals for specialty care needed by a Member and maintaining overall continuity of a Member's care.
- 1.15 **PROGRAM.** The Iowa High Quality Health Initiative procured by the Iowa Department of Human Services ("IDHS") under RFP #MED-16-009, for the delivery of high quality healthcare services for the Iowa Medicaid, Iowa Health and Wellness Plan and Healthy and Well Kids in Iowa (*hawk-i*) programs.
- 1.16 **PROVIDER MANUAL.** The ACIA manual of standards, policies, procedures and corrective actions together with amendments or modifications ACIA may adopt from time to time. The Provider Manual is herein incorporated by reference and made part of this Agreement. The Provider Manual may be amended or modified by ACIA from time to time in accordance with **Section 3.3** herein below.
- 1.17 **QUALITY MANAGEMENT PROGRAM.** An ongoing review process and plan which functions to define, monitor, review, and recommend corrective action for managing and improving the quality of health care services to Members.
- 1.18 **UTILIZATION MANAGEMENT PROGRAM.** A process of review of the medical necessity, appropriateness and efficiency of health care services, procedures, equipment, supplies, and facilities rendered to Members.

2. OBLIGATIONS OF HOSPITAL:

- 2.1 Throughout the term of this Agreement, Hospital shall have and maintain, without restriction, all licenses, certificates, registrations and permits as are required under applicable State and federal statutes and regulations to provide the Covered Services furnished by Hospital and/or other related activities delegated by ACIA under this Agreement. Hospital shall obtain a unique identifier (national provider identifier) in accordance with the system established under Section 1173(b) of the Social Security Act, submit such identifier number to ACIA, and include such identifier on all claims. At all times during the term of this Agreement, Hospital shall be eligible for participation in the Iowa Medicaid program; and, if required by the Iowa Medicaid program as a condition of furnishing services to Iowa Medicaid recipients, Hospital shall participate in the Iowa Medicaid program. To the extent that Covered Services are furnished to Medicare beneficiaries under this Agreement, Hospital shall also participate in the Medicare program. Hospital shall ensure that all services provided pursuant to this Agreement are within the Hospital's scope of professional responsibility.
- 2.2 Hospital shall provide to Members the Covered Services described in **Appendix A** hereto; provided, however, that Hospital shall only be obligated to provide Covered Services to a Member upon an admission or referral of said Member to Hospital by a Participating Provider and otherwise in accordance with ACIA's admission policies as described in the Provider Manual, other than Emergency Services, which will be provided as needed. In providing Covered Services, Hospital agrees to abide by the relevant standards, policies and procedures of ACIA, including, but not limited to administrative, credentialing, quality management, utilization management, and Member Appeal Procedures set forth in the Provider Manual and other ACIA

notices. Hospital shall provide Covered Services in the same manner and with the same availability as services provided to other patients without regard to reimbursement and shall further provide these services in the most cost effective setting in accordance with appropriate quality of care and performance standards which are professionally recognized as industry standards and/or otherwise adopted, accepted or established by ACIA.

- 2.3 Hospital shall ensure that any employed physician, or any physician practice which Hospital or Hospital affiliate owns or controls that has admitting privileges at or provides services at the Hospital, shall accept all Members. Hospital shall notify ACIA within sixty (60) days of the acquisition of any physician practice by Hospital or a Hospital affiliate if such practice has admitting privileges at or provides services at the Hospital. Hospital acknowledges that if any acquired physician practice is participating with ACIA at the time of such acquisition, appropriate addenda shall be executed by Hospital or Hospital affiliate, physician/physician practice and ACIA, as may be applicable. If the physician practice or new employed physician is not participating with ACIA at the time of such acquisition or employment, as applicable, upon request by ACIA, Hospital shall ensure that such physician promptly apply for ACIA participation, comply with ACIA credentialing requirements and execute an appropriate ACIA provider agreement. ACIA's credentialing process must be successfully completed prior to providing services to Members. In the event Hospital or Hospital affiliate must limit the growth of any such acquired physician practice due to capacity constraints, Hospital or the Hospital affiliate shall cause the practice to make itself available to Members on the same basis as it is to any other patients.
- 2.4 Hospital shall provide ACIA with complete and accurate statements of all Covered Services provided to Members in conformance with ACIA billing procedures, including without limitation, use of complete applicable diagnosis, procedure and revenue codes, and applicable Present on Admission (POA) indicators for primary and secondary diagnoses. ACIA will not be liable for any bills relating to services that are submitted the later of: (a) after twelve (12) months from the date the services were provided or the Member was discharged (consistent with 42 CFR §447.45(d)), or (b) after sixty (60) days of the date of the Explanation of Benefits from another payor when services are first billed by Hospital to another payor. Any appeal or request for adjustment of a payment by Hospital must be made in accordance with applicable provisions of the Provider Manual and ACIA policies and procedures and, in any case, must be received by ACIA within sixty (60) days of the original payment or denial. Hospital may not bring legal action on claims which have not been appealed through the appeal mechanisms described herein.
- Encounter Data and Other Reports. Hospital shall deliver all reports and clinical information required to be submitted to ACIA pursuant to this Agreement for reporting purposes, including but not limited to encounter data, Healthcare Effectiveness Data and Information Set (HEDIS), Agency for Healthcare Research and Quality (AHRQ), and EPSDT data in a format which will allow ACIA to transmit required data to the Agency electronically and in a format identical to or consistent with the format used or otherwise required by ACIA and the Agency. Hospital shall submit this information to ACIA within the time frames set forth in the Provider Manual or as otherwise required by the Agency. Hospital shall submit all encounter data to the same standards of completeness and accuracy as required for proper adjudication of fee-for-service claims by ACIA.
- 2.5 Hospital's charges for Covered Services to Members shall be the same as its charges to all patients for the same services. During the term of this Agreement, Hospital shall maintain in its accounting records a system of recording gross charges by patient and payor. Hospital shall

submit its then current schedule of charges by revenue code and procedure code to ACIA upon thirty (30) days prior written request.

- 2.6 Hospital may directly bill Members for non-Covered Services if the Member is advised in writing before the service is rendered: (i) the nature of the service(s) to be rendered; (ii) that ACIA does not cover the services; and (iii) that the Member will be financially responsible for the services if the Member elects to receive the services. Furthermore, Hospital shall hold harmless ACIA for any claim or expense arising from such services.
- 2.7 Hospital shall not bill or collect from any Member any amount or charges for any Covered Services provided hereunder, except for authorized co-payments, co-insurance, and/or deductibles. Hospital shall not deny Covered Services to a Member in the event that a Member is unable to pay any authorized co-payment amounts. 42 CFR §447.15.
- 2.8 Under no circumstances, including ACIA's failure to pay for Covered Services, termination of this Agreement, or the insolvency of ACIA, will Hospital make any charges or claims against any Member directly or indirectly for Covered Services authorized by ACIA, except for authorized co-payments. Hospital shall look only to ACIA for compensation for Covered Services.
- 2.9 During the term of this Agreement and in the event of termination of this Agreement for any reason, Hospital agrees to fully cooperate with each Member and with ACIA in arranging for the transfer of copies of Member medical records to other ACIA participating providers.
- 2.10 Record Maintenance, Inspection, Reporting and Auditing
- (a) Record Retention. As required by 42 CFR 434.6(a)(7) and otherwise in accordance with the standards of ACIA, Hospital shall maintain an adequate record system for recording services, service providers, charges, dates and all other commonly required information elements for services rendered to Members pursuant to this Agreement (including but not limited to such records as are necessary for the evaluation of the quality, appropriateness, and timeliness of services performed under this Agreement and the Agency Contract).
- (b) All records originated or prepared in connection with Hospital's performance of its obligations under this Agreement will be retained and safeguarded by Hospital in accordance with the terms and conditions of the Agency Contract and other relevant State and federal law. Hospital agrees to retain all financial and programmatic records, supporting documents, statistical records and other records of Members relating to the delivery of care or service under the Agency Contract and as further required by the Agency, for a period of no less than seven (7) years from the expiration date of the Agency Contract, including any contract extension(s), and to retain all Member records, including but not limited to administrative, financial and medical records (whether electronic or paper) for a period of no less than seven (7) years after the last payment was made for services provide to the Member. If any audit, litigation, claim, or other actions involving the records have been initiated prior to the expiration of the seven (7) year period, the records shall be retained until completion of the action and resolution of all issues which arise from it or until the end of the seven (7) year period, whichever is later. If Hospital stores records on microfilm or microfiche or other electronic means, Hospital agrees to produce, at its expense, legible hard copy records promptly upon the request of state or federal authorities.
- (c) Medical Record Maintenance. Hospital shall ensure that all medical records are in compliance with the medical record keeping requirements set forth in the Provider Manual,

the Agency Contract and Agency guides. Hospital shall maintain up-to-date medical records at the site where medical services are provided for each Member enrolled under this Agreement. Each Member's record must be accurate, legible and maintained in detail consistent with good medical and professional practice which permits effective internal and external quality review and/or medical audit and facilitates an adequate system of follow-up treatment.

- (d) ACIA shall be entitled to audit, examine and inspect Hospital's books and records, including but not limited to medical records, financial information and administrative information pertaining to Hospital's relationship with ACIA, at any time during normal business hours, upon reasonable notice. Hospital agrees to provide ACIA, at no cost to ACIA, with such medical, financial and administrative information, and other records as may be necessary for ACIA to meet its obligations related to the Agency Contract and other regulatory obligations, Utilization Management Program and Quality Management Program standards, including NCQA standards, and other relevant accreditation standards which ACIA may require of ACIA participating providers.
- 2.11 Hospital authorizes ACIA to include Hospital's name, address, telephone number, information related to Hospital's facilities, services and staff, and other similar information relevant to Hospital, its operations and staff in the ACIA provider directory and in various marketing materials identifying Provider as a provider of services to Members. Hospital agrees to afford ACIA the same opportunity to display brochures, signs or advertisements in Hospital's facilities as Hospital affords any other insurance company or other third party payor.
- 2.12 While both parties support Hospital's open and active communication with Members concerning Medically Necessary services, available treatment alternatives, benefit coverage information and/or any other information pertaining to the hospital-patient relationship, Hospital shall not, during the term of this Agreement, and any renewal thereof, solicit or require any Member, either orally or in writing, to subscribe to or enroll in any managed care plan other than ACIA. The provisions of this Section 2.12 shall similarly apply to Hospital's employees, agents and/or contractors.
- 2.13 Hospital shall cooperate with ACIA in the identification of other sources of payment available to Members, such as other health insurance, government programs, liability coverage, motor vehicle coverage or worker's compensation coverage, as applicable. Hospital shall be responsible for reporting all applicable third party resources to ACIA in a timely manner.
- Hospital will cooperate with ACIA in coordinating benefits with other payors in accordance with coordination of benefits claim processing rules and requirements outlined in the Provider Manual, the Agency Contract, and applicable Program manuals, as amended from time to time. Hospital will make a reasonable attempt to determine whether any other payor has primary responsibility for the payment of a claim for services that Hospital rendered to a Member and bill that payor before billing ACIA. Unless otherwise prohibited by applicable law, ACIA retains the right to recover payments made to Hospital in the event ACIA determines that another payor is primarily responsible for all or a portion of the claim.
- 2.14 Hospital understands and agrees that any payments ACIA makes directly or indirectly to Hospital under this Agreement shall not be made as an inducement to reduce, limit or delay Medically Necessary services to any Member.

- 2.15 Hospital will refer Members to ACIA-participating hospitals whenever Hospital is unable to provide Medically Necessary services and when consistent with sound medical judgment and accepted standards of care.
- 2.16 Hospital shall use best efforts to use ACIA's electronic utilization management and claims interfaces to improve the efficiency of utilization management and claims payment processes.
- 2.17 Hospital will assist ACIA in providing orientation services to Hospital staff to the extent ACIA may reasonably request.
- 2.18 **Fraud and Abuse.** Hospital recognizes that payments made by ACIA pursuant to this Agreement are derived from federal and State funds, and acknowledges that it may be held civilly and/or criminally liable to ACIA and/or the Agency, in the event of non-performance, misrepresentation, fraud or abuse for services rendered to Members, including but not limited to, the submission of false claims/statements for payment by Hospital, its employees or agents. Hospital shall be required to comply with all policies and procedures as developed by ACIA and the Agency, including but not limited to the requirements set forth in the Provider Manual and the Agency Contract, for the detection and prevention of fraud and abuse. Such compliance may include, but not be limited to, referral of suspected or confirmed fraud or abuse to ACIA.

3. OBLIGATIONS OF ACIA:

- 3.1 ACIA shall pay Hospital for Covered Services provided to Members pursuant to the terms of this Agreement. ACIA shall have the right to offset claims payments to Hospital by any amount owed by Hospital to ACIA, following at least thirty (30) days' written notice. Hospital shall not be entitled to reimbursement if the Member was not eligible at the time services were rendered.
- 3.2 ACIA shall compensate Hospital for Covered Services provided to Members upon receipt of a statement thereof, as defined in Section 2.4, and in accordance with Section 2.13 and the Covered Services Payment Schedule set forth in Appendix A-1 but, in no event, will ACIA's payment exceed submitted charges. No additional charges will be made by Hospital to ACIA for Covered Services provided hereunder, and Hospital recognizes and accepts the fees set forth in Appendix A-1 as payment in full.
- 3.2 ACIA will establish payment policies for inpatient and outpatient services including, but not limited to, policies with respect to pre-admission testing, services included in inpatient rates and services included in outpatient rates. ACIA will provide at least thirty (30) days' prior written notice of any modifications to such payment policies. ACIA may, based on changes in clinical practice and modifications to standard coding systems, add and/or delete outpatient fee schedule procedures and re-categorize outpatient surgery fee schedule procedures, upon thirty (30) days' prior written notice to Hospital.
- 3.3 ACIA shall furnish or otherwise make available to Hospital a copy of the Provider Manual, as amended from time to time. Provider Manual updates will become effective thirty (30) days from the date of notification, unless otherwise specified in writing by ACIA.
- 3.4 ACIA shall pay all Clean Claims for Covered Services in accordance with applicable laws, regulations and Agency requirements; and ACIA will in any event meet the claim payment timeframes required under 42 CFR §447.45(d).
- 3.5 Hospital Protections.

- (a) ACIA shall not exclude or terminate Hospital from ACIA's provider network because the Hospital advocated on behalf of a Member including in the context of a utilization management appeal or another dispute with ACIA over appropriate medical care, provided that such advocacy is consistent with the degree of learning and skill ordinarily possessed by a health care provider practicing in accordance with the applicable standard of care.
- (b) No Hospital shall be excluded or terminated from participation with ACIA due to the fact that the Hospital has a practice that includes a substantial number of patients with expensive medical conditions.
- (c) Hospital shall not be excluded from participation, nor shall this Agreement be terminated, because Hospital objects to the provision of or refuses to provide a healthcare service on moral or religious grounds.

4. QUALITY MANAGEMENT/UTILIZATION MANAGEMENT:

- 4.1 Whether announced or unannounced, Hospital agrees to cooperate with, participate in, and abide by internal or external quality assessment reviews, Member Appeal Procedures, Utilization Management Program procedures, and Quality Management Program procedures established by ACIA and/or the Agency or their designees, and to follow practice guidelines as described in the Provider Manual, the Agency Contract, and the applicable Program manuals. Hospital shall permit a representative of ACIA, or its designee, to review medical records concurrently as well as retrospectively. Hospital shall provide copies of such medical records, either in paper or electronic form, to ACIA or its designee upon request. The Utilization Management and Quality Management Programs are described in the Provider Manual.
- 4.2 ACIA's Quality Management Programs consist of review of credentials and performance of hospitals and other provider types that are applying for participation in, or are participating in, ACIA's network of providers to determine whether the hospital or other provider meets ACIA's standards for quality, availability, accessibility and cooperation.
- 4.3 ACIA's Utilization Management Programs include requirements for pre-authorization of certain services rendered in physicians' offices and in inpatient, outpatient and ancillary hospital settings. Utilization Management Programs include concurrent, retrospective and prospective review of certain services and procedures to assure that care is delivered in the most appropriate setting and is Medically Necessary. Certain Covered Services may require prior approval from ACIA. The Covered Services subject to prior approval are more fully described in the Provider Manual and other ACIA notices. ACIA is obligated to pay for and Hospital is entitled to reimbursement for only those services that are Medically Necessary. Where reimbursement for an admission, inpatient day or outpatient service is denied as not prior approved or Medically Necessary, the Hospital shall not charge either ACIA or the Member for any health care services rendered or furnished with respect to such admission, inpatient day or outpatient service. If Hospital disputes any such denial, the case in question shall be appealed through ACIA's provider appeal process. Hospital may not bring legal action for disputes which have not been appealed through the provider appeal process.
- 4.4 ACIA shall monitor and report the quality of services delivered under the Agreement and initiate a plan of correction, where necessary, to improve quality of care, in accordance with that level of care which is recognized as acceptable professional practice in the respective community in which the Hospital practices and/or the standards established by ACIA, the Agency, or their

respective designees. Hospital shall cooperate with and abide by any corrective action plan initiated by ACIA and/or required by the Agency or any other State or federal regulatory agency with governing authority over the services provided under this Agreement.

- 4.6 Hospital agrees that to the extent penalties, fines or sanctions are assessed against ACIA by the Agency or another regulatory agency with governing authority over the services provided under this Agreement as a result of Hospital's failure to comply with Hospital's obligations under this Agreement, including but not limited to, Hospital's failure or refusal to respond to ACIA's the Agency's request for medical records, credentialing information, and other information required to be provided under this Agreement, Hospital shall be responsible for the immediate payment of such penalties, fines or sanctions. In the event such payment is not made in a timely manner to ACIA, ACIA shall have the right to offset claims payments to Hospital by the amount owed by Hospital to ACIA.

5. PROFESSIONAL LIABILITY INSURANCE/ADVERSE ACTIONS:

- 5.1 Hospital, at its sole expense, shall provide professional liability, comprehensive general liability, and, as applicable, medical malpractice insurance coverage (including coverage for vicarious liability, if any, for the acts of employees, agents and representatives of Hospital) upon execution of this Agreement and at all times during the term of this Agreement, as follows:
- (a) Amounts and extent of such insurance coverage as deemed necessary by ACIA to adequately insure Members and ACIA against any claim or claims for damages arising by reason of personal injury or death occasioned, directly or indirectly, in connection with Hospital's performance of any service pursuant to this Agreement; in no event shall such coverage be less than the amounts required by law.
 - (b) Hospital shall provide ACIA with written verification of the existence of such coverage upon execution of this Agreement and as otherwise requested by ACIA throughout the term of the Agreement, which may include providing copies of face sheets of such coverage. Hospital shall notify ACIA reasonably in advance of any change or cancellation of such coverage.
- 5.2 Hospital shall immediately notify ACIA in writing, by certified mail, of any written or oral notice of any adverse action, including, without limitation, litigation, investigation, complaint, claim or transaction, regulatory action or proposed regulatory action, or other action naming or otherwise involving Hospital or ACIA, or any other event, occurrence or situation which may reasonably be considered to have a material impact on Hospital's ability to perform Hospital's duties or obligations under this Agreement. Hospital also shall immediately notify ACIA of any action against any applicable license, certification or participation under Title XVIII or other applicable provision of the Social Security Act or other State or federal law, State and/or DEA narcotic registration certificate, or medical staff privileges at any facility, and of any material change in the ownership or business operations of Hospital. All notices required by this Section 5.2 shall be furnished as provided in Section 10.6 of this Agreement.
- 5.3 Hospital agrees to defend, indemnify and hold harmless ACIA and its officers, directors and employees from and against any and all claims, costs and liabilities (including the fees and expenses of counsel) as a result of a breach of this Agreement by Hospital, the negligent or willful misconduct of Hospital and/or Hospital's employees, agents and representatives, and from and against any death, personal injury or malpractice arising in connection with the performance of any services by the Hospital in connection with this Agreement. This section shall survive the termination or expiration of this Agreement for any reason.

ACIA agrees to defend, indemnify and hold harmless Hospital and its officers, directors and employees from and against all claims, costs and liabilities (including the fees and expenses of counsel) as a result of ACIA's breach of this Agreement or the negligent or willful misconduct of ACIA and/or ACIA's employees, agents and representatives in connection with ACIA's performance under this Agreement. This section shall survive the termination or expiration of this Agreement for any reason.

6. CONFIDENTIALITY:

ACIA and Hospital shall each comply with all applicable State and federal laws respecting the confidentiality of the medical, personal or business affairs of Members acquired in the course of providing services pursuant to this Agreement. Each party shall maintain as confidential and shall not disclose to third parties financial, operating, proprietary or business information relating to the other party which is not otherwise public information. The payment rates in this Agreement are confidential and proprietary and shall not be disclosed by either party. However, nothing herein shall prohibit either party from making any disclosure or transmission of information to the extent that such disclosure or transmission is required by the Agency or other applicable state regulatory agency, or is necessary or appropriate to enable the disclosing party to perform its obligations or enforce its rights under this Agreement, or is required by law or legal process. Should disclosure be required by law or legal process, the disclosing party shall immediately notify the other party of the disclosure.

7. COOPERATION; RESOLUTION OF DISPUTES:

- 7.1 Cooperation. To the extent compatible with separate and independent management of each, ACIA and Hospital shall at all times maintain an effective liaison and close cooperation with each other to provide maximum benefits to Members at the most reasonable cost consistent with high standards of care. ACIA and Hospital shall use best efforts to exchange information regarding material matters directly or indirectly related to this Agreement.
- 7.2 Resolution of Disputes. ACIA and Hospital shall both fully cooperate in resolving any and all controversies among or between said parties, their employees, agents, or representatives pertaining to their respective duties under this Agreement. Such disputes shall be submitted for resolution in accordance with the provider appeal procedures as referenced in the Provider Manual and ACIA policies and procedures. Neither ACIA nor Hospital shall permit a dispute between the parties to disrupt or interfere with the provision of services to Members.

8. TERM; TERMINATION:

The term of this Agreement shall commence as of the Effective Date and continue for an initial one (1) year term (the "Initial Term"). After the Initial Term, the Agreement shall automatically renew for successive one (1) year terms unless the Agreement is terminated pursuant to this **Section 8** as set forth herein.

Either party may terminate this Agreement without cause at the end of the Initial Term or at the end of the subsequent terms by providing the other party with at least one hundred twenty (120) days' prior written notice before the end of the then current term. The effective date of termination without cause will be on the first of the month following the expiration of the notice period. Either party may terminate this Agreement for cause due to a material breach by giving ninety (90) days' prior written notice. The notice of termination for cause will not be effective if the breaching party cures the breach within the first sixty (60) days of the ninety (90) day notice period. In the event that the breaching party does not cure the breach within the sixty

(60) day period, the effective date of termination will be the first of the month following the expiration of the ninety (90) day notice period.

In the event any change in federal or State laws, rules and regulations or the Iowa Medicaid Program or the Medicare Advantage program would have a material adverse impact on either ACIA or Hospital in connection with the performance of this Agreement (the "Mandated Changes") such that the basis for the financial bargain of this Agreement is undermined, then the affected party shall have the right to require the other, by written notice, to enter into negotiations regarding the affected or pertinent terms of this Agreement while still maintaining the original Agreement purposes. If renegotiated, such terms shall become effective no later than thirty (30) days after the parties have reached agreement on the renegotiated terms. The parties agree to make a good faith attempt to renegotiate the Agreement to the extent necessary to comply with any Mandated Changes. If, after good faith renegotiations, the parties fail to reach an agreement satisfactory to both parties within thirty (30) days of the request for renegotiation, the party requesting such renegotiation may terminate this Agreement upon ninety (90) days prior written notice to the other party.

Notwithstanding the above, ACIA may terminate this Agreement immediately in the event any of the following occur:

- 8.1 If Hospital is expelled, disciplined, barred from participation in, or suspended from receiving payment under any state's Medicaid program, Children's Health Insurance Program (CHIP), the Medicare Program or any other federal health care program.
- 8.2 If Hospital is debarred, suspended or otherwise excluded from procurement or non-procurement activities under the Federal Acquisition Regulations.
- 8.3 Upon the loss or suspension of the Hospital's liability coverage set forth under **Section 5** of this Agreement.
- 8.4 The suspension or revocation of Hospital's license or other certification or authorization, including Hospital's JCAHQ accreditation, necessary for Hospital to render Covered Services, or upon ACIA's reasonable determination that the health, safety or welfare of any Member may be in jeopardy if this Agreement is not terminated.

Upon termination of this Agreement for any reason, ACIA shall notify affected Members of the termination of Hospital prior to the effective date of termination. Regardless of the reason for termination, Hospital shall promptly supply to ACIA all information necessary for the reimbursement of outstanding claims, 42 CFR 434.6(a)(6).

9. REGULATORY AND PROGRAM-SPECIFIC PROVISIONS:

Attached hereto and incorporated herein by reference is **Schedule 9**, setting forth such terms and conditions as are necessary to meet State and Federal statutory and regulatory requirements, and other Agency requirements, of the Program. **Schedule 9** is consecutively sub-numbered as necessary for each Program under which Hospital is furnishing services under this Agreement. Hospital acknowledges that the specific terms as set forth in **Schedule 9** are subject to amendment in accordance with federal and/or State statutory and regulatory changes to the Program. Such amendment shall not require the consent of the Hospital or ACIA and will be effective immediately on the effective date thereof, as set forth in **Section 10.3**.

10. MISCELLANEOUS:

- 10.1 It is understood that Hospital is an independent contractor and in no way is Hospital to be considered an employee, agent, or representative of ACIA. It is further understood that Hospital provides specified services to Members in exchange for an agreed upon fee. This Agreement shall not create, nor be deemed or construed to create any relationship between ACIA and Hospital other than that of independent contractors, contracting with each other solely for the purpose of performing this Agreement and each party shall be liable solely for their own activities and neither ACIA nor Hospital shall be liable to any third party for the activities of the other party to this Agreement.
- 10.2 This Agreement, being for the purpose of retaining the professional services of Hospital, shall not be assigned, subcontracted, or delegated by Hospital without the express written consent of ACIA.
- 10.3 No alterations or modifications of the terms of this Agreement shall be valid unless such alterations or modifications are incorporated into the Agreement through a written amendment, signed by both parties hereto, and attached to this Agreement; provided, however, ACIA may amend this Agreement with 30 days' notice to Hospital via a(n) ACIA bulletin or other written communication provided in accordance with the notice provisions in Section 10.6, and unless Hospital notifies ACIA, as applicable, of any objection, such amendment shall then take effect. Any amendment to this Agreement subject to prior regulatory approval(s) shall be effective once such regulatory approval(s) has been received.

Notwithstanding the foregoing, amendments required because of legislative, regulatory or governmental agency requirements do not require the consent of Hospital or ACIA and shall be effective immediately on the effective date thereof. This Agreement remains subject to the approval of the State of Iowa, and may be amended by ACIA to comply with any requirements of the State of Iowa. Hospital acknowledges that all Agency requirements, as may be amended from time to time, are incorporated to this Agreement.

- 10.4 This Agreement shall be deemed to have been made and shall be construed and interpreted in accordance with the laws of the State of Iowa.
- 10.5 This Agreement and its exhibits, appendices, schedules, addenda or other attachments constitute the entire understanding and agreement between the parties concerning the subject matter hereof. This Agreement supersedes all prior written or oral agreements or understandings existing between the parties concerning the subject matter hereof including, but not limited to, any such agreement which may have been previously executed between Hospital and ACIA or any of its Affiliates relating to the provision of Covered Services under the Program. In the event of a conflict between the terms of this Agreement and the Provider Manual, the terms of the later document shall control.
- 10.6 Written notices to be given hereunder shall be sent by Certified Mail, Return Receipt Requested, or by an overnight delivery service which provides a written receipt evidencing delivery to the address set forth by the party, or by confirmed facsimile followed by written notice through the U.S. postal service. All notices called for hereunder shall be effective upon receipt.

If to Hospital:

With a copy to:

If to AmeriHealth Caritas Iowa:

With a copy to: General Counsel
AmeriHealth Caritas
200 Stevens Drive
Philadelphia, PA 19113

- 10.7 Both parties agree that there shall be no discrimination in the performance of this Agreement against any patient or other person as the result of that individual's race, color, religion, gender, sexual orientation, handicap, age, national origin, source of payment, or any other basis prohibited by law.
- 10.8 The failure of any of the parties to insist upon strict performance of any of the terms of this Agreement shall not be deemed a waiver of any of their respective rights or remedies, and shall not be deemed a waiver of any subsequent breach or default in any of the terms contained in this Agreement.
- 10.9 In the event that any provision under this Agreement is declared null or void, for any reason, the remaining provisions of this Agreement shall remain in full force and effect.
- 10.10 The parties will use reasonable care and due diligence in performing this Agreement. Hospital will be solely responsible for the services provided under this Agreement.
- 10.11 All captions contained in this Agreement are solely for the convenience of the parties hereto and shall not be deemed part of the content of this Agreement.
- 10.12 All terms used in this Agreement are deemed to refer to the masculine, feminine, neuter, singular or plural as the content may require.
- 10.13 Non-Discrimination. Hospital shall comply with (i) Title VI of the Civil Rights Act of 1964 and the rules, regulations and orders; (ii) the Rehabilitation Act of 1973 and the rules, regulations, and orders thereunder; (iii) the Americans With Disabilities Act of 1990 and the rules, regulations, and orders thereunder; and (iv) any and all applicable laws, rules and regulations prohibiting discriminatory practices. Furthermore, in accordance with Title VI of the Civil Rights Act of 1964 and the rules, regulations and orders thereunder, Hospital shall take adequate steps to ensure that Members with limited English skills receive free of charge the language assistance necessary to afford them meaningful and equal access to the benefits and services provided under this Agreement (see 42 U.S.C. 2000d et seq. and 45 C.F.R. Part 80, 2001 as amended).
- 10.14 No Offshore Contracting. No Covered Services under this Agreement may be performed outside of the United States without ACIA's prior written consent. In addition, Hospital will not hire any individual to perform any services under this Agreement if that individual is required to have a work visa approved by the U.S. Department of Homeland Security and such individual has not met this requirement.

[SIGNATURES ON FOLLOWING PAGE; REMAINDER OF PAGE INTENTIONALLY BLANK]

DRAFT - Subject to approval of Iowa Department of Human Services and Iowa Insurance Division

IN WITNESS WHEREOF, and intending to be legally bound hereby, the parties hereto, each by its officers duly authorized, hereby affix their hands as of the date written below.

<p>HOSPITAL</p> <p>Print Name _____</p> <p>Signature _____</p> <p>Title _____</p> <p>Address _____</p> <p>National Provider ID Number _____</p> <p>Medicaid ID Number _____ Medicare ID Number _____</p> <p>Tax ID Number _____</p> <p>Date _____</p> <p>Assignment of Payment <i>(applicable to Group Physician only):</i> By signing below, Hospital hereby assigns and transfers all Hospital's right to and interest in compensation payable by ACIA pursuant to this Agreement to the party identified below, and Hospital therefore directs ACIA to pay such compensation to said party:</p> <p>Hospital Signature _____</p> <p>Name of Group _____</p> <p>Address _____</p> <p>Group Tax ID Number _____</p> <p>Check and initial if Assignment of Payment Not Applicable: <input type="checkbox"/> Hospital Initials</p>	<p>AMERIHEALTH CARITAS IOWA, INC.</p> <p>Name _____</p> <p>Signature _____</p> <p>Title _____</p> <p>Date _____</p> <p>Effective Date of Agreement: _____ [To be completed by AmeriHealth Caritas Iowa]</p>
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APPENDIX A
HOSPITAL SERVICES PROVIDER
COVERED SERVICES

Hospital services are those healthcare services that Hospital furnishes to patients who present themselves to Hospital for treatment as inpatients, outpatients, or emergency patients. Hospital shall provide the following hospital services to Members:

1. Inpatient hospital services;
2. Emergency Services;
3. Short procedure unit services and observation services; and
4. Ancillary and other outpatient services.

Hospital's compensation for Covered Services is set forth in Appendix A-1.

DRAFT - Subject to approval of Iowa Department of Human Services and Iowa Insurance Division

APPENDIX A-1

HOSPITAL SERVICES PROVIDER

COVERED SERVICES COMPENSATION SCHEDULE

Commencing on the Effective Date, ACIA will compensate Hospital for Covered Services rendered by Hospital to Members in accordance with the terms of this Agreement at a rate of [___]. In no event will ACIA's payment exceed Hospital's charges.

DRAFT - Subject to approval of Iowa Department of Human Services and Iowa Insurance Division

APPENDIX B
HOSPITAL SERVICES PROVIDER
ACIA AFFILIATES

[Insert ACIA Affiliates Covered by Agreement]

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Schedule 9-1

Federal Requirements – Medicaid and Medicaid Managed Care

1. No payment will be made to Hospital for provider-preventable conditions or health care-acquired conditions. For purposes hereof:
 - a. **Health care-acquired condition** (“HAC”) means a condition occurring in any inpatient hospital setting, identified as a HAC by the Secretary of the U.S. Department of Health and Human Services (“HHS”) under section 1886(d)(4)(D)(iv) of the Social Security Act (the “Act”) for purposes of the Medicare program identified in the State plan as described in section 1886(d)(4)(D)(ii) and (iv) of the Act, other than deep vein thrombosis/pulmonary embolism as related to total knee replacement or hip replacement surgery in pediatric and obstetric patients.
 - b. **Other provider-preventable condition** means a condition occurring in any health care setting that meets the following criteria: (i) is identified in the Iowa Medicaid plan; (ii) has been found by the Iowa, based upon a review of medical literature by qualified professionals, to be reasonably preventable through the application of procedures supported by evidence-based guidelines (iii) has a negative consequence for the Member; (iv) is auditable; and (v) includes, at a minimum, wrong surgical or other invasive procedure performed on a patient, surgical or other invasive procedure performed on the wrong body part, or surgical or other invasive procedure performed on the wrong patient.
 - c. **Provider-preventable condition** (“PPC”) means a condition that meets the definition of “health care-acquired condition” or an “other provider-preventable condition.”

No reduction in payment will be made for a PPC when the condition existed prior to the initiative of treatment for that patient by Hospital. Hospital shall identify PPCs when submitting claims for payment or, if no claim will be submitted, if Medicaid payment would otherwise be available for the course of treatment in which the PPC occurred, or as otherwise required by the State. **42 CFR §§438.6(f)(2), 434.6(a)(12) and 447.26.**

2. The State Agency and HHS may inspect and audit any financial records of Hospital or its subcontractors. **42 CFR §438.6(g).**
3. **Physician Incentives.** Hospital shall disclose to ACIA annually any Physician Incentive Plan (PIP) or risk arrangements Hospital may have with physicians, either within Hospital’s group practice or other physicians not associated with Hospital’s group practice, even if there is no substantial financial risk between ACIA and the physician or physician group. The term “substantial financial risk” means a financial risk set at greater than twenty-five percent (25%) of potential payments for Covered Services, regardless of the frequency of assessment (i.e., collection) or distribution of payments. The term “potential payments” means simply the maximum anticipated total payments that the physician or physician group could receive if the use or cost of referral services were significantly low. **42 CFR §§438.6(g), 422.208, 422.210.**
4. **Provider Discrimination Prohibited.** ACIA may not, with respect to Hospital compensation or indemnification under this Agreement, discriminate against Hospital to the extent that the Hospital is acting within the scope of his, her or its license or certification under applicable State law, solely on the basis of that license or certification. Without limiting the foregoing, ACIA shall not discriminate against Hospital for serving high-risk populations or specializing in

conditions that require costly treatment. Nothing herein shall be construed to: (i) require ACIA to contract with Hospital if not necessary to meet the needs of Members; (ii) preclude ACIA from using different reimbursement amounts for different specialties or for different practitioners in the same specialty; or (iii) preclude ACIA from establishing measures that are designed to maintain quality of services and control costs and are consistent with ACIA's responsibilities to Members. 42 CFR §438.12.

5. Continued Treatment Obligation. Notwithstanding any other provision of this Agreement, in the event of either party's termination of this Agreement, insolvency of either ACIA, or other cessation of ACIA's operations, Hospital shall continue to provide Covered Services to Members (i) until the end of the month in which the effective date of termination of this Agreement falls, (ii) until the end of the month for which capitation or premium has been paid to ACIA by Agency, or (iii) until the date of a Member's discharge from an inpatient facility, whichever is later. 42 CFR §438.62.
6. Member Rights. Hospital shall adhere to all applicable Federal and State laws that pertain to Member rights, and shall take such rights into account when furnishing services to Members. 42 CFR §438.100(a)(2).
7. Hospital-Member Communications. Nothing in this Agreement shall be construed to prohibit, restrict or impede Hospital's ability to freely and openly discuss with Members, within the Hospital's lawful scope of practice, all available treatment options and any information the Member may need in order to decide among all relevant treatment options, including but not limited to the risks, benefits and consequences of treatment or non-treatment, regardless of whether the services may be considered Covered Services in accordance with this Agreement. Further, nothing in this Agreement shall be construed to prohibit, restrict or impede Hospital from discussing Medically Necessary care and advising or advocating appropriate medical care with or on behalf of a Member, including: information regarding the nature of treatment options, risks of treatment, alternative treatments or the availability of alternative therapies, consultation or tests that may be self-administered, and the Member's right to participate in decisions regarding his or her care, including the right to refuse treatment and to express preferences about future treatment decisions. 42 CFR §438.102(a).
8. Member Hold Harmless. Hospital shall accept the final payment made by ACIA as payment in full for Covered Services provided pursuant to this Agreement. Hospital agrees that in no event, including, but not limited to, nonpayment by the Agency to ACIA, nonpayment by ACIA to Hospital, the insolvency of ACIA, or breach of this Agreement, shall Hospital bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, solicit or accept any surety or guarantee of payment, or have any recourse against Members or persons other than ACIA acting on their behalf (including parent(s), guardian, spouse or any other person legally, or potentially legally, responsible person of the Member) for Covered Services listed in this Agreement. This provision shall not prohibit collection of supplemental charges or co-payments on ACIA's behalf made in accordance with terms of an enrollment agreement between ACIA and Members.

Hospital further agrees that:

- a. this hold harmless 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 Members; and that

- b. this hold harmless provision supersedes any oral or written contrary agreement now existing or hereafter entered into between Hospital and Members or persons acting on their behalf.

42 CFR §§438.106, 447.15.

9. **Coverage and Payment for Emergency Services.** ACIA shall cover and pay for Emergency Services rendered by Hospital and obtained when a Member had an Emergency Medical Condition, or when a representative of ACIA has instructed the Member to seek Emergency Services. 42 CFR §438.114(c)(1)(ii).
10. **Timely Access.** Hospital shall meet Agency standards for timely access to care and services, taking into account the urgency of the need for services. Hospital shall offer hours operation to Members that are no less than the hours of operation offered to commercial enrollees or comparable to Medicaid fee-for-service, if Hospital serves only Medicaid enrollees. Hospital services shall be available 24 hours a day, 7 days a week, when medically necessary.
11. **Excluded Providers.** Pursuant to 42 CFR §438.214(d), ACIA may not employ or contract with providers excluded from participation in Federal health care programs under either Section 1128 or 1128A of the Act. In addition, section 2455 of the Federal Acquisition Streamlining Act of 1994 and the Federal Acquisition Regulations (including but not limited to 48 CFR §9.405), ACIA may not make payment to any person or entity or an affiliate thereof, who has been debarred or suspended from participation in federal procurement or non-procurement activities. Hospital shall comply with the disclosure requirements of 42 C.F.R. Section 455, Subpart B and, upon reasonable request, provide such information to ACIA in accordance with the requirements specified therein.

Hospital represents and warrants that neither it, nor any of its contractors or employees who will furnish goods or services under the Agreement, directors or officers, or any person with an ownership interest in Hospital of five percent (5%) or more, is or ever has been: (i) debarred, suspended or excluded from participation in Medicare, Medicaid, the State Children's Health Insurance Program (SCHIP) or any other Federal health care program; (ii) convicted of a criminal offense related to the delivery of items or services under the Medicare or Medicaid program; (iii) had any disciplinary action taken against any professional license or certification held in any state or U.S. territory, including disciplinary action, board consent order, suspension, revocation, or voluntary surrender of a license or certification; or (iv) debarred or suspended from participation in procurement or non-procurement activities by any federal agency (collectively, "Sanctioned Persons"). Hospital shall screen all employees and contractors who will furnish goods or services under this Agreement to determine whether they have been excluded from participation in any Federal health care program, by searching applicable Federal and State databases (including but not limited to the OIG's LEIE and the HIPDB) upon initial employment or engagement of or contracting with a contractor, employee, director or officer, and on a monthly basis thereafter.

Hospital shall immediately notify ACIA upon knowledge by Hospital that any of its contractors or employees who furnish goods or services under the Agreement, directors, officers or owners has become a Sanctioned Person, or is under any type of investigation which may result in their becoming a Sanctioned Person. In the event that Subcontractor cannot provide reasonably satisfactory assurance to ACIA that a Sanctioned Person will not receive payment from ACIA under this Agreement, ACIA may immediately terminate this Agreement. ACIA reserves the right to recover all amounts paid by ACIA for items or services furnished by a Sanctioned Person.

Further, and without limiting Hospital's indemnification obligations set forth elsewhere in this Agreement, to the extent penalties, fines or sanctions are assessed against ACIA as a result of Hospital's having a relationship with a Sanctioned Person, Hospital shall be responsible for the immediate payment of such penalties, fines or sanctions. In the event such payment is not made in a timely manner to ACIA, ACIA shall have the right to offset claims payments to Hospital by the amount owed by Hospital to ACIA.

12. State and Federal Regulator Access. Hospital acknowledges that the U.S. Department of Health and Human Services (HHS), Centers for Medicare and Medicaid Services (CMS), Office of the Inspector General, the Comptroller, the Agency [SPECIFY STATE AGENCIES/REPRESENTATIVES], and their designees have the right to evaluate through audit, inspection, or other means, whether announced or unannounced, any records pertinent to this Agreement, including quality, appropriateness and timeliness of services and the timeliness and accuracy of encounter data and Hospital claims submitted to ACIA. Such evaluation, when performed, shall be performed with the cooperation of the Hospital and ACIA. Upon request, Hospital and ACIA shall assist in such reviews. 42 CFR §434.6(a)(5).
13. Hospital shall safeguard information about Members as required by Part 431, Subpart D of 42 CFR. 42 CFR 434.6(a)(8).
14. Any permitted subcontracts entered into by Hospital in order to carry out its obligations under this Agreement must be in writing and fulfill the requirements of 42 CFR Part 434 that are appropriate to the service or activity delegated under the subcontract. 42 CFR 434.6(a)(11), (b).

DRAFT - Subject to approval of Iowa Department of Human Services and Iowa HealthCare Division

Schedule 9-2 (Hospital Form)

State of Iowa Requirements – Medicaid and Medicaid Managed Care

1. Unless defined in this Schedule 9-2 or elsewhere in the Agreement, all capitalized terms used herein shall have their respective meanings given to them in the contract between the Iowa Department of Human Services (“IDHS”) and AmeriHealth Caritas Iowa, Inc. (“ACIA”) dated as of [____], 201[] (the “State Contract”).
2. In accordance with **191 IAC 40.18**, Hospital, or its assignee or subcontractor as applicable, hereby agrees that in no event, including but not limited to nonpayment by the ACIA, ACIA insolvency or breach of this Agreement, shall Hospital, or its assignee or subcontractor if applicable, bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against any Member or persons other than ACIA acting on the Member’s behalf for services provided pursuant to this Agreement. This provision shall not prohibit collection of supplemental charges or copayments on ACIA’s behalf made in accordance with terms of the Program.

Hospital, or its assignee or subcontractor if applicable, 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 the Member; and that (2) this provision supersedes any oral or written contrary agreement now existing or hereafter entered into between Hospital and Member or persons acting on behalf of the Member.

3. Pursuant to **191 IAC 40.22**:
 - a. ACIA shall not prohibit Hospital from or penalize Hospital for discussing treatment options with Members, irrespective of ACIA’s position on the treatment options, or from advocating on behalf of Members within the utilization review or grievance processes established by ACIA or a person contracting with ACIA.
 - b. ACIA shall not penalize Hospital because Hospital, in good faith, reports to state or federal authorities any act or practice by ACIA that, in the opinion of Hospital, jeopardizes patient health or welfare.
4. Compliance with Pro-Children Act of 1994. Hospital hereby certifies compliance with Public Law 103-227, Part C Environmental Tobacco Smoke, also known as the Pro-Children Act of 1994 (“Act”). The Act requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted by an entity and used routinely or regularly for the provision of health, day care, education or library services to children under the age of 18, if the services are funded by federal programs either directly or through State or local governments. Federal programs include grants, cooperative agreements, loans or loan guarantees, and contracts. The law also applies to children’s services that are provided in indoor facilities that are constructed, operated or maintained with such federal funds. The law does not apply to children’s services provided in private residences, portions of facilities used for inpatient drug or alcohol treatment, service providers whose sole source of applicable federal funds is Medicare or Medicaid,

- or facilities (other than clinics) where WIC coupons are redeemed. (**Ref. RFP Exhibit D**)
5. ACIA follows all applicable Federal and State laws pertinent to Member confidentiality and rights; Hospital shall take those rights into account when furnishing services to Members. (**SOW §1.4.1**)
 6. Hospital shall not require any cost-sharing or Member liability responsibilities for Covered Services except to the extent that cost-sharing or Member liability responsibilities are required for those services in accordance with law and as described in the Agency Contract. Further, Hospital shall not charge Members for missed appointments. (**SOW §3.2.15.3**)
 7. Hospital agrees that all applicable terms and conditions set out in the RFP, the Agency Contract, any incorporated documents and all applicable State and federal laws, as amended, govern the duties and responsibilities of Hospital with regard to the provision of services to Members. (**SOW §6.1.2**)
 8. Hospital's responsibilities regarding third-party liability (TPL) include Hospital's obligations to identify TPL coverage, including Medicare and long-term care coverage as applicable, and except as otherwise required, seek such TPL payment before submitting claims to ACIA. (**SOW §6.1.2**)
 9. Hospital shall submit claims which do not involve a third-party payer within **ninety (90) days** of the date of service. (**SOW §6.1.2**)
 10. IDHS reserves the right to direct ACIA to terminate or modify this Agreement when IDHS determines it to be in the best interest of the State. (**SOW §6.1.2**)
 11. ACIA may not prohibit or otherwise restrict a health care professional acting within the lawful scope of practice from advising or advocating on behalf of a Member who is his or her patient regarding: (1) the Member's health status; (2) medical, behavioral health, or long-term care treatment options, including any alternative treatment that may be self-administered; (3) any information the Member needs in order to decide among all relevant treatment options; (4) the risks, benefits and consequences of treatment or non-treatment; or (5) 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. (**SOW §6.1.5**)
 12. Hospital shall maintain complete and legible medical and financial (fiscal) records as required pursuant to **IAC 441-79.3**. Without limiting the foregoing, Hospital's medical records shall document all medical services that the Member receives from Hospital. Medical records shall be maintained in a detailed and comprehensive manner that conforms to good professional medical practice, permits effective professional medical review and medical audit processes, and facilitates an accurate system for follow-up treatment. Medical records must be legible, signed, dated and maintained as required by law. (**SOW §6.1.9**)

As required pursuant to **IAC 441-79.3(3)**, Hospital shall maintain medical records: (1) during the time the Member is receiving services from Hospital; (2) for a minimum of five (5) years from the date when a claim for the service was submitted to ACIA for payment; and (3) as may required by any licensing authority or accrediting body associated with determining Hospital's qualification.

13. Each Member shall have the right to request and receive a copy of his her medical records, and to request that they be amended or corrected. Upon reasonable request of a Member, Hospital shall provide a copy of a Member's medical record at no charge. Hospital must facilitate the transfer of a Member's medical record to another provider at the Member's request. **(SOW §6.1.9.2)**
14. Within the timeframe designated by IDHS or other authorized entity, Hospital must permit ACIA, representatives of IDHS, and other authorized entities to review Members' records for the purpose of monitoring Hospitals' compliance with the records standards, capturing information for clinical studies, monitoring quality of care, or any other reason. **(SOW 6.1.9.3)**
15. All medical records of Members shall be confidential and shall not be released without the written consent of the Member or responsible party. Written consent is not required under the following circumstances: (1) for transmission of medical record information to physicians, other practitioners or facilities who are providing services to Members under contract with ACIA; and (2) for transmission of medical record information to physicians or facilities providing emergency care. Written consent is required for the transmission of the medical record information of a former Member to any physician not connected with ACIA. The extent of medical record information to be released in each instance shall be based upon tests of medical necessity and a "need to know" on the part of the practitioner or facility requesting the information. All release of medical records shall be compliant with 45 CFR Parts 162 and 164. **(SOW §6.1.9.4)**
16. Hospital shall offer hours of operation that are no less than the hours of operation offered to commercial members or comparable Medicaid members, if Hospital sees only the Medicaid population. Covered Services shall be available twenty-four (24) hours a day, seven (7) days a week, when medically necessary. **(SOW 6.1.9.5)**
17. Upon determination by IDHS of a credible allegation of fraud for which an investigation is pending under the Medicaid program against Hospital and upon the approval of the Medicaid Fraud Control Unit (MFCU) and IDHS, ACIA shall suspend all payments to Hospital, in compliance with 42 CFR 455.23. ACIA shall issue a notice of payment suspension that comports in all respects with the obligations set forth in 42 CFR 455.23(b) (including notice that payments are being withheld in accordance with 42 CFR 455.23), and shall maintain the suspension for the durational period set forth in 42 CFR 455.23(c). ACIA will afford a grievance process to Hospital in the event of payment suspension under this **paragraph 17**. **(SOW §12.7)**

Provider Contract Agreement Templates (Physician)

AMERIHEALTH CARITAS IOWA, INC.

PHYSICIAN PROVIDER AGREEMENT

With

[PROVIDER NAME]

DRAFT - Subject to approval of Iowa Department of Human Services and Iowa Insurance Division

AMERIHEALTH CARITAS IOWA, INC.
PHYSICIAN PROVIDER AGREEMENT

This Physician Provider Agreement (the "Agreement"), dated as of the Effective Date (defined below), is made by and between AmeriHealth Caritas Iowa, Inc., a corporation organized under the laws of the State of Iowa, (hereinafter referred to as ("ACIA") and the Provider ("Provider") identified on the signature page.

WHEREAS, ACIA is a managed care organization that is responsible for providing or arranging for the provision of health care services to its Members; and

WHEREAS, Provider and ACIA mutually desire to enter into this Agreement, whereby Provider shall render services to Members enrolled with ACIA and be compensated by ACIA in accordance with the terms and conditions hereof.

NOW, THEREFORE, in consideration of the mutual promises made herein, it is mutually agreed by and between ACIA and Provider as follows:

1. DEFINITIONS

As used in this Agreement, each of the following terms shall have the meaning specified herein, unless the context clearly requires otherwise.

- 1.1 **AFFILIATES.** An Affiliate is any corporation or other organization that is identified as an Affiliate in a written notice to Provider and is owned or controlled, either directly or through parent or subsidiary corporations, by or under common control with, ACIA shall give Provider thirty (30) days advance written notice of the addition of Affiliates added under this provision. Unless otherwise specified in this Agreement or any other attachment hereto, references to "ACIA" shall include the Affiliates referenced in **Appendix D**.
- 1.2 **AGENCY.** The State and/or Federal governmental agency that administers the Program(s) under which ACIA is obligated to provide or arrange for the provision of Covered Services.
- 1.3 **AGENCY CONTRACT.** The contract or contracts between ACIA and the Agency, as in effect from time to time, pursuant to which ACIA is responsible for coordinating health care services and supplies for Program recipients enrolled with ACIA.
- 1.4 **CLEAN CLAIM.** A claim for payment for a health care service, which has been received by ACIA, has no defect or impropriety. A defect or impropriety shall include a lack of required substantiating documentation or a particular circumstance requiring special treatment that prevents timely payment from being made on the claim. Consistent with 42 CFR §447.45(b), the term shall not include a claim from a health care provider who is under investigation for fraud or abuse regarding that claim, or a claim under review for medical necessity.
- 1.5 **COVERED SERVICES.** Those Medically Necessary health care services and supplies to which Members are entitled pursuant to the Agency Contract, and which shall be provided to Members by Provider, as described more specifically in **Appendix A**. Covered Services shall be furnished in the amount, duration and scope required under the Program.

- 1.6 **EFFECTIVE DATE.** The later of (i) the effective date on the signature page of this Agreement or (ii) the effective date of the Agency Contract, provided that Provider has been successfully credentialed by ACIA and that all required regulatory approvals have been obtained by ACIA.
- 1.7 **EMERGENCY MEDICAL CONDITION.** Health care services provided to a Member after the sudden onset of a medical condition that manifests itself by acute symptoms of sufficient severity or severe pain, such 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:
- (a) Placing the health of the Member (or with respect to a pregnant woman, the health of the Member or her unborn child) in serious jeopardy;
 - (b) Serious impairment to bodily functions; or
 - (c) Serious dysfunction of any bodily organ or part.
- 1.8 **EMERGENCY SERVICES.** Covered inpatient and outpatient services that are furnished by a provider that is qualified to furnish these services under 42 C.F.R. Section 438.114(a) and 42 U.S.C. Section 1932(b)(2) and that are needed to screen, evaluate, and stabilize an Emergency Medical Condition.
- 1.9 **GROUP PHYSICIAN.** A physician who practices with Provider as an employee, partner, shareholder, or contractor.
- 1.10 **MEDICALLY NECESSARY.** Those Covered Services that are, under the terms and conditions of the Agency Contract, determined through ACIA utilization management to be: (1) appropriate and necessary for the symptoms, diagnosis or treatment of the condition of the Member; (2) provided for the diagnosis or direct care and treatment of the condition of Member enabling the Member to make reasonable progress in treatment; (3) within standards of professional practice and given at the appropriate time and in the appropriate setting; (4) not primarily for the convenience of the Member, the Member's physician or other provider; and (5) the most appropriate level of Covered Services which can safely be provided. (Ref. Agency Contract – Scope of Work document)
- 1.11 **MEMBER.** An individual that is eligible for a Program and who has enrolled in ACIA under the Program.
- 1.12 **MEMBER APPEAL PROCEDURES.** The written procedures describing ACIA's standards for the prompt resolution of Member problems, grievances and appeals, as described in the Provider Manual.
- 1.13 **PARTICIPATING PROVIDER.** A physician duly licensed to practice medicine in the State of Iowa participating in or eligible to participate in the Iowa Medicaid program, and who is a member of the medical staff of a(n) ACIA- participating hospital, or a licensed, appropriately supervised allied health professional, either of whom has entered into, or who is recognized by ACIA as a member of a group which has entered into, an agreement with ACIA to provide medical services to Members under the Program.
- 1.14 **PRIMARY CARE PROVIDER.** A duly licensed pediatrician, internist, family practitioner, or doctor of general medicine, obstetrician/gynecologist or group thereof or a licensed, appropriately supervised allied health professional, who has been successfully credentialed by, and is a

Participating Provider with ACIA, and who is responsible for the supervision, coordination, and provision of primary care services to Members who have selected, or have been assigned to, that provider. The Primary Care Provider also is responsible for initiating any required referrals for specialty care needed by a Member and maintaining overall continuity of a Member's care.

- 1.15 **PRIMARY CARE SERVICES.** Covered Services specified in **Appendix A** hereto and any additional services specified as Primary Care Services in the Provider Manual, as updated or amended from time to time. All Covered Services shall be provided in the amount, duration and scope set forth in the State Contract and as otherwise required under the Program.
- 1.16 **PROGRAM.** The Iowa High Quality Health Initiative procured by the Iowa Department of Human Services ("IDHS") under RFP #MED-16-009, for the delivery of high quality healthcare services for the Iowa Medicaid, Iowa Health and Wellness Plan and Healthy and Well Kids in Iowa (*hwk-i*) programs.
- 1.17 **PROVIDER MANUAL.** The ACIA manual of standards, policies, procedures and corrective actions together with amendments or modifications ACIA may adopt from time to time. The Provider Manual is herein incorporated by reference and made part of this Agreement. The Provider Manual may be amended or modified by ACIA from time to time in accordance with **Section 4.8** herein below.
- 1.18 **QUALITY MANAGEMENT PROGRAM.** An ongoing review process and plan which functions to define, monitor, review, and recommend corrective action for managing and improving the quality of health care services to Members.
- 1.19 **SPECIALTY CARE PROVIDER.** A duly licensed physician who has been successfully credentialed by ACIA and who has entered into an agreement to provide Specialty Care Services to Members in accordance with the referral and preauthorization requirements of the Provider Manual.
- 1.20 **SPECIALTY CARE SERVICES.** Covered Services specified in **Appendix A** hereto and any additional specified as "Specialty Care Services" in the Provider Manual, as updated and amended from time to time.
- 1.21 **UTILIZATION MANAGEMENT PROGRAM.** A process of review of the medical necessity, appropriateness and efficiency of health care services, procedures, equipment, supplies, and facilities rendered to Members.

2. SERVICES:

- 2.1 Provider agrees to provide and cause its Group Physicians to provide, as applicable, (i) Primary Care Services to Members who have selected, or are otherwise assigned to, Provider as their Primary Care Provider, and (ii) Specialty Care Services to Members who have been referred to Provider. Covered Services shall be provided in accordance with the terms of this Agreement and ACIA referral, preauthorization and other Utilization Management Program polices as described in the Provider Manual, other than Emergency Services, which will be provided as needed. Provider will refer Members to providers participating in the ACIA network whenever Provider is unable to provide Medically Necessary services and/or when consistent with sound medical judgment and accepted standards of care. Provider and Group Physicians shall provide such services in the same manner and with the same availability as services provided to other patients without regard to reimbursement and shall further provide these services in accordance with the clinical quality of

care and performance standards which are professionally recognized as industry practice and/or otherwise adopted, accepted or established by ACIA.

- 2.2 Provider will deliver office-based medical services to Members only at those office locations set forth in **Appendix B** hereto as such appendix is modified from time to time by mutual agreement of the parties. Provider shall notify ACIA at least sixty (60) days prior to making any addition or change to office locations.
- 2.3 Primary Care Providers shall accept as patients those Members who have selected or have been assigned to Provider, and Specialty Care Providers shall accept as patients those Members who have been referred to Provider, in either case without regard to the health status or medical condition of such Members. Primary Care Providers may decline to accept additional Members (excluding persons already in Provider's practice that enroll in ACIA) by giving ACIA written notice of such intent ninety (90) days in advance of the effective date of such closure. Provider agrees to accept any Members selecting the Primary Care Provider's practice during the ninety (90) day notice period.
- 2.4 Provider shall provide ACIA with complete and accurate statements of all Covered Services provided to Members in conformance with ACIA billing procedures, including without limitation, use of complete applicable diagnosis, procedure and revenue codes. ACIA will not be liable for any bills relating to services that are submitted the later of: (a) after twelve (12) months from the date the services were provided (consistent with 42 CFR §447.45(d)), or (b) after sixty (60) days of the date of the Explanation of Benefits from another payor when services are first billed by Provider to another payor. Any appeal or request for adjustment of a payment by Provider must be made in accordance with applicable provisions of the Provider Manual and ACIA policies and procedures and, in any case, must be received by ACIA within sixty (60) days of the original payment or denial. Provider may not bring legal action on claims which have not been appealed through the appeal mechanisms described herein.

Encounter Data and Other Reports. Provider shall deliver all reports and clinical information required to be submitted to ACIA pursuant to this Agreement for reporting purposes, including but not limited to encounter data, Healthcare Effectiveness Data and Information Set (HEDIS), Agency for Healthcare Research and Quality (AHRQ), and EPSDT data in a format which will allow ACIA to transmit required data to the Agency electronically and in a format identical to or consistent with the format used or otherwise required by ACIA and the Agency. Provider shall submit this information to ACIA within the time frames set forth in the Provider Manual or as otherwise required by the Agency. Provider shall submit all encounter data to the same standards of completeness and accuracy as required for proper adjudication of fee-for-service claims by ACIA.

- 2.5 In accordance with ACIA policies and procedures, only successfully credentialed Participating Providers may provide Covered Services to Members under this Agreement.

3. COMPENSATION:

- 3.1 ACIA shall pay Provider for Covered Services provided to Members pursuant to the terms of this Agreement. ACIA shall have the right to offset claims payments to Provider by any amount owed by Provider to ACIA, following at least thirty (30) days' written notice. Provider shall not be entitled to reimbursement if the Member was not eligible at the time services were rendered.

- 3.2 ACIA agrees to pay Provider the amount set forth in **Appendix C** for Covered Services rendered by Provider to Members. Provider understands and agrees that any payments ACIA makes directly or indirectly to Provider under this Agreement shall not be made as an inducement to reduce, limit, or delay Medically Necessary Covered Services to any Member. Except as may be otherwise specifically set forth in **Appendix C**, in no event will ACIA's payment exceed submitted charges. Provider recognizes and accepts the fees set forth in **Appendix C** as payment in full, and no additional charges will be made by Provider to ACIA for Covered Services provided hereunder.
- 3.3 Under no circumstances, including ACIA's failure to pay for Covered Services, termination of this Agreement, or the insolvency of ACIA, will Provider or any Group Physician bill or collection, or make any charges or claims against any Member directly or indirectly for Covered Services authorized by ACIA, except for authorized co-payments, co-insurance and/or deductibles. Provider and Group Physicians shall look only to ACIA for compensation for Covered Services. Provider shall not deny Covered Services to a Member in the event that a Member is unable to pay any authorized co-payment amounts. 42 CFR §447.15.
- 3.4 Provider may directly bill Members for non-Covered Services if the Member is advised in writing before the service is rendered of: (i) the nature of the service(s) to be rendered; (ii) that ACIA does not cover the services; and (iii) that the Member will be financially responsible for the services if the Member elects to receive the services. Furthermore, Provider shall hold harmless ACIA for any claim or expense arising from such services.
- 3.5 ACIA shall pay all Clean Claims for Covered Services in accordance with applicable laws, regulations and Agency requirements; and ACIA will in any event meet the claim payment timeframes required under 42 CFR §447.45(d).

4. ADMINISTRATION:

- 4.1 Throughout the term of this Agreement, Provider and all Group Physicians shall: (a) have and maintain, without restriction, all licenses, certificates, registrations and permits as are required under applicable State and federal statutes and regulations to provide the Covered Services furnished by Provider and/or other related activities delegated by ACIA under this Agreement. Provider shall obtain a unique identifier (national provider identifier) in accordance with the system established under Section 1173(b) of the Social Security Act, submit such identifier number to ACIA, and include such identifier on all claims. At all times during the term of this Agreement, Provider shall be eligible for participation in the Iowa Medicaid program; and, if required by the Iowa Medicaid program as a condition of furnishing services to Iowa Medicaid recipients, Provider shall participate in the Iowa Medicaid program. To the extent that Covered Services are furnished to Medicare beneficiaries under this Agreement, Provider shall also participate in the Medicare program. Provider shall ensure that all services provided pursuant to this Agreement are within the Provider's and, if applicable, Group Physicians' scope of professional responsibility.
- 4.2 During the term of this Agreement and in the event of termination of this Agreement for any reason, Provider and its Group Physicians will fully cooperate with each Member and with ACIA in arranging for the transfer of copies of Member medical records to other Participating Providers.
- 4.3 Record Maintenance, Inspection, Reporting and Auditing.
- (a) Record Retention. As required by 42 CFR 434.6(a)(7) and otherwise in accordance with the standards of ACIA, Provider and Group Physicians shall maintain an adequate record

system for recording services, service providers, charges, dates and all other commonly required information elements for services rendered to Members pursuant to this Agreement (including but not limited to such records as are necessary for the evaluation of the quality, appropriateness, and timeliness of services performed under this Agreement and the Agency Contract).

- (b) All records originated or prepared in connection with Provider's performance of its obligations under this Agreement will be retained and safeguarded by Provider in accordance with the terms and conditions of the Agency Contract and other relevant State and federal law. Provider agrees to retain all financial and programmatic records, supporting documents, statistical records and other records of Members relating to the delivery of care or service under the Agency Contract and as further required by the Agency, for a period of no less than seven (7) years from the expiration date of the Agency Contract, including any contract extension(s), and to retain all Member records, including but not limited to administrative, financial and medical records (whether electronic or paper) for a period of no less than seven (7) years after the last payment was made for services provide to the Member. If any audit, litigation, claim, or other actions involving the records have been initiated prior to the expiration of the seven (7) year period, the records shall be retained until completion of the action and resolution of all issues which arise from it or until the end of the seven (7) year period, whichever is later. If Provider stores records on microfilm or microfiche or other electronic means, Provider agrees to produce, at its expense, legible hard copy records promptly upon the request of state or federal authorities.
- (c) Medical Record Maintenance. Provider shall ensure that all medical records are in compliance with the medical record keeping requirements set forth in the Provider Manual, the Agency Contract and Agency guides. Provider shall maintain up-to-date medical records at the site where medical services are provided for each Member enrolled under this Agreement. Each Member's record must be accurate, legible and maintained in detail consistent with good medical and professional practice which permits effective internal and external quality review and/or medical audit and facilitates an adequate system of follow-up treatment.
- (d) ACIA shall be entitled to audit, examine and inspect Provider's books and records, including but not limited to medical records, financial information and administrative information pertaining to Provider's relationship with ACIA, at any time during normal business hours, upon reasonable notice. Provider agrees to provide ACIA, at no cost to ACIA, with such medical, financial and administrative information, and other records as may be necessary for ACIA to meet its obligations related to the Agency Contract and other regulatory obligations, Utilization Management Program and Quality Management Program standards, including NCQA standards, and other relevant accreditation standards which ACIA may require of ACIA participating providers.
- 4.4 Whether announced or unannounced, Provider agrees to, and shall cause its Group Physicians to, cooperate with, participate in, and abide by internal or external quality assessment reviews, Member Appeal Procedures, Utilization Management Program procedures, and Quality Management Program procedures established by ACIA, and to follow practice guidelines as described in the Provider Manual, the Agency Contract and the applicable Program manuals. Provider shall permit a representative of ACIA, or its designee, to review medical records concurrently as well as retrospectively. Provider shall provide copies of such medical records, either in paper or electronic

form, to ACIA or its designee upon request. The Utilization Management and Quality Management Programs are described in the Provider Manual.

- 4.5 Provider authorizes ACIA to include Provider's and its Group Physicians' name(s), address(es), telephone number(s), medical specialty(ies), hospital affiliations, and other similar information relevant to Provider and/or Group Physicians, Provider's operations and its staff in the ACIA provider directory and in various marketing materials identifying Provider and/or Group Physicians as a provider(s) of services to Members. Provider agrees to afford ACIA the same opportunity to display brochures, signs, or advertisements in Provider's office(s) as Provider affords any other insurance company or other third party payor.
- 4.6 While both parties support Provider's open and active communication with Members concerning Medically Necessary services, available treatment alternatives, benefit coverage information and/or any other information pertaining to the provider-patient relationship, neither Provider nor any of its Group Physicians shall, during the term of this Agreement, and any renewal thereof, solicit or require any Member, either orally or in writing, to subscribe to or enroll in any managed care plan other than ACIA. The provisions of this [Section 4.6](#) shall similarly apply to Provider's employees, agents and/or contractors (including all Group Physicians).
- 4.7 Provider shall cooperate with ACIA in the identification of other sources of payment available to Members, such as other health insurance, government programs, liability coverage, motor vehicle coverage or worker's compensation coverage, as applicable. Provider shall be responsible for reporting all applicable third party resources to ACIA in a timely manner.
- Provider will cooperate with ACIA in coordinating benefits with other payors in accordance with coordination of benefits claim processing rules and requirements outlined in the Provider Manual, the Agency Contract and applicable Program manuals, as amended from time to time. Provider will make a reasonable attempt to determine whether any other payor has primary responsibility for the payment of a claim for services that Provider rendered to a Member and bill that payor before billing ACIA. Unless otherwise prohibited by applicable law, ACIA retains the right to recover payments made to Provider if ACIA determines that another payor is primarily responsible for all or a portion of the claim.
- 4.8 ACIA shall furnish or otherwise make available to Provider a copy of the Provider Manual, as amended from time to time. Provider Manual updates will become effective thirty (30) days from the date of notification, unless otherwise specified in writing by ACIA.
- 4.9 ACIA shall monitor and report the quality of services delivered under the Agreement and initiate a plan of correction, where necessary, to improve quality of care, in accordance with that level of care which is recognized as acceptable professional practice in the respective community in which the Provider practices and/or the standards established by ACIA, the Agency, or their respective designees. Provider shall cooperate with and abide by any corrective action plan initiated by ACIA and/or required by the Agency or any other State or federal regulatory agency with governing authority over the services provided under this Agreement.
- 4.9 Provider agrees that to the extent penalties, fines or sanctions are assessed against ACIA by the Agency or another regulatory agency with governing authority over the services provided under this Agreement as a result of Provider's or any Group Physician's failure to comply with their respective obligations under this Agreement, including but not limited to, failure or refusal to respond to the Agency's request for medical records, credentialing information, and other information required to be provided under this Agreement, Provider shall be responsible for the

immediate payment of such penalties, fines or sanctions. In the event such payment is not made in a timely manner to ACIA, ACIA shall have the right to offset claims payments to Provider by the amount owed by Provider to ACIA.

- 4.10 Provider will assist ACIA in providing orientation services to Provider staff, to the extent ACIA may reasonably request.
- 4.11 **Fraud and Abuse.** Provider recognizes that payments made by ACIA pursuant to this Agreement are derived from federal and State funds, and acknowledges that it may be held civilly and/or criminally liable to ACIA and/or the Agency, in the event of non-performance, misrepresentation, fraud or abuse for services rendered to Members, including but not limited to, the submission of false claims/statements for payment by Provider, its employees or agents. Provider shall be required to comply with all policies and procedures as developed by ACIA and the Agency, including but not limited to the requirements set forth in the Provider Manual and the Agency Contract, for the detection and prevention of fraud and abuse. Such compliance may include, but not be limited to, referral of suspected or confirmed fraud or abuse to ACIA.
- 4.12 **Provider Protections.**
- (a) ACIA shall not exclude or terminate Provider or a Group Physician from ACIA's provider network because the Provider or Group Physician advocated on behalf of a Member including in the context of a utilization management appeal or another dispute with ACIA over appropriate medical care, provided that such advocacy is consistent with the degree of learning and skill ordinarily possessed by a health care provider practicing in accordance with the applicable standard of care.
 - (b) Provider shall not be excluded or terminated from participation with ACIA due to the fact that the Provider may have a practice that includes a substantial number of patients with expensive medical conditions.
 - (c) Provider shall not be excluded from participation, nor shall this Agreement be terminated, because Provider objects to the provision of or refuses to provide a healthcare service on moral or religious grounds.

5. PROFESSIONAL LIABILITY INSURANCE/ADVERSE ACTIONS:

- 5.1 Provider, at his/her sole expense, shall provide professional liability, comprehensive general liability, and medical malpractice insurance coverage (including coverage for vicarious liability, if any, for the acts of employees, agents and representatives of Provider (including without limitation all Group Physicians)) upon execution of this Agreement and at all times during the term of this Agreement, as follows:
- (a) Amounts and extent of such insurance coverage as deemed necessary by ACIA to insure against any claim or claims for damages arising by reason of personal injury or death occasioned, directly or indirectly, in connection with Provider's performance of any service pursuant to this Agreement; in no event shall such coverage be less than the amounts required by law.
 - (b) Provider shall provide ACIA with written verification of the existence of such coverage upon execution of this Agreement and as otherwise requested by ACIA throughout the term of the

Agreement, which may include providing copies of face sheets of such coverage. Provider shall notify ACIA reasonably in advance of any change or cancellation of such coverage.

- 5.2 Provider shall immediately notify ACIA in writing, by certified mail, of any written or oral notice of any adverse action, including, without limitation, litigation, investigation, complaint, claim or transaction, regulatory action or proposed regulatory action, or other action naming or otherwise involving Provider or a Group Physician, or any other event, occurrence or situation which may reasonably be considered to have a material impact on Provider's or a Group Physician's ability to perform Provider's duties or obligations under this Agreement. Provider also shall immediately notify ACIA of any action against any applicable license, certification or participation under Title XVIII or other applicable provision of the Social Security Act or other State or federal law, State and/or DEA narcotic registration certificate, or medical staff privileges at any facility, and of any material change in the ownership or business operations of Provider or a Group Physician. All notices required by this **Section 5.2** shall be furnished as provided in **Section 10.6** of this Agreement.
- 5.3 Provider agrees to defend, indemnify and hold harmless ACIA and its officers, directors and employees from and against any and all claims, costs and liabilities (including the fees and expenses of counsel) as a result of a breach of this Agreement by Provider, the negligent or willful misconduct of Provider and/or Provider's employees, agents and representatives (including without limitation Group Physicians), and from and against any death, personal injury or malpractice arising in connection with the performance of any services by the Provider and all Group Physicians in connection with this Agreement. This section shall survive the termination or expiration of this Agreement for any reason.

ACIA agrees to defend, indemnify and hold harmless Provider and its officers, directors and employees from and against all claims, costs and liabilities (including the fees and expenses of counsel) as a result of ACIA's breach of this Agreement or the negligent or willful misconduct of ACIA and/or ACIA's employees, agents and representatives in connection with ACIA's performance under this Agreement. This section shall survive the termination or expiration of this Agreement for any reason.

6. CONFIDENTIALITY:

ACIA and Provider shall each comply with all applicable State and federal laws respecting the confidentiality of the medical, personal or business affairs of Members acquired in the course of providing services pursuant to this Agreement. Each party shall maintain as confidential and shall not disclose to third parties financial, operating, proprietary or business information relating to the other party which is not otherwise public information. The payment rates in this Agreement are confidential and proprietary and shall not be disclosed by either party. However, nothing herein shall prohibit either party from making any disclosure or transmission of information to the extent that such disclosure or transmission is required by CMS or an applicable state regulatory agency, or is necessary or appropriate to enable the disclosing party to perform its obligations or enforce its rights under this Agreement, or is required by law or legal process. Should disclosure be required by law or legal process, the disclosing party shall immediately notify the other party of the disclosure.

7. COOPERATION; RESOLUTION OF DISPUTES:

- 7.1 Cooperation. To the extent compatible with separate and independent management of each, ACIA and Provider shall at all times maintain an effective liaison and close cooperation with each other to provide maximum benefits to Members at the most reasonable cost consistent with

high standards of care. ACIA and Provider shall use best efforts to exchange information regarding material matters directly or indirectly related to this Agreement.

- 7.2 **Resolution of Disputes.** ACIA and Provider shall both fully cooperate in resolving any and all controversies among or between said parties, their employees, agents, or representatives pertaining to their respective duties under this Agreement. Such disputes shall be submitted for resolution in accordance with the provider appeal procedures as referenced in the Provider Manual and ACIA policies and procedures. Neither ACIA nor Provider shall permit a dispute between the parties to disrupt or interfere with the provision of services to Members.

8. TERM; TERMINATION:

- 8.1 The term of this Agreement shall commence as of the Effective Date and, unless earlier terminated in accordance herewith, shall continue for an initial one (1) year term. Thereafter, this Agreement shall automatically renew for successive one (1) year terms unless the Agreement is terminated pursuant to this **Section 8** as set forth herein.
- 8.2 Either party may terminate this Agreement at the end of the initial term or at any time thereafter by providing the other party with at least ninety (90) days prior written notice of its intention to terminate this Agreement. The effective date of termination will be on the first of the month following the expiration of the notice period.
- 8.3 Either party may terminate this Agreement for cause due to a material breach by giving ninety (90) days' prior written notice. The notice of termination for cause will not be effective if the breaching party cures the breach within the first sixty (60) days of the ninety (90) day notice period. In the event that the breaching party does not cure the breach within the sixty (60) day period, the effective date of termination will be the first of the month following the expiration of the ninety (90) day notice period.
- 8.4 Termination of this Agreement for any reason, including without limitation the insolvency of ACIA, shall not release Provider from his or her obligations to serve Members when continuation of a Member's treatment is Medically Necessary.
- 8.5 In the event any change in federal or State laws, rules and regulations or the Iowa Medicaid Program or the Medicare Advantage program would have a material adverse impact on either ACIA or Provider in connection with the performance of this Agreement (the "Mandated Changes") such that the basis for the financial bargain of this Agreement is undermined, then the affected party shall have the right to require the other, by written notice, to enter into negotiations regarding the affected or pertinent terms of this Agreement while still maintaining the original Agreement purposes. If renegotiated, such terms shall become effective no later than thirty (30) days after the parties have reached agreement on the renegotiated terms. The parties agree to make a good faith attempt to renegotiate the Agreement to the extent necessary to comply with any Mandated Changes. If, after good faith renegotiations, the parties fail to reach an agreement satisfactory to both parties within thirty (30) days of the request for renegotiation, the party requesting such renegotiation may terminate this Agreement upon ninety (90) days prior written notice to the other party.
- 8.6 Notwithstanding the above, ACIA may terminate this Agreement immediately in the event any of the following occur:
- (a) If Provider (or, if Provider is a group, any Group Physician) or a person with an ownership or control interest in Provider is expelled, disciplined, barred from participation in, or

suspended from receiving payment under any state's Medicaid program, Children's Health Insurance Program (CHIP), the Medicare Program under Section 1128 or 1128A of the Social Security Act or any other federal health care program.

- (b) If Provider (or, if Provider is a group, any Group Physician) is debarred, suspended or otherwise excluded from procurement or non-procurement activities under the Federal Acquisition Regulations.
 - (c) If Provider (or, if Provider is a group, any Group Physician) is convicted of any felony or any crime related to the practice of medicine.
 - (d) Upon the loss or suspension of the Provider's professional liability coverage set forth under **Section 5** of this Agreement.
 - (e) The suspension or revocation of Provider's license or other certification or authorization necessary for Provider to render Basic Health Services, or upon ACIA's reasonable determination that the health, safety or welfare of any Member may be in jeopardy if this Agreement is not terminated.
 - (f) If Provider (or, if Provider is a group, any Group Physician) fails to satisfy any or all of the credentialing requirements of ACIA or fails to cooperate with or abide by the Quality Management Program.
 - (g) If Provider (or, if Provider is a group, a Group Physician) breaches a material provision of this Agreement or is engaged in any conduct which would injure the business of ACIA.
- 8.7 With respect to a Group Physician, if ACIA decides to suspend or terminate the Agreement, ACIA shall give the Group Physician written notice, to the extent required under CMS regulations, of the reasons for the action, including, if relevant, the standards and the profiling data the organization used to evaluate the Group Physician and the numbers and mix of Participating Physicians ACIA needs. Such written notice shall also set forth the Group Physician's right to appeal the action and the process and timing for requesting a hearing.
- 8.8 Upon termination of this Agreement for any reason, ACIA shall notify affected Members of the termination of Provider (or, if Provider is a group, any Group Physician) in accordance with the notification requirements under 42 C.F.R. §422.111(e). Regardless of the reason for termination, Provider shall promptly supply to ACIA all information necessary for the reimbursement of outstanding claims. 42 CFR 434.6(a)(6).

9. PROGRAM REQUIREMENTS:

Attached hereto and incorporated herein by reference is **Schedule 9**, setting forth such terms and conditions as are necessary to meet State and Federal statutory and regulatory requirements, and other Agency requirements, of the Program. **Schedule 9** is consecutively sub-numbered as necessary for each Program under which Provider is furnishing services under this Agreement. Provider acknowledges that the specific terms as set forth in **Schedule 9** are subject to amendment in accordance with federal and/or State statutory and regulatory changes to the Program. Such amendment shall not require the consent of the Provider or ACIA and will be effective immediately on the effective date thereof, as set forth in **Section 10.3**.

10. MISCELLANEOUS:

- 10.1 It is understood that Provider is an independent contractor and in no way is Provider to be considered an employee, agent, or representative of ACIA. It is further understood that Provider provides specified services to Members in exchange for an agreed upon fee. This Agreement shall not create, nor be deemed or construed to create any relationship between ACIA and Provider other than that of independent contractors, contracting with each other solely for the purpose of performing this Agreement and each party shall be liable solely for their own activities and neither ACIA nor Provider shall be liable to any third party for the activities of the other party to this Agreement.
- 10.2 This Agreement, being for the purpose of retaining the professional services of Provider, shall not be assigned, subcontracted, or delegated by Provider without the express written consent of ACIA.
- 10.3 No alterations or modifications of the terms of this Agreement shall be valid unless such alterations or modifications are incorporated into the Agreement through a written amendment, signed by both parties hereto, and attached to this Agreement; provided, however, ACIA may amend this Agreement with 30 days' notice to Provider via a(n) ACIA bulletin or other written communication provided in accordance with the notice provisions in **Section 10.6**, and unless Provider notifies ACIA, as applicable, of any objection, such amendment shall then take effect. Any amendment to this Agreement subject to prior regulatory approval(s) shall be effective once such regulatory approval(s) has been received.
- Notwithstanding the foregoing, amendments required because of legislative, regulatory or governmental agency requirements do not require the consent of Provider or ACIA and shall be effective immediately on the effective date thereof. This Agreement remains subject to the approval of the State of Iowa, and may be amended by ACIA to comply with any requirements of the State of Iowa. Provider acknowledges that all Agency requirements, as may be amended from time to time, are incorporated to this Agreement.
- 10.4 This Agreement shall be deemed to have been made and shall be construed and interpreted in accordance with the laws of the State of Iowa.
- 10.5 This Agreement and its exhibits, appendices, schedules, addenda or other attachments constitute the entire understanding and agreement between the parties concerning the subject matter hereof. This Agreement supersedes all prior written or oral agreements or understandings existing between the parties concerning the subject matter hereof including, but not limited to, any such agreement which may have been previously executed between Provider and ACIA or any of its Affiliates relating to the provision of Covered Services under the Program. In the event of a conflict between the terms of this Agreement and the Provider Manual, the terms of the later document shall control.
- 10.6 Written notices to be given hereunder shall be sent by Certified Mail, Return Receipt Requested, or by an overnight delivery service which provides a written receipt evidencing delivery to the address set forth by the party, or by confirmed facsimile followed by written notice through the U.S. postal service. All notices called for hereunder shall be effective upon receipt.

If to Provider:

With a copy to:

If to AmeriHealth Caritas Iowa:

ATTN:

With a copy to: General Counsel
AmeriHealth Caritas
200 Stevens Drive
Philadelphia, PA 19113

- 10.7 Both parties agree that there shall be no discrimination in the performance of this Agreement against any patient or other person as the result of that individual's race, color, religion, gender, sexual orientation, handicap, age, national origin, source of payment, or any other basis prohibited by law.
- 10.8 The failure of any of the parties to insist upon strict performance of any of the terms of this Agreement shall not be deemed a waiver of any of their respective rights or remedies, and shall not be deemed a waiver of any subsequent breach or default in any of the terms contained in this Agreement.
- 10.9 In the event that any provision under this Agreement is declared null or void, for any reason, the remaining provisions of this Agreement shall remain in full force and effect.
- 10.10 The parties will use reasonable care and due diligence in performing this Agreement. Provider will be solely responsible for the services provided under this Agreement.
- 10.11 All captions contained in this Agreement are solely for the convenience of the parties hereto and shall not be deemed part of the content of this Agreement.
- 10.12 All terms used in this Agreement are deemed to refer to the masculine, feminine, neuter, singular or plural as the content may require.
- 10.13 Non-Discrimination. Provider shall comply with (i) Title VI of the Civil Rights Act of 1964 and the rules, regulations, and orders; (ii) the Rehabilitation Act of 1973 and the rules, regulations, and orders thereunder; (iii) the Americans With Disabilities Act of 1990 and the rules, regulations, and orders thereunder; and (iv) any and all applicable laws, rules and regulations prohibiting discriminatory practices. Furthermore, in accordance with Title VI of the Civil Rights Act of 1964 and the rules, regulations and orders thereunder, Provider shall take adequate steps to ensure that Members with limited English skills receive free of charge the language assistance necessary to afford them meaningful and equal access to the benefits and services provided under this Agreement (see 42 U.S.C. 2000d et seq. and 45 C.F.R. Part 80, 2001 as amended).
- 10.14 No Offshore Contracting. No Covered Services under this Agreement may be performed outside of the United States without ACIA's prior written consent. In addition, Provider will not hire any individual to perform any services under this Agreement if that individual is required to have a work visa approved by the U.S. Department of Homeland Security and such individual has not met this requirement.

[SIGNATURES ON FOLLOWING PAGE; REMAINDER OF PAGE INTENTIONALLY BLANK]

IN WITNESS WHEREOF, and intending to be legally bound hereby, the parties hereto, each by its officers duly authorized, hereby affix their hands as of the date written below.

<p>PROVIDER</p> <p>_____</p> <p>Print Name</p> <p>_____</p> <p>Signature</p> <p>_____</p> <p>Title</p> <p>_____</p> <p>Address</p> <p>_____</p> <p>National Provider ID Number</p> <p>_____</p> <p>Medicaid ID Number</p> <p>_____</p> <p>Group Tax ID Number Group Medicare #/PTAN</p> <p>_____</p> <p>Date</p> <p>Assignment of Payment (applicable to Group Physician only): By signing below, Provider hereby assigns and transfers all Provider's right to and interest in compensation payable by ACIA pursuant to this Agreement to the party identified below, and Provider therefore directs ACIA to pay such compensation to said party.</p> <p>_____</p> <p>Provider Signature</p> <p>_____</p> <p>Name of Group</p> <p>_____</p> <p>Address</p> <p>_____</p> <p>Group Tax ID Number Group Medicare #/PTAN</p> <p>Check and initial if Assignment of Payment Not Applicable: <input type="checkbox"/> Provider Initials</p>	<p>AMERIHEALTH CARITAS IOWA, INC.</p> <p>_____</p> <p>Name</p> <p>_____</p> <p>Signature</p> <p>_____</p> <p>Title</p> <p>_____</p> <p>Date</p> <p>Effective Date of Agreement: _____ [To be completed by AmeriHealth Caritas Iowa]</p>
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DRAFT - Subject to approval by Iowa Department of Human Services and Iowa Insurance Division

APPENDIX A

COVERED SERVICES

Primary Care Services

In Provider's capacity as a Primary Care Provider, Provider shall provide all Basic Health Services to Members who have selected or been assigned to Provider as their Primary Care Provider including the following:

1. All primary ambulatory care visits and routine office procedures;
2. Periodic physical examinations;
3. Routine injections and immunizations, including vaccinations;
4. Arrange for and/or provide inpatient medical care at ACIA participating hospital providers;
5. Referrals, as required, to Specialty Care Providers;
6. Referrals, as required, to ACIA participating providers for lab, radiology and other appropriate services;
7. Provision or arrangement for Basic Health Services twenty-four (24) hours a day, seven (7) days a week; and
8. Exercise primary responsibility for arranging and coordinating the delivery of Medically Necessary health care services to Members.

Specialty Care Services

In Specialty Provider's capacity as a Specialty Care Provider, Provider shall provide all Specialty Care Services to Members including the following:

1. Ambulatory care visits;
2. Arrange for and/or provide inpatient medical care at ACIA participating hospital providers; and
3. Emergency or consultative Specialty Care Services twenty-four (24) hours a day, seven (7) days a week.

APPENDIX B

PROVIDERS AND OFFICE LOCATIONS
COVERED BY AGREEMENT

PRIMARY/SPECIALTY CARE PROVIDER(S) PRIMARY/SPECIALTY CARE PROVIDER(S)

Name

PRACTICE LOCATION ADDRESS

PRACTICE LOCATION ADDRESS

Address

Address

City, State, ZIP

City, State, ZIP

Phone Number

Phone Number

DRAFT - Subject to approval of Iowa Department of Human Services and Iowa Insurance Division

APPENDIX C

COMPENSATION

Primary Care Provider Compensation

Commencing on the Effective Date, ACIA will compensate Provider for all Basic Health Services rendered by Provider to Members in accordance with the terms of this Agreement at a rate of [____], in accordance with Medicare Payment Policies, less applicable co-insurance and deductibles. In no event will ACIA's payment exceed Provider's charges.

Specialty Care Provider Compensation

Commencing on the Effective Date, ACIA will compensate Provider for all Specialty Care Services rendered by Provider to Members in accordance with the terms of this Agreement at a rate of [____]. In no event will ACIA's payment exceed Specialty Provider's charges.

DRAFT - Subject to approval of Iowa Department of Human Services and Iowa Insurance Division

APPENDIX D
PHYSICIAN PROVIDER

ACIA AFFILIATES

ACIA Affiliates Covered by Agreement

DRAFT - Subject to approval of Iowa Department of Human Services and Iowa Insurance Division

Schedule 9-1

Federal Requirements – Medicaid and Medicaid Managed Care

1. No payment will be made to Provider for provider-preventable conditions or health care-acquired conditions. For purposes hereof:
 - a. **Health care-acquired condition** (“HAC”) means a condition occurring in any inpatient hospital setting, identified as a HAC by the Secretary of the U.S. Department of Health and Human Services (“HHS”) under section 1886(d)(4)(D)(iv) of the Social Security Act (the “Act”) for purposes of the Medicare program identified in the State plan as described in section 1886(d)(4)(D)(ii) and (iv) of the Act, other than deep vein thrombosis/pulmonary embolism as related to total knee replacement or hip replacement surgery in pediatric and obstetric patients.
 - b. **Other provider-preventable condition** means a condition occurring in any health care setting that meets the following criteria: (i) is identified in the Iowa Medicaid plan; (ii) has been found by the Iowa, based upon a review of medical literature by qualified professionals, to be reasonably preventable through the application of procedures supported by evidence-based guidelines (iii) has a negative consequence for the Member; (iv) is auditable; and (v) includes, at a minimum, wrong surgical or other invasive procedure performed on a patient, surgical or other invasive procedure performed on the wrong body part, or surgical or other invasive procedure performed on the wrong patient.
 - c. **Provider-preventable condition** (“PPC”) means a condition that meets the definition of “health care-acquired condition” or an “other provider-preventable condition.”

No reduction in payment will be made for a PPC when the condition existed prior to the initiative of treatment for that patient by Provider. Provider shall identify PPCs when submitting claims for payment or, if no claim will be submitted, if Medicaid payment would otherwise be available for the course of treatment in which the PPC occurred, or as otherwise required by the State. **42 CFR §§438.6(f)(2), 434.6(a)(12) and 447.26.**

2. The State Agency and HHS may inspect and audit any financial records of Provider or its subcontractors. **42 CFR §438.6(g).**
3. **Physician Incentives.** Provider shall disclose to ACIA annually any Physician Incentive Plan (PIP) or risk arrangements Provider may have with physicians, either within Provider’s group practice or other physicians not associated with Provider’s group practice, even if there is no substantial financial risk between ACIA and the physician or physician group. The term “substantial financial risk” means a financial risk set at greater than twenty-five percent (25%) of potential payments for Covered Services, regardless of the frequency of assessment (i.e., collection) or distribution of payments. The term “potential payments” means simply the maximum anticipated total payments that the physician or physician group could receive if the use or cost of referral services were significantly low. **42 CFR §§438.6(g), 422.208, 422.210.**
4. **Provider Discrimination Prohibited.** ACIA may not, with respect to Provider compensation or indemnification under this Agreement, discriminate against Provider to the extent that the Provider is acting within the scope of his, her or its license or certification under applicable State law, solely on the basis of that license or certification. Without limiting the foregoing, ACIA shall not discriminate against Provider for serving high-risk populations or specializing in

conditions that require costly treatment. Nothing herein shall be construed to: (i) require ACIA to contract with Provider if not necessary to meet the needs of Members; (ii) preclude ACIA from using different reimbursement amounts for different specialties or for different practitioners in the same specialty; or (iii) preclude ACIA from establishing measures that are designed to maintain quality of services and control costs and are consistent with ACIA's responsibilities to Members. 42 CFR §438.12.

5. Continued Treatment Obligation. Notwithstanding any other provision of this Agreement, in the event of either party's termination of this Agreement, insolvency of either ACIA, or other cessation of ACIA's operations, Provider shall continue to provide Covered Services to Members (i) until the end of the month in which the effective date of termination of this Agreement falls, (ii) until the end of the month for which capitation or premium has been paid to ACIA by Agency, or (iii) until the date of a Member's discharge from an inpatient facility, whichever is later. 42 CFR §438.62.
6. Member Rights. Provider shall adhere to all applicable Federal and State laws that pertain to Member rights, and shall take such rights into account when furnishing services to Members. 42 CFR §438.100(a)(2).
7. Provider-Member Communications. Nothing in this Agreement shall be construed to prohibit, restrict or impede Provider's ability to freely and openly discuss with Members, within the Provider's lawful scope of practice, all available treatment options and any information the Member may need in order to decide among all relevant treatment options, including but not limited to the risks, benefits and consequences of treatment or non-treatment, regardless of whether the services may be considered Covered Services in accordance with this Agreement. Further, nothing in this Agreement shall be construed to prohibit, restrict or impede Provider from discussing Medically Necessary care and advising or advocating appropriate medical care with or on behalf of a Member, including: information regarding the nature of treatment options, risks of treatment, alternative treatments or the availability of alternative therapies, consultation or tests that may be self-administered, and the Member's right to participate in decisions regarding his or her care, including the right to refuse treatment and to express preferences about future treatment decisions. 42 CFR §438.102(a).
8. Member Hold Harmless. Provider shall accept the final payment made by ACIA as payment in full for Covered Services provided pursuant to this Agreement. Provider agrees that in no event, including, but not limited to, nonpayment by the Agency to ACIA, nonpayment by ACIA to Provider, the insolvency of ACIA, or breach of this Agreement, shall Provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, solicit or accept any surety or guarantee of payment, or have any recourse against Members or persons other than ACIA acting on their behalf (including parent(s), guardian, spouse or any other person legally, or potentially legally, responsible person of the Member) for Covered Services listed in this Agreement. This provision shall not prohibit collection of supplemental charges or co-payments on ACIA's behalf made in accordance with terms of an enrollment agreement between ACIA and Members.

Provider further agrees that:

- a. this hold harmless 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 Members; and that
- b. this hold harmless provision supersedes any oral or written contrary agreement now existing or hereafter entered into between Provider and Members or persons acting on their behalf.

42 CFR §§438.106, 447.15.

9. Coverage and Payment for Emergency Services. ACIA shall cover and pay for Emergency Services rendered by Provider and obtained when a Member had an Emergency Medical Condition, or when a representative of ACIA has instructed the Member to seek Emergency Services. **42 CFR §438.114(c)(1)(ii).**
10. Timely Access. Provider shall meet Agency standards for timely access to care and services, taking into account the urgency of the need for services. Provider shall offer hours operation to Members that are no less than the hours of operation offered to commercial enrollees or comparable to Medicaid fee-for-service, if Provider serves only Medicaid enrollees. Provider services shall be available 24 hours a day, 7 days a week, when medically necessary.
11. Excluded Providers. Pursuant to **42 CFR §438.214(d)**, ACIA may not employ or contract with providers excluded from participation in Federal health care programs under either Section 1128 or 1128A of the Act. In addition, section 2455 of the Federal Acquisition Streamlining Act of 1994 and the Federal Acquisition Regulations (including but not limited to 48 CFR §9.405), ACIA may not make payment to any person or entity, or an affiliate thereof, who has been debarred or suspended from participation in federal procurement or non-procurement activities. Provider shall comply with the disclosure requirements of **42 C.F.R. Section 455, Subpart B** and, upon reasonable request, provide such information to ACIA in accordance with the requirements specified therein.

Provider represents and warrants that neither it, nor any of its contractors or employees who will furnish goods or services under the Agreement, directors or officers, or any person with an ownership interest in Provider of five percent (5%) or more, is or ever has been: (i) debarred, suspended or excluded from participation in Medicare, Medicaid, the State Children's Health Insurance Program (SCHIP) or any other Federal health care program; (ii) convicted of a criminal offense related to the delivery of items or services under the Medicare or Medicaid program; (iii) had any disciplinary action taken against any professional license or certification held in any state or U.S. territory, including disciplinary action, board consent order, suspension, revocation, or voluntary surrender of a license or certification; or (iv) debarred or suspended from participation in procurement or non-procurement activities by any federal agency (collectively, "Sanctioned Persons"). Provider shall screen all employees and contractors who will furnish goods or services under this Agreement to determine whether they have been excluded from participation in any Federal health care program, by searching applicable Federal and State databases (including but not limited to the OIG's LEIE and the HIPDB) upon initial employment or engagement of or contracting with a contractor, employee, director or officer, and on a monthly basis thereafter.

Provider shall immediately notify ACIA upon knowledge by Provider that any of its contractors or employees who furnish goods or services under the Agreement, directors, officers or owners has become a Sanctioned Person, or is under any type of investigation which may result in their becoming a Sanctioned Person. In the event that Subcontractor cannot provide reasonably

satisfactory assurance to ACIA that a Sanctioned Person will not receive payment from ACIA under this Agreement, ACIA may immediately terminate this Agreement. ACIA reserves the right to recover all amounts paid by ACIA for items or services furnished by a Sanctioned Person. Further, and without limiting Provider's indemnification obligations set forth elsewhere in this Agreement, to the extent penalties, fines or sanctions are assessed against ACIA as a result of Provider's having a relationship with a Sanctioned Person, Provider shall be responsible for the immediate payment of such penalties, fines or sanctions. In the event such payment is not made in a timely manner to ACIA, ACIA shall have the right to offset claims payments to Provider by the amount owed by Provider to ACIA.

12. State and Federal Regulator Access. Provider acknowledges that the U.S. Department of Health and Human Services (HHS), Centers for Medicare and Medicaid Services (CMS), Office of the Inspector General, the Comptroller, the Iowa Department of Human Services, and their designees have the right to evaluate through audit, inspection, or other means, whether announced or unannounced, any records pertinent to this Agreement, including quality, appropriateness and timeliness of services and the timeliness and accuracy of encounter data and Provider claims submitted to ACIA. Such evaluation, when performed, shall be performed with the cooperation of the Provider and ACIA. Upon request, Provider and ACIA shall assist in such reviews. 42 CFR §434.6(a)(5).
13. Provider shall safeguard information about Members as required by Part 431, Subpart D of 42 CFR. 42 CFR 434.6(a)(8).
14. Any permitted subcontracts entered into by Provider in order to carry out its obligations under this Agreement must be in writing and fulfill the requirements of 42 CFR Part 434 that are appropriate to the service or activity delegated under the subcontract. 42 CFR 434.6(a)(11), (b).

Schedule 9-2 (Physician Form)

State of Iowa Requirements – Medicaid and Medicaid Managed Care

1. Unless defined in this Schedule 9-2 or elsewhere in the Agreement, all capitalized terms used herein shall have their respective meanings given to them in the contract between the Iowa Department of Human Services (“IDHS”) and AmeriHealth Caritas Iowa, Inc. (“ACIA”) dated as of [____], 201[] (the “State Contract”).
2. In accordance with **191 IAC 40.18**, Provider, or its assignee or subcontractor as applicable, hereby agrees that in no event, including but not limited to nonpayment by the ACIA, ACIA insolvency or breach of this Agreement, shall Provider, or its assignee or subcontractor if applicable, bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against any Member or persons other than ACIA acting on the Member’s behalf for services provided pursuant to this Agreement. This provision shall not prohibit collection of supplemental charges or copayments on ACIA’s behalf made in accordance with terms of the Program.

Provider, or its assignee or subcontractor if applicable, 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 the Member; and that (2) this provision supersedes any oral or written contrary agreement now existing or hereafter entered into between Provider and Member or persons acting on behalf of the Member.

3. Pursuant to **191 IAC 40.22**:
 - a. ACIA shall not prohibit Provider from or penalize Provider for discussing treatment options with Members, irrespective of ACIA’s position on the treatment options, or from advocating on behalf of Members within the utilization review or grievance processes established by ACIA or a person contracting with ACIA.
 - b. ACIA shall not penalize Provider because Provider, in good faith, reports to state or federal authorities any act or practice by ACIA that, in the opinion of Provider, jeopardizes patient health or welfare.
4. **Compliance with Pro-Children Act of 1994**. Provider hereby certifies compliance with Public Law 103-227, Part C Environmental Tobacco Smoke, also known as the Pro-Children Act of 1994 (“Act”). The Act requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted by an entity and used routinely or regularly for the provision of health, day care, education or library services to children under the age of 18, if the services are funded by federal programs either directly or through State or local governments. Federal programs include grants, cooperative agreements, loans or loan guarantees, and contracts. The law also applies to children’s services that are provided in indoor facilities that are constructed, operated or maintained with such federal funds. The law does not apply to children’s services provided in private residences, portions of facilities used for inpatient drug or alcohol treatment, service providers whose sole source of applicable federal funds is Medicare or Medicaid,

or facilities (other than clinics) where WIC coupons are redeemed. (**Ref. RFP Exhibit D**)

5. ACIA follows all applicable Federal and State laws pertinent to Member confidentiality and rights; Provider shall take those rights into account when furnishing services to Members. (**SOW §1.4.1**)
6. Provider shall not require any cost-sharing or Member liability responsibilities for Covered Services except to the extent that cost-sharing or Member liability responsibilities are required for those services in accordance with law and as described in the Agency Contract. Further, Provider shall not charge Members for missed appointments. (**SOW §3.2.15.3**)
7. Provider agrees that all applicable terms and conditions set out in the RFP, the Agency Contract, any incorporated documents and all applicable State and federal laws, as amended, govern the duties and responsibilities of Provider with regard to the provision of services to Members. (**SOW §6.1.2**)
8. Provider's responsibilities regarding third-party liability (TPL) include Provider's obligations to identify TPL coverage, including Medicare and long-term care coverage as applicable, and except as otherwise required, seek such TPL payment before submitting claims to ACIA. (**SOW §6.1.2**)
9. Provider shall submit claims which do not involve a third-party payer within **ninety (90) days** of the date of service. (**SOW §6.1.2**)
10. IDHS reserves the right to direct ACIA to terminate or modify this Agreement when IDHS determines it to be in the best interest of the State. (**SOW §6.1.2**)
11. ACIA may not prohibit or otherwise restrict a health care professional acting within the lawful scope of practice from advising or advocating on behalf of a Member who is his or her patient regarding: (1) the Member's health status; (2) medical, behavioral health, or long-term care treatment options, including any alternative treatment that may be self-administered; (3) any information the Member needs in order to decide among all relevant treatment options; (4) the risks, benefits and consequences of treatment or non-treatment; or (5) 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. (**SOW §6.1.5**)
12. Provider shall maintain complete and legible medical and financial (fiscal) records as required pursuant to **IAC 441-79.3**. Without limiting the foregoing, Provider's medical records shall document all medical services that the Member receives from Provider. Medical records shall be maintained in a detailed and comprehensive manner that conforms to good professional medical practice, permits effective professional medical review and medical audit processes, and facilitates an accurate system for follow-up treatment. Medical records must be legible, signed, dated and maintained as required by law. (**SOW §6.1.9**)

As required pursuant to **IAC 441-79.3(3)**, Provider shall maintain medical records: (1) during the time the Member is receiving services from Provider; (2) for a minimum of five (5) years from the date when a claim for the service was submitted to ACIA for payment; and (3) as may required by any licensing authority or accrediting body associated with determining Provider's qualification.

13. Each Member shall have the right to request and receive a copy of his her medical records, and to request that they be amended or corrected. Upon reasonable request of a Member, Provider shall provide a copy of a Member's medical record at no charge. Provider must facilitate the transfer of a Member's medical record to another provider at the Member's request. **(SOW §6.1.9.2)**
14. Within the timeframe designated by IDHS or other authorized entity, Provider must permit ACIA, representatives of IDHS, and other authorized entities to review Members' records for the purpose of monitoring Providers' compliance with the records standards, capturing information for clinical studies, monitoring quality of care, or any other reason. **(SOW 6.1.9.3)**
15. All medical records of Members shall be confidential and shall not be released without the written consent of the Member or responsible party. Written consent is not required under the following circumstances: (1) for transmission of medical record information to physicians, other practitioners or facilities who are providing services to Members under contract with ACIA; and (2) for transmission of medical record information to physicians or facilities providing emergency care. Written consent is required for the transmission of the medical record information of a former Member to any physician not connected with ACIA. The extent of medical record information to be released in each instance shall be based upon tests of medical necessity and a "need to know" on the part of the practitioner or facility requesting the information. All release of medical records shall be compliant with 45 CFR Parts 162 and 164. **(SOW §6.1.9.4)**
16. Provider shall offer hours of operation that are no less than the hours of operation offered to commercial members or comparable Medicaid members, if Provider sees only the Medicaid population. Covered Services shall be available twenty-four (24) hours a day, seven (7) days a week, when medically necessary. **(SOW 6.1.9.5)**
17. Upon determination by IDHS of a credible allegation of fraud for which an investigation is pending under the Medicaid program against Provider and upon the approval of the Medicaid Fraud Control Unit (MFCU) and IDHS, ACIA shall suspend all payments to Provider, in compliance with 42 CFR 455.23. ACIA shall issue a notice of payment suspension that comports in all respects with the obligations set forth in 42 CFR 455.23(b) (including notice that payments are being withheld in accordance with 42 CFR 455.23), and shall maintain the suspension for the durational period set forth in 42 CFR 455.23(c). ACIA will afford a grievance process to Provider in the event of payment suspension under this **paragraph 17**. **(SOW §12.7)**

Provider Contract Agreement Templates (Ancillary Services)

AMERIHEALTH CARITAS IOWA, INC.

ANCILLARY SERVICES AGREEMENT

with

[PROVIDER NAME]

DRAFT - Subject to approval of Iowa Department of Human Services and Iowa Insurance Division

**AMERIHEALTH CARITAS IOWA, INC.
ANCILLARY SERVICES AGREEMENT**

This Provider Services Agreement (the "Agreement"), dated as of the Effective Date (defined below), is made by and between AmeriHealth Caritas Iowa, Inc., a corporation organized under the laws of the State of Iowa, (hereinafter referred to as "ACIA") and the provider ("Provider") identified on the signature page.

WHEREAS, ACIA is a managed care organization that is responsible for providing or arranging for the provision of health care services to its Members; and

WHEREAS, Provider is duly licensed to furnish certain health care services; and

WHEREAS, Provider and ACIA mutually desire to enter into this Agreement, whereby Provider shall render services to Members enrolled with ACIA and be compensated by ACIA in accordance with the terms and conditions hereof.

NOW, THEREFORE, in consideration of the mutual promises made herein, it is mutually agreed by and between ACIA and Provider as follows:

1. DEFINITIONS

As used in this Agreement, each of the following terms shall have the meaning specified herein, unless the context clearly requires otherwise.

- 1.1 **AFFILIATES.** An Affiliate is any corporation or other organization that is identified as an Affiliate in a written notice to Provider and is owned or controlled, either directly or through parent or subsidiary corporations, by or under common control with, ACIA. ACIA shall give Provider thirty (30) days advance written notice of the addition of Affiliates added under this provision. Unless otherwise specified in this Agreement or any other attachment hereto, references to "ACIA" shall include the Affiliates referenced in Appendix B.
- 1.2 **AGENCY.** The State and/or Federal governmental agency that administers the Program(s) under which ACIA is obligated to provide or arrange for the provision of Covered Services.
- 1.3 **AGENCY CONTRACT.** The contract or contracts between ACIA and the Agency, as in effect from time to time, pursuant to which ACIA is responsible for coordinating health care services and supplies for Program recipients enrolled with ACIA.
- 1.4 **CLEAN CLAIM.** A claim for payment for a health care service, which has been received by ACIA, has no defect or impropriety. A defect or impropriety shall include a lack of required substantiating documentation or a particular circumstance requiring special treatment that prevents timely payment from being made on the claim. Consistent with 42 CFR §447.45(b), the term shall not include a claim from a health care provider who is under investigation for fraud or abuse regarding that claim, or a claim under review for medical necessity.
- 1.5 **COVERED SERVICES.** Those Medically Necessary health care services and supplies to which Members are entitled pursuant to the Agency Contract, and which shall be provided to Members by

- Provider, as described more specifically in **Appendix A**. Covered Services shall be furnished in the amount, duration and scope required under the Program.
- 1.6 **EFFECTIVE DATE.** The later of (i) the effective date on the signature page of this Agreement or (ii) the effective date of the Agency Contract, provided that Provider has been successfully credentialed by ACIA, as applicable, and that all required regulatory approvals have been obtained by ACIA.
- 1.7 **EMERGENCY MEDICAL CONDITION.** Health care services provided to a Member after the sudden onset of a medical condition that manifests itself by acute symptoms of sufficient severity or severe pain, such 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:
- (a) Placing the health of the Member (or with respect to a pregnant woman, the health of the Member or her unborn child) in serious jeopardy;
 - (b) Serious impairment to bodily functions; or
 - (c) Serious dysfunction of any bodily organ or part.
- 1.8 **EMERGENCY SERVICES.** Covered inpatient and outpatient services that are furnished by a provider that is qualified to furnish these services under 42 C.F.R. Section 438.114(a) and 42 U.S.C. Section 1932(b)(2) and that are needed to screen, evaluate, and stabilize an Emergency Medical Condition.
- 1.9 **MEDICALLY NECESSARY.** Those Covered Services that are, under the terms and conditions of the Agency Contract, determined through ACIA utilization management to be: (1) appropriate and necessary for the symptoms, diagnosis or treatment of the condition of the Member; (2) provided for the diagnosis or direct care and treatment of the condition of Member enabling the Member to make reasonable progress in treatment; (3) within standards of professional practice and given at the appropriate time and in the appropriate setting; (4) not primarily for the convenience of the Member, the Member's physician or other provider; and (5) the most appropriate level of Covered Services which can safely be provided. (Ref. Agency Contract – Scope of Work document)
- 1.10 **MEMBER.** An individual who is eligible for the Program and who has enrolled in ACIA under the Program.
- 1.11 **MEMBER APPEAL PROCEDURES.** The written procedures describing ACIA's standards for the prompt resolution of Member problems, grievances and appeals, as described in the Provider Manual.
- 1.12 **PARTICIPATING PROVIDER.** A duly licensed or certified, as applicable, health care provider that has entered into an agreement with ACIA to provide health care services to Members.
- 1.13 **PROGRAM.** The Iowa High Quality Health Initiative procured by the Iowa Department of Human Services ("IDHS") under RFP #MED-16-009, for the delivery of high quality healthcare services for the Iowa Medicaid, Iowa Health and Wellness Plan and Healthy and Well Kids in Iowa (*hawk-i*) programs.

- 1.14 **PROVIDER MANUAL.** The ACIA manual of standards, policies, procedures and corrective actions together with amendments or modifications ACIA may adopt from time to time. The Provider Manual is herein incorporated by reference and made part of this Agreement. The Provider Manual may be amended or modified by ACIA from time to time in accordance with **Section 3.3** herein below.
- 1.15 **QUALITY MANAGEMENT PROGRAM.** An ongoing review process and plan which functions to define, monitor, review, and recommend corrective action for managing and improving the quality of health care services to Members.
- 1.16 **UTILIZATION MANAGEMENT PROGRAM.** A process of review of the medical necessity, appropriateness and efficiency of health care services, procedures, equipment, supplies, and facilities rendered to Members.

2. OBLIGATIONS OF PROVIDER:

- 2.1 Throughout the term of this Agreement, Provider shall have and maintain, without restriction, all licenses, certificates, registrations and permits as are required under applicable State and federal statutes and regulations to provide the Covered Services furnished by Provider and/or other related activities delegated by ACIA under this Agreement. Provider shall obtain a unique identifier (national provider identifier) in accordance with the system established under Section 1173(b) of the Social Security Act, submit such identifier number to ACIA, and include such identifier on all claims. At all times during the term of this Agreement, Provider shall be eligible for participation in the Iowa Medicaid program; and, if required by the Iowa Medicaid program as a condition of furnishing services to Iowa Medicaid recipients, Provider shall participate in the Iowa Medicaid program. To the extent that Covered Services are furnished to Medicare beneficiaries under this Agreement, Provider shall also participate in the Medicare program. Provider shall ensure that all services provided pursuant to this Agreement are within the Provider's scope of professional responsibility.
- 2.2 Provider shall provide to Members the Covered Services described in **Appendix A** hereto; provided, however, that Provider shall only be obligated to provide Covered Services to a Member in accordance with ACIA's pre-authorization and other Utilization Management Program policies as described in the Provider Manual, other than Emergency Services, which will be provided as needed. In providing Covered Services, Provider agrees to abide by the relevant standards, policies and procedures of ACIA, including, but not limited to administrative, credentialing, quality management, utilization management, and Member Appeal Procedures set forth in the Provider Manual and other ACIA notices. Provider shall provide Covered Services in the same manner and with the same availability as services provided to other patients without regard to reimbursement and shall further provide these services in the most cost effective setting in accordance with appropriate quality of care and performance standards which are professionally recognized as industry standards and/or otherwise adopted, accepted or established by ACIA.
- 2.3 Provider shall provide ACIA with complete and accurate statements of all Covered Services provided to Members in conformance with ACIA billing procedures as set forth in the applicable Program manuals, the Provider Manual and other written ACIA billing guidelines. ACIA will not be liable for any bills relating to services that are submitted the later of: (a) after twelve (12) months from the date the services were provided (consistent with 42 CFR §447.45(d)), or (b) after sixty (60) days of the date of the Explanation of Benefits from another payor when services are first billed by Provider to another payor. Any appeal or request for adjustment of a payment

by Provider must be made in accordance with applicable provisions of the Provider Manual and ACIA policies and procedures and, in any case, must be received by ACIA within sixty (60) days of the original payment or denial. Provider may not bring legal action on claims which have not been appealed through the appeal mechanisms described herein.

Encounter Data and Other Reports. Provider shall deliver all reports and clinical information required to be submitted to ACIA pursuant to this Agreement for reporting purposes, including but not limited to encounter data, Healthcare Effectiveness Data and Information Set (HEDIS), Agency for Healthcare Research and Quality (AHRQ), and EPSDT data in a format which will allow ACIA to transmit required data to the Agency electronically and in a format identical to or consistent with the format used or otherwise required by ACIA and the Agency. Provider shall submit this information to ACIA within the time frames set forth in the Provider Manual or as otherwise required by the Agency. Provider shall submit all encounter data to the same standards of completeness and accuracy as required for proper adjudication of fee-for-service claims by ACIA.

- 2.4 Provider may directly bill Members for non-Covered Services if the Member is advised in writing before the service is rendered: (i) the nature of the service(s) to be rendered; (ii) that ACIA does not cover the services; and (iii) that the Member will be financially responsible for the services if the Member elects to receive the services. Furthermore, Provider shall hold harmless ACIA for any claim or expense arising from such services.
- 2.5 Provider shall not bill or collect from any Member any amount or charges for any Covered Services provided hereunder, except for authorized co-payments, co-insurance, and/or deductibles. Provider shall not deny Covered Services to a Member in the event that a Member is unable to pay any authorized co-payment amounts. 42 CFR §447.15.
- 2.6 Under no circumstances, including ACIA's failure to pay for Covered Services, termination of this Agreement, or the insolvency of ACIA, will Provider make any charges or claims against any Member directly or indirectly for Covered Services authorized by ACIA, except for authorized co-payments. Provider shall look only to ACIA for compensation for Covered Services.
- 2.7 During the term of this Agreement and in the event of termination of this Agreement for any reason, Provider agrees to fully cooperate with each Member and with ACIA in arranging for the transfer of copies of Member medical records to other ACIA Participating Providers.
- 2.8 Record Maintenance, Inspection, Reporting and Auditing
- (a) Record Retention. As required by 42 CFR 434.6(a)(7) and otherwise in accordance with the standards of ACIA, Provider shall maintain an adequate record system for recording services, service providers, charges, dates and all other commonly required information elements for services rendered to Members pursuant to this Agreement (including but not limited to such records as are necessary for the evaluation of the quality, appropriateness, and timeliness of services performed under this Agreement and the Agency Contract).
- (b) All records originated or prepared in connection with Provider's performance of its obligations under this Agreement will be retained and safeguarded by Provider in accordance with the terms and conditions of the Agency Contract and other relevant State and federal law. Provider agrees to retain all financial and programmatic records, supporting documents, statistical records and other records of Members relating to the delivery of care or service under the Agency Contract and as further required by the Agency, for a period of no less than

- seven (7) years from the expiration date of the Agency Contract, including any contract extension(s), and to retain all Member records, including but not limited to administrative, financial and medical records (whether electronic or paper) for a period of no less than seven (7) years after the last payment was made for services provide to the Member. If any audit, litigation, claim, or other actions involving the records have been initiated prior to the expiration of the seven (7) year period, the records shall be retained until completion of the action and resolution of all issues which arise from it or until the end of the seven (7) year period, whichever is later. If Provider stores records on microfilm or microfiche or other electronic means, Provider agrees to produce, at its expense, legible hard copy records promptly upon the request of state or federal authorities.
- (c) Medical Record Maintenance. Provider shall ensure that all medical records are in compliance with the medical record keeping requirements set forth in the Provider Manual, the Agency Contract and Agency guides. Provider shall maintain up-to-date medical records at the site where medical services are provided for each Member enrolled under this Agreement. Each Member's record must be accurate, legible and maintained in detail consistent with good medical and professional practice which permits effective internal and external quality review and/or medical audit and facilitates an adequate system of follow-up treatment.
- (d) ACIA shall be entitled to audit, examine and inspect Provider's books and records, including but not limited to medical records, financial information and administrative information pertaining to Provider's relationship with ACIA, at any time during normal business hours, upon reasonable notice. Provider agrees to provide ACIA, at no cost to ACIA, with such medical, financial and administrative information, and other records as may be necessary for ACIA to meet its obligations related to the Agency Contract and other regulatory obligations, Utilization Management Program and Quality Management Program standards, including NCQA standards, and other relevant accreditation standards which ACIA may require of ACIA Participating Providers.
- 2.9 Provider authorizes ACIA to include Provider's name, address, telephone number, information related to Provider's facilities, services and staff, and other similar information relevant to Provider, its operations and staff in the ACIA provider directory and in various marketing materials identifying Provider as a provider of services to Members. Provider agrees to afford ACIA the same opportunity to display brochures, signs, or advertisements in Provider's facilities as Provider affords any other insurance company or other third party payor.
- 2.10 While both parties support Provider's open and active communication with Members concerning Medically Necessary services, available treatment alternatives, benefit coverage information and/or any other information pertaining to the provider-patient relationship, Provider shall not, during the term of this Agreement, and any renewal thereof, solicit or require any Member, either orally or in writing, to subscribe to or enroll in any managed care plan other than ACIA. The provisions of this **Section 2.10** shall similarly apply to Provider's employees, agents and/or contractors.
- 2.11 Provider shall cooperate with ACIA in the identification of other sources of payment available to Members, such as other health insurance, government programs, liability coverage, motor vehicle coverage or worker's compensation coverage, as applicable. Provider shall be responsible for reporting all applicable third party resources to ACIA in a timely manner.

Provider will cooperate with ACIA in coordinating benefits with other payors in accordance with coordination of benefits claim processing rules and requirements outlined in the Provider Manual, the Agency Contract, and applicable Program manuals, as amended from time to time. Provider will make a reasonable attempt to determine whether any other payor has primary responsibility for the payment of a claim for services that Provider rendered to a Member and bill that payor before billing ACIA. Unless otherwise prohibited by applicable law, ACIA retains the right to recover payments made to Provider in the event ACIA determines that another payor is primarily responsible for all or a portion of the claim.

- 2.12 Provider understands and agrees that any payments ACIA makes directly or indirectly to Provider under this Agreement shall not be made as an inducement to reduce, limit or delay Medically Necessary services to any Member.
- 2.13 Provider will refer Members to ACIA-Participating Hospitals whenever Provider is unable to provide Medically Necessary services and when consistent with sound medical judgment and accepted standards of care.
- 2.14 Provider shall use best efforts to use ACIA's electronic utilization management and claims interfaces to improve the efficiency of utilization management and claims payment processes.
- 2.15 Provider will assist ACIA in providing orientation services to Provider staff to the extent ACIA may reasonably request.
- 2.16 **Fraud and Abuse.** Provider recognizes that payments made by ACIA pursuant to this Agreement are derived from federal and State funds, and acknowledges that it may be held civilly and/or criminally liable to ACIA and/or the Agency, in the event of non-performance, misrepresentation, fraud or abuse for services rendered to Members, including but not limited to, the submission of false claims/statements for payment by Provider, its employees or agents. Provider shall be required to comply with all policies and procedures as developed by ACIA and the Agency, including but not limited to the requirements set forth in the Provider Manual and the Agency Contract, for the detection and prevention of fraud and abuse. Such compliance may include, but not be limited to, referral of suspected or confirmed fraud or abuse to ACIA.
- 2.17 Provider will deliver location-based services to Members only at those service locations set forth in **Appendix C** hereto as such appendix is modified from time to time by mutual agreement of the parties. Provider shall notify ACI at least sixty (60) days prior to making any addition or change to service locations.

3. OBLIGATIONS OF ACIA:

- 3.1 ACIA shall pay Provider for Covered Services provided to Members pursuant to the terms of this Agreement. ACIA shall have the right to offset claims payments to Provider by any amount owed by Provider to ACIA, following at least thirty (30) days' written notice. Provider shall not be entitled to reimbursement if the Member was not eligible at the time services were rendered.
- 3.2 ACIA shall compensate Provider for Covered Services provided to Members upon receipt of a statement thereof, as defined in **Section 2.3**, and in accordance with **Section 2.11** and the Covered Services Payment Schedule set forth in **Appendix A-1** but, in no event, will ACIA's payment exceed submitted charges. No additional charges will be made by Provider to ACIA for Covered Services provided hereunder, and Provider recognizes and accepts the fees set forth in **Appendix A-1** as payment in full.

- 3.2 ACIA will establish payment policies for inpatient and outpatient services including, but not limited to, policies with respect to pre-admission testing, services included in inpatient rates and services included in outpatient rates. ACIA will provide at least thirty (30) days' prior written notice of any modifications to such payment policies. ACIA may, based on changes in clinical practice and modifications to standard coding systems, add and/or delete outpatient fee schedule procedures and re-categorize outpatient surgery fee schedule procedures, upon thirty (30) days' prior written notice to Provider.
- 3.3 ACIA shall furnish or otherwise make available to Provider a copy of the Provider Manual, as amended from time to time. Provider Manual updates will become effective thirty (30) days from the date of notification, unless otherwise specified in writing by ACIA.
- 3.4 ACIA shall pay all Clean Claims for Covered Services in accordance with applicable laws, regulations and Agency requirements; and ACIA will in any event meet the claim payment timeframes required under 42 CFR §447.45(d).
- 3.5 Provider Protections.
- (a) ACIA shall not exclude or terminate Provider from ACIA's provider network because the Provider advocated on behalf of a Member including in the context of a utilization management appeal or another dispute with ACIA over appropriate medical care, provided that such advocacy is consistent with the degree of learning and skill ordinarily possessed by a health care provider practicing in accordance with the applicable standard of care.
- (b) No Provider shall be excluded or terminated from participation with ACIA due to the fact that the Provider has a practice that includes a substantial number of patients with expensive medical conditions.
- (c) Provider shall not be excluded from participation, nor shall this Agreement be terminated, because Provider objects to the provision of or refuses to provide a healthcare service on moral or religious grounds.
4. **QUALITY MANAGEMENT/UTILIZATION MANAGEMENT:**
- 4.1 Whether announced or unannounced, Provider agrees to cooperate with, participate in, and abide by internal or external quality assessment reviews, Member Appeal Procedures, Utilization Management Program procedures, and Quality Management Program procedures established by ACIA and/or the Agency or their designees, and to follow practice guidelines as described in the Provider Manual, the Agency Contract, and the applicable Program manuals. Provider shall permit a representative of ACIA, or its designee, to review medical records concurrently as well as retrospectively. Provider shall provide copies of such medical records, either in paper or electronic form, to ACIA or its designee upon request. The Utilization Management and Quality Management Programs are described in the Provider Manual.
- 4.2 ACIA's Quality Management Programs consist of review of credentials and performance of ancillary and other provider types that are applying for participation in, or are participating in, ACIA's network of providers to determine whether the provider meets ACIA's standards for quality, availability, accessibility and cooperation.

- 4.3 ACIA's Utilization Management Programs include requirements for pre-authorization of certain services rendered in physicians' offices and in inpatient, outpatient and ancillary settings. Utilization Management Programs include concurrent, retrospective and prospective review of certain services and procedures to assure that care is delivered in the most appropriate setting and is Medically Necessary. Certain Covered Services may require prior approval from ACIA. The Covered Services subject to prior approval are more fully described in the Provider Manual and other ACIA notices. ACIA is obligated to pay for and Provider is entitled to reimbursement for only those services that are Medically Necessary. Where reimbursement for an admission, inpatient day or outpatient service is denied as not prior approved or Medically Necessary, the Provider shall not charge either ACIA or the Member for any health care services rendered or furnished with respect to such admission, inpatient day or outpatient service. If Provider disputes any such denial, the case in question shall be appealed through ACIA's provider appeal process. Provider may not bring legal action for disputes which have not been appealed through the provider appeal process.
- 4.4 ACIA shall monitor and report the quality of services delivered under the Agreement and initiate a plan of correction, where necessary, to improve quality of care, in accordance with that level of care which is recognized as acceptable professional practice in the respective community in which the Provider practices and/or the standards established by ACIA, the Agency, or their respective designees. Provider shall cooperate with and abide by any corrective action plan initiated by ACIA and/or required by the Agency or any other State or federal regulatory agency with governing authority over the services provided under this Agreement.
- 4.6 Provider agrees that to the extent penalties, fines or sanctions are assessed against ACIA by the Agency or another regulatory agency with governing authority over the services provided under this Agreement as a result of Provider's failure to comply with Provider's obligations under this Agreement, including but not limited to, Provider's failure or refusal to respond to ACIA's the Agency's request for medical records, applicable credentialing information, and other information required to be provided under this Agreement, Provider shall be responsible for the immediate payment of such penalties, fines or sanctions. In the event such payment is not made in a timely manner to ACIA, ACIA shall have the right to offset claims payments to Provider by the amount owed by Provider to ACIA.

5. PROFESSIONAL LIABILITY INSURANCE/ADVERSE ACTIONS:

- 5.1 Provider, at its sole expense, shall provide professional liability, comprehensive general liability, and, as applicable, medical malpractice insurance coverage (including coverage for vicarious liability, if any, for the acts of employees, agents and representatives of Provider) upon execution of this Agreement and at all times during the term of this Agreement, as follows:
- Amounts and extent of such insurance coverage as deemed necessary by ACIA to adequately insure Members and ACIA against any claim or claims for damages arising by reason of personal injury or death occasioned, directly or indirectly, in connection with Provider's performance of any service pursuant to this Agreement; in no event shall such coverage be less than the amounts required by law.
 - Provider shall provide ACIA with written verification of the existence of such coverage upon execution of this Agreement and as otherwise requested by ACIA throughout the term of the Agreement, which may include providing copies of face sheets of such coverage. Provider shall notify ACIA reasonably in advance of any change or cancellation of such coverage.

- 5.2 Provider shall immediately notify ACIA in writing, by certified mail, of any written or oral notice of any adverse action, including, without limitation, litigation, investigation, complaint, claim or transaction, regulatory action or proposed regulatory action, or other action naming or otherwise involving Provider or ACIA, or any other event, occurrence or situation which may reasonably be considered to have a material impact on Provider's ability to perform Provider's duties or obligations under this Agreement. Provider also shall immediately notify ACIA of any action against any applicable license, certification or participation under Title XVIII or other applicable provision of the Social Security Act or other State or federal law, State and/or DEA narcotic registration certificate, or medical staff privileges at any facility, and of any material change in the ownership or business operations of Provider. All notices required by this Section 5.2 shall be furnished as provided in Section 10.6 of this Agreement.
- 5.3 Provider agrees to defend, indemnify and hold harmless ACIA and its officers, directors and employees from and against any and all claims, costs and liabilities (including the fees and expenses of counsel) as a result of a breach of this Agreement by Provider, the negligent or willful misconduct of Provider and/or Provider's employees, agents and representatives, and from and against any death, personal injury or malpractice arising in connection with the performance of any services by the Provider in connection with this Agreement. This section shall survive the termination or expiration of this Agreement for any reason.

ACIA agrees to defend, indemnify and hold harmless Provider and its officers, directors and employees from and against all claims, costs and liabilities (including the fees and expenses of counsel) as a result of ACIA's breach of this Agreement or the negligent or willful misconduct of ACIA and/or ACIA's employees, agents and representatives in connection with ACIA's performance under this Agreement. This section shall survive the termination or expiration of this Agreement for any reason.

6. CONFIDENTIALITY:

ACIA and Provider shall each comply with all applicable State and federal laws respecting the confidentiality of the medical, personal or business affairs of Members acquired in the course of providing services pursuant to this Agreement. Each party shall maintain as confidential and shall not disclose to third parties financial, operating, proprietary or business information relating to the other party which is not otherwise public information. The payment rates in this Agreement are confidential and proprietary and shall not be disclosed by either party. However, nothing herein shall prohibit either party from making any disclosure or transmission of information to the extent that such disclosure or transmission is required by the Agency or other applicable state regulatory agency, or is necessary or appropriate to enable the disclosing party to perform its obligations or enforce its rights under this Agreement, or is required by law or legal process. Should disclosure be required by law or legal process, the disclosing party shall immediately notify the other party of the disclosure.

7. COOPERATION; RESOLUTION OF DISPUTES:

- 7.1 Cooperation. To the extent compatible with separate and independent management of each, ACIA and Provider shall at all times maintain an effective liaison and close cooperation with each other to provide maximum benefits to Members at the most reasonable cost consistent with high standards of care. ACIA and Provider shall use best efforts to exchange information regarding material matters directly or indirectly related to this Agreement.
- 7.2 Resolution of Disputes. ACIA and Provider shall both fully cooperate in resolving any and all controversies among or between said parties, their employees, agents, or representatives pertaining

to their respective duties under this Agreement. Such disputes shall be submitted for resolution in accordance with the provider appeal procedures as referenced in the Provider Manual and ACIA policies and procedures. Neither ACIA nor Provider shall permit a dispute between the parties to disrupt or interfere with the provision of services to Members.

8. TERM; TERMINATION:

The term of this Agreement shall commence as of the Effective Date and continue for an initial one (1) year term (the "Initial Term"). After the Initial Term, the Agreement shall automatically renew for successive one (1) year terms unless the Agreement is terminated pursuant to this Section 8 as set forth herein.

Either party may terminate this Agreement without cause at the end of the Initial Term or at the end of the subsequent terms by providing the other party with at least ninety (90) days' prior written notice before the end of the then current term. The effective date of termination without cause will be on the first of the month following the expiration of the notice period. Either party may terminate this Agreement for cause due to a material breach by giving thirty (30) days' prior written notice. The notice of termination for cause will not be effective if the breaching party cures the breach within the thirty (30) day notice period. In the event that the breaching party does not cure the breach within the thirty (30) day period, the effective date of termination will be the first of the month following the expiration of the thirty (30) day notice period.

In the event any change in federal or State laws, rules and regulations or the Iowa Medicaid Program or the Medicare Advantage program would have a material adverse impact on either ACIA or Provider in connection with the performance of this Agreement (the "Mandated Changes") such that the basis for the financial bargain of this Agreement is undermined, then the affected party shall have the right to require the other, by written notice, to enter into negotiations regarding the affected or pertinent terms of this Agreement while still maintaining the original Agreement purposes. If renegotiated, such terms shall become effective no later than thirty (30) days after the parties have reached agreement on the renegotiated terms. The parties agree to make a good faith attempt to renegotiate the Agreement to the extent necessary to comply with any Mandated Changes. If after good faith renegotiations, the parties fail to reach an agreement satisfactory to both parties within thirty (30) days of the request for renegotiation, the party requesting such renegotiation may terminate this Agreement upon ninety (90) days prior written notice to the other party.

Notwithstanding the above, ACIA may terminate this Agreement immediately in the event any of the following occur:

- 8.1 If Provider is expelled, disciplined, barred from participation in, or suspended from receiving payment under any state's Medicaid program, Children's Health Insurance Program (CHIP), the Medicare Program or any other federal health care program.
- 8.2 If Provider is debarred, suspended or otherwise excluded from procurement or non-procurement activities under the Federal Acquisition Regulations.
- 8.3 Upon the loss or suspension of the Provider's liability coverage set forth under Section 5 of this Agreement.
- 8.4 The suspension or revocation of Provider's license or other certification or authorization, including Provider's JCAHO or other applicable accreditation, necessary for Provider to render Covered Services, or upon ACIA's reasonable determination that the health, safety or welfare of any Member may be in jeopardy if this Agreement is not terminated.

Upon termination of this Agreement for any reason, ACIA shall notify affected Members of the termination of Provider prior to the effective date of termination. Regardless of the reason for termination, Provider shall promptly supply to ACIA all information necessary for the reimbursement of outstanding claims. 42 CFR 434.6(a)(6).

9. REGULATORY AND PROGRAM-SPECIFIC PROVISIONS:

Attached hereto and incorporated herein by reference is **Schedule 9**, setting forth such terms and conditions as are necessary to meet State and Federal statutory and regulatory requirements, and other Agency requirements, of the Program. **Schedule 9** is consecutively sub-numbered as necessary for each Program under which Provider is furnishing services under this Agreement. Provider acknowledges that the specific terms as set forth in **Schedule 9** are subject to amendment in accordance with federal and/or State statutory and regulatory changes to the Program. Such amendment shall not require the consent of the Provider or ACIA and will be effective immediately on the effective date thereof, as set forth in **Section 10.3**.

10. MISCELLANEOUS:

10.1 It is understood that Provider is an independent contractor and in no way is Provider to be considered an employee, agent, or representative of ACIA. It is further understood that Provider provides specified services to Members in exchange for an agreed upon fee. This Agreement shall not create, nor be deemed or construed to create any relationship between ACIA and Provider other than that of independent contractors, contracting with each other solely for the purpose of performing this Agreement and each party shall be liable solely for their own activities and neither ACIA nor Provider shall be liable to any third party for the activities of the other party to this Agreement.

10.2 This Agreement, being for the purpose of retaining the professional services of Provider, shall not be assigned, subcontracted, or delegated by Provider without the express written consent of ACIA.

10.3 No alterations or modifications of the terms of this Agreement shall be valid unless such alterations or modifications are incorporated into the Agreement through a written amendment, signed by both parties hereto, and attached to this Agreement; provided, however, ACIA may amend this Agreement with 30 days notice to Provider via a(n) ACIA bulletin or other written communication provided in accordance with the notice provisions in **Section 10.6**, and unless Provider notifies ACIA, as applicable, of any objection, such amendment shall then take effect. Any amendment to this Agreement subject to prior regulatory approval(s) shall be effective once such regulatory approval(s) has been received.

Notwithstanding the foregoing, amendments required because of legislative, regulatory or governmental agency requirements do not require the consent of Provider or ACIA and shall be effective immediately on the effective date thereof. This Agreement remains subject to the approval of the State of Iowa, and may be amended by ACIA to comply with any requirements of the State of Iowa. Provider acknowledges that all Agency requirements, as may be amended from time to time, are incorporated to this Agreement.

10.4 This Agreement shall be deemed to have been made and shall be construed and interpreted in accordance with the laws of the State of Iowa.

10.5 This Agreement and its exhibits, appendices, schedules, addenda or other attachments constitute the entire understanding and agreement between the parties concerning the subject matter hereof. This Agreement supersedes all prior written or oral agreements or understandings existing between the

parties concerning the subject matter hereof including, but not limited to, any such agreement which may have been previously executed between Provider and ACIA or any of its Affiliates relating to the provision of Covered Services under the Program. In the event of a conflict between the terms of this Agreement and the Provider Manual, the terms of the later document shall control.

- 10.6 Written notices to be given hereunder shall be sent by Certified Mail, Return Receipt Requested, or by an overnight delivery service which provides a written receipt evidencing delivery to the address set forth by the party, or by confirmed facsimile followed by written notice through the U.S. postal service. All notices called for hereunder shall be effective upon receipt.

If to Provider:

With a copy to:

If to AmeriHealth Caritas Iowa

With a copy to: General Counsel
AmeriHealth Caritas
200 Stevens Drive
Philadelphia, PA 19113

- 10.7 Both parties agree that there shall be no discrimination in the performance of this Agreement against any patient or other person as the result of that individual's race, color, religion, gender, sexual orientation, handicap, age, national origin, source of payment, or any other basis prohibited by law.
- 10.8 The failure of any of the parties to insist upon strict performance of any of the terms of this Agreement shall not be deemed a waiver of any of their respective rights or remedies, and shall not be deemed a waiver of any subsequent breach or default in any of the terms contained in this Agreement.
- 10.9 In the event that any provision under this Agreement is declared null or void, for any reason, the remaining provisions of this Agreement shall remain in full force and effect.
- 10.10 The parties will use reasonable care and due diligence in performing this Agreement. Provider will be solely responsible for the services provided under this Agreement.
- 10.11 All captions contained in this Agreement are solely for the convenience of the parties hereto and shall not be deemed part of the content of this Agreement.
- 10.12 All terms used in this Agreement are deemed to refer to the masculine, feminine, neuter, singular or plural as the content may require.

- 10.13 Non-Discrimination. Provider shall comply with (i) Title VI of the Civil Rights Act of 1964 and the rules, regulations, and order; (ii) the Rehabilitation Act of 1973 and the rules, regulations, and orders thereunder; (iii) the Americans With Disabilities Act of 1990 and the rules, regulations, and orders thereunder; and (iv) any and all applicable laws, rules and regulations prohibiting discriminatory practices. Furthermore, in accordance with Title VI of the Civil Rights Act of 1964 and the rules, regulations and orders thereunder, Provider shall take adequate steps to ensure that Members with limited English skills receive free of charge the language assistance necessary to afford them meaningful and equal access to the benefits and services provided under this Agreement (see 42 U.S.C. 2000d et seq. and 45 C.F.R. Part 80, 2001 as amended).
- 10.14 No Offshore Contracting. No Covered Services under this Agreement may be performed outside of the United States without ACIA's prior written consent. In addition, Provider will not hire any individual to perform any services under this Agreement if that individual is required to have a work visa approved by the U.S. Department of Homeland Security and such individual has not met this requirement.

[SIGNATURES ON FOLLOWING PAGE; REMAINDER OF PAGE INTENTIONALLY BLANK]

DRAFT - Subject to approval of Iowa Department of Human Services and Iowa Insurance Division

IN WITNESS WHEREOF, and intending to be legally bound hereby, the parties hereto, each by its officers duly authorized, hereby affix their hands as of the date written below.

ANCILLARY PROVIDER	AMERIHEALTH CARITAS IOWA, INC.
Print Name	Name
Signature	Signature
Title	Title
Address	Date
National Provider ID Number	Effective Date of Agreement: _____ [To be completed by AmeriHealth Caritas Iowa]
Medicaid ID Number	Medicare ID Number
Tax ID Number	
Date	
<p>Assignment of Payment (applicable to Group Physician only): By signing below, Provider hereby assigns and transfers all Provider's right to and interest in compensation payable by ACIA pursuant to this Agreement to the party identified below, and Provider therefore directs ACIA to pay such compensation to said party:</p>	
Provider Signature	
Name of Group	
Address	
Group Tax ID Number	
<p>Check and initial if Assignment of Payment Not Applicable: <input type="checkbox"/> Provider Initials</p>	

APPENDIX A
ANCILLARY SERVICES PROVIDER
COVERED SERVICES

Provider shall furnish the following Covered Services to Members:

[Insert description of Covered Services – specific to Provider]

Provider's compensation for Covered Services is set forth in Appendix A-1.

DRAFT - Subject to approval of Iowa Department of Human Services and Iowa Insurance Division

APPENDIX A-1

ANCILLARY SERVICES PROVIDER

COVERED SERVICES COMPENSATION SCHEDULE

Commencing on the Effective Date, ACIA will compensate Provider for Covered Services rendered by Provider to Members in accordance with the terms of this Agreement at a rate of [___]. In no event will ACIA's payment exceed Provider's charges.

DRAFT - Subject to approval of Iowa Department of Human Services and Iowa Insurance Division

APPENDIX B
ANCILLARY SERVICES PROVIDER
ACIA AFFILIATES

[Insert ACIA Affiliates Covered by Agreement]

DRAFT - Subject to approval of Iowa Department of Human Services and Iowa Insurance Division

APPENDIX C
ANCILLARY SERVICES PROVIDER
PROVIDERS AND SERVICE LOCATIONS
COVERED BY AGREEMENT

PROVIDER AND SERVICE LOCATION

Name

Address

City, State, Zip

Phone Number

PROVIDER AND SERVICE LOCATION

Name

Address

City, State, Zip

Phone Number

PROVIDER AND SERVICE LOCATION

Name

Address

City, State, Zip

Phone Number

DRAFT - Subject to approval of Iowa Department of Human Services and Iowa Insurance Division

Schedule 9-1

Federal Requirements – Medicaid and Medicaid Managed Care

1. No payment will be made to Provider for provider-preventable conditions or health care-acquired conditions. For purposes hereof:
 - a. **Health care-acquired condition** (“HAC”) means a condition occurring in any inpatient hospital setting, identified as a HAC by the Secretary of the U.S. Department of Health and Human Services (“HHS”) under section 1886(d)(4)(D)(iv) of the Social Security Act (the “Act”) for purposes of the Medicare program identified in the State plan as described in section 1886(d)(4)(D)(ii) and (iv) of the Act, other than deep vein thrombosis/pulmonary embolism as related to total knee replacement or hip replacement surgery in pediatric and obstetric patients.
 - b. **Other provider-preventable condition** means a condition occurring in any health care setting that meets the following criteria: (i) is identified in the Iowa Medicaid plan; (ii) has been found by the Iowa, based upon a review of medical literature by qualified professionals, to be reasonably preventable through the application of procedures supported by evidence-based guidelines (iii) has a negative consequence for the Member; (iv) is auditable; and (v) includes, at a minimum, wrong surgical or other invasive procedure performed on a patient, surgical or other invasive procedure performed on the wrong body part, or surgical or other invasive procedure performed on the wrong patient.
 - c. **Provider-preventable condition** (“PPC”) means a condition that meets the definition of “health care-acquired condition” or an “other provider-preventable condition.”

No reduction in payment will be made for a PPC when the condition existed prior to the initiative of treatment for that patient by Provider. Provider shall identify PPCs when submitting claims for payment or, if no claim will be submitted, if Medicaid payment would otherwise be available for the course of treatment in which the PPC occurred, or as otherwise required by the State. **42 CFR §§438.6(f)(2), 434.6(a)(12) and 447.26.**

2. The State Agency and HHS may inspect and audit any financial records of Provider or its subcontractors. **42 CFR §438.6(g).**
3. **Physician Incentives.** Provider shall disclose to ACIA annually any Physician Incentive Plan (PIP) or risk arrangements Provider may have with physicians, either within Provider’s group practice or other physicians not associated with Provider’s group practice, even if there is no substantial financial risk between ACIA and the physician or physician group. The term “substantial financial risk” means a financial risk set at greater than twenty-five percent (25%) of potential payments for Covered Services, regardless of the frequency of assessment (i.e., collection) or distribution of payments. The term “potential payments” means simply the maximum anticipated total payments that the physician or physician group could receive if the use or cost of referral services were significantly low. **42 CFR §§438.6(g), 422.208, 422.210.**
4. **Provider Discrimination Prohibited.** ACIA may not, with respect to Provider compensation or indemnification under this Agreement, discriminate against Provider to the extent that the Provider is acting within the scope of his, her or its license or certification under applicable State law, solely on the basis of that license or certification. Without limiting the foregoing, ACIA shall not discriminate against Provider for serving high-risk populations or specializing in

conditions that require costly treatment. Nothing herein shall be construed to: (i) require ACIA to contract with Provider if not necessary to meet the needs of Members; (ii) preclude ACIA from using different reimbursement amounts for different specialties or for different practitioners in the same specialty; or (iii) preclude ACIA from establishing measures that are designed to maintain quality of services and control costs and are consistent with ACIA's responsibilities to Members. 42 CFR §438.12.

5. Continued Treatment Obligation. Notwithstanding any other provision of this Agreement, in the event of either party's termination of this Agreement, insolvency of either ACIA, or other cessation of ACIA's operations, Provider shall continue to provide Covered Services to Members (i) until the end of the month in which the effective date of termination of this Agreement falls, (ii) until the end of the month for which capitation or premium has been paid to ACIA by Agency, or (iii) until the date of a Member's discharge from an inpatient facility, whichever is later. 42 CFR §438.62.
6. Member Rights. Provider shall adhere to all applicable Federal and State laws that pertain to Member rights, and shall take such rights into account when furnishing services to Members. 42 CFR §438.100(a)(2).
7. Provider-Member Communications. Nothing in this Agreement shall be construed to prohibit, restrict or impede Provider's ability to freely and openly discuss with Members, within the Provider's lawful scope of practice, all available treatment options and any information the Member may need in order to decide among all relevant treatment options, including but not limited to the risks, benefits and consequences of treatment or non-treatment, regardless of whether the services may be considered Covered Services in accordance with this Agreement. Further, nothing in this Agreement shall be construed to prohibit, restrict or impede Provider from discussing Medically Necessary care and advising or advocating appropriate medical care with or on behalf of a Member, including: information regarding the nature of treatment options, risks of treatment, alternative treatments or the availability of alternative therapies, consultation or tests that may be self-administered, and the Member's right to participate in decisions regarding his or her care, including the right to refuse treatment and to express preferences about future treatment decisions. 42 CFR §438.102(a).
8. Member Hold Harmless. Provider shall accept the final payment made by ACIA as payment in full for Covered Services provided pursuant to this Agreement. Provider agrees that in no event, including, but not limited to, nonpayment by the Agency to ACIA, nonpayment by ACIA to Provider, the insolvency of ACIA, or breach of this Agreement, shall Provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, solicit or accept any surety or guarantee of payment, or have any recourse against Members or persons other than ACIA acting on their behalf (including parent(s), guardian, spouse or any other person legally, or potentially legally, responsible person of the Member) for Covered Services listed in this Agreement. This provision shall not prohibit collection of supplemental charges or co-payments on ACIA's behalf made in accordance with terms of an enrollment agreement between ACIA and Members.

Provider further agrees that:

- a. this hold harmless 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 Members; and that

- b. this hold harmless provision supersedes any oral or written contrary agreement now existing or hereafter entered into between Provider and Members or persons acting on their behalf.

42 CFR §§438.106, 447.15.

- 9. Coverage and Payment for Emergency Services. ACIA shall cover and pay for Emergency Services rendered by Provider and obtained when a Member had an Emergency Medical Condition, or when a representative of ACIA has instructed the Member to seek Emergency Services. 42 CFR §438.114(c)(1)(ii).
- 10. Timely Access. Provider shall meet Agency standards for timely access to care and services, taking into account the urgency of the need for services. Provider shall offer hours of operation to Members that are no less than the hours of operation offered to commercial enrollees or comparable to Medicaid fee-for-service, if Provider serves only Medicaid enrollees. Provider services shall be available 24 hours a day, 7 days a week, when medically necessary.
- 11. Excluded Providers. Pursuant to 42 CFR §438.214(d), ACIA may not employ or contract with providers excluded from participation in Federal health care programs under either Section 1128 or 1128A of the Act. In addition, section 2455 of the Federal Acquisition Streamlining Act of 1994 and the Federal Acquisition Regulations (including but not limited to 48 CFR §9.405), ACIA may not make payment to any person or entity, or an affiliate thereof, who has been debarred or suspended from participation in federal procurement or non-procurement activities. Provider shall comply with the disclosure requirements of 42 C.F.R. Section 455, Subpart B and, upon reasonable request, provide such information to ACIA in accordance with the requirements specified therein.

Provider represents and warrants that neither it, nor any of its contractors or employees who will furnish goods or services under the Agreement, directors or officers, or any person with an ownership interest in Provider of five percent (5%) or more, is or ever has been: (i) debarred, suspended or excluded from participation in Medicare, Medicaid, the State Children's Health Insurance Program (SCHIP) or any other Federal health care program; (ii) convicted of a criminal offense related to the delivery of items or services under the Medicare or Medicaid program; (iii) had any disciplinary action taken against any professional license or certification held in any state or U.S. territory, including disciplinary action, board consent order, suspension, revocation, or voluntary surrender of a license or certification; or (iv) debarred or suspended from participation in procurement or non-procurement activities by any federal agency (collectively, "Sanctioned Persons"). Provider shall screen all employees and contractors who will furnish goods or services under this Agreement to determine whether they have been excluded from participation in any Federal health care program, by searching applicable Federal and State databases (including but not limited to the OIG's LEIE and the HIPDB) upon initial employment or engagement of or contracting with a contractor, employee, director or officer, and on a monthly basis thereafter.

Provider shall immediately notify ACIA upon knowledge by Provider that any of its contractors or employees who furnish goods or services under the Agreement, directors, officers or owners has become a Sanctioned Person, or is under any type of investigation which may result in their becoming a Sanctioned Person. In the event that Subcontractor cannot provide reasonably satisfactory assurance to ACIA that a Sanctioned Person will not receive payment from ACIA under this Agreement, ACIA may immediately terminate this Agreement. ACIA reserves the right to recover all amounts paid by ACIA for items or services furnished by a Sanctioned Person. Further, and without limiting Provider's indemnification obligations set forth elsewhere in this

Agreement, to the extent penalties, fines or sanctions are assessed against ACIA as a result of Provider's having a relationship with a Sanctioned Person, Provider shall be responsible for the immediate payment of such penalties, fines or sanctions. In the event such payment is not made in a timely manner to ACIA, ACIA shall have the right to offset claims payments to Provider by the amount owed by Provider to ACIA.

12. State and Federal Regulator Access. Provider acknowledges that the U.S. Department of Health and Human Services (HHS), Centers for Medicare and Medicaid Services (CMS), Office of the Inspector General, the Comptroller, the Agency [SPECIFY STATE AGENCIES/REPRESENTATIVES], and their designees have the right to evaluate through audit, inspection, or other means, whether announced or unannounced, any records pertinent to this Agreement, including quality, appropriateness and timeliness of services and the timeliness and accuracy of encounter data and Provider claims submitted to ACIA. Such evaluation, when performed, shall be performed with the cooperation of the Provider and ACIA. Upon request, Provider and ACIA shall assist in such reviews. 42 CFR §434.6(a)(5).
13. Provider shall safeguard information about Members as required by Part 431, Subpart D of 42 CFR. 42 CFR 434.6(a)(8).
14. Any permitted subcontracts entered into by Provider in order to carry out its obligations under this Agreement must be in writing and fulfill the requirements of 42 CFR Part 434 that are appropriate to the service or activity delegated under the subcontract. 42 CFR 434.6(a)(11), (b).

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Schedule 9-2 (Ancillary Provider Form)

State of Iowa Requirements – Medicaid and Medicaid Managed Care

1. Unless defined in this Schedule 9-2 or elsewhere in the Agreement, all capitalized terms used herein shall have their respective meanings given to them in the contract between the Iowa Department of Human Services (“IDHS”) and AmeriHealth Caritas Iowa, Inc. (“ACIA”) dated as of [____], 201[] (the “State Contract”).
2. In accordance with **191 IAC 40.18**, Provider, or its assignee or subcontractor as applicable, hereby agrees that in no event, including but not limited to nonpayment by the ACIA, ACIA insolvency or breach of this Agreement, shall Provider, or its assignee or subcontractor if applicable, bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against any Member or persons other than ACIA acting on the Member’s behalf for services provided pursuant to this Agreement. This provision shall not prohibit collection of supplemental charges or copayments on ACIA’s behalf made in accordance with terms of the Program.

Provider, or its assignee or subcontractor if applicable, 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 the Member; and that (2) this provision supersedes any oral or written contrary agreement now existing or hereafter entered into between Provider and Member or persons acting on behalf of the Member.
3. Pursuant to **191 IAC 40.22**:
 - a. ACIA shall not prohibit Provider from or penalize Provider for discussing treatment options with Members, irrespective of ACIA’s position on the treatment options, or from advocating on behalf of Members within the utilization review or grievance processes established by ACIA or a person contracting with ACIA.
 - b. ACIA shall not penalize Provider because Provider, in good faith, reports to state or federal authorities any act or practice by ACIA that, in the opinion of Provider, jeopardizes patient health or welfare.
4. Compliance with Pro-Children Act of 1994. Provider hereby certifies compliance with Public Law 103-227, Part C Environmental Tobacco Smoke, also known as the Pro-Children Act of 1994 (“Act”). The Act requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted by an entity and used routinely or regularly for the provision of health, day care, education or library services to children under the age of 18, if the services are funded by federal programs either directly or through State or local governments. Federal programs include grants, cooperative agreements, loans or loan guarantees, and contracts. The law also applies to children’s services that are provided in indoor facilities that are constructed, operated or maintained with such federal funds. The law does not apply to children’s services provided in private residences, portions of facilities used for inpatient drug or alcohol treatment, service providers whose sole source of applicable federal funds is Medicare or Medicaid,

or facilities (other than clinics) where WIC coupons are redeemed. (**Ref. RFP Exhibit D**)

5. ACIA follows all applicable Federal and State laws pertinent to Member confidentiality and rights; Provider shall take those rights into account when furnishing services to Members. (**SOW §1.4.1**)
6. Provider shall not require any cost-sharing or Member liability responsibilities for Covered Services except to the extent that cost-sharing or Member liability responsibilities are required for those services in accordance with law and as described in the Agency Contract. Further, Provider shall not charge Members for missed appointments. (**SOW §3.2.15.3**)
7. Provider agrees that all applicable terms and conditions set out in the RFP, the Agency Contract, any incorporated documents and all applicable State and federal laws, as amended, govern the duties and responsibilities of Provider with regard to the provision of services to Members. (**SOW §6.1.2**)
8. Provider's responsibilities regarding third-party liability (TPL) include Provider's obligations to identify TPL coverage, including Medicare and long-term care coverage as applicable, and except as otherwise required, seek such TPL payment before submitting claims to ACIA. (**SOW §6.1.2**)
9. Provider shall submit claims which do not involve a third-party payer within **ninety (90) days** of the date of service. (**SOW §6.1.2**)
10. IDHS reserves the right to direct ACIA to terminate or modify this Agreement when IDHS determines it to be in the best interest of the State. (**SOW §6.1.2**)
11. ACIA may not prohibit or otherwise restrict a health care professional acting within the lawful scope of practice, from advising or advocating on behalf of a Member who is his or her patient regarding: (1) the Member's health status; (2) medical, behavioral health, or long-term care treatment options, including any alternative treatment that may be self-administered; (3) any information the Member needs in order to decide among all relevant treatment options; (4) the risks, benefits and consequences of treatment or non-treatment; or (5) 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. (**SOW §6.1.5**)
12. Provider shall maintain complete and legible medical and financial (fiscal) records as required pursuant to **IAC 441-79.3**. Without limiting the foregoing, Provider's medical records shall document all medical services that the Member receives from Provider. Medical records shall be maintained in a detailed and comprehensive manner that conforms to good professional medical practice, permits effective professional medical review and medical audit processes, and facilitates an accurate system for follow-up treatment. Medical records must be legible, signed, dated and maintained as required by law. (**SOW §6.1.9**)

As required pursuant to **IAC 441-79.3(3)**, Provider shall maintain medical records: (1) during the time the Member is receiving services from Provider; (2) for a minimum of five (5) years from the date when a claim for the service was submitted to ACIA for payment; and (3) as may required by any licensing authority or accrediting body associated with determining Provider's qualification.

13. Each Member shall have the right to request and receive a copy of his her medical records, and to request that they be amended or corrected. Upon reasonable request of a Member, Provider shall provide a copy of a Member's medical record at no charge. Provider must facilitate the transfer of a Member's medical record to another provider at the Member's request. **(SOW §6.1.9.2)**
14. Within the timeframe designated by IDHS or other authorized entity, Provider must permit ACIA, representatives of IDHS, and other authorized entities to review Members' records for the purpose of monitoring Providers' compliance with the records standards, capturing information for clinical studies, monitoring quality of care, or any other reason. **(SOW 6.1.9.3)**
15. All medical records of Members shall be confidential and shall not be released without the written consent of the Member or responsible party. Written consent is not required under the following circumstances: (1) for transmission of medical record information to physicians, other practitioners or facilities who are providing services to Members under contract with ACIA; and (2) for transmission of medical record information to physicians or facilities providing emergency care. Written consent is required for the transmission of the medical record information of a former Member to any physician not connected with ACIA. The extent of medical record information to be released in each instance shall be based upon tests of medical necessity and a "need to know" on the part of the practitioner or facility requesting the information. All release of medical records shall be compliant with 45 CFR Parts 162 and 164. **(SOW §6.1.9.4)**
16. Provider shall offer hours of operation that are no less than the hours of operation offered to commercial members or comparable Medicaid members, if Provider sees only the Medicaid population. Covered Services shall be available twenty-four (24) hours a day, seven (7) days a week, when medically necessary. **(SOW 6.1.9.5)**
17. Upon determination by IDHS of a credible allegation of fraud for which an investigation is pending under the Medicaid program against Provider and upon the approval of the Medicaid Fraud Control Unit (MFCU) and IDHS, ACIA shall suspend all payments to Provider, in compliance with 42 CFR 455.23. ACIA shall issue a notice of payment suspension that comports in all respects with the obligations set forth in 42 CFR 455.23(b) (including notice that payments are being withheld in accordance with 42 CFR 455.23), and shall maintain the suspension for the durational period set forth in 42 CFR 455.23(c). ACIA will afford a grievance process to Provider in the event of payment suspension under this **paragraph 17**. **(SOW §12.7)**
18. Nursing Facility Provisions. **(SOW §6.1.2.1)**

- a. Provider shall promptly notify ACIA of a Member's admission or request for admission to the Provider nursing facility as soon as Provider has knowledge of such admission or request for admission.
- b. Provider shall notify ACIA immediately and consult with the Member's care coordinator if Provider is considering discharging a Member.
- c. Provider shall notify the Member and/or the Member's representative (if applicable) in writing prior to discharge in accordance with State and Federal requirements.
- d. Provider shall be responsible for the collection of any patient liability (also referred to as "client participation") amounts, as such amounts are determined by the State of Iowa. The patient liability amount must be met before reimbursement from ACIA will be available under this Agreement, and ACIA's payment obligations under this Agreement are net of the applicable payment liability amount.
- e. Provider shall notify ACIA 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.
- f. Provider must comply with the federal Preadmission Screening and Resident Review (PASSR) requirements to provide or arrange to provide specialized services, and all applicable Iowa state law governing admission, transfer and discharge policies.
- g. Notwithstanding any other termination provision set forth in **Section 8** of the Agreement, this Agreement shall automatically terminate in accordance with federal requirements in the event Provider is involuntarily decertified by the State or CMS.

19. Home & Community Based Services (HCBS) Providers. (SOW §6.1.2.2)

- a. Provider shall furnish ACIA with at least thirty (30) days' advance written notice when Provider is no longer willing or able to provide services to a Member. Provider will cooperate with the Member's care coordinator to facilitate a seamless transition to another provider.

In the event of a change from Provider to another HCBS provider, regardless of any other provision in this Agreement, Provider shall continue to provide services to the Member in accordance with the Member's plan of care until the Member has been transitioned to a new provider, as determined by ACIA, or as otherwise directed by ACIA, which may exceed the thirty (30)-day notice period.

- b. Provider shall immediately report to the Member's care coordinator any deviations from a Member's service schedule.

- c. Provider shall comply with ACIA's critical incident reporting requirements. Provider's obligations thereunder shall include, at minimum: (1) the reporting of critical incidents to ACIA and other appropriate entities within required timeframes; (2) addressing and responding to critical incidents; (3) documentation of critical incidents; and (4) cooperating with any critical incident investigation by ACIA or an outside agency.
- d. Provider shall comply with all child and dependent adult abuse reporting requirements.

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