Response to Solicitation No: CRFQ 0511 BMS 160000002

March 10, 2016

Submitted To:
April Battle, Boyer
Dept. of Administration, Purchasing Division
2019 Washington Street East
Charleston, WV 25605-0130
CRRQ form and Price Quote

Submitted By:
Mr. Thomas Duncan
Chairman
Trusted Health Plan (District of Columbia), Inc. DBA Trusted Health Plan
Targeted **High Touch Health Plan**

03/10/16 10:04:09
WV Purchasing Division

1	1 CRFQ Form
2	Terms and Conditions
3	Specifications
4	Pricing Page (sealed)
5	HIPPA Business Associate Agreement
6	Purchasing Affidavit
7	2 CRFQ Form
8	Addendum #1Form
9	Addendum #2
10	3 CRFQ
11	Addendum #3
12	4 CRFQ
13	Addendum #4
14	5 CRFQ
15	6 CRFQ
16	Addendum #5
17	Addendum #6
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2019 Washington Street East
Post Office Box 50130
Charleston, WV 25305-0130

State of West Virginia
Request for Quotation
34 — Service - Prof

Proc Folder: 185743

Doc Description: Managed Care Services Request for Quotation

Proc Type: Central Master Agreement

Date Issued	Solicitation Closes	Solicitation No	Version
2016-02-01	2016-03-03 13:30:00	CRFQ 0511 BMS1600000002	1

SHIP RECEIVING LOCATION

BID CLERK
DEPARTMENT OF ADMINISTRATION
PURCHASING DIVISION
2019 WASHINGTON ST E
CHARLESTON WV 25305
US

VENDOR

Vendor Name, Address and Telephone Number:

Trusted Health Plan
1100 New Jersey Ave #840
Washington, DC 20003
202 821-1100 / 202-821-5568

FOR INFORMATION CONTACT THE BUYER

April Battle
(304) 558-0067
april.e.battle@wv.gov

Signature X [signature] **FEIN #** 45-2375150 **DATE** 3/9/2016

All rs subject to all terms and conditions contained in this solicitation

FORM ID : WV-PRC-CRFQ-001

The West Virginia Department of Administration, Purchasing Division (hereinafter referred to as the "Purchasing Division") is soliciting bids pursuant to West Virginia Code Subsection 5A-3-10 for the WV Departmetn of Health and Human Resources, Bureau for Medical Services (hereinafter referred to as the "Agency") to provide contracts to a maximum of the six lowest, responsible vendors meeting requirements for the provision of statewide managed care services for the Mountain Health Trust program. These services include, but are not limited to, administering the following benefits: physical and behavioral health services; establishing and managing a credentialed provider network; utilization management, quality management; member services; financial management; claims management; and maintaining sufficient information systems.

INVOICE TO	SHIP TO
PROCUREMENT OFFICER - 304-356-5052 HEALTH AND HUMAN RESOURCES BUREAU FOR MEDICAL SERVICES 350 CAPITOL ST, RM 251 CHARLESTON WV25301-3709 US	PROCUREMENT OFFICER - 304-356-5052 HEALTH AND HUMAN RESOURCES BUREAU FOR MEDICAL SERVICES 350 CAPITOL ST, RM 251 CHARLESTON WV 25301-3709 US

Line	Comm Ln Desc	Qty	Unit Issue	Unit Price	Total Price
1	Health or hospitalization insurance	0.00000	EA		

Comm Code	Manufacturer	Specification	Model #
84131602			

Extended Description :
See Exhibit A Pricing Page

SCHEDULE OF EVENTS

Line	Event	Event Date
1	Technical Questions	2016-02-16

ADDITIONAL TERMS AND CONDITIONS

See attached document(s) for additional Terms and Conditions

INSTRUCTIONS TO VENDORS SUBMITTING BIDS

1. REVIEW DOCUMENTS THOROUGHLY: The attached documents contain a solicitation for bids. Please read these instructions and all documents attached in their entirety. These instructions provide critical information about requirements that if overlooked could lead to disqualification of a Vendor's bid. All bids must be submitted in accordance with the provisions contained in these instructions and the Solicitation. Failure to do so may result in disqualification of Vendor's bid.

2. MANDATORY TERMS: The Solicitation may contain mandatory provisions identified by the use of the words "must," "will," and "shall." Failure to comply with a mandatory term in the Solicitation will result in bid disqualification.

3. PREBID MEETING: The item identified below shall apply to this Solicitation.

☑ A pre-bid meeting will not be held prior to bid opening

☐ A **NON-MANDATORY PRE-BID** meeting will be held at the following place and time:

☐ A **MANDATORY PRE-BID** meeting will be held at the following place and time:

All Vendors submitting a bid must attend the mandatory pre-bid meeting. Failure to attend the mandatory pre-bid meeting shall result in disqualification of the Vendor's bid. No one person attending the pre-bid meeting may represent more than one Vendor.

An attendance sheet provided at the pre-bid meeting shall serve as the official document verifying attendance. The State will not accept any other form of proof or documentation to verify attendance. Any person attending the pre-bid meeting on behalf of a Vendor must list on the attendance sheet his or her name and the name of the Vendor he or she is representing.

Additionally, the person attending the pre-bid meeting should include the Vendor's E-Mail address, phone number, and Fax number on the attendance sheet. It is the Vendor's responsibility

to locate the attendance sheet and provide the required information. Failure to complete the attendance sheet as required may result in disqualification of Vendor's bid.

All Vendors should arrive prior to the starting time for the pre-bid. Vendors who arrive after the starting time but prior to the end of the pre-bid will be permitted to sign in, but are charged with knowing all matters discussed at the pre-bid.

Questions submitted at least five business days prior to a scheduled pre-bid will be discussed at the pre-bid meeting if possible. Any discussions or answers to questions at the pre-bid meeting are preliminary in nature and are non-binding. Official and binding answers to questions will be published in a written addendum to the Solicitation prior to bid opening.

4. VENDOR QUESTION DEADLINE: Vendors may submit questions relating to this Solicitation to the Purchasing Division. Questions must be submitted in writing. All questions must be submitted on or before the date listed below and to the address listed below in order to be considered. A written response will be published in a Solicitation addendum if a response is possible and appropriate. Non-written discussions, conversations, or questions and answers regarding this Solicitation are preliminary in nature and are nonbinding.

Submitted e-mails should have solicitation number in the subject line.

Question Submission Deadline: February 16, 2016, at 3:00 PM EST

Submit Questions to: April Battle, Buyer 22
2019 Washington Street, East
Charleston, WV 25305
Fax: (304) 558-4115 (Vendors should not use this fax number for bid submission)
Email: april.e.battle@wv.gov

5. VERBAL COMMUNICATION: Any verbal communication between the Vendor and any State personnel is not binding, including verbal communication at the mandatory pre-bid conference. Only information issued in writing and added to the Solicitation by an official written addendum by the Purchasing Division is binding.

6. BID SUBMISSION: All bids must be submitted electronically through wvOASIS or signed and delivered by the Vendor to the Purchasing Division at the address listed below on or before the date and time of the bid opening. Any bid received by the Purchasing Division staff is considered to be in the possession of the Purchasing Division and will not be returned for any reason. The Purchasing Division will not accept bids, modification of bids, or addendum acknowledgment forms via e-mail. Acceptable delivery methods include electronic submission via wvOASIS, hand delivery, delivery by courier, or facsimile.

The bid delivery address is:
Department of Administration, Purchasing Division
2019 Washington Street East
Charleston, WV 25305-0130

A bid that is not submitted electronically through wvOASIS should contain the information listed below on the face of the envelope or the bid may be rejected by the Purchasing Division.:

SEALED BID: Managed Care Services
BUYER: April Battle, Buyer 22
SOLICITATION NO.: CRFQ 0511 BMS1600000002
BID OPENING DATE: March 3, 2016
BID OPENING TIME: 1:30 PM EST
FAX NUMBER: (304) 558-3970

In the event that Vendor is responding to a request for proposal, the Vendor shall submit one original technical and one original cost proposal plus _____ convenience copies of each to the Purchasing Division at the address shown above. Submission of a response to a request for proposal is not permitted in wvOASIS. Additionally, the Vendor should identify the bid type as either a technical or cost proposal on the face of each bid envelope submitted in response to a request for proposal as follows:

BID TYPE: (This only applies to CRFP)
☐ Technical
☐ Cost

7. BID OPENING: Bids submitted in response to this Solicitation will be opened at the location identified below on the date and time listed below. Delivery of a bid after the bid opening date and time will result in bid disqualification. For purposes of this Solicitation, a bid is considered delivered when confirmation of delivery is provided by wvOASIS (in the case of electronic submission) or when the bid is time stamped by the official Purchasing Division time clock (in the case of hand delivery).

Bid Opening Date and Time: March 3, 2016, at 1:30 PM EST

Bid Opening Location: Department of Administration, Purchasing Division
2019 Washington Street East
Charleston, WV 25305-0130

8. ADDENDUM ACKNOWLEDGEMENT: Changes or revisions to this Solicitation will be made by an official written addendum issued by the Purchasing Division. Vendor should acknowledge receipt of all addenda issued with this Solicitation by completing an Addendum Acknowledgment Form, a copy of which is included herewith. Failure to acknowledge addenda may result in bid disqualification. The addendum acknowledgement should be submitted with the bid to expedite document processing.

9. BID FORMATTING: Vendor should type or electronically enter the information onto its bid to prevent errors in the evaluation. Failure to type or electronically enter the information may result in bid disqualification.

10. ALTERNATES: Any model, brand, or specification listed in this Solicitation establishes the acceptable level of quality only and is not intended to reflect a preference for, or in any way favor, a particular brand or vendor. Vendors may bid alternates to a listed model or brand provided that the alternate is at least equal to the model or brand and complies with the required specifications. The equality of any alternate being bid shall be determined by the State at its sole discretion. Any Vendor bidding an alternate model or brand should clearly identify the alternate items in its bid and should include manufacturer's specifications, industry literature, and/or any other relevant documentation demonstrating the equality of the alternate items. Failure to provide information for alternate items may be grounds for rejection of a Vendor's bid.

11. EXCEPTIONS AND CLARIFICATIONS: The Solicitation contains the specifications that shall form the basis of a contractual agreement. Vendor shall clearly mark any exceptions, clarifications, or other proposed modifications in its bid. Exceptions to, clarifications of, or modifications of a requirement or term and condition of the Solicitation may result in bid disqualification.

12. COMMUNICATION LIMITATIONS: In accordance with West Virginia Code of State Rules §148-1-6.6, communication with the State of West Virginia or any of its employees regarding this Solicitation during the solicitation, bid, evaluation or award periods, except through the Purchasing Division, is strictly prohibited without prior Purchasing Division approval. Purchasing Division approval for such communication is implied for all agency delegated and exempt purchases.

13. REGISTRATION: Prior to Contract award, the apparent successful Vendor must be properly registered with the West Virginia Purchasing Division and must have paid the $125 fee, if applicable.

14. UNIT PRICE: Unit prices shall prevail in cases of a discrepancy in the Vendor's bid.

15. PREFERENCE: Vendor Preference may only be granted upon written request and only in accordance with the West Virginia Code § 5A-3-37 and the West Virginia Code of State Rules. A Vendor Preference Certificate form has been attached hereto to allow Vendor to apply for the preference. Vendor's failure to submit the Vendor Preference Certificate form with its bid will result in denial of Vendor Preference. Vendor Preference does not apply to construction projects.

16. SMALL, WOMEN-OWNED, OR MINORITY-OWNED BUSINESSES: For any solicitations publicly advertised for bid, in accordance with West Virginia Code §5A-3-37(a)(7) and W. Va. CSR § 148-22-9, any non-resident vendor certified as a small, women-owned, or minority-owned business under W. Va. CSR § 148-22-9 shall be provided the same preference made available to any resident vendor. Any non-resident small, women-owned, or minority-owned business must identify itself as such in writing, must submit that writing to the Purchasing Division with its bid, and must be properly certified under W. Va. CSR § 148-22-9 prior to contract award to receive the preferences made available to resident vendors. Preference for a non-resident small, women-owned, or minority owned business shall be applied in accordance with W. Va. CSR § 148-22-9.

17. WAIVER OF MINOR IRREGULARITIES: The Director reserves the right to waive minor irregularities in bids or specifications in accordance with West Virginia Code of State Rules § 148-1-4.6.

18. ELECTRONIC FILE ACCESS RESTRICTIONS: Vendor must ensure that its submission in wvOASIS can be accessed by the Purchasing Division staff immediately upon bid opening. The Purchasing Division will consider any file that cannot be immediately opened and/or viewed at the time of the bid opening (such as, encrypted files, password protected files, or incompatible files) to be blank or incomplete as context requires, and are therefore unacceptable. A vendor will not be permitted to unencrypt files, remove password protections, or resubmit documents after bid opening if those documents are required with the bid.

19. NON-RESPONSIBLE: The Purchasing Division Director reserves the right to reject the bid of any vendor as Non-Responsible in accordance with W. Va. Code of State Rules § 148-1-5.3, when the Director determines that the vendor submitting the bid does not have the capability to fully perform, or lacks the integrity and reliability to assure good-faith performance."

20. ACCEPTANCE/REJECTION: The State may accept or reject any bid in whole, or in part in accordance with W. Va. Code of State Rules § 148-1-4.5. and § 148-1-6.4.b."

21. YOUR SUBMISSION IS A PUBLIC DOCUMENT: Vendor's entire response to the Solicitation and the resulting Contract are public documents. As public documents, they will be disclosed to the public following the bid/proposal opening or award of the contract, as required by the competitive bidding laws of West Virginia Code §§ 5A-3-1 et seq., 5-22-1 et seq., and 5G-1-1 et seq. and the Freedom of Information Act West Virginia Code §§ 29B-1-1 et seq.

DO NOT SUBMIT MATERIAL YOU CONSIDER TO BE CONFIDENTIAL, A TRADE SECRET, OR OTHERWISE NOT SUBJECT TO PUBLIC DISCLOSURE.

Submission of any bid, proposal, or other document to the Purchasing Division constitutes your explicit consent to the subsequent public disclosure of the bid, proposal, or document. The Purchasing Division will disclose any document labeled "confidential," "proprietary," "trade secret," "private," or labeled with any other claim against public disclosure of the documents, to

include any "trade secrets" as defined by West Virginia Code § 47-22-1 et seq. All submissions are subject to public disclosure without notice.

GENERAL TERMS AND CONDITIONS:

1. CONTRACTUAL AGREEMENT: Issuance of a Award Document signed by the Purchasing Division Director, or his designee, and approved as to form by the Attorney General's office constitutes acceptance of this Contract made by and between the State of West Virginia and the Vendor. Vendor's signature on its bid signifies Vendor's agreement to be bound by and accept the terms and conditions contained in this Contract.

2. DEFINITIONS: As used in this Solicitation/Contract, the following terms shall have the meanings attributed to them below. Additional definitions may be found in the specifications included with this Solicitation/Contract.

2.1. "Agency" or "Agencies" means the agency, board, commission, or other entity of the State of West Virginia that is identified on the first page of the Solicitation or any other public entity seeking to procure goods or services under this Contract.

2.2. "Bid" or "Proposal" means the vendors submitted response to this solicitation.

2.3. "Contract" means the binding agreement that is entered into between the State and the Vendor to provide the goods or services requested in the Solicitation.

2.4. "Director" means the Director of the West Virginia Department of Administration, Purchasing Division.

2.5. "Purchasing Division" means the West Virginia Department of Administration, Purchasing Division.

2.6. "Award Document" means the document signed by the Agency and the Purchasing Division, and approved as to form by the Attorney General, that identifies the Vendor as the contract holder.

2.7. "Solicitation" means the official notice of an opportunity to supply the State with goods or services that is published by the Purchasing Division.

2.8. "State" means the State of West Virginia and/or any of its agencies, commissions, boards, etc. as context requires.

2.9. "Vendor" or "Vendors" means any entity submitting a bid in response to the Solicitation, the entity that has been selected as the lowest responsible bidder, or the entity that has been awarded the Contract as context requires.

3. CONTRACT TERM; RENEWAL; EXTENSION: The term of this Contract shall be determined in accordance with the category that has been identified as applicable to this Contract below:

☑ **Term Contract**

Initial Contract Term: This Contract becomes effective on award and extends for a period of one (1) year(s).

Renewal Term: This Contract may be renewed upon the mutual written consent of the Agency, and the Vendor, with approval of the Purchasing Division and the Attorney General's office (Attorney General approval is as to form only). Any request for renewal should be submitted to the Purchasing Division thirty (30) days prior to the expiration date of the initial contract term or appropriate renewal term. A Contract renewal shall be in accordance with the terms and conditions of the original contract. Renewal of this Contract is limited to three (3) successive one (1) year periods or multiple renewal periods of less than one year, provided that the multiple renewal periods do not exceed thirty-six (36) months in total. Automatic renewal of this Contract is prohibited. Notwithstanding the foregoing, Purchasing Division approval is not required on agency delegated or exempt purchases. Attorney General approval may be required for vendor terms and conditions.

Delivery Order Limitations: In the event that this contract permits delivery orders, a delivery order may only be issued during the time this Contract is in effect. Any delivery order issued within one year of the expiration of this Contract shall be effective for one year from the date the delivery order is issued. No delivery order may be extended beyond one year after this Contract has expired.

☐ **Fixed Period Contract:** This Contract becomes effective upon Vendor's receipt of the notice to proceed and must be completed within _____ days.

☐ **Fixed Period Contract with Renewals:** This Contract becomes effective upon Vendor's receipt of the notice to proceed and part of the Contract more fully described in the attached specifications must be completed within _____ days.

Upon completion, the vendor agrees that maintenance, monitoring, or warranty services will be provided for one year thereafter with an additional _____ successive one year renewal periods or multiple renewal periods of less than one year provided that the multiple renewal periods do not exceed _____ months in total. Automatic renewal of this Contract is prohibited.

☐ **One Time Purchase:** The term of this Contract shall run from the issuance of the Award Document until all of the goods contracted for have been delivered, but in no event will this Contract extend for more than one fiscal year.

☐ **Other:** See attached.

4. NOTICE TO PROCEED: Vendor shall begin performance of this Contract immediately upon receiving notice to proceed unless otherwise instructed by the Agency. Unless otherwise specified, the fully executed Award Document will be considered notice to proceed.

5. QUANTITIES: The quantities required under this Contract shall be determined in accordance with the category that has been identified as applicable to this Contract below.

☐ **Open End Contract:** Quantities listed in this Solicitation are approximations only, based on estimates supplied by the Agency. It is understood and agreed that the Contract shall cover the quantities actually ordered for delivery during the term of the Contract, whether more or less than the quantities shown.

☑ **Service:** The scope of the service to be provided will be more clearly defined in the specifications included herewith.

☐ **Combined Service and Goods:** The scope of the service and deliverable goods to be provided will be more clearly defined in the specifications included herewith.

☐ **One Time Purchase:** This Contract is for the purchase of a set quantity of goods that are identified in the specifications included herewith. Once those items have been delivered, no additional goods may be procured under this Contract without an appropriate change order approved by the Vendor, Agency, Purchasing Division, and Attorney General's office.

6. PRICING: The pricing set forth herein is firm for the life of the Contract, unless specified elsewhere within this Solicitation/Contract by the State. A Vendor's inclusion of price adjustment provisions in its bid, without an express authorization from the State in the Solicitation to do so, may result in bid disqualification.

7. EMERGENCY PURCHASES: The Purchasing Division Director may authorize the Agency to purchase goods or services in the open market that Vendor would otherwise provide under this Contract if those goods or services are for immediate or expedited delivery in an emergency. Emergencies shall include, but are not limited to, delays in transportation or an unanticipated increase in the volume of work. An emergency purchase in the open market, approved by the Purchasing Division Director, shall not constitute of breach of this Contract and shall not entitle the Vendor to any form of compensation or damages. This provision does not excuse the State from fulfilling its obligations under a One Time Purchase contract.

8. REQUIRED DOCUMENTS: All of the items checked below must be provided to the Purchasing Division by the Vendor as specified below.

☐ **BID BOND:** All Vendors shall furnish a bid bond in the amount of five percent (5%) of the total amount of the bid protecting the State of West Virginia. The bid bond must be submitted with the bid.

☐ **PERFORMANCE BOND:** The apparent successful Vendor shall provide a performance bond in the amount of _____. The performance bond must be received by the Purchasing Division prior to Contract award. On construction contracts, the performance bond must be 100% of the Contract value.

☐ **LABOR/MATERIAL PAYMENT BOND:** The apparent successful Vendor shall provide a labor/material payment bond in the amount of 100% of the Contract value. The labor/material payment bond must be delivered to the Purchasing Division prior to Contract award.
In lieu of the Bid Bond, Performance Bond, and Labor/Material Payment Bond, the Vendor may provide certified checks, cashier's checks, or irrevocable letters of credit. Any certified check, cashier's check, or irrevocable letter of credit provided in lieu of a bond must be of the same amount and delivered on the same schedule as the bond it replaces. A letter of credit submitted in lieu of a performance and labor/material payment bond will only be allowed for projects under $100,000. Personal or business checks are not acceptable.

☐ **MAINTENANCE BOND:** The apparent successful Vendor shall provide a two (2) year maintenance bond covering the roofing system. The maintenance bond must be issued and delivered to the Purchasing Division prior to Contract award.

☑ **INSURANCE:** The apparent successful Vendor shall furnish proof of the following insurance prior to Contract award and shall list the state as a certificate holder:

☑ **Commercial General Liability Insurance:** In the amount of $1,000,000.00 _____ or more.

☐ **Builders Risk Insurance:** In an amount equal to 100% of the amount of the Contract.

☑ Professional Liability $1,000,000.00 or more per occurrence.

☐

☐

☐

☐

The apparent successful Vendor shall also furnish proof of any additional insurance requirements contained in the specifications prior to Contract award regardless of whether or not that insurance requirement is listed above.

☑ **LICENSE(S) / CERTIFICATIONS / PERMITS:** In addition to anything required under the Section entitled Licensing, of the General Terms and Conditions, the apparent successful Vendor shall furnish proof of the following licenses, certifications, and/or permits prior to Contract award, in a form acceptable to the Purchasing Division.

☑ Certificate of Authority

☑ National Committee for Quality Assurance

☐

☐

The apparent successful Vendor shall also furnish proof of any additional licenses or certifications contained in the specifications prior to Contract award regardless of whether or not that requirement is listed above.

9. WORKERS' COMPENSATION INSURANCE: The apparent successful Vendor shall comply with laws relating to workers compensation, shall maintain workers' compensation insurance when required, and shall furnish proof of workers' compensation insurance upon request.

10. LITIGATION BOND: The Director reserves the right to require any Vendor that files a protest of an award to submit a litigation bond in the amount equal to one percent of the lowest bid submitted or $5,000, whichever is greater. The entire amount of the bond shall be forfeited if the hearing officer determines that the protest was filed for frivolous or improper purpose, including but not limited to, the purpose of harassing, causing unnecessary delay, or needless expense for the Agency. All litigation bonds shall be made payable to the Purchasing Division. In lieu of a bond, the protester may submit a cashier's check or certified check payable to the Purchasing Division. Cashier's or certified checks will be deposited with and held by the State Treasurer's office. If it is determined that the protest has not been filed for frivolous or improper purpose, the bond or deposit shall be returned in its entirety.

11. LIQUIDATED DAMAGES: Vendor shall pay liquidated damages in the amount of see Exhibit D Service Level Agreements for failure to meet service level agreements as specified.

This clause shall in no way be considered exclusive and shall not limit the State or Agency's right to pursue any other available remedy.

12. ACCEPTANCE: Vendor's signature on its bid, or on the certification and signature page, constitutes an offer to the State that cannot be unilaterally withdrawn, signifies that the product or service proposed by vendor meets the mandatory requirements contained in the Solicitation for that product or service, unless otherwise indicated, and signifies acceptance of the terms and conditions contained in the Solicitation unless otherwise indicated.

13. FUNDING: This Contract shall continue for the term stated herein, contingent upon funds being appropriated by the Legislature or otherwise being made available. In the event funds are not appropriated or otherwise made available, this Contract becomes void and of no effect beginning on July 1 of the fiscal year for which funding has not been appropriated or otherwise made available.

14. PAYMENT: Payment in advance is prohibited under this Contract. Payment may only be made after the delivery and acceptance of goods or services. The Vendor shall submit invoices, in arrears.

15. TAXES: The Vendor shall pay any applicable sales, use, personal property or any other taxes arising out of this Contract and the transactions contemplated thereby. The State of West Virginia is exempt from federal and state taxes and will not pay or reimburse such taxes.

16. CANCELLATION: The Purchasing Division Director reserves the right to cancel this Contract immediately upon written notice to the vendor if the materials or workmanship supplied do not conform to the specifications contained in the Contract. The Purchasing Division Director may also cancel any purchase or Contract upon 30 days written notice to the Vendor in accordance with West Virginia Code of State Rules §§ 148-1-6.1.e.

17. TIME: Time is of the essence with regard to all matters of time and performance in this Contract.

18. APPLICABLE LAW: This Contract is governed by and interpreted under West Virginia law without giving effect to its choice of law principles. Any information provided in specification manuals, or any other source, verbal or written, which contradicts or violates the West Virginia Constitution, West Virginia Code or West Virginia Code of State Rules is void and of no effect.

19. COMPLIANCE: Vendor shall comply with all applicable federal, state, and local laws, regulations and ordinances. By submitting a bid, Vendor acknowledges that it has reviewed, understands, and will comply with all applicable laws, regulations, and ordinances.

20. PREVAILING WAGE: Vendor shall be responsible for ensuring compliance with prevailing wage requirements and determining when prevailing wage requirements are applicable.

21. ARBITRATION: Any references made to arbitration contained in this Contract, Vendor's bid, or in any American Institute of Architects documents pertaining to this Contract are hereby deleted, void, and of no effect.

22. MODIFICATIONS: This writing is the parties' final expression of intent. Notwithstanding anything contained in this Contract to the contrary no modification of this Contract shall be binding without mutual written consent of the Agency, and the Vendor, with approval of the Purchasing Division and the Attorney General's office (Attorney General approval is as to form only). Any change to existing contracts that adds work or changes contract cost, and were not included in the original contract, must be approved by the Purchasing Division and the Attorney General's Office (as to form) prior to the implementation of the change or commencement of work affected by the change.

23. WAIVER: The failure of either party to insist upon a strict performance of any of the terms or provision of this Contract, or to exercise any option, right, or remedy herein contained, shall not be construed as a waiver or a relinquishment for the future of such term, provision, option, right, or remedy, but the same shall continue in full force and effect. Any waiver must be expressly stated in writing and signed by the waiving party.

24. SUBSEQUENT FORMS: The terms and conditions contained in this Contract shall supersede any and all subsequent terms and conditions which may appear on any form documents submitted by Vendor to the Agency or Purchasing Division such as price lists, order forms, invoices, sales agreements, or maintenance agreements, and includes internet websites or other electronic documents. Acceptance or use of Vendor's forms does not constitute acceptance of the terms and conditions contained thereon.

25. ASSIGNMENT: Neither this Contract nor any monies due, or to become due hereunder, may be assigned by the Vendor without the express written consent of the Agency, the Purchasing Division, the Attorney General's office (as to form only), and any other government agency or office that may be required to approve such assignments. Notwithstanding the foregoing, Purchasing Division approval may or may not be required on certain agency delegated or exempt purchases.

26. WARRANTY: The Vendor expressly warrants that the goods and/or services covered by this Contract will: (a) conform to the specifications, drawings, samples, or other description furnished or specified by the Agency; (b) be merchantable and fit for the purpose intended; and (c) be free from defect in material and workmanship.

27. STATE EMPLOYEES: State employees are not permitted to utilize this Contract for personal use and the Vendor is prohibited from permitting or facilitating the same.

28. BANKRUPTCY: In the event the Vendor files for bankruptcy protection, the State of West Virginia may deem this Contract null and void, and terminate this Contract without notice.

29. PRIVACY, SECURITY, AND CONFIDENTIALITY: The Vendor agrees that it will not disclose to anyone, directly or indirectly, any such personally identifiable information or other confidential information gained from the Agency, unless the individual who is the subject of the information consents to the disclosure in writing or the disclosure is made pursuant to the Agency's policies, procedures, and rules. Vendor further agrees to comply with the Confidentiality Policies and Information Security Accountability Requirements, set forth in http://www.state.wv.us/admin/purchase/privacy/default.html.

30. YOUR SUBMISSION IS A PUBLIC DOCUMENT: Vendor's entire response to the Solicitation and the resulting Contract are public documents. As public documents, they will be disclosed to the public following the bid/proposal opening or award of the contract, as required by the competitive bidding laws of West Virginia Code §§ 5A-3-1 et seq., 5-22-1 et seq., and 5G-1-1 et seq. and the Freedom of Information Act West Virginia Code §§ 29B-1-1 et seq.

DO NOT SUBMIT MATERIAL YOU CONSIDER TO BE CONFIDENTIAL, A TRADE SECRET, OR OTHERWISE NOT SUBJECT TO PUBLIC DISCLOSURE.

Submission of any bid, proposal, or other document to the Purchasing Division constitutes your explicit consent to the subsequent public disclosure of the bid, proposal, or document. The Purchasing Division will disclose any document labeled "confidential," "proprietary," "trade secret," "private," or labeled with any other claim against public disclosure of the documents, to include any "trade secrets" as defined by West Virginia Code § 47-22-1 et seq. All submissions are subject to public disclosure without notice.

31. LICENSING: In accordance with West Virginia Code of State Rules § 148-1-6.1.e, Vendor must be licensed and in good standing in accordance with any and all state and local laws and requirements by any state or local agency of West Virginia, including, but not limited to, the West Virginia Secretary of State's Office, the West Virginia Tax Department, West Virginia Insurance Commission, or any other state agency or political subdivision. Upon request, the Vendor must provide all necessary releases to obtain information to enable the Purchasing Division Director or the Agency to verify that the Vendor is licensed and in good standing with the above entities.

32. ANTITRUST: In submitting a bid to, signing a contract with, or accepting a Award Document from any agency of the State of West Virginia, the Vendor agrees to convey, sell, assign, or transfer to the State of West Virginia all rights, title, and interest in and to all causes of action it may now or hereafter acquire under the antitrust laws of the United States and the State of West Virginia for price fixing and/or unreasonable restraints of trade relating to the particular commodities or services purchased or acquired by the State of West Virginia. Such assignment shall be made and become effective at the time the purchasing agency tenders the initial payment to Vendor.

33. VENDOR CERTIFICATIONS: By signing its bid or entering into this Contract, Vendor certifies (1) that its bid or offer was made without prior understanding, agreement, or connection with any corporation, firm, limited liability company, partnership, person or entity submitting a bid or offer for the same material, supplies, equipment or services; (2) that its bid or offer is in all respects fair and without collusion or fraud; (3) that this Contract is accepted or entered into without any prior understanding, agreement, or connection to any other entity that could be considered a violation of law; and (4) that it has reviewed this Solicitation in its entirety; understands the requirements, terms and conditions, and other information contained herein.

Vendor's signature on its bid or offer also affirms that neither it nor its representatives have any interest, nor shall acquire any interest, direct or indirect, which would compromise the performance of its services hereunder. Any such interests shall be promptly presented in detail to the Agency. The individual signing this bid or offer on behalf of Vendor certifies that he or she is authorized by the Vendor to execute this bid or offer or any documents related thereto on Vendor's behalf; that he or she is authorized to bind the Vendor in a contractual relationship; and that, to the best of his or her knowledge, the Vendor has properly registered with any State agency that may require registration.

34. PURCHASING CARD ACCEPTANCE: The State of West Virginia currently utilizes a Purchasing Card program, administered under contract by a banking institution, to process payment for goods and services. The Vendor must accept the State of West Virginia's Purchasing Card for payment of all orders under this Contract unless the box below is checked.

☐ Vendor is not required to accept the State of West Virginia's Purchasing Card as payment for all goods and services.

35. VENDOR RELATIONSHIP: The relationship of the Vendor to the State shall be that of an independent contractor and no principal-agent relationship or employer-employee relationship is contemplated or created by this Contract. The Vendor as an independent contractor is solely liable for the acts and omissions of its employees and agents. Vendor shall be responsible for selecting, supervising, and compensating any and all individuals employed pursuant to the terms of this Solicitation and resulting contract. Neither the Vendor, nor any employees or subcontractors of the Vendor, shall be deemed to be employees of the State for any purpose whatsoever. Vendor shall be exclusively responsible for payment of employees and contractors for all wages and salaries, taxes, withholding payments, penalties, fees, fringe benefits, professional liability insurance premiums, contributions to insurance and pension, or other deferred compensation plans, including but not limited to, Workers' Compensation and Social Security obligations, licensing fees, etc. and the filing of all necessary documents, forms, and returns pertinent to all of the foregoing.

Vendor shall hold harmless the State, and shall provide the State and Agency with a defense against any and all claims including, but not limited to, the foregoing payments, withholdings, contributions, taxes, Social Security taxes, and employer income tax returns.

36. INDEMNIFICATION: The Vendor agrees to indemnify, defend, and hold harmless the State and the Agency, their officers, and employees from and against: (1) Any claims or losses for services rendered by any subcontractor, person, or firm performing or supplying services, materials, or supplies in connection with the performance of the Contract; (2) Any claims or losses resulting to any person or entity injured or damaged by the Vendor, its officers, employees, or subcontractors by the publication, translation, reproduction, delivery, performance, use, or disposition of any data used under the Contract in a manner not authorized by the Contract, or by Federal or State statutes or regulations; and (3) Any failure of the Vendor, its officers, employees, or subcontractors to observe State and Federal laws including, but not limited to, labor and wage and hour laws.

37. PURCHASING AFFIDAVIT: In accordance with West Virginia Code § 5A-3-10a, all Vendors are required to sign, notarize, and submit the Purchasing Affidavit stating that neither the Vendor nor a related party owe a debt to the State in excess of $1,000. The affidavit must be submitted prior to award, but should be submitted with the Vendor's bid. A copy of the Purchasing Affidavit is included herewith.

38. ADDITIONAL AGENCY AND LOCAL GOVERNMENT USE: This Contract may be utilized by other agencies, spending units, and political subdivisions of the State of West Virginia; county, municipal, and other local government bodies; and school districts ("Other Government Entities"). Any extension of this Contract to the aforementioned Other Government Entities must be on the same prices, terms, and conditions as those offered and agreed to in this Contract, provided that such extension is in compliance with the applicable laws, rules, and ordinances of the Other Government Entity. If the Vendor does not wish to extend the prices, terms, and conditions of its bid and subsequent contract to the Other Government Entities, the Vendor must clearly indicate such refusal in its bid. A refusal to extend this Contract to the Other Government Entities shall not impact or influence the award of this Contract in any manner.

39. CONFLICT OF INTEREST: Vendor, its officers or members or employees, shall not presently have or acquire an interest, direct or indirect, which would conflict with or compromise the performance of its obligations hereunder. Vendor shall periodically inquire of its officers, members and employees to ensure that a conflict of interest does not arise. Any conflict of interest discovered shall be promptly presented in detail to the Agency.

40. REPORTS: Vendor shall provide the Agency and/or the Purchasing Division with the following reports identified by a checked box below:

☑ Such reports as the Agency and/or the Purchasing Division may request. Requested reports may include, but are not limited to, quantities purchased, agencies utilizing the contract, total contract expenditures by agency, etc.

☐ Quarterly reports detailing the total quantity of purchases in units and dollars, along with a listing of purchases by agency. Quarterly reports should be delivered to the Purchasing Division via email at purchasing.requisitions@wv.gov.

41. BACKGROUND CHECK: In accordance with W. Va. Code § 15-2D-3, the Director of the Division of Protective Services shall require any service provider whose employees are regularly employed on the grounds or in the buildings of the Capitol complex or who have access to sensitive or critical information to submit to a fingerprint-based state and federal background inquiry through the state repository. The service provider is responsible for any costs associated with the fingerprint-based state and federal background inquiry.

After the contract for such services has been approved, but before any such employees are permitted to be on the grounds or in the buildings of the Capitol complex or have access to sensitive or critical information, the service provider shall submit a list of all persons who will be physically present and working at the Capitol complex to the Director of the Division of Protective Services for purposes of verifying compliance with this provision. The State reserves the right to prohibit a service provider's employees from accessing sensitive or critical information or to be present at the Capitol complex based upon results addressed from a criminal background check.

Service providers should contact the West Virginia Division of Protective Services by phone at (304) 558-9911 for more information.

42. PREFERENCE FOR USE OF DOMESTIC STEEL PRODUCTS: Except when authorized by the Director of the Purchasing Division pursuant to W. Va. Code § 5A-3-56, no contractor may use or supply steel products for a State Contract Project other than those steel products made in the United States. A contractor who uses steel products in violation of this section may be subject to civil penalties pursuant to W. Va. Code § 5A-3-56. As used in this section:

a. "State Contract Project" means any erection or construction of, or any addition to, alteration of or other improvement to any building or structure, including, but not limited to, roads or highways, or the installation of any heating or cooling or ventilating plants or other equipment, or the supply of and materials for such projects, pursuant to a contract with the State of West Virginia for which bids were solicited on or after June 6, 2001.
b. "Steel Products" means products rolled, formed, shaped, drawn, extruded, forged, cast, fabricated or otherwise similarly processed, or processed by a combination of two or more or such operations, from steel made by the open heath, basic oxygen, electric furnace, Bessemer or other steel making process. The Purchasing Division Director may, in writing, authorize the use of foreign steel products if:
c. The cost for each contract item used does not exceed one tenth of one percent (.1%) of the total contract cost or two thousand five hundred dollars ($2,500.00), whichever is greater. For the purposes of this section, the cost is the value of the steel product as delivered to the project; or
d. The Director of the Purchasing Division determines that specified steel materials are not produced in the United States in sufficient quantity or otherwise are not reasonably available to meet contract requirements.

43. PREFERENCE FOR USE OF DOMESTIC ALUMINUM, GLASS, AND STEEL: In Accordance with W. Va. Code § 5-19-1 et seq., and W. Va. CSR § 148-10-1 et seq., for every contract or subcontract, subject to the limitations contained herein, for the construction, reconstruction, alteration, repair, improvement or maintenance of public works or for the purchase of any item of machinery or equipment to be used at sites of public works, only domestic aluminum, glass or steel products shall be supplied unless the spending officer determines, in writing, after the receipt of offers or bids, (1) that the cost of domestic aluminum, glass or steel products is unreasonable or inconsistent with the public interest of the State of West Virginia, (2) that domestic aluminum, glass or steel products are not produced in sufficient quantities to meet the contract requirements, or (3) the available domestic aluminum, glass, or steel do not meet the contract specifications. This provision only applies to public works contracts awarded in an amount more than fifty thousand dollars ($50,000) or public works contracts that require more than ten thousand pounds of steel products.

The cost of domestic aluminum, glass, or steel products may be unreasonable if the cost is more than twenty percent (20%) of the bid or offered price for foreign made aluminum, glass, or steel products. If the domestic aluminum, glass or steel products to be supplied or produced in a "substantial labor surplus area", as defined by the United States Department of Labor, the cost of domestic aluminum, glass, or steel products may be unreasonable if the cost is more than thirty percent (30%) of the bid or offered price for foreign made aluminum, glass, or steel products. This preference shall be applied to an item of machinery or equipment, as indicated above, when the item is a single unit of equipment or machinery manufactured primarily of aluminum, glass or steel, is part of a public works contract and has the sole purpose or of being a permanent part of a single public works project. This provision does not apply to equipment or machinery purchased by a spending unit for use by that spending unit and not as part of a single public works project.

All bids and offers including domestic aluminum, glass or steel products that exceed bid or offer prices including foreign aluminum, glass or steel products after application of the preferences provided in this provision may be reduced to a price equal to or lower than the lowest bid or offer price for foreign aluminum, glass or steel products plus the applicable preference. If the reduced bid or offer prices are made in writing and supersede the prior bid or offer prices, all bids or offers, including the reduced bid or offer prices, will be reevaluated in accordance with this rule.

CERTIFICATIONAND SIGNATURE PAGE

By signing below, or submitting documentation through wvOASIS, I certify that I have reviewed this Solicitation in its entirety; that I understand the requirements, terms and conditions, and other information contained herein; that this bid, offer or proposal constitutes an offer to the State that cannot be unilaterally withdrawn; that the product or service proposed meets the mandatory requirements contained in the Solicitation for that product or service, unless otherwise stated herein; that the Vendor accepts the terms and conditions contained in the Solicitation, unless otherwise stated herein; that I am submitting this bid, offer or proposal for review and consideration; that I am authorized by the vendor to execute and submit this bid, offer, or proposal, or any documents related thereto on vendor's behalf; that I am authorized to bind the vendor in a contractual relationship; and that to the best of my knowledge, the vendor has properly registered with any State agency that may require registration.

Trusted Health Plan
(Company)

Thom: Dunn CEO
(Authorized Signature) (Representative Name, Title)

202 821 5568 / 202821-1098 March 9, 2016
(Phone Number) (Fax Number) (Date)

SPECIFICATIONS

1. **PURPOSE AND SCOPE:** The West Virginia Department of Administration, Purchasing Division (hereinafter referred to as the "Purchasing Division") is soliciting bids pursuant to **West Virginia Code** §5A-3-10 for the WV Department of Health and Human Resources, Bureau for Medical Services (hereinafter referred to as the "Agency") to provide contracts to a maximum of the six lowest, responsible vendors meeting requirements for the provision of statewide managed care services for the Mountain Health Trust program. These services include, but are not limited to, administering the following benefits: physical and behavioral health services; establishing and managing a credentialed provider network; utilization management; quality management; member services; financial management; claims management; and maintaining sufficient information systems.

   Exhibit B: Service Provider Agreement Model (hereinafter referred as "SPA"), has been attached to provide overall guidance in responding to this Request for Quotation. The contractual terms and/or rates outlined in this Agreement are subject to change based upon state or federal mandates and regulations, waiver modifications, or State Plan modifications. The State Fiscal Year (SFY) 2017 contract, July 1, 2016 – June 30, 2017 will be issued to winning vendors for signature upon completion of the best and final offer (BAFO) process, under Sec. 5A-3-11b of the State Purchasing Code. Vendors will be expected to participate in good faith. The State will be adding the SSI population and personal care benefit under the SFY2017 contract. Rate information on this addition will be available as part of the BAFO process.

   The best and final offers must be received in the manner specified by the DOA Purchasing Division. If a best and final offer is not submitted, the previous submittal will be construed as the best and final offer and may be subject to disqualification if not within the actuarially sound rate ranges. BAFO solicitations must be prepared in the same number of copies and packaged and submitted according to the same instructions that apply to the initial bid submission. Final ranking of responses and award of the contracts will be made after the DHHR reviews all bids.

   This solicitation may be funded in whole or in part with federal funds and thus this solicitation and its resulting awarded contract are subject to the requirements of Attachment 1: Provisions Required for Federally Funded Procurements.

2. **DEFINITIONS:** The terms listed below shall have the meanings assigned to them below. Additional definitions can be found in section 2 of the General Terms and Conditions.

   2.1 DHHR: Department of Health and Human Resources

   2.2 BMS: Bureau for Medical Services

2.3 FFS: Fee-for-Service

2.4 MCO: Managed Care Organization; entity responsible for management of Medicaid individuals not under Fee-For-Service Medicaid

2.5 MHT: Mountain Health Trust; the name of the Managed Care Program in WV

2.6 NCQA: National Committee for Quality Assurance

2.7 PMPM: Per Member Per Month

2.8 HEDIS: Healthcare Effectiveness Data and Information Set

2.9 SSI: Supplemental Security Income

Additional definitions that relate to the WV Medicaid Managed Care Program are outlined in Exhibit B.

3. **QUALIFICATIONS:** Vendor, or Vendor's staff if requirements are inherently limited to individuals rather than corporate entities, shall have the following minimum qualifications:

3.1 At a minimum, the vendor shall meet the staffing requirements as outlined in the MHT Application, Exhibit D.

3.2 The vendor shall inform the State agency in writing within seven (7) calendar days of staffing changes in any key positions. The vendor shall fill vacancies in any key position identified within Exhibit D within ninety (90) calendar days of the departure of the former staff. The agency shall have the right to participate in the selection process and approve or disapprove the assignment of any key staff positions.

3.3 At least one key staff member shall be available during BMS hours of operation (8am to 5pm EST/EDT Monday-Friday) and available for in-person or video conferencing meetings upon request.

4. **MANDATORY REQUIREMENTS:** The mandatory requirements set forth below must be met by the vendor to be a qualifying applicant for this solicitation. Failure on the part of the vendor to meet any of the mandatory specifications shall result in the disqualification of the bid. Any exceptions, which shall result in disqualification shall be expressly stated in the vendor's bid. By signing their bid the vendor affirms that it will:

4.1Comply with all applicable requirements outlined in the Service Provider Agreement and any modifications pursuant to changes to State policy, state or federal laws and regulations, waiver amendments, or State Plan amendments.

4.2 Be in compliance with 42 CFR 455.104, Disclosure by Medicaid Providers and Fiscal Agents: Information on Ownership and Control.

4.3 Have met the Certificate of Authority (COA) requirements as outlined by the WV Offices of the Insurance Commissioner and be in good standing in the State of WV. The vendor shall provide a copy of its COA prior to award.

4.4 Be responsible for the care/case management of the Medicaid SSI population upon integration during the SFY 2017 contract period, including meeting any revised network standards required.

4.5 Meet all reporting requirements as defined by the WV Bureau for Medical Services and outlined in the Service Provider Agreement.

4.6 Cover all counties in which network adequacy standards are met. Vendors shall be required to bid on all regions in Exhibit A, but are not subject to participate in all counties dependent upon network.

4.7 Be a National Committee for Quality Assurance (NCQA)-accredited entity and remain so for the duration of the contract or be in the process of becoming an NCQA-accredited entity within the timeframes outlined in Service Provider Agreement, Exhibit B.

4.8 Prior to award, provide an organizational chart outlining its internal organizational structure for this project, as well as any subcontractors.

4.9 Complete, if not already on file, the MHT MCO Application prior to contract award. The issuance of a contract shall be dependent upon the receipt of the MHT MCO Application by the Department of Administration, Purchasing Division, upon review and approval by the WV Bureau for Medical Services. See Exhibit D. Completed MHT MCO Application should be submitted with vendor bid, but will be required prior to award.

4.10 Agree to provide the covered services as outlined in Exhibit B, the Service Provider Agreement.

4.11 Agree to performance evaluations and agency implemented corrective action plans as necessary and defined by the agency, and agree to the contractual Service Levels developed by the agency, outlined in Exhibit E.

4.12 Honor any pre-established prior authorization obtained under Fee-For-Service (FFS) Medicaid or by another MCO until the end of the authorization period or until medical necessity has been met, and ensure continuity of care is not disrupted.

4.13 Establish provider networks that are capable of the full array of services as outlined in the Service Provider Agreement.

4.14 Assign a Primary Care Provider (PCP) to each member in the event an individual does not already have an established provider relationship.

4.15 Agree to the marketing regulations as outlined in Exhibit B, the Service Provider Agreement, and submit all materials to BMS for review prior to issuance of the marketing materials.

4.16 Maintain a Provider Services Department and operate a toll-free provider phone line from 8am to 5pm EST/EDT, Monday – Friday, minimum. Vendor is permitted to be closed on New Year's Day, Independence Day, Thanksgiving Day, and Christmas Day, and may request alternate hours for other holidays to be reviewed by BMS for authorization.

4.17 Be responsible for reimbursing providers the full amount of directed payment dollars provided by the Bureau upon calculation using the Bureau's directed payment methodology. This amount will be added to the contracted rate and administered as a pass-through payment to the appropriate medical facility.

4.18 Maintain a Member Services Department to assist members in obtaining Medicaid-covered services, and operate a toll-free number from 8am to 5pm EST/EDT, Monday – Friday, minimum. Vendor is permitted to be closed on New Year's Day, Independence Day, Thanksgiving Day, and Christmas Day, and may request alternate hours for other holidays to be reviewed by BMS for authorization.

4.19 Develop member ID cards, a member handbook, provider handbook, provider directory and website, as well as any other materials as requested by the Bureau as outlined in Exhibit B, the Service Provider Agreement.

4.20 Be responsible for submitting complete and accurate encounter data for all services rendered that fall within the defined benefit package to the State's Medicaid Management Information System. Complete and accurate encounter data must be submitted monthly and no later than 30 calendar days after the end of the period in which the service was paid. Encounter data must follow the format and data elements as required by the Health Insurance Portability and Accountability Act (HIPAA)-compliant 837 transaction for medical and dental claims, and D.0

transaction for pharmacy claims. The vendor shall sign the Business Associate Agreement, Exhibit F, prior to contract award.

4.21 Develop and implement written policies for an ongoing quality assessment and performance improvement program (QAPI) for services rendered.

4.22 Be subject to Service Levels as outlined in Exhibit E for failure to perform. The liquated damages, once assessed, cannot be recovered by the vendor.

5. CONTRACT AWARD:

5.1 Contract Award: The Contract is intended to provide the Department of Health and Human Resources, and the Bureau for Medical Services, with a purchase price for Managed Care Services. The Contract shall be awarded to a maximum of six responsible vendors meeting requirements for the lowest overall total cost as shown on the Pricing Pages.

The State will conduct discussions with, and obtain best and final offers (BAFO) from, responsive and responsible bidders who submit quotations determined to be reasonably susceptible of being selected for award for the purpose of clarification to assure full understanding of, and responsiveness to, the solicitation requirements in accordance with West Virginia Code Sec. 5A-3-11b.

Exhibit B: Service Provider Agreement Model (hereinafter referred as "SPA"), has been attached to provide overall guidance in responding to this Request for Quotation. The contractual terms and/or rates outlined in this Agreement are subject to change based upon state or federal mandates and regulations, waiver modifications, or State Plan modifications. The State Fiscal Year (SFY) 2017 contract, July 1, 2016 – June 30, 2017 will be issued to winning vendors for signature upon completion of the best and final offer (BAFO) process, under Sec. 5A-3-11b of the State Purchasing Code. Vendors will be expected to participate in good faith. The State will be adding the SSI population and personal care benefit under the SFY2017 contract. Rate information on this addition will be available as part of the BAFO process.

The State will adjust both price and contractual terms for State Fiscal Year 2017 (July 1, 2016-June 30, 2017) based upon updated information that will be available to the State in the first quarter of calendar year 2016. Rates will be developed based upon actuarial review, as defined under 42 CFR 438.6.

For future year contract renewal periods, the amount bid for each population cohort shall remain the same unless falling outside of the actuarially developed rate range for the new fiscal year. In the event the rate is no longer within the rate range, the Department shall adjust rates to the lowest actuarially sound rate per rate cell, as deemed by independent actuarial review, pursuant to applicable policies pertaining to 5% retainage.

Additionally, rates shall be subject to an annual directed payment adjustment. The adjustment will be an add-on to the contracted rate and will serve as a pass-through to participating directed payment entities. The MCO shall not retain any amount provided as directed payment. The Department reserves the right to adjust rates based on directed payment percentage changes.

5.2 Pricing Page: Vendor should complete the Pricing Page by completing Exhibit A. Vendor should complete the Pricing Page in full as failure to complete the Pricing Page in its entirety may result in Vendor's bid being disqualified. Final pricing as established through this solicitation will be included as Appendix B of the Service Provider Agreement.

The vendor shall provide a proposed rate for each population cohort in the highlighted rate cells of Exhibit A. The annual total for each population cohort will auto-calculate based on the number of members months multiplied by the proposed rate. Vendors are required to provide a proposed rate for each highlighted cell. The total SFY 2017 amount will auto-calculate based on the sum of all annual totals. Vendors shall use Exhibit C to help complete the Pricing Page.

Participant population (member months) were developed based on historical program participation. Vendors will be paid a capitated rate on a per member per month basis in accordance with the vendor's price bid as set forth in Exhibit A, which shall be firm and fixed for the period of the contract, subject to any rate adjustments warranted for modifications to State or Federal regulation, waiver amendments, State Plan amendments, etc. Payment will be based on actual monthly participation. The final payment will be made upon determination by BMS that all contractual requirements have been completed. Payments related to retainage will be processed after the contract termination date due to timing of information availability.

Vendor should type or electronically enter the information into the Pricing Pages through wvOASIS, if available, or as an electronic document. In most cases, the Vendor can request an electronic copy of the Pricing Pages for bid purposes by sending an email request to the following address:

April Battle, Senior Buyer
304-558-0067
Email: April.E.Battle@wv.gov

6. **PERFORMANCE:** Vendor and Agency shall agree to provide the services outlined in the Service Provider Agreement, including all necessary reporting and other requirements as outlined. In the event that this Contract is designated as an open-end contract, Vendor shall perform in accordance with the release orders that may be issued against this Contract. Vendor will be subject to the Service Level language under Exhibit E.

7. **PAYMENT:** Agency shall pay a capitated rate on a per member per month basis, as shown on the Pricing Pages, for all Contract Services performed and accepted under this Contract. Vendor shall accept payment in accordance with the payment procedures of the State of West Virginia.

   Five (5) percent of payment shall be withheld on a PMPM basis for retainage and provided back to each vendor based on performance of 10 select HEDIS quality measures, using the following methodology:

Percentage of Total Capitation Payment Earned Back per Measure	Target/Goal
0.00 of 5%	Under the targeted benchmark
0.25 of 5%	Equal to the targeted benchmark
0.30 of 5%	Greater than or equal to 1 percentage point above the targeted benchmark
0.35 of 5%	Greater than or equal to 2 percentage points above the targeted benchmark
0.40 of 5%	Greater than or equal to 3 percentage points above the targeted benchmark
0.45 of 5%	Greater than or equal to 4 percentage points above the targeted benchmark
0.50 of 5%	Greater than or equal to 5 percentage points above the targeted benchmark

   Example: If an MCO equals the targeted benchmark of two (2) measures and is 5 percentage points higher than the benchmark on one (1) measure, while being under the benchmark for the remaining seven (7) measures, the MCO would earn back 20% of the withheld 5.0% of capitation (1 point [.25+.25+.5] of 5 points).

   Retainage of capitation will not be applied to the SSI population under the SFY2017 contract, but may be modified in future years. Withhold payments will be made as a one-time, lump sum annual payment upon certification of quality scores.

8. **TRAVEL:** Vendor shall be responsible for all mileage and travel costs, including travel time, associated with performance of this Contract. Any anticipated mileage or travel costs may be included in the flat fee or hourly rate listed on Vendor's bid, but such costs will not be paid by the Agency separately.

9. **FACILITIES ACCESS:** Performance of Contract Services may require access cards and/or keys to gain entrance to Agency's facilities. In the event that access cards and/or keys are required:

   9.1. Vendor must identify principal service personnel which will be issued access cards and/or keys to perform service.

   9.2. Vendor will be responsible for controlling cards and keys and will pay replacement fee, if the cards or keys become lost or stolen.

   9.3. Vendor shall notify Agency immediately of any lost, stolen, or missing card or key.

   9.4. Anyone performing under this Contract will be subject to Agency's security protocol and procedures.

   9.5. Vendor shall inform all staff of Agency's security protocol and procedures.

10. MISCELLANEOUS:

10.1. Contract Manager: During its performance of this Contract, Vendor must designate and maintain a primary contract manager responsible for overseeing Vendor's responsibilities under this Contract. The Contract manager must be available during normal business hours to address any customer service or other issues related to this Contract. Vendor should list its Contract manager and his or her contact information below.

Contract Manager: Thomas Duncan
Telephone Number: 202-821-5568
Fax Number: 202-821-1098
tduncan@trustedhp.com

Exhibit A – Pricing Page

Please refer to Exhibit C, SFY2016 Rate Development Document, to assist with completion of the Pricing Page, as well as the instructions outlined within Exhibit A.

Exhibit B – Service Provider Agreement

Exhibit C – SFY2016 Rate Development Document

Exhibit D – MHT MCO Application

Exhibit E – Service Levels

Each vendor shall be subject to the following liquated damages. If Service Levels are not met, the liquated damages specified below will be enacted. The liquated damage penalty cannot be recovered by the vendor. These are also outlined within the Service Provider Agreement.

#	Program Non-Performance	Measurement Period	Liquidated Damages
1	Failure to submit required reports, documentation, ad hoc reports, data certification forms, or any other data required within the timeframes provided by this contract or by the Department. The MCO may have a one business day grace period following the due date of the data, report, or form. Article II, 4.12, unless otherwise specified in this Exhibit.	Ongoing	$250 per calendar day per each item that is overdue until the satisfactory submission of the required report, documentation, ad hoc report, data certification form, or data required to meet any State or federal reporting requirements After three (3) instances of non-performance during the contract period, the

#	Program Non-Performance	Measurement Period	Liquidated Damages
			amount is increased by $1,000 per calendar day per each item that is overdue.
2	Failure to comply with encounter data submission requirements including the failure to address or resolve problems with encounter records in a timely manner as required by Article III, 5.11.	Monthly	$1,000 per single encounter file per reporting period.
3	Failure to resolve at least 98% of member appeals within 45 calendar days from the date the appeal is filed with the MCO, unless an enrollee requests an extension or the MCO shows that a delay is necessary and in the interest of the enrollee. Article III, 3.8.	Quarterly	$1,000 for each percentage point below 98% if the MCO fails to meet the standard.
4	Failure to respond to the State drug rebate disputes within 60 days as described in Article III, 9.13.	Ongoing	$35 per single NDC drug code submitted in each claim.
5	Failure to notify affected members of program or service site changes, at least fourteen calendar days before the intended effective date of the change. Article III, 3.4.	Ongoing	$250 per each incident per affected member.
6	Failure to report timely to BMS significant network changes as described in Article III, 2.1, Network Changes.	Ongoing	$500 per incident of non-compliance.
7	Failure to meet provider credentialing requirements, including background screening requirements, specified in Article III, 2.1, Provider Qualification and Selection.	Ongoing	$500 per incident of non-compliance.
8	Failure to comply with the marketing requirements, or engagement in prohibited marketing practices. Article III, 3.1 and Appendix D.	Ongoing	$1,000 per each incident of non-compliance.

#	Program Non-Performance	Measurement Period	Liquidated Damages
9	Failure to pay 7% annual interest on the same date as an in-network clean claim that remained unpaid beyond the 30-day claims payment deadline. Article III, 2.7, Timely Payment Requirement.	Quarterly	$500 per each in-network clean claim for which the interest remained unpaid on the same date as a claim's payment.
10	Failure to provide timely MCO covered service as described in the Appendix A of this Contract when, in the determination of BMS, such failure results in actual harm to a member or places a member at risk of imminent harm.	Ongoing	$7,500 per day for each incident of non-compliance.
11	Failure to provide timely service authorization (prior authorization) as described in Article III, Section 5.4 or a failure to honor service authorization as described in Article III, Section 5.4, Continuity of Care.	Ongoing	$5,000 per incident of noncompliance.
12	Failure to reimburse a pharmacy for providing a 72-hour emergency supply of prescription drug as outlined in Article III, 9.6 or failure to make a prior authorization determination within 24 hours of the request without providing sufficient amount of the emergency medication supply as outlined in Article III, Section 9.3.	Ongoing	$5,000 per incident of noncompliance.
13	The MCO shall spend at least 85% of total capitation revenue on health care and health care-related expenses, including quality improvement activities.	Annual	The dollar value related to the percentage difference between 85% of capitation revenue and percentage of revenue actually spent on medical and quality services.

Exhibit F: Business Associate Addendum

WV STATE GOVERNMENT

HIPAA BUSINESS ASSOCIATE ADDENDUM

This Health Insurance Portability and Accountability Act of 1996 (hereafter, HIPAA) Business Associate Addendum ("Addendum") is made a part of the Agreement ("Agreement") by and between the State of West Virginia ("Agency"), and Business Associate ("Associate"), and is effective as of the date of execution of the Addendum.

The Associate performs certain services on behalf of or for the Agency pursuant to the underlying Agreement that requires the exchange of information including protected health information protected by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), as amended by the American Recovery and Reinvestment Act of 2009 (Pub. L. No. 111-5) (the "HITECH Act"), any associated regulations and the federal regulations published at 45 CFR parts 160 and 164 (sometimes collectively referred to as "HIPAA"). The Agency is a "Covered Entity" as that term is defined in HIPAA, and the parties to the underlying Agreement are entering into this Addendum to establish the responsibilities of both parties regarding HIPAA-covered information and to bring the underlying Agreement into compliance with HIPAA.

Whereas it is desirable, in order to further the continued efficient operations of Agency to disclose to its Associate certain information which may contain confidential individually identifiable health information (hereafter, Protected Health Information or PHI); and

Whereas, it is the desire of both parties that the confidentiality of the PHI disclosed hereunder be maintained and treated in accordance with all applicable laws relating to confidentiality, including the Privacy and Security Rules, the HITECH Act and its associated regulations, and the parties do agree to at all times treat the PHI and interpret this Addendum consistent with that desire.

NOW THEREFORE: the parties agree that in consideration of the mutual promises herein, in the Agreement, and of the exchange of PHI hereunder that:

1. **Definitions.** Terms used, but not otherwise defined, in this Addendum shall have the same meaning as those terms in the Privacy, Security, Breach Notification, and Enforcement Rules at 45 CFR Part 160 and Part 164.

    a. **Agency Procurement Officer** shall mean the appropriate Agency individual listed at: http://www.state.wv.us/admin/purchase/vrc/agencyli.html.

    b. **Agent** shall mean those person(s) who are agent(s) of the Business Associate, in accordance with the Federal common law of agency, as referenced in 45 CFR § 160.402(c).

    c. **Breach** shall mean the acquisition, access, use or disclosure of protected health information which compromises the security or privacy of such information, except as excluded in the definition of Breach in 45 CFR § 164.402.

    d. **Business Associate** shall have the meaning given to such term in 45 CFR § 160.103.

    e. **HITECH Act** shall mean the Health Information Technology for Economic and Clinical Health Act. Public Law No. 111-05. 111th Congress (2009).

f. **Privacy Rule** means the Standards for Privacy of Individually Identifiable Health Information found at 45 CFR Parts 160 and 164.

g. **Protected Health Information or PHI** shall have the meaning given to such term in 45 CFR § 160.103, limited to the information created or received by Associate from or on behalf of Agency.

h. **Security Incident** means any known successful or unsuccessful attempt by an authorized or unauthorized individual to inappropriately use, disclose, modify, access, or destroy any information or interference with system operations in an information system.

i. **Security Rule** means the Security Standards for the Protection of Electronic Protected Health Information found at 45 CFR Parts 160 and 164.

j. **Subcontractor** means a person to whom a business associate delegates a function, activity, or service, other than in the capacity of a member of the workforce of such business associate.

2. **Permitted Uses and Disclosures.**

a. **PHI Described.** This means PHI created, received, maintained or transmitted on behalf of the Agency by the Associate. This PHI is governed by this Addendum and is limited to the minimum necessary, to complete the tasks or to provide the services associated with the terms of the original Agreement, and is described in Appendix A.

b. **Purposes.** Except as otherwise limited in this Addendum, Associate may use or disclose the PHI on behalf of, or to provide services to, Agency for the purposes necessary to complete the tasks, or provide the services, associated with, and required by the terms of the original Agreement, or as required by law, if such use or disclosure of the PHI would not violate the Privacy or Security Rules or applicable state law if done by Agency or Associate, or violate the minimum necessary and related Privacy and Security policies and procedures of the Agency. The Associate is directly liable under HIPAA for impermissible uses and disclosures of the PHI it handles on behalf of Agency.

c. **Further Uses and Disclosures**. Except as otherwise limited in this Addendum, the Associate may disclose PHI to third parties for the purpose of its own proper management and administration, or as required by law, provided that (i) the disclosure is required by law, or (ii) the Associate has obtained from the third party reasonable assurances that the PHI will be held confidentially and used or further disclosed only as required by law or for the purpose for which it was disclosed to the third party by the Associate; and, (iii) an agreement to notify the Associate and Agency of any instances of which it (the third party) is aware in which the confidentiality of the information has been breached. To the extent practical, the information should be in a limited data set or the minimum necessary information pursuant to 45 CFR § 164.502, or take other measures as necessary to satisfy the Agency's obligations under 45 CFR § 164.502.

3. **Obligations of Associate.**

a. **Stated Purposes Only.** The PHI may not be used by the Associate for any purpose other than as stated in this Addendum or as required or permitted by law.

b. **Limited Disclosure.** The PHI is confidential and will not be disclosed by the Associate other than as stated in this Addendum or as required or permitted by law. Associate is prohibited from directly or indirectly receiving any remuneration in exchange for an individual's PHI unless Agency gives written approval and the individual provides a valid authorization. Associate will refrain from marketing activities that would violate HIPAA, including specifically Section 13406 of the HITECH Act. Associate will report to Agency any use or disclosure of the PHI, including any Security Incident not provided for by this Agreement of which it becomes aware.

c. **Safeguards.** The Associate will use appropriate safeguards, and comply with Subpart C of 45 CFR Part 164 with respect to electronic protected health information, to prevent use or disclosure of the PHI, except as provided for in this Addendum. This shall include, but not be limited to:

i. Limitation of the groups of its workforce and agents, to whom the PHI is disclosed to those reasonably required to accomplish the purposes stated in this Addendum, and the use and disclosure of the minimum PHI necessary or a Limited Data Set;

ii. Appropriate notification and training of its workforce and agents in order to protect the PHI from unauthorized use and disclosure;

iii. Maintenance of a comprehensive, reasonable and appropriate written PHI privacy and security program that includes administrative, technical and physical safeguards appropriate to the size, nature, scope and complexity of the Associate's operations, in compliance with the Security Rule;

iv. In accordance with 45 CFR §§ 164.502(e)(1)(ii) and 164.308(b)(2), if applicable, ensure that any subcontractors that create, receive, maintain, or transmit protected health information on behalf of the business associate agree to the same restrictions, conditions, and requirements that apply to the business associate with respect to such information.

d. **Compliance With Law.** The Associate will not use or disclose the PHI in a manner in violation of existing law and specifically not in violation of laws relating to confidentiality of PHI, including but not limited to, the Privacy and Security Rules.

e. **Mitigation.** Associate agrees to mitigate, to the extent practicable, any harmful effect that is known to Associate of a use or disclosure of the PHI by Associate in violation of the requirements of this Addendum, and report its mitigation activity back to the Agency.

f. **Support of Individual Rights.**

i. **Access to PHI.** Associate shall make the PHI maintained by Associate or its agents or subcontractors in Designated Record Sets available to Agency for inspection and copying, and in electronic format, if requested, within ten (10) days of a request by Agency to enable Agency to fulfill its obligations under the Privacy Rule, including, but not limited to, 45 CFR § 164.524 and consistent with Section 13405 of the HITECH Act.

ii. **Amendment of PHI.** Within ten (10) days of receipt of a request from Agency for an amendment of the PHI or a record about an individual contained in a Designated Record Set, Associate or its agents or subcontractors shall make such PHI available to Agency for amendment and incorporate any such amendment to enable Agency to fulfill its obligations under the Privacy Rule, including, but not limited to, 45 CFR § 164.526.

iii. **Accounting Rights.** Within ten (10) days of notice of a request for an accounting of disclosures of the PHI, Associate and its agents or subcontractors shall make available to Agency the documentation required to provide an accounting of disclosures to enable Agency to fulfill its obligations under the Privacy Rule, including, but not limited to, 45 CFR §164.528 and consistent with Section 13405 of the HITECH Act. Associate agrees to document disclosures of the PHI and information related to such disclosures as would be required for Agency to respond to a request by an individual for an accounting of disclosures of PHI in accordance with 45 CFR § 164.528. This should include a process that allows for an accounting to be collected and maintained by Associate and its agents or subcontractors for at least six (6) years from the date of disclosure, or longer if required by state law. At a minimum, such documentation shall include:

- the date of disclosure;
- the name of the entity or person who received the PHI, and if known, the address of the entity or person;
- a brief description of the PHI disclosed; and
- a brief statement of purposes of the disclosure that reasonably informs the individual of the basis for the disclosure, or a copy of the individual's authorization, or a copy of the written request for disclosure.

iv. **Request for Restriction**. Under the direction of the Agency, abide by any individual's request to restrict the disclosure of PHI, consistent with the requirements of Section 13405 of the HITECH Act and 45 CFR § 164.522, when the Agency determines to do so (except as required by law) and if the disclosure is to a health plan for payment or health care operations and it pertains to a health care item or service for which the health care provider was paid in full "out-of-pocket."

v. **Immediate Discontinuance of Use or Disclosure.** The Associate will immediately discontinue use or disclosure of Agency PHI pertaining to any individual when so requested by Agency. This includes, but is not limited to, cases in which an individual has withdrawn or modified an authorization to use or disclose PHI.

g. **Retention of PHI.** Notwithstanding section 4.a. of this Addendum, Associate and its subcontractors or agents shall retain all PHI pursuant to state and federal law and shall continue to maintain the PHI required under Section 3.f. of this Addendum for a period of six (6) years after termination of the Agreement, or longer if required under state law.

h. **Agent's, Subcontractor's Compliance.** The Associate shall notify the Agency of all subcontracts and agreements relating to the Agreement, where the subcontractor or agent receives PHI as described in section 2.a. of this Addendum. Such notification shall occur within 30 (thirty) calendar days of the execution of the subcontract and shall be delivered to the Agency Procurement Officer. The Associate will ensure that any of its subcontractors, to whom it provides any of the PHI it receives hereunder, or to whom it provides any PHI which the Associate creates or receives on behalf of the Agency, agree to the restrictions and conditions which apply to the Associate hereunder. The Agency may request copies of downstream subcontracts and agreements to determine whether all restrictions, terms and conditions have been flowed down. Failure to ensure that downstream contracts, subcontracts and agreements contain the required restrictions, terms and conditions may result in termination of the Agreement.

j. **Federal and Agency Access.** The Associate shall make its internal practices, books, and records relating to the use and disclosure of PHI, as well as the PHI, received from, or created or received by the Associate on behalf of the Agency available to the U.S. Secretary of Health and Human Services consistent with 45 CFR § 164.504. The Associate shall also make these records available to Agency, or Agency's contractor, for periodic audit of Associate's compliance with the Privacy and Security Rules. Upon Agency's request, the Associate shall provide proof of compliance with HIPAA and HITECH data privacy/protection guidelines, certification of a secure network and other assurance relative to compliance with the Privacy and Security Rules. This section shall also apply to Associate's subcontractors, if any.

k. **Security.** The Associate shall take all steps necessary to ensure the continuous security of all PHI and data systems containing PHI. In addition, compliance with 74 FR 19006 Guidance Specifying the Technologies and Methodologies That Render PHI Unusable, Unreadable, or Indecipherable to Unauthorized Individuals for Purposes of the Breach Notification Requirements under Section 13402 of Title XIII is required, to the extent practicable. If Associate chooses not to adopt such methodologies as defined in 74 FR 19006 to secure the PHI governed by this Addendum, it must submit such written rationale, including its Security Risk Analysis, to the Agency Procurement Officer for review prior to the execution of the Addendum. This review may take up to ten (10) days.

l. **Notification of Breach.** During the term of this Addendum, the Associate shall notify the Agency and, unless otherwise directed by the Agency in writing, the WV Office of Technology immediately by e-mail or web form upon the discovery of any Breach of unsecured PHI; or within 24 hours by e-mail or web form of any suspected Security Incident, intrusion or unauthorized use or disclosure of PHI in violation of this Agreement and this Addendum, or potential loss of confidential data affecting this Agreement. Notification shall be provided to the Agency Procurement Officer at www.state.wv.us/admin/purchase/vrc/agencyli.htm and,

unless otherwise directed by the Agency in writing, the Office of Technology at incident@wv.gov or https://apps.wv.gov/ot/ir/Default.aspx

The Associate shall immediately investigate such Security Incident, Breach, or unauthorized use or disclosure of PHI or confidential data. Within 72 hours of the discovery, the Associate shall notify the Agency Procurement Officer, and, unless otherwise directed by the Agency in writing, the Office of Technology of: (a) Date of discovery; (b) What data elements were involved and the extent of the data involved in the Breach; (c) A description of the unauthorized persons known or reasonably believed to have improperly used or disclosed PHI or confidential data; (d) A description of where the PHI or confidential data is believed to have been improperly transmitted, sent, or utilized; (e) A description of the probable causes of the improper use or disclosure; and (f) Whether any federal or state laws requiring individual notifications of Breaches are triggered.

Agency will coordinate with Associate to determine additional specific actions that will be required of the Associate for mitigation of the Breach, which may include notification to the individual or other authorities.

All associated costs shall be borne by the Associate. This may include, but not be limited to costs associated with notifying affected individuals.

If the Associate enters into a subcontract relating to the Agreement where the subcontractor or agent receives PHI as described in section 2.a. of this Addendum, all such subcontracts or downstream agreements shall contain the same incident notification requirements as contained herein, with reporting directly to the Agency Procurement Officer. Failure to include such requirement in any subcontract or agreement may result in the Agency's termination of the Agreement.

m. **Assistance in Litigation or Administrative Proceedings.** The Associate shall make itself and any subcontractors, workforce or agents assisting Associate in the performance of its obligations under this Agreement, available to the Agency at no cost to the Agency to testify as witnesses, or otherwise, in the event of litigation or administrative proceedings being commenced against the Agency, its officers or employees based upon claimed violations of HIPAA, the HIPAA regulations or other laws relating to security and privacy, which involves inaction or actions by the Associate, except where Associate or its subcontractor, workforce or agent is a named as an adverse party.

4. Addendum Administration.

a. **Term.** This Addendum shall terminate on termination of the underlying Agreement or on the date the Agency terminates for cause as authorized in paragraph (c) of this Section, whichever is sooner.

b. **Duties at Termination.** Upon any termination of the underlying Agreement, the Associate shall return or destroy, at the Agency's option, all PHI received from, or created or received by the Associate on behalf of the Agency that the Associate still maintains in any form and retain no copies of such PHI or, if such return or destruction is not feasible, the Associate shall extend the protections of this Addendum to the PHI and limit further uses and disclosures to the purposes that make the return or destruction of the PHI infeasible. This shall also apply to all agents and subcontractors of Associate. The duty of the Associate and its agents

and subcontractors to assist the Agency with any HIPAA required accounting of disclosures survives the termination of the underlying Agreement.

c. **Termination for Cause.** Associate authorizes termination of this Agreement by Agency, if Agency determines Associate has violated a material term of the Agreement. Agency may, at its sole discretion, allow Associate a reasonable period of time to cure the material breach before termination.

d. **Judicial or Administrative Proceedings.** The Agency may terminate this Agreement if the Associate is found guilty of a criminal violation of HIPAA. The Agency may terminate this Agreement if a finding or stipulation that the Associate has violated any standard or requirement of HIPAA/HITECH, or other security or privacy laws is made in any administrative or civil proceeding in which the Associate is a party or has been joined. Associate shall be subject to prosecution by the Department of Justice for violations of HIPAA/HITECH and shall be responsible for any and all costs associated with prosecution.

e. **Survival.** The respective rights and obligations of Associate under this Addendum shall survive the termination of the underlying Agreement.

5. **General Provisions/Ownership of PHI.**

a. **Retention of Ownership.** Ownership of the PHI resides with the Agency and is to be returned on demand or destroyed at the Agency's option, at any time, and subject to the restrictions found within section 4.b. above.

b. **Secondary PHI.** Any data or PHI generated from the PHI disclosed hereunder which would permit identification of an individual must be held confidential and is also the property of Agency.

c. **Electronic Transmission.** Except as permitted by law or this Addendum, the PHI or any data generated from the PHI which would permit identification of an individual must not be transmitted to another party by electronic or other means for additional uses or disclosures not authorized by this Addendum or to another contractor, or allied agency, or affiliate without prior written approval of Agency.

d. **No Sales.** Reports or data containing the PHI may not be sold without Agency's or the affected individual's written consent.

e. **No Third-Party Beneficiaries.** Nothing express or implied in this Addendum is intended to confer, nor shall anything herein confer, upon any person other than Agency, Associate and their respective successors or assigns, any rights, remedies, obligations or liabilities whatsoever.

f. **Interpretation.** The provisions of this Addendum shall prevail over any provisions in the Agreement that may conflict or appear inconsistent with any provisions in this Addendum. The interpretation of this Addendum shall be made under the laws of the state of West Virginia.

g. **Amendment.** The parties agree that to the extent necessary to comply with applicable law they will agree to further amend this Addendum.

h. **Additional Terms and Conditions.** Additional discretionary terms may be included in the release order or change order process.

AGREED.

Name of Agency:_____

Name of Associate: I Thomas Dugan

Signature:_____

Signature: Thomas Dugan

Title:_____

Title: CEO

Date:_____

Date: 3/9/16

Form - WVBAA-012004
Amended 06.26.2013

APPROVED AS TO FORM THIS 26th
DAY OF January 20 16
Patrick Morrisey
Attorney General
BY _____

Appendix A

(To be completed by the Agency's Procurement Officer prior to the execution of the Addendum, and shall be made a part of the Addendum. PHI not identified prior to execution of the Addendum may only be added by amending Appendix A and the Addendum, via Change Order.)

Name of Associate: _____

Name of Agency: _____

Describe the PHI (do not include any actual PHI). If not applicable, please indicate the same.

STATE OF WEST VIRGINIA
Purchasing Division

PURCHASING AFFIDAVIT

MANDATE: Under W. Va. Code §5A-3-10a, no contract or renewal of any contract may be awarded by the state or any of its political subdivisions to any vendor or prospective vendor when the vendor or prospective vendor or a related party to the vendor or prospective vendor is a debtor and: (1) the debt owed is an amount greater than one thousand dollars in the aggregate; or (2) the debtor is in employer default.

EXCEPTION: The prohibition listed above does not apply where a vendor has contested any tax administered pursuant to chapter eleven of the W. Va. Code, workers' compensation premium, permit fee or environmental fee or assessment and the matter has not become final or where the vendor has entered into a payment plan or agreement and the vendor is not in default of any of the provisions of such plan or agreement.

DEFINITIONS:

"Debt" means any assessment, premium, penalty, fine, tax or other amount of money owed to the state or any of its political subdivisions because of a judgment, fine, permit violation, license assessment, defaulted workers' compensation premium, penalty or other assessment presently delinquent or due and required to be paid to the state or any of its political subdivisions, including any interest or additional penalties accrued thereon.

"Employer default" means having an outstanding balance or liability to the old fund or to the uninsured employers' fund or being in policy default, as defined in W. Va. Code § 23-2c-2, failure to maintain mandatory workers' compensation coverage, or failure to fully meet its obligations as a workers' compensation self-insured employer. An employer is not in employer default if it has entered into a repayment agreement with the Insurance Commissioner and remains in compliance with the obligations under the repayment agreement.

"Related party" means a party, whether an individual, corporation, partnership, association, limited liability company or any other form or business association or other entity whatsoever, related to any vendor by blood, marriage, ownership or contract through which the party has a relationship of ownership or other interest with the vendor so that the party will actually or by effect receive or control a portion of the benefit, profit or other consideration from performance of a vendor contract with the party receiving an amount that meets or exceed five percent of the total contract amount.

AFFIRMATION: By signing this form, the vendor's authorized signer affirms and acknowledges under penalty of law for false swearing (*W. Va. Code* §61-5-3) that neither vendor nor any related party owe a debt as defined above and that neither vendor nor any related party are in employer default as defined above, unless the debt or employer default is permitted under the exception above.

WITNESS THE FOLLOWING SIGNATURE:

Vendor's Name: Trusted Health Plan

Authorized Signature: _____ Date: March 9, 2016

State of District of Columbia.

County of _____, to-wit:

Taken, subscribed, and sworn to before me this 9 day of March, 2016

My Commission expires 8-14-20, 20___.

AFFIX SEAL HERE

SALOME ORTIZ DITREN NOTARY PUBLIC EXP. 8-14-20 DISTRICT OF COLUMBIA

NOTARY PUBLIC _____

Purchasing Division
2019 Washington Street East
Post Office Box 50130
Charleston, WV 25305-0130

State of West Virginia
Request for Quotation
34 — Service - Prof

Proc Folder: 185743

Doc Description: Addendum #1 To provide a revised pricing page.

Proc Type: Central Master Agreement

Date Issued	Solicitation Closes	Solicitation No	Version
2016-02-02	2016-03-03 13:30:00	CRFQ 0511 BMS1600000002	2

BID RECEIVING LOCATION

BID CLERK
DEPARTMENT OF ADMINISTRATION
PURCHASING DIVISION
2019 WASHINGTON ST E
CHARLESTON WV 25305
US

VENDOR

Vendor Name, Address and Telephone Number:

Trusted Health Plan
1100 New Jersey Ave #840
Washington DC 20003
202 821 1100 / 202 821 5568

FOR INFORMATION CONTACT THE BUYER

April Battle
(304) 558-0067
april.e.battle@wv.gov

Signature X [signature] FEIN # 45-2375150 DATE 3/9/2016

All offers subject to all terms and conditions contained in this solicitation

ADDITIONAL INFORMATION:

Addendum #1 - To provide a revised pricing page.

INVOICE TO	SHIP TO
PROCUREMENT OFFICER - 304-356-5052 HEALTH AND HUMAN RESOURCES BUREAU FOR MEDICAL SERVICES 350 CAPITOL ST, RM 251 CHARLESTON WV 25301-3709 US	PROCUREMENT OFFICER - 304-356-5052 HEALTH AND HUMAN RESOURCES BUREAU FOR MEDICAL SERVICES 350 CAPITOL ST, RM 251 CHARLESTON WV 25301-3709 US

Line	Comm Ln Desc	Qty	Unit Issue	Unit Price	Total Price
1	Health or hospitalization insurance	0.00000	EA		

Comm Code	Manufacturer	Specification	Model #
84131602			

Extended Description :
See Exhibit A Pricing Page

SCHEDULE OF EVENTS

Line	Event	Event Date
1	Technical Questions	2016-02-16

ADDITIONAL TERMS AND CONDITIONS

See attached document(s) for additional Terms and Conditions

SOLICITATION NUMBER: CRFQ 0511 BMS1600000002
Addendum Number: 1

The purpose of this addendum is to modify the solicitation identified as ("Solicitation") to reflect the change(s) identified and described below.

Applicable Addendum Category:

[ ] Modify bid opening date and time

[ ] Modify specifications of product or service being sought

[ ] Attachment of vendor questions and responses

[ ] Attachment of pre-bid sign-in sheet

[ ] Correction of error

[✓] Other

Description of Modification to Solicitation:

To provide a revised pricing page.

Additional Documentation: Documentation related to this Addendum (if any) has been included herewith as Attachment A and is specifically incorporated herein by reference.

Terms and Conditions:

1. All provisions of the Solicitation and other addenda not modified herein shall remain in full force and effect.

2. Vendor should acknowledge receipt of all addenda issued for this Solicitation by completing an Addendum Acknowledgment, a copy of which is included herewith. Failure to acknowledge addenda may result in bid disqualification. The addendum acknowledgement should be submitted with the bid to expedite document processing.

ATTACHMENT A

ADDENDUM ACKNOWLEDGEMENT FORM
SOLICITATION NO.: BMS1600000002

Instructions: Please acknowledge receipt of all addenda issued with this solicitation by completing this addendum acknowledgment form. Check the box next to each addendum received and sign below. Failure to acknowledge addenda may result in bid disqualification.

Acknowledgment: I hereby acknowledge receipt of the following addenda and have made the necessary revisions to my proposal, plans and/or specification, etc.

Addendum Numbers Received:
(Check the box next to each addendum received)

[✓] Addendum No. 1	[✓] Addendum No. 6
[✓] Addendum No. 2	[ ] Addendum No. 7
[✓] Addendum No. 3	[ ] Addendum No. 8
[✓] Addendum No. 4	[ ] Addendum No. 9
[✓] Addendum No. 5	[ ] Addendum No. 10

I understand that failure to confirm the receipt of addenda may be cause for rejection of this bid. I further understand that any verbal representation made or assumed to be made during any oral discussion held between Vendor's representatives and any state personnel is not binding. Only the information issued in writing and added to the specifications by an official addendum is binding.

Trusted Health Plan
Company

Authorized Signature

3/9/2016
Date

NOTE: This addendum acknowledgement should be submitted with the bid to expedite document processing.
Revised 6/8/2012

SOLICITATION NUMBER: CRFQ 0511 BMS1600000002
Addendum Number: 2

The purpose of this addendum is to modify the solicitation identified as ("Solicitation") to reflect the change(s) identified and described below.

Applicable Addendum Category:

[✓] Modify bid opening date and time

[ ] Modify specifications of product or service being sought

[ ] Attachment of vendor questions and responses

[ ] Attachment of pre-bid sign-in sheet

[ ] Correction of error

[ ] Other

Description of Modification to Solicitation:

To extend the bid opening date from March 3, 2016, at 1:30 PM EST to March 10, 2016, at 1:30 PM EST.

Additional Documentation: Documentation related to this Addendum (if any) has been included herewith as Attachment A and is specifically incorporated herein by reference.

Terms and Conditions:

1. All provisions of the Solicitation and other addenda not modified herein shall remain in full force and effect.

2. Vendor should acknowledge receipt of all addenda issued for this Solicitation by completing an Addendum Acknowledgment, a copy of which is included herewith. Failure to acknowledge addenda may result in bid disqualification. The addendum acknowledgement should be submitted with the bid to expedite document processing.

ADDENDUM ACKNOWLEDGEMENT FORM
SOLICITATION NO.: BMS1600000002

Instructions: Please acknowledge receipt of all addenda issued with this solicitation by completing this addendum acknowledgment form. Check the box next to each addendum received and sign below. Failure to acknowledge addenda may result in bid disqualification.

Acknowledgment: I hereby acknowledge receipt of the following addenda and have made the necessary revisions to my proposal, plans and/or specification, etc.

Addendum Numbers Received:
(Check the box next to each addendum received)

[✓]	Addendum No. 1	[✓]	Addendum No. 6
[✓]	Addendum No. 2	[ ]	Addendum No. 7
[✓]	Addendum No. 3	[ ]	Addendum No. 8
[✓]	Addendum No. 4	[ ]	Addendum No. 9
[✓]	Addendum No. 5	[ ]	Addendum No. 10

I understand that failure to confirm the receipt of addenda may be cause for rejection of this bid. I further understand that any verbal representation made or assumed to be made during any oral discussion held between Vendor's representatives and any state personnel is not binding. Only the information issued in writing and added to the specifications by an official addendum is binding.

Trusted Health Plan
Company

Authorized Signature

3/9/2016
Date

NOTE: This addendum acknowledgement should be submitted with the bid to expedite document processing.
Revised 6/8/2012

ATTACHMENT A

Purchasing Divison
2019 Washington Street East
Post Office Box 50130
Charleston, WV 25305-0130

State of West Virginia
Request for Quotation
34 — Service - Prof

Proc Folder: 185743

Doc Description: Addendum #2 Managed Care Services

Proc Type: Central Master Agreement

Date Issued	Solicitation Closes	Solicitation No	Version
2016-02-17	2016-03-10 13:30:00	CRFQ 0511 BMS1600000002	3

BID RECEIVING LOCATION

BID CLERK
DEPARTMENT OF ADMINISTRATION
PURCHASING DIVISION
2019 WASHINGTON ST E
CHARLESTON WV 25305
US

VENDOR

Vendor Name, Address and Telephone Number:

Trusted Health Plan
1100 New Jersey #240
Washington, DC 20003
202 821 1100 / 202 821 5568

FOR INFORMATION CONTACT THE BUYER

April Battle
(304) 558-0067
april.e.battle@wv.gov

ature X _____ FEIN # 45-2375150 DATE 3/9/2016

All offers subject to all terms and conditions contained in this solicitation

ADDITIONAL INFORMATION:

Addendum #2 - To extend the bid opening date from March 3, 2016, at 1:30 PM EST to March 10, 2016, at 1:30 PM EST.

INVOICE TO	SHIP TO
:OCUREMENT OFFICER - 304-356-5052	PROCUREMENT OFFICER - 304-356-5052
HEALTH AND HUMAN RESOURCES	HEALTH AND HUMAN RESOURCES
BUREAU FOR MEDICAL SERVICES	BUREAU FOR MEDICAL SERVICES
350 CAPITOL ST, RM 251	350 CAPITOL ST, RM 251
CHARLESTON WV25301-3709	CHARLESTON WV 25301-3709
US	US

Line	Comm Ln Desc	Qty	Unit Issue	Unit Price	Total Price
1	Health or hospitalization insurance	0.00000	EA		

Comm Code	Manufacturer	Specification	Model #
84131602			

Extended Description :

See Exhibit A Pricing Page

SCHEDULE OF EVENTS

Line	Event	Event Date
1	Technical Questions	2016-02-16

ADDITIONAL TERMS AND CONDITIONS

See attached document(s) for additional Terms and Conditions

SOLICITATION NUMBER: CRFQ 0511 BMS1600000002
Addendum Number: 3

The purpose of this addendum is to modify the solicitation identified as ("Solicitation") to reflect the change(s) identified and described below.

Applicable Addendum Category:

[ ] Modify bid opening date and time

[ ] Modify specifications of product or service being sought

[✓] Attachment of vendor questions and responses

[ ] Attachment of pre-bid sign-in sheet

[ ] Correction of error

[✓] Other

Description of Modification to Solicitation:

1) To provide an updated pricing page
2) To provide a change log.
3) To provide the responses to questions submitted to vendors.

Additional Documentation: Documentation related to this Addendum (if any) has been included herewith as Attachment A and is specifically incorporated herein by reference.

Terms and Conditions:

1. All provisions of the Solicitation and other addenda not modified herein shall remain in full force and effect.

2. Vendor should acknowledge receipt of all addenda issued for this Solicitation by completing an Addendum Acknowledgment, a copy of which is included herewith. Failure to acknowledge addenda may result in bid disqualification. The addendum acknowledgement should be submitted with the bid to expedite document processing.

ATTACHMENT A

ADDENDUM ACKNOWLEDGEMENT FORM
SOLICITATION NO.: BMS1600000002

Instructions: Please acknowledge receipt of all addenda issued with this solicitation by completing this addendum acknowledgment form. Check the box next to each addendum received and sign below. Failure to acknowledge addenda may result in bid disqualification.

Acknowledgment: I hereby acknowledge receipt of the following addenda and have made the necessary revisions to my proposal, plans and/or specification, etc.

Addendum Numbers Received:
(Check the box next to each addendum received)

[✓] Addendum No. 1	[✓] Addendum No. 6
[✓] Addendum No. 2	[ ] Addendum No. 7
[✓] Addendum No. 3	[ ] Addendum No. 8
[✓] Addendum No. 4	[ ] Addendum No. 9
[✓] Addendum No. 5	[ ] Addendum No. 10

I understand that failure to confirm the receipt of addenda may be cause for rejection of this bid. I further understand that any verbal representation made or assumed to be made during any oral discussion held between Vendor's representatives and any state personnel is not binding. Only the information issued in writing and added to the specifications by an official addendum is binding.

Trusted Health Plan
Company

[signature]
Authorized Signature

3/9/2016
Date

NOTE: This addendum acknowledgement should be submitted with the bid to expedite document processing.
Revised 6/8/2012

ADDENDUM ACKNOWLEDGEMENT FORM

SOLICITATION NO.: BMS1600000002

Instructions: Please acknowledge receipt of all addenda issued with this solicitation by completing this addendum acknowledgment form. Check the box next to each addendum received and sign below. Failure to acknowledge addenda may result in bid disqualification.

Acknowledgment: I hereby acknowledge receipt of the following addenda and have made the necessary revisions to my proposal, plans and/or specification, etc.

Addendum Numbers Received:
(Check the box next to each addendum received)

☑ Addendum No. 1	☑ Addendum No. 6
☑ Addendum No. 2	☑ Addendum No. 7
☑ Addendum No. 3	☐ Addendum No. 8
☑ Addendum No. 4	☐ Addendum No. 9
☑ Addendum No. 5	☐ Addendum No. 10

I understand that failure to confirm the receipt of addenda may be cause for rejection of this bid. I further understand that any verbal representation made or assumed to be made during any oral discussion held between Vendor's representatives and any state personnel is not binding. Only the information issued in writing and added to the specifications by an official addendum is binding.

Trusted Health Plan

Company

Authorized Signature

3/9/2016

Date

NOTE: This addendum acknowledgement should be submitted with the bid to expedite document processing.

Purchasing Divison
2019 Washington Street East
Post Office Box 50130
Charleston, WV 25305-0130

State of West Virginia
Request for Quotation
34 — Service - Prof

Proc Folder: 185743

Doc Description: Addendum #3 Managed Care Services

Proc Type: Central Master Agreement

Date Issued	Solicitation Closes	Solicitation No	Version
2016-02-29	2016-03-10 13:30:00	CRFQ 0511 BMS1600000002	4

BID CLERK
DEPARTMENT OF ADMINISTRATION
PURCHASING DIVISION
2019 WASHINGTON ST E
CHARLESTON WV 25305
US

Vendor Name, Address and Telephone Number:
Trusted Health Plan
1100 New Jersey Ave #840
Washington, DC 20003
202 821 1100 / 202 821 5568

FOR INFORMATION CONTACT THE BUYER
April Battle
(304) 558-0067
april.e.battle@wv.gov

Signature X [signature] **FEIN #** 45-2375150 **DATE** 3-9-2016

All offers subject to all terms and conditions contained in this solicitation

ADDITIONAL INFORMATION:

'endum #3 - To provide an updated pricing page, change log and the responses to questions submitted by vendors.

INVOICE TO	SHIP TO
PROCUREMENT OFFICER - 304-356-5052 HEALTH AND HUMAN RESOURCES BUREAU FOR MEDICAL SERVICES 350 CAPITOL ST, RM 251 CHARLESTON WV25301-3709 US	PROCUREMENT OFFICER - 304-356-5052 HEALTH AND HUMAN RESOURCES BUREAU FOR MEDICAL SERVICES 350 CAPITOL ST, RM 251 CHARLESTON WV 25301-3709 US

Line	Comm Ln Desc	Qty	Unit Issue	Unit Price	Total Price
1	Health or hospitalization insurance	0.00000	EA		

Comm Code	Manufacturer	Specification	Model #
84131602			

Extended Description :

See Exhibit A Pricing Page

SCHEDULE OF EVENTS

Line	Event	Event Date
1	Technical Questions	2016-02-16

ADDITIONAL TERMS AND CONDITIONS

See attached document(s) for additional Terms and Conditions

SOLICITATION NUMBER: CRFQ 0511 BMS1600000002
Addendum Number: 4

The purpose of this addendum is to modify the solicitation identified as ("Solicitation") to reflect the change(s) identified and described below.

Applicable Addendum Category:

[ ] Modify bid opening date and time

[ ] Modify specifications of product or service being sought

[ ] Attachment of vendor questions and responses

[ ] Attachment of pre-bid sign-in sheet

[ ] Correction of error

[✓] Other

Description of Modification to Solicitation:

1) To provide pages inadvertently left out of Addendum #3.

Additional Documentation: Documentation related to this Addendum (if any) has been included herewith as Attachment A and is specifically incorporated herein by reference.

Terms and Conditions:

1. All provisions of the Solicitation and other addenda not modified herein shall remain in full force and effect.

2. Vendor should acknowledge receipt of all addenda issued for this Solicitation by completing an Addendum Acknowledgment, a copy of which is included herewith. Failure to acknowledge addenda may result in bid disqualification. The addendum acknowledgement should be submitted with the bid to expedite document processing.

ADDENDUM ACKNOWLEDGEMENT FORM
SOLICITATION NO.: BMS1600000002

Instructions: Please acknowledge receipt of all addenda issued with this solicitation by completing this addendum acknowledgment form. Check the box next to each addendum received and sign below. Failure to acknowledge addenda may result in bid disqualification.

Acknowledgment: I hereby acknowledge receipt of the following addenda and have made the necessary revisions to my proposal, plans and/or specification, etc.

Addendum Numbers Received:
(Check the box next to each addendum received)

[✓] Addendum No. 1	[✓] Addendum No. 6
[✓] Addendum No. 2	[ ] Addendum No. 7
[✓] Addendum No. 3	[ ] Addendum No. 8
[✓] Addendum No. 4	[ ] Addendum No. 9
[✓] Addendum No. 5	[ ] Addendum No. 10

I understand that failure to confirm the receipt of addenda may be cause for rejection of this bid. I further understand that any verbal representation made or assumed to be made during any oral discussion held between Vendor's representatives and any state personnel is not binding. Only the information issued in writing and added to the specifications by an official addendum is binding.

Trusted Health Plan
Company

Authorized Signature

3/9/2016
Date

NOTE: This addendum acknowledgement should be submitted with the bid to expedite document processing.
Revised 6/8/2012

ATTACHMENT A

Purchasing Division
2019 Washington Street East
Post Office Box 50130
Charleston, WV 25305-0130

State of West Virginia
Request for Quotation
34 — Service - Prof

Proc Folder: 185743

Doc Description: Addendum #4 Managed Care Services

Proc Type: Central Master Agreement

Date Issued	Solicitation Closes	Solicitation No	Version
2016-03-01	2016-03-10 13:30:00	CRFQ 0511 BMS1600000002	5

BID RECEIVING LOCATION

BID CLERK
DEPARTMENT OF ADMINISTRATION
PURCHASING DIVISION
2019 WASHINGTON ST E
CHARLESTON WV 25305
US

VENDOR

Vendor Name, Address and Telephone Number:

Trusted Health Plan
1100 New Jersey Ave #840
Washington, DC 20003
202 821 1100 / 202 821 5568

FOR INFORMATION CONTACT THE BUYER

April Battle
(304) 558-0067
april.e.battle@wv.gov

...ature X _____ FEIN # 45-2375150 DATE 3-9-2016

...offers subject to all terms and conditions contained in this solicitation

ADDITIONAL INFORMATION:

Addendum #4 - To provide pages inadvertently left out of Addendum #3.

INVOICE TO	SHIP TO
:OCUREMENT OFFICER - 304-356-5052 HEALTH AND HUMAN RESOURCES BUREAU FOR MEDICAL SERVICES 350 CAPITOL ST, RM 251 CHARLESTON WV25301-3709 US	PROCUREMENT OFFICER - 304-356-5052 HEALTH AND HUMAN RESOURCES BUREAU FOR MEDICAL SERVICES 350 CAPITOL ST, RM 251 CHARLESTON WV 25301-3709 US

Line	Comm Ln Desc	Qty	Unit Issue	Unit Price	Total Price
1	Health or hospitalization insurance	0.00000	EA		

Comm Code	Manufacturer	Specification	Model #
84131602			

Extended Description :
See Exhibit A Pricing Page

SCHEDULE OF EVENTS

Line	Event	Event Date
1	Technical Questions	2016-02-16

ADDITIONAL TERMS AND CONDITIONS

See attached document(s) for additional Terms and Conditions

Purchasing Divison
2019 Washington Street East
Post Office Box 50130
Charleston, WV 25305-0130

State of West Virginia
Request for Quotation
34 — Service - Prof

Proc Folder: 185743

Doc Description: Addendum #5 Managed Care Services

Proc Type: Central Master Agreement

Date Issued	Solicitation Closes	Solicitation No	Version
2016-03-02	2016-03-10 13:30:00	CRFQ 0511 BMS1600000002	6

BID RECEIVING LOCATION

BID CLERK
DEPARTMENT OF ADMINISTRATION
PURCHASING DIVISION
2019 WASHINGTON ST E
CHARLESTON WV 25305
US

VENDOR

Vendor Name, Address and Telephone Number:

Trusted Health Plan
1100 New Jersey Ave #840
Washington, DC 20003
202 821 1100 / 202 821 5562

FOR INFORMATION CONTACT THE BUYER

April Battle
(304) 558-0067
april.e.battle@wv.gov

ature X [signature] FEIN # 45-2375150 DATE 3-9-2016

All offers subject to all terms and conditions contained in this solicitation

ADDITIONAL INFORMATION:

Addendum #5 - To provide a revised pricing page.

INVOICE TO	SHIP TO
PROCUREMENT OFFICER - 304-356-5052 HEALTH AND HUMAN RESOURCES BUREAU FOR MEDICAL SERVICES 350 CAPITOL ST, RM 251 CHARLESTON WV 25301-3709 US	PROCUREMENT OFFICER - 304-356-5052 HEALTH AND HUMAN RESOURCES BUREAU FOR MEDICAL SERVICES 350 CAPITOL ST, RM 251 CHARLESTON WV 25301-3709 US

Line	Comm Ln Desc	Qty	Unit Issue	Unit Price	Total Price
1	Health or hospitalization insurance	0.00000	EA		

Comm Code	Manufacturer	Specification	Model #
84131602			

Extended Description :
See Exhibit A Pricing Page

SCHEDULE OF EVENTS

Line	Event	Event Date
1	Technical Questions	2016-02-16

ADDITIONAL TERMS AND CONDITIONS

See attached document(s) for additional Terms and Conditions

SOLICITATION NUMBER: CRFQ 0511 BMS1600000002
Addendum Number: 5

The purpose of this addendum is to modify the solicitation identified as ("Solicitation") to reflect the change(s) identified and described below.

Applicable Addendum Category:

[ ] Modify bid opening date and time

[ ] Modify specifications of product or service being sought

[ ] Attachment of vendor questions and responses

[ ] Attachment of pre-bid sign-in sheet

[ ] Correction of error

[✓] Other

Description of Modification to Solicitation:

1) To provide a revised pricing page.

Additional Documentation: Documentation related to this Addendum (if any) has been included herewith as Attachment A and is specifically incorporated herein by reference.

Terms and Conditions:

1. All provisions of the Solicitation and other addenda not modified herein shall remain in full force and effect.

2. Vendor should acknowledge receipt of all addenda issued for this Solicitation by completing an Addendum Acknowledgment, a copy of which is included herewith. Failure to acknowledge addenda may result in bid disqualification. The addendum acknowledgement should be submitted with the bid to expedite document processing.

ATTACHMENT A

ADDENDUM ACKNOWLEDGEMENT FORM
SOLICITATION NO.: BMS1600000002

Instructions: Please acknowledge receipt of all addenda issued with this solicitation by completing this addendum acknowledgment form. Check the box next to each addendum received and sign below. Failure to acknowledge addenda may result in bid disqualification.

Acknowledgment: I hereby acknowledge receipt of the following addenda and have made the necessary revisions to my proposal, plans and/or specification, etc.

Addendum Numbers Received:
(Check the box next to each addendum received)

[✓]	Addendum No. 1	[✓]	Addendum No. 6
[✓]	Addendum No. 2	[ ]	Addendum No. 7
[✓]	Addendum No. 3	[ ]	Addendum No. 8
[✓]	Addendum No. 4	[ ]	Addendum No. 9
[✓]	Addendum No. 5	[ ]	Addendum No. 10

I understand that failure to confirm the receipt of addenda may be cause for rejection of this bid. I further understand that any verbal representation made or assumed to be made during any oral discussion held between Vendor's representatives and any state personnel is not binding. Only the information issued in writing and added to the specifications by an official addendum is binding.

Trusted Health Plan
Company

Authorized Signature

3/9/2016
Date

NOTE: This addendum acknowledgement should be submitted with the bid to expedite document processing.
Revised 6/8/2012

SOLICITATION NUMBER: CRFQ 0511 BMS1600000002
Addendum Number: 6

The purpose of this addendum is to modify the solicitation identified as ("Solicitation") to reflect the change(s) identified and described below.

Applicable Addendum Category:

[ ] Modify bid opening date and time

[ ] Modify specifications of product or service being sought

[ ] Attachment of vendor questions and responses

[ ] Attachment of pre-bid sign-in sheet

[✓] Correction of error

[ ] Other

Description of Modification to Solicitation:

1) To clarify that solicitation documents cannot be submitted online. Hard copies must be submitted as indicated in the Instructions to Vendors.

Additional Documentation: Documentation related to this Addendum (if any) has been included herewith as Attachment A and is specifically incorporated herein by reference.

Terms and Conditions:

1. All provisions of the Solicitation and other addenda not modified herein shall remain in full force and effect.

2. Vendor should acknowledge receipt of all addenda issued for this Solicitation by completing an Addendum Acknowledgment, a copy of which is included herewith. Failure to acknowledge addenda may result in bid disqualification. The addendum acknowledgement should be submitted with the bid to expedite document processing.

ADDENDUM ACKNOWLEDGEMENT FORM
SOLICITATION NO.: BMS1600000002

Instructions: Please acknowledge receipt of all addenda issued with this solicitation by completing this addendum acknowledgment form. Check the box next to each addendum received and sign below. Failure to acknowledge addenda may result in bid disqualification.

Acknowledgment: I hereby acknowledge receipt of the following addenda and have made the necessary revisions to my proposal, plans and/or specification, etc.

Addendum Numbers Received:
(Check the box next to each addendum received)

[✓] Addendum No. 1	[✓] Addendum No. 6
[✓] Addendum No. 2	[ ] Addendum No. 7
[✓] Addendum No. 3	[ ] Addendum No. 8
[✓] Addendum No. 4	[ ] Addendum No. 9
[✓] Addendum No. 5	[ ] Addendum No. 10

I understand that failure to confirm the receipt of addenda may be cause for rejection of this bid. I further understand that any verbal representation made or assumed to be made during any oral discussion held between Vendor's representatives and any state personnel is not binding. Only the information issued in writing and added to the specifications by an official addendum is binding.

Trusted Health Plan
Company

Authorized Signature

3/9/2016
Date

NOTE: This addendum acknowledgement should be submitted with the bid to expedite document processing.
Revised 6/8/2012

	Purchasing Divison **2019 Washington Street East** **Post Office Box 50130** **Charleston, WV 25305-0130**	**State of West Virginia** **Request for Quotation** **34 — Service - Prof**

Proc Folder: 185743

Doc Description: Addendum #6 Managed Care Services

Proc Type: Central Master Agreement

Date Issued	Solicitation Closes	Solicitation No	Version
2016-03-04	2016-03-10 13:30:00	CRFQ 0511 BMS1600000002	7

BID RECEIVING LOCATION

BID CLERK
DEPARTMENT OF ADMINISTRATION
PURCHASING DIVISION
2019 WASHINGTON ST E
CHARLESTON WV 25305
US

VENDOR

Vendor Name, Address and Telephone Number:

Trusted Health Plan
1100 New Jersey #840
Washington, DC 20003
202 821 1100 / 202 821 5568

FOR INFORMATION CONTACT THE BUYER

April Battle
(304) 558-0067
april.e.battle@wv.gov

Signature X _____ FEIN # 45-2375150 DATE 3/9/2016

All offers subject to all terms and conditions contained in this solicitation

'endum #6 - To clarify that solicitation documents cannot be submitted online. Hard copies must be submitted as indicated in the Instructions endors.

PROCUREMENT OFFICER - 304-356-5052 HEALTH AND HUMAN RESOURCES BUREAU FOR MEDICAL SERVICES 350 CAPITOL ST, RM 251 CHARLESTON WV25301-3709 US	PROCUREMENT OFFICER - 304-356-5052 HEALTH AND HUMAN RESOURCES BUREAU FOR MEDICAL SERVICES 350 CAPITOL ST, RM 251 CHARLESTON WV 25301-3709 US

Line	Comm Ln Desc	Qty	Unit Issue	Unit Price	Total Price
1	Health or hospitalization insurance	0.00000	EA		

Comm Code	Manufacturer	Specification	Model #
84131602			

Extended Description :
See Exhibit A Pricing Page

SCHEDULE OF EVENTS

Line	Event	Event Date
	Technical Questions	2016-02-16

ADDITIONAL TERMS AND CONDITIONS

See attached document(s) for additional Terms and Conditions

TRUSTED Health Plan
THP

03/11/16 08:10:49
WV Purchasing Division

March 10, 2016

April Battle
Department of Administration, Purchasing Division
2019 Washington Street East
Charleston, WV. 25305-0103

Dear Ms. Battle:

I write to acknowledge that Trusted Health Plan (District of Columbia), Inc. d/b/a Trusted Health Plan ("Trusted") has received the most recent Addendum 7 issued on March 9, 2016. Trusted is sending this letter, along with the enclosed Addendum Acknowledgment Form for Solicitation Number BMS1600000002 (3 copies), separate and apart from its responsive proposal because Trusted's responsive proposal was mailed via FedEx yesterday, before Trusted learned of Addendum 7.

Pursuant to the Terms and Conditions issued with Solicitation Number BMS1600000002, please find below identifying information required to be clearly visible along with any bid submissions not submitted electronically through wvOASIS:

SEALED BID: Managed Care Services
BUYER: April Battle, Buyer 22
SOLICITATION NO.: CRFQ 0511 BMS1600000002
BID OPENING DATE: March 3, 2016
BID OPENING TIME: 1:30 PM EST
FAX NUMBER: (304) 558-3970

Thank you in advance for your consideration, and please let me know if you require anything else from Trusted.

Sincerely,

Chika Duru
General Counsel

03/11/16 08:24:19
WV Purchasing Division

1100 New Jersey Avenue, SE, Suite 840, Washington, DC 20003
202.821.1100
www.trustedhp.com

ADDENDUM ACKNOWLEDGEMENT FORM
SOLICITATION NO.: BMS1600000002

Instructions: Please acknowledge receipt of all addenda issued with this solicitation by completing this addendum acknowledgment form. Check the box next to each addendum received and sign below. Failure to acknowledge addenda may result in bid disqualification.

Acknowledgment: I hereby acknowledge receipt of the following addenda and have made the necessary revisions to my proposal, plans and/or specification, etc.

Addendum Numbers Received:
(Check the box next to each addendum received)

[✓] Addendum No. 1	[✓] Addendum No. 6
[✓] Addendum No. 2	[✓] Addendum No. 7
[✓] Addendum No. 3	[ ] Addendum No. 8
[✓] Addendum No. 4	[ ] Addendum No. 9
[✓] Addendum No. 5	[ ] Addendum No. 10

03/11/16 08:10:56
WV Purchasing Division

I understand that failure to confirm the receipt of addenda may be cause for rejection of this bid. I further understand that any verbal representation made or assumed to be made during any oral discussion held between Vendor's representatives and any state personnel is not binding. Only the information issued in writing and added to the specifications by an official addendum is binding.

Trustco HealthPlan Capital Inc. DBA Trustco Health Pl.
Company

Authorized Signature

3/10/16
Date

NOTE: This addendum acknowledgement should be submitted with the bid to expedite document processing.
Revised 6/8/2012

ADDENDUM ACKNOWLEDGEMENT FORM
SOLICITATION NO.: BMS1600000002

Instructions: Please acknowledge receipt of all addenda issued with this solicitation by completing this addendum acknowledgment form. Check the box next to each addendum received and sign below. Failure to acknowledge addenda may result in bid disqualification.

Acknowledgment: I hereby acknowledge receipt of the following addenda and have made the necessary revisions to my proposal, plans and/or specification, etc.

Addendum Numbers Received:
(Check the box next to each addendum received)

[✓] Addendum No. 1	[✓] Addendum No. 6
[✓] Addendum No. 2	[✓] Addendum No. 7
[✓] Addendum No. 3	[ ] Addendum No. 8
[✓] Addendum No. 4	[ ] Addendum No. 9
[✓] Addendum No. 5	[ ] Addendum No. 10

03/11/16 08:11:01
WV Purchasing Division

I understand that failure to confirm the receipt of addenda may be cause for rejection of this bid. I further understand that any verbal representation made or assumed to be made during any oral discussion held between Vendor's representatives and any state personnel is not binding. Only the information issued in writing and added to the specifications by an official addendum is binding.

Trustco HealthPlan Capital Area Inc. DBA Trustco HealthPlan
Company

Authorized Signature

3/10/16
Date

NOTE: This addendum acknowledgement should be submitted with the bid to expedite document processing.
Revised 6/8/2012

ADDENDUM ACKNOWLEDGEMENT FORM
SOLICITATION NO.: BMS1600000002

Instructions: Please acknowledge receipt of all addenda issued with this solicitation by completing this addendum acknowledgment form. Check the box next to each addendum received and sign below. Failure to acknowledge addenda may result in bid disqualification.

Acknowledgment: I hereby acknowledge receipt of the following addenda and have made the necessary revisions to my proposal, plans and/or specification, etc.

Addendum Numbers Received:
(Check the box next to each addendum received)

[✓] Addendum No. 1	[✓] Addendum No. 6
[✓] Addendum No. 2	[✓] Addendum No. 7
[✓] Addendum No. 3	[ ] Addendum No. 8
[✓] Addendum No. 4	[ ] Addendum No. 9
[✓] Addendum No. 5	[ ] Addendum No. 10

03/11/16 08:11:07
WV Purchasing Division

I understand that failure to confirm the receipt of addenda may be cause for rejection of this bid. I further understand that any verbal representation made or assumed to be made during any oral discussion held between Vendor's representatives and any state personnel is not binding. Only the information issued in writing and added to the specifications by an official addendum is binding.

Trustco HealthPlan Capital Area, Inc. DBA Trustco HealthPlan
Company

Authorized Signature

3/10/16
Date

NOTE: This addendum acknowledgement should be submitted with the bid to expedite document processing.
Revised 6/8/2012

Instructions: Provided below are actuarial ranges for managed care members in 5 population groups, segmented by age and region. The vendor shall provide a pro
The SFY2017 Total Amount that is highlighted in cells E33 and F33 will be the sum of all annual totals and will auto-calculate.

Population	Lower Bound	Upper Bound	Member Months	Proposed Rate	Annual Total	Lower Bound	Upper Bound
	<1 yr						
Traditional	$ 434.15	$ 434.20	55,000	$ 434.15	$ 23,878,250.00	$ 136.95	$ 137.00
Pregnant Women	$ -	$ -	-	$ -	$ -	$ -	$ -
Med Needy	$ 434.15	$ 434.20	200	$ 434.15	$ 86,830.00	$ 144.44	$ 144.49
CSHCN	$ 2,688.44	$ 2,688.49	500	$ 2,688.44	$ 1,344,220.00	$ 848.03	$ 848.08
ACA Expansion	$ -	$ -	-	$ -	$ -	$ -	$ -

Population	Lower Bound	Upper Bound	Member Months	Proposed Rate	Annual Total	Lower Bound	Upper Bound
	<1 yr						
Traditional	$ 426.64	$ 426.69	55,000	$ 426.64	$ 23,465,200.00	$ 134.58	$ 134.63
Pregnant Women	$ -	$ -	-	$ -	$ -	$ -	$ -
Med Needy	$ 426.64	$ 426.69	200	$ 426.64	$ 85,328.00	$ 141.94	$ 141.99
CSHCN	$ 2,641.88	$ 2,641.93	500	$ 2,641.88	$ 1,320,940.00	$ 833.34	$ 833.39
ACA Expansion	$ -	$ -	-	$ -	$ -	$ -	$ -

Population	Lower Bound	Upper Bound	Member Months	Proposed Rate	Annual Total	Lower Bound	Upper Bound
	<1 yr						
Traditional	$ 490.19	$ 490.24	55,000	$ 490.19	$ 26,960,450.00	$ 154.62	$ 154.67
Pregnant Women	$ -	$ -	-	$ -	$ -	$ -	$ -
Med Needy	$ 490.19	$ 490.24	200	$ 490.19	$ 98,038.00	$ 163.09	$ 163.14
CSHCN	$ 3,035.41	$ 3,035.46	500	$ 3,035.41	$ 1,517,705.00	$ 957.47	$ 957.52
ACA Expansion	$ -	$ -	-	$ -	$ -	$ -	$ -

SFY 2017 Total Amount	$ 1,151,530,467.00

posed rate for each population cohort below in the highlighted rate cells. The annual total for each cohort will auto-calculate based on the number of members months * the proposed rat

Member Months	Proposed Rate	Annual Total	Lower Bound	Upper Bound	Member Months	Proposed Rate	Annual Total
1 yr					2-14 yr		
45,000	$ 136.95	$ 6,162,750.00	$ 137.25	$ 137.30	450,000	$ 137.25	$ 61,762,500.00
-	$ -	$ -	$ 354.97	$ 355.02	100	$ 354.97	$ 35,497.00
200	$ 144.44	$ 28,888.00	$ 145.47	$ 145.52	200	$ 145.47	$ 29,094.00
500	$ 848.03	$ 424,015.00	$ 849.90	$ 849.95	700	$ 849.90	$ 594,930.00
-	$ -	$ -	$ -	$ -	-	$ -	$ -

Member Months	Proposed Rate	Annual Total	Lower Bound	Upper Bound	Member Months	Proposed Rate	Annual Total
1 yr					2-14 yr		
45,000	$ 134.58	$ 6,056,100.00	$ 134.87	$ 134.92	450,000	$ 134.87	$ 60,691,500.00
-	$ -	$ -	$ 348.82	$ 348.87	100	$ 348.82	$ 34,882.00
200	$ 141.94	$ 28,388.00	$ 142.95	$ 143.00	200	$ 142.95	$ 28,590.00
500	$ 833.34	$ 416,670.00	$ 835.18	$ 835.23	700	$ 835.18	$ 584,626.00
-	$ -	$ -	$ -	$ -	-	$ -	$ -

Member Months	Proposed Rate	Annual Total	Lower Bound	Upper Bound	Member Months	Proposed Rate	Annual Total
1 yr					2-14 yr		
45,000	$ 154.62	$ 6,957,900.00	$ 154.96	$ 155.01	450,000	$ 154.96	$ 69,732,000.00
-	$ -	$ -	$ 400.78	$ 400.83	100	$ 400.78	$ 40,078.00
200	$ 163.09	$ 32,618.00	$ 164.25	$ 164.30	200	$ 164.25	$ 32,850.00
500	$ 957.47	$ 478,735.00	$ 959.59	$ 959.64	700	$ 959.59	$ 671,713.00
-	$ -	$ -	$ -	$ -	-	$ -	$ -

e. Vendors are required to provide a proposed rate for each highlighted cell. The total SFY 2017 amount (Cell F33) will auto-calculate based on the sum of all annual totals.

Lower Bound	Upper Bound	Member Months	Proposed Rate	Annual Total	Lower Bound	Upper Bound	Member Months
15-19 F							15-19 M
$ 215.98	$ 216.03	50,000	$ 215.98	$ 10,799,000.00	$ 156.67	$ 156.72	47,000
$ 354.97	$ 355.02	5,000	$ 354.97	$ 1,774,850.00	$ -	$ -	-
$ 228.72	$ 228.77	500	$ 228.72	$ 114,360.00	$ 166.16	$ 166.21	500
$ 1,337.45	$ 1,337.50	200	$ 1,337.45	$ 267,490.00	$ 970.17	$ 970.22	200
$ 198.98	$ 199.03	10,000	$ 198.98	$ 1,989,800.00	$ 138.09	$ 138.14	10,000

Lower Bound	Upper Bound	Member Months	Proposed Rate	Annual Total	Lower Bound	Upper Bound	Member Months
15-19 F							15-19 M
$ 212.24	$ 212.29	50,000	$ 212.24	$ 10,612,000.00	$ 153.96	$ 154.01	47,000
$ 348.82	$ 348.87	5,000	$ 348.82	$ 1,744,100.00	$ -	$ -	-
$ 224.76	$ 224.81	500	$ 224.76	$ 112,380.00	$ 163.29	$ 163.34	500
$ 1,314.29	$ 1,314.34	200	$ 1,314.29	$ 262,858.00	$ 953.37	$ 953.42	200
$ 190.55	$ 190.60	10,000	$ 190.55	$ 1,905,500.00	$ 132.24	$ 132.29	10,000

Lower Bound	Upper Bound	Member Months	Proposed Rate	Annual Total	Lower Bound	Upper Bound	Member Months
15-19 F							15-19 M
$ 243.86	$ 243.91	50,000	$ 243.86	$ 12,193,000.00	$ 176.89	$ 176.94	47,000
$ 400.78	$ 400.83	5,000	$ 400.78	$ 2,003,900.00	$ -	$ -	-
$ 258.24	$ 258.29	500	$ 258.24	$ 129,120.00	$ 187.61	$ 187.66	500
$ 1,510.06	$ 1,510.11	200	$ 1,510.06	$ 302,012.00	$ 1,095.38	$ 1,095.43	200
$ 206.73	$ 206.78	10,000	$ 206.73	$ 2,067,300.00	$ 143.47	$ 143.52	10,000

Region 1

Proposed Rate	Annual Total	Lower Bound	Upper Bound	Member Months	Proposed Rate	Annual Total	Lower Bound
			20-29 F				
$ 156.67	$ 7,363,490.00	$ 292.10	$ 292.15	36,000	$ 292.10	$ 10,515,600.00	$ 200.37
$ -	$ -	$ 354.97	$ 355.02	20,000	$ 354.97	$ 7,099,400.00	$ -
$ 166.16	$ 83,080.00	$ 306.43	$ 306.48	3,000	$ 306.43	$ 919,290.00	$ 210.65
$ 970.17	$ 194,034.00	$ 290.10	$ 290.15	100	$ 290.10	$ 29,010.00	$ 200.37
$ 138.09	$ 1,380,900.00	$ 231.13	$ 231.18	80,000	$ 231.13	$ 18,490,400.00	$ 191.77

Region 2

Proposed Rate	Annual Total	Lower Bound	Upper Bound	Member Months	Proposed Rate	Annual Total	Lower Bound
			20-29 F				
$ 153.96	$ 7,236,120.00	$ 287.04	$ 287.09	36,000	$ 287.04	$ 10,333,440.00	$ 196.90
$ -	$ -	$ 348.82	$ 348.87	20,000	$ 348.82	$ 6,976,400.00	$ -
$ 163.29	$ 81,645.00	$ 301.12	$ 301.17	3,000	$ 301.12	$ 903,360.00	$ 207.00
$ 953.37	$ 190,674.00	$ 287.04	$ 287.09	100	$ 287.04	$ 28,704.00	$ 196.90
$ 132.24	$ 1,322,400.00	$ 221.34	$ 221.39	80,000	$ 221.34	$ 17,707,200.00	$ 183.65

Region 3

Proposed Rate	Annual Total	Lower Bound	Upper Bound	Member Months	Proposed Rate	Annual Total	Lower Bound
			20-29 F				
$ 176.89	$ 8,313,830.00	$ 329.80	$ 329.85	36,000	$ 329.80	$ 11,872,800.00	$ 226.22
$ -	$ -	$ 400.78	$ 400.83	20,000	$ 400.78	$ 8,015,600.00	$ -
$ 187.61	$ 93,805.00	$ 345.97	$ 346.02	3,000	$ 345.97	$ 1,037,910.00	$ 237.83
$ 1,095.38	$ 219,076.00	$ 329.80	$ 329.85	100	$ 329.80	$ 32,980.00	$ 226.22
$ 143.47	$ 1,434,700.00	$ 240.13	$ 240.18	80,000	$ 240.13	$ 19,210,400.00	$ 199.24

Upper Bound	Member Months	Proposed Rate	Annual Total	Lower Bound	Upper Bound	Member Months	Proposed Rate
20-29 M						30-39 F	
$ 200.42	7,000	$ 200.37	$ 1,402,590.00	$ 411.55	$ 411.60	30,000	$ 411.55
$ -	-	$ -	$ -	$ 354.97	$ 355.02	10,000	$ 354.97
$ 210.70	3,000	$ 210.65	$ 631,950.00	$ 432.87	$ 432.92	5,000	$ 432.87
$ 200.42	100	$ 200.37	$ 20,037.00	$ -	$ -	-	$ -
$ 191.82	70,000	$ 191.77	$ 13,423,900.00	$ 288.04	$ 288.09	80,000	$ 288.04

Upper Bound	Member Months	Proposed Rate	Annual Total	Lower Bound	Upper Bound	Member Months	Proposed Rate
20-29 M						30-39 F	
$ 196.95	7,000	$ 196.90	$ 1,378,300.00	$ 404.43	$ 404.48	30,000	$ 404.43
$ -	-	$ -	$ -	$ 348.82	$ 348.87	10,000	$ 348.82
$ 207.05	3,000	$ 207.00	$ 621,000.00	$ 425.38	$ 425.43	5,000	$ 425.38
$ 196.95	100	$ 196.90	$ 19,690.00	$ -	$ -	-	$ -
$ 183.70	70,000	$ 183.65	$ 12,855,500.00	$ 275.84	$ 275.89	80,000	$ 275.84

Upper Bound	Member Months	Proposed Rate	Annual Total	Lower Bound	Upper Bound	Member Months	Proposed Rate
20-29 M						30-39 F	
$ 226.27	7,000	$ 226.22	$ 1,583,540.00	$ 464.67	$ 464.72	30,000	$ 464.67
$ -	-	$ -	$ -	$ 400.78	$ 400.83	10,000	$ 400.78
$ 237.88	3,000	$ 237.83	$ 713,490.00	$ 488.74	$ 488.79	5,000	$ 488.74
$ 226.27	100	$ 226.22	$ 22,622.00	$ -	$ -	-	$ -
$ 199.29	70,000	$ 199.24	$ 13,946,800.00	$ 299.26	$ 299.31	80,000	$ 299.26

Annual Total	Lower Bound	Upper Bound	Member Months	Proposed Rate	Annual Total	Lower Bound	Upper Bound
			30-39 M				
$ 12,346,500.00	$ 345.20	$ 345.25	11,000	$ 345.20	$ 3,797,200.00	$ 477.46	$ 477.51
$ 3,549,700.00	$ -	$ -	-	$ -	$ -	$ 354.97	$ 355.02
$ 2,164,350.00	$ 363.26	$ 363.31	5,000	$ 363.26	$ 1,816,300.00	$ 502.17	$ 502.22
$ -	$ -	$ -	-	$ -	$ -	$ -	$ -
$ 23,043,200.00	$ 282.32	$ 282.37	75,000	$ 282.32	$ 21,174,000.00	$ 430.93	$ 430.98

Annual Total	Lower Bound	Upper Bound	Member Months	Proposed Rate	Annual Total	Lower Bound	Upper Bound
			30-39 M				
$ 12,132,900.00	$ 339.23	$ 339.28	11,000	$ 339.23	$ 3,731,530.00	$ 469.19	$ 469.24
$ 3,488,200.00	$ -	$ -	-	$ -	$ -	$ 348.82	$ 348.87
$ 2,126,900.00	$ 356.97	$ 357.02	5,000	$ 356.97	$ 1,784,850.00	$ 493.48	$ 493.53
$ -	$ -	$ -	-	$ -	$ -	$ -	$ -
$ 22,067,200.00	$ 270.36	$ 270.41	75,000	$ 270.36	$ 20,277,000.00	$ 412.67	$ 412.72

Annual Total	Lower Bound	Upper Bound	Member Months	Proposed Rate	Annual Total	Lower Bound	Upper Bound
			30-39 M				
$ 13,940,100.00	$ 389.75	$ 389.80	11,000	$ 389.75	$ 4,287,250.00	$ 539.08	$ 539.13
$ 4,007,800.00	$ -	$ -	-	$ -	$ -	$ 400.78	$ 400.83
$ 2,443,700.00	$ 410.15	$ 410.20	5,000	$ 410.15	$ 2,050,750.00	$ 566.98	$ 567.03
$ -	$ -	$ -	-	$ -	$ -	$ -	$ -
$ 23,940,800.00	$ 293.32	$ 293.37	75,000	$ 293.32	$ 21,999,000.00	$ 447.74	$ 447.79

Member Months	Proposed Rate	Annual Total	Lower Bound	Upper Bound	Member Months	Proposed Rate	Annual Total
40+					Delivery		
20,000	$ 477.46	$ 9,549,200.00	$ 4,586.01	$ 4,586.06	-	$ -	$ -
2,500	$ 354.97	$ 887,425.00	$ 4,586.01	$ 4,586.06	4,000	$ 4,586.01	$ 18,344,040.00
5,000	$ 502.17	$ 2,510,850.00	$ 4,586.01	$ 4,586.06	-	$ -	$ -
-	$ -	$ -	$ 4,586.01	$ 4,586.06	-	$ -	$ -
250,000	$ 430.93	$ 107,732,500.00	$ 4,586.01	$ 4,586.06	-	$ -	$ -

Member Months	Proposed Rate	Annual Total	Lower Bound	Upper Bound	Member Months	Proposed Rate	Annual Total
40+					Delivery		
20,000	$ 469.19	$ 9,383,800.00	$ 4,611.97	$ 4,612.02	-	$ -	$ -
2,500	$ 348.82	$ 872,050.00	$ 4,611.97	$ 4,612.02	4,000	$ 4,611.97	$ 18,447,880.00
5,000	$ 493.48	$ 2,467,400.00	$ 4,611.97	$ 4,612.02	-	$ -	$ -
-	$ -	$ -	$ 4,611.97	$ 4,612.02	-	$ -	$ -
250,000	$ 412.67	$ 103,167,500.00	$ 4,611.97	$ 4,612.02	-	$ -	$ -

Member Months	Proposed Rate	Annual Total	Lower Bound	Upper Bound	Member Months	Proposed Rate	Annual Total
40+					Delivery		
20,000	$ 539.08	$ 10,781,600.00	$ 4,470.13	$ 4,470.18	-	$ -	$ -
2,500	$ 400.78	$ 1,001,950.00	$ 4,470.13	$ 4,470.18	4,000	$ 4,470.13	$ 17,880,520.00
5,000	$ 566.98	$ 2,834,900.00	$ 4,470.13	$ 4,470.18	-	$ -	$ -
-	$ -	$ -	$ 4,470.13	$ 4,470.18	-	$ -	$ -
250,000	$ 447.74	$ 111,935,000.00	$ 4,470.13	$ 4,470.18	-	$ -	$ -



Response to West Virginia Bureau for Medical Services Medicaid MCO Provider Application SFY 2016 Solicitation No.0511 BMS1600000002

March 10, 2016

Submitted To:

West Virginia DHHR
Bureau of Medical Services
Attention: Jeff Wiseman
1 Davis Square, Suite 100 E
Charleston, WV 25301-3708
Tel. 304-558-6052
Jeff.A.Wiseman@ws.gov

The Lewin Group
Attention: West Virginia Medicaid
3130 Fairview Park Drive, Suite 500
Falls Church, VA 22042
WV.Medicaid@lewin.com

Submitted By:

Mr. Thomas Duncan
Chairman
Trusted Health Plan (District of Columbia), Inc. DBA Trusted Health Plan
Targeted High Touch Health Plan

March 10, 2016

Mr. Jeff Wiseman
1 Davis Square, Suite 100 E
Charleston, WV 25301-3708

The Lewin Group
Attention: West Virginia Medicaid
3130 Fairview Park Drive, Suite 500
Falls Church, VA 22042

RE: Response to West Virginia Bureau for Medical Services Medicaid MCO Provider Application SFY 2016

Dear Mr. Wiseman and the Lewin Group

Trusted Health Plans, Inc. ("Trusted") is a NCQA accredited Medicaid Managed Care company that is currently operating in the District of Columbia. The owners include, Thomas (Tom) Scully, the former Head of Centers for Medicare and Medicaid Services ("CMS") and the former President and CEO of the Federation of American Hospitals. As a part of Trusted's ownership and executive leadership team, Tom serves as the Chairman of Trusted's Board of Directors. Trusted ownership team is strengthened by the inclusion of Morgan Noble Healthcare Partners ("Morgan Noble"), a Washington, D.C. based principal investment firm focused on keeping patients healthy by investing in and working closely with healthcare service and healthcare IT companies. Like Tom Scully, Morgan Noble's Managing Partner, Robert Haft, brings his considerable healthcare experience and expertise, having been the former CEO of Vitamins.com, Phar-Mor Drugs ($1.5 billion drug retail chain) and Dart Group ($1 billion healthcare company), to Trusted's Board, as a Director. Juggernaut Capital Partners ("JCP"), a Maryland based investment firm with over $600 million of capital under management, is also an owner of Trusted. Finally, Bruce Anderson, co-founder of Welsh, Carson, Anderson & Stowe ("WCAS"), one of the nation's largest healthcare investors with over $20 billion under management, is an investor and thought leader. Trusted's founder and CEO, Thomas Duncan, is also a shareholder. Mr. Duncan holds an MBA in Finance, and completed the Key Executives program at Harvard Business School.
Morgan Noble's current investment holdings include:

- **Continuum Health Alliance**: A physician enablement and population health management company working with payors and providers to drive higher clinical quality, lower cost of care and higher patient satisfaction.
- **Privia Health**: A physician practice management and population health technology company that partners with top doctors to keep people healthy, prevent disease and improve care coordination in-between office visits.
- **Mindoula Health**: A behavioral health collaborative care technology and services platform that partners with providers and payors to provide individualized, 24/7 access to dedicated case management support.

- **Ambient Healthcare**: A specialty pharmacy and home infusion services company supporting disease treatment programs for individuals with acute and chronic diseases.

Prior representative investments made by the Morgan Noble principals include: behavioral health specialty managed care, diabetes focused supplies and care management, correctional healthcare services, community behavioral health services and skilled nursing provider services.

Juggernaut Capital Partners ("Juggernaut" or "JCP") has a 14 year track record in growing middle market companies with proven management teams. We target industries where we have extensive knowledge and experience. JCP and its Principals have substantial expertise investing in the healthcare and insurance industries: Investment examples include:

- **BenefitMall:** underwrites over $5 billion in health insurance premiums
- **Studer Group:** improves clinical outcomes and patient satisfaction
- **Navicure:** health insurance payment solutions
- **Cranford Pharmaceuticals:** specialty prescription pharmaceutical company
- **Foundation Consumer Healthcare:** over-the-counter health brands
- **Ceuta Healthcare Group:** sales and marketing services to healthcare companies

Trusted Health Plans is responding to a Centralized Request for Quotation ("CRFQ"), solicitation number #0511 BMS1600000002, which has been issued by the West Virginia Department of Administration, Purchasing Division, for managed care services. In the event that Trusted is successful through the award of a contract by West Virginia Department of Health and Human Services, Juggernaut and Morgan Noble intend to provide Trusted with the capital required to achieve no less than 300% of RBC (risk based capital) reserves. Based on our actuarial estimates, upon award of a contract with the State of West Virginia, we will need to initially fund $15.5 million to achieve this goal. Therefore, we have committed the $15.5 million to this project.

If you have any questions, please contact me at tducan@trustedhp.com or 202.281.5568.

Sincerely,

Mr. Thomas Duncan
Chairman
Trusted Health Plan (District of Columbia), Inc. DBA Trusted Health Plan
Email: tduncan@trustedhp.com
Mobile: 202.821.5568

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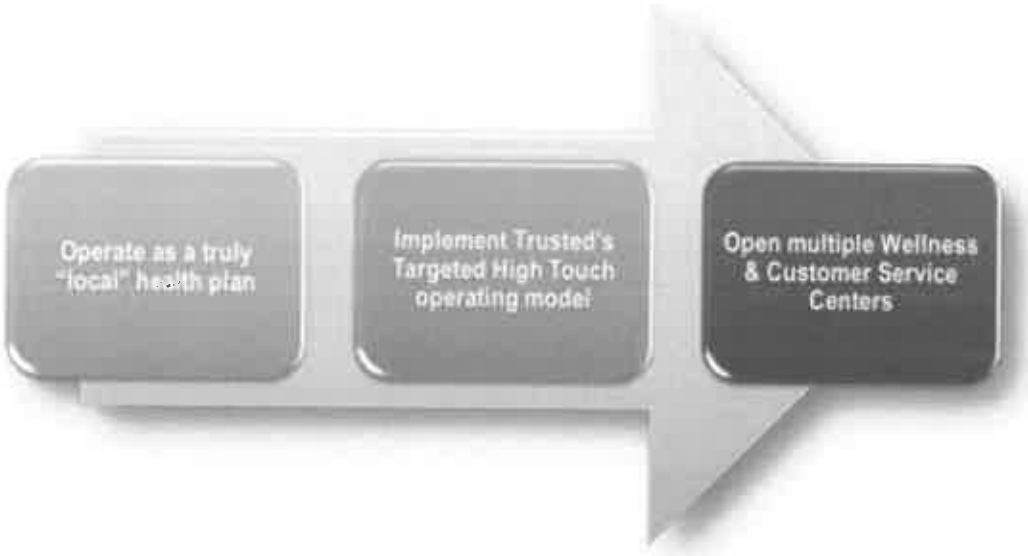
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INTRODUCTION

Trusted Health Plan (District of Columbia), Inc. DBA Trusted Health Plan ("Trusted") is pleased to submit this response for proposal to the West Virginia Department of Administration, Purchasing Division to provide pursuant to **West Virginia Code** §5A-3-10 for the WV Department of Health and Human Resources, Bureau for Medical Services for the provision of statewide managed care services for the Mountain Health Trust program – **RFQ Solicitation Number #0511 BMS1600000002.** We are NCQA accredited, and committed to making a difference in the lives of Medicaid consumers enrolled in Trusted using key differentiators incorporated into our internal operations and overall health plan approach. Trusted is currently operating a Medicaid MCO in DC with 32,000 members. Trusted operates a strategic three-prong approach, as depicted below.

Exhibit 1: Trusted Strategic Approach



A. Local Health Plan

As a key differentiator, Trusted will operate as a "local" company by becoming a part of the community. We will hire and employ its staff in West Virginia. At its office located in the West Virginia, Trusted will perform the following functions:

- Provider Relations & Credentialing
- Care Management & Coordination
- Utilization Review
- Complaints, Grievance, and Appeals
- Community Outreach
- Program Integrity & Compliance
- Enrollment & Eligibility
- Quality & Accreditation
- IT Infrastructure and Operations
- Contract Management

As part of the community, Trusted will partner with local community based organizations to participate in events such as job & health fairs, and participate in initiatives affecting West Virginia.

Trusted's operating model as a local health plan will have a significant economic impact on West Virginia by providing tax revenue and generating revenue for neighborhood restaurants and other small businesses.

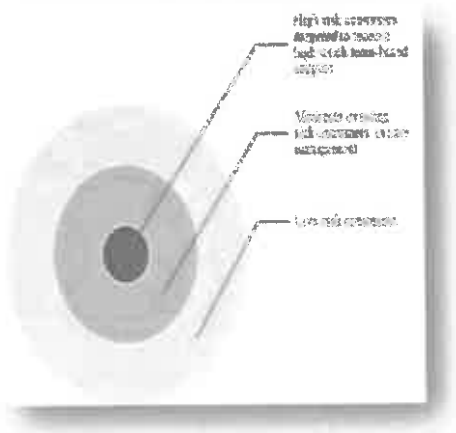


Operating as a truly "local" health plan provides Trusted with the capability to respond optimally to all stakeholder issues, particularly providers'. Trusted can respond quickly and in-person to complaints, training needs, or proactive collaborations to improve access to care.

B. Targeted High Touch

To assist West Virginia in achieving the Triple Aim of better health, better care, and lower costs, Trusted will leverage THP's "**Targeted High Touch**" model to optimize the effectiveness of each area of MCO operations for the benefit of consumers. For example, every week, Trusted will review refreshed claims data to identify new high volume ER utilizers. Trusted will have a collaborative discussion regarding each member with nurse care management and outreach to identify a plan of action to get that member into primary care. Trusted will also discuss consumers that are inpatient with a length of stay higher than 7 days, as well as any members readmitted within 30 days.

Upon identifying consumers with the greatest needs, Trusted will implement real-time team-based "high touch" action plans to address those consumers with the greatest need. Each of these members will be for our complex case management program, which includes high frequency outreach from nurse case managers. Appointments will be set with the consumer to meet face-to-face with us in our Wellness Center or in their community setting. When applicable, Trusted will assign a licensed social worker and/ or nutritionist to the team. Additionally, based on the primary issue affecting the consumer, Trusted will deploy technology as well (e.g. for consumers with uncontrolled diabetes, we provide a state-of-the-art glucometer which helps the member & Trusted nurse care managers simultaneously electronically track their blood sugar).



To optimize results, in all aspects of our operation, including Provider Relations, Claims Processing, Outreach, Program Integrity, and Medical Management, Trusted will utilize this "Targeted High Touch" approach. Trusted's "**Targeted High Touch**" model has been woven throughout its operating model, and has driven significant results for its DC health plan.

ED Utilization	Baseline 2013 vs 2015	• 15% reduction
Readmissions within 30 Days of Discharge	Baseline 2013 vs 2015	• 11% reduction
Behavioral Health Case Management Participation	Baseline 2013 vs 2015	• 14% increase

C. Wellness & Customer Service Centers

In an effort to combat some of the issues that impact the population's health, Trusted will replicate THP's best practice of developing Wellness & Customer Service Centers to provide a brick-and-mortar resource conveniently located for consumers to utilize to engage in daily wellness activities and to receive personal customer services. Trusted will open three (3) Wellness and Customer Service Centers strategically placed throughout West Virginia. **Our Wellness and Customer Service Centers will not be clinics that provide direct clinical care. Rather, they will provide a community-based brick-and-mortar resource that focuses on consumer empowerment through health literacy, nutrition guidance, prevention services, chronic disease and care coordination.** A variety of staff (community outreach workers, social workers, nurses, dieticians, pharmacists, trainers and chefs) will be directly accessible to the membership and their families to promote attainment of health goals and to address social determinants of health.

Exhibit 2: Wellness & Customer Service Centers







Measured results from Trusted's Wellness Center Care Coordination efforts in Washington, DC are below:

Exhibit 3: Wellness Center Care Coordination Results for Diabetes Program

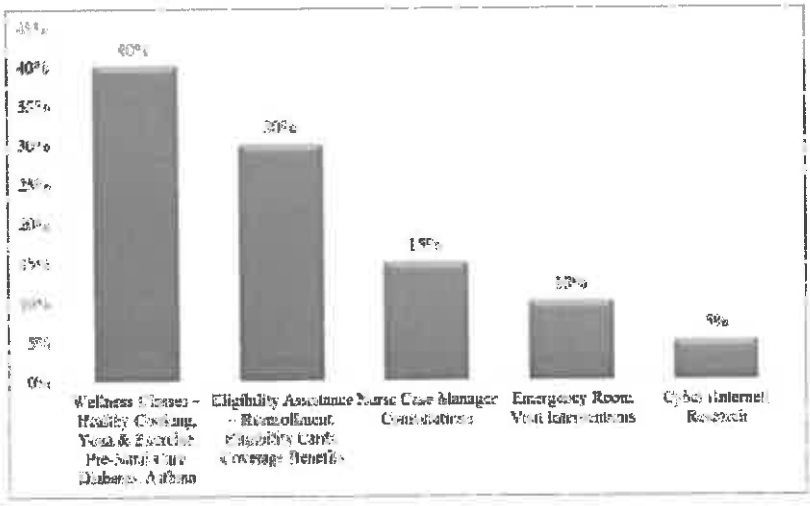
Referred to Provider Types Below:	% of Referrals to Each Provider Type
Primary Care Physician	33%
Ophthalmologist	24%
Podiatrist	36%
Behavioral Health	7%

Clinical Measures			
Averages	**Baseline**	**2nd Visit**	**Difference**
A1C	8.54%	7.2%	-1.34%
BP Systolic	148 mmHg	139 mmHg	-9 mmHg
BP Diastolic	87 mmHg	85 mmHg	-2 mmHg
Random BG	230.0mg/dL	201.6 mg/dL	-29mg/dL
Weight	216.31 lbs	212.6 lbs	-3.71 lbs
BMI	32.8	32.1	-.7
%Body Fat	34.7%	33.6%	-.9%

Clinical Measures			
Percentages	**Baseline**	**2nd Visit**	**Difference**
Members w/ HbA1c > 9%	40%	26%	-14%
Members w/ systolic >140mmHg	49%	43%	-6%
Members w/ diastolic >90mmHg	73%	73%	0%

Based on Trusted's experience in DC, Trusted expects the Centers' utilization to be comprised of the activities below.

Exhibit 4: Wellness Center Utilization



Trusted is dedicated to operating in a "unique partnership" with West Virginia by doing the following:

- ✓ Capital investments in the community and promoting the local economy through hiring locally.
- ✓ Applying a rigorously targeted high touch model to measurably improve our members' health status.
- ✓ Hiring over 80% of our employees from West Virginia.
- ✓ Partnering with FQHCs to drive them panel volume & share in savings based on quality outcomes
- ✓ Structuring its contracts to be heavily value based purchasing (VBP) driven.

I. ORGANIZATIONAL/MANAGEMENT INFORMATION

THP's wholly owned subsidiary, Trusted Health Plan (District of Columbia)	
Legal Name	Trusted Health Plan
Headquarters	District of Columbia 1100 New Jersey Ave., SE Suite 840 Washington, DC 20003
Telephone **Facsimile**	Tel. 202.821.1100 Fax. 202.821.1098
Tax ID	45-2375150
West Virginia POC	**Mr. Thomas Duncan** Chairman Trusted Health Plan (District of Columbia), Inc. DBA Trusted Health Plan Email: tduncan@trustedhp.com Mobile: 202.821.5568

1. Please provide an organizational chart (Chart 1) showing the corporate structure, lines of responsibility, and authority in the administration of the MCO's business as a health plan; and an organizational chart (Chart 2) showing the West Virginia organizational structure and how it relates to the proposed Service Area(s), including staffing and functions performed at the local level. The organizational Chart 2 shall include the names, titles, and contact information for the following key staff positions or functions: Medicaid Line of Business Manager, Medicaid Administrator/Contract Liaison, Chief Financial Officer, Compliance Officer, Medical Director, Medical Management (Utilization Review/Care Management) Director, Care Management Director, Quality Director, Member Services Director, Claims Payment Director, Provider Relations/Network Director, and Information Technology Director. This chart should also indicate the reporting relationships of each of the individuals listed. Provide names and contact information for key personnel who will be assigned to this contract as available. Indicate the city and state where each position will be located.

Exhibit 5: Corporate Structure

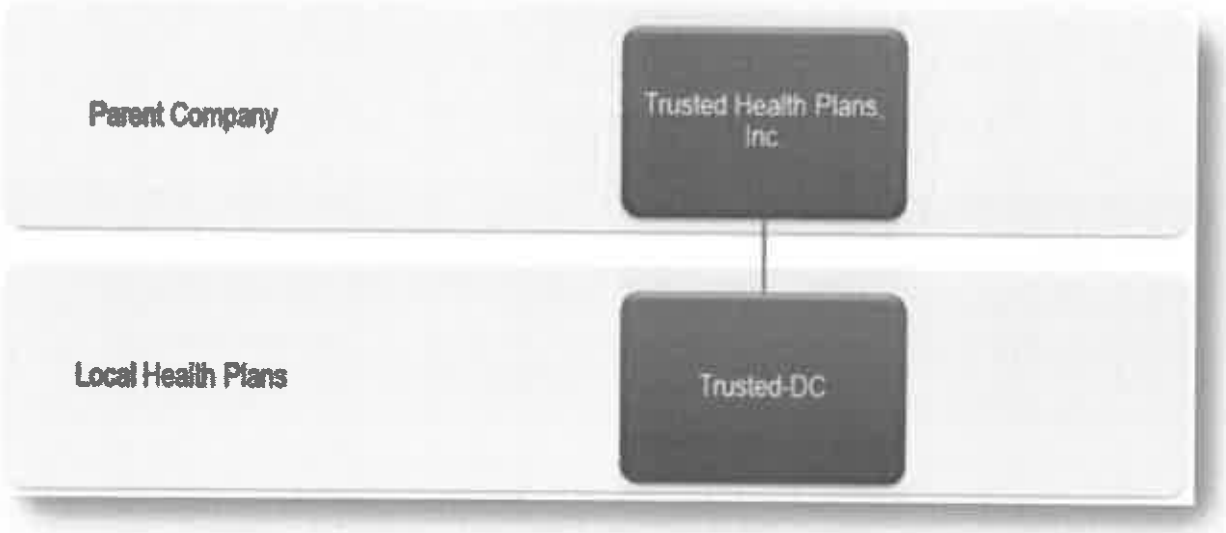
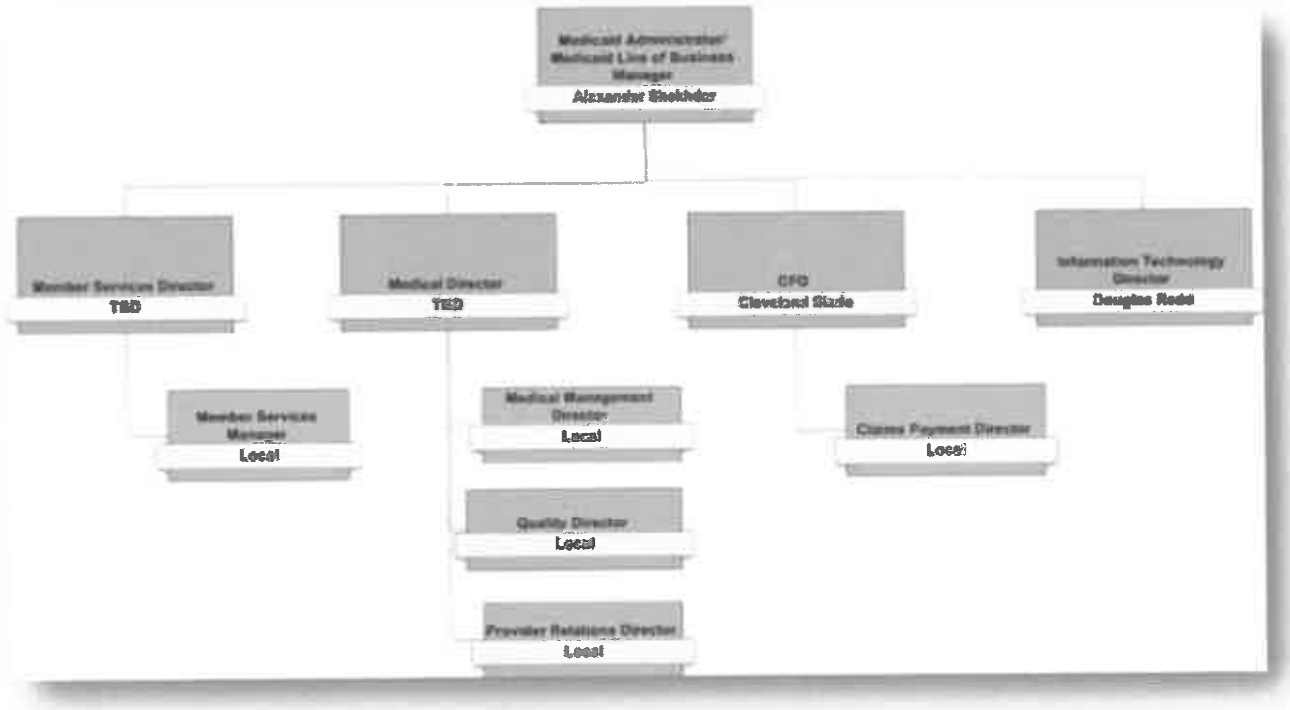


Exhibit 6: West Virginia Organizational Structure



2. Submit a brief narrative explaining the organizational charts submitted, and highlighting the key functional responsibilities and reporting requirements of each organizational unit relating to the MCO's proposed management of the MCO program(s), including its management of any proposed subcontractors.

THP is contracted with the District of Columbia to manage health care services for its Medicaid (DC Healthy Families) and DC Health Care Alliance Program (uninsured) members. THP is responsible for providing medical, dental, vision, pharmaceutical, behavioral health, and transportation services to its members. THP started operations in July 2013 with 26K consumers. Membership has grown by over 17% , and its MLR has dropped from 91.2% to 86.6%. Another noteworthy achievement is THP's EPSDT compliance rate increased by 35% to the highest rate for MCOs in DC at 76% in an unregulated school environment (e.g., vaccinations were not required to attend school). THP achieved the highest EPSDT compliance rate by executing its Targeted High Touch model as depicted below.

Exhibit 7: Targeted High Touch Model

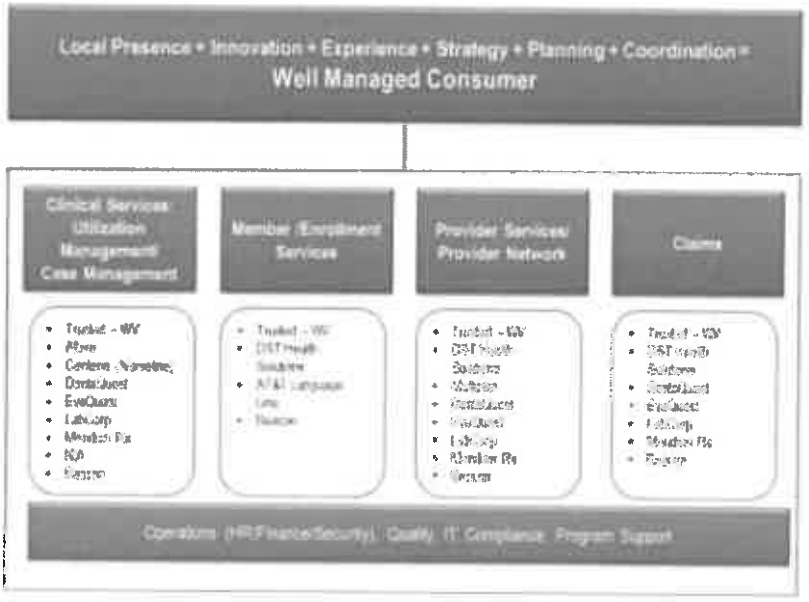


Trusted has created a well-defined organizational structure capable of operating a local health care system that is safe, accountable and of high quality.

Functional Structure

In selecting the Trusted Team, Executives and Key Personnel, we carefully evaluated sections of the West Virginia Medicaid program requirements, NCQA accreditation standards, our experience in the District of Columbia market, Best Practice MCO operations and other RFP requirements. Each team member brings specialized Medicaid expertise, and collectively they provide direct experience in every component outlined in this response. Contract roles of the team members and subcontractors are outlined in the Exhibit below.

Exhibit 8: Trusted's Functional Structure



Recognizing that we have built a large team representing multiple capabilities, geographies, and small business types, Trusted will be the local on-the-ground presence and pay particular attention to subcontract management. We will use our proven lifecycle subcontractor management processes that extend from the start of the subcontract through the quality assurance process to project completion and ongoing monitoring. Our teammates will be fully integrated and managed within the framework of our project team. This "one team" concept ensures open and ongoing communication and visibility into subcontractor task execution and quality of work products. Trusted knows that our success is tied to our subcontractors' success and thus we value and provide continuous team oversight.

The key personnel identified in the Exhibit above comply with the requirements outlined in this Scope of Work (SOW) and their roles and responsibilities are clearly defined. However, Trusted is promoting a culture that erases disparities in the health care outcomes of its consumers; therefore, regardless of whether a person is designated as key, every employee, provider or subcontractor working as a Trusted team member has a responsibility to ensure an consumer receives the best possible comprehensive care based on the belief that everyone, regardless of economic status or behavioral/ physical ability has the right to receive equal treatment. The culture of Trusted is to ensure that any person working for Trusted is empowered to remove barriers to care and find a solution that allows prompt access to services and results in successful health outcomes for the consumer. The Medicaid Administrator/Contract Liaison will serve as the contact for West Virginia's Medicaid Program on day-to-day operational issues between the Department and Trusted.

Key Personnel	Position
Alexander Shekhdar	Serving as both the **Medicaid Line of Business Manager and the Medicaid Administrator/ Contract Liaison**, has authority over the Trusted-WV Medicaid operation including the management of the program, finance, medical management (UM, CM, data, consumer and provider utilization). He will oversee the operation of the Agreement between Trusted-WV and the Medicaid program. He is responsible for overseeing Trusted's responsibilities under this Contract. He will be available during normal business hours to address any customer service or other issues related to this Contract.
Cleveland Slade	**Chief Financial Officer**, a fulltime executive that will oversee the budget and accounting systems implemented by Trusted-WV. He will ensure the timeliness and accuracy of all financial reports.
George Aloth	**Compliance Officer**, a fulltime executive that will oversee and manage the regulatory compliance issues. They will ensure the board of directors and employees are in compliance with the rules of the regulatory agency.
TBD	**Medical Director**, is a West Virginia-licensed physician, he/she will be actively involved in all major clinical program components of Trusted and will directly participate in the oversight of the SNU, QM Department, UM Departments and Wellness and Customer Service Centers.

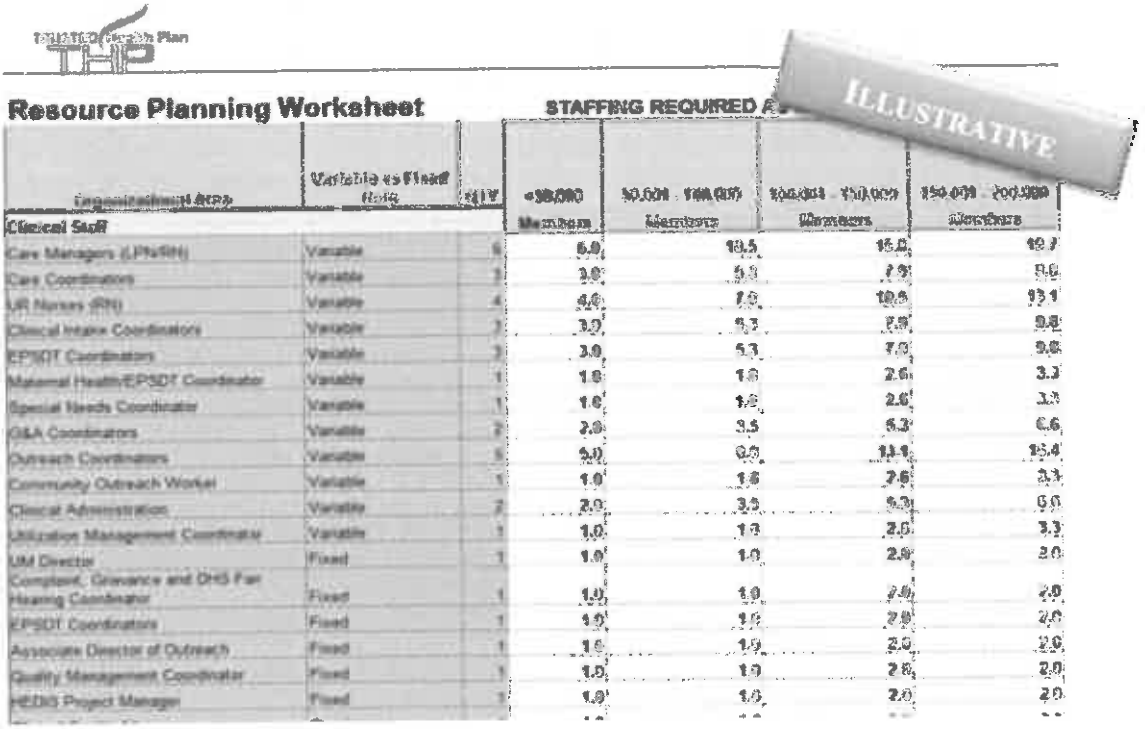
Key Personnel	Position
TBD	**Medical Management Director**, reports to the Medical Director and will oversee the utilization/ case management program.
TBD	**Care Management Director**, a fulltime resource, reports to the Medical Director and is responsible for the case, special needs, EPSDT and disease management programs.
TBD	**Quality Director**, a fulltime resource that will lead and implement continuous survey readiness to meet accreditation requirements, core measures, national patient safety goals, peer review and oversight of the performance process.
Felicia Sears	**Member Services Director,** a fulltime resource that oversees all aspects of the organization's member services policies, objectives and initiatives.
Richard Gillette	**Claims Payment Director,** a fulltime resource that oversees the management and processing of claims.
TBD	**Provider Relations/Network Director,** a fulltime resource that oversees the management and monitoring of Providers.
Douglas Redd	**Information Technology Director,** a fulltime resource that oversees all IT systems and implementations.

3. Provide information on how MCO staffing numbers will change to service the WV Medicaid benefit.

Trusted has developed a graduated staffing plan that accounts for its comprehensive on-the-ground approach to providing for its consumers and still balances the need to incorporate stewardship of costs. Trusted through its experienced management and subcontractors, as well as established networks have first-hand knowledge of what it takes to implement a start-up operation as demonstrated in the District of Columbia. This experience has shaped the implementation phase allowing a ramp up in staff as the membership increases.

A staffing model has been created for the implementation phase. Enrollment is broken up into ranges initiating at less than 50,000 consumers through 200,000+. For each department to be in place by the "Go Live" date, the number of staff needed and the category (e.g. clinical, operations, etc.) for each resource has been identified as well as whether or not the resource is variable (will increase with membership) or fixed (will remain constant regardless of membership). Refer to Appendix H for detailed Staffing Plan.

Exhibit 9: Staffing Plan



Resource Planning Worksheet — STAFFING REQUIRED A… — ILLUSTRATIVE

	Variable vs Fixed Role	FTE	<30,000 Members	30,001 - 100,000 Members	100,001 - 150,000 Members	150,001 - 200,000 Members
Clinical Staff						
Care Managers (LPN/RN)	Variable	5	6.0	10.5	15.0	19.7
Care Coordinators	Variable	1	3.0	5.3	7.5	9.8
UR Nurses (RN)	Variable	4	5.0	7.9	10.5	13.1
Clinical Intake Coordinators	Variable	2	3.0	5.3	7.5	9.8
EPSDT Coordinators	Variable	2	3.0	5.3	7.9	9.8
Maternal Health/EPSDT Coordinator	Variable	1	1.0	1.8	2.6	3.3
Special Needs Coordinator	Variable	1	1.0	1.8	2.6	3.3
Q&A Coordinators	Variable	2	2.0	3.5	5.3	6.6
Outreach Coordinators	Variable	5	5.0	8.8	13.1	16.4
Community Outreach Worker	Variable	1	1.0	1.8	2.6	3.3
Clerical Administration	Variable	2	2.0	3.5	5.3	6.6
Utilization Management Coordinator	Variable	1	1.0	1.8	2.6	3.3
UM Director	Fixed	1	1.0	1.0	2.0	2.0
Complaint, Grievance and DHS Fair Hearing Coordinator	Fixed	1	1.0	1.0	2.0	2.0
EPSDT Coordinators	Fixed	1	1.0	1.0	2.0	2.0
Associate Director of Outreach	Fixed	1	1.0	1.0	2.0	2.0
Quality Management Coordinator	Fixed	1	1.0	1.0	2.0	2.0
HEDIS Project Manager	Fixed	1	1.0	1.0	2.0	2.0

4. Provide a hiring plan for WV Medicaid contract administration

The foundation of our hiring/recruiting methodology is based on sourcing the best candidate for the position. Our recruiting strategy is to aggressively recruit for all positions utilizing our detailed market research, experienced recruiting staff and by posting positions in online portals along with other multi-media advertising. We begin our recruiting process by understanding the contract's specific requirements and differences in skills, the complexity of various disciplines, and professional job difficulty. Trusted's compensation plan provides fair salaries and fringe benefits for the professionals who will work under this contract. Trusted places a heavy emphasis on sourcing staff locally and within a reasonable radius of the work location.

Applicant Tracking: Our Team of recruiters places announcements of openings on the company Web site, which is accessible directly and through numerous job sites and professional associations. Trusted will maintain an extensive database of potential hires for all professional positions. These candidates will be pre-qualified and have passed initial credentialing. These individuals are credentialed and ready to start upon contract award. We rountinely scan our internal Job Bank for appropriate candidates during the start-up phase of each new contract and whenever vacancies occur due to attrition.

Telemarketing Campaigns: Telemarketing calls to prospective staff is as successful as Internet advertising. Cold-calls to passive candidates not only exhibit a proactive and source-intensive approach to meet immediate staffing needs; it is also a way to acquire potential staff for future requirements. These aggressive efforts contributes to the development of active staff pools and also allows Trusted recruiters to effectively establish contact with passive applicants who would have not been identified by means of a less proactive approach.

Professional Referrals: Trusted understands that word-of-mouth, reputation, and relationships are key actors in all recruiting efforts. Our recruiters stay in close touch with current and former staff, and leverage their networks in order to increase our reach.

Exhibit 10: Our familiarity with media lead-time requirements enables more responsive recruiting strategies

Chanel	Example	Lead Time
Web Sites/ Social Media	Indeed, Monster, LinkedIn, Facebook, Twitter, Alumni/Association email databases	Hours
Newspapers	Local and national newspapers	Days
Professional Journals	Journal of Managed Care, Case Management,	Months
Professional Associations	National Association of Healthcare Quality, National Nurses Association	Months

5. Please provide the names of the manager of the West Virginia Medicaid line of business and the Medicaid Administrator/Contract Liaison. If either individual is to be hired in the future, provide an approximate time line for appointment. Provide a current organizational chart for the business unit that will administer the Medicaid line of business. The organizational chart shall include the names, titles, and contact information for the following key staff positions or functions: Medicaid Line of Business Manager, Medicaid Administrator/Contract Liaison, Chief Financial Officer, Medical Director, Medical Management (Utilization Review/Care Management) Director, Quality Director, Member Services Director, Claims Payment Director, Provider Relations Director, and Information Technology Director. This chart should also indicate the reporting relationships of each of the individuals listed.

Refer to Exhibit 6: West Virginia Organizational Structure.

Noted below are Key Administrative positions, name, title, contact information and location of position. The majority of positions will be resourced locally from the community served.

Exhibit 11: Key Administrative Positions/Location

Key Administrative Positions/Functions	Name Title	Contact	Location (City/ State)
Medicaid Line of Business Manager	Alexander Shekhdar	202.821.1100	Charleston, WV
Medicaid Administrator/Contract Liaison	Alexander Shekhdar	202.821.1100	Charleston, WV
Chief Financial Officer	Cleveland Slade	202.821.1100	Washington, DC

Key Administrative Positions/Functions	Name Title	Contact	Location (City/ State)
Medical Director	TBD		Charleston, WV
Medical Management (Utilization Review/Care Management) Director	TBD		Charleston, WV
Quality Director	TD		Charleston, WV
Member Services Director	Felicia Sears	202.821.1100	Washington, DC
Claims Payment Director	Richard Gillette	202.821.1100	Washington, DC
Provider Relations/Network Director	TBD		Charleston, WV
Information Technology Director	Douglas Redd	202.821.1100	Washington, DC

6. Provide resumes of the manager of the West Virginia Medicaid line of business and the Medicaid Administrator/Contract Liaison. If either individual is to be hired in the future, provide an approximate timeline for appointment and job descriptions.

Alexander Shekhdar



Mr. Shekhdar is a strategic business consultant, specializing in Healthcare Law, and Public Health. In his extensive career, he has held responsibilities of developing new State business opportunities, Medicaid expansion, and implementation of government health programs.

7. MCOs are required to have a Medicaid Administrator/Contract Liaison with substantial experience in health care, experience working with low-income populations, and cultural sensitivity. Define the timeframe for initiating and completing training of the Medicaid Administrator/Contract Liaison. Describe any additional training or materials the MCO will provide to the Member Administrator/Contract Liaison to support the enrollment of the SSI population.

Mr. Shekhdar is an experienced healthcare attorney that has worked in the physical and behavioral aspects of managed care. Although he has ample experience in healthcare, he will undergo required

training working closely with BMS. Training will be initiated upon contract award and continue for 90 days with annual refresher training thereafter. Training materials specific to the WV region will be developed and will include defined procedures around the enrollment and management of the SSI population.

8. Submit a copy of the MCO's Certificate of Authority from the Office of the Insurance Commissioner and a copy of all materials submitted to the West Virginia Insurance Commissioner in accordance with the Health Maintenance Organization Application for Certificate of Authority.

Trusted is currently operating a Medicaid MCO in DC with 32,000 members with a DC HMO License. We filed, prior to the submission to this RFQ, for an expedited approval of a HMO license with the WV Department of Insurance as a Foreign HMO. The expedited review process takes 45-60 days. However, because the RFQ specifications did not state the exact date the HMO license is required, and clarifying answers to the question posed were not received until February 29th (11 calendar days prior to the due date of March 10th, making it impossible for an interested MCO that is not currently licensed in West Virginia to bid on the RFQ, we are respectfully submitting our response to CRFQ 0511 BMS1600000002.

9. Provide a list of all counties for which the MCO intends to serve enrollees and indicate whether the MCO has received approval from the Department of Insurance to serve Medicaid enrollees in each county.

Trusted is awaiting approval from the Department of Insurance to Service Medicaid enrollees in the following counties as depicted in the Exhibit below.

Exhibit 12: West Virginia Counties

• Barbour	• Gilmer	• Lewis	• Monongalia	• Raleigh	• Webster
• Berkeley	• Grant	• Lincoln	• Monroe	• Randolph	• Wetzel
• Boone	• Greenbrier	• Logan	• Morgan	• Ritchie	• Wirt
• Braxton	• Hampshire	• Marion	• Nicholas	• Roane	• Wood
• Brooke	• Hancock	• Marshall	• Ohio	• Summers	• Wyoming
• Cabell	• Hardy	• Mason	• Pendleton	• Taylor	
• Calhoun	• Harrison	• McDowell	• Pleasants	• Tucker	
• Clay	• Jackson	• Mercer	• Pocahontas	• Tyler	
• Doddridge	• Jefferson	• Mineral	• Preston	• Upshur	
• Fayette	• Kanawha	• Mingo	• Putnam	• Wayne	

10. Provide the type of ownership of the MCO by its ultimate parent company:

Wholly-owned subsidiary of a private (closely-held) stock corporation.

11. Please provide the following information in accordance with 42 C.F.R. § 455.104:

a) The name and address of any person (individual or corporation) with an ownership or control interest in the MCO. The address for corporate entities must include as applicable the primary business address, every business location, and the P.O. Box address. Date of birth and Social Security Number (in the case of an individual);

Name	Address	DOB	SSN/TIN	%
Frost BPO, LLC				41.5%
Juggernaut Capital Partners III, LP				34.37%
Morgan Noble Healthcare Partners				16.13%
Bruce Anderson				6.4%
Tom Scully				1.6%

Upon Award

b) Tax identification number for a corporation with an ownership or control interest in the MCO or in a subcontractor in which the MCO has a 5 percent or more interest;

Refer to table above.

c) Whether the person (individual or corporation) with ownership or control interest in the MCO and/or subcontractor is related to any other person with ownership or control interest such as a spouse, parent, child, or sibling;

Not applicable.

d) The name of any other organization in which a person with ownership or control interest in the MCO also has an ownership or control interest; and

Refer to Cover Letter.

e) The name, address, date of birth, and Social Security Number of an agent or a managing employee of the MCO.

Name	Address	DOB	SSN
Tommy Duncan	1100 New Jersey SE Washington, DC 20003		**Upon Award**

12. Please describe if the MCO has ever sought, or is currently seeking, National Committee for Quality Assurance (NCQA) or American Accreditation HealthCare Commission (URAC) accreditation status, and indicate: if NCQA or URAC accredited, its current NCQA or URAC accreditation status and its accreditation term effective dates; and if not accredited, a statement describing whether and when NCQA or URAC accreditation status was ever denied.

Trusted-DC is fully accredited by the National Committee for Quality Assurance (NCQA).

Provide the same information for any proposed subcontractors.

- NIA is NCQA certified for UM
- Alere is NCQA certified for CM
- Beacon is a NCQA accredited MBHO
- Although Meridian is NCQA accredited Trusted is not contracted with them for any of their accredited services

13. Provide the number of current Medicaid enrollees in other states, by state. Describe any experience managing services, including pharmacy benefits, for members in other Medicaid programs or other lines of business within West Virginia.

THP currently holds a contract to provide managed care services with the District of Columbia Department of Health Care Finance. Trusted Health Plan, Inc., currently services 31,000 enrollees, which includes Medicaid and Alliance beneficiaries. Pharmacy benefits are included in the managed care scope of services.

14. List any regulatory actions, sanctions, citations, deficiencies, audit findings, investigations, or recommendations received in any state within the last two years, along with the MCO's response and plan of correction.

Trusted Health Plan has not been subject to any regulatory actions, sanctions, citations, deficiencies, audit findings, investigations or recommendation within the last 2 years.

15. Disclose if the MCO or its parent company (including other managed care subsidiaries of the parent) had a Medicaid, Medicare, or any other federal health program managed care contract terminated or not renewed for any reason within the past five (5) years. In such instances, the MCO must describe the issues and the parties involved, and provide the address and telephone number of the principal terminating party. The MCO must also describe any corrective action taken to prevent any future occurrence of the problem(s) that may have led to the termination or non-renewal.

Trusted Health Plan nor Trusted-DC has had a Medicaid, Medicare, or any other federal health program managed care contract terminated or not renewed for any reason within the past five (5) years.

16. Please submit a completed copy of the following table:

Medicaid Administrative Function	Location (City/State)	In-House or Contracted Out?	Other Lines of Business Supported				
			Medicare	Medicaid (List States)	S-CHIP (List States)	Other ____	Other ____
Manager, Medicaid line of business	Charleston, WV	In-house		WV	WV		
Medicaid Administrator/ Contract Liaison	Charleston, WV	In-house		WV	WV		
Member Services	Charleston, WV	In-house		WV	WV		
Provider Contracting		Contracted Out	Nationwide				
Provider Relations	Charleston, WV	In-house		WV	WV		
Utilization Management	Charleston, WV	BH: Contracted Out Medical: In-House					
Care Management	Charleston, WV						
Claims processing		Contracted Out	Nationwide				
Other _____							

17. If the MCO retains a subcontractor for claims processing, pharmacy benefit management (PBM), dental benefits management (DBM), behavioral health management, utilization management, or network development, describe the subcontractor monitoring plan, including activities and monitoring tools of such subcontractor. Provide subcontractor agreements for review and approval.

Trusted's Vendor Oversight will ensure that all subcontractor agreements contain language that states the subcontractor's obligation to meet the same applicable requirements as Trusted's agreement with West Virginia. Subcontractors are responsible for ensuring that its conduct, and that of its directors, officers, and employees complies with all standards of the main contract. Subcontractors are charged with communicating these standards to its directors, officers, and employees, ensuring the understanding of and compliance with the standards, making reasonable efforts to detect and prevent violations of law and the standards. They should also take prompt remedial action when required to

assure continuing compliance. Disregarding or failing to comply could lead to termination of their contract with THP and other possible sanctions. Trusted utilizes a variety of methods to ensure that these standards are being met.

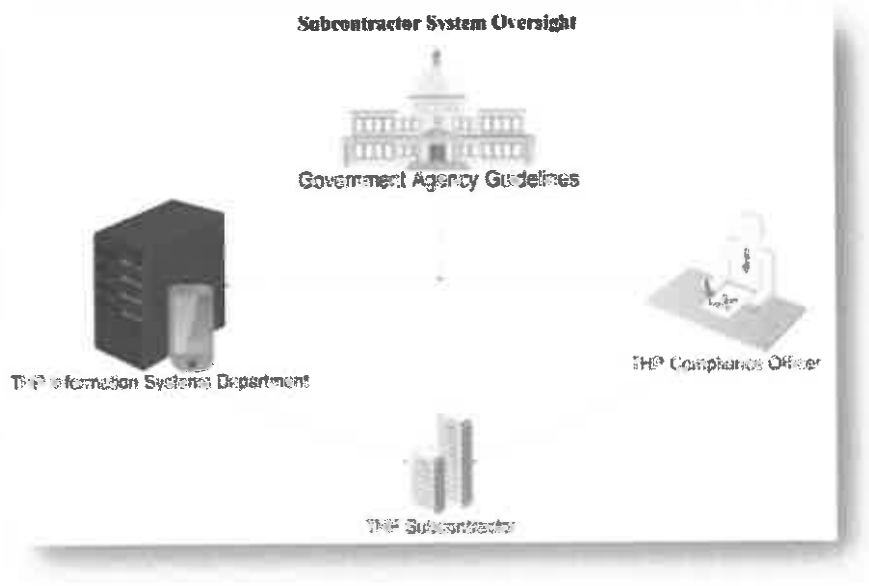
Trusted will meet at least on a quarterly basis with its subcontractors for a performance review and update. During these meetings the subcontractors will report on their key metrics. If they are not meeting their service level agreements then they may be placed on a corrective action plan which may include monetary sanctions. If the vendors continue to fail to meet required standard levels then contract revocation and/or termination may occur.

Vendor Oversight Committee: Trusted will have an internal vendor oversight committee which meets bi-monthly (once every two months). The committee will consist of the vendor oversight manager, the compliance officer, a representative from Quality, a representative from Medical Management, a representative from Finance, a representative from Operations, a representative from Provider Services.

The purpose of the Vendor Oversight Committee (VOC) is to ensure that Trusted Health Plan remains accountable and compliant with regulatory standards for the delegation of core administrative and management functions through the ongoing monitoring of network providers, vendors and other contractors.

Delegated core administrative and management functions may include, but are not limited to, credentialing, network development, pharmacy benefit management and claims administration. The VOC is responsible to oversee the ongoing assessment of performance results to ensure business goals and outcomes are achieved to further the delivery of quality health goals and outcomes for our members.

Exhibit 13: Subcontractor System Oversight



Onboarding

Trusted always includes contract language in their subcontractor agreements that specifically mirrors the MIS requirements to those that are in our contract with the Agency. This ensures that the subcontractors are held accountable to the same standards as Trusted.

Additionally, as part of the onboarding process, Trusted trains the subcontractors on these MIS requirements. Examples of this include: reporting, exchanging of files via secure FTP connection, and encounter data requirements. Process requirement documents are signed off on by both sides after any implementation or change to a MIS-related process.

Monitoring

Trusted performs various monitoring functions to ensure that the vendors are meeting the MIS requirements outlined in their contract with Trusted. If the vendor fails to meet these requirements they are put on a corrective action plan with possible monetary sanctions imposed. If the vendor continues to fail to remediate the issue(s), then it may lead to possible revocation and/or termination of the contract.

Quality Control Audit

Trusted performs periodic audits of subcontractor policies and systems (claims processing, enrollment and eligibility). These audits include an assessment of cyber security results and a review of MIS-related policies and procedures among others.

Periodic Reporting

Trusted regularly reviews reports submitted from subcontractors for reasonableness and accuracy. Subcontractors are required to submit a variety of reports to satisfy various regulatory requirements. Trusted uses this report in conjunction with operational reports to help to ensure that subcontractors are meeting the same minimum requirements that Trusted is required to meet.

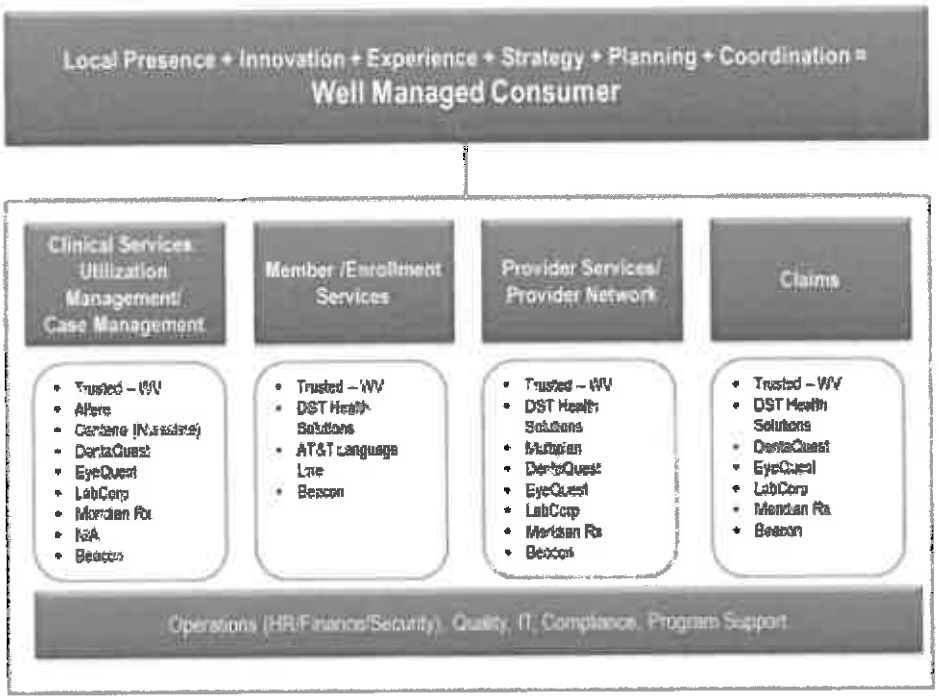
Review of Governmental Audit Results

In many cases subcontractors must undergo regulatory audits similar to those that Trusted Health Plan must undergo. Trusted is able to review the results of those audits when released by the government agency. In some cases the audits are conducted in tandem with Trusted Health Plan. In those instances Trusted Health Plan and the subcontractor are audited side-by-side.

Subcontractor agreements are provided in Appendix D.

18. Provide an organizational chart for subcontractors demonstrating how the subcontractor(s) will be managed within the MCO's WV organizational structure, including the primary individuals at the MCOs organization and at each subcontractor organization responsible for overseeing such subcontract. This information may be included in Chart 2 or in a separate organizational chart(s).

Exhibit 14: Trusted's Functional Structure



Recognizing that we have built a large team representing multiple capabilities, geographies, and small business types, Trusted will be the local on-the-ground presence and pay particular attention to subcontract management. We will use our proven lifecycle subcontractor management processes that extend from the start of the subcontract through the quality assurance process to project completion and ongoing monitoring. Our teammates will be fully integrated and managed within the framework of our project team. This "one team" concept ensures open and ongoing communication and visibility into subcontractor task execution and quality of work products. Trusted knows that our success is tied to our subcontractors' success and thus we value and provide continuous team oversight.

Below are the Point of Contacts (POC) at Trusted that will provide oversight of each subcontractor along with the subcontractor's POC.

Subcontractor	Trusted POC	Subcontractor POC
Beacon	Judith Hinton, RN, MBA	Kim Farley, LICSW, LCSW-C
Meridian RX	Jose Diaz-Luna, RPh	Andrew Miller
DST	Richard Gillette	John Brown
DentaQuest	Ahna Millat	Miguel McInnis

19. If contracting with a PBM or other benefits manager, provide a separate listing/table of PBM functions vs. MCO functions in administering the pharmacy and/or other benefit (e.g., recruitment, member calls, provider education)

MerdianRX is Trusted's Pharmacy Benefit Manager. The following outlines the functions and applicable responsible organization.

Function	Trusted	MeridianRX
Recruitment		X
Network Development		X
Credentialing		X
Member Calls	X	
Provider Education	X	

20. If not provided within a subcontractor monitoring plan, identify types of reports/data that will be provided to the MCO, from the subcontractor, to help manage the medical, pharmacy, or any other benefit. Indicate the overall content of reports and the frequency with which they will be provided to the MCO. Please provide sample reports where available.

Attached in Appendix D are a list of reports/ data required from the subcontractor and the frequency with which they are provided to Trusted. An example of the reports are also included.

21. If not provided within a subcontractor monitoring plan, provide a description of how the MCO will use reports/data from the subcontractor to ensure appropriate vendor oversight and beneficiary access/satisfaction/continuity of care.

Trusted has outlined in its Subcontractor Policy (Appendix D) how it will use reporting and data to monitor its subcontractor's performance.

22. If not provided within a subcontractor monitoring plan, identify the frequency of contact/status calls with the subcontractor upon go-live and on an ongoing basis.

Trusted will meet at least on a quarterly basis with its subcontractors for a performance review and update

23. Describe a plan that will be followed in the event that the subcontractor does not fulfill its contract or service obligations including details on any corrective action plan processes.

During the vendor oversight meetings, the subcontractors will report on their key metrics. If they are not meeting their service level agreements then the subcontractor may be placed on a corrective action plan which may include monetary sanctions. If the vendors continue to fail to meet required standard levels then contract revocation and/or termination may occur.

24. Describe the MCO's contingency plan in the event that the MCO or the subcontractor terminates its contract, including plans to identify another subcontractor and transition steps that would take place to ensure uninterrupted beneficiary access.

Trusted has incorporated a sufficient notice clause into the agreement and prior to termination replacement of subcontractor will be identified. The detailed Contingency Plan will be provided upon award.

25. Describe whether each subcontractor is an affiliate of the MCO or an unrelated third party.

All of Trusted's Subcontractors are unaffiliated and an unrelated third party.

26. Describe each subcontractor's corporate background and experience, including its estimated annual revenues from unaffiliated parties, number of employees, location(s), and identification of three (3) major clients.

Exhibit 15: Our Team

	Managed Experience	Experience with Various State Programs	Auditing Experience	Data Mining/Analysis Experience	Healthcare Fraud Experience	Experience Implementing Multiple, Interdependent Operatations
DST Health Solutions, LLC	✓	✓	✓	✓		✓
AT&T Language Line	✓	✓	✓	✓		✓
NIA	✓	✓	✓	✓		✓
DentaQuest	✓	✓	✓	✓		✓
Meridian RX	✓	✓	✓	✓		✓
Alere	✓	✓	✓	✓		✓
LabCorp	✓	✓	✓	✓		✓
Centene	✓	✓	✓	✓		✓
HMS	✓	✓	✓	✓		✓

DST has extensive experience with State Medicaid plans. DST has the largest health plan claims BPO supplier in the United States. DST's systems and services provide health claims processing and support for more than 250 payers representing nearly 23 million lives. DST's clients range in size from 10,000 members to more than one million covered lives.

DST has worked with *THP* since 2013. They have knowledge of State encounter data filing/processing/submission, health care processing knowledge, CMS Regulation changes for Medicaid, claims processing and adjustments handling Medicaid contracts in West Virginia.

- **Service Provided:** Provide BPO to include claims management; eligibility and encounter management; provider services; MMIS; IT services and reporting.
- Upon award Trusted will provide the following information:
    1. Estimated Annual Revenues from unaffiliated parties:
    2. Number of Employees:
    3. Locations:
    4. Clients:

Language Line has worked with THP since 2013. Today, the Language Line meets the spoken language and American Sign Language requirements of customers throughout North America and the United Kingdom. On any given day, they provide in excess of one hundred thousand interpretations. They serve governments, hospitals, police departments, emergency response organizations, as well as financial services, insurance companies, transportation agencies and countless other organizations that encounter language barriers.

- **Service Provided:** Translation Services
- Upon award Trusted will provide the following information:
    1. Estimated Annual Revenues from unaffiliated parties:
    2. Number of Employees:
    3. Locations:
    4. Clients:

NIAMagellan.

NIA has worked with THP since 2014. NIA's portfolio includes the management of advanced imaging, cardiac (diagnostic and therapeutic), OB Ultrasound, radiation oncology, emergency department (CT) imaging, and musculoskeletal (spine surgery, interventional pain management, and physical medicine) services, and the optimization of genetic benefits testing. NIA offers myriad of management strategies including prior authorization, retrospective review, clinical decision support, site of service, network builds, provider assessment, physician profiling, and claims auditioning/editing based on customers' needs.

- **Services Provided:** Provide Radiology Benefit Management services; UM; peer-to-peer consultations; claims audits and quality reporting
- Upon award Trusted will provide the following information:
    1. Estimated Annual Revenues from unaffiliated parties:
    2. Number of Employees:
    3. Locations:
    4. Clients:

DentaQuest

DentaQuest/EyeQuest: Administers dental and eye care benefits to over 15 million people nationally improving oral and eye health in 23 states including the District of Columbia through highly effective prevention-focused initiatives. They offer innovative dental and eye care benefit programs, exploring ways to improve effectiveness of care while supporting efforts to raise awareness in the importance of oral and eye care health. DentaQuest has worked with THP since 2013.

- **Services Provided:** Provide dental and vision services; provider credentialing; UM; network access and adequacy requirements and quality reporting.
- Upon award Trusted will provide the following information:
    1. Estimated Annual Revenues from unaffiliated parties:
    2. Number of Employees:
    3. Locations:
    4. Clients:

MeridianRx is a full-service Pharmacy Benefit Manager (PBM) committed to transparency, flexibility and innovation. Our clients have complete network access, lower administrative fees and fast, reliable claims processing. Meridian Rx has worked with THP since 2013.

- **Services Provided:** Provide Pharmacy Benefit Management services; credentialing; network adequacy requirements; claims payment and quality reporting
- Upon award Trusted will provide the following information:
    1. Estimated Annual Revenues from unaffiliated parties:
    2. Number of Employees:
    3. Locations:
    4. Clients:

Alere empowers women to make choices that enable them to experience successful pregnancies. Delivering services across the entire continuum for maternal-newborn care, programs include risk assessment and education. Alere has the nation's leading neonatal program (NICU Care Management Program) for early infant care management. Alere has worked with THP since 2013.

- **Services Provided:** Provide OB assessments and evaluations; OB case management services; OB home care services and NICU utilization management
- Upon award Trusted will provide the following information:
    1. Estimated Annual Revenues from unaffiliated parties:
    2. Number of Employees:
    3. Locations:
    4. Clients:

LabCorp: A pioneer in genomic testing and the commercialization of new diagnostic technologies, LabCorp is one of the world's largest clinical laboratories. LabCorp is also listed on the S&P 500. They offer a broad range of routine and esoteric/genomic assays, and test more than 370,000 specimens daily for over 220,000 clients nationwide. LabCorp's reputation and proven record in the area of advanced genomic testing continues to attract the leading minds and technological pioneers in the field. Lab Corp has worked with THP since 2013.

- **Services Provided:** Provide lab services; credentialing; CLIA certification, network adequacy requirements and quality reporting
- Upon award Trusted will provide the following information:
    1. Estimated Annual Revenues from unaffiliated parties:
    2. Number of Employees:
    3. Locations:
    4. Clients:

Centene is committed to improving the health of the community through health insurance solutions for the under-insured and uninsured, and through specialty services that align with a focus on whole health. Centene provides health plans through Medicaid, Medicare and the Health Insurance Marketplace and other Health Solutions through our specialty services companies.

Trusted will partner with Centene for their "NurseWise" Services. Nurse Wise is a medical triage and health education phone service that provides 24/7 support to the patients of contracted clients. Centene has worked with THP since 2014.

- **Services Provided:** Nurse Advice Line.
- Upon award Trusted will provide the following information:
    1. Estimated Annual Revenues from unaffiliated parties:
    2. Number of Employees:
    3. Locations:
    4. Clients:



HMS will provide coordination of benefits services, including cost avoidance and third party recovery. The company currently provides these services to more than 220 health plans and 45 state agencies, generating billions of dollars in savings for clients annually.

- **Services Provided:** Provide coordination of benefits services; cost avoidance; third party recovery.
- Upon award Trusted will provide the following information:
  1. Estimated Annual Revenues from unaffiliated parties:
  2. Number of Employees:
  3. Locations:
  4. Clients:

27. Describe any screening processes designed to ensure that the MCO does not subcontract with entities that are prohibited, suspended, or excluded from participating in Medicare, Medicaid, or other federal health care programs. See 42 C.F.R. § 455 et.seq. as a reference to what minimum screenings are required.

Trusted screens its subcontractors to ensure they are not prohibited, suspended, or excluded from participating in Medicare, Medicaid, or other federal health care programs.

28. Provide a written draft of the MCO's Fraud and Abuse Compliance Plan.

Refer to Appendix P for the Trusted's Fraud and Abuse Compliance Plan.

29. Submit for review employee False Claims training in fraud and abuse detection, prevention, and reporting.

The Employee False Claims Training in fraud and abuse detection, prevention, and reporting is attached in Appendix E.

30.

31. Submit for review any Value-Added Services to be offered.

Trusted was founded based on the premise that a Medicaid managed care organization can assist its membership improve their health behaviors through personal engagement, health education and improved access to the continuum of health care services. Trusted encourages consumers to take personal responsibility for their own health care benefits and involves them to achieve wellness and healthy lifestyles through a variety of strategies identified below:

- Wellness & Customer Service Center
- Wellness Warriors Program
- Telcare
- HIGI
- WellSource
- mHealth
- Website Health Portal
- Text4Baby
- Incentives

Wellness & Customer Service Centers

Trusted will utilize its Wellness Centers to provide face-to-face access to its members in the communities in which they live. Members can go to a Wellness Center to change or replace their ID card, change their PCP, get assistance with transportation, file a complaint or get questions answered. Our Wellness Centers will have wellness coaches, case managers, care coordinators, health educators, yoga, aerobic exercise classes and a cooking kitchen where we demonstrate healthy cooking. Computers are also available so that members can go online to access the member portal, and search for employment.

In an effort to combat some of the issues that impact the population's health, Trusted will have three (3) Wellness and Customer Service Centers strategically placed throughout West Virginia.. **Our Wellness and Customer Service Centers provide a community-based brick-and-mortar resource that focuses on consumer empowerment through health literacy, nutrition guidance, prevention services, chronic disease and care coordination.** Measured results from THP's Wellness Center in Washington, DC are below:

Exhibit 16: Wellness Center Care Coordination Results for Diabetes Program

Referred to Provider Types Below:	% of Referrals to Each Provider Type
Primary Care Physician	33%
Ophthalmologist	24%
Podiatrist	36%
Behavioral Health	7%

Clinical Measures			
Averages	**Baseline**	**2nd Visit**	**Difference**
A1C	8.54%	7.2%	-1.34%
BP Systolic	148 mmHg	139 mmHg	-9 mmHg
BP Diastolic	87 mmHg	85 mmHg	-2 mmHg
Random BG	230.0mg/dL	201.6 mg/dL	-29mg/dL
Weight	216.31 lbs	212.6 lbs	-3.71 lbs
BMI	32.8	32.1	-.7
%Body Fat	34.7%	33.6%	-.9%

Clinical Measures			
Percentages	**Baseline**	**2nd Visit**	**Difference**
Members w/ HbA1c > 9%	40%	26%	-14%
Members w/ systolic >140mmHg	49%	43%	-6%
Members w/ diastolic >90mmHg	73%	73%	0%

Wellness Warriors

In the District of Columbia, members have utilized THP's Wellness Center at a surprising rate, and rely on the center to support their mission to improve their health through changing their health behaviors, and monitoring their chronic conditions. In recognition of the effort and changes that many of the participants were making, THP created a program entitled: Wellness Warriors. The

Wellness Warrior program is a program designed to inspire consumers to take a proactive role in improving their health care status. The Wellness Warrior program videotapes, interviews and profiles members that participate in health education, case management, exercise and other classes held at the Wellness Center. The videos are entirely voluntary for members that wish to participate.

In addition, members will be able to view the videos on the Trusted's website, and all heads of households will receive quarterly newsletters which will highlight a Wellness Warrior. Wellness Warriors are also promoted through advertisements and flyers to promote Trusted community events.

A Wellness Warrior story:
"...I started using the Wellness Center...initially using the computer in the Cyber Cafe. I was invited to a cooking demonstration and I tried some of the recipes out at home. I took the aerobics classes and participated in the Diabetes classes. Since joining, I have dropped over 30lbs and my HbA1c went from 12 to 8."

Website Health Portal

Trusted will provide its members with a robust website health portal that will serve as the online hub for a wide range of health care related activities, services and resources. The website will offer a rich library of multi- media resources designed to address different learning styles and individual education preferences. Consumers will be able to retrieve their claims and medical record data. Additionally, Trusted will offer the following web-based educational resources:

- WellSource – a web based self-management tool that enables members to take self-assessments and access health educational materials at the 4th grade level through the Trusted member portal.
- Community Health TV – Culturally competent health video programming that members can access through the Trusted member portal.
- Calendar of Events
- Newsletters
- Disease Management self-referrals
- Case Management self-referrals
- PCP referrals and changes
- Email directly to Member Services with a 24 hour turnaround time
- Member Handbook
- Provider Directory

Text4baby

Trusted will promote Text4Baby, a free mobile information service designed to promote maternal and child health amongst our perinatal population. Text4baby provides pregnant women and new moms with information regarding their health and health of their babies in order to give their babies the best possible start in life. Women who sign up will receive free SMS text messages three times each week. The messages will focus on a variety of critical maternal and child health topics, including fetal development, birth defects prevention, immunizations, pregnancy symptoms, nutrition, breast-feeding, alcohol, drugs and smoking use, mental health as well as various hotline numbers for additional help and guidance.

mHealth

Trusted will assist members apply the mHealth app on their cell phones, based on the member's condition. The purpose is to build their knowledge of their condition, remain engaged with treatment regimens and ultimately better manage their conditions. Trusted case managers will assist members apply the app and be available to answer any questions.

HEDIS Education and Screening Program

Members identified as having a care gap based on the Comprehensive Diabetes Care and Appropriate Asthma Medication Management HEDIS measures will be contacted by a Trusted Care Coordinator or Case Manager depending on level of disease severity. The goal of the outreach is to encourage certain self-management behaviors in order to close known care gaps of members and improve compliance with these HEDIS measures, resulting in improved quality of care and improvement in HEDIS rates.

Incentives

Trusted will provide incentives to members to comply with EPSDT well child visits, immunization schedules, adult HEDIS measures and perinatal visit standards. Incentives will include but not be limited to gift cards, school uniforms, car seats, and pack-n-plays.

Telcare

Trusted has embarked on an innovative technology called Telcare, which is an electronic glucometer that uses cloud computing to transmit each member's blood sugar reading to the members cell phone and email, as well as to the Trusted case manager, who can monitor the member's results. The electronic transmissions are color coded so the member may receive a reading message in red! The outcome of using this glucometer is that the member is encouraged to be aware of his/her readings and enables Trusted to monitor the member's glucose levels.

HIGI

HIGI – HIGI machines are located throughout West Virginia. Trusted members will be able to go to any of those stores to monitor their weight, blood pressure and BMI. This information is transmitted to the members email and cell phone. In addition, the information utilizes cloud technology and transmits the member's information to Trusted. The readings are color coded, and give the member a message with explanation regarding the results. For example, if the member registers a systolic blood pressure of 140, the reading will be in red, with a message that says "dangerous", and an explanation to go to your PCP. They are free. We advise our members to utilize the machines on a regular basis and to call us with any questions.

32. Provide a high-level description of the records retention process.

In accordance with its agreement with the Department, Trusted will maintain its books and records relating to WV's Medicaid managed care program services and expenditures, including reports to BMS and source information used in preparation of these reports. These reports will include but are not limited to financial statements, records relating to quality of care, and medical records. Trusted agrees to permit inspection of its records, in accordance with Federal and State laws and regulations regarding confidentiality. Any information requested by BMS, will be submitted by Trusted in a manner that maintains the confidentiality of involved parties (e.g., blacking out members' and

providers' names).

Trusted will comply with the record retention requirements of Title 45, Sections 74.21 through 74.23 (45 CFR 74.21 through 74.23) and such records, with the exception of medical records and member and provider quality assurance and quality improvement records when confidentiality is protected by law, are the property of BMS.

Upon non-renewal or termination of this contract, Trusted agrees to turn over or provide copies to BMS or to a designee of BMS all documents, files and records relating to persons receiving services and to the administration of this contract that BMS may request.

Trusted will provide BMS and its authorized agents with reasonable access to its records for the purposes of this contract. Trusted understands that BMS and its authorized agents will request access in writing except in cases of suspected fraud and abuse. Trusted will make all requested medical records available within ten working days of BMS' request. Any of Trusted's subcontractor agreements will include a provision specifically authorizing access in accordance with the terms set forth in the WV contract.

Audit Accounting and Retention of Records

Trusted, for purposes of audit, will provide WV, the Secretary of the U.S. Department of Health and Human Services and his/her designated agent, and any other legally authorized governmental entity or their authorized agents access to all its materials and information pertinent to the services provided under this contract, at any time, until the expiration of five years from the completion date of this contract as extended. Trusted agrees to comply with the provisions of Section 1861 (v)(1)(I) of the Social Security Act, as amended, governing the maintenance of documentation to verify the cost of services rendered under this contract.

Trusted agrees that authorized State representatives including, but not limited to, Department personnel, the State Auditor and other State and/or any applicable Federal agencies providing funds will have access to and the right to examine the items listed above during the contract period and during the five year post contract period or until final resolution of all pending audit questions and litigation. During the contract period, access to these items will be provided to BMS at all reasonable times. This may require the identification and collection of data for use by medical audit personnel. During the five year post contract period, delivery of and access to the listed items will be at no cost to the State.

Trusted understands that BMS may, at its option, conduct an audit of its operations as they pertain to services and recoveries pursuant to the contracted services.

The State and its authorized agents may record any information and make copies of any materials maintained for the purposes of this contract necessary for the audit, except member and provider quality assurance and quality improvement records when confidentiality is protected by law.

Accounting

Trusted will maintain accounting records relating to the performance of the contract. These accounting records must be maintained in accordance with generally accepted accounting principles.

Separate Accounting Records

Trusted agrees to maintain separate books, records, documents, and other evidence pertaining to the

administrative costs and expenses of the contract to the extent and in such detail will properly reflect all revenues and all costs of whatever nature for which reimbursement is claimed under the provisions of the contract. All such documents will be made available to BMS at its request, and will be clearly identifiable as pertaining to the contract.

Retention of Records

All financial and programmatic records, supporting documents, statistical records and other records of enrollees, which are required to be maintained by the terms of this contract, will be retained for at least five years from the date of expiration or until any ongoing audits have been settled, if longer. If any litigation, claim, negotiation, audit or other action involving the records has been started before the expiration of the five year period, the records will be retained until completion of the action and resolution of all issues which arise from it or until the end of the regular five year period, whichever is later. Trusted agrees to retain the source records for its data reports for a minimum of five years and will have written policies and procedures for storing this information.

II. NETWORK DEVELOPMENT

33. Provide a general recruitment plan describing the mechanisms the MCO/PBM/other benefits manager will use to build network access. The plan must also describe methods the MCO/PBM/other benefits manager will use to monitor and evaluate ongoing access to services (e.g., time/distance, appointment timeliness)

Trusted is committed to establishing and maintaining a robust provider network in geographically accessible locations for the populations we serve. Trusted's ability to establish a full provider network adequate to provide coverage to the WV Medicaid population is demonstrated by executing our signed Letter of Intent directly with Multiplan Inc., a Preferred Provider Organization with over 5,900 providers including:

- 78% of area hospitals
- One hospital within 15 miles, for 63% of the service area
- Two primary care physicians and two specialists within 8 miles, for 64% and 60% of the service area respectively
- 28% of practitioners have at least one primary care specialty and 79% have at least one non-primary care specialty

This network ensures that Trusted will meet the requirements for providers and ensure that all Medicaid beneficiaries enrolled in Trusted WV will have access to the appropriate numbers and types of providers.

Upon award, Trusted will employ a network implementation team under the leadership of Alex Shekhdar, **Medicaid Administrator/ Contract Liaison** to finalize contracting, recruit new providers and begin orienting providers to Trusted WV and the HealthChoices program. In parallel, Trusted's Credentialing Manager will ensure all direct and delegated credentialing activities are completed by the contract start date.

Trusted's delegates it pharmacy network development activities to MeridianRx. MeridianRx is responsible for ensuring adequate and timely access to medications for its membership. MeridianRx's national pharmacy network currently has direct contracts with over 66,287 pharmacies. Each pharmacy in our network has signed a contract with MeridianRx that obligates them to dispense covered outpatient medications under the payment terms outlined in the contract.

Network Development

Trusted's subcontractor, MultiPlan will develop and maintain its Provider network (PHCS Network) in WV. The PHCS Network is certified for credentialing and re-credentialing by the National Committee for Quality Assurance (NCQA); therefore, consumers can be sure that our provider network is committed to quality. In addition, Trusted will provide delegated credentialing oversight. In WV, the PHCS Network provides access to 5,900 practitioners, acute care hospitals and multiple ancillary facilities.

MultiPlan intends to replicate the footprint of its existing PHCS Network in WV through the use of unilateral amendments as allowed and through direct negotiations with participating providers for the WV Medicaid program. Additional provider types such as Rural Health Clinics, Federally Qualified Health Centers, Community Health Clinics, Critical Access Hospitals, and other eligible provider types will be targeted for recruitment. Trusted has already received several Letters of Intent from established providers, FQHCs, Hospitals and ACO for inclusion in the Network upon award.

Upon finalization of the contract template and addendum documents for use in West Virginia (in progress), mailings will commence to providers offering them an opportunity to participate with Trusted-WV. Follow-up activity will be conducted through a variety of means, including telephonic, e-mail, and face-to-face contact to ensure rapid return of documents and to allow providers an opportunity to ask questions and clarify materials needed for inclusion in this program. Additionally, recruitment mailings will target eligible providers as identified through external sources such as the BMS website and other lists available to the MCOs.

Our goal is to have a fully contracted and credentialed network that meets adequacy standards in preparation for readiness and review activities and events, including directory submission and open enrollment activities.

Trusted will monitor network adequacy using the published access and availability standards and census data as available to ensure compliance with the network access standards. Progress will be monitored using dashboard reporting and resources will be assigned as warranted to ensure that benchmarks are met throughout readiness review, implementation and through ongoing monitoring to address network attrition as applicable. MultiPlan's dashboard reports are also used to illustrate to the state or Trusted its network development progress by provider type and geographical area. Refer to Appendix F - Sample Dashboard Reports.

MultiPlan's network development team comprises experienced and seasoned veterans in the Managed Care Industry. At a minimum, each member possesses a bachelor's degree or equivalent work experience in the healthcare industry and field of Managed Care. Each has specialized knowledge and experience with Medicaid, CHIP and commercial, CHIP programs in multiple states such as Texas, Kansas, Ohio and with Medicare Advantage programs across the nation. Job descriptions for each role are available for review.

Trusted will maintain and support a robust Provider Recruitment and Retention Plans that provides opportunities for primary care providers to participate in community based health care initiatives, networks, and cooperative agreements and/or develop affiliations with other health care entities for the purpose of continued personal, professional and/or academic growth and development.

34. Describe efforts the MCO has made or will make to contract with providers who currently serve Medicaid TANF, ACA Expansion and SSI-related members including providers with experience and expertise in treating populations with special health care needs. Please address multiple types of providers (e.g., physicians and other providers, facilities, pharmacies).

The special needs of Medicaid recipients vary greatly. Some require minimal treatment modification, while others require highly specialized care and treatment plans. At the time of recruitment, we determine a provider's ability to treat a variety of special-needs patients. The local WV Provider Services Representatives will **visit providers one on one** to verify that the providers can meet the unique needs of our members, help the members acclimate to our program, and educate them about the

care coordination services available through Trusted. These Representatives offer resources that will reduce the administrative burden often associated with participating in a Medicaid Program and with caring for special-needs members.

Network Adequacy and Accessibility: Trusted will routinely evaluate network participation based on its access and availability standards. MultiPlan networks have also consistently realized national net growth, and will continue in advance of Trusted's access needs.

The PHCS Network will use the following network adequacy standards for the state of WV as directed by BMS.

Provider Group	Urban Standard (Minutes)	Suburban Standard (Minutes)	Rural Standard (Minutes)
PHCS-MPI: HOSPITALS	1 in 30	1 in 45	1 in 60
PHCS-MPI: NURSING FACILITY	1 in 30	1 in 45	1 in 60
PHCS-MPI: PRIMARY CARE PHYSICIAN	2 in 30	2 in 45	2 in 60
PHCS-MPI: PCP - FAMILY PRACTICE	2 in 30	2 in 45	2 in 60
PHCS-MPI: PCP - GENERAL PRACTICE	2 in 30	2 in 45	2 in 60
PHCS-MPI: PCP - INTERNAL MEDICINE	2 in 30	2 in 45	2 in 60
PHCS-MPI: CARDIOLOGY	2 in 30	2 in 45	2 in 60
PHCS-MPI: DERMATOLOGY	1 in 30	1 in 45	1 in 60
PHCS-MPI: GENERAL SURGERY	2 in 30	2 in 45	2 in 60
PHCS-MPI: NEUROLOGY	1 in 30	1 in 45	1 in 60
PHCS-MPI: OBSTETRICS & GYNECOLOGY	2 in 30	2 in 45	2 in 60
PHCS-MPI: ONCOLOGY	2 in 30	2 in 45	2 in 60
PHCS-MPI: ORAL SURGERY	1 in 30	1 in 45	1 in 60
PHCS-MPI: ORTHOPEDIC SURGERY	2 in 30	2 in 45	2 in 60
PHCS-MPI: OTOLARYNGOLOGY	1 in 30	1 in 45	1 in 60
PHCS-MPI: PEDIATRICIAN	2 in 30	2 in 45	2 in 60
PHCS-MPI: PHYSICAL THERAPY	2 in 30	2 in 45	2 in 60
PHCS-MPI: RADIOLOGY	2 in 30	2 in 45	2 in 60
PHCS-MPI: UROLOGY	1 in 30	1 in 45	1 in 60

To review the PHCS Network adequacy scorecard for WV, please refer to Appendix F - Network Adequacy Scorecard.

35. Describe the process for ensuring access to the full range of specialty and facility service providers for members with complex needs.

In addition to a geographical analysis, MultiPlan's Network Development staff use feedback from Trusted's Case Managers and network providers to identify any insufficiencies in network access especially for its members with complex needs. If review of data indicates a deficit of providers in a

certain market, then Network Development staff will identify steps required to bolster access in that area. MultiPlan also regularly performs analysis of client "white space" data to identify network needs. MultiPlan uses both these tools to draft contracting goals for Trusted's networks.

To further enhance access, MultiPlan encourages clients and members to nominate non-participating providers for inclusion in MultiPlan's networks. Nominations can be submitted online at www.multiplan.com or by calling MultiPlan's toll-free customer service line. Clients may also contact their dedicated account manager to nominate providers. All providers must meet MultiPlan's credentialing criteria in accordance with the NCQA standards applicable to MultiPlan.

To promote continuity of care for consumers with complex needs that are transitioning between and among delivery systems, Trusted's Provider Services Department upon the recommendation of the Case Managers or UM staff will negotiate a Letter of Agreement (LOA) for non-participating providers. Trusted has developed a streamlined the process for drafting, negotiating, distributing and implementing provider LOAs for out of network services. LOAs are used to ensure that members are able to receive services from providers not contracted with Trusted. The intent is to enter into a formal contract with provider. Additionally LOAs are used by Provider Services to identify new providers for contracting to be included in the network based on volume and frequency of the need for these services out of network.

Upon determination that a non-network provider is needed to ensure continuity of care, the Medical Management Department forwards the LOA request form to the Provider Services. The designated Provider Services Staff uses the member and provider information from the LOA Request Form to develop the LOA. After dialogue with the provider and terms are established, Trusted will send the LOA to the provider for signature and will send the countersigned LOA back to the provider. The rates are determined by Provider Services Leadership. Trusted's fee schedule and the Medicaid fee schedule will be factored in to all rate negotiations.

36. Describe MCO methods to ensure beneficiary access to covered services in areas where the provider network standards do not require a specialist (e.g., physical medicine and rehabilitation providers, geriatricians, hospice facilities)

MultiPlan rounds out network coverage by contracting with national and regional ancillary facilities as well as those associated with contracted hospitals. MultiPlan and Trusted will also recruit local ancillary providers nominated by members, payers and providers to fill any gaps in coverage.

37. Describe the recruitment strategy for specialty care providers and hospitals.

Trusted is able to attract providers because together we are able to offer extensive resources that remove the administrative burden often associated with government programs. We continually analyze provider data to determine gaps in the network and identify areas for recruitment:

Actions to incent providers	Benefits to the Medical Assistance Program	Results Realized
To recruit Specialty providers and hospitals, Trusted continually monitors the competitiveness of our fee schedule. We recognize this and work with providers to accommodate their request.	More robust provider network	Increased Access

Actions to incent providers	Benefits to the Medical Assistance Program	Results Realized
We negotiate with non-participating providers on a case-by-case basis to assist with special member placement cases through the Case/ Utilization Management Team.	Access for members with placement issues (location, specialty services, etc.) Opportunity to further grow the network	Member access standards met
We hold quarterly provider updates to educate providers and their office staff on plans, upcoming changes and initiatives, program benefits and administrative processes for the patients they service.	More efficient administration, streamlined processes, opportunity for provider feedback	Provider satisfaction

Our recruitment campaigns outline the benefits of joining the Trusted network, including:

- Competitive fee schedules
- Online eligibility verification and member claims history
- Fast, compliant turnaround on authorization requests
- Local Provider Services Representatives
- Biweekly adjudication and payment cycle
- Provider Office Reference Manual detailing benefit coverage and limitations, authorization requirements, clinical criteria, and more
- Free online claims and authorization submission
- 24/7 self-service via an interactive voice response system and Provider Portal

38. Describe the recruitment strategy for Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs). If the MCO does not intend to contract with these providers, please describe how the MCO will ensure that members can access these providers.

Nationally, FQHCs have consistently out-performed their peers in HEDIS measures for both children and adult access to care. Due to optimal clinical outcomes realized, Trusted will aggressively pursue contracts with WV's FQHC and RHCs. These outcomes will result in the implementation of a process that assigns consumers that do not select a PCP upon enrollment and that live within the proximity guidelines to a FQHC or RHC, to their panel. If quality remains high, this process will continue until the panel size limits are met.

39. Describe the recruitment strategy for the publicly-supported providers listed below. If the MCO does not intend to contract with these providers, please describe how the MCO will ensure that members can access these types of services.

Trusted is committed to expanding its provider network to include Community Based Care Management providers, traditional and non-traditional. Trusted strives to build a collaborative relationship with community agencies and providers that are involved in managing and providing care to members, with special focus on members in the top 5%, or "super-utilizers," high-risk pregnant women, and members with complex, chronic conditions. The goal is to reduce preventable

admissions, readmissions, non-emergent visits to the emergency department (ED), enhancing behavioral and physical health coordination of services, target providers/organizations that serve a large volume of complex MA recipients, and increasing access to pediatric dental preventive and restorative services.

Trusted recruits providers that spend the majority of their time in face-to-face encounters with members either in the community setting, provider outpatient setting, hospital or ED. They will operate out of various settings from a community agency, outpatient service site, float between multiple outpatient sites, provide transition of care services from the hospital or ED setting or provide home based care coordination.

Trusted is dedicated to partnering with community organizations to meet the needs of the diverse population. Wherever possible, Trusted pursues linkages with national, state-level and local organizations dedicated to advancing both the broad interests and the health interests of groups having needs for culturally-based supports.

a) Local Health Departments

Trusted's Provider Services department will actively recruit and contract with local health departments across its region for services defined as public health services under State law and will pay for the service at the lesser of the health department's fee rate or the Medicaid fee rate for enrollee that seeks these service directly from a non-contracted local health department.

Through these contractual relationships, Trusted members will at a minimum have access to:

- All sexually transmitted disease services including screening, diagnosis, and treatment.
- Human immunodeficiency virus (HIV) services including screening and diagnostic studies.
- Tuberculosis services including screening, diagnosis, and treatment.
- Childhood immunizations (using vaccines from the State Bureau for Public Health's Immunization Program at its current Medicaid FFS rate or the cost of the vaccine).
- Environmental lead assessments for children with elevated blood levels (these services will be reimbursed directly by BMS).

b) Critical Access Hospitals

Trusted will include all CAH in its provider network to ensure access to inpatient and outpatient hospital services. Trusted understands the commitment of working with a publicly-supported organization and upon notification of any rate changes update its claims payment system within 30 days of notice from the Department.

c) Primary Care Centers

Trusted will actively recruit state-designated primary care centers to provide services to its membership.

d) School-Based Health Centers

Trusted agrees with the Department in its belief that SBHC are increasingly important providers of primary health care, especially in rural communities which face shortages of primary care physicians and will ensure they are part of Trusted's provider network. The agreements will designate the SBHC

as the medical home for the child, and will have defined processes for referring students to other providers.

e) Right from the Start (RFTS) providers

The WV State program, Right from the Start (RFTS), is aimed at improving early access to prenatal care and lowering infant mortality, and improved pregnancy outcomes. Trusted will promote RFTS' program that provides access to multidisciplinary care and comply with BMS' monitoring guidelines.

f) Bureau for Public Health Laboratories

Trusted will, per the regulatory requirement, use Bureau for Public Health Laboratories for certain cases (e.g., metabolic testing for newborns, rabies) and to monitor its members for public health purposes.

g) Children with Special Health Care Needs (CSHCN) Program

Trusted will contract with CSHCN providers to manage its Special Needs population. Trusted will require that the CSHCN providers coordinate a multidisciplinary team approach. Trusted will comply with BMS' monitoring guidelines.

40. Provide a description of the MCO monitoring process for the PCP panels. Note that the Bureau for Medical Services requires a limit of no more than 2,000 Medicaid enrollees assigned per PCP.

Trusted will take measures to monitor and ensure that the Medicaid member caseload of any of its PCPs within its network does not exceed 2,000 Medicaid members. Notices that come from BMS regarding PCP caseloads that exceed the threshold will result in the closing of the PCP's panel; however, Trusted will adjust the ratio for PCP teams. Any exceptions to this limit will be at the consent of the physician and BMS. Only the following reasons will be considered for panel sizes greater than 2,000:

- Continuation of established care
- Assignment of a family unit
- Availability of mid-level clinicians in the practice that effectively expand the capacity of the physician
- Inadequate numbers of providers in the geographic area.

41. Submit network documentation and geographic mapping reports in accordance with the instructions for the Medicaid network standards.

Refer to Appendix F for Trusted's Geographic Mapping reports.

42. Provide what specialists will be able to serve as a PCP. Describe the circumstances and process under which a member may select a specialist as his/her primary care provider, including any MCO approvals required, and describe any restrictions on the types of specialists that can serve as PCPs for SSI members or other members with complex needs.

Trusted designates the following providers as PCPs:

1. Physicians with specialties in general practice, family practice, internal medicine, obstetrics/gynecology, and pediatrics\
2. Certified nurse midwives
3. Advanced practice nurse (nurse practitioners)

Trusted may designate physicians outside of these specialties as PCPs for specific individuals with complex needs, including those within the disabled health population whose underlying health conditions are best managed by specialists. If it is deemed reasonable and the Specialists can meet the comprehensive needs of the SSI member, they will be permitted to serve as the PCP. The Specialist will be supported in the same manner as a PCP receiving reminders of preventative service timeframes and inpatient/ ED utilization. If it is determined, after review of the member's response to the treatment plan, the Specialist is unable to provide comprehensive management of the member, a recommendation will be made to transfer to a provider for their primary care services.

43. Describe how the MCO/PBM will ensure that the contracted network has a suitable range of therapies to meet beneficiary needs, including the availability of compounds and specialty drug pharmacies.

MeridianRx has built a national pharmacy network consisting of retail, specialty/compounding, mail order, home infusion, long-term care, and Indian Tribal Unit/Indian Health Service pharmacies. MeridianRx provides access to a robust network of pharmacies nationally, as well as in Puerto Rico, Guam, and the U.S. Virgin Islands. Each pharmacy type is available in every state. MeridianRx has agreements with large national retail chains and Pharmacy Services Administration Organizations (PSAO) that can provide these services throughout the United States. Any gaps in the coverage area are filled with independent pharmacies.

MeridianRx has a contract pharmacy network of 65,227 nationally. The contracted pharmacy network is comprised of 1,075 independent pharmacy locations and 64,152 chain or PSAO affiliated pharmacies. MeridianRx utilizes a network of specialty pharmacies to promote the highest efficacy at the lowest possible cost.

Increased support for Specialty Drug Users

Trusted provides a number of clinical support programs in conjunction with our management of specialty pharmacy. All consumers who are receiving specialty medications are enrolled in our case management program that gives each consumer a dedicated care coordinator who serves as their personal contact and liaison. The Trusted Pharmacist provides the consumer their personal telephone number and extension, as well as a backup phone number to call if that care coordinator is out of the office or otherwise unavailable. The Community Outreach Workers assist the member in navigating any difficulties they may experience during the course of their care. The Case Manager in collaboration with Pharmacist (as needed) is also responsible for arranging the free delivery of any associated products, providing personalized patient education and therapy management, informing the member of any free ancillary supplies associated with therapy, calling the member to remind them of upcoming refills, and letting them know of all covered services under their benefit, such as 24 hours, 7 days a week and 365 days a year access to a nurse and pharmacist, transportation benefits, etc.

44. Describe any additional efforts MCO/PBM will make to outreach to high volume or rural pharmacies.

MeridianRx has established criteria and processes to measure actual performance in comparison to those criteria and make improvements where necessary to maintain the pharmacy network and meet contractual requirements. GeoAccess reports will be executed per customer to ensure proper coverage of each pharmacy distribution type. GeoAccess enables MeridianRx to present a detailed view of the network to prospective Clients. This software produces presentation-quality maps, graphs, and tabular reports that are widely recognized as the industry's best for analyzing and communicating network accessibility.

MeridianRx has the ability to run a query of each pharmacy and the type of distribution channel that they fall into. These queries are made available to staff of MeridianRx to accurately assist any consumer who calls to direct them to the appropriate pharmacy type.

Availability will be monitored according to the following:

Distribution Channel	Availability Criteria	Performance Goal	How Measured
Retail Pharmacies	**Commercial (unless specified by the Client)** 1 Retail Pharmacy within: Urban Areas– 2 miles of the consumer Suburban Areas– 5 miles of consumer Rural Areas– 15 miles of consumer	Urban Areas– 90% within 2 miles of the consumer Suburban Areas–90% within 5 miles of consumer Rural Areas– 70% within 15 miles of consumer	• GeoAccess zip code analysis – Annually • Consumer Complaints - PRN
Retail Pharmacies	**Medicare (all states)** 1 Retail Pharmacy within: Urban Areas– 2 miles of the consumer Suburban Areas– 5 miles of consumer Rural Areas– 15 miles of consumer	Urban Areas– 90% within 2 miles of the consumer Suburban Areas– 90% within 5 miles of consumer Rural Areas– 70% within 15 miles of consumer	• GeoAccess zip code analysis – Annually • Consumer Complaints - PRN

Distribution Channel	Availability Criteria	Performance Goal	How Measured
Specialty Pharmacies	• Turnaround time 48-72 hours. • Turnaround time 5 days or less	• 48 -72 hours 90% • 5 days or less 100%	• Annual audit reports from Specialty Pharmacies • Consumer Complaints - PRN
Mail Order Pharmacies	• Turnaround time 48-72 hours. • Turnaround time 5 days or less	• 48 -72 hours 90% • 5 days or less 100%	• Annual audit reports from Mail Order Company • Consumer Complaints - PRN

45. Describe how the MCO/PBM will ensure that pharmacy services are available to members in a timely manner, including nights and weekends.

A number of pharmacies within the network provide 24/7 access to Trusted's consumers for prescription dispensing. MeridianRx provides benefit information 24/7 via their call center. The MeridianRx Call Distribution and Management workflow is provided in Appendix K. For prescriptions that require Prior Authorization (PA), both Trusted and MeridianRx will ensure that appropriate transition fills are initiated. When a pharmacy receives a new medication prescription requiring a PA, the submitted claim will adjudicate with a 72 hour supply. When a pharmacy receives an ongoing medication prescription requiring a PA, the claim will adjudicate with a 15-day supply. The Ongoing medication policy will not apply if the dispensing pharmacist determines that taking the mediation would jeopardize the member's health or safety.

Trusted does not require pharmacy interventions or edits at point-of-sale for Medicare transition claims when the medication is requested for the above noted day supply. However, the point-of-sale pharmacist will be alerted by a secondary message in MERLIN (MeridianRx's software system) regarding the appropriate days' supply submission after the claim initially rejects for prior authorization required. This will occur via standard National Council for Prescription Drug Programs (NCPDP) response messaging.

When a transition claim processes, the claim is flagged and relevant claim information is communicated to the member. A written notice is sent via U.S. Mail to the member who obtains a transition fill within three (3) business days of the fill.

The written notice includes:

1. An explanation of the temporary nature of the transition supply
2. Instructions for working with Trusted and the member's prescriber to identify appropriate therapeutic alternatives that are on the formulary.

3. A description of the procedures for requesting a prior authorization.

Extension of transition timeframes are provided on a case-by-case basis to the extent that the prior authorization has not been processed by the end of the minimum transition period and until such time that a transition has been made either through a switch to an appropriate formulary medication or a prior authorization is obtained.

46. Submit for review provider credentialing policies and procedures. If different for pharmacy providers, please indicate.

Refer to Appendix H for Credentialing and Re-Credentialing Plan. Pharmacy credentialing is managed by MeridianRx. Trusted provides monitoring through its subcontractor monitoring program.

47. Describe the provider re-credentialing cycle. If different for pharmacy providers, please indicate.

Trusted requires re-credentialing of Licensed Independent Practitioners (LIP) at least every 36 months. The process replicates the initial credentialing process. Refer to Appendix H for Trusted's Credentialing and Re-Credentialing Plan.

Each participating LIP must continue to meet the following criteria to be considered for considered for continued participation:

1. All initial credentialing criteria:
   A. Required medical or professional education and training
   B. Verification of post-graduate education or training
   C. Current licensure or certification
   D. Valid DEA or Controlled Substance Certificate or Acceptable Substitute
   E. Medicare/Medicaid Program Participation Eligibility
   F. Work History
   G. Insurance or state-approved alternative
   H. Malpractice History
   I. Passing score on site visit
   J. Sanction and Limitation on Licensure
   K. No prior denial or terminations
   L. Hospital Staff Privileges
   M. Other credentialing requirements such as AMA profile or criminal history review as required by Credentialing Authorities
   N. No affirmative responses to Disclosure Questions on the Credentialing Application
      a. Reasons for inability to perform
      b. Lack of present illegal drug use
      c. History of loss of license and felony convictions
      d. History of loss or limitation of privileges or disciplinary actions
      e. Current malpractice insurance coverage
      f. Current and signed attestation confirming the correctness and completeness of the application
2. An applicant for re-credentialing must have demonstrated compliance with all terms of the Participation Agreement, specifically including completion of individual Improvement Plans requested by Trusted.
3. An applicant for re-credentialing is subject to review of license status, insurance status,

malpractice and sanctions history and history of potential quality of care/quality of service concerns within the re-credentialing cycle. If a history of malpractice claims and substantiated quality concerns are found, the Credentialing Committee will conduct a clinical review of these findings.

4. Specialty change. A LIP who requests a specialty change must provide documentation of training and/or education in that specialty that conforms to the requirements by the Trusted for other specialists in the same area, and that information will be Primary Source Verified by Trusted. Trusted is not required to accept a request for specialty change unless there is a Network need.

Trusted Provider Services Department performs a monthly check of the exclusions list to ensure no participating providers in our network are excluded, including delegated providers. Any provider credentialed directly with Trusted are vetted through the credentialing process described above. Additionally, trusted uses confirmed credentialing webpages such as AMA (Board Certification/Education/Residency), ABMS (Board Certification/Education/Residency), NPI Registry (NPI/Taxonomy) and the National Student Clearinghouse (Non-MD Education) to verify the received information.

48. Submit the training curriculum for MCO/PBM provider enrollment and credentialing teams for review.

For Providers, from the moment they join the Trusted network, they are immersed in the Trusted culture of targeting their focus on the consumer experience and ensuring complex conditions are well-managed. To that end, our Providers must know how to request and provide services for consumers. Providers receive a comprehensive Provider Handbook, they are invited to attend Provider Orientation, a Trusted Provider Representative is assigned to the Provider's Office as a resource of information and to facilitate answering any questions. We have found that comprehensive provider communication, targeted education and a review of issues submitted to our service department are valuable tools. Trusted will establish a comprehensive provider relations and communication strategy for WV providers contracted on MultiPlan paper to ensure that provider education and outreach given by Trusted's Provider Relations Representatives is timely, meaningful, and consistent with client and state guidelines which shall include, but is not limited to, the following:

- Face-to-face provider visits and routine contact by Provider Relations Representative
- Provider in-service/orientation meetings or "Town Hall" forums
- Webinars
- Website materials/resources and "on-demand" training which can be distributed electronically or downloaded from website link
- Provider Newsletter

An example of Provider training curriculum will be provided upon award.

49. Submit the draft provider directory for review (To be submitted at later date. Timeframes and guidance to be provided by BMS.)

Trusted maintains a current provider directory on its website as well as a printed version that is mailed to the consumer upon enrollment into the health plan.

50. Submit the standard provider contract templates for review (PCPs, specialists, hospitals, pharmacy).

Refer to Appendix I for a copy of Trusted's standard provider contracts.

51. Submit the provider disclosure forms (templates only, de-identified) for review. See 42 C.F.R. §§ 455.104,105, 106.

Refer to Appendix I for a copy of Trusted's standard provider contracts.

III. MEMBER SERVICES

52. Describe the MCO's process for developing materials for members, including members with special health care needs (e.g., consulting with persons with disabilities, advocacy groups).

Trusted has an extensive library of training materials online and in hard copy format. Trusted will provide its members with a robust website health portal that will serve as the online hub for a wide range of health care related activities, services and educational resources. The website will offer a rich library of multi- media resources designed to address different learning styles and individual education preferences.

Trusted will offer the following web-based educational resources:

- WellSource – a web based self-management tool that enables members to take
- Self-Assessments and access health educational materials at the 4th grade level through the Trusted member portal.
- Community Health TV – Culturally competent health video programming that members can access through the Trusted member portal, hosted by Dr. Corey Hebert, a nationally recognized health care expert.
- Quarterly, Member Advocacy Group and the Program director review the need for materials based on the population of our members. Additional materials are then prepared based on those needs.

53. Submit the member handbooks for review. (To be submitted at a later date. Guidance and timelines will be provided by BMS.)

A draft copy of the member handbook will be provided upon award.

54. Submit the MCO.com website content for WV Medicaid for review. (To be submitted at a later date. Guidance and timelines will be provided by BMS at a later date.)

Trusted will create a robust website upon confirmation of contract award.

55. Submit the marketing plan for review. (To be submitted at a later date. Guidance and timelines will be provided by BMS.)

Trusted will submit a robust marketing plan that complies with state guidelines upon confirmation of contract award.

56. Submit MCO/PBM grievance and appeals acknowledgement letters and resolution letters for review. (To be submitted at a later date. Guidance and timeline will be provided by BMS.)

Trusted has a comprehensive Grievance and appeals process that will be submitted to BMS upon confirmation of contract award.

57. Submit adverse determination letters including Fair Hearing rights for review. (To be submitted at a later date. Guidance and timelines will be provided by BMS.)

Trusted has a comprehensive Grievance and appeals process that will be submitted to BMS upon confirmation of contract award.

58. For members who do not indicate a PCP preference at the time of enrollment, describe the

MCO's process for notifying the member of PCP assignment, educating members of the right to change PCPs, and any follow-up communications the MCO will conduct to ensure that the member is aware of the assignment.

Trusted will allow enrollees the freedom of choice to make a PCP selection. In an effort to help an enrollee best meet their needs, Trusted will provide assistance to enrollees in selecting a PCP who meets unique medical, physiological, cultural or geographical needs. We understand, when an enrollee is satisfied with their medical home, they are less likely to utilize the ED and more likely to utilize other preventive services provided by their MCO. Encouraging PCP selection is an important part of an enrollee's overall healthcare program enrollment process.

We understand many enrollees may not be familiar with the concept or importance of the PCP. In educating the Enrollee on the program, we stress the importance and benefits of selecting a PCP. Information on the role of the PCP is included in our enrollment packages and enrollment materials. These materials are developed in compliance with all language access. We explain the PCP is each Enrollee's central point of contact for many services, including coordinating all covered care under Trusted, issuing authorizations and referrals to specialists, and authorizing all hospital services except covered emergency care. Materials also include information and instructions on how an enrollee can change their PCP.

For continuity of care, Trusted allows an enrollee to remain with his/her PCP, if that PCP belongs to our network. Trusted will ensure all enrollees have selected or are assigned a PCP within ten days of his/her enrollment. Prior to the ten day deadline, Trusted will conduct outbound calls to all enrollees who have not selected a PCP to assist them with selecting one.

If an Enrollee does not select a PCP within 10 days of enrollment, Trusted will automatically select one for the enrollee using the process below:

- Assign enrollees to a provider who has previously provided services to the enrollee.
- Assign all children with a single family to the same PCP.
- Assign a child with a special health care need to a health professional with the training and experience to appropriately treat and manage the condition.
- In the absence of previous service by a PCP within the network, designate a PCP who is geographically accessible to the enrollee; preferably a FQHC or RHC if in accordance within access standards.

Once Trusted assigns a PCP, we will notify the enrollee, and send them their Member ID Card and Welcome Package within ten days of the assignment. This written communication is followed by a Welcome Call.

59. Submit sample letters notifying members of the PCP assignment for review. (To be submitted at a later date. Guidance and timelines will be provided by BMS.)

Trusted's sample letters notifying members of the PCP assignment will be submitted to BMS upon confirmation of contract award.

60. Provide a copy of the explanation of benefits (EOB) form if used by MCO/PBM.

A copy of Trusted's EOB form is in Appendix J.

61. Provide a description of any outreach and transition planning efforts directed toward beneficiaries with special health care needs who are identified through the enrollment broker's health assessment. Describe if outreach will be conducted via telephone or mail.

Individuals with special health care needs identified by the enrollment broker will be referred for follow-up by the Trusted Special Needs Unit (SNU). The target population for the SNU are consumers with ongoing physical, developmental, emotional or behavioral conditions or life circumstance which serve as a barrier to the member's access to care or services. Examples include:

- Children with Special Health Care Needs
- Children in Substitute Care
- Consumers that are Limited English Proficiency or special communication needs due to sensory deficits and have ongoing physical, developmental, emotional or behavioral conditions
- Consumers with Physical and/or Intellectual/ Developmental Disabilities
- Consumers with HIV/AIDS
- Consumers with significant behavioral challenges
- Consumers with Special Health Care Needs; requiring transportation

Special Needs consumers and their families will be made aware of SNU through a combination of methods. Each primary Wellness and Customer Service location will have an assigned Special Needs Coordinator (SNC) on location and available to answer questions and work one-on-one with anyone identified as a potential candidate. The secondary/ satellite locations will have informational materials and during new member orientations, the SNC will introduce the functionality of the SNU and how to engage the resources. A special mailing will be sent by the SNU informing them of the program and how to access SNU support services. We will also create a special SNU page on its website, which describes the program along with tools and community resource information. Part of our SNU program includes establishing a registry of participating Trusted SNU participants. On this registry, we will be able to track outreach contacts and also receipt services. Provider Services will be responsible for education providers on the availability and role of the SNU as well as how to contact/ refer a consumer for services. Additionally information about the SNU will be made available in the Provider Manual.

The function of the special needs unit is to develop relationships with the community and identify community resources that will improve members' lives. These resources are not necessarily directly related to health-care benefits, but they may contribute indirectly to improving health status. The special needs unit looks at the impact of the community on members' lives, and the staff work to identify and fill gaps in the community service network.

Special Needs Coordinators review member needs, find available help and link members to a variety of services and community programs, including:

- Follow-up care after a hospital stay or emergency room visit
- Services to help members apply for Supplemental Security Income
- HIV/AIDS case management
- Programs to provide early help for children with physical health needs or developmental delays
- Behavioral health services
- Dental care
- Social services agency and other special programs not covered by Medicaid.

The Special Needs Care Coordinator will contact members in the targeted population through mail and phone outreach efforts within the first three months of eligibility for services. They will develop a care plan, including an assessment, planned interventions, desired outcomes/goals, and evaluation as to the degree the goals/outcomes have been met.

62. Describe how members will be made aware of available community resources and social services (e.g., member handbook, newsletter, case managers).

Trusted takes a community based approach to engaging consumers, and we will utilize community health workers to assist, coach and engage our consumers to take control of their health care status.

Our initial approach will be to partner with the County Health Departments to determine their needs and the ways that Trusted can partner to support the goals of the Counties.

Trusted will engage our consumers through immediate communication – initially the new member health risk assessment. Community health workers will be trained to provide the initial outreach phone calls, and make home visits to members that we are unable to reach.

Due to our brick-and-mortar presence, Trusted will begin its schedule of activities; identifying collaborations with community agencies and churches; we will also collaborate with school based health centers. Trusted has a philosophy of developing relationships with school based health centers to assure that children have a primary care physician that they can access.

Trusted will create activities to engage our membership. We will have diabetes health education classes, asthma education classes, nutritional coaching, cooking demonstrations, Healthy Beginnings programs, HIV/AIDS case management, social workers, EPSDT community health workers, and HEDIS community health workers located throughout our Wellness/Customer service centers. Outreach becomes our imperative as we communicate with our consumers regarding our programming.

To communicate with our members we use telephones, text messages, email, robo-calls, flyers, direct mailers, letters, and posters to advertise our events. We schedule at least five weekly events for consumers, monthly events throughout the centers and quarterly events to support health screenings. We also sponsor Member Appreciation days, both at our centers and at community recreation centers to communicate with our members.

Trusted will have an annual Back to School Fair in partnership with a community partner. We will provide school uniforms as incentives for children to get their well child physicals and immunizations. We will also provide gift certificates for children that get their dental exams and lead screenings. Trusted uses a passport system that provides proof that the exams were given.

Trusted has found that promotions work for major events, and uses community based celebrities, spokespersons and entertainment to attract participation.

In our mission to improve our consumers' health status, we depend on the face-to-face interactions of our Case Managers and Community Health Workers. The personal touch has been the most effective way to improve our consumers' health status. In the District of Columbia, we have seen Emergency Room visits decline over 15% in two years, hospital readmissions decline 11% and our case management load increase 50%.

Most of our consumers have multiple challenges in their lives, including health issues, employment, housing and often domestic problems. Trusted provides social workers to address these issues, and will collaborate with the Behavioral Health agencies and to assist members that need social assistance as well as clinical assistance.

63. Provide a timeline with mailing dates for member materials. (To be submitted at a later date. Guidance and timelines will be provided by BMS.)

Trusted's timeline with mailing dates for member materials will be submitted to BMS upon confirmation of contract award.

64. Provide the turnaround time for mailing, on an ongoing basis, the new member handbook, updates to handbooks, and handbooks requested ad hoc by a member.

The Trusted Member Handbook will be updated any time Trusted makes a material change in services, coverage, procedures or provider network, or upon DHHR request. Trusted will send the most current version of the Trusted Member Handbook to all enrollees at least annually, as well as at the time of initial enrollment. Trusted understands that DHHR reserves the right to determine at its sole discretion when Trusted will fully revise and redistribute the Handbook. Trusted will notify DHHR of any changes at least 30 days before the intended effective date of the change

Trusted has developed a member portal that contains an online version of the Member Handbook. We also post notifications regarding legal changes, regulations, bulletins and alerts regarding material changes to operations.

Ad hoc requests for hard copy manuals will be addressed per Trusted Protocol. Per NCQA standards Customer service will respond to written requests from members received via mail, fax or email within one business day of receipt. For faxed and paper service requests, it is expected that they will be opened and reviewed within 1 business day.

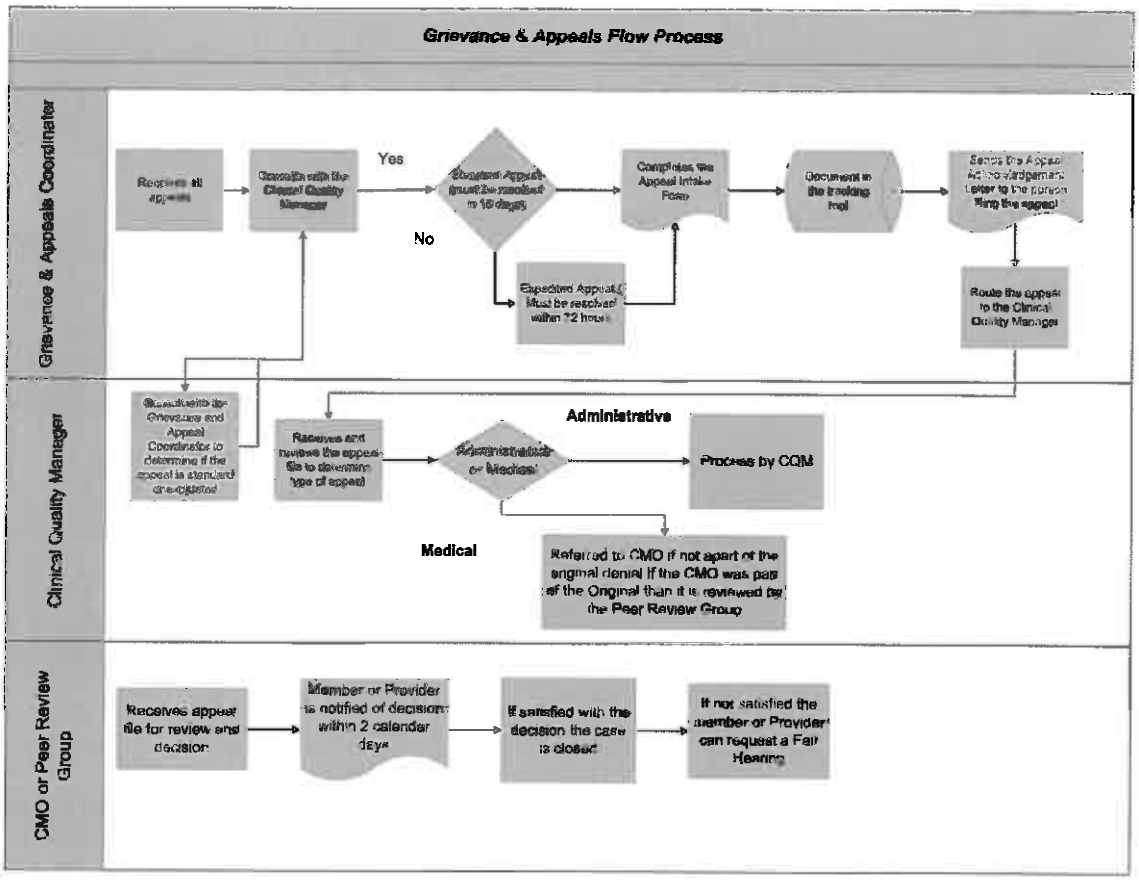
65. Submit grievance policies and procedures for review.

A copy of Trusted's Grievance Policies and Procedures are in Appendix J.

66. Provide MCO/PBM grievance and appeals process flow-chart, including the turnaround time and levels of authority for review.

Trusted's grievance and appeals process flowchart is depicted below. It outlines the steps and roles involved in addressing a member's grievance or appeal of a decision.

Exhibit 17: Grievance & Appeals Flow Process



The steps followed for PBM Grievances are outlined below:

1. The consumer, prescriber and/or the consumer's representative contacts MeridianRx by phone or in writing to file a Level 1 grievance.
2. The Grievance Coordinator reviews the grievance and determines whether to handle the complaint under the grievance procedure or appeal procedure, and determines who the responsible contact will be for resolving the grievance.
3. The Grievance Coordinator determines if the complaint may be Clinically Urgent.
    a. If possibly Clinically Urgent, the complaint is forwarded to a clinical Pharmacist via email and the Chief Medical Officer and Chief Operating Officer are copied on the email.
        i. If after review, the complaint is deemed Clinically Urgent, it will be treated as an expedited grievance and resolved within 72 hours from initial receipt of the complaint.
        ii. If after review, the complaint is not deemed Clinically Urgent, it will be treated as a routine complaint sent back to the Grievance Coordinator. Routine complaints are resolved within 15 calendar days.

4. The Grievance Coordinator contacts the responsible person to notify them of the Level 1 grievance and the required time frame for a response/resolution.
5. An acknowledgement letter is sent to the consumer, prescriber and/or the consumer's representative within five business days. This letter includes information about a Medicaid consumer's right to request a hearing through the state hearing office, at any time and a Medicare consumer's right to file a quality of care complaint with the State QIO.
6. It is the responsibility of the designated responsible contact person to report to the Grievance Coordinator any actions and results of actions performed in response to the Level 1 Grievance within 10 calendar days.
7. The Grievance Coordinator sends the letter to the consumer, prescriber and/or the consumer's representative advising them of the resolution of their Level 1 Grievance and the right for an internal Level 2 Grievance if they are dissatisfied with the resolution.
8. If the consumer, prescriber and/or the consumer's representative submit a Level 2 Grievance, the Grievance Coordinator ensures that the review by the Grievance Committee takes place within seven calendar days. But in no event will the Level 2 Grievance take place more than 30 days after the grievance was received by MeridianRx.
9. The Grievance Coordinator sends the letter to the consumer, prescriber and/or the consumer's representative advising them of the resolution of their Level 2 Grievance and a Medicaid consumer's right for an external review by the state regulatory office and a Medicare consumer's right to contact the State QIO if they are dissatisfied with the resolution.
10. Final decisions rendered by the state regulatory office during the external review are upheld by MeridianRx and previous decisions are reversed in order to be consistent with this determination.
11. Copies of all grievances, their investigation and disposition are maintained at MeridianRx and are available for inspection by CMS, and state organizations for ten years following the year the grievance was filed.
12. On a quarterly basis, the Grievance Coordinator reviews the number and type of complaints and looks for trends for improvement opportunities. The analysis is presented to the Grievance Work Group. Based on analysis of the complaints and any subsequent investigation, the Grievance Work Group determines if further action is needed and prepares recommendations for presentation to the QIC such as assessing problems with access to services.
13. The Grievance Report, including both Level 1 and Level 2 Grievances, is submitted to the Quality Improvement Committee on a quarterly basis for review in conjunction with consumer appeals to monitor consumer satisfaction and to ensure that appropriate actions are taken. These reports are also reviewed at the quarterly meeting of the Executive Committee.
14. MeridianRx provides summary data on the number and types of grievances as well as timeframes for resolution to Trusted on a regular frequency.
15. For Medicare grievances, MeridianRx maintains a rolling 12 month period of grievance data. This data is calculated every six months and then added to the previous 6 months. All

Quality of Care Grievances and consumer appeals data is reported by MeridianRx as a rate per 1000 members. This information is provided to consumers in 12 point font that is easy to understand, with an informational copy of the report sent to the Regional Medicare Office.

16. All grievances are logged in the grievance module. The system automatically assigns and monitors timeframes based on the type of grievance. Bi-weekly, the Grievance Coordinator shall run a report of all timeframes to ensure each step of the grievance process has remained in timeframe for all consumers. The Manager of Pharmacy shall review these reports and report them to each Quality Improvement Committee meeting.

67. Describe the MCO's plan to provide enabling services, such as providing assistance with complaints and grievances, to members with physical or developmental disabilities. How will the Medicaid Administrator/Contract Liaison monitor grievances?

Trusted Member Services staff assist members who are unable to file a written Grievance or Appeal on their own behalf. Staff are trained in filing appeals and following up with members, regarding appeal status. Members and/or guardians may appear in person, at any of the Trusted Outreach Centers, or they may call Member Services for assistance. Individuals with hearing impairments may use TTY services to communicate with staff. Members who are visually impaired may receive materials on audio tape, Braille or printed in large text format.

The Grievance and Appeals department records and tracks all enrollee and provider disputes received in the appeals application of its computer system, Care Connect. The Care Connect System allows the denials and appeals coordinator to record, track and report enrollee and provider disputes by many different identifiers, including program, dispute type, status of appeal, decision, and corrective action, if any. Grievance and Appeals prepares and submits its periodic activity reports using this system and capturing the information required by the regulating agency.

All enrollee grievance and appeals are reported to Trusted's UM and QEC committee on a quarterly basis, including the types, volume and outcomes. Additional information is made available to the UM/QEC committee, at their request, such as trends in medication appeal decisions, home health/skilled nursing appeal issues and complaints regarding Trusted providers. The committee often charges the denials and appeals coordinator or other Trusted departments to take certain action or further investigate trends identified through these quarterly grievance reports. Those charged with such action report back to the committee on any resulting plan policy changes or other results.

68. Indicate how members will be able to contact the MCO/PBM member services department (e.g., hours of operation, emergency hotline, toll-free number).

Reference Trusted's contact information for member services in the table below.

69. Submit the number for the MCO's member services hotline.

Trusted Members can access staff 24 hours a day, 7 days a week. Phone numbers are listed on the Trusted website and in the member handbook, in addition to any written communication such as quarterly member newsletters. Trusted also provides a secure member portal, with Member Services Assistance online with a 24 hour turn-around-time.

Important Numbers - Get Connected with Your Health Care Services

Member Services 24/7 is 1-202-821-1100 and the toll free number is 1-8[illegible]1852.

ILLUSTRATIVE

Need	Who to Call	Numbers	Hours
For Questions About Trusted call:	Member Services	(202) 821-1100 OR (855) 855-326-4831	8:00am-5:30pm Mond[illegible] Friday
	TTY/TDD Member Services	711	8:00am-5:30pm Monday-Friday
If you need care after your doctor's office closes or have a question you need to ask a nurse call:	Nurse Helpline	(855) 872-1852 (toll free)	24 hours a day, 7 days a week
	TTY/TDD Nurse Helpline	After Hours dial 711 for TTY Assistance calling (855) 872-1852	24 hours a day, 7 days a week
If you need mental health care or have a mental health question call:	Your PCP's Office	(fill in your PCP's information here)	
	Nurse Helpline	(855) 481-7041 (toll free)	24 hours a day, 7 days a week
		(888) 793-4357	24 hours a day, 7 days a week
If you need to see a doctor within 24 hours ("Urgent Care") call:	Your PCP's Office	(fill in your PCP's information here)	
	Nurse Helpline	(855) 481-7041 (toll free)	24 hours a day, 7 days a week
If you need someone who speaks your language or if you are Hearing Impaired, call:	Member Services	(202) 821-1100 OR (855) 326-4831 (toll free)	8:00am-5:30pm Monday-Friday
	TTY/TDD Member Services	711	8:00am-5:30pm Monday-Friday
If you need a ride to an Appointment, call:	Member Services	(202) 821-1100 OR (855) 326-4831 (toll free)	24 hours a day, 7 days a week
For dental questions:	DentaQuest	(855) 418-1620	8:00am-5:30pm Monday-Friday
For vision questions:	EyeQuest	(855) 418-1620	8:00am-5:30pm Monday-Friday
FOR AN EMERGENCY, DIAL 911 OR GO TO YOUR NEAREST EMERGENCY ROOM			

70. Submit the process and guidelines for transferring calls between the MCO and subcontractors (e.g., PBM) for review, if applicable.

A copy of Trusted's guidelines for transferring calls to its subcontractors is found in its Enrollee Policy and Procedure in Appendix J.

71. Submit call transfer protocols and decision trees for the MCO's member services hotline for review.

A copy of Trusted's ACD call transfer workflow is in Appendix J.

72. MCOs may employ a Medicaid Member Advocate who has substantial experience in health care, experience working with low-income populations, and cultural sensitivity. Describe on what specific topics, including those that support enrollment of individuals with special health care needs, the Medicaid member advocate will be prepared to address (e.g., assistance with resolving access issues, obtaining materials in alternate formats, receiving assistance with grievances and appeals, promoting continuity of care). Provide the timeframe for initiating and completing training of the Medicaid Member Advocate as well as copies of the training curricula. Please provide copies of the training materials that the MCO will provide to the Medicaid Member Advocate.

Trusted understands that navigating the healthcare system can be a challenge to members and their families, especially those with special needs. For this reason, Trusted will employ Medicaid Member Advocates to better assist our population. The Trusted member advocate(s) will work closely with members, providers, and plan personnel. The advocate will serve as a point of contact to receive Medicaid member inquiries directed to the State and assist members (or their representatives) referred by the State in obtaining care and accessing SSI and other benefits.

Trusted's Medicaid Member Advocate is Responsible for working with members, providers and the member's case managers as needed to assure the member's continuity of care. Duties include scheduling appointments, advising, enrolling in and accessing benefits. The advocate will also have a role in assisting the member with the Contractor's Grievance and Appeals process. If the member or member representative attends the Appeal meeting in person, the Member Advocate shall accompany them. Throughout this process, the advocate will keep the member advised of the appeal status. If the member has special health needs or disabilities, the advocate will provide members with materials in alternative formats, to best meet the needs of the member.

All staff at Trusted, including the Medicaid Member Advocates, will receive Cultural Sensitivity training, in addition to the other training upon award.

73. How will the Medicaid Member Advocate be evaluated in regard to meeting and addressing SSI members' needs?

Trusted evaluates the member experience via the annual Consumer Assessment of Healthcare Providers and Systems (CAHPS) to obtain an overall less of satisfaction with the health plan. However, specifically to address the satisfaction of service coordination and advocacy of the SSI member, surveys are completed every six months. Informal feedback is gleaned at the end of each interaction through a script:

"Was I able to meet your needs today?" Members that express dis-satisfaction will be addressed either by the Advocate or the supervisor. Information from the CAHPS, Complex Case Management Surveys and informal feedback will be aggregated and used in the annual staff

performance review process.

74. Provide advance directive policies and procedures, including procedures for:
    - Informing enrollees of their right to make advance directives;
    - Providing physicians and members with appropriate forms or guidance, and
    - Ensuring that advance directives are maintained in enrollees' medical records.

Trusted's Advance Directive Policy is in Appendix J.

Trusted provides for education of staff concerning its policies and procedures on advance directives, situations in which Advance Directives may be of benefit to Members, and their responsibility to educate Enrollees about this tool and assist them to make use of it.

Trusted provides written notification to Enrollees of their right to make decisions concerning medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate, at the individual's option, advance directives. This includes a statement of any limitation regarding the implementation of Advance Directives as a matter of conscience

This information is available on the Member and Provider portals, in the Member Handbook, and in quarterly newsletters for Members and Providers. It is also available at Member Outreach Centers. In addition to written notification, the Case Management team discusses Advanced Directives with all adult members upon initial assessment.

Trusted will ensure compliance with requirements of State law regarding advance directives and notify adult enrollees of any changes in State law regarding advance directives as soon as possible, but no later than ninety days after the effective date of the change.

75. Describe how members are educated about the ability to request out-of-network referrals (e.g., member handbook). Include a description of how member services representatives are educated on the referral process.

Members are educated about the ability to request out-of-network referrals via the Member Handbook, the Member Portal, and through Member Services, Medicaid Member Advocate, UM, Case Manager and Outreach Staff. Member services staff are trained to work in conjunction with the Provider Relations staff to facilitate a single-case-agreement or a new provider network contract. In lieu of this agreement, Member Services work with the Utilization Review department to assist the member in requesting a Prior Authorization for these services.

76. Submit for review MCO/PBM training curriculum for member services staff on WV Medicaid program requirements. Please specify whether the training curriculum addresses serving members with special health care needs. Describe how the MCO will train member services representatives on serving members with disabilities and chronic conditions, the culture of disability, and the resources available to members.

Trusted training curriculum for member services staff and an overview of serving the special needs population and individuals in the case or disease management will be provided upon award. Member Services staff will be trained on the role of the Medicaid Member Advocate and how to access their assistance on behalf of the member.

77. Submit training curriculum, including frequency of trainings, for staff that perform outreach to members with special health care needs upon enrollment.

Trusted training curriculum for outreach staff and an overview of serving the special needs population and individuals in the case or disease management will be provided upon award. Outreach staff that interact with the special needs population will be trained on the role of the Medicaid Member Advocate and how to access their assistance on behalf of the member. Training will occur upon hire and at minimum, annual thereafter.

78. Describe the customer service performance standards the MCO/PBM uses (e.g., member-to-representative ratios, call answering time, turn-around time for member requests) and the standards that will apply to the Medicaid program (i.e. call abandonment rate not to exceed 5%, single contact resolution, 83% of calls answered in 30 seconds).

The Trusted Member Call Center aims to achieve an abandonment rate of less than 5% and a call answer timeliness of 20 seconds or less to reach a live representative, exceeding NCQA standard of 30 seconds or less.

Managers, team leaders, and our dedicated workforce management team monitor service levels through multiple sources. Warning indicators will alert them if there are high hold times and multiple callers in queue, allowing Team Leaders to address service inquiries immediately. Electronic wallboards also prominently display real-time call performance statistics throughout the department, making Service Advisors aware if calls are in queue and Trusted is meeting all service level criteria.

Team leaders and managers also monitor service levels through system-generated reports. Daily, weekly and monthly reports include call volume, abandonment rates and the percentage of calls answered within 30 seconds. These reports also monitor average handle time, average speed of answer and service level. Other reports measure the productivity of individual service advisors.

79. Discuss the MCO's new member enrollment and education process, including member contact, from the time of initial notification of the member's enrollment by the enrollment broker through the first month of actual enrollment. During initial enrollment, describe the MCO's steps and timeframes for:

- Contacting members (e.g., welcome calls or letters, home visits);
- Reaching out to members who are difficult to contact (e.g., disabled members, members without telephones);
- Processing and issuing identification cards; and
- Distributing Medicaid member handbooks.

From the moment of enrollment, Trusted will begin educating its consumers to be engaged in their care through the provision of usable information that will modify behavior, increase prevention and improve compliance. Monthly orientation sessions will be held at the Wellness and Customer Service Center locations. These sessions will provide opportunity to learn about offerings that will result in healthy behaviors and decisions.

New Members will receive a welcome call and welcome packet within 10 days of initial orientation. The welcome packet contains information on how to reach Trusted staff in person, through the Member Portal, and utilizing TTY/TDD and language services. This packet will also contain the monthly orientation schedule, Member Handbook and Identification cards.

In an effort to combat some of the issues that impact the population's health, Trusted will have one

(1) Wellness and Customer Service Center strategically placed in Charleston and several mobile units throughout the state. **Our Wellness and Customer Service Centers are not clinics that provide direct clinical care. Rather, they provide a community-based brick-and-mortar resource that focuses on consumer empowerment through health literacy, nutrition guidance, prevention services, chronic disease and care coordination.** A variety of staff (community outreach workers, social workers, nurses, dieticians, pharmacists, trainers and chefs) will be directly accessible to the membership and their families to promote attainment of health goals and to address social determinants of health.

Trusted's Wellness & Customer Service Centers provide the following Customer Service needs Monday – Saturday:

- Same-day New ID Cards
- Assist Consumers with Changing PCPs
- Provide Access to Computers to Look for Jobs or Research Health Conditions.

In addition, our mobile app (mHealth) is available to members and contains many of the tools and functionality found on our member portal. mHealth is designed to help consumers manage different aspects of their health, like searching for providers, provide access to a digital health plan ID card and find a physician or facility near them.

80. Submit for review a sample member ID card. (To be submitted at a later date. Guidance and timelines will be provided by BMS.)

Trusted's sample member ID card will be submitted to BMS upon confirmation of contract award.

81. Submit for review the policy on disenrollment of members.

Refer to Appendix J for the Trusted's member Disenrollment Policy.

82. Submit for review the initial PCP assignment process and procedures for handling PCP assignment/change.

Refer to Appendix J for the Trusted's policy outlining its PCP assignment process.

83. Submit for review a description of methodology for a PCP assignment. Provide member characteristics (i.e. claims history, proximity), particularly for new members when auto-assigning to a PCP. Describe any restrictions on the types of specialists that can serve as PCPs for members with complex needs.

Trusted will ensure that members are assigned to a participating Primary Care Practitioner (PCP) of choice. Upon enrollment into Trusted Health Plan, members select their PCP (through the Enrollment Broker or through Customer Service). In the event that a member chooses to delay their PCP choice and no selection is made, a mandatory selection processes will occur:

- If a member's PCP is a Trusted Health Plan provider, the member is reassigned to their previous PCP of record.
    - If the provider is out-of-network, this will be referred to Provider Relations in an effort to contract with the provider.
- If a member does not have a previous in-network provider, The Enrollment Department assigns the member to a PCP who is located in the same zip code as the member's residence. This is

done to ensure that the member is assigned within 30 minutes travel time of their home via public transportation

- Trusted will assign all children with a single family to the same PCP.
- Trusted will assign individuals with special health care needs to a health professional with the training and experience to appropriately treat and manage the condition.

Trusted has no restrictions on what types of Specialists can serve as a PCP for members with complex needs

84. Submit for review call transfer protocols and decision trees for the MCO and/or PBM member services hotline. Submit a PA (72h emergency prescription medication dispense) call flow separately.

Refer to Appendix J for the Trusted's policy outlining its call transfer protocols and decision trees for Trusted and MeridianRx.

85. Submit for review the pharmacy lock-in assignment process and procedures for handling changes.

Refer to Appendix K for the Trusted's policy outlining its pharmacy lock-in assignment process.

86. Submit for review the pharmacy lock-in notification letter (To be submitted at a later date. Guidance and timelines will be provided by BMS.)

Trusted's pharmacy lock-in notification letter will be submitted to BMS upon confirmation of contract award.

87. Describe the process of how PDL and formulary changes affecting members' care will be distributed to the members. Include timeframes and methods of delivery.

Trusted posts formulary changes on the website within15 days of approval by the P&T Committee. Trusted prints formulary updates at least annually and mails the updated formulary to its members.

IV. PROVIDER SERVICES

88. Submit for review provider manuals. (To be submitted at a later date. Guidance and timelines will be provided by BMS.)

Trusted's provider manuals will be submitted to BMS upon confirmation of contract award.

89. Describe the process of how the MCO/PBM/behavioral health/dental provider manuals will be distributed, including timeframes and methods of delivery.

From the moment they join the Trusted network, providers are immersed in the Trusted culture of targeting their focus on the consumer experience and ensuring complex conditions are well-managed. To that end, our Providers must know how to request and provide services for consumers. Providers receive a comprehensive Provider Handbook, they are invited to attend Provider Orientation, a Trusted Provider Representative is assigned to the Provider's Office as a resource of information and to facilitate answering any questions.

Trusted will submit a copy of the Provider Manual to BMS by July 1 of each contract year. Trusted will maintain documentation that verifies the Provider Manual has been reviewed at least annually by Trusted's Administrator and Medical Director. Each provider is issued a printed or electronic copy of the provider manual during the contracting process with Trusted. Trusted also provides a copy of the manual upon request. Providers are notified of any program or service site changes at least thirty (30) days prior to the intended effective date of the change. Notifications are sent through the mail and are posted on the Trusted website. The Trusted Provider Manual is located on the Provider Portal of the Trusted Website.

90. Submit for review the schedule for provider training and webinars during the implementation phases

Trusted Health Plan places a great deal of importance on the patient – provider relationship. To enhance that relationship, Trusted keeps its providers, especially independent small group practices, well informed of our efforts in the community to maintain health status and improve patient outcomes. Trusted's Provider Services Unit conducts ongoing provider training sessions.

Trusted's Provider Services Unit has an organized training program for network providers based upon Trusted's annual assessment of training needs. The training program may consist of web-based courses, face to face meetings and mailings. Some sample topics covered may be:

- Fluoride Varnish Training
- EPSDT Well Child Visits
- PCP Oral Health Training
- Coordination of Care for Specialists Training
- Coordination of Care for Members with Complex Health Needs Training
- Pediatric Dental Provider Training
- Oral Health Literacy
- Pediatric Mental Health Screening
- Perinatal Mental Health Screening
- Behavioral Illness and Mental Health Screening
- Utilization Review Process

Trusted provides training regarding EPSDT and IDEA to all new providers within 3 months of entering Trusted's network and biannually thereafter. This includes an overview of the IDEA and

the roles and responsibilities of the schools, the Early Intervention Program, Providers and Trusted.

The provider training schedule during the implementation period will be provided upon award.

91. Submit for review the process, schedule, and content for providing ongoing training to existing providers.

Trusted's provider training process, schedule and content for existing providers will be provided upon award.

92. Submit for review the MCO/PBM process for handling provider complaints and appeals, including those related to credentialing, claims, authorization and other complaints and appeals as applicable.

Trusted understands providers' concerns and provides adequate resources and an escalation process for timely and efficient resolution.

Toll-free Customer Service Line for Providers: Trusted has a customer service team that acts as a point of contact for incoming provider calls. Inquiries range from general information, application requests, and fee schedule information to claim resolution and complaints. These service advisors are available via a toll-free number to answer provider questions from 8:30 a.m. to 6:00 p.m. ET, Monday through Friday.

Mangers, team leaders, and our dedicated workforce management team monitor service level through multiple sources. Warning indicators will alert them if there are high hold times and multiple callers in queue, allowing Team Leaders to address service inquiries immediately. Electronic wallboards also prominently display real-time call performance statistics throughout the department, making Service Advisors aware if calls are in queue and Trusted is meeting all service level criteria.

Team Leaders and Managers also monitor service level through system-generated reports. Daily, weekly, and monthly reports include call volume, abandonment rates and the percentage of calls answered within 30 seconds. These reports also monitor average handle time, average speed of answer and service level. Other reports measure the productivity of individual service advisors.

Providers will work directly with Trusted to resolve any issues through the complaints and appeals process. The standard turnaround for the resolution of inquiries is 5 business days for those not involving claims and 15 days for those involving claims. Weekly meetings are held between team leads, supervisors and managers to discuss any trends and this information is communicated to provider relations staff.

93. Describe the MCO/PBM's capabilities to accept and pay claims on time. Provide a claims turnaround report for each of the past 12 months, indicating the percentage of total claims that are clean, and the percentage of clean claims processed within 30 days and within 90 days. If any aspect of claims processing is contracted out (e.g., data entry), provide a copy of the contract with the vendor.

Refer to Appendix L for the Claims TAT Report for past 12 months (% total claims that are clean and the % of clean claims processed within 30 days).

Trusted will adjudicate provider claims within the timeframes listed below. Trusted's subcontractors are also required to meet these timelines via service level agreements. If the service

levels are not met, the subcontractors will be put on a corrective action plan, possibly resulting in monetary sanctions.

Claims received from a hospital for inpatient admissions ("Inpatient):	Drug Claims:	All Claims other than inpatient and drug:
• 90.0% of Clean Claims must be adjudicated within thirty (30) days of receipt. • 100.0% of Clean Claims must be adjudicated within forty-five (45) days of receipt. • 100.0% of all Claims must be adjudicated within ninety (90) days of receipt.	• 90.0% of Clean Claims must be adjudicated within thirty (30) days of receipt. • 100.0% of Clean Claims must be adjudicated within forty-five (45) days of receipt. • 100.0% of all Claims must be adjudicated within ninety (90) days of receipt.	• 90.0% of Clean Claims must be adjudicated within thirty (30) days of receipt. • 100.0% of Clean Claims must be adjudicated within forty-five (45) days of receipt. • 100.0% of all Claims must be adjudicated within ninety (90) days of receipt.

Timeliness

Trusted's Claims Payment Platform provides a comprehensive, flexible automated claims adjudicated system. It is designed to provide high efficiency auto-adjudication. Additionally, the provider pricing module is a flexible, efficient system that blends a complex contract configuration tool with an automated pricing component. It creates an environment that supports contract modeling, testing and pricing applications without redundancy.

Trusted will be able to electronically accept and adjudicate claims and will encourage providers to submit claims electronically as it results in faster submissions, quicker payments and increased accuracy. Trusted will establish and regularly update their claim payment policies to stay in compliance with industry standards as well as state and federal requirements. However, if a provider chooses to submit a paper claim, Trusted will utilize OCR for increased accuracy.

Financial Accuracy

Daily Audits

Trusted will conduct daily audits utilizing the daily A/P ready to bill report. A sample of claims will be reviewed to determine whether the claim was priced appropriately prior to the finalized payment of the claim. The following items of a claim are reviewed:

- Eligibility for date of service
- Fee schedule/inpatient calculator
- Payable charge/benefit
- Authorized service

Audits	Description
High Dollar Audits—Pre-Payment	Claims that are $50,000 or greater in billed charges will be routed via AWD to a Trusted Claims Manager to review procedural, financial and payment accuracy prior to adjudication.

Audits	Description
Post Adjudication but Pre-Payment Audits	Trusted will utilize an audit process between claims adjudication and claims payment to ensure improved payment accuracy. All adjudicated claims will be screened for audit exceptions. Any claim with an audit exception will be held for audit review. The audit review will consist of multiple screenings for: net-to-gross payment percentage, payment to contract verification, inpatient/APRDRG matching, per unit billing, and duplicate billing for similar charges. Once a held claim has passed audit review, it will be approved for payment and transitioned to payment processing.
Post Payment Audits	Trusted will conduct monthly claims overpayment audits. The audit will consist of a review of a targeted sample of paid claims for correct payment based on billing rules and contracts with the sampled providers. If any claims are determined to have paid incorrectly then they will be reconciled and recoupments will be made when necessary. The audit results will act as an effective tool for Trusted's claims management to identify trends and remediate any errors.

94. Describe how the MCO will process and approve out-of-network provider claims, including hospitals, on an ongoing basis (after the 90-day exemption timeframe) and state whether the MCO will reimburse these providers using the Medicaid fee schedule or an alternate fee schedule.

Trusted will pay out-of-network hospitals for all emergencies and authorized covered services provided outside of the established network. Out-of-network hospital claims will be paid at the established Medicaid rate in effect on the date of service. The steps to make a medical necessity decision for a non-participating does not differ from a participating provider. However, there are additional steps to determine whether there is capacity within network to provide the requested service and to negotiate payment terms.

Trusted will through its Care Management processes arrange and administer covered services to consumers through its network. Where Trusted's network is not able to adequately furnish covered services in a timely manner, we will arrange for the services to be provided on an out-of-network basis in accordance with its established procedures. If the consumer is in Case Management or assigned to the Special Needs Unit (SNU), the CM, upon determination that the service is medically necessary, will facilitate obtaining a Single Case Agreement outlining payment, benefit, duration and frequency terms to ensure care is not disrupted. Additionally, steps will be taken for consumers transitioning into Trusted in accordance with our Transition Policy, to maintain continuity of care over a designated period.

95. Submit for review the policy on prohibitions of inappropriate physician incentives.

Refer to Appendix I for Trusted's policy on the prohibition of inappropriate physician incentives.

96. Describe the review process for payments for emergency services. Indicate which types of claims are automatically paid, which types are pended, and how pended claims are evaluated for payment. If algorithms are used to evaluate pended claims, describe how the MCO will ensure that the "prudent layperson" standard is upheld.

Trusted covers emergency services necessary to screen and stabilize members without prior authorization in cases where a prudent layperson, acting reasonably, would have believed that an emergency medical condition existed. Trusted will not retroactively deny a claim for any emergency screening examination because the condition, which appeared to be an emergency medical condition under the prudent layperson standard, turned out to be non-emergency in nature. Trusted does not require prior authorization for emergency services. This applies to out-of-network as well as to in-network services, which an Enrollee seeks in an emergency.

Trusted policies and procedures and the provider handbook state that a provider is not required to verify an enrollee's MCO membership and eligibility when an enrollee requests services for an emergency medical condition. In an emergency medical situation, the provider shall provide immediate services for an enrollee's emergency medical condition in accordance with the provider's license and scope of practice. A medical screening examination needed to diagnose an enrollee's emergency medical condition must be provided in a hospital-based emergency department that meets the requirements of the Emergency Medical Treatment and Active Labor Act. Trusted will pay for the member's emergency medical screening examination. Trusted will reimburse for both the physician's services and the hospital's emergency services, including the emergency room and its ancillary services, so long as the "prudent layperson" standard has been met.

Trusted will not refuse to cover emergency services based on the failure of the emergency room provider, hospital, or fiscal agent to notify the enrollee's primary care provider or Trusted of screening and treatment within 10 calendar days of presentation for emergency services. Trusted covers emergency services if an authorized representative authorizes the provision of emergency services, including ambulance transport.

Trusted enrollees will not be held liable for payment of ED services and subsequent screening and treatment needed to diagnose the specific condition and to stabilize the patient. The attending emergency physician, treating the enrollee is responsible for determining when the enrollee is stable for transfer or discharge. This determination is upheld by Trusted.

It is Trusted's policy that reviews performed for utilization are only made by appropriately licensed and/or trained individuals. Benefit coverage decisions are handled as follows. A member or member's treating practitioner/provider requests coverage of services. The request is received by a Utilization Management (UM) intake coordinator by phone, electronically, or via fax. The intake coordinator opens a UM request file in CareConnect and forwards the case to a Medical Review nurse. The nurse determines member eligibility. If the member is eligible, the nurse proceeds to review the case. If the member is not eligible for services (i.e., not enrolled in the health plan), s/he calls the member to inform him or her of their enrollment status. If the member is enrolled in Trusted, the case is reviewed to determine if the request is a benefit or a medical necessity case.

97. Describe the process for payments of 72-hour emergency prescription medication dispense supply.

Any time a Medicaid claim rejects for prior authorization required, a 72-hour emergency supply of medication must be dispensed. Trusted will reimburse the dispensing pharmacy for the 72-hour emergency supply.

Trusted Member Services staff receive training about the emergency prescription dispensing process and what steps to take to address problems immediately if pharmacies do not provide a 72-hour supply of medication. Trusted's 24-hour member hotline staff is trained to respond immediately to problems concerning emergencies by explaining the rules to Medicaid members so that they understand their rights, and by offering to contact the pharmacy that is refusing to fill the prescription to explain the 72-hour supply policy.

Trusted works with its hospital pharmacies to ensure that enrollees discharged from the Emergency Department and/or the inpatient setting after pharmacy hours or on the weekends have 72 hours of prescribed medications.

98. Submit for review MCO policies on reimbursement for crisis stabilization services.

Refer to Appendix M for Trusted's policy on reimbursement for crisis stabilization services.

99. Submit for review call transfer protocols and decision trees for the MCO/PBM's provider services hotline.

Refer to Appendix J for Trusted and MeridianRx's call transfer protocols and decision trees.

100. Describe how the MCO educates PCPs on their responsibility to coordinate a member's overall health.

Historically, consumers have not been proactively engaged in their health care decision-making. Providers have managed and told consumers what to do to improve their health. Unfortunately when considerations regarding self, family, environment and culture are not incorporated into the treatment plan, there is a higher probability of noncompliance. The Institute of Medicine (IOM) (Silow-Carroll, 2006) advocates a partnership between clinicians and patients that is characterized by informed, shared decision making, development of patient knowledge, self-management skills, and preventive behaviors leading to a treatment plan that is informed by an understanding of the consumer's needs and environment (family, home life, job, relationships, cultural background, and other factors). Evidence has shown instilling a culture of Patient Centered Care has led to better health outcomes as well as greater clinician satisfaction, reduced malpractice claims, and higher clinician loyalty (Wagner, 1998).

To support this model of patient-centeredness, Trusted has structured its organizational and functional operations to operate with the consumer/family always at the center of its activities. The consumer and their family are provided a comprehensive multi-faceted approach that will promote the partnering with the consumers and their family ultimately improving health outcomes. Examples of patient centered care are seen in the composition and behavior of its Provider Network:

Providers are required to coordinate a consumer's care collaboratively, ensuring they understand their health and the importance of preventive services and treatment options. A comprehensive network of providers promotes convenient access to quality services and coordinated care;

decreasing health care disparities. Providers are required to use evidenced-based medicine as a guide to treatment; however, the consumer's individual circumstances are incorporated into plans.

For each engagement with the consumer, Trusted will utilize both its human and technology resources to promptly identify the consumer and determine risk factors, coordinate care and ensure continuity across systems; provide timely and comprehensive access to services and monitor the quality and outcomes of the care provided.

Trusted will utilize its screening tools (including evaluation of claims and encounters for certain patterns of care, multi-disciplinary reviews with Trusted PCPs to identify consumer's with chronic problems, and through electronic transmission/ exchange of data electronically with providers and hospitals) as well as notifications received directly from the Commonwealth regarding consumers with special health care needs. Once consumers with special health care needs are identified, a comprehensive treatment and monitoring process will be established and the care manager will coordinate care as needed across the continuum. Consumers identified with chronic conditions and/or illnesses that require treatment and monitoring by a specialty provider will be designated as such in the system and will have direct access to that specialty provider or group of providers responsible for diagnosing, treating and/or monitoring the progression of the condition. The Care Manager will collaborate and coordinate efforts amongst the treating team to ensure effective, cost efficient solutions that are evidenced-based and take the individual situation into consideration.

In addition, Trusted's comprehensive provider relations and communication strategy for providers ensures that provider education and outreach is timely, meaningful and consistent with its goals. Trusted uses a variety of avenues to communicate information with providers as depicted in the following exhibit.

Exhibit 18: Provider Relations and Communication Strategy for Providers



101. Describe the MCO's protocol for conducting outreach to all specialists regarding the importance of encouraging members with complex needs to seek primary care services.

Primary Care is a critical component of healthcare delivery. Starfield[1] highlighted several essential features of primary care. Primary care is integrated, encompassing the provision of comprehensive, coordinated, and continuous services that provide a seamless process of care. Integration combines information about events occurring in disparate settings and levels of care as well as over time, preferably throughout the life span. Comprehensive care addresses any health problem at any given stage of a patient's life cycle. Coordinated care ensures the provision of a combination of health services and information to meet a patient's needs. Continuous care refers to the effective and timely maintenance and communication of health information between providers. Accessibility refers to the ease with which a patient can initiate an interaction for any health problem with a clinician, including efforts to eliminate barriers such as those posed by geography, administrative hurdles, financing, culture and language.

Members with complex needs often benefit from specialty care, but there is a difference in the focus and in the role of the primary care specialist. PCPs understand the "big picture" of member health and is tasked with coordinating care as such. Primary care should be the mainstay in the long term management of patients with complex medical conditions such as diabetes, heart failure or chronic lung diseases.

Trusted communicates the importance of primary care with specialists in the network via the same channels as regular provider education takes place, such as webinars and the provider newsletter. Gaps in care for members with complex needs are monitored by the case manager. Multidisciplinary care teams that include the member, Specialist and Primary Care provider are scheduled by the Case Manager to develop a plan of care. The Case Manager communicates with the member, Specialist and Primary Care provider serving as a conduit to ensure awareness and alignment with the plan.

102. Describe how the MCO will educate and provide guidance to PCPs on coordinating physical health services and ensuring that the PCP coordinates the member's medical health services, as appropriate, with behavioral health services.

Within any population, there is a specific subset of high behavioral health users whose severity of illness, functional status, and patterns of utilization suggests gaps in care that are resulting in negative health and social outcomes. Among this group, individuals with serious mental illness (SMI) and children with serious emotional disturbances (SED), in particular, demonstrate greater reliance on higher levels of care, including inpatient acute psychiatric services, criminal justice recidivism, increased rates of homelessness, unemployment, and higher use of avoidable emergency room and hospital admissions, or in the worst case, tragic community events. With access to appropriate care and support through well-designed systems of care, individuals with SMI and children with SED are able to improve their overall level of functioning and quality of life, increasing their community tenure.

[1] B. Starfield, Primary Care: Balancing Health Needs, Services and Technology, Oxford University Press, New York, NY, USA, 1998.

Specialized Care Management Program

Trusted's Case Management program offers a rich continuum of care for members who are in need of behavioral health or substance use disorder services to support their recovery. To ensure our membership has access to these resources, we will provide a specialized care management program for individuals with SMI or SED. The goal of this program is to identify members with behavioral health and physical health co-morbidities and ensure that they are receiving fully integrated care. Our dedicated behavioral health care managers will liaison directly with the care team through care planning and coordination activities that are focused on improving access to care and are based on a comprehensive assessment of the member's needs. The focus of the program will be to connect individuals with proven treatment resources and promote self-care behaviors. We strongly believe in, and adhere to, the principles of recovery and resiliency, incorporating holistic, person-centered, and community-based interventions.

Risk Stratification

We will rely on sophisticated care analytics and outcomes-informed metrics to guide our interventions both on the individual level as well as with the larger population that we will serve. We will use available medical, pharmacy, and behavioral health claims and authorization data to identify, stratify, and segment members at the population level (i.e., claims data, utilization data, etc.). This data will be incorporated into our predictive modeling/risk stratification software, which stratifies members into high, moderate, or low risk based on acuity, condition severity, and utilization. Upon identification and stratification, members will receive targeted interventions to address the primary condition(s) that are driving health costs or future risk (i.e., physical health, behavioral health, frequent or inappropriate ER utilization). We refer to this primary cost driver as the "driver condition" and focus interventions on care plan problems that are related to the driver condition. Members with high or moderate risk whose primary diagnosis is behavioral health or substance use disorder will be assigned a behavioral health case manager who will outreach to the assigned PCP to begin the process of integrated care planning.

Integrated Care Plan

Members with co-morbid behavioral health/substance use disorders and physical health needs will have a person-centered care plan that will be developed in collaboration with the PCP, case manager and behavioral health/substance use disorder provider whenever possible. For example, if a member in an acute medical setting who has a history of behavioral health needs is discharged, his/her discharge and care plan will include both physical health and behavioral health interventions and supports. Our case manager will engage all known treatment providers as part of the discharge planning process (with member consent) to ensure that the member's integrated care team is prepared for the member's return to the community.

Our case managers will also establish relationships with the member's key behavioral health resources to ensure that we are engaged when members present for acute behavioral health care as well. Our goal is to ensure that we provide the PCP with the resources needed to allow for "whole person" treatment planning. For example, if a member with diabetes is admitted to an acute psychiatric hospital, we will work with the PCP to ensure that upon discharge, the member not only his or her psychotropic medications, but his or her insulin and testing supplies as well. We will also notify the member's primary care physician regarding any changes to the member's medications that could impact his or her diabetes as part of this integrated care management

process.

The integrated care plan will be used to identify short-term (immediate and acute needs as well as shorter objectives within long-term goals) and long-term (anticipated case results including sustained health improvements and optimal functioning) needs as well as methods and resources to meet those needs. The integrated care plan will define goals, objectives, and appropriate time frames. Members will be encouraged establish realistic goals designed to maximize self-management and optimal functioning related to the member's behavioral condition.

103. Describe how the MCO will educate PCPs about the importance of dental screenings to ensure appropriate referrals to dental providers. In particular, PCPs should verify that beginning at 6 months after the first tooth erupts or by 12 months of age (as part of the EPSDT process), the member should be referred to dental providers

Trusted strives to increase awareness of the importance of oral health to overall health and well-being, to increase acceptance and adoption of effective preventive interventions, and to reduce disparities in access to effective preventive and dental treatment services. The public health infrastructure for oral health is insufficient to address the needs of disadvantaged groups. The people who are at the highest for dental disease often have the greatest difficulty in accessing care. Integration of oral health into medical care expands the potential for high-risk individuals to have access to care that halts and even reverses dental disease, avoiding or reducing the need for expensive treatment. Provider education on the importance of integrating oral and medical health has the triple aim of improved health outcomes, lower health care costs and improved health care quality.

PCPs can play an important role in improving each patient's oral health by educating members, promoting self-care and utilizing therapies to reverse or prevent disease progression. Trusted takes an integrative approach to oral health services.

Trusted's Oral Health PCP Training strives to ensure that PCPs incorporate oral health as a key component of a routine medical visit for all patients, and especially those with chronic diseases. Trusted PCPs are encouraged to treat ordinary oral health conditions in their practice, actively consult with dental providers if patient does not improve and refer patients with treatment needs to dental providers. PCPs retain responsibility for routine care. For high-risk patients and those with chronic conditions, the primary care provider should follow clinical protocols designed to lower risk factors.

Trusted's PCP Dental Training delineates the role and tasks of PCPs to:

- Screen for disease and risk during its medical history, risk assessment and examination
- Educate patients on the nature of dental disease and self-care strategies to prevent/reverse disease
- Recommend and prescribe therapies to maintain optimum oral pH levels, reduce unhealthy bacteria and remineralize teeth
- Make appropriate referrals for dental care
- Identify dental providers who will collaborate to integrate medical and dental care for patients.

PCPS are trained to counsel patients and caregivers on the need (and strategies) to 1) maintain optimum oral pH levels; 2) reduce levels of bad bacteria in the mouth; 3) practice effective home

care.

Compliance with oral health as part of EPSDT recommendations are monitored through claims analysis and referrals to dentists upon eruption of a child's first teeth are evaluated. Trusted's Care Analyzer identifies children out of compliance with routine dental care visits. For members non-compliant, not only is a reminder letter sent to the member, but also to the provider reminding them to refer the member for dental services.

104. Describe how providers will be educated about the ability to request out-of-network referrals.

Trusted will inform providers about the ability to request out-of-network referrals, and when referrals are not required, such as for family planning services.

Trusted will reimburse out-of-network providers for family planning services rendered to enrollees. Providers of family planning services will be reimbursed at the Medicaid rate.

Trusted will encourage out-of-network family planning providers to coordinate services with Trusted providers and to educate enrollees to return to their network provider for continuity of care. If a non-network provider of family planning services detects a problem outside the scope of services, the provider must refer the enrollee back to Trusted.

105. Describe the e-Prescribing functions supported.

Trusted supports a real time e-prescribing system that will allow prescribers and pharmacies to utilize the following functions: eligibility confirmation, PDL benefit confirmation, identification of "alternative" (i.e., preferred) drugs that can be used in place of non-preferred drugs, medication history, and prescription routing. Trusted's system will be certified to accept electronic prescriptions for controlled substances as described in 21 CFR Part 1311.

MeridianRx contracts with Surescripts to provide e-prescribing functionality. In addition, MeridianRx provides complete medication history through Surescripts to the prescriber to allow for the most accurate and well informed prescribing environment possible.

E-prior authorizations are handled through the Prescriber Portal to the MERLIN system. This portal function allows the prescriber to initiate a prior authorization request directly into the PBM. Once created, the pharmacy technician at MeridianRx can identify the e-prior authorizations and take action to ensure quick responses and improved member care.

MeridianRx implemented real-time Customer eligibility verification and batch mode benefit and formulary load for the ePrescribe solution. This solution greatly improves the performance and utilization of low cost drugs, avoidance of prescribing a non-covered drug, reduced call volume from a pharmacy to prescriber's office and overall cycle time to fill a prescription. MeridianRx underwent the Surescripts certification process for Network Connectivity, Real-time Consumer eligibility verification, Consumer Data Load, Formulary Load, Security and PHI Compliance.

The formulary data load file contains covered drug information. These are drugs that require a prior authorization; drugs that require Step Therapy; and drugs that have age, quantity or gender limitations.

Consumer eligibility verification is done by most prescribers before prescribing electronically to make sure the consumer has valid drug benefit coverage. Upon successful verification, the prescriber is presented with the client's formulary that is applicable for the consumer who is at the

prescriber's office. Prescribers then look up the drug coverage to make sure they are prescribing a covered drug for the consumer. If a prior authorization is required for a drug, the physician would put in a prior authorization request which would reduce the cycle time in filling the prescription.

106. Describe any special provider education efforts that will be used to educate primary and specialty care physicians about SSI beneficiaries and members with complex needs (e.g., opportunities for standing referrals or for specialists to serve as PCPs, availability of case management/disease management). Please provide an overall summary of provider training topics.

Care coordination is of particular importance for members with complex needs. Trusted recognizes that most high-cost beneficiaries do not have just one disease or condition, thus programs must take a holistic approach and treat the whole person with care coordination, preventive care and medical management. Trusted's program emphasizes coordinated care through educating PCPs, Specialty Providers and enrollees about the benefits of coordinated care.

Trusted supports care coordination with provider payment incentives, information sharing, and performance and quality reporting.

V. BENEFIT ADMINISTRATION

107. Describe how the MCO's will impose, monitor and track member copays and quarterly household maximums for medical and pharmacy services.

Trusted will not impose copays or quarterly household maximums for medical or pharmacy services.

108. Describe the MCO's Utilization Management (UM) guidelines. Additionally, describe the process for development and revision.

Trusted operates its Utilization Management system in compliance with current NCQA "Standards for Accreditation of Managed Care Organization". The purpose of the Utilization Management (UM) Program is to ensure appropriate allocation of resources by providing quality care/service in the most cost effective manner to Trusted's enrollees. The Utilization Management Program is designed to monitor, evaluate, and manage the cost and quality of health care services delivered to all members of Trusted. The program will ensure that services are medically necessary, are of high quality and are delivered at appropriate levels of care. The scope of the program includes outpatient and inpatient services and medical and behavioral health services.

Written UM policies and procedures define Trusted's prior approval and utilization review program. All services authorized by the UR Staff will be evaluated to determine necessity based on standard criteria. Trusted's medical necessity guidelines are evidence-based peer reviewed criteria, including McKesson Care Review Manager Criteria, Interqual criteria, Managed Care Appropriateness Protocol (MCAP) criteria, American College of Obstetrics & Gynecology (ACOG) recommendations, American Academy of Pediatrics (AAP) recommendations, Center for Disease Control and Prevention recommendations; for Behavioral Health, guidelines include American Medical Association (AMA) care recommendations; American Psychiatric Association (APA), Substance Abuse and Mental Health Services Administration (SAMHSA) and the American Society of Addiction Medicine (ASAM) recommendations & Beacon Level of Care criteria

Trusted utilizes a comprehensive approach to determining medical necessity that places the consumer and his/her individual circumstances at the center of the process. Various special circumstances that can impact the decision include, but are not limited to the following: Coordination of care with community and state agencies, Age (e.g. less than age 21 will use EPSDT standards), Co-morbidities, Progress of treatment Psychosocial situations, Coordination of care with primary care physician, Access and transportation limitations, Urgency of the situation (emergent, urgent, routine), member's presenting problem(s), current symptoms and the psychological and social conditions that affect his/her medical and psychiatric status, Risk management issues, Medication history, Substance use history For BH decisions diagnosis Axis I-IV and past treatment history; Coordination of care with current medical and behavioral health provider(s); Physical disability.

Utilization Review staff use InterQual Criteria, which are the Clinical decision support guidelines licensed for use by hospitals and managed care companies to evaluate the appropriateness of medical interventions and level of care based on clinical criteria and standards. A secondary clinical review is performed by a Physician Advisor or physician member of the Utilization

Management Committee when InterQual guidelines suggest a different patient status or level of care than that ordered by the patient's Physician and/or a potential quality concern.

The CMO, a licensed physician, is responsible for the overall supervision of all of the authorization decisions of the UM System to ensure that decisions are based on all relevant medical information available about the consumer and in accordance with best medical practice and all relevant standards of care. All denials for necessity or changes in the amount, duration, or scope that are less than requested are reviewed and approved by a health care professional who has appropriate clinical experience in treating the consumer's condition. Such decisions shall also be made in compliance with the Medical Necessity Criteria.

Trusted's Prior Authorization list is dynamic and based on a multitude of factors, some of which are noted below:

- Benefits/ covered service requirements
- Evidence-based guidelines
- Industry standards
- Provider feedback
- Utilization patterns
- Competitor offerings

Trusted also considers characteristics of the local delivery system such as:

- Availability of skilled nursing facilities, subacute care facilities or home care in the service area to support the patient after hospital discharge
- Coverage of benefits for skilled nursing facilities, subacute care facilities or home care where needed
- Availability of specialists
- Local hospitals' ability to provide all recommended services within the estimated length of Stay Medical Necessity and LOC criteria are reviewed and updated as needed when new treatment applications and technologies are adopted as generally accepted medical practice. Trusted will update and submit its Medical Necessity Criteria annually.

The UM Committee (a subcommittee of the Quality Executive Committee (QEC)) is responsible for reviewing the Medical Necessity Criteria on an annual basis. Changes to the criteria will be submitted for approval to BMS prior to execution. Once Medical Necessity Criteria is reviewed and approved by the UM Committee, QEC and BMS, it will be communicated to Trusted internal staff and the Provider Network. The Provider Manual and Member Handbook will incorporate Trusted Utilization Management System to include criteria used and scope of services for referral and prior authorizations.

109. Describe how the UM guidelines will generally be applied to authorize or retrospectively review the payments or Medicaid services.

Preauthorization, concurrent review and retrospective decisions and processes are supervised by qualified licensed professionals. A licensed professional who has appropriate clinical experience in treating the enrollee's condition or disease can make the decision to deny service after conducting a review for appropriateness.

It is Trusted' s policy that reviews performed for utilization are only made by appropriately licensed and/or trained individuals. When Trusted receives a request for a prospective (Prior

Authorization), Concurrent or Retrospective review with ***all*** necessary medical or behavioral health clinical information:

- The nurse compares the clinical information provided with the request against InterQual/McKesson Care Review Manager and/or other Trusted Clinical Guidelines
    - If the clinical information supplied with the request meets the guidelines and/or the criteria, then Trusted notifies the provider (verbally and in writing) of the review outcome and documents the result in the CareConnect system.
    - If the clinical information supplied with the request does NOT meet the guidelines and/or criteria pertaining to the request, the Trusted Medical Staff Reviewer refers the request to a physician or Peer Advisor for review. The Medical Staff Reviewer prints/compiles all applicable material relating to the denial, including any and all materials provided by the requester.
- Additional information sources used to evaluate the case and determine medical necessity decisions include:
    - Inpatient and outpatient records
    - A history of the presenting problem
    - Clinical exam results
    - Diagnostic testing results
    - Treatment plans and progress notes
    - Patient psychosocial history
    - Information on consultations with the treating practitioner
    - Evaluations from other health care practitioners and providers
    - Rehabilitation evaluations
    - Printed copy of criteria related to the request
    - Information regarding benefits for services or procedures
    - Information regarding the local delivery system
    - Patient characteristics and information
    - Information from family members and others in the patient's support system
    - Consultations with specialists
    - Language and/or cultural issues
    - LOC criteria
    - Trusted UM P&Ps

In some cases, the Physician Reviewer may be the board certified specialist best able to evaluate the case. If the physician/peer advisor can NOT recommend approval, the reviewer calls the requestor and offers to discuss the case. Based on the available information, the Medical Director makes a recommendation for approval or denial of the request. Approval and denial letters are sent by the Medical Review Staff utilizing appropriate timeframes. Denial decisions include all relevant information on the member's right to appeal, and the appeal procedure.

110. Submit training curriculum for WV UM and clinical staff.

Trusted's training materials will be provided upon award.

111. Describe how UM monitoring activities will operate in conjunction with fraud and abuse detection activities. Describe the MCO's processes for preventing and detecting fraud and abuse related to pharmacy services.

The MERLIN adjudication system (MeridianRx's proprietary claims processing system called MeridianRx Live Integrated Network (MERLIN), routinely checks all incoming claims for fraudulent activity; Every processed claim is subjected to MeridianRx's desk level audit from a pre-service and retrospective standpoint. Pre-service edits are in place to prevent potentially fraudulent claims before they are ever adjudicated, in step with the Center for Medicare & Medicaid Services (CMS) initiative to move away from the pay-and-chase fraud detection and recovery method. Some of the fraud detection methods MeridianRx currently utilizes are: FDA guidelines; requiring prior authorization; Controlled substance medication quantity limits; Monitoring for Multiple narcotic medication fills; identical same patient medications from different pharmacies; Identical same patient medications from different prescribers; Extraneous quantities in relation to days' supply; Abnormally high brand or narcotic dispensing rates; Inappropriate drugs per gender; Refilling too soon.

As Meridian's proprietary claims processing system was exclusively built and programmed with the customer in mind, edits are entirely customizable per Trusted's request. Desk level audits also take a retrospective approach by utilizing quarterly reports that focus on high cost/dispense as written (DAW) code combinations, outlier status, high controlled substance dispensing rates, and lower than average generic dispensing rates. These reports are used to identify inaccurate billing practices.

Outpatient Drug Utilization Strategies

The Trusted Specialty program includes the development of comprehensive review criteria for determination of coverage. In addition, we have a network of contracted specialty pharmacies and utilize techniques to steer dispensing through the most cost effective channel. Medication compliance is monitored, aberrant drug utilization patterns are identified and then our care management team is involved to follow up with members to address issues with drug therapy. In addition, all Hepatitis C members are monitored for tolerance and compliance to therapy to ensure members obtain the highest level of care to increase quality of life and health outcomes. Short-cycle dispensing is offered for certain drug therapies where appropriate.

Narcotic Monitoring

An initiative to prevent overutilization of narcotic drug therapy and to identify potential fraud and abuse among members, prescribers and pharmacies

112. Describe how the MCO will modify its standard utilization management protocols when reviewing referral and treatment requests for members with special health care needs (e.g., standing referrals, expedited utilization review processes).

Upon plan enrollment, consumers identified as having Special Health Care Needs may be enrolled into Trusted Special Needs Unit Care (SNU) –Coordination program. In the case of a consumer with Special Health Care needs that is under the age of 21, a Trusted advocate (outreach staff) is assigned to monitor and to assist the consumer and caregivers with "decoding" a complicated EPSDT schedule.

The approach begins with a thorough Assessment to determine health care needs. A clinical assessment is performed and an environmental scan is conducted.

Trusted's multi-disciplinary care coordination team will then develop a Treatment Plan (for both new consumers and current consumers who are identified as having Special Needs). The

treatment Plan is based on the Individualized Family Service Plan (IFSP), Individualized Education Plan (IEP) and/or Medical Needs of the Child.

The Care Plan/Treatment Plan will be updated every 30-days and monitored for any needed modifications. Services are authorized per the Care plan. Benefits to consumers and their families include traditional Medicaid benefits plus expanded health services, additionally the Special Needs Case Manager (SNCM) will coordinate non-Medicaid services. Complex cases will be decided in partnership with Trusted's UM Department and the Medical Director and all denials will be handled by the Trusted Medical Director.

Trusted's Medical Management Department will partner with the SNU to provide care coordination services for consumers with special health care needs. Because of their unique focus and expertise, Trusted's Medical Management Department is going to refer unique/ complex cases to the SNU. The Special Needs Coordinator (SNC) will garner feedback and support on how to manage that individual case but will be responsible for the coordination.

Coordination services by the SNC includes; setting up appointments, transportation, coordination of EPSDT services (if applicable) and transition planning for children aging out of IDEA and pediatric services.

Quality Assurance and Provider Services will monitor provider and subcontractor compliance through our ongoing oversight process.

113. Describe any condition-specific protocols or standards that will be used to manage members with special health care needs. Describe how these standards and protocols will be updated and shared with primary and specialty care providers.

In addition to the process outlined above, Trusted utilizes condition specific Clinical Guidelines to manage members with specific conditions and special health needs. These guidelines include, but are not limited to the following:

Condition	Evidence-Based Guideline
Pediatric Asthma	*Global Initiative for Asthma (GINA)* **http://www.ginasthma.org/Guidelines/guidelines-resource.html**
Diabetes	*American Diabetes Association: Clinical Practice Recommendations 2015* **http://professional.diabetes.org/ResourcesForProfessionals.aspx?cid=84160**
ADHD	*American Academy of Pediatrics (AAP)* **http://pediatrics.aappublications.org/content/early/2011/10/14/peds.2011-2654**
Depression in people with Diabetes	*American Diabetes Association: Clinical Practice Recommendations 2015* **http://professional.diabetes.org/ResourcesForProfessionals.aspx?cid=84160** *American Psychiatric Association Practice Guidelines* **http://psychiatryonline.org/guidelines**
Sickle-Cell Disease	*National Heart, Lung, and Blood Institute* **http://www.nhlbi.nih.gov/health-pro/guidelines/sickle-cell-disease-guidelines**

Condition	Evidence-Based Guideline
Preventative Measure	**Evidence-Based Guideline**
Perinatal Care	*American College of Obstetricians and Gynecologists (ACOG) Clinical Guidelines* **http://www.acog.org/About-ACOG/ACOG-Departments/Deliveries-Before-39-Weeks/ACOG-Clinical-Guidelines** *American Academy of Pediatrics (AAP) Guidelines for Perinatal Care* **http://www2.aap.org/sections/perinatal/index.html**
Children up to 24 months	*American Academy of Pediatrics Recommendations for Preventive Pediatric Care* **http://pediatrics.aappublications.org/content/suppl/2007/12/03/120.6.1376.DC1/Preventive_Health_Care_Chart.pdf**
Children ages 0-20	*American Academy of Pediatrics Recommendations for Preventive Pediatric Care* **http://pediatrics.aappublications.org/content/suppl/2007/12/03/120.6.1376.DC1/Preventive_Health_Care_Chart.pdf**
A1C Testing for Diabetes and Pre-Diabetes in Adults 20+	*American Diabetes Association: Clinical Practice Recommendations 2015* **http://professional.diabetes.org/ResourcesForProfessionals.aspx?cid=84160**
Cervical Cancer Screening for Women ages 21-64	*US Preventive Services Task Force Recommendations for Primary Care Practice* **http://www.uspreventiveservicestaskforce.org/Page/Topic/recommendation-summary/cervical-cancer-screening**
Adult Vaccinations 21-64	*Centers for Disease Control- Advisory Committee on Immunization Practices* **http://www.cdc.gov/vaccines/acip/recs/**
Colonoscopy for Adults ages 50+	*US Preventive Services Task Force Recommendations for Primary Care Practice* **http://www.uspreventiveservicestaskforce.org/Page/Topic/recommendation-summary/colorectal-cancer-screening**

114. List the services or types of services (as described in the MHT and WVHB MCO benefits package found in Exhibit A of the MCO Contract) that require prior authorization by the MCO, those that can be approved by the member's PCP, and those to which the member can self-refer.

The PCP can approve primary preventive Adult Wellness Services, acute, and chronic health care services, most routine recommended screenings for adults and children, order lab tests and routine radiology tests, immunizations. Most specialist visits, Outpatient Services (preventive, diagnostic, therapeutic, rehabilitative, or palliative Services) require a referral.

Self-Referral Services include: PCP visits; emergency care; OB/GYN services from in network

doctor for routine or preventive services (females only); Family Planning Services; services for sexually transmitted diseases (STDs); Immunizations (shots); vision provider visits in network; in network dental provider visits; emergency mental health or services for alcohol or other drugs related problems up to 10 mental health sessions (A treatment plan is required after 10 visits) and non-emergency and medically necessary transportation. Physical/Occupational therapy-limited to the lesser of maintenance level not to exceed 20 visits/calendar year in addition to the evaluation and re-evaluation visits up to twenty visits (20) in a calendar year do not require referral, referral is required only when visits exceed the limit of 20/calendar year for PT or OT.

Speech therapy: For members over age 21, speech therapy services are limited to specific medical/surgical conditions and prior authorization is required.

An enrollee who has been diagnosed with diabetes has the right to access optometrist or ophthalmologist services without a PCP referral for an annual examination.

If the annual diabetic eye examination reveals abnormal conditions, any follow up appointment with a specialist will require prior authorization from the member's PCP.

Podiatry requires prior authorization after 2 visits/calendar year; routine foot care is not covered.

Chiropractic Services - There may be copay, and prior authorization is required from PCP only for out-of-network; limited services, subject to Plan review, limited to a maximum of 24 visits per calendar year to include spinal manual manipulation and X-ray exam related to service.

Dental Services - (Emergent Treatment) requires prior authorization only for extraction of 3 or more teeth, wisdom teeth, or general anesthesia; Adults covered only for accident or injury, tumor removal, or emergency extraction

Inpatient Services - There may be a co-pay. All elective Inpatient hospital care, urgent, emergent, tertiary, Ambulatory Surgical Center Services, Inpatient behavioral health and substance abuse and out-of-area care requires pre-authorization.

Inpatient rehabilitation (in a rehabilitation facility; limited to 60 days per calendar year) - requires pre-authorization.

Durable Medical Equipment – requires prior authorization if > $500 and molded-to-patient or custom-made orthotics with Limited replacement, some limitations may apply and must meet The Health Plan guidelines. Orthotics and prosthetics

Heart, bone marrow, liver, kidney, pancreas/kidney, lung, heart/lung, small intestine, organ and corneal transplants may be covered with authorization. Transplants require prior authorization

115. Describe the medical services prior authorization (PA) process, including the turnaround time and levels of authority. Provide elements included in the PA approval/denial letters to members and providers. If the behavioral health PA process is different, describe the process.

As a commitment to providing timely, quality care, Trusted will apply an aggressive authorization decision timeframe within the UM system which exceed the Balanced Budget Act of 1997 (BBA) requirements.

Standard Authorizations are processed no more than seven (7) calendar days following receipt of request for service. Extensions of up to five (7) calendar days will be granted if requested by enrollee or provider or if Trusted justifies that it is in the best interest of enrollee.

Expedited Authorizations are processed as expeditiously as the enrollee's health condition requires, but not more than two (2) working days following receipt of the request for service, unless additional information is needed. . This period may be extended up to 5 additional business days upon request of the enrollee or provider, or if Trusted justifies to BMS in advance and in writing that the enrollee will benefit from such extension

All authorization decisions will be communicated orally to the provider who has requested authorization within two (2) business days of the decision.

As a commitment to providing timely, quality care, Trusted will apply an aggressive authorization decision timeframe within it's UM system in compliance with its agreement with WV's requirements.

Exhibit 19: Authorization Decision Timeframe

UM Process	Days from Receipt of all Relevant Information to Decision	Days from Decision to Verbal Notification	Days from Decision to Written Notification
Precertification			
• Non-urgent/Routine	7 calendar	2 working	2 working
• Urgent	2 working	2 working	2 working
Concurrent Review			
• Inpatient, intensive outpatient, residential behavioral health	1 working	2 working	2 working
• Ongoing ambulatory	10 working	2 working	2 working
Retrospective Review			
• Routine	30 working	N/A	5 working

Trusted will process each request for Prior Authorization of a service and notify the consumer of the decision as expeditiously as the consumer's health condition requires, or at least orally, within two (2) Business Days of receiving the request, unless additional information is needed. Any decision to deny, limit, reduce, delay or terminate a service will be provided to the requesting provider and consumer orally and in written format mailed to the consumer, the consumer's PCP, and the prescribing Provider noting the reason for the decision and the consumer's right to file a grievance or an appeal. This notice of the decision will be mailed to two (2) Business Days after the decision is made.

Trusted has documented policies and procedures for Prior Authorization. Medical necessity determinations are made in accordance with the Medicaid Program definition. Authorization of services is based on any one of the following standards:

1. The service or benefit will, or is reasonably expected to, prevent the onset of an illness, condition or disability;
2. The service or benefit will, or is reasonable expected to, reduce or ameliorate the physical, mental or developmental effects of an illness, condition, injury or disability;
3. The service or benefit will, assist the Member to achieve or maintain maximum functional capacity in performing daily activities, taking into account both the functional capacity of the Member and those functional capacities that are appropriate for Members of the same age.

The UM Department will conduct clinical record reviews. Preauthorization decisions and processes are supervised by qualified licensed professionals. Licensed consultants are utilized to review cases from the appropriate specialty areas as needed.

A UM Review Nurse receives service request, verifies in-network status for the provider or practitioner where the service is to be performed. For an out of network provider or practitioner request, the reviewer will determine if the service is available within Trusted's network. If the service is not available within the network, or the distance for the member to travel to obtain these services is unreasonable, Trusted will cover medically necessary services out of network for the enrollee. Clinical information supplied is reviewed against the applicable InterQual criteria set. If the requested service meets the applied InterQual criteria, or in the professional clinical judgment of the reviewer is deemed to meet medical necessity standards, the service is approved, and the requesting provider is contacted within 48 hours and given verbal approval. The decision is documented the in the system, utilizing the Trusted documentation guidelines.

If the reviewer is unable to approve the requested service, the case is assigned to the Medical Director's queue. The Medical Director reviews the clinical information provided, and if necessary, requests additional information in order to make a determination, and consults with appropriate clinical Peer Advisors, as needed, to render a determination, renders a determination, documents the determination and returns the decision to the reviewer's queue.

When the Medical Director is unable to approve the service requested, the denial reason is documented in the denial database and information returned to the UM Review Nurse who reviews the MD decision. Medical management staff verbally communicates adverse determinations with the rationale to the requesting practitioner/provider within 48 hours, and documentation is placed in the system along the InterQual Criteria set and subset used to evaluate service request and the name and title of the Medical Director or other professional who made the denial decision.

All denials/adverse determinations based on Medical Necessity are made by an appropriate, licensed practitioner. Depending on the type of case, the practitioner may be a physician, psychologist, pharmacist, chiropractor, dentist or other practitioner type, as appropriate. Medical review staff (RNs, LPNs and others), may not make any medical necessity adverse determinations.

A denial letter is mailed to the requesting practitioner and the member within 48 hours of the decision.

It is the policy of Trusted that the Medical Director, or the Peer Advisor who made the initial adverse determination, be available to the requesting practitioner for peer-to-peer discussion of any medical necessity denial when the requesting practitioner asks for such a discussion. Medical management staff communicates to the requesting provider or designee that the Medical or Behavioral Health Director or designee is available to discuss a denial decision with the requesting physician/ provider and the time frames and process for initiating the discussion.

Any decision to deny, limit, reduce, delay or terminate a service will be provided to the requesting provider and consumer orally and in written format mailed to the member, the PCP, and the prescribing Provider noting the reason for the decision and the consumer's right to file a grievance or an appeal. This notice of the decision will be mailed within two (2) Business Days after the decision is made.

The Trusted contract allows an extension of 5 days for standard or expedited appeals.

116. Provide the MCO's required length of time for providers to request prior authorizations for services. If this varies by service or circumstance, provide the applicable length of time for each service/situation.

The PCP is responsible for overseeing for its patients, referral services to Specialists, Participating Hospitals, and ancillary service provider according to the procedures established by Plan as set forth in the Provider Manual. Evidence of referrals made by PCP must be submitted to Plan's utilization management department via facsimile transmission, via U.S. mail, or other pre-approved methodology within three (3) days of the date of arrangement of Referral Services. To promote continuity of care with the member's other treating physicians, the PCP will request copies of medical records of physicians to whom referrals are made in order to maintain an integrated medical record for assigned Members. In the event a Member needs specialty services and a contracting Specialist is unavailable, the PCP will contact Trusted's utilization management department to obtain authorization for the referral of the Member to a non-participating Specialist. The PCP is expected to evaluate the outcome of the Referral Services and coordinate any of the member's further medical needs.

117. Describe the process to honor medical, behavioral health and pharmacy authorization approvals from previous coverage during the transition period.

Medical and Behavioral Health- Trusted will honor a member's prior-authorizations during the first ninety (90) days after an individual's enrollment (i.e., the Transition Period). To promote continuity of care for consumers during the transition phase, Trusted's Provider Services Department will negotiate a Letter of Agreement (LOA) for non-participating providers. Trusted has developed a streamlined the process for drafting, negotiating, distributing and implementing provider LOAs for out of network services. LOAs are used to ensure that members are able to receive services from providers not contracted with Trusted. The intent is to enter into a formal contract with provider. Additionally LOAs are used by Provider Services to identify new providers for contracting to be included in the network based on volume and frequency of the need for these services out of network.

Pharmacy- Both Trusted and MeridianRx will ensure that appropriate transition fills are initiated. When a pharmacy receives a new medication prescription requiring a PA, the submitted claim will adjudicate with a 72-hour supply. When a pharmacy receives an ongoing medication prescription requiring a PA, the claim will adjudicate with a 15-day supply. The Ongoing medication policy will not apply if the dispensing pharmacist determines that taking the mediation would jeopardize the member's health or safety. Trusted does not require pharmacy interventions or edits at point-of-sale for Medicare transition claims when the medication is requested for the above noted day supply. However, the point-of sale pharmacist will be alerted by a secondary message in MERLIN regarding the appropriate days' supply submission after the claim initially rejects for prior authorization required. This will occur via standard National Council for Prescription Drug Programs (NCPDP) response messaging.

When a transition claim processes, the claim is flagged and relevant claim information is communicated to the member. A written notice is sent via U.S. Mail to the member who obtains a transition fill within three (3) business days of the fill. The written notice includes:

- An explanation of the temporary nature of the transition supply
- Instructions for working with Trusted and the member's prescriber to identify appropriate therapeutic alternatives that are on the formulary.
- A description of the procedures for requesting a prior authorization.

Extension of transition timeframes are provided on a case-by-case basis to the extent that the prior authorization has not been processed by the end of the minimum transition period and until such time that a transition has been made either through a switch to an appropriate formulary medication or a prior authorization is obtained.

118. Describe how providers and/or members will be notified regarding expiration of existing medical and pharmacy authorizations.

Upon authorization of services the parameters by which the member should comply, are communicated explicitly noting the frequency and duration of services. One-time authorizations tend not to have an expiration date.

119. Describe the process for authorizing out-of-network access, including emergency situations, travel, and medical necessity.

Trusted covers emergency services necessary to screen and stabilize members without prior authorization in cases where a prudent layperson, acting reasonably, would have believed that an emergency medical condition existed. Trusted does not require prior authorization for emergency services. This applies to out-of-network, out of state, and in-network services, which an Enrollee seeks in an emergency.

Trusted will not refuse to cover emergency services based on the failure of the emergency room provider, hospital, or fiscal agent to notify the enrollee's primary care provider or Trusted of screening and treatment within 10 calendar days of presentation for emergency services. Trusted covers emergency services if an authorized representative authorizes the provision of emergency services, including ambulance transport. Trusted enrollees will not be held liable for payment of ED services and subsequent screening and treatment needed to diagnose the specific condition and to stabilize the patient. The attending emergency physician, treating the enrollee is responsible for determining when the enrollee is stable for transfer or discharge. This determination is upheld by Trusted.

Out-of-network hospital claims will be paid at the established Medicaid rate in effect on the date of service. Steps for making medical necessity decisions for a non-participating provider do not differ from a participating provider.

120. Describe the circumstances under which a member might be granted a standing referral to a specialist provider, including the duration and/or number of visits usually granted or maximally allowed. Also indicate the extent to which a specialist provider may:

SSI and Special needs populations may likely be provided standing referrals. Typically, standing referrals will not exceed a period of 3 months but may be shorter depending on the complexity of the request. High-dollar services may require subsequent referrals after a

designated timeframe. Specialty providers that are granted permission to serve as a member's PCP may provide the following services usually reserved for a PCP:

- Admit patients for inpatient care, choose the hospital of admission, and keep the patient hospitalized;
- Schedule or provide ancillary services, such as laboratory testing; and
- Refer patients to sub-specialists or other providers.

CareAnalyzer will alert the Case Manager and/or the Data Analyst as a potential high-utilizer case and require an active treatment plan to ensure comprehensive services are provided efficiently and effectively.

121. Describe the circumstances in which members might be referred to out-of-network providers and the process for members and/or providers to request out-of-network referrals. Explain the procedures for ensuring that information from non-network providers is shared with the member's PCP.

A PCP may refer a patient to an out-of-network provider when a service is not available within the network, or the distance for the member to travel to obtain these services is unreasonable. Before submitting the referral, the PCP must request a prior-authorization to determine medical necessity and the capacity for Trusted to provide the service in-network. Prior-Authorizations will be reviewed per the Utilization Management policies and procedures. Upon determination that the service is medically necessary, Trusted will facilitate obtaining a Single Case Agreement outlining payment, benefit, duration and frequency terms to ensure care is not disrupted.

122. Provide the timeframes for reviewing and processing medical referrals. Describe the average duration of medical referrals.

The PCP must be the (ordering) physician that generates the referral for the member to see the Specialist (rendering) provider. A specialist cannot generate a referral for a member.

Referrals must be created through the Trusted Health Plan Provider Portal. Referrals are valid for 90 days. The member must have the first appointment with the specialist within the first 30 days or the referral is considered void.

Referral Guidelines

The Referral Process is outlined below:

- Referrals are required for evaluation and follow-up with specialists, diagnostic testing, and other ancillary services.
- Practitioners may not refer to a non-participating practitioner or facility without prior authorization from Trusted.
- Referral requests for nonparticipating practitioners are reviewed on a case-by-case basis the Utilization Management Department.
- Availability of service or specialty within the network and member's history with a practitioner is considered when reviewing referrals to nonparticipating practitioners.
- The first service should occur within thirty- (30) days from the date of referral. Referrals expire after ninety- (90) days.

- Practitioners should indicate the number of visits on a referral, up to three (3) or it will be valid for only one visit.
- Referrals must be generated before the service, procedure, and/or evaluation occurs.
- The PCP is charged with coordinating the care of members assigned to their panel.

If the network is unable to provide necessary medical services, covered under the contract, to a particular member, TRUSTED will adequately and timely cover these services out of network for the member for as long as the MCO is unable to provide them. TRUSTED will coordinate services for out of network providers with respect to payment and will ensure that the cost for services provided to the member is not greater than it would be if the services were furnished within the network to the extent possible. Approval of out of network services must be obtained in advance of the services unless a delay in care based on the need to obtain such authorization would jeopardize the medical outcome for the member. In such emergent or urgent situations, the plan should be notified as soon as possible.

123. Describe the circumstances and process under which a member may continue an existing relationship with an out-of-network provider (or provider who leaves the MCO's network) if it is considered to be in the best medical interest of the member. Specify how long the MCO will allow members to see out-of-network providers that refuse to contract with the health plan for ongoing courses of treatment past the first 90 days.

Special Needs/ SSI or complex cases will have a formal transition plan developed and adequately resourced to ensure all aspects of care are defined and addressed. For each enrollee identified as needing Level I, II or III Care Coordination services upon enrollment, will have an action item within the treatment plan that outlines transfer of services, the continuation of services with non-network providers through the credentialing process, and more frequent follow-up to ensure services are not disrupted. Enrollees actively receiving services according to its treatment plan (e.g. cancer treatment-radiation, chemotherapy, etc.) may choose to continue treatment until the course of therapy is concluded with the existing treating provider even if it extends beyond the first 90 days.

124. Separately describe ongoing monitoring of emergency room (ER) usage. Explain application of the prudent layperson standard for all ER visits and if it would not require any prior authorization for screening and stabilization of members.

CareAnalyzer provides Medical Management the ability to be proactive in their care management approach, providing the tools needed to evaluate patient risk and make recommendations for better consumer care. CareAnalyzer combines elements of regulatory reporting, predictive modeling, provider network evaluation, and risk adjustment.

Risk Management: Care Managers are able to evaluate gaps in care in the context of a member's overall clinical profile, rather than narrowly focusing on a specific gap in care. Care Managers can identify patients at high risk for hospitalization or complications and minimize that risk with appropriate, proactive interventions.

Predictive Modeling: CareAnalyzer integrates The Johns Hopkins University ACG System, a comprehensive set of predictive modeling tools. These tools provide THP's care managers with risk-stratified data that is effectively applied to target high-risk members for early intervention and improve the overall coordination of care.

CareAnalyzer produces a number of reports that can be utilized to identify consumers at risk of illness or diagnosed with a condition that requires support. CareAnalyzer allows the team to identify key items for population assessment:

- Age and Gender (number, rate and ranges) Distribution
- Racial, Ethnic and Language Preferences
- Top 10 Inpatient Diagnosis (including number and rate of occurrences)
- Top 10 Ambulatory diagnosis (including number and rate of occurrences)
- Top 5 Emergency Room Diagnosis (including number and rate of occurrences)
- Top 5 Behavioral Health Diagnosis (including number and rate of occurrences)
- Needs of children and adolescents including physical, mental emotional and other special needs for complex case management
- Prevalence and needs of members with comorbidities, physical disabilities and with serious and persistent mental illness.

CareAnalyzer serves as a primary platform for data used for identification of members for complex case management. On a monthly basis, data is refreshed in CareAnalyzer and used to identify and conduct an initial risk stratification of all members eligible for the Case Management program. The algorithm, at a minimum, takes into consideration inpatient hospital claims, emergency room use, co-morbid conditions and pharmacy claims.

CareAnalyzer is also a NCQA-certified HEDIS Software solution, which the Quality team will be able to use to measure and report quality standards with industry-accepted HEDIS methodology, as well as an enhanced measurement list from other industry-recognized quality organizations.

Trusted covers emergency services necessary to screen and stabilize members without prior authorization in cases where a prudent layperson, acting reasonably, believed a medical emergency condition existed. No prior authorization is required, whether services are rendered in or out of network facilities or contracted network providers. The attending emergency physician is responsible for determining when the enrollee is stable for discharge, and Trusted will uphold this determination. Trusted enrollees will not be held financially liable for payment of ED services.

125. Describe compliance with the post-stabilization care per 42 C.F.R §§438.114(b)&(e) and 42 C.F.R. §422.113(c)(iii).

Trusted Health Plan is responsible for post stabilization care services after the treatment of an emergency medical condition whether obtained within network or out of network that are pre-approved by a plan provider or Trusted Health Plan representative; are not pre-approved but which services are provided to the member within one hour of a request to Trusted for pre-approval to maintain member's stabilized condition; were administered to maintain, improve or resolve the member's stabilized condition and Trusted did not respond to a pre-approval request within one hour; Trusted cannot be contacted; or no agreement is reached between Trusted's representative and no plan physician is available for consultation. The treating physician may continue with the member's care and treatment until a plan physician is available for consultation. Trusted's Post stabilization fiscal responsibility ends when: A Trusted Health Plan representative and the treating provider reach an agreement regarding the member's care; a plan provider with privileges at the treating facility assumes responsibility for the member's care, or assumes care of the member after

transfer or the member is discharged.

126. For SSI members, describe the process by which the MCO will work with the prospective member, his or her non-network provider, and the enrollment broker to assist in enrolling and pairing the beneficiary with an appropriate in-network provider within 90 days of enrollment and transferring necessary clinical information to the new provider.

Trusted's transition plan will ensure continuity of care and an intact treatment plan for incoming enrollees with SSI. The Special Needs Care Manager will partner with the prospective member, his or her non-network provider, and the enrollment broker to assist in enrolling and pairing the beneficiary with an appropriate in-network provider within the transition period. An activity/ task will be clearly defined within the treatment plan that outlines transfer of services, the continuation of services with non-network providers through the credentialing process, and frequent follow-up and transfer of records to the in-network provider to ensure services are not disrupted.

127. Describe Family Planning services.

Family Planning Services are those services provided to individuals of childbearing age to temporarily or permanently prevent or delay pregnancy. These services include: health education and counseling necessary to make informed choices and understand contraceptive methods; limited history and physical examination; laboratory tests if medically indicated as part of decision making process for choice of contraceptive methods; diagnosis and treatment of sexually transmitted diseases (STDs) if medically indicated; screening, testing, and counseling of at-risk individuals for human immunodeficiency virus (HIV) and referral for treatment; follow-up care for complications associated with contraceptive methods issued by the family planning provider; provision of contraceptive pills /devices/supplies; tubal ligation; vasectomies; and pregnancy testing and counseling.

Trusted members can get birth control and other Family Planning Services from any provider they choose. Members may go to Family Planning providers who are out of–network without prior authorization, and a referral is not required to obtain these services. Members choosing a Family Planning Services doctor other than their PCP are advised to inform their PCP. All birth control and other Family Planning Services are confidential.

Family Planning Services include:

- Pregnancy Testing
- Counseling for Women and Couples
- Routine and Emergency Contraception
- Counseling and Immunizations
- Screening for all Sexually Transmitted Diseases
- Treatment for all Sexually Transmitted Diseases
- Sterilization Procedures (Requires signing a form 30 days before the procedure)
- HIV/AIDS Testing and Counseling

Family Planning Services do not include:

- Routine infertility studies or procedures
- Hysterectomy for sterilization
- Reversal of voluntary sterilization, HIV/AIDs Treatment,
- Abortion Services

128. Describe how the MCO will ensure that individuals who have specialists as PCPs are receiving primary care services on an ongoing basis.

Trusted will utilize its screening tools to identify consumer's with chronic problems, and through electronic transmission and exchange of data electronically with providers and hospitals as well as notifications received directly from the enrollment broker regarding consumers with special health care needs. Once consumers with special health care needs are identified, a comprehensive treatment and monitoring process will be established and care manager will coordinate care as needed across the continuum. Consumers identified with chronic conditions and/or illnesses that require treatment and monitoring by a specialty provider will be designated as such in the system and will have direct access to that specialty provider or group of providers responsible for diagnosing, treating and/or monitoring the progression of the condition. The Care Manager will collaborate and coordinate efforts amongst the treating team to ensure effective, cost efficient solutions that are evidenced-based and take the individual situation into consideration. Using Trusted's Care Analyzer software, all members of the health plan will be aware of any gaps in care that the Specialist may have overlooked. Additionally, monthly reports of members out of compliance with preventive care recommendations, will be sent to the Specialist.

129. Describe the mechanisms the MCO will employ to identify pregnant women at enrollment and on an ongoing basis, and the mechanisms that will be used to promote "early and often" prenatal care for women who are identified as being pregnant.

Trusted recognizes the importance of the delivery of care for pregnant women. To combat the high rates of maternal and infant mortality, an enhanced, comprehensive package of prenatal and postpartum services is offered to eligible Medical Assistance recipients through enrolled qualified providers. THP receives a list of new enrollees shortly after the beneficiary's enrollment is confirmed by CMS. To identify newly enrolled pregnant members, THP has a comprehensive health risk assessment process in place to assess new member health status which applies an acuity that helps direct nursing staff to appropriate services the member may need or require. THP created a standardized Health Risk Assessment questionnaire designed to help identify key care needs and evaluates the physical, psychosocial, cognitive, and functional needs of all new members. The risk assessment process is to assess new members and identify specific needs. THP will contact newly enrolled beneficiaries to perform the survey telephonically. If the beneficiary cannot be contacted by phone, the survey will be mailed to the beneficiary; a last resort will be a home visit. All calls and visits, successful and unsuccessful will be documented. This information is entered into CareConnect Software, which directs the nurse on specific actions (referrals).THP ensures adherence to conducting all initial assessments within 90 days of enrollment. Other mechanisms used for early identification of pregnant moms includes: the Member Services Department calls for information/ services; the Obstetrical Needs Assessment Form (ONAF); Claims Profiling; and, providers. Pregnant members regardless of entry point into the system are advised to contact their PCP or OB/GYN doctor right away. Members may also contact Member Services for assistance to make an appointment for a pregnancy test. Additionally, they are advised to schedule their initial prenatal checkup within 14 days of the date on which they find out that they are pregnant, and are informed that they can see the OB/Gyn doctor without seeing or calling their PCP first to get a referral. Members are also reminded of the importance of regular prenatal visits throughout their pregnancy. Trusted offers within sixty days of enrollment, monthly new enrollee orientation to cover benefits and access to care and services.

Trusted will promote Text4Baby, a free mobile information service designed to promote maternal

and child health amongst our perinatal population. Text4baby provides pregnant women and new moms with information regarding their health and health of their babies in order to give their babies the best possible start in life. Women who sign up will receive free SMS text messages three times each week. The messages will focus on a variety of critical maternal and child health topics, including fetal development, birth defects prevention, immunizations, pregnancy symptoms, nutrition, breast-feeding, alcohol, drugs and smoking use, mental health as well as various hotline numbers for additional help and guidance.

Care Coordination for high-risk pregnant moms will include all components of its High Risk case management model. A Trusted case manager would then coordinate the community visits by the nurses to provide high-risk maternity or special services. Trusted's potential partner, Voxiva, Inc.,- a digital health population management provider- will help to provide the features of this benefit. Through the use of Voxiva's Text4baby application and text messaging service, Trusted would reach, communicate and engage with members in order to improve quality measures and close gaps in care. Text4baby includes a series of messaging modules that ensure that pregnant women and new moms follow recommended services including prenatal and postnatal care, immunization reminders and well-baby care.

We believe that our multi-pronged approach will effect change within the prenatal populations and lead to improvements in HEDIS measures relating to prenatal care. We fully expect to be a Medicaid "high performer" relating to NCQA accreditation on HEDIS measures across all areas including customer satisfaction, prevention, and treatment.

130. Discuss the procedures for identifying individuals with complex or serious medical conditions on an ongoing basis, including to what extent the MCO's information systems will be used to identify members with special needs and isolate data specific to eligibility category or diagnosis.

UM/CM/Care Coordination utilizes data from CareAnalyzer, which provides Medical Management the ability to be proactive in their care management approach, providing the tools needed to evaluate patient risk and make recommendations for better consumer care. CareAnalyzer combines elements of regulatory reporting, predictive modeling, provider network evaluation, and risk adjustment.

Care Managers are able to evaluate gaps in care in the context of a member's overall clinical profile, rather than narrowly focusing on a specific gap in care. Care Managers can identify patients at high risk for hospitalization or complications and minimize that risk with appropriate, proactive interventions.

CareAnalyzer provides THP's care managers with risk-stratified data that is effectively applied to target high-risk members for early intervention and improve the overall coordination of care.

CareAnalyzer produces a number of reports with data from inpatient hospital claims, emergency room use, co-morbid conditions and pharmacy claims that can be utilized to identify consumers at risk of illness or diagnosed with a condition that requires support, and allows the team to identify key items for population assessments, including:

- Age and Gender (number, rate and ranges)
- Racial, Ethnic and Language Preferences
- Needs of children and adolescents including physical, mental emotional and other special needs for complex case management

- Top 10 Inpatient Diagnosis
- Top 10 Ambulatory diagnosis
- Top 5 Emergency Room Diagnosis
- Top 5 Behavioral Health Diagnosis
- Prevalence and needs of members with comorbidities, physical disabilities and with serious and persistent mental illness.

CareAnalyzer also serves as a primary platform for data used for identification of members for complex case management. Data is refreshed monthly in CareAnalyzer and used to identify and conduct an initial risk stratification of all members eligible for the Case Management program. The algorithm, at a minimum, takes into consideration inpatient hospital claims, emergency room use, co-morbid conditions and pharmacy claims.

CareConnect unifies Care, Disease and Utilization Management in a single, coordinated system. CareAnalyzer data is imported into CareConnect. CareConnect provides case managers with simultaneous access to critical medical, drug, lab and utilization data, allowing them to connect with patients and caregivers on a personalized level throughout the care continuum, thus allowing the plan to provide consumers with a holistic approach to care. CareConnect provides the ability to identify members most in need of outreach and intervention; Integrate care for comorbidities, including both medical and behavioral health conditions; Utilize technology that supports case management workflow and health risk assessment automation; Maintain a complete history of all member activity for those enrolled in a care plan; View member profiles, medical claims and pharmacy data all in one place; Complete health risk assessments to evaluate and educate members; Support surveys for medication therapy management; Create clinically-valid care plans to monitor and close existing care gaps; Provide UM referrals and authorizations; Complete discharge planning surveys; Assist with transitional care plans and schedule necessary appointments and equipment use and track quality of care issues.

131. If crisis stabilization services are subject to medical necessity review criteria, describe how the MCO will ensure timely access to these services and how the MCO will address these types of services that are provided out of network.

Emergency room and urgent/immediate care center services will be reviewed retrospectively for appropriateness of level of care based on:

- Patient contact with primary care physician for prior authorization.
- Documentation in medical record of actual emergent need for care.

Trusted covers emergency services necessary to screen and stabilize members without prior authorization in cases where a prudent layperson, acting reasonably, would have believed that an emergency medical condition existed.

Trusted also covers emergency services if an authorized representative authorizes the provision of emergency services, including ambulance transport.

132. Describe the procedures and materials that will be used to ensure compliance with EPSDT program requirements, as outlined in the MCO contract. Please provide:

• A plan detailing the specific activities to be performed and responsible staff/departments;

Trusted is committed to providing resources to assist with assessing enrollees upon enrollment quickly for high-risk conditions and to assign them to appropriate care coordinators. Enrollees

identified between the ages of 0-21 years old are screened to identify their last EPSDT visit and verified with the provider.

The EPSDT Outreach Team will receive weekly reports. The New Enrollees Report identifies all newly enrolled Medicaid enrollees under the age of 21. The EPSDT Outreach team will use these reports to identify enrollees then telephonically contact the enrollee's parent/guardian. Once identified, Trusted will assist these enrollees to help them access the appropriate screening(s) and any follow-up care determined necessary through the exam. On a monthly basis, Trusted will distribute a roster to PCPs that identifies all assigned enrollees who are due or overdue for a screening, or have not had a PCP encounter within a certain number of days of enrollment. PCPs are required to conduct EPSDT screenings according to the American Academy of Pediatrics recommendations for pediatric health care for screening, vision, hearing, and dental services.

Once the EPSDT Outreach team makes contact with the parent/guardian, s/he explains:

- The importance of preventive care, the periodicity schedule, and services available.
- How and where to access services, including available transportation.
- Lastly, we offer to make a three-way conference call to the PCP's office or transportation vendor (if necessary) to schedule an appointment.

Trusted's innovative and proactive tracking system will incorporate the EPSDT recommended periodicity schedule into each enrollee's (under the age of 21) case file. Reminder notifications based on the month due (or in the case of newborns-week due) will be established. Reminders will include an offer to schedule an appointment or provide transportation to and from the appointment. Auto-reminders will be processed and sent at 90, 60 and 30 day intervals (or at latest within two weeks) prior to the due date based on the enrollee's notification preference:

1. Telephone Reminder **2.** SMS Text/Secure Message **3.** Mailing

When an appointment is scheduled through the EPSDT Outreach Team, or if the parent or guardian already made an appointment, Trusted will send a reminder of the time, place and date of their upcoming appointment. If the parent or guardian declines to schedule an appointment during the call with the EPSDT Outreach Team, they will be encouraged to make an appointment on their own. The parents/guardians will be re-contacted to verify whether an appointment was scheduled or occurred.

Trusted will utilize multiple avenues to identify and educate enrollees about EPSDT screens and facilitate compliance with the periodicity schedule, including birthday cards, targeted mailings and telephone calls. After completing a comprehensive assessment, Trusted offers non-cash incentives to increase enrollee compliance. Trusted's incentive program will be established in accordance with applicable incentive regulations.

Incentives will be used to motivate the enrollee not only to attend the recommended EPSDT appointment, but also notify Trusted's EPSDT staff of the appointment date and kept appointments.

Trusted will utilize an aggressive data-mining process to identify enrollees that are out of EPSDT compliance through a multipronged approached:

1. Past due or missing appointment dates as determined by the EPSDT periodicity schedule are identified within the case file.

2. Claims are evaluated monthly to identify EPSDT enrollees that lack PCP, dental and/or lab encounters within the past month for newborns or within the past year for enrollees between ages 1 year and 21 years.
3. Electronic notification of missed or past due appointments exchanged between the PCP's Electronic Health Records.
4. Notification by other source (PCP Office, specialty, Care Coordinator, etc.).

The aforementioned processes will allow the outreach worker to validate noncompliance and tag the enrollee as non-compliant or the enrollee's caregiver (if a Trusted enrollee) as having a non-compliant dependent. The tagging of noncompliant enrollees will allow the following:

1. Visibility of the non-compliant status throughout the system. If a member of the Trusted staff interacts with the enrollee, upon accessing the electronic case file, an alert notifying the staff member of the non-compliant status will fire and the staff member will have to actively work with the enrollee/ caregiver to schedule an appointment via three-way call to the provider or warm-transfer to the EPSDT outreach staff to assist with scheduling. The staff member will be required to document a reason for not scheduling an appointment prior to closing the enrollee's file.
2. Auto-mailings notifying the enrollee/caregiver of the need to contact the PCP or outreach worker to schedule an appointment.
3. Inclusion on the Telephone log. An assigned outreach worker will make calls to non-compliant enrollees/ caregivers on the telephone log daily to attempt to schedule appointments.
4. Inclusion on the EPSDT visit log. EPSDT enrollees that remain out of compliance past ninety days according to the EPSDT periodicity schedule will be placed on an EPSDT visit log. The assigned outreach worker will schedule an appointment with the caretaker to urge the importance of making an appointment and identify any barriers (e.g. transportation, office hours, childcare, knowledge deficits) impacting scheduling. Documentation of the visit will be updated in the case record.

If Trusted employees encounter either a disconnected or incorrect telephone number when attempting to contact an enrollee we will verify the address and phone number. Trusted will also routinely gather secondary telephone numbers for enrollees, such as a mobile, work, or family member's phone number(s). If Trusted is unable to contact an enrollee, we will document that fact in our system and a follow-up mailing is automatically generated explaining the reason for the EPSDT outreach call and requesting that the enrollee or parent/guardian contact Trusted.

If an enrollee mailing is returned as undeliverable, Trusted will verify the address in our system, and another attempt will be made to reach the enrollee (parent/guardian). As a final effort, Trusted will contact the enrollee's PCP or other source for any additional addresses, phone numbers or other contact information.

If appointments are scheduled, the EPSDT Outreach Team will confirm the appointment with the PCP's office and request confirmation that the enrollee kept the appointment.

As part of the EPSDT initiative, Trusted will identify all enrollees across the State who are due for a screening under the age of 21 for Medicaid. Trusted's system is set up to use date-of-birth logic

to track enrollees due for EPSDT screenings in accordance with state and federal guidelines, as well as American Academy of Pediatric guidelines.

Once identified, Trusted will contact enrollees to help them access the appropriate screening(s) and any follow-up care determined necessary through the exam. On a monthly basis, Trusted will distribute a roster to PCPs that identifies all assigned enrollees who are due or overdue for a screening, or have not had a PCP encounter within a certain number of days of enrollment. PCPs will conduct EPSDT screenings according to state and federal guidelines for screening, vision, hearing, and dental services.

Trusted will utilize multiple avenues to identify and educate enrollees about EPSDT screens and facilitate compliance with the periodicity schedule, including birthday cards, targeted mailings, telephone calls and face-to-face visits using our "Feet on the Street" initiative.

The primary EPSDT program initiative focuses on ensuring children, adolescents and young

adults receive appropriate preventive, dental, behavioral health, developmental and specialty services. Our EPSDT Outreach Department will make daily outreach phone calls to enrollees who are due for an EPSDT exam. The team members will promote the benefits of routine primary and preventive health care as well as needed follow-up and treatment services to enrollees.

Some of the activities that will be implemented to supplement the actions of the outreach team will include:

- Educational materials will be mailed to enrollees to remind them of the importance of well care visits and pediatric dental visits.
- Articles that promote pediatric dental preventive service will be included in the quarterly member newsletter.
- Trusted will host monthly community-based dental clinic in each county called "Let's Smile". The event will be located at a Trusted Wellness and Customer Service Center. The events will assist with increasing the EPSDT compliance rate.

Trusted has incorporated EPSDT outreach activities within the Care Coordination Department. For children identified as having Special Health Care Needs, enrollment in and support by the Care Coordination team is available. In the case of a "well-child" enrollee under the age of 21 (the majority of EPSDT cases), a complex preventative and early detection regimen has been established to promote continued health and early diagnostic and treatment services to maintain optimal health. This regime (EPSDT periodicity schedule) can be complicated and may require care coordination activities to comply with recommended treatment. A Trusted advocate (outreach staff) is assigned to monitor and to assist the enrollee and caregivers with "decoding" a complicated EPSDT schedule.

The Quality Improvement Department, specifically the EPSDT Outreach Manager, is responsible for establishing and maintaining effective performance monitoring surrounding all EPSDT functions in accordance with regulatory and contractual requirements, and federal laws.

Management and supervisory oversight and strict accountability requirements anchor the system of internal control for all EPSDT employees in the performance of their specific job responsibilities. Trusted performance monitoring structure and management oversight consists of the following key elements:

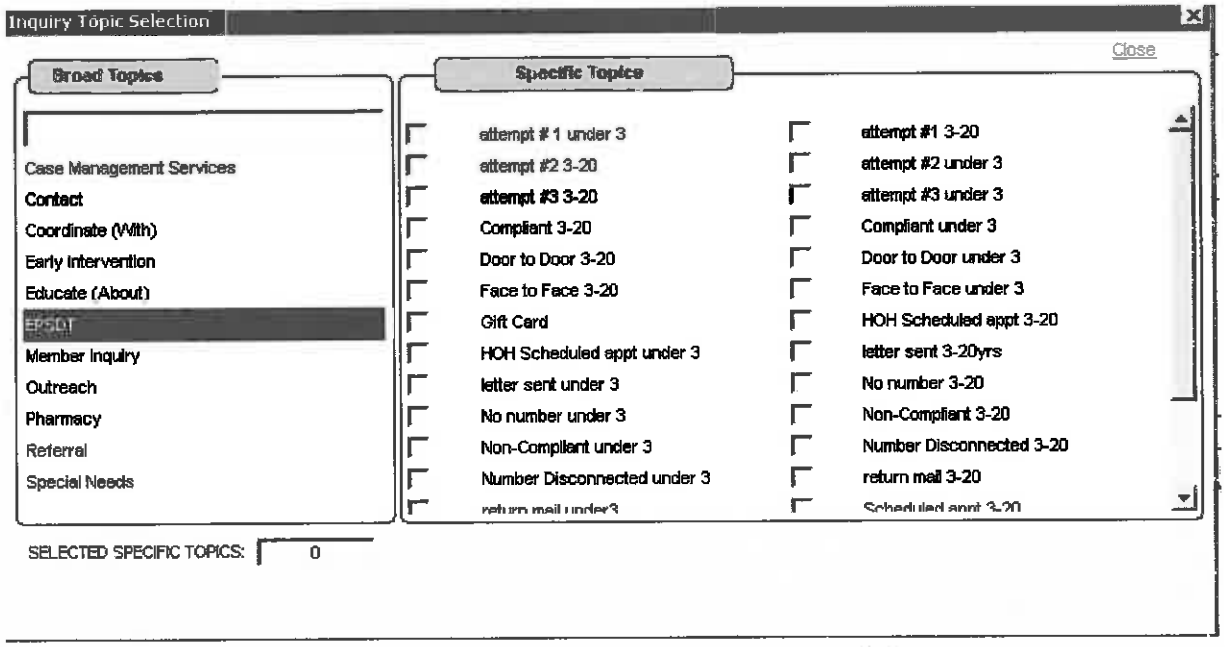
- Daily productivity tracking of the EPSDT Coordinator's outreach to non-compliant members;
- Daily (or as needed) collaboration with Provider Services, transportation vendor, and Medical
- Management staff to effectively coordinate appointments;
- Weekly compliance status meetings to discuss strategies to address member non-compliance with
- EPSDT requirements;
- Weekly "refresh" of EPSDT non-compliant list to determine efficacy of outreach efforts on a weekly basis;
- Participation in monthly meetings with regulators pertaining to EPSDT to keep abreast of updates, changes, and exchange of ideas as deemed appropriate and necessary;
- Quarterly EPSDT activity and compliance reporting to regulators
- Annual reporting of CMS 416 participation ratio.

Trusted's claims department will review denials on a biweekly basis to determine denial reasons, types of services denied, provider types, and individual provider trends in an effort to identify areas that require clarification, re-evaluation of the authorization process for a particular service and/or provider-specific training. **For Trusted, this *targeted* approach has resulted in a decrease of administrative denials from 18% (upon program start-up) to 12% within the last six (6) months. Denials associated with the EPSDT population are rare, accounting for less than 3% of all denials plan wide.**

Tracking

Trusted maintains a tracking system to readily access claims data through a reporting tool (Care Analyzer) in the CareConnect system. The tracking system is used to identify gaps in care and evaluate the effectiveness of the program as well as help to direct outreach efforts. The data is collected from the encounter information submitted or confirmed by providers. A report, based on member birthdate, is generated to identify those members under the age of 21, who have not received EPSDT related services. Outreach efforts are conducted to reasonably achieve up to a100% compliance rate.

Exhibit 20: Inquiry Topic Selection Screen



133. Describe how the MCO will ensure that children who are receiving primary care from a specialist receive EPSDT services.

Trusted works closely with PCP's to assure that EPSDT screenings are conducted according to state and federal guidelines for screening, vision, hearing, and dental services. On a monthly basis, Trusted will distribute a roster to PCPs that identifies all assigned consumers who are due or overdue for a screening, or have not had a PCP encounter within a certain number of days of enrollment.

The EPSDT outreach team works in close collaboration with the Children with Special Needs Care Coordinator to assure that routine screening services are an integral part of the Care Plan and are coordinated efficiently.

Trusted will implement its successful PCP collaboration in WV. The underlying principle of the PCP collaboration is to promote a partnership/ relationship between the PCP, Trusted members and Trusted. The provider and Trusted will select either, one (1) to two (2) days per month or a portion of two (2) to three (3) partial days per month to set aside for Trusted members only to attend. Members obtain physicals (for the entire family), screenings and health education in a setting that is geared specifically to serve Trusted members. It is positioned as a "no judgment zone" and serve as a resource to improve compliance with preventive health recommendations. The member is able to walk-in or schedule time through their Case Manager, Outreach Coordinator or Member Services Representative to have a physical or screening with the physician/ provider. Communication regarding the physician's practice, their professional experience and Trusted designated "Clinic Days" (days set aside for Trusted members only) are provided on the website and written communication such as the member newsletter and signage at its Wellness and Outreach Center are displayed.

The rationale was to provide access close to where our members live or where they historically seek care. Upon identification of the PCP, they were offered an opportunity to partner with

Trusted to provide this service. Materials outlining the provider's role and responsibilities, as well as Trusted's were defined and provided to our regulators for approval prior to implementation. The benefit to the provider is Trusted commitment to "filling" appointment slots for the day and assisting with any administrative duties such as conducting reminder calls prior to the appointment, assisting with check in and post appointment required follow-up. Upon agreement to participate in the PCP collaboration, a list of roles and responsibilities were submitted to the PCP and the VP of Provider Relations for signatures.

The PCP agreed to the following:

1. Designated 1-2 days per month to a Trusted "Clinic Day" (or 3-4 partial days) with an assigned Provider
2. Set aside appointments and walk-in slots on that day or designated time period for Trusted members only
3. If deemed necessary, extend its hours to impact Emergency Department utilization
4. Sign-off on Trusted appointment roster attesting that Trusted members were seen during the Trusted Clinic Day and no prohibited marketing took place.

Trusted responsibilities during Clinic Days include:

1. Only having Trusted staff onsite during designated Trusted Clinic Days
2. Interacting only with Trusted members
3. Scheduling all open appointment slots with the partnering PCP on pre-designated clinic days. Members that would be targeted include:
    a. Trusted members out of compliance with preventive care and screening requirements
    b. Trusted members not actively under the care of another PCP
    c. Trusted members seeking urgent, same day appointments for acute but non-emergent symptoms (that would otherwise go to the Emergency Department)
4. Conducting reminder calls the week and day prior to the appointment
5. Coordinating transportation to the appointment
6. Obtaining any related results (discharge instructions, lab, radiology, immunizations) and forwarding to partnering PCP (upon permission of the member)
7. On the designated clinic day the Outreach Coordinator will:
    a. Welcome/ check in the member and be responsible for assuring that members are comfortable, receive the services needed and are provided all information needed for follow-up care (referrals, contact information for transportation, etc.)
    b. Facilitate a discussion with the Case Manager or Pharmacist for any questions the member may have.
    c. Complete and submit necessary paperwork needed to comply with Trusted Health Incentive Program (HIP)
    d. Schedule follow-up appointment.

134. Provide a general description of how the MCO will manage pharmacy benefits, ensure contractual and regulatory compliance, and coordinate services.

Trusted manages critical pharmacy cost drivers through a variety of avenues. We establish a formulary or preferred drug list so that purchasing choices are focused on making appropriate drugs available to most consumers, while allowing for medically necessary alternatives to selected patients. We promote the use of appropriate generic products, determined by the Food and Drug Administration (FDA) and trusted to be as safe and effective as the original product and interchangeable with it. Trusted educates providers and consumers on generic utilization use and ensures they are using drugs appropriately based on sound scientific evidence and principles.

The most significant pharmacy cost savings come from improved utilization of prescriptions for better health outcomes and from the avoidance of unnecessary medical services that result from inappropriate drug use, noncompliance with drug therapy, or adverse drug reactions. We implement comprehensive disease management and medication therapy management programs designed to improve the quality and efficiency of patient care.

Trusted's comprehensive Case Management program promotes better health outcomes by coordinating care through the use of clinical pharmacy programs and the tracking and trending of data. Trusted uses a robust utilization management program to track and trend pharmacy claims data for appropriate medication use. We implement medication evaluation policies and systems such as drug utilization review, prior authorization and quantity and dosage management to ensure high quality, medically safe and effective therapy and cost efficient use of prescription drugs.

Our Pharmacy Benefit Manager, MeridianRx aids cost management. MeridianRx evaluates, reviews, and prepares formulary review packages for presentation to the P&T Committee. In cases where the regulatory formulary or mandated benefit has changed, the changes are brought forth to the Committee within 90 days for evaluation. When an FDA approved drug is added to an existing therapeutic class of drugs, an evaluation will be made to determine if inclusion on the Trusted formulary is necessary or if existing drugs already on the formulary continue to meet consumer needs. The P&T Committee is responsible to advise on all drugs and approve modification decisions. Non-formulary drugs will be considered if physician demand exists (e.g. frequent drug exception requests received and approved). New FDA approved drugs with a 1A or priority "P" rating must be reviewed for possible inclusion. Other new FDA approved drugs will be reviewed at the discretion of the committee. Drugs may be removed from the formulary in cases where the more cost effective and equally therapeutic substitutions have been added to the formulary. Any modifications to existing step therapy, prior authorization protocols and quantity limits are made by the P&T Committee. For generic drugs, Trusted mandates the use of A-rated generic drugs.

Changes to the formulary can also be made by submitting a formulary change request form to the Trusted's Medical Management Department to the attention of the Pharmacy Director. These will be taken into consideration and presented through the P&T process.

Trusted Health Plan's Outpatient Drug Utilization strategies include the development of comprehensive review criteria for determination of coverage. In addition, we have a network of contracted specialty pharmacies and utilize techniques to steer dispensing through the most cost effective channel. Medication compliance is monitored, aberrant drug utilization patterns are identified and then our care management team is involved to follow up with members to address issues with drug therapy. In addition, all Hepatitis C members are monitored for tolerance and compliance to therapy to ensure members obtain the highest level of care to increase quality of life

and health outcomes. Short-cycle dispensing is offered for certain drug therapies where appropriate.

Additionally, there is an initiative to improve patient safety identifying high risk medications for those who are 65 or older to transition therapy to safer alternatives, as well as a drug interaction initiative to improve patient safety for members who are on multiple medications.

The Trusted Pharmacist and MeridianRx's Specialty Pharmacy team is a highly skilled and experienced group of pharmacists that only deal with Specialty Medication and/or certain disease states.

MeridianRx utilizes a very unique approach to specialty drug cost containment. All specialty medications are initially stopped from adjudication upon submission. Using the MERLIN system, Trusted's Pharmacist Director and the MeridianRx specialty pharmacy team receives specialty claim alerts in real time. When reviewing a claim, both Trusted and MeridianRx reviews the member's entire profile, taking both medical and pharmaceutical data into consideration. After reviewing and analyzing the member's disease state and health history, the MeridianRx's Specialty Pharmacy team compares the case to their internally developed, evidence based, specialty drug criteria. If necessary, the MeridianRx's Specialty Pharmacy will coordinate with the prescribing physician for follow up or other further lab notes.

The Trusted P&T Committee uses evidence-based data to promote superior health outcomes by managing client formularies, promoting appropriate utilization, and increasing access to safe, effective, quality drugs. A drug's clinical appropriateness is the P&T Committee's foremost consideration.

The P&T Committee is composed of practicing physicians, pharmacists and other Trusted personnel responsible for meeting Trusted's consumer needs. All voting committee members have appropriate credentials and the majority are practicing physicians and/or pharmacists with required clinical specialties that represent the needs of clients and members. The P&T Committee reviews, evaluates and selects drugs and/or drug classes for client formularies. Such review shall include, but not be limited to, analyses of use, safety, access, efficacy, outcomes, effectiveness, adverse reactions, type and frequency of side effects and potential drug interactions among alternative drug products. It also includes assessing the likely impact of a drug product on patient compliance when compared to alternative products. The P&T Committee bases formulary decisions on a thorough review and evaluation of benefits and risks, focusing on increasing member health outcomes.

On an annual basis and as needed, the P&T Committee develops, reviews and evaluates the clinical appropriateness protocols and procedures for formulary exceptions and other utilization management activities such as prior authorizations, step therapies, quantity limits, generic substitutions, drug utilization, drug compliance and related activities that impact consumer access to drugs. The P&T Committee sets protocols and procedures to ensure that drug utilization management decisions are evidence-based. The P&T Committee develops, reviews and evaluates policies and procedures to educate and inform healthcare prescribers, pharmacists, other healthcare professionals, consumers and payers regarding drug products, usage, formulary changes, and factors that affect formulary decisions such as cost containment measures, procedures for obtaining non-formulary drugs and importance of formulary compliance to improve quality of care and control healthcare costs. The P&T Committee reviews and approves quality improvement and drug utilization management programs to ensure high-level clinical appropriateness and rigor is maintained. The P&T Committee ensures that formularies meet all applicable state and federal

regulations. The P&T Committee has the authority to establish or solicit input from expert advisory panels in its decision-making process regarding formulary placement, prior authorization, edit criteria and any other area deemed appropriate by the P&T Committee. The P&T Committee meets on a quarterly basis at minimum.

Multiple criteria are used by the P&T committee to identify which drugs are added to the formulary. And updates are made to the THP website throughout the year. The following information is available on the THP formulary website: A list of pharmaceuticals, including restrictions and preferences; How to use the pharmaceutical management procedures; an explanation of limits or quotas; process prescribing practitioner must follow to provide information to support an exception request; THP's process for generic substitution, therapeutic interchange and step-therapy protocols.

The MERLIN adjudication system (MeridianRx's proprietary claims processing system called MeridianRx Live Integrated Network (MERLIN), routinely checks all incoming claims for fraudulent activity.

135. Describe the MCO's approach for creating and updating a non-PDL formulary for drugs not included on the State's preferred drug list (PDL). Provide related policies and procedures.

Trusted will not reimburse for drugs, drug products, and related services, which are defined as a non-covered benefit by the Department's Outpatient Drug Pharmacy Program. Trusted's Pharmacy Director will keep abreast of drugs that are non-PDL formulary and ensure its P&T committee does not add or approve them. Periodically, the Pharmacy Director will review Trusted's formulary for compliance with the Departments non-PDL formulary.

In accordance with 42 U.S.C. § 1396r-8, Trusted will exclude coverage for any drug marketed by a drug company (or labeler) that does not participate in the federal drug rebate program and will not provide coverage for any drug product, brand name or generic, legend or non-legend, sold or distributed by a company that did not sign an agreement with the federal government to provide Medicaid rebates for that product. Trusted will not provide coverage under any circumstances for drug products that have been classified as less-than-effective by the Food and Drug Administration (FDA) Drug Efficacy Study Implementation (DESI).

Trusted's policies related to its approach for creating and updating a non-PDL formulary for drugs not included on the State's PDL will be provided upon contract award.

136. Describe the MCO's strategy for ensuring compliance with the State's PDL. Provide related policies and procedures.

The Pharmacy Director will routinely review the State's PDL and run a comparison audit to Trusted Formulary to identify any variances between the two. Variances will be reviewed and brought to the P&T committee to evaluate. If any Non-PDL drugs are identified on Trusted's formulary, the P&T Committee will make the recommendation to remove and if needed, identify a substitution that complies with its federal and local regulatory requirements.

Trusted's policies related to its strategy for ensuring compliance with the State's PDL will be provided upon contract award.

137. Describe the MCO's process for assisting the State with the rebate resolution process. Provide related policies and procedures.

Trusted is not authorized to collect or negotiate rebates with drug companies for preferred pharmaceutical products. Trusted will implement a process to support the Department's Medicaid rebate dispute resolution processes. The Department will notify Trusted of claims submitted with incorrect information and will within 60 days from receipt of the rebate dispute from the Department, correct and resubmit any of the disputed encounters or provide an explanation as to why the encounter was appropriately processed. Trusted will submit responses to disputed encounters in the format specified by the Department. Trusted will establish a single point of contact for the Department during the rebate dispute resolution process.

Trusted will submit its policies for assisting the State with the rebate resolution process prior to contract award.

138. Describe any prescription limits the MCO plans to impose, including limitations on brand name and generic prescriptions. If applicable, provide the policies and procedures for how the limits will be managed and how cases of medical necessity will be handled.

Trusted will develop policies and procedures to comply with the Department's prescription drug limitations, if any prior to contract award. Trusted will ensure it is able to recognize its members who are not subject to any prescription drug limitations and will educate its members and providers on limitations in prescription drug coverage.

139. Describe any strategies the MCO will use to identify and manage polypharmacy.

The MeridianRx Polypharmacy program identifies members who are filling 15 or more medications and completes a medication review to ensure that members are receiving adequate treatment while eliminating duplicate medication therapy and adverse reactions.

Eligibility is determined through MERLIN via a report detailing all members on fifteen or more medications. Each case is reviewed by a qualified MeridianRx employee to suggest interventions for the following:

1. Duplicate medications
2. Drug interactions
3. Multiple prescribers
4. Compliance
5. Specialist prescribers
6. All other concerns or issues as determined by a qualified MRx employee

Cases may be referred to other internal programs based on members that are identified as having specific needs:

1. Asthma
2. Pain Management
3. Care Coordination
4. All other available programs as determined by a qualified MRx employee

After interventions and optional referrals are identified by a qualified MRx employee, the cases are transitioned to an MRx Care Coordinator for necessary follow up and outreach.

140. Describe how the MCO monitors potential abuse or inappropriate utilization of controlled prescription medications and what strategies the MCO may use to manage members with a history of prescription drug abuse (e.g., lock-in). (Note any data that may be needed from BMS to facilitate this transition.)

The MERLIN adjudication system (MeridianRx's proprietary claims processing system called MeridianRx Live Integrated Network (MERLIN), routinely checks all incoming claims for fraudulent activity, including, but not limited to:

- Multiple narcotic medication fills
- Identical same patient medications from different pharmacies
- Identical same patient medications from different prescribers
- Extraneous quantities in relation to days' supply
- Abnormally high brand or narcotic dispensing rates

Every single processed claim is subjected to MeridianRx's desk level audit from a pre-service and retrospective standpoint. Pre-service edits are in place to prevent potentially fraudulent claims before they are ever adjudicated, which is in step with the Center for Medicare & Medicaid Services (CMS) initiative to move away from the pay-and-chase fraud detection and recovery method. Some of the methods MeridianRx currently utilizes are:

- Controlled substance medication quantity limits
- FDA guidelines
- Prior authorization required
- Harmful drug interaction
- Inappropriate drugs per gender
- Refill too soon

Because Meridian's proprietary claims processing system was exclusively built and programmed with the customer in mind, edits are entirely customizable per Trusted's request. Desk level audits also take a retrospective approach by utilizing quarterly reports that focus on high cost/dispense as written (DAW) code combinations, outlier status, high controlled substance dispensing rates, and lower than average generic dispensing rates. These reports are used to identify inaccurate billing practices.

Member's with a history of prescription drug abuse will be referred to Trusted Behavioral Health Case Management team to develop and coordinate a treatment plans with the appropriate individuals.

141. Describe the pharmacy PA process including the turnaround time and levels of authority. Provide elements included in the PA approval/denial letters to members and providers.

MeridianRx utilizes a prior authorization process to promote appropriate, safe and effective utilization of drugs through the establishment of clinical guidelines. MeridianRx bases its decisions solely on the clinical information available to the prescriber or MeridianRx at the time the medical care was provided.

Practitioners who choose to prescribe a formulary drug that is on the prior authorization list must complete the Request for Medication Prior Authorization Form and submit it to MeridianRx.

The Pharmaceutical Prior Authorization process may be initiated in either of two ways. They are as follows:

1. **POINT OF SERVICE:** Drugs that are subject to a Prior Authorization are automatically

subjected to on-line edits at the participating pharmacies that trigger the appropriate Prior Authorization process. The pharmacist will receive an electronic message at the point of service that he/she should notify the prescriber and/or consumer that the drug requires a Prior Authorization. Requests for Pharmaceutical Prior Authorization will only be accepted by the prescribing practitioner.

2. **PRIOR TO POINT OF SERVICE:** A Prior Authorization form can be completed by the prescribing practitioner and faxed to MeridianRx.

All requests are evaluated by Pharmacy Technicians to ensure completeness of information received. If more information is needed the Pharmacy Technician shall contact the prescriber to request additional information. Once the information is received, the Pharmacy Technicians forwards it to the Pharmacist review queue. The request is reviewed by a MeridianRx pharmacist or designee against MeridianRx criteria and the pharmacist will render a decision. MeridianRx notifies the practitioner when the prior authorization request is approved or denied

Prior authorization determination notification occurs within 14 calendar days of the prior authorization request being received by MeridianRx for a pre-service non-urgent request, 72 hours for pre-service concurrent, 72 hours for a pre-service urgent, or 24 hours for an urgent concurrent request to extend a previously approved medication. If the urgent concurrent request is to extend a currently approved medication and received less than 24 hours before the expiration, the decision is rendered and notification is provided 72 hours of receipt of request. Non-urgent concurrent request will have a decision rendered within 72 hours of receipt of request. If the request is approved, a fax will be sent back to the prescriber.

When MeridianRx denies the request, a denial letter is sent to the practitioner and the consumer, informing them of the specific reason for the denial, including reference to the information upon which the decision was based, and an explanation of their appeal rights (see attached denial letter template). The practitioner is also notified that he/she has the option of discussing the decision further with a MeridianRx pharmacist or designee and the phone number where they can be reached.

If the prescribing practitioner/consumer chooses to appeal the decision, the appeal is reviewed by a MeridianRx pharmacist reviewer. This reviewer is a practitioner who did not participate in the original decision. MeridianRx may elect to enlist the services of an Independent Review Organization (IRO) to review the request and make a recommendation. The consumer and practitioner are notified of the approval or denial within 30 calendar days. When the appeal is denied, the consumer is notified of further appeal rights.

142. Submit policies and procedure for authorizing 72h emergency prescription medication supply.

Both Trusted and MeridianRx will ensure that appropriate transition fills are initiated. When a pharmacy receives a new medication prescription requiring a PA, the submitted claim will adjudicate with a 72 hour supply. When a pharmacy receives an ongoing medication prescription requiring a PA, the claim will adjudicate with a 15-day supply. The Ongoing medication policy will not apply if the dispensing pharmacist determines that taking the mediation would jeopardize the member's health or safety.

Trusted does not require pharmacy interventions or edits at point-of-sale for Medicare transition claims when the medication is requested for the above noted day supply. However, the point-of-

sale pharmacist will be alerted by a secondary message in MERLIN regarding the appropriate days' supply submission after the claim initially rejects for prior authorization required. This will occur via standard National Council for Prescription Drug Programs (NCPDP) response messaging.

When a transition claim processes, the claim is flagged and relevant claim information is communicated to the member. A written notice is sent via U.S. Mail to the member who obtains a transition fill within three (3) business days of the fill.

The written notice includes:

1. An explanation of the temporary nature of the transition supply
2. Instructions for working with Trusted and the member's prescriber to identify appropriate therapeutic alternatives that are on the formulary.
3. A description of the procedures for requesting a prior authorization.

Extension of transition timeframes are provided on a case-by-case basis to the extent that the prior authorization has not been processed by the end of the minimum transition period and until such time that a transition has been made either through a switch to an appropriate formulary medication or a prior authorization is obtained.

Trusted policies will be submitted upon award.

143 Describe the MCO's process for ensuring that PCPs maintain information shared by behavioral health providers as to the outcome of behavioral health screenings and evaluations (e.g., in a patient's medical record).

Trusted uses CareAnalyzer to review and trend medical encounter data, such as hospitalization, emergency department visits and diagnosis codes, and to identify gaps in refills that signal non-adherence. Trusted will use pharmacy claims data to develop a baseline for documenting coordination of care between member's primary care provider (PCP) and his/her behavioral health specialist. Monitoring these claims provides opportunities to identify gaps in communication between PCPs and behavioral health specialists.
Additionally, Trusted and MeridianRx have collaborated to integrate pharmacy and medical information using its technology platforms in three (3) different ways:

1. MCS (Managed Care System): Encompasses all consumer information including Medical Claims, Inpatient visits, Emergency Department, Diagnosis codes and pharmaceutical information. This is available to all members of the Trusted Case Management and Care Coordination Teams.

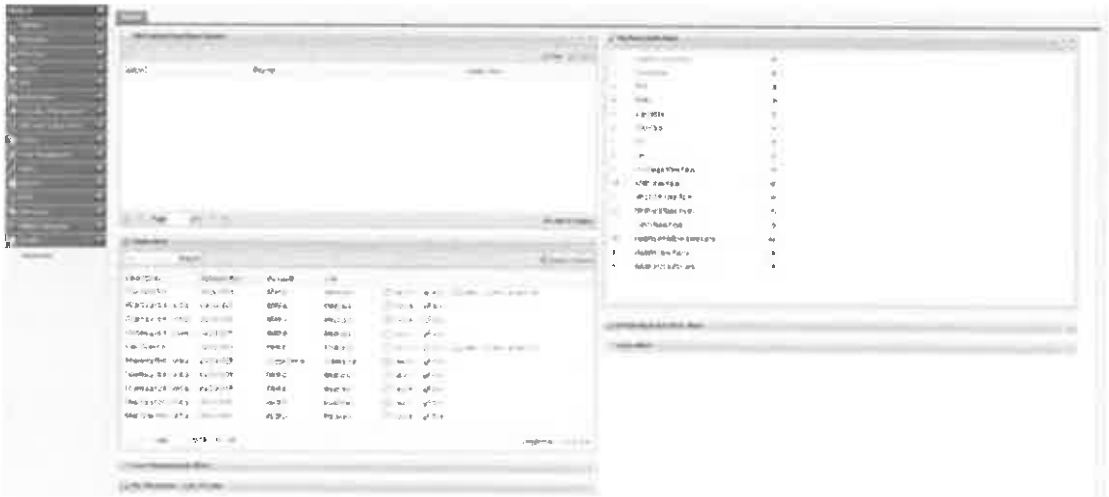
Exhibit 21: Screen Shots From the MCS System





2. MERLIN the MeridianRx Pharmacy Benefit Management System allows for Pharmacy Care Coordinators, Technicians, Pharmacists, and Physicians to enter Care Management notes and information through MERLIN directly into MCS for coordination with Trusted.
3. Trusted and MeridianRx have also created a member dashboard that allows for information about a member to be accessed in one coordinated area. This allows for specific identification of trends and gives an overview of the member spend and services rendered.

Exhibit 22: Consumer Dashboard



144. Describe the MCO's process for informing PCPs on changes in a member's behavioral health status (e.g., hospitalization, emergency room usage, change of medication). Explain what constitutes a change in behavioral health status, and how the MCO will assist members to access additional services as a result of a change in behavioral health status (e.g., care manager can assist in making appointments for members).

The frequency and type of interventions that our Case Managers interact with member's with behavioral health concerns are generally based on risk level, but will ultimately be decided by the specific needs of each member. For example, a member with recently diagnosed diabetes may have been screened with possible mild depression, referred for additional screening, confirmed as likely depressed, provided education about treatment, connected to routine outpatient treatment, and followed up to ensure the referral met their behavioral needs.

Members with increased needs receive extended and more intensive care management. For example, the same member described above may have been screened to be significantly depressed with multiple major life stressors in addition to the diagnosis of diabetes. With the member's participation, a more extensive care plan is developed to address additional needs and the case management relationship is more intensive over a longer period of time. The same Clinical Care Manager provides the care management services regardless of intensity level, eliminating the need for unnecessary transitions between Clinical Care Managers because of varying program needs. These interaction allow the Case Manager to establish and document a baseline functional status for the member. Changes and/or deviations from the norm will be identified and promptly shared with the treatment team inclusive of the member's PCP.

Daily Emergency Room alerts and hospital census reports will be shared with the PCP in an effort to ensure a comprehensive view of the member's health is available when making adjustments to the treatment plan.

145. Describe how the MCO will facilitate coordination of care between PCPs and children's dental providers, especially for children with special health care needs.

Trusted believes in the importance of pediatric dental preventive services. We will utilize DentaQuest to provide dental services to our consumers. Throughout its 20 year history, DentaQuest has worked with states and health plans to positively impact the oral health of Medicaid and CHIP members. Through their experience, we learned that access to dental services reduces the incidence and treatment costs of a variety of diseases and conditions. We address this crucial link with communications to our team, members and PCPs. We will maintain a working relationship with Dental Quest and educate our team on the process for effectively coordinating with them. Information will be sent to members and providers identifying DentalQuest as the provider and detailing how to reach and engage them. We will provide educational information for PCPs in our *Provider Manual*, reinforcing the importance of timely dental services for children, promoting integration of primary and dental services. We will develop community-based strategies to increase oral health awareness as well as increase access to care by removing social barriers.

Trusted Pediatric Dental Program Goals are to increase EPSDT compliance, decrease ER utilization for non-traumatic dental needs and ensure children with special health care needs get the care they need.

The primary EPSDT program initiative focuses on ensuring children, adolescents and young adults receive appropriate preventive, dental BH, developmental and specialty services. Our

EPSDT Outreach Department will make daily outreach phone calls to enrollees who are due for an EPSDT exam. The team members will promote the benefits of routine primary and preventive health care as well as needed follow-up and treatment services to enrollees.

Educational materials will be mailed to enrollees to remind them of the importance of well care visits and pediatric dental visits. In addition, articles that promote pediatric dental preventive service will be included in the quarterly member newsletter. Trusted will host monthly community-based dental clinic in each county called "Let's Smile". The event will be located at a Trusted Wellness and Customer Service Center. The events will assist with increasing the EPSDT compliance rate. Trusted will design, print and mail collateral EPSDT materials to members

Managing dental emergencies in hospital emergency rooms is not cost effective and can be draining on the already short resources in many emergency rooms. Many members use emergency rooms as a walk in dental clinic and never see a dentist for follow up care after an emergency room visit. Non-emergency, primary dental care can be more appropriately and economically treated in an office setting. An informational letter will be mailed to every member that utilizes the ER, to emphasize the importance of preventive dental treatment and offers ways to access dental care in emergency situations. Enrollees who use the emergency room for dental services will also be telephoned to provide assistance making a preventive appointment. Call center staff also recommends dental follow-up visits, provide dentist referrals, and set up dental appointments.

DentaQuest ensures children with special health care needs are placed with a dentist who can accommodate them. In addition to providing assistance when members contact DentaQuest's customer care center, they have also created a training program for community organizations on how to ensure special needs children get the care they need. DentaQuest also conducts training sessions for various community based groups such as Local Health Departments, Departments of Children's Services, Housing Authorities, School-based health programs, Foster care, Head Start, Human Services Departments, Homeless shelters and other groups that work with children and families

The training provides an overview of DentaQuest and how they help these members access care. The training sessions educate attendees on how to access care, find a dentist, transportation, interpreter & translation services, and TDD/TTY, LEP and Braille. Written and audio Oral health educational materials are provided.

Trusted will utilize community mobile dental units at health fairs and community events, and will promote pediatric dental health at all of its events, and through the Wellness/customer service centers. Trusted is committed to raising the level of dental exams for children.

146. Describe the MCO's approach for providing dental services for individuals 21 years of age as covered services in an amount, duration, and scope reasonably expected to achieve the purpose for which the services are furnished.

Individuals that are over 21 years of age will be eligible for the adult dental benefit that includes 2 routine visits/ year and treatment of fractures of mandible and manilla, biopsy, removal of tumors, and emergency extractions. **ROUTINE CARE IS NOT A REQUIRED SERVICE.**

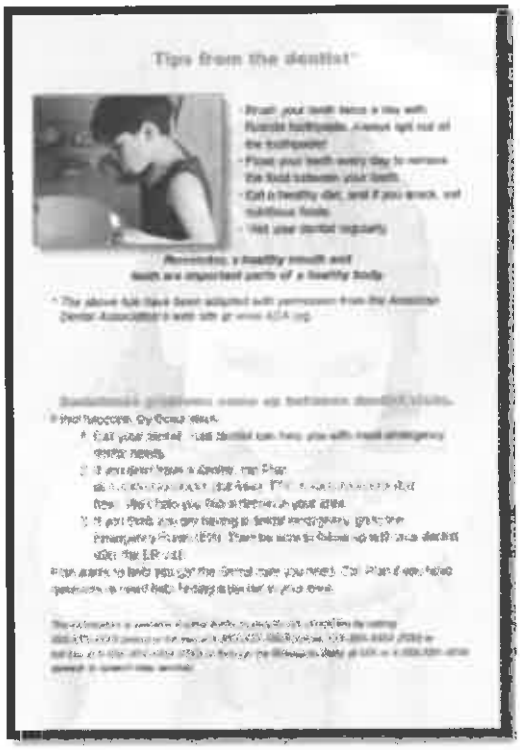
147. Describe the mechanisms the MCO will use to remind members of upcoming initial and periodic dental screenings as well as the mechanisms to ensure completion of these screenings.

The primary EPSDT program initiative focuses on ensuring children, adolescents and young adults receive appropriate preventive, dental BH, developmental and specialty services. Our EPSDT Outreach Department will make daily outreach phone calls to enrollees who are due for an EPSDT exam. The team members will promote the benefits of routine primary and preventive health care as well as needed follow-up and treatment services to enrollees.

- To supplement the actions of the outreach team, educational materials will be mailed to enrollees to remind them of the importance of well care visits and pediatric dental visits. In addition, articles that promote pediatric dental preventive service will be included in the quarterly member newsletter.
- Trusted will host monthly community-based dental clinic in each county called "Let's Smile". The event will be located at a Trusted Wellness and Customer Service Center. The events will assist with increasing the EPSDT compliance rate.

Trusted will design, print and mail collateral EPSDT materials to members

- Community collaborations
- Training series
- Non-compliant mailings
- Outreach to target audiences such as teens, pregnant women
- Mock prescription pads for primary care physicians
- Attending community events


Tips from the dentist



148. Describe MCO arrangements with in- and outpatient facilities for the provision of dental services to members with special needs.

DentaQuest ensures children with special health care needs are placed with a dentist who can accommodate them. In addition to providing assistance when members contact DentaQuest's

customer care center, they have also created a training program for community organizations on how to ensure special needs children get the care they need in the setting that is appropriate for the child (whether inpatient or outpatient). DentaQuest has conducted training sessions for groups such as:

- Local health departments
- Departments of children's services
- Housing authorities
- School-based health programs
- Foster care
- Head Start
- Departments of human services
- Homeless shelters
- Other groups that work with children and families

The training provides an overview of DentaQuest and how they help these members access care. We review the roles of various departments within our organization including customer care center, health coaches, member placements and complaints and grievances, and introduce them to local staff. DentaQuest's goal is to give them the tools and resources to ensure Medicaid and CHIP children in interact with on a day-to-day basis get the care they need. The training sessions educate attendees on:

- How to access care
- Program information and benefits
- How to find a dentist
- Continuation of care
- Coordination of care
- Case and disease management
- Appointment assistance
- Member placement
- Transportation assistance
- Interpretation/translation services
- TDD/TTY, LEP and Braille
- Oral health educational materials both written and audio

DentaQuest has implemented this program in several states and have been well received by all of them.



Additionally, Trusted will utilize community mobile dental units at health fairs and community events. Trusted will promote pediatric dental health at all of its events, and through the Wellness/customer service centers. Trusted is committed to raising the level of dental exams for children in WV.

149. Describe any mechanisms the MCO will use to remind members of upcoming initial and periodic dental screenings and ensure completion of these screenings.

Trusted utilizes multiple avenues to identify knowledge deficits and parental engagement. An initial questionnaire is used to confirm that the parent understands the importance of preventive care and an understanding of where to access appropriate services. Consumers and their parents are educated about EPSDT health screens and compliance with the periodicity schedule is strongly encouraged using birthday cards, targeted mailings, telephone calls and face-to-face visits through the "*Feet on the Street*" initiative. In addition, articles that promote well care visits and immunizations are included in the consumer newsletter quarterly. Immunization cards will also be provided to help parents/guardians track the immunizations that their children have received. All

materials will be available in both English and Spanish, and translation services are provided in other languages when needed.

Coordination with PCPs

Trusted contacts consumers to help them access the appropriate screening(s) and any follow-up care determined necessary through the exam. On a monthly basis, Trusted will distribute a roster to PCPs that identifies all assigned consumers who are due or overdue for a screening, or have not had a PCP encounter within a certain number of days of enrollment. PCPs conduct EPSDT screenings according to state and federal guidelines for screening, vision, hearing, and dental services.

150. Describe the MCO's process for monitoring dental screening utilization on an ongoing basis and intervening if a member has not had a screening in over one year.

The EPSDT Outreach Manager, is responsible for establishing and maintaining effective performance monitoring surrounding all EPSDT functions in accordance with regulatory and contractual requirements, and federal laws. Management and supervisory oversight and strict accountability requirements anchor the system of internal control for all EPSDT employees in the performance of their specific job responsibilities. Trusted performance monitoring structure and management oversight consists of the following key elements:

- Daily productivity tracking of the EPSDT Coordinator's outreach to non-compliant members;
- Daily (or as needed) collaboration with Provider Services, transportation vendor, and Medical Management staff to effectively coordinate appointments;
- Weekly compliance status meetings to discuss strategies to address member non-compliance with EPSDT requirements;
- Weekly "refresh" of EPSDT non-compliant list to determine efficacy of outreach efforts on a weekly basis;
- Participation in monthly meetings with regulators pertaining to EPSDT to keep abreast of updates, changes, and exchange of ideas as deemed appropriate and necessary;
- Quarterly EPSDT activity and compliance reporting to regulators
- Annual reporting of CMS 416 participation ratio.

Trusted will use the aforementioned reports to identify and contact non-compliant individuals.

VI. CARE MANAGEMENT

151. Provide a general overview of the medical, behavioral health, oral health and pharmacy care management programs.

The Trusted Case Management Program is intended to provide a framework for ensuring that the best, most appropriate medical and behavioral health case management, consistent with the member's disease or illness. Trusted's organizational structure ensures high performance by defining authority and accountability and defining program goals.

The scope of the program encompasses our customers, including members and employers, as well as key partners including physicians, institutional and ancillary providers, and community-based agencies. The program scope focuses on appropriateness, continuity and coordination of care, and effectiveness from a service and clinical perspective in the delivery of health care services.

The Case Management Program integrates medical and behavioral health services under a clinical structure that utilizes primary care, sub-specialists and behavioral health physicians and practitioners to support day-to-day activities. Registered Nurse Case Managers confer with Trusted Medical Directors, primary care physicians, and specialists routinely in the coordination of care for members with complex conditions.

152. Describe how the case/care management department is organized (i.e. by disease or problem type).

The Case/Care Management department is organized by disease. Case Managers with education and experience within a particular field are assigned to each team. Teams include the areas of:

1. Chronic Diseases
    a. Childhood Asthma
    b. Adult Hypertension
    c. Adult Cardiovascular Disease
    d. Childhood or Adult Diabetes
    e. Childhood or Adult Obesity
    f. COPD/Respiratory Diseases
2. Enrollees with Special Health Care Needs:
    a. Severe Disabilities
    b. HIV/AIDS
3. EPSDT – Healthy Children
4. Behavioral Health - Beacon Behavioral Health Sub-Contractor
5. Oral Health - DentaQuest Sub-Contractor

Upon initial Case Management Assessment, members are given a Case Management Assessment, specific to their condition.

Based on the assessment results, the enrollee will be stratified into one (1) of three (3) categories:

Level I: Disease Management Stable Condition	Level II: Care Coordination needs are Moderate	Level III: Care Coordination needs are Complex
6. Chronic Condition; well-maintained	1. Newly diagnosed with a chronic/ complex	1. Enrollees with Special Health Care Needs:

Level I: Disease Management Stable Condition	Level II: Care Coordination needs are Moderate	Level III: Care Coordination needs are Complex
7. Low-risk Pregnancy; no history of untoward outcomes 8. The Disease Management portion of the program encompasses a primary diagnosis of the following, controlled disease process and no hospitalizations or emergency room visits within the past 180 days: a. Asthma b. Adult Hypertension c. Adult Cardiovascular Disease d. Childhood or Adult Diabetes e. Childhood or Adult Obesity f. COPD	condition; 2. Receiving home health care services or continuous or special order DME; or 3. Requires consistent monitoring of needs	a. Severe Disabilities b. HIV/AIDS 2. Other disabling conditions with a cognitive, biological, or psychological basis that is a results of the following: a. Medical care or special services at home, place of employment or school b. Dependency on daily medical care, special diet, medical technology, assistive devices, or personal assistance in order to function c. Complex conditions requiring coordinated services from multiple treatment providers on a frequent basis d. Infants, Toddlers, School-aged children and adolescents with evidence of developmental/ behavioral disability or delay e. Childhood or Adult Cancer f. Adult Behavioral Illness and Substance Abuse related Condition g. High Risk Pregnancies h. Young maternal age i. Short inter-conceptional period j. Late onset of prenatal care k. Alcohol and drug abuse l. Domestic violence in the home m. Documented barriers to accessing health care n. Maternal illness that may affect the birth of the fetus o. Complex Disease Management Regimens p. Risk of serious life threatening conditions q. Behavioral Health care needs r. Receiving IDEA services s. Inpatient setting/ Multiple Admissions/ ED visits t. High-cost, high utilization of resources, and/or u. Non-compliant

Care Coordination Level II-Moderate or III-Complex are comprised of High-Risk OB, Complicated medical regimens, Children with Special Needs, and Behavioral Health. The

enrollees who have catastrophic medical issues are also eligible for Level III-Complex care coordination.

153. Describe how members are identified for participation in care management programs. Describe at a high level the MCO member screening process and screening timelines upon enrollment. Describe the SSI process, if different from above. Specify whether services are coordinated by the member's primary care provider or through some other means, such as a care manager.

Identification of Members for Care Management

Trusted's Care Management program uses multiple sources in the identification of members to be included in care management such as:

1. Claim or encounter data
2. Hospital discharge data
3. Pharmacy data, if applicable
4. Data collected through the UM Management process
   - Prior authorization data
   - Concurrent review data
   - Hospital admission data
5. Data supplied by purchasers (enrollment broker data)
6. Data supplied by members or caregivers
7. Data supplied by practitioners

CareAnalyzer™ serves as a primary platform for data used for identification of members for Care Management. On a monthly basis data is refreshed in CareAnalyzer™ and used to identify and conduct an initial risk stratification of all members eligible for the CM program. The algorithm, at a minimum, takes into consideration inpatient hospital claims, emergency room use, co-morbid conditions and pharmacy claims.

It is the goal of the program to ensure that members who experience critical events or diagnosis will receive timely complex case management services. To that end, Trusted has developed several sources of referrals that can be initiated upon immediate identification, at the time of care. Multiple referral options minimize the time between member identification and active case management participation.

Referral Types	
1. Nurse Line Referral	Trusted Medical Management receives daily reports of all inbound calls to Trusted's nurse line. Nurse Line provides health information and triage response to members who call with inquiries or problems. Member information, reason for the call, as well as instructions provided during the triage or health education process are documented by Nurse Line staff, and may include CM referral requests and care recommendations based on inbound member calls.

Referral Types	
2. Disease Management Referral	Members that are participating in a Disease Management program may, based on their acuity, need more intense coordination and management of their health. At any time during the disease management process, the Disease Manager or Outreach staff may refer the member to a higher/ highest level of services within the Complex Case Management Program. The referral may be based on assessment findings or increased utilization of services.
3. Discharge Planner Referral/ UM Referral	The Trusted UM nurses communicate complex case management program availability to the Hospital Discharge Planners and provide information about how to refer members with each daily hospital discharge communication log. As needed, assistance is provided to the Discharge planner by the Trusted' UM nurse to complete referrals. The UM staff through their prior authorization, concurrent review, retrospective review and/or appeals review process, may identify members that qualify for complex case management service and have the ability to refer directly for immediate assessment and identification of needs while hospitalized (if applicable). Additionally, Trusted Medical Management may identify a case based on the daily census review of the member, diagnosis, length of stay, or during UM case rounds and refer to a CM to reach out immediately to implement the complex CM program.
4. Member/ Caregiver Referral	Members and/or caregivers can self-refer either by calling the Case Management department directly, presenting at the Outreach Center or by completing the online case management referral form on the Trusted website and forwarding to Trusted (either via mail or fax). Information about Complex Case Management services and how to contact CM, are communicated via new member orientation, educational sessions and written communications periodically (e.g. member flyers/ newsletters).

Referral Types	
5. Practitioner Referral	Practitioners that have identified a member that meets the complex case management criteria can refer a member for complex case management either telephonically or electronically by downloading the referral form and sending directly to the case management department. Case Management services and CM program contact information are communicated via provider training, Trusted website portal and written communications periodically (e.g. provider flyers/ newsletters). Referral sources have the ability to submit a complex case management referral using the referral form to the CM Program using multiple routes: • Electronically • Via E-mail or fax to Medical Management • TRUSTED Website • Internal task using the CM referral task queue via CareConnect™ *(TRUSTED UM and DM Staff only)*

Case Managers, Care Coordinators and EPSDT staff are trained to identify potential candidates for SSI benefits. CM staff refer to the SSI Blue Book for a complete listing of qualifying diagnoses (http://www.ssa.gov/disability/professionals/bluebook/)

- Potential candidates are under 18 years old with medically determinable physical or mental impairment which
    - Results in marked and severe functional limitations; and
    - Can be expected to result in death; or
    - Has lasted or can be expected to last for a continuous period of not less than 12 months.

Physical and Mental Impairments and Qualifying Conditions are divided into three categories by the Social Security Administration:

Presumptive	Compassionate	Chronic/Other
Conditions that will automatically qualify an individual *Examples* include Downs Syndrome, Neonates, blindness, deafness Allows presumed eligibility	Likelihood that the condition will result in the individual's death after long term disability *Examples* include cancer and blood disorders Allows presumed eligibility for seriously ill clients while	Conditions that could be considered disabling Case by case consideration, without well-defined criteria *Examples* include coronary artery disease, diabetes and epilepsy/seizures

Presumptive	Compassionate	Chronic/Other
for seriously ill clients while paperwork/determination is being made	paperwork/determination is being made	

New members will also be identified from the NICU, if they fall under the following categories.

TIPS FOR REFERRING NICU CASES FOR SSI	
Childhood Detail	http://www.ssa.gov/disability/professionals/bluebook/ChildhoodListings.htm
Presumptive Conditions	a child has not attained his or her first birthday and available medical evidence shows a **gestational age (GA) at birth with these corresponding birth-weights:** GA: **37-40 weeks**; weight at birth: **less than 2000 grams** (4 pounds, 6 ounces) GA: **36 weeks;** weight at birth; **1875 grams (4 pounds, 2 ounces) or less** GA: **35 weeks**; weight at birth: **1700 grams (3 pounds, 12 ounces) or less** GA: **34 weeks**; weight at birth: **1500 grams (3 pounds, 5 ounces) or less**; or GA: **33 weeks; weight at birth: at least 1200 grams, but no more than 1325 grams** (2 pounds, 15 ounces);
Presumptive Conditions	• Cerebral Palsy • Muscular Dystrophy • Down Syndrome
Compassionate Allowance	• Trisomy 13 (Patau Syndrome) • Trisomy 18 (Edward Syndrome) • Cri du Chat • Tay Sachs Disease, Infantile Type
Compassionate Allowance	**life-threatening congenital heart impairment** that will require or already has required surgical treatment in the first year of life • Aortic Atresia • Eisenmenger Syndrome • Endomyocardial Fibrosis

TIPS FOR REFERRING NICU CASES FOR SSI	
	• Heart Transplant Graft Failure • Heart Transplant Wait List 1A/1B • Hypoplastic Left Heart Syndrome • Left Ventricular Assist Device Recipient • Mitral Valve Atresia • Primary Cardiac Amyloidosis • Pulmonary Atresia • Single Ventricle • Tricuspid Atresia
Childhood Impairment	**Impairments that affect Multiple Body Systems** • PKU • Triple X or Fragile X Syndrome • Caudal Regression Syndrome • Fetal Alcohol Syndrome
Childhood Impairment	◦ Tetralogy of Fallot • Transposition of Great Vessels • Coarctation of Aorta • Congenital anomalies of pulmonary artery • Congenital atresia of pulmonary valve
Childhood Impairment	• Necrotizing Entercolitis • Short Gut Syndrome • Congenital anomaly of diaphragm • Congenital anomalies of abdominal wall • Convulsions in newborn • Unspecified birth asphyxia in live born infant

Outreach to Potential Candidates and their Families

Education and outreach is conducted by Case Management Staff. The Case Manager will:

- Call potential SSI candidates and/or their guardians (see scripts in Appendices A&B)

- Educate members and provide awareness of SSI Disability Entitlement.
- Provide an overview of eligibility and benefits.
- Direct them to the SSI starter kit to assist them in the application process. (http://www.socialsecurity.gov/disability/disability_starter_kits_child_eng.htm)
- Assist them in contacting the Social Security Offices (and/or website) and assure an interview appointment is made.
- Advise the member that we can assist them with any questions that they have about their application (such as a list of providers they have visited and services that they have received). This will help Social Security know who to contact for medical records. Let them know what to expect and how to plan for it.

154. Describe the MCO's protocol for assigning members to an appropriate health care professional who is formally responsible for coordinating the member's overall health care, to include behavioral health and specify whether services are coordinated by the member's primary care provider or through some other means, such as a care manager.

Upon enrollment, Trusted members will continue care in partnership with the same in-network PCP. Members with Special Needs may choose a Specialist as the PCP. If a PCP is not chosen by a member with special health needs, Trusted will assign a primary or specialty provider with the credentials and experience to best manage their care. The member's overall health care will is coordinated through the Trusted Case Management and Care Coordination team.

Members with co-morbid behavioral health/substance use disorders and physical health needs will have a person-centered care plan that will be developed in collaboration with the BH-MCO care manager or behavioral health/substance use disorder provider whenever possible. For example, if a member in an acute medical setting who has a history of behavioral health needs is discharged, his/her discharge and care plan will include both physical health and behavioral health interventions and supports. Our care manager will engage all known treatment providers as part of the discharge planning process (with member consent) to ensure that the member's integrated care team is prepared for the member's return to the community.

155. Describe any differences in how the MCO will approach adults versus children and any internal processes that may vary between these two groups, including education, member materials, and outreach. Identify any activities or linkages with the WV Children with Special Health Care Needs (Title V) program clinics, providers, or other professionals.

Trusted's care coordination process for children focuses on the EPSDT calendar. Trusted has proven success in the District of Columbia.

THP showed a 35% improvement from 2013-2014. For the 2014 school year, THP had the highest EPSDT compliance rate amongst the full-risk Medicaid MCOs.

In 2013, changes in the DC public school system resulted in the ability for children that are not up to-date with preventive care, as outlined in the EPSDT periodicity schedule, to attend school. This regulatory change impacted compliance with EPSDT rates across the city. However, even without the assistance of regulation, the Trusted EPSDT team was able to connect children with their PCPs for preventive health visits.

THP was able to achieve this milestone by instituting the following procedures:

EPSDT manager works collaboratively with the Utilization Management Department to provide comprehensive EPSDT services to all its consumers under age twenty-one (21). Within 60 calendar days of enrollment, EPSDT services, at a minimum include outreach to inform consumers and their parents/ guardians of the:

- Benefit of preventive care.
- Services available under EPSDT.
  - Where to access services.
  - How to access services.
  - o How to access transportation.
- Need for age-appropriate immunizations against vaccine-preventable diseases.
- Services provided under the EPSDT program are free of cost to the eligible individuals under the age of 21.

Services that fall within the recommended periodicity schedule outlined in health check periodicity schedule are covered without a need for prior-authorization or request from the consumer or consumer's guardian. No amount, duration or scope limitations are applied to any EPSDT related services for consumers under the age of 21.

Coordination between Trusted outreach and EPSDT programs and its innovative use of technology aids providers in offering and reminding consumers of their appointments and the need to seek care based on the periodicity schedule. Technology such as patient portals, secure messaging and text messaging are just a few of the capabilities leveraged to impact compliance with EPSDT requirements.

The primary EPSDT program initiative focuses on building the capacity of our consumers. EPSDT Outreach Department team members make daily outreach phone calls to consumers who are due for an EPSDT exam. The team members promote the benefits of routine primary and preventive health care as well as needed follow-up and treatment services to consumers.

Trusted utilizes multiple avenues to identify knowledge deficits and parental engagement. An initial questionnaire is used to confirm that the parent understands the importance of preventive care and an understanding of where to access appropriate services. Consumers and their parents are educated about EPSDT health screens and compliance with the periodicity schedule is strongly encouraged using birthday cards, targeted mailings, telephone calls and face-to-face visits through the ***"Feet on the Street"*** initiative. In addition, articles that promote well care visits and immunizations are included in the consumer newsletter quarterly. Immunization cards will also be provided to help parents/guardians track the immunizations that their children have received. All materials will be available in both English and Spanish, and translation services are provided in other languages when needed.

Coordination with PCPs

Trusted contacts consumers to help them access the appropriate screening(s) and any follow-up care determined necessary through the exam. On a monthly basis, Trusted will distribute a roster to PCPs that identifies all assigned consumers who are due or overdue for a screening, or have not had a PCP encounter within a certain number of days of enrollment. PCPs conduct EPSDT screenings according to state and federal guidelines for screening, vision, hearing, and dental services.

EPSDT Performance/ Monitoring/ Oversight

The Quality Improvement Department, specifically the EPSDT Outreach Manager, is responsible for establishing and maintaining effective performance monitoring surrounding all EPSDT functions in accordance with regulatory and contractual requirements, and federal laws.

Management and supervisory oversight and strict accountability requirements anchor the system of internal control for all EPSDT employees in the performance of their specific job responsibilities. Trusted performance monitoring structure and management oversight consists of the following key elements:

- Daily productivity tracking of the EPSDT Coordinator's outreach to non-compliant members;
- Daily (or as needed) collaboration with Provider Services, transportation vendor, and Medical
- Management staff to effectively coordinate appointments;
- Weekly compliance status meetings to discuss strategies to address member non-compliance with EPSDT requirements;
- Weekly "refresh" of EPSDT non-compliant list to determine efficacy of outreach efforts on a weekly basis;
- Participation in monthly meetings with regulators pertaining to EPSDT to keep abreast of updates, changes, and exchange of ideas as deemed appropriate and necessary;
- Quarterly EPSDT activity and compliance reporting to regulators
- Annual reporting of CMS 416 participation ratio.

Trusted would also identify providers that are in close proximity to high utilization Emergency Departments or are in known areas of prominent health disparities.

Tracking

Trusted maintains a tracking system to readily access claims data through a reporting tool (Care Analyzer) in the CareConnect system. The tracking system is used to identify gaps in care and evaluate the effectiveness of the program as well as help to direct outreach efforts. The data is collected from the encounter information submitted or confirmed by providers. A report, based on member birthdate, is generated to identify those members under the age of 21, who have not received EPSDT related services. Outreach efforts are conducted to reasonably achieve up to a 100% compliance rate.

Trusted, through the Department, will coordinate with the Bureau for Public Health, Office of Maternal, Child and Family Health, to:

1. Help to ensure that its members with special health care needs, ages 0 to 21, receive comprehensive, coordinated services and supports pursuant to national standards for systems of care for children and youth with special health care needs;
2. Assure better access to and receipt of the full range of screening, diagnostic, and treatment services covered under EPSDT.

Trusted will establish a Memorandum of Understanding (MOU) with the Department, the Bureau for Public Health, and the Office of Maternal, Child and Family Health to implement coordination

strategies to better serve children under the age of 21, including those individuals with special health care needs, who are eligible for Medicaid managed care services.

156. Describe identification of and services for members with special needs. Discuss any additional screening or assessment the MCO will perform and what clinical, social, or other criteria the MCO will use to determine which members require case management and assign members to case managers. If the MCO will conduct its own health risk assessment, please provide a copy of the form or protocol.

In addition to the enrollment health risk assessment, Trusted has formed a partnership with Nurse Wise. A trained team of CCP's conduct Health Risk assessments with clinical, social and other criteria to determine if the member is in need of Wellness Services, Disease Management or Case Management Care. Nurse Wise utilizes scripting, assessments and pre-determined referral triggers developed by Trusted. NurseWise utilizes an auto-dialer to make up to three (3) attempts to reach each targeted member (if needed) each month. On a daily bases, an Adult and Child referral list is securely transferred into the Trusted Care Connect system, to provide seamless referrals to the Case Management team.

157. Describe identification of and services for members with behavioral health needs. Discuss any additional screening or assessment the MCO will perform and what clinical, social, or other criteria the MCO will use to determine which members require case management and assign members to case managers. If the MCO will conduct its own health risk assessment, please provide a copy of the form or protocol. Include any additional screening tools utilized in this process.

Within any population, there is a specific subset of high behavioral health users whose severity of illness, functional status, and patterns of utilization suggest gaps in care that are resulting in negative health and social outcomes. Among this group, individuals with serious mental illness (SMI) and children with serious emotional disturbances (SED), in particular, demonstrate greater reliance on higher levels of care, including inpatient acute psychiatric services, criminal justice recidivism, increased rates of homelessness, unemployment, and higher use of avoidable emergency room and hospital admissions, or in the worst case, tragic community events. With access to appropriate care and support through well-designed systems of care, individuals with SMI and children with SED are able improve their overall level of functioning and quality of life and increasing their community tenure.

Specialized Care Management Program

Trusted offers a rich continuum of care for members who are in need of behavioral health or substance use disorder services to support their recovery. To ensure our membership has access to these resources, we will provide a specialized care management program for individuals with SMI or SED. The goal of this program is to identify members with behavioral health and physical health co-morbidities and ensure that they are receiving fully integrated care. Our dedicated behavioral health care managers will assist care planning and coordination activities that are focused on improving access to care and are based on a comprehensive assessment of the member's needs. The focus of the program will be to connect individuals with proven treatment resources and promote self-care behaviors. We strongly believe in, and adhere to, the principles of recovery and resiliency, incorporating holistic, person-centered, and community-based interventions.

We will rely on sophisticated care analytics and outcomes-informed metrics to guide our interventions both on the individual level as well as with the larger population that we will serve. We will use available medical, pharmacy, and behavioral health claims and authorization data to identify, stratify, and segment members at the population level (i.e., claims data, utilization data, etc.). This data will be incorporated into our predictive modeling/risk stratification software, which stratifies members into high, moderate, or low risk based on acuity, condition severity, and utilization. Upon identification and stratification, members will receive targeted interventions to address the primary condition(s) that are driving health costs or future risk (i.e., physical health, behavioral health, frequent or inappropriate ER utilization). We refer to this primary cost driver as the "driver condition" and focus interventions on care plan problems that are related to the driver condition. Members with high or moderate risk whose primary diagnosis is behavioral health or substance use disorder will be assigned a behavioral health case manager who will outreach to the assigned program to begin the process of integrated care planning.

158. Describe any special member or medical management services, such as health risk assessments or targeted education programs (including those specific to members with special health care needs), that will be made available upon enrollment to members and/or their representatives. What is the MCO's process for identifying who will receive targeted education programs? What is the timeframe for creating education materials and educating the member education and care management staff?

In addition to targeting members through health risk assessments, Trusted offers a platform for members to identify their own needs through our Wellsource Self-Management Tool.

Self-Directed Education, available on the website

WellSource – a web based self-management tool that enables members to take self-assessments and access health educational materials at the 4th grade level is available through the Trusted member portal. Upon completion of the self-assessment, a member will be referred to with articles, healthy recipes, self-checks, and how-to guidance that motivates actions to prevent disease or mitigate the risk of existing health problems. This in turn creates healthier populations, which reduces costs of care.

Members navigate a user-friendly library of content for topics that interest them the most. Every bit of its scientifically sound information and advice is written at a respectful and engaging 4th grade health literacy level.

Health Shelf provides content for 16 health topics, including:

- Healthy weight maintenance
- Smoking cessation
- Physical activity
- Healthy eating
- Stress management
- Safety
- Emotional well-being
- Disease prevention

Accessed through the WellSuite® IV portal, Health Shelf content is informative, interactive, actionable, and motivational. It empowers your population to make choices that can have a positive impact on the physical, emotional, and social aspects of their lives. It inspires them to incorporate healthy habits into their daily activities.

159. Describe the qualifications and training of MCO staff who will be involved in coordinating care. Indicate whether specialized case/care managers will be used for certain conditions (e.g., experienced pediatric or cardiac nurses, behavioral health specialists). If the MCO will hire care management staff, provide the MCO's plan for hiring, including timeframes, number of the CMs, and maximum case load.

Trusted has developed a graduated staffing plan that accounts for its comprehensive on-the-ground approach to providing for its consumers and still balances the need to incorporate stewardship of costs. Trusted through its experienced management and subcontractors, as well as established networks have first-hand knowledge of what it takes to implement a start-up operation as demonstrated in the District of Columbia. Trusted launched its contract in the District of Columbia in 60 days. The contract was awarded May 1st, 2013 and Trusted went live operationally July 1st, 2013 with 27,000 Medicaid members. This experience has shaped the implementation phase allowing a ramp up in staff as the membership increases.

A draft staffing plan is provided in Appendix B. This plan will be evaluated based on the needs of the population and location of Wellness Centers upon contract award.

Qualifications

The Case Management Team will all have the following Qualifications:

- Current unencumbered West Virginia Registered Nurse licensure
- Current BLS certification for Healthcare Providers
- Three to five years of experience in area of specialty
- Advanced clinical skills in area of expertise
- Two years of Utilization/ Case Management experience, preferably in Managed Care Setting
- Proficient knowledge and understanding of utilization management, case management, healthcare finances, alternative care options, goals and outcomes, regulatory and professional implications.
- Skilled in conflict management and resolution
- Critical thinking skills
- Knowledge and application of computer software programs such as Microsoft Office, Word, and Excel

Training

Trusted Health Plan has a robust training program for the orientation of the new employee. Case Management staff will also be required to complete Comprehensive training on the CareConnect System as well as cultural competency training in which they gain an understanding of the perspectives, traditions, values, practices, and family systems of culturally diverse individuals, families, communities, and populations.

160. Describe the MCO's protocol for assigning members to a care manager. Provide the expected timeframe for care manager assignment to the identified member.

Trusted transition plan will be adequately resourced to ensure all departments within the organization are implemented in accordance with contractual requirements. Specifically, any activities that fall under the CMO's responsibility and that impact consumer access to care

coordination of services, and ultimately well-being, will have its own designated project plan and allocated resources identified to ensure timely achievement of time-sensitive milestones such as the provision of services to its consumers. For each consumer identified as needing Level I, II or III Case Management services within the transition period, will have an action item within the treatment plan that outlines transfer of services, the continuation of services with non-network providers through the credentialing process, more frequent follow-up to ensure services are not disrupted. Consumers actively receiving services according to their treatment plan (e.g. cancer treatment-radiation, chemotherapy, etc.) may choose to continue treatment until the course of therapy is concluded with the existing treating provider.

Activity	Role
Transitioning Into Trusted	
1. Daily review of HRA/ referrals for Case Management, Historical Claims information, diagnosis, procedures available for new consumers	Case Management Administrative Assistant
2. Consumers identified and flagged in case management tracking system if they have received in the past or require case management	Case Management Administrative Assistant
3. Case Management intake process initiated	Case Manager
4. Case Management Intake	Case Manager
5. Letter sent introducing case management and requesting consent within 3 business days of identification	Case Management Administrative Assistant
6. Call placed introducing case management and requesting consent to participate within 3 days of identification	Case Manager
7. Those unable to be reached with initial contact attempts, will be contacted again within 3 additional business days and a subsequent 3 business days if unavailable.	Case Manager
8. A referral to outreach will occur after the 3rd unsuccessful attempt	Case Manager
9. Outreach Process Initiated	Outreach
10. Consumer enrolled into Case Management	Case Manager
11. Complete Case Management Assessment	Case Manager
12. Obtain list of providers, contact information and services receiving; identify primary provider coordinating care.	Case Manager
13. Determine if provider is in network, pending credentialing or OON	Case Manager
14. Consumers diagnosed with cancer and receiving Chemotherapy or radiation therapy and accessing services through OON provider, will be given choice to remain with OON provider or transition to network provider.	Case Manager
15. Contact OON and pending providers to providing Trusted billing information and develop single case agreements to ensure uninterrupted care.	Case Manager
16. Authorize/ approve and document authorization in medical management system	Case Manager
17. Consumer is stratified based on case management criteria and placed within Level I, II or III programs	Case Manager

Activity	Role
18. Consumers placed in level III case management: A face to face Multidisciplinary Care Team meeting will occur with consumer, primary provider, and Trusted CMO, Case Manager and Pharmacy Manager to develop and implement the treatment plan (within 30 days of consumer identification). If a face-to-face is not practical, a conference call will be completed.	Case Manager, Medical Director, Pharmacy Manager, Consumer, Provider
19. Consumers placed in level I or II case management: A face to face Multidisciplinary Care Team meeting will occur with consumer, primary provider, and Trusted CMO, Case Manager and Pharmacy Manager to develop and implement the treatment plan (within 30 days of consumer identification).	Case Manager, Medical Director, Pharmacy Manager, Consumer, Provider
20. If the provider is unwilling to continue treatment due to out of network status, Trusted CMO and Case Manager will be notified and will facilitate transition of the member to a new provider, will communicate to the receiving provider the treatment plan and will ensure services continue and an initial appointment occurs within 5 business days of notification that the provider will no longer continue treating the member.	Case Manager, Care Coordination Manager, Medical Director
Transitioning out of Trusted	
1. The consumer's case manager will contact the member to identify the new plan/ payor/ case manager and obtain permission to transition the treatment plan.	Case Manager
2. Trusted case manager will contact the receiving plan/ payer/ case manager to hand-off the treatment plan, goals and progress to date.	Case Manager
3. A medication reconciliation process will be conducted with the receiving pharmacy manager / PBM as needed	Pharmacy Manager

161. Describe utilization analysis methods used to identify beneficiaries with special needs or receiving high cost care that would benefit from case management.

Within the Care Coordination System, Trusted will actively coordinate the care in collaboration with the treating provider for high-cost and/or high risk cases. High-cost and/or High-risk cases will be designated as a Level III-Complex case and require the highest level of engagement of the CM with the enrollee/ care giver and treating providers. All Level-III Complex cases will have an assigned and experienced CM with conditions similar to the Enrollee to coordinate services. High cost protocols required are clearly defined in the Care Coordination policy and will include documented interaction, roles and responsibilities of each person within the enrollee's treatment team. A high-level of enrollee and caregiver involvement is required for all care coordination cases. The Care Coordination Management team (inclusive of the CM) will, at minimum hold weekly High-cost and/or High-risk Team reviews to ensure all needs and being managed appropriately, positive outcomes are being achieved and applicable protocols are being followed. The ultimate goals to contain costs and promote positive health outcomes will be monitored by the management team.

Decreasing High Cost Care

30 Day Readmissions Reduction Program

To proactively manage and develop a program that promotes providing the right care at the right

level of service at the right time, Trusted must utilize its robust analytics and profiling capabilities to identify enrollees that are likely to over-utilize or inappropriately utilize services. Elsevier (Piper, 2012), in its research found that high-cost Medicaid patients are more likely to have dual physical and behavioral health diagnoses.

Behavioral Health/Substance Abuse Co-Morbidities

Behavioral Health	Substance Abuse
• 34% Hypertension • 24% Asthma/ COPD • 31% Heart Disease	• 22% HIV/AIDS • 26% Asthma/ COPD • 33% Heart Disease
30-60% higher than non-behavioral health beneficiaries	50-300% higher than non-substance abuse beneficiaries

Medicaid behavioral health and substance abuse (BH/SA) services are often disjointed and multiple providers are involved in an enrollee's care with limited or inconsistent follow-up or adherence to self-care instructions. Hence, the reason ***Trusted's*** focus and emphasis is heavy on BH/SA. We are not content to hire a behavioral health contractor and relinquish control but will actively implement programs collaboratively with Beacon and its providers. To ensure the best services rendered to our enrollees, our Care Coordination Manager will oversee all of ***Trusted's*** behavioral health services, including all services provided by Beacon.

Other tactical strategies to decrease readmissions include the following:

- Each enrollee with a length of stay greater than 3 days (excluding normal obstetrical deliveries) will receive an in-person visit by a Trusted Case Manager. The Case Manager will meet and engage the enrollee's support network to impact compliance and facilitate discharge follow-up. The Case Manager will contact the enrollee's PCP/ Specialist directly to communicate care received in the hospital and to communicate and receive agreement regarding the treatment plan.
- Each enrollee participant in complex case management upon admission to the hospital will receive an in-person visit by their designated Care Manager.

L.A.N.E. (Low Acuity Non-Emergent) ED Visit Tactical Strategy

Many potentially avoidable ER visits are related to failures of the payment and delivery systems. With adequate primary care, dental and mental health services widely available and paid for, the use of ERs would be reduced and services could be better provided as a part of coordinated patient care in better, less costly settings. Directing patients to other alternatives requires patient education and interventions. This can only be accomplished by all parts of the health care system working on this issue.

- Work with the providers on strategies for proper coding for primary care, urgent care and emergency care.
- Perform a review of historical claims for beneficiaries.
- Conduct daily review of ER visits and corresponding admissions.

- Segment into groups –
  - High ER visits or "frequent fliers"
  - ER visits likely due to poorly managed chronic disease
  - Acuity likely indicates visit could have been more appropriate for urgent care setting.

L.A.N.E. Care Teams

Based on both a historical and prospective review of utilization, Trusted will develop care teams and assign them with geographic distribution. Care teams will work with patients and primary care providers to perform outreach, education, and develop care plans for all beneficiaries to improve treatment adherence and appropriate navigation of the health care system.

L.A.N.E. Investment in Urgent Care

The acuity of some of these "avoidable" visits appears to indicate that an individual is potentially much sicker than would be assumed based on the primary diagnosis, which may indicate a need for investing in urgent care.

Urgent Care Centers provide walk-in medical care for acute, non-life or limb threatening conditions:

- Services are available during the day, after hours and on the weekends
- Staffing and equipment allow for treatment of higher acuity and a wider scope of conditions than typically cared for in the primary care setting.
- Services include simple suturing, splinting, incision and drainage, IV hydration
- Do not provide typical primary care, preventative care, or chronic disease management
- Provide an alternative to Emergency Departments for non-emergent conditions.

Integration in Medical System / Continuum of Care

- Increase continuity of care between primary care, urgent care and specialty care
- Urgent care services for ease of access for non-emergent care
- Facilitate follow-up primary care after an urgent care visit
- Open access primary care appointments available for non-urgent conditions
- Facilitate referrals to specialty care, particularly with specialty providers
- Improve preventative care and chronic disease management, by establishing relationship with medical home with every urgent visit
- Reduce over-utilization of Emergency Departments by providing an alternative for non-emergent needs.

Health Information Technology

- Utilize Electronic Medical Records (EMRs) across provider types for clinical, practice management, social services and reporting functions to improve patient care and safety.
- Improve communication between all healthcare providers.
- Electronic scheduling for effective follow-up with medical home and specialty care.
- Assess wait times at other centers to allow for alternative options.
- Nurse Advice line and triage.
- Monitor utilization, wait times, deficiencies.

Community Education

- Update Emergency Medical Services' protocols for transport of less acute cases to urgent care centers.
- Change practices of primary care physicians to utilize urgent care.
- Educate community on urgent and emergent conditions and appropriate source of care for various conditions.
- Encourage Emergency Departments to offer alternative of urgent care for appropriate patients when wait times are high.

Trusted will implement an aggressive wellness and prevention program through its Health Education Department. We will partner with health centers, hospitals and provider offices to offer same day preventative appointments (physicals), Screening clinics (in collaboration with CVS, Rite-Aid and Walgreens throughout the community), Mobile units (vaccinations, mammography, physicals, and dental). Seasonal marketing campaigns that promote flu shots and educate about the importance of preventative health will be a point of emphasis throughout an enrollee's membership. Specifically Trusted will focus on and develop programs that assist and promote early detection for the following conditions:

- Obstetrics and Well Baby Care
- Diabetes (Juvenile and Adult)
- Hypertension
- Psychological illness (ADD & ADHD in children)
- Breast and Cervical Cancer in Women
- High Blood Pressure

162. Describe the steps MCO care managers will take to establish relationships with their assigned members. Based on the member's acuity level, how often do care managers contact members after the initial care management contact on average.

The Case Manager will initiate the relationship with the member through either a call or face-to-face visit depending on the accessibility and comfort level of the member. The assessment may be conducted via telephone, the Wellness and Customer Service Center, doctors office of hospital facility. The assessment will allow the Case Manager to understand the barriers to care and any knowledge deficits that may exist. Based on the complexity of the member's condition, a frequency of ongoing contact will be followed. The care manager contacts, monitors and documents the progress of the implemented treatment plan based on the individual and at minimum criteria outlined below.

Level I: Disease Management	Level II: Care Coordination-Moderate	Level III: Care Coordination-Complex
1. Enrollee telephonic contact at minimum semi-annually. 2. Invitation to applicable educational sessions at minimum semi-annually. 3. Written educational updates at minimum quarterly.	1. Face-to-face visit during hospitalizations after 7 day hospitalization 2. Enrollee face-to-face contact at minimum annually (at PCP/ Specialty appointment or Wellness Center; semi-annually by Outreach Representative.	1. Face-to-face visit during hospitalizations after 7 day hospitalization 2. Enrollee face-to-face contact at minimum semi-annually (at PCP/ Specialty appointment or Wellness Center acceptable); quarterly by Outreach Representative.

Level I: Disease Management	Level II: Care Coordination-Moderate	Level III: Care Coordination-Complex
4. Assessment of compliance with recommended guidelines (using claims and encounter data) at minimum quarterly.	3. Enrollee telephonic contact at minimum bi-monthly; monthly if top 5% of targeted disease. 4. Multi-disciplinary Team Meeting to discuss progress semi-annually (enrollee, treating provider(s), applicable agencies and care manager). 5. Assessment of compliance with recommended treatment plans (using claims and encounter data) bi-monthly (automated process). 6. Updating of treatment plan at minimum monthly.	3. Multi-disciplinary Team Meeting to discuss progress quarterly (enrollee, treating provider(s), applicable agencies and care manager). 1. Enrollee telephonic contact at minimum monthly; bi-weekly if top 1% of medically fragile population. 2. Assessment of compliance with recommended treatment plans (using claims and encounter data) bi-monthly (automated process). 3. Updating of treatment plan at minimum monthly.

163. Describe how care managers will be monitored and evaluated in regards to establishing relationships with members. Include statistics the MCO will collect and frequency with which they will be collected.

The CMO and Utilization Management Workgroup members will be involved in overseeing these care coordination functions. Efficiency, effectiveness, provider satisfaction and enrollee satisfaction will be monitored in accordance with the Quality Management Work plan.

Complex Case Management is evaluated annually through:

- Impact on admission rates
- Impact on readmission rates
- Member Survey: Experience with Case Management
- Evaluation includes
  - Quantitative results and specific measures
  - Setting a performance goal
  - Comparing performance to the goal
  - Analysis of the results
  - Identification of opportunities for improvement
  - Plan for intervention and re-measurement.

164. Describe the protocol for addressing a member that would benefit from a care manager, but does not want one or cannot be reached once a care manager has been assigned.

All potential CM/DM members receive a welcome call upon internal identification or referral. This call is logged into the CareAnalyzer system, to open the case, and a disease specific health risk assessment is performed in order to begin their plan of care. If the member is not available, they 2 additional phone call attempts are conducted.

With the first call attempt, a disease specific "Welcome Packet" is sent to the members address. This welcome packet has an introduction to the member's Case Manager, Instructions on how to use the program, educational information and/or logs, a calendar of activities held at the Wellness Center, and information on how to opt-in or opt-out of the program.

If the member opts out, but based on utilization data is not appropriately managing their health and/or has high utilization, educational material will be offered and invitations to participate in activities at the Wellness Center and/or the Mobile unite extended. Case Management services will be offered again at minimum annually.

165. Describe the process by which the MCO will develop, update, and use clinically appropriate treatment plans that address the coordination of primary, specialty, ancillary, community and social support, and carved-out services for members identified as having special health care needs. How will the MCO identify members in need of such a care plan, and which members will receive care plans. Please provide a sample care plan.

Once an assessment has been completed by the Care Manager he/ she develops a plan of care, which includes an interdisciplinary action plan (team treatment plan), a link to the appropriate institutional and community resources, specific goals and expected outcomes. Trusted has established a policy and tool that defines basic requirements that must be in the treatment plan according to the assigned category. Enrollees will be actively involved in developing the treatment plan and goals. A mutual agreement between the treatment team (PCP/ Specialist, and Care manager) and the enrollee will be established. The plan will outline at minimum the following:

- Identification of barriers to meeting goals and complying with the plans.
- Facilitation of member referrals to resources and follow-up to determine whether members act on referrals. When referrals include arranging for appointments or services with a health care provider or other health organization, the RN will follow up with the member and/or provider to verify whether the appointment was kept and the findings. When referrals are of a coaching nature, follow-up may be indicated as part of evaluating the member's follow-through on self-management actions
- Case Manager Interventions based on the member's needs
    a. Behavioral Health and Alcohol and Drug Abuse Services (if applicable and consented to share with the treatment team by Enrollee).
    b. Support Services necessary to carry out or maintain the treatment plan.
    c. [For children with more complex needs] Planned Care Coordination Activities.
    d. EPSDT standards are developed into the treatment plan for enrollee's less than age 21.
    e. Coordination with other needed treatment services
- When developing the treatment plan, the Care Manager will take into account the spiritual, cultural values and any special communication needs of the family and/or the child. A thorough educational overview of the following will be reviewed with the enrollee in order to make informed treatment decisions and give informed consent:

1. Benefits (both covered and non-covered) that are clinically appropriate (as determined by the enrollee's provider).
2. Treatment options as well as the recommended options (regardless of whether the option is a covered benefit).
    a. Their expected effects.
    b. Any risks or side effects of each option.
    c. The right to refuse treatment.

- Initial target dates are assigned to goals with ongoing assessment of progress toward goals; target dates are modified and extended as necessary to work with the member toward successful completion of goals.
    - Development and communication of member self-management plans verbally and/or in writing (Actions)
    - A schedule for follow-up and communication with members for the purpose of assessing progress against case management plans.

Treatment plans developed for the Special Needs population will be reviewed and updated according to complexity and provider recommendations based on assessment of the enrollee's health and developmental status and needs, but no less than annually (every 12 months). The treatment plan and any updates/ revisions will be maintained in THP's Information System and a copy sent to the applicable members of the enrollee's treatment team.

166. Provide the frequency with which care plans will be shared with PCPs and other providers and in what manner (e.g., letter, phone call). Describe who is responsible for sharing care plans with a member's PCP, and what will prompt the MCO to share care plans (i.e., events that occur before the next scheduled date to share the plan with a PCP).

Care plans will be shared with the PCP or applicable providers at a minimum, upon initiation of case or disease management services; upon changes in member status and at the completion of case management services.

167. Describe which members identified as needing care management receive a treatment plan.

Members enrolled in Trusted's Complex Case Management program will receive a documented Care Plan within our documentation system.

168. Describe how the MCO tracks the completion of care plans.

Trusted's care plans are documented and captured in its case management system (Care Connect). The system has the ability to track the initiation, updating and closure of care plans. Additionally, due dates for milestones as well as reminders can be set for the care manager to ensure timely follow-up and completion of tasks associated with the plan of care are completed.

169. Describe episodic and/or catastrophic case management interventions.

Trusted will hire a Case Manager experienced in managing catastrophic losses such as closed head injuries, severe burns, spinal cord injuries and other significant traumas. Catastrophic case management begins within the critical/intensive care settings. The Catastrophic Case Manager will

develop a rapport with critical care nurses in regional trauma settings to facilitate our communication with the patient and family. By attending team and patient conferences, our catastrophic case manager will identify problems which require rehabilitation goals to be modified or expanded. He/She will provide continuous coordination of medical attention for optimal outcomes, while referencing evidence based guidelines as benchmarks for treatment and anticipated disability.

The Catastrophic Case Manager will possess the expertise to advocate, negotiate, and communicate professionally and appropriately.

The Catastrophic CM duties will include:

- Response to the trauma unit the same day as referral
- Recommendations immediately following the assessment
- Communication with medical providers to assist in determining the appropriate course of treatment
- Partner with the Trusted Medical Director to consult and intercede with our nurses and the medical providers on CAT cases to assess the progress and assist in determining the course of treatment as needed
- Assess the appropriate clinical pathways for recovery and document predicted future medical exposure in every care plan and formal report

170. Describe the protocol for addressing a provider who does not perform coordination activities. How will this be identified and what action will the MCO take to improve coordination?

Providers that do not participate in the care coordination plan will be identified by the case manager and referred to the Provider Relations Department for follow-up. Additionally, members and /or other providers may place a complaint with the Provider Relations Department. Contractually, the Provider is obligated to participate in quality and care coordination activities within the health plan. For providers that do not comply, Provider Relations will initiate a corrective action plan and monitoring activities.

171. Describe MCO programs for coordination of care that include coordination of services with community resources and social services in the area served by the MCO. Include: procedures that will be in place for coordination with community resources and social services for members, including those with special health needs; timeframes for identification of such resources and services, and a plan for coordinating community resources and social services for members with special health care needs who have not been assigned to a care manager, but require these services.

The Care Coordination Team, under the auspices of the Case Management department will provide coordination of care to include coordination of services with community and social services through contracting or non-contracting providers.

Case Managers, Special Needs Care Coordinators, Medicaid Advocates and Outreach Center Staff will receive New Employee training which includes an orientation to community resources and social services within in each region. This training module will serve as a reference guide for resources in the area.

Within the transition period (the first 90 days of enrollment) the Case Management department will utilize Enrollment Broker Information, Health Risk Assessment Information and Claims data to identify enrollees with special needs that would benefit from these services. These enrollees will be flagged and referred to Case Management. Even before a formal Case Management Assessment is completed, the Outreach team will conduct and initial contact to explain the Special Needs Care Coordination program and provide information on member specific community resources and social services.

Trusted will work with a variety of community organizations for Special Needs including:

- West Virginia Family Support Program, Bureau for Behavioral Health and Health Facilities
- West Virginia Parent Training and Information, Inc.
- West Virginia Advocates, Inc.
- Parent Network Specialists (PNS), WVU Center for Excellence in Disabilities
- Mountain State Parents, Children & Adolescent Network (MSPCAN)

VII. QUALITY

172. Describe general administration of the QAPI Program within the MCO. Provide Medicaid and any commercial HEDIS reports from the past two years.

Trusted has an established a Quality Assessment and Performance Improvement Program (QAPI), or Continuous Quality Improvement (CQI) program which includes quality management functions and quality improvement activities in compliance with 42 C.F.R. § 438.240. The Annual Continuous Quality Improvement Plan (CQI Plan) is consistent with the utilization control requirements of 42 C.F.R. Part 456 and Trusted's Utilization Review and Care Coordination requirements. At a minimum, it;

- Provides for review by appropriate health professionals and Providers of Trusted's policies, procedures and processes for providing health services.
- Provides for systematic collection of data concerning performance and enrollee outcomes.
- Maintains a health information system that collects analyzes and integrates the data necessary to implement the CQI program.
- Provides for interpretation of data concerning performance and enrollee outcomes to network providers.
- Identifies and evaluates methods for identifying enrollees with multiple or sufficiently severe chronic conditions that would benefit from participation in a complex case management program.
- Provides mechanisms for monitoring enrollees that are participating in the complex case management program.
- Provides a mechanism for making necessary changes to Trusted operations, policies and procedures.
- Annually measures and reports its performance under the CQI program.

Trusted will develop, annually update , and submit to BMS a written CQI Plan that includes a description of Trusted's performance goals and objectives including measurable goals for:

- Improving performance as a result of information obtained through analysis of HEDIS performance measures, survey results including CAHPS surveys and chart reviews.
- Improving health outcomes for enrollees with chronic preventable health conditions.
- Reducing racial, socioeconomic and ethnic disparities in health care utilization and in health outcomes indicated by baseline data comparing health care utilization data for enrollees by enrollee subgroups, against prior year performance and where possible, against national benchmarks.
- Improving performance in response to information obtained through the EQRO report.
- Addressing trends that warrant review.

Specifically, program activities include the following:

- Measurement of performance against key monitors for quality improvement as identified by the CQI and activities identified in the Work Plan.
- System interventions, including the establishment or alteration of practice guidelines.
- Systematic and periodic follow-up on the effect of interventions.
- Implementation of an annual CQI program that is relevant to the population and that can be expected to have a favorable effect on health outcomes and/or member satisfaction.
- Ensuring compliance with applicable regulatory and contractual requirements including district and federal regulations as well as accreditation standards.
- Analyze, identify and address continuity and coordination of care within treatment plans.
- Analysis, identification of areas of under and over-utilization, if applicable.
- Monitoring, identification and investigation of potential Quality of Care/Quality of Service (QOC/QOS) and patient safety issues. Implementation of improvement actions as needed.
- Profiling Quality of Care for network practitioners
- Conducting multi-year performance improvement projects addressing clinical and non-clinical areas
- Tracking and trending of member and practitioner satisfaction information.
- Monitoring and analysis of enrollee access to and availability of care
- Solicitation of member and provider input on performance and QI activities.
- Detection of both underutilization and overutilization of services,
- Assessment of the quality and appropriateness of care provided to enrollees with special health care needs.

Trusted will make every effort to comply with external quality reviews. This may include participating in the design of the external review, collecting medical records and other data, and/or making data available to the external quality review organization.

173. Submit a Quality Improvement Plan.

The Quality Improvement Plan is in Appendix O.

174. Describe the types of data the MCO will use to identify barriers to care for individuals with special health care needs (e.g. focus groups, surveys, "secret shopper calls" aggregate utilization monitoring). How often will quality measures be collected and analyzed? Describe how this data will be analyzed separately for SSI and TANF and WVHB members.

Each individual identified with special health care needs will be assigned a Case Manager to assist with ensuring continuity of care amongst the treatment team and accessibility to care is maintained. Tools utilized to monitor timely access to care in addition to the "secret shopper call" program includes: For specific SSI/ TANF or WVHB members, the Case Management department will monitor daily ED utilization reports; Urgent Care utilization reports, Hospital Admission

Reports and Gaps in Care Reports to identify trends for enrollees assigned to particular PCP providers. CareAnalyzer will be used to identify Gaps in Care. Providers that show a significantly higher number of gaps in care or trends that point to access limitations as well as complaints regarding access will be referred to the Provider Relations Department.

Secret Shopper Program – In an effort to identify and mitigate barriers to care, the Program Integrity department will work in collaboration with the Provider Relations department to conduct Secret Shopper Audits either randomly or as a result of a complaint and/or recommendation. Monthly Trusted employees conduct unscheduled and anonymous audits onsite and telephonically.

Onsite: Trusted staff conducts onsite "Secret Shopping" visits to 5 to 10 provider offices per month, including 1-2 pharmacies. These visits assure that Patient Safety, Privacy, Security and Dignity standards are upheld at the practice site.

Telephonic: Trusted conducts regular surveys using secret shoppers to verify that practitioners comply with the NCQA access standards for:

- Regular and Routine Care appointments
- After hours care
- Urgent Care Appointments
- Member Services, by telephone

All survey results, including any recommendations for improvement, will be communicated to the practitioner in writing at the conclusion of the review. A Corrective Action Plan (CAP) is developed and implemented for any practitioners who fail to fully meet the access standards. Follow-up surveys and visits will be conducted in three to six months to monitor the practitioner's progress towards compliance, and as necessary, with the standard panel closing requirements.

175. Provide a general description of the MCO's process for developing and updating clinical guidelines, and for disseminating them to participating providers.

The QEC is responsible for arranging for the development, periodic review and updating of Clinical Practice Guidelines that may be used by providers to determine how specific conditions can most effectively and appropriately be prevented, diagnosed, treated and managed. The guidelines include preventative acute and chronic care services that are relevant to the enrolled membership. Based on the guidelines produced, the QEC develops medical criteria and performance measures for the monitoring and evaluation of care provided to members.

Guidelines are based upon established national evidenced-based guidelines. Guidelines are peer reviewed and developed by consensus and are reviewed every two years and revised if necessary to ensure that they are consistent with current literature and national guidelines as well as the outcomes and experience of the provider network.

The approved and adopted guidelines are distributed to providers as they are developed and/or revised through educational sessions, mailings, newsletters and updates to provider manuals. Guidelines are provided to enrollees, available on our website and providers upon request.

176. Describe the MCO's approach for addressing quality issues including what steps will be taken, who is responsible for addressing issues, and the timeframes for resolution.

CQI is a problem-solving technique that is applied to specific and measurable performance indicators. The CQI Process is used whenever an opportunity for improvement is identified through the monitoring of quality of care or service indicators. The steps in the CQI Process follow the steps outlined below:

Exhibit 23: CQI Process



All steps in the CQI Process are documented and results and action plans are presented to the QEC for review and approval.

The monitoring of quality indicators is designed to reveal trends and performance opportunities in specific areas and facilitate plan-wide improvement. To this end, a variety of care and service indicators to monitor is derived from as many sources as appropriate. The quality indicators are:

- Objective, clearly and unambiguously defined, and based on current clinical knowledge or health services research
- Capable of measuring outcomes such as changes in health status, functional status an enrollee satisfaction, or valid proxies of those outcomes.

Topics for routine monitoring and focused activities are chosen based on the demographic and epidemiological characteristics of the population. Examples of monitoring indicators may include tracking and trending of inpatient or outpatient acute or chronic conditions, access performance measurements, member and claims service, member and provider satisfaction or unique specific indicators as identified from local epidemiology or demographics. QI activities are designed to objectively and systematically monitor and evaluate the quality and appropriateness of care and service provided to its members and are presented to the appropriate committee for review and recommendation. The QI Department works with functional areas throughout the organization to assess quality indicators in each department.

When applicable, measurements and reporting of performance will use the measurement tools required by CMS, report performance and make available to CMS information on quality and outcomes measures that will enable beneficiaries to compare health coverage options and select among them. Trusted will conduct and/or participate in at least two (2) Performance Improvement

Projects (PIPs) each year for populations with complex heath needs.

Objectives for serving members with complex health needs include:

- Maximizing physical functioning
- Maximizing social and behavioral functioning
- Managing chronic and acute conditions to minimize pain and disability, and achieve optimal functioning
- Coordinating care between multiple medical providers and behavioral health providers.

All Complex Case Management members have an annual risk assessment and individualized care plan developed and completed each year to assure the most accurate data is available

Resolution timeframes will be determined individually and based upon the gravity of the situation but will not exceed an acceptable timeframe that demonstrated progress towards the goal.

177. Describe data-driven clinical initiatives that the MCO initiated within the past 24 months that have yielded improvement in clinical care for a managed care population.

Improving Adverse Pregnancy Outcomes

Background: The DC Department of Health Care Finance (DHCF) selected perinatal outcomes as part of a multiyear initiative to improve the health of infants born to mothers in the DC Medicaid program. The original collaborative effort began in 2009 and closed in 2013. Because perinatal health and birth outcomes continues to be an important and relevant topic within the District, DHCF's Division of Quality and Health Outcomes requested the perinatal collaborative continue. With the emergence of new Medicaid Managed Care Organizations (MCOs), the collaborative began a new baseline year measurement year 2014. The collaborative will focus on improving perinatal and birth outcomes. Adverse event indicators will be tracked.

MY 2014 <u>Baseline</u> Data Submission:

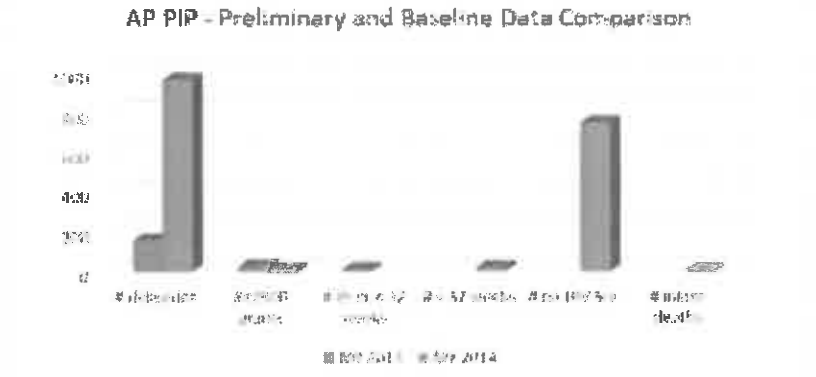
Data/Results Table							
Complete for each indicator and add additional rows if necessary.							
Indicator #1: The number of neonates delivered during the measurement year with birth weight <2,500 grams.							
Time Period	Measurement	Numerator	Denominator	Rate or Results	Goal	Benchmark	Statistical Test and Significance *
1/1/2014 – 12/31/2014	Baseline	10	967	1.034			
Indicator #2: The number of neonates delivered during the measurement year with gestational age of less than 37 weeks.							
Time Period	Measurement	Numerator	Denominator	Rate or Results	Goal	Benchmark	Statistical Test and Significance *
1/1/2014 – 12/31/2014	Baseline	18	967	1.86%			

Indicator #3: The number of women who did not receive an HIV test during the pregnancy prior to giving birth.							
Time Period	Measurement	Numerator	Denominator	Rate or Results	Goal	Benchmark	Statistical Test and Significance *
1/1/2014 – 12/31/2014	Baseline	750	967	77.56%			
Indicator #4: The number of pregnancies ending in miscarriage or fetal loss (early or late).							
Time Period	Measurement	Numerator	Denominator	Rate or Results	Goal	Benchmark	Statistical Test and Significance *
1/1/2014 – 12/31/2014	Baseline	49	967	5.07%			
Indicator #5: The number of pregnancies during the measurement year for which the birth outcome is unknown.							
Time Period	Measurement	Numerator	Denominator	Rate or Results	Goal	Benchmark	Statistical Test and Significance *
1/1/2014 – 12/31/2014	Baseline	0	967	0%			
Indicator #6A: The rate of adverse perinatal outcomes. (INCLUDING ADVERSE EVENT : NO MATERNAL HIV TESTING)							
Time Period	Measurement	Numerator	Denominator	Rate or Results	Goal	Benchmark	Statistical Test and Significance *
1/1/2014 – 12/31/2014	Baseline	830	3286	25.26%			
Indicator #6B: The rate of adverse perinatal outcomes. (EXDLUCING ADVERSE EVENT 3: NO MATERNAL HIV TESTING)							
Time Period	Measurement	Numerator	Denominator	Rate or Results	Goal	Benchmark	Statistical Test and Significance *
1/1/2014 – 12/31/2014	Baseline	80	3286	2.43%			
Indicator #7: The number of infant deaths (age 0-365 days) due to any cause during the measurement year.							
Time Period	Measurement	Numerator	Denominator	Rate or Results	Goal	Benchmark	Statistical Test and Significance *
1/1/2014 – 12/31/2014	Baseline	3	2319	0.13%			

Exhibit 24: Utilization Data

Utilization Data						
Measurement Year	# deliveries	#<2500 grams	# @ or < 32 weeks	# < 37 weeks	# no HIV Scx	# infant deaths
MY 2013	158	24	13	n/a	Unknown	unknown
MY 2014	967	10	n/a	18	750	3

Exhibit 25: AP PIP



Trusted's preliminary data submission for MY 2013 represented six (6) months of utilization for this population. There were 158 pregnant members transitioned to Trusted from a preceding MCO in July 2013. Of those members 100% delivered prior to 12/31/2013. There were 48 (39%) deliveries classified as high risk pregnancies and 31 (19%) resulted in a NICU admission.

In comparison to a full year of utilization in MY 2014, we believe the denominator for MY 2014 more accurately reflects the pregnant population and associated deliveries for Trusted Health Plan. Due to data collection challenges during Trusted's "startup" phase, we were not able to accurately identify the pregnancies during which there were no HIV screenings in the preliminary reporting for MY 2013. Additionally, infant deaths were not being tracked/reported appropriately. A full data analysis with comparison's to the HEDIS and EPSDT related proxy indicators will be performed during Q32015 and the Perinatal Outcomes PIP will be revised/updated as needed.

Barrier Analysis	Trusted's Senior Director of Quality and Accreditation met with the Clinical Quality Manager and the OB Case Manager to discuss barriers and interventions:
Member Barriers:	1. Lack of knowledge of Trusted's OB Case Management program and community based partnerships 2. Lack of member awareness regarding importance of early prenatal and postpartum care and services 3. Members considered "hard to reach" due to missing or erroneous contact information

Provider Barriers:	1. Lack of documented evidence (via initial administrative data review) that providers are administering 2 HIV screenings during the pregnancy. 2. Obstetrical Needs Assessment Form (ONAF – the mandatory DHCF QI Collaborative intervention) delivered to the health plan untimely (sometimes received post-delivery) and incomplete.
MCO Barriers:	1. Lack of systematic process to identify and manage pregnant members. 2. Lack of ability to identify (early) and intervene on high risk pregnancies due to receipt of incomplete/late ONAFs received from providers. 3. Inefficient/non-existent process for monitoring infant mortality in the 1st year of life.

The following interventions have a number or numbers listed next to them to indicate the barrier that is being addressed:

a) Trusted's OB Case Manager will team with the Provider Operations (beginning in the 1st quarter 2015) to visit provider practices to educate OBs and referring practitioners regarding the parameters of the QI Collaborative initiative, Trusted's OB Case Management program, appropriate use of the ONAF including the importance of timeliness and completeness of submission, available programs and services such as: 1. Healthy Beginnings program on lactation, nutrition, 2. "Back to Sleep" crib/car seat safety programs located at Trusted's Health and Wellness Outreach Center and 3. WIC assistance available to Trusted's pregnant members and newborns, the HIV screening requirements, and the necessity of receiving newborn weight in grams vs pounds. Additionally, Trusted's OB Case Management program information will be added to provider education documents.

b) Trusted's OB Case Manager will work collaboratively with the Customer Service, Utilization Review, and Outreach teams to identify and implement alternate contact methods for hard to reach members including: 1. Door to door outreach; 2. Participation in UM rounds and monitoring daily census; 3. "CRISP" (Chesapeake Regional Information System for our Patients – Maryland and DCs designated health information exchange for the electronic connection of healthcare providers across the nation) referrals; and 4. Use of customer service module "alternate number/address" field entries.

c) Trusted's Quality Department and OB Case Manager will utilize Lab Corp's datalink service to perform monthly queries to determine HIV screening statuses for known pregnancies. "Non-compliant" pregnant members will be forwarded via fax to the service provider for confirmation of receipt of the screenings or he/she will receive a gentle reminder to perform the screenings. Documentation of findings will be maintained in Trusted's care management system "Care connect".

d) Trusted has contracted with Alere Womens and Childrens Health, LLC for monitoring and to conduct interventions as necessary of high risk pregnancies which includes pregnancies that threaten the health or life of the mother or her fetus. Risk factors for a high-risk

pregnancy can include existing health conditions, such as high blood pressure, diabetes, or being HIV-positive, overweight and obese. Pregnancy in teens and women aged 35 or over increases the risk for preeclampsia and gestational high blood pressure. Alere will perform 48 hour assessments for NICU discharges, and will assist with setting up home care services post NICU discharge. Additional services provided by Alere include:

- Preterm labor management
- Obstetrical nurse assessments
- Multiple gestation pregnancy management
- 17P (17 Alpha-hydroxy progesterone caproate) administration nursing service
- Gestational hypertension management
- Preeclampsia management
- Obstetrical diabetes program – continuous subcutaneous insulin infusion
- Continuous heparin, ondansetron, and metoclopramide therapies
- Home/skilled nursing visits and
- Betamethasone therapy via intermittent injections.

Trusted's OB Case Manager's role consists of identifying special needs of the newborn and assisting the mother with accessing the necessary benefits and services to address the needs.

e) Trusted is in the developmental stages of a "Reverse Referral" program. This program will consist of Trusted's use of the Office of the State Superintendent of Education (OSSE) Strong Start Program's developmental milestone guide for newborns. We have transformed the guide (with the assistance of our OSSE liaison) into an assessment form using the same milestone indicators. Each section will be scored and once the scoring methodology is applied we will know the score that is actually a trigger for a referral to OSSE for intervention via their Strong Start special needs case management program which includes care coordination, home visitation/assessments, and connection with needed community or home based resources. Trusted will monitor infant mortality and all monitoring activities will be documented in our care management system "Care Connect". This function will be performed during the newborn's first year of life at the intervals identified via the milestone assessment tool. Trusted's Early Interventions (EI) Coordinator will be the process owner and will refer internally to Case Management newborns who are deemed "ineligible" per OSSEs treatment criteria. Additionally, the EI Coordinator works collaboratively with the EPSDT team. Outreach services will be engaged for members (0-12months) who are missing preventive visits and required immunizations. Trusted's EI Coordinator works with and reports to our Special Needs Case Manager who has oversight of early interventions members, pediatric members, and all members with special needs. She is a seasoned registered nurse with numerous years of experience in providing care coordination for members in the aforementioned categories.

f) Trusted developed and implemented a comprehensive OB Case Management program "Healthy Beginnings" and hired a seasoned RN with over 21 years of experience in managing OB populations in the community, public health, and managed care arenas.

g) Trusted's Healthy Beginnings OB Case Management program includes the following service offerings and programs at our Outreach and Wellness Center:

- Distribution of information on the importance of prenatal care, and awareness of bodily changes and nutrition demands of pregnancy
- OB Case Manager will be stationed at the center for face to face engagement with pregnant members who access the center for education and other pregnancy related services
- Partnering with the Department of Health (maternal health program) mom and baby van for SIDS training every 6 weeks offered at the Outreach Center. Participants will receive a FREE "Pack and Play" upon completion of the training.
- Partnering with Capitol Hill Pregnancy Center – participating in Trusted's OB program kickoff at the Outreach Center on 7/31/14. They provide FREE baby supplies, clothing, cribs, strollers and other baby related necessities as needed.
- Partnering with Young Lives – will perform training and assist with access to community resources for teen moms. Training consists of helping teen parents to learn coping skills, newborn care, and family planning.
- There will be healthy cooking demonstrations at the Outreach Center for pregnant members. Additionally, Trusted has contracted with a lactation specialists who will provide weekly training regarding breastfeeding.
- Partnering with the WIC van for implementation of WIC recertification process at the Outreach Center.
- Trusted's members will be notified of activities occurring at the Health and Wellness Outreach Center through distribution of fliers regarding OB program activities that are mailed to members and OB practitioners. Additionally, information will be shared via telephonic and face-to-face outreach encounters or when members call the enrollee service department.

Adverse Chronic Conditions Performance Improvement Project (Pediatric Asthma):

Background: The District of Columbia's Medicaid Managed Care Organizations (MCOs) and Prepaid Inpatient Health Plan (PIHP) recently completed a multi-year Chronic Condition Collaborative that focused on asthma, diabetes, congestive heart failure, and hypertension. Results indicate high emergency department (ED) utilization for members with asthma (42% based on FY 2011 data). This high rate of ED utilization did not have a corresponding high rate of hospitalizations, indicating that there is potential to decrease ED visits by focusing on medication compliance, coordination of care, and better access to primary care physicians for members with asthma. With this information in mind, DHCF's Division of Quality and Health Outcomes proposed that the new collaborative focus on asthma.

Multiple studies have consistently shown that asthma is a readily treatable condition that can be managed in an outpatient setting.1 The District's data has shown that members with asthma too frequently rely on the ED to manage their illness. Further, a recent study conducted by the Children's National Medical Center's Impact DC Program found that nearly 68% of ED visits for asthma were for children less than eight years of age. Consequently, the Chronic Condition

Collaborative Work Group concluded that the asthma collaborative should focus on children and young adults 2-20 years of age.

The Chronic Condition Collaborative goal is to reduce emergency department utilization and inpatient hospital admissions for children and young adults with asthma. It is believed that improving medication compliance for this population will result in better control and ultimately decrease ED utilization and acute hospital admissions. The PIP will focus on appropriate medication compliance and also measure the members' ED utilization and hospital admissions related to asthma.

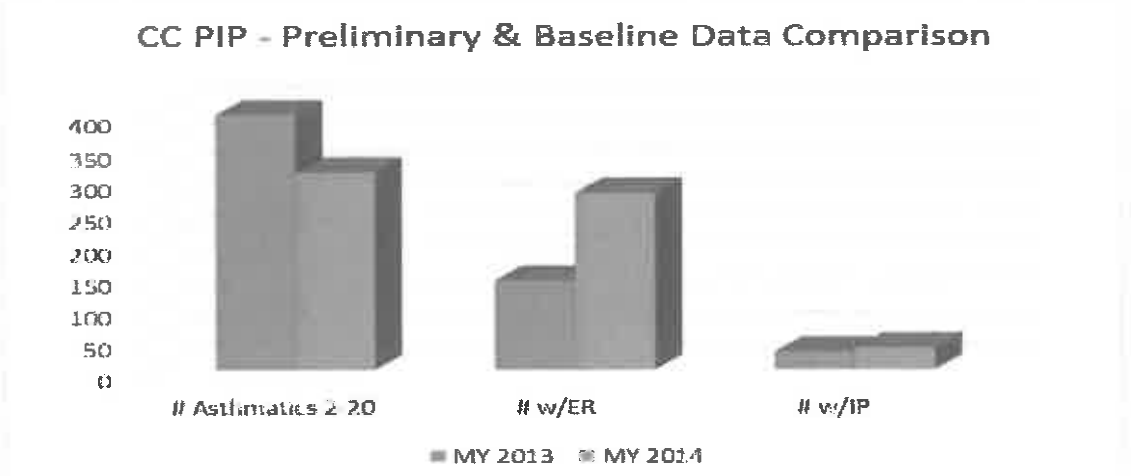
MY 2014 Baseline Data Submission:

Data/Results Table							
Complete for each indicator and add additional rows if necessary.							
Indicator #1: The number of children in the eligible population, ages 2 through 20 years, who had one or more ED visits with a principle diagnosis of asthma during the measurement year.							
Time Period	Measurement	Numerator	Denominator	Rate or Results	Goal	Benchmark	Statistical Test and Significance*
1/1/2014 – 12/31/2014	Baseline	277	310	89.35%			
Indicator #2: The number of children in the eligible population, ages 2 through 20 years, who had one or more acute hospital inpatient admissions with a principle diagnosis of asthma during the measurement year.							
Time Period	Measurement	Numerator	Denominator	Rate or Results	Goal	Benchmark	Statistical Test and Significance*
1/1/2014 – 12/31/2014	Baseline	34	310	10.97%			
Indicator #3: The Use of Appropriate Medications for People with Asthma - The number of members in the eligible population, ages 2 through 20 years, who were appropriately prescribed asthma medication during the measurement year.							
Time Period	Measurement	Numerator	Denominator	Rate or Results	Goal	Benchmark	Statistical Test and Significance*
1/1/2014 – 12/31/2014	Baseline	141	310	45.48%			
Indicator #4: Medication Management for People with Asthma - The number of members in the eligible population, ages 2 through 20 years, who were dispensed appropriate asthma controller medications that they remained on during the treatment period in the measurement year. The percentage of members who remained on an asthma controller medication for at least 50% of their treatment period.							
Time Period	Measurement	Numerator	Denominator	Rate or Results	Goal	Benchmark	Statistical Test and Significance*
1/1/2014 – 12/31/2014	Baseline	20	310	6.45%			
Indicator #5: Medication Management for People with Asthma - The number of members in the eligible population, ages 2 through 20 years, who were dispensed appropriate asthma controller medications that they remained on during the treatment period in the measurement year. The percentage of members who remained on an asthma controller medication for at least 75% of their treatment period.							
Time Period	Measurement	Numerator	Denominator	Rate or Results	Goal	Benchmark	Statistical Test and Significance*
1/1/2014 – 12/31/2014	Baseline	20	310	6.45%			

Exhibit 26: Utilization Data

Utilization Data			
Measurement Year	**# Asthmatics 2-20**	**# w/ER**	**# w/IP**
MY 2013	400	140	28
MY 2014	310	277	34

Exhibit 27: AP PIP



Trusted's preliminary data submission for MY 2013 represented six (6) months of utilization for this population. In MY 2013, Trusted Health Plan identified 836 asthmatics of which 400 (47%) were asthmatics between the ages of 2-20. Approximately 8% of Trusted's target population were asthmatics assigned to primary care practitioners that are part of Children's National Medical Center. In comparison to a full year of utilization in MY 2014 the denominators are relatively similar. Additionally, the numerator events appear to occur at the same rate. We feel comfortable in assuming that the MY 2013 utilization (numerator events) would have been double the amount reported had the measurement period been for a full year.

A full data analysis with comparisons to the aforementioned proxy indicators will be performed during Q32015 and the Chronic Conditions PIP will be revised/updated as necessary.

Barrier Analysis	Trusted's Senior Director of Quality and Accreditation met with the Clinical Quality Manager and the OB Case Manager to discuss barriers and interventions:

Member Barriers	1. Over-reliance on acute care: Our initial data analysis shows that 35% of our study population was treated in the ED with asthma as the primary diagnosis in 2013. This population is transient and has a tendency to access the Emergency Department (ED) as primary healthcare source. 2. Underuse of self-management: Members lack an understanding of asthma exacerbation events (triggers). 3. Members considered "hard to reach" due to missing or erroneous contact information
Health Plan (MCO) Barriers	1. Members who do not select a primary care doctor at the time of enrollment are auto-assigned to a PCP. Trusted had several pediatric groups erroneously assigned to providers who didn't serve that age group causing members to use the ED as Primary Care Physician (PCP) or not go for primary care 2. Trusted did not have a formal Disease Management (DM) program for asthma in 2013
Provider Barriers	1. Lack of PCP participation as the coordinator of care among their patient's providers and lack of member awareness of the importance of coordination between providers

The following interventions have a number or numbers listed next to them to indicate the barrier that is being addressed:

- Trusted's newly developed Asthma Disease Management program has components designed to specifically address the following:
    a. Identification of and Outreach to at-risk members: The following avenues are sources for identifying children diagnosed with asthma or children with asthma-like conditions:
        1. **Health Risk Assessment (HRA)**: An HRA is conducted on every child enrolled in Trusted Health Plan. A parent/guardian completes a telephonic HRA, which contains questions regarding whether the child has or had a diagnosis of asthma, takes medication, and/or has had a recent ER visit or hospitalization for asthma related issues A positive response to any of these assessment questions results in a referral to the asthma disease management program.
        2. **Claims Data**: Individuals age 2 – 20 years, with a claim containing a primary or secondary diagnosis of asthma, are identified quarterly. Names are matched to the existing database of asthma disease management program enrollment. For those not on the current list, referral to the asthma disease management program is made, and a pediatric asthma assessment is conducted. Results of the assessment determine which stratification category the individual is eligible for, and program interventions ensue as determined by the stratification level.

3. **Pharmacy Data**: The Trusted Pharmacy Manager will run a report to identify members (aged 2-20) receiving asthma medications per HEDIS specifications. Reports will be run on a quarterly basis through the Meridian PBM database. Children with a report of asthma medication this will then be compared against the current list of members in the Asthma DM program, to identify any new candidates for the program, or monitor receipt of medications for current members. Those who are not on the current list of program enrollees are referred to the program for enrollment screening.
4. **Interdepartmental referrals**: Data from Trusted's utilization management (UM) processes, care management (CM) processes, EPSDT staff and health management program (including wellness and health coaching activities): Referrals from staff managing member cases, or who are made aware of members cases, are received by asthma DM staff electronically or verbally. When a member is referred interdepartmentally, the patient history and contacts are summarized and communicated to the disease management staff. Outreach is then conducted by the DM staff to perform the Pediatric Asthma Assessment. Results determine which stratification category to place the member. Program interventions ensue as determined by the stratification level.
5. **Practitioner/Provider referrals**: Electronic or telephonic referrals from providers may occur at any time. When a member is referred by a practitioner or provider as much information as possible about the patient's history and current status is gathered. Outreach is then conducted by the DM staff to perform the Pediatric Asthma Assessment. Results determine which stratification category to place the member. Program interventions ensue as determined by the stratification level.
6. **Member referrals**: A parent/guardian of a child with asthma may refer them into the asthma disease management program at any time. As much information as possible is gathered from the parent/guardian about the child's history and current status during the referral request. Outreach is then conducted by the DM staff to perform the Pediatric Asthma Assessment. Results determine which stratification category to place the member. Program interventions ensue as determined by the stratification level.

b. Patient education through distribution of educational materials –

Trusted will distribute an asthma disease management program welcome packet and educational materials to all members eligible for the program. The welcome packet contains the following information:

- What is asthma?
- Identifying asthma triggers and how to avoid them
- Explanation of Trusted's asthma disease management program, including use of our outreach center's programs
- How to contact DM program staff

- How to access their pediatrician/doctor for help
- Resources available in the community
- Asthma educational programs and resources at Trusted's Health and Wellness Outreach Center

c. Educational seminars and other activities at the Health and Wellness Outreach Center – Trusted's members will be notified of activities occurring at the Health and Wellness Outreach Center through distribution of the asthma disease management program welcome packet. Additionally, information will be shared via telephonic and face-to-face outreach encounters or when members call the enrollee service department.

d. Quarterly (telephonic) outreach to PCPs (by the Asthma disease manager) will be conducted to:

- Determine if member has an asthma care plan; monitor compliance with the plan
- Assess patient compliance with asthma plan from the PCP's perspective
- Assess barriers to care
- Coordinate PCP/specialist care as necessary
- Inform PCPs of their members that have been referred to Breathe DC or Impact DC programs

e. Trusted has contracted with Breathe DC – Service offerings include home assessments to identify and educate member regarding asthma triggers, suggestions regarding smoking cessation services, integrated pest/rodent management, and HEPA filter installation as needed. Additionally, Trusted's members will participate in the Breath DC summer asthma camp. During the camping experience, children are taught:

- How to identify their specific individual asthma triggers
- How to recognize the signs and symptoms of an impending asthmatic episode
- The importance and proper use of medications, spacers, and peak flow meters
- Breathing and relaxation exercises to help alleviate asthmatic symptoms
- How to communicate their illness more effectively with family members, peers, teachers, school nurses and doctors.

f. Trusted is in discussions with "Let's Breathe" – The Healthy Homes Intervention project regarding formulating a partnership to assist members with identification of asthma triggers, home visits to follow-up on instructions given by service provider, mold remediation and provision of FREE HEPA filters.

g. Trusted is conducting a reassignment of members to pediatric panels and will develop a standard operating procedure (SOP) to address the inefficiencies in the auto-assignment process.

h. Trusted is hiring a licensed clinician with experience in asthma care to manage the newly developed Asthma Disease Management program.

i. Trusted will develop and distribute a pocket guide for physicians containing information on the Trusted formulary and the clinical guidelines for treatment of asthma. Additionally, a member of the Case Management team will accompany Provider Operations staff (monthly) to treating practitioner's offices to educate them regarding the Asthma PIP and Trusted's Asthma DM program.

j. Trusted's Asthma Case Manager will work collaboratively with the Customer Service, Utilization Review, and Outreach teams to identify and implement alternate contact methods for hard to reach members including: 1. Door to door outreach; 2. Participation in UM rounds and monitoring daily census; 3. "CRISP" (Chesapeake Regional Information System for our Patients – Maryland and DCs designated health information exchange for the electronic connection of healthcare providers across the nation) referrals; and 4. Use of customer service module "alternate number/address" field entries.

178. Describe statistically significant improvements generated by the MCO's clinical initiatives.

Outcomes information is being tabulated and will be provided upon award.

179. Provide beneficiary satisfaction measures that will be collected following the "go-live" date. Describe past efforts that the MCO has made to assess member satisfaction.

Quarterly, Trusted administers Member Satisfaction Surveys to evaluate member experience with Trusted providers and services. Following go-live and transition, Trusted will conduct a satisfaction survey focusing on enrollee services and Case Management initial assessments. ??

In addition, Trusted completes the National Committee for Quality Assurance (NCQA) required surveys. The survey tool and results will be reported to the Department no later than the 15th day of the second month following the end of the reporting period, to include any identified areas for improvement and planned action items.

Below is an example of past member satisfaction survey results and analysis.

CAHPS 5.0H - Adults					
Getting Care Quickly Composite (Usually, Always)	**2014 Rate**	**2015 Rate**	**Difference**	**Question**	**NCQA %tile**
Getting care as soon as needed	68%	69.90%	(+) 1.9%	Q4	<25th
Getting appointment as soon as needed	69%	64.00%	(-) 5%	Q6	<25th
Getting Needed Care Composite (Usually, Always)	**2014 Rate**	**2015 Rate**	**Difference**	**Question**	
How often was it easy to get the care, tests, or treatment you needed?	73%	77.80%	(+) 4.8%	Q14	25th
How often did you get an appointment to see a specialist as soon as you needed?	91%	90.00%	(-) 1%	Q17	75th
CAHPS 5.0H - Child					
Getting Needed Care Composite (Usually, Always)	**2014 Rate**	**2015 Rate**	**Difference**	**Question**	
How often was it easy to get the care, tests, or treatment your child needed?	77%	79.80%	(+) 2.8%	Q14	25th
Easy to get appointment for child with specialist	64%	51.20%	(-) 12.8%	Q28	<25th
Getting Care Quickly Composite (Usually, Always)	**2015 Rate**	**2015 Rate**	**Difference**	**Question**	
Getting care for child as soon as needed	79%	77.30%	(-) 2.3%	Q4	25th
Getting appointment for child as soon as needed	74%	72.30%	(-) 2.3%	Q6	<25th

Analysis: Performance on the two components of the "Getting Care Quickly" and "Getting Needed Care" composites of the Adult and Child surveys showed both rate increases and decreases from 2014 to 2015. As it relates to member access and availability of practitioners within Trusted's networks, the percentage of respondents who indicated that they received care as soon as they thought they needed when they needed it right away decreased from 69% to 64% (-5%) (Adult), compared to 77.30% (Child) a slightly lower rate than in 2014 in which the rating was 79% (-2.3%). Similarly the percentage of respondents who indicated that they received were able to easily receive an appointment with a specialist decreased from 91% to 90% (Adult), compared to the same category on the child survey in which Trusted's rating decreased significantly (-12.8) from 2014 to 2015. Only 51.2% of child respondents felt it was usually or always easy to get an appointment with a specialists as opposed to 64% in 2014.

Trusted has performed a comparative analysis of the satisfaction survey ratings for the child survey question Q28, "Easy to get appointment for child with specialist and the outcomes of the appointment availability survey performed which indicated that there was an issue with securing timely appointments with child neurologists. It is our determination that there may be a direct correlation between the outcomes of these surveys.

Interventions: Trusted developed a CAHPS corrective action plan to address all areas that fell below the 75th percentile for NCQA per the contract with the Department of Healthcare Finance. Access to appropriate care as quickly as needed will be monitored closely throughout CY 2015 and status updates will be provided to the QEC.

180. Describe the MCO's practice of profiling the quality of care delivered by network PCPs and any other acute care providers (e.g. high volume specialists, hospitals), including the methodology for determining which and how many providers will be profiled.

As part of the annual CQI evaluation, Trusted will assess the quality of care provided by network providers. Sampling methodology will target the top 10% of high volume providers per measure, per region.

Trusted will utilize Chronic Care and Preventative Quality Indicators including:

Diabetes Mellitus	• HbA1c Management: Percentage of diabetic patients with one or more HbA1c tests. Lipid Measurement: Percentage of diabetic patients with at least one low-density lipoprotein (LDL) cholesterol test. • Urine Protein Testing: Percentage of diabetic patients with at least one test for microalbumin during the measurement year; or who had evidence of medical attention for existing nephropathy (diagnosis of nephropathy or documentation of microalbuminuria or albuminuria). • Eye Exam: Percentage of diabetic patients who received a dilated eye exam or seven standard stereoscopic photos with interpretation by an optometrist or ophthalmologist or imaging validated to match diagnosis from these photos during the reporting year, or during the prior year if the patient is at low risk

		for retinopathy. A patient is considered low risk if the following criterion is met: has no evidence of retinopathy in the prior year. (This measure is adapted for claims data measurement.)
Heart Failure	•	Left Ventricular Ejection Fraction Testing: Percentage of patients hospitalized with a principal diagnosis of heart failure during the current year who had left ventricular ejection fraction testing during the current year.
Coronary Artery Disease	•	Lipid Profile: Percentage of coronary artery disease patients receiving at least one lipid profile during the reporting year.
Preventive Care	•	Breast Cancer Screening: Percentage of female beneficiaries age 50-69 who had a mammogram during the measurement year or the year prior to the measurement year.

181. Describe how the MCO will monitor and reinforce PCP compliance with Medicaid program requirements (e.g., 24 hour coverage, appointment scheduling standards) as outlined in the MCO contract.

The Trusted Compliance Department, in conjunction with Provider Services will monitor and reinforce Medicaid Program Requirements. All Trusted primary care practitioners, specialty care practitioners and behavioral health practitioners must adhere to contract requirements for appointment accessibility and communication. Trusted will conduct Secret-Shopper Site Visits and quarterly audits to assure compliance with contract requirements. If a provider is deemed out of compliance, they will be put on a Corrective Action Plan.

Access to Medical Care:

PCP Physician Coverage	24 hours a day
Emergency care (life threatening)	Immediately at the nearest facility
Urgent Care or Sick Care appointments with PCP	Within 24 hours of request
Urgent Care with a Specialist	Within 48 hours
Routine Appointments (including Health Check and IDEA appointments)	Within 30 days of request
Initial Appointments for pregnant women or persons needing family Planning	Within 10 days of request
Routine Physical Examinations	Within 30 days of request
Waiting Time in Practitioners office	Not to exceed 45 minutes

Use of free interpreter services	As needed during all appointments

Access to Behavioral Health Care

Behavioral Health Emergency care (life threatening)	Immediately at the nearest facility
Behavioral Health Telephone Crisis Triage	Within 15 minutes over the telephone
Psychiatric Intervention or face-to-face Assessment	Within 90 minutes of completion of telephone assessment, when needed. Available on a 24 hours basis, 7 days a week
Treatment for a non-life threatening emergency	Treated as emergency care
Urgent Care with Outpatient Behavioral Health Program and Doctor	Within 48 hours of request
Routine Behavioral Health Appointments	Within 10 days of request
Waiting Time in Practitioner's office	Not to exceed 45 minutes
Use of free interpreter services	As needed during all appointments

Access to After-Hours Care:

Trusted requires that all network practitioners have coverage for after-hours care and to have the appropriate member instructions on any practitioner telephone service available after hours. All practitioners must provide the following instructions:

Emergency Care	Call 911 and/or go to the nearest facility immediately
Urgent non-medical emergency where care is needed before business hours	Provide a telephone number for the covering practitioner
Urgent non-medical emergency where care is not needed until business hours	Advise member to call during business hours

182. Describe how the MCO will review complaints and grievances, PCP changes requests, out-of-network referrals, emergency room usage, or other data to identify access barriers for members with special needs. Please confirm that this data will be analyzed separately for TANF members.

Complaint, Grievance and Fair Hearings: Trusted's electronic Appeals & Grievances module automates case tracking, routing processes, and reporting by storing and categorizing all

correspondence and delivering the work to the appropriate resource, using Trusted's defined rules. AWD acts as an integrated and centralized repository to process all transactions regardless of type (email, letter, fax or electronic documents). AWD allows Trusted's staff the ability to categorize each transaction either as a grievance, appeal or complaint. Even PCP changes, based on defined rules, can be tracked and analyzed on a monthly basis or more frequent if needed. The issue is then routed to the correct team member for resolution. The system was designed to include triggers and escalation points to ensure work is processed based on Trusted's policies and procedures and meets regulatory requirements. Attachments can be stored within issues, with demographic, claims, and authorization information retrieved from the claims system and passed along with the source documents. Reporting functionality include: aging information, current inventory, and number and type of issues by entity.

Information is available and will be monitored and analyzed based on the enrollment program (e.g. SSI, TANF, etc.) of the member as outlined above through Care Analyzer.

183. Describe how the MCO will use reports/ data from the subcontractor to ensure appropriate vendor oversight and beneficiary access/ satisfaction/ continuity of care.

Trusted has a robust and actively engaged provider and vendor monitoring program within its Compliance department. Each subcontracted vendor that utilizes membership data has a signed delegation agreement that outlines activities, reporting and ensures the vendor complies with the standards of the contract between Trusted and the applicable State and Federal agencies and NCQA. Providers have an obligation per their agreement with Trusted to submit encounter data.

Prior to execution of the delegated agreement, a Trusted representative conducts a pre-delegation review of the delegate to determine if the vendor's infrastructure can fully comply with Trusted's requirements. Once requirements are satisfactorily met, periodically throughout the year, the delegate reports to Trusted, claims, member complaints and any internal reports agreed upon during the initial engagement.

All vendors are required to submit accurate, complete, and timely information to Trusted. Trusted monitors this through a monthly reconciliation of encounters to claims, monitoring of encounter errors, and vendor reporting for predesignated performance indicators.

If a subcontracted vendor does not comply with the delegated agreement to submit encounter data timely and/or accurately, the vendor is placed on a corrective action plan. In addition, the vendor needs to submit a work plan to correct the issues, complete with target dates for resolution. Regular meetings are then scheduled to monitor progress. If the vendor continues to have compliance issues with submitting encounter data, monetary sanctions will be imposed.

Trusted's monthly monitoring process is more thorough than its competitors resulting in better accountability and performance.

Exhibit 28: Monthly Monitoring Process

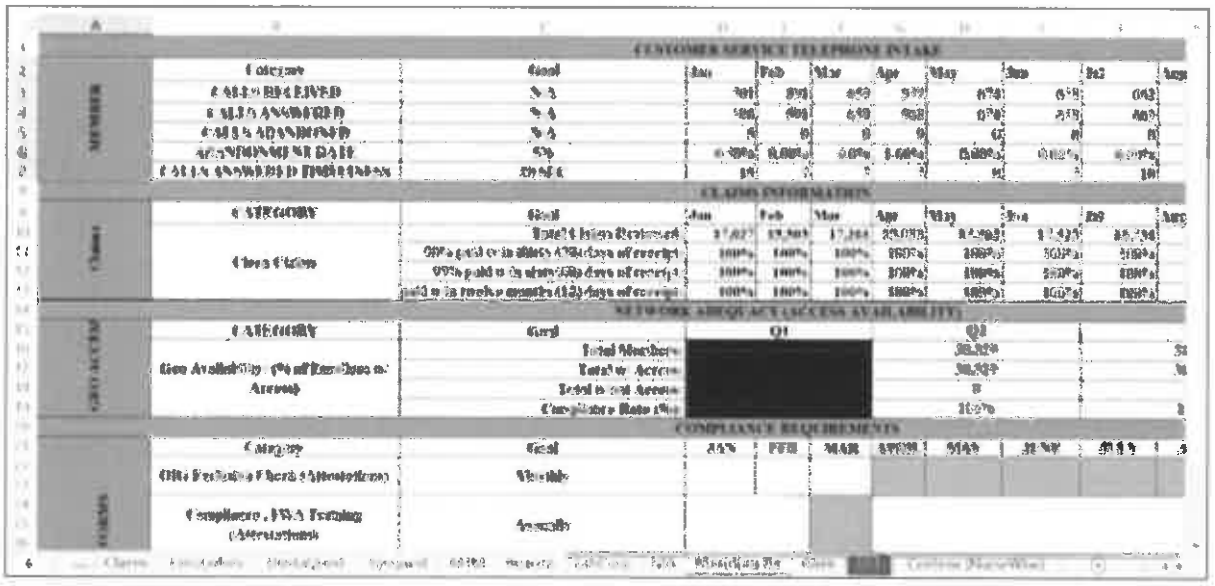
Compliance:	
Monthly Performance Monitoring	• Trusted gathers and evaluates contractual and quality metrics on all nine (9) vendors: • DentaQuest, EyeQuest, MTM (Transportation), Beacon, Alere, DST, Meridian Rx, Lab Corp and Centene.

Compliance:	
	• Trusted's Compliance Department may issue a corrective action plan (CAP) based on any deficiencies found during performance monitoring.
Internal Audits (Compliance Department)	• Trusted conducts audits of its vendors periodically. The types of audits range from Claims audits, Enrollment audits, Operational audits, etc.
OIG Exclusion List Checking	• The Credentialing Manager verifies OIG exclusion for all participating providers on a monthly basis. • The Compliance Department receives monthly attestation from vendors to verify OIG Exclusion List checks are completed for all of their employees who work on the Trusted contract.
Compliance and FWA Training	• The Compliance Department receives attestations from all vendors for annual Compliance and FWA training. • Trusted provides copies of our trainings and, if applicable, receives copies of each vendor's training.
Fraud, Waste and Abuse Reporting	• The Compliance Department receives monthly FWA reports from vendors. • The Compliance Department schedules bi–monthly calls with all vendors for FWA status.
Compliance Committee / Risk Committee	• Vendor performance and compliance are routinely discussed at these meetings.
Annual Vendor Assessment	• The Assessment Tool serves as an annual written monitoring and oversight document for all delegated vendors.

Exhibit 29: Vendor Oversight

Vendor Oversight:	
Vendor Oversight Committee	• The Vendor Oversight Committee is an Internal committee that meets once a month and consists of all business owners of Trusted's vendors.
Quarterly Oversight Meetings with Vendors	• Quarterly oversight meetings are scheduled with each of Trusted's vendors. Metrics, compliance, performance and open issues are discussed during the meeting.
Weekly Vendor Calls	• Weekly and bi-weekly ongoing calls are held with DST and DentaQuest.
Vendor Reporting	• All vendor reports are reviewed and distributed to the business owners of Trusted's vendors. • To further enhance the oversight process, plans are underway to develop an automated reporting distribution system (autosys jobs) in conjunction with IT.

Exhibit 30: Vendor Delegated Monitoring



184. Describe the mechanisms the MCO uses to determine and identify which members have/ have not received primary care services (e.g. what types of data and who is responsible for tracking) How frequently will the MCO run this data and how long after identification will the MCO reach out to PCPs and members.

The Outreach Department monitors EPSDT and adult preventative services to identify, educate, and assist members who are due or non-compliant for routine and preventive exams, immunizations, preventive dental and vision screenings/treatments, and age appropriate developmental assessments. THP collaborates with its contracted Primary Care Physicians (PCPs) to provide eligible members with an annual, age appropriate primary care services

Trusted maintains a tracking system to access claims data through the CareAnalyzer reporting tool. The tracking system is used to evaluate the effectiveness of the program and help direct outreach efforts. The data is collected from the encounter information submitted or confirmed by providers.

Trusted collects data on Adult Preventative Services such as Immunizations, Mammograms, Colonoscopies and Well Woman Exams. For EPSDT and Special Needs Clients, a report, based on member birthdate, will be generated to identify those members under the age of 21, who have not received EPSDT related services. Outreach efforts will be conducted to reasonably achieve up to a 100% compliance rate. The Outreach Team utilizes the following reports.

Encounter Data

- Monthly- Claims Data
- Monthly - Care Analyzer Reports
- Gaps in Care Reports

EPSDT Reports

- Monthly – Blood Lead Report
- Quarterly- EPSDT Outreach Report
- CMS 416 Annual Report

Member Outreach

The Outreach team aggressively conducts outreach to educate members and their caregivers

about routine and preventive exams, immunizations, benefits of preventive dental and vision screenings/treatments, and age appropriate developmental assessments to achieve optimal health and functioning. Members and caregivers are informed of where to access available services and how to obtain them. The outreach coordinator will also explain the process of how to receive scheduling assistance and necessary transportation

Outreach is conducted utilizing member mailings, such as member newsletters, reminder cards, and birthday cards. Small non-cash incentives are routinely offered for completion of preventative services. Phone calls are conducted using TeleVox system to inform member of non-compliant status, and to offer appointment assistance to those in need.

Provider Outreach

The EPSDT PCP outreach initiative identifies and notifies PCP's of non-compliant members, monthly. Trusted sends the noncompliant list to the PCP via server, encrypted email to identified office staff person. If server or email are unavailable, send to verified, confidential fax machine or through standard mail. Telephonic follow up with PCP is conducted within 24 hours to assure receipt of list.

The PCP office conducts outreach activities and documents any obstacles/barriers which may impact ability to contact. At the end of each month, the outreach coordinator receives PCP reviewed/completed list (via server, secure fax, or encrypted email) to allow for data collection of visits completed during the last week of the month.

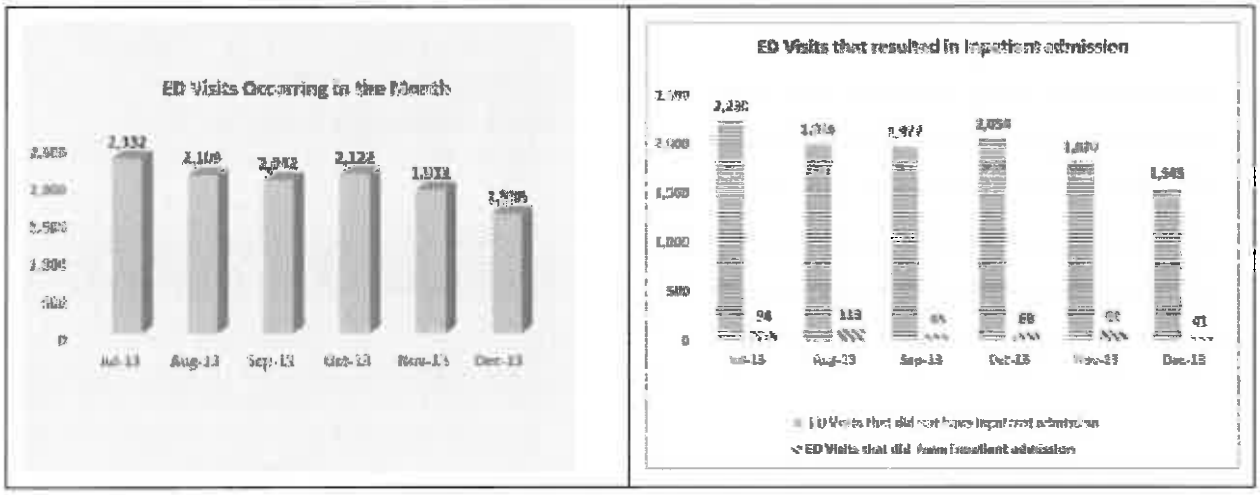
A similar process is followed for Adult Immunizations and Preventative Exams on an annual basis.

185. Describe any enhancements that will be made to the MCO's ongoing quality monitoring activities to ensure quality for Medicaid beneficiaries and compliance with MHT program requirements (e.g. emergency room utilization, 24-hour PCP coverage, focused clinical studies for West Virginia Medicaid)

Trusted is committed to providing programs that emphasize and encourage health, wellness, and prevention, with a goal of improved performance annually. Through the year, Trusted participates in NCQA, HEDIS, EQRO and other audits to measure our performance against district and federal regulations as well as NCQA requirements. Additionally, Trusted participates in the district-wide QI collaborative with an emphasis on pediatric asthma and perinatal outcomes. Gap-analysis and procedural enhancements are integral to Trusted's Ongoing QI Program.

Emergency Department Utilization - Trusted Health Plan experienced 12,102 enrollees present to the Emergency Department between the period of July 1, 2013 and December 31, 2013. Of the 12,102 visits 472 or 4% were admitted to the hospital. 96% of the ED visits did not require hospitalization. The trend during the 6 month period was a decline in the number of ED visits and a decline in the number of admissions to the hospital as a result of an emergency department visit.

Exhibit 31: Emergency Department Trends



Barriers: Trusted identified that 40% of its population had not engaged with a primary care provider. Additionally, members were generally unaware of their assigned primary care provider and the scope of benefits and services offered by Trusted.

Interventions: In CY 2014, Trusted implemented the following strategies in an effort to decrease low acuity ED utilization:

- Utilize CRISP list to identify members that frequent the ED also obtain correct address and contact information for the member from this list
- Deploy community outreach workers to locate and provide information to members regarding scope of benefits and primary care provider information
- Case managers located in the community at the Trusted Health and Wellness Outreach Center to assist members with accessing programs and services
- Care Coordinators utilize CRISP list to conduct outreach and care coordination with members on list
- ED utilizers aged 0-20 referred to EPSDT team for coordination of services
- Wellness events offered at Health and Wellness center to assist in connecting ED utilizers with preventative services needed

As a result of implementation of the aforementioned strategies, ***Trusted realized a 25% decrease in costs for low acuity non-emergent emergency department utilization and received best practice honors from the Medicaid Health Plans of America.*** Trusted will continue to monitor this portion of our population to ensure all members are aware of their benefit offerings and are engaged with their primary care provider and specialists as needed.

As described (in question 180) above, Trusted will use data and analytics to help identify the right care partners to assure adequate coverage per MHT Program Requirements. Trusted provides ongoing measurement and management to achieve optimal outcomes and identify new areas of improvement. Based on shared information and quality outcomes (PQRS and GPRO), Trusted will assess practice patterns and is ready to align with several locally based practices to participate in its VBP and other incentive programs.

LIST OF REQUESTED DOCUMENTS

1. Please provide a copy of each of the documents listed below at the time of application. If multiple documents requested below are contained within a single policy, procedure, or manual, you may submit the whole policy or manual and indicate where each of the components is located within it. All contracts, procedures, and reports must be in compliance with program requirements as outlined in the contract.

Request Documents	Trusted Document Location
a) MCO and Subcontractor organizational charts;	Appendix A
b) Hiring plan;	Appendix B
c) Certificate of Authority from the Office of the Insurance Commissioner and a copy of all materials submitted to the West Virginia Insurance Commissioner;	Appendix C
d) MCO Ownership and Control Disclosures;	Appendix C
e) Subcontractor monitoring plan;	Appendix D
f) Standard provider contracts and disclosure forms (PCPs, specialists (including dentists and behavioral health providers, hospitals, pharmacy);	Appendix I
g) Fraud and Abuse Compliance plan;	Appendix P
h) Employee False Claims training;	Appendix E
i) Advance Directive policies and procedures;	Appendix J
j) MCO/PBM/other benefit manager grievance and appeals policies and procedures;	Appendix J
k) Provider recruitment plan;	Appendix H
l) MCO/PBM/other benefit manager credentialing policies and procedures;	Appendix H
m) EOB sample forms;	Appendix J
n) Member/Provider Services Department toll-free contact phone numbers;	Appendix G

Request Documents	Trusted Document Location
o) Phone call transfer protocols and decisions trees;	Appendix J
p) Disenrollment Policies;	Appendix J
q) Policy on prohibitions of inappropriate physician incentives;	Appendix I
r) MCO policies on reimbursement for crisis stabilization services;	Appendix M
s) Medical and Pharmacy Prior Authorization policies, procedures, and a flow-charts;	Appendix N
t) Policies and procedures for authorizing 72h emergency prescription medication supply;	Appendix N
u) Sample case management plan;	Appendix N
v) Quality improvement plan;	Appendix O
w) Medicaid and commercial HEDIS reports from past two years	Appendix O

2. Please provide a copy of each of the documents listed below at a later time specified by BMS:

Request Documents	Trusted Document Location
a) MCO member handbooks for medical and pharmacy benefits;	**Upon Award**
b) MCO.com website content for WV Medicaid;	**Upon Award**
c) MCO marketing plan;	**Upon Award**
d) MCO grievance and appeals acknowledgement letters and resolution letters;	**Upon Award**
e) MCO/PBM adverse determination letters including Fair Hearing rights;	**Upon Award**
f) Mountain Health Trust Provider Manual (medical and pharmacy);	**Upon Award**
g) MCO Provider Directory;	**Upon Award**
h) Sample MCO letters notifying members of the PCP assignment;	**Upon Award**
i) Single MCO member ID card;	**Upon Award**
j) Pharmacy lock-in notification letter;	**Upon Award**
k) Schedule for provider training and webinars during implementation phase;	**Upon Award**
l) Grievance and appeals procedures including the contents and timeframes from notice of action, resolution of grievances and appeals, and how to access continuation benefits.	**Upon Award**

ATTACHMENT A:

WEST VIRGINIA BUREAU FOR MEDICAL SERVICES MEDICAID MCO SAMPLE ON-SITE REVIEW AGENDA

Potential MCOs will participate in an on-site review, approximately two-three days in duration, by BMS to assess the MCO's readiness to serve Medicaid members and ensure that operations and provider networks are consistent with application documentation prior to contracting. The following is a sample agenda. A final agenda will be developed by BMS after reviewing the application. MCOs should expect to discuss their responses and answer additional follow-up questions during the on-site review.

Site Review Agenda
Introductions
Organization, Staffing, and Management • Overview of corporate structure and oversight of WV program • Processes for coordinating work and sharing information among offices • Staffing levels and experience for each major function (for WV line ofbusiness)
Walk-thru of MCO
Enrollment and Member Services • Enrollment process and procedures for handling PCP assignment • Organization and training for call center staff • Coordination with Medicaid Administrator/Contract Liaison in WV • Reporting and information sharing
EPSDT and Outreach • Coordination with enrollment broker • Identification and services for members with special needs • Health promotion and education activities • Prenatal care and EPSDT initiatives, including tracking of appointments, follow-
Provider Network • Provider contracting update • Monitoring access and availability • Accountability and processes for credentialing
Claims Payment, MIS, and Reporting Capabilities • Timely payment standards and experience • Third party liability • Encounter data submission • Overview of information systems and capabilities

Site Review Agenda
Medical Management • Overview of utilization management program • Processing of referrals and pre-authorization requirements • Health risk assessment • Case management
Document Review
Concluding Meeting

ATTACHMENT B:

WEST VIRGINIA BUREAU FOR MEDICAL SERVICES PROVIDER NETWORK STANDARDS SFY16

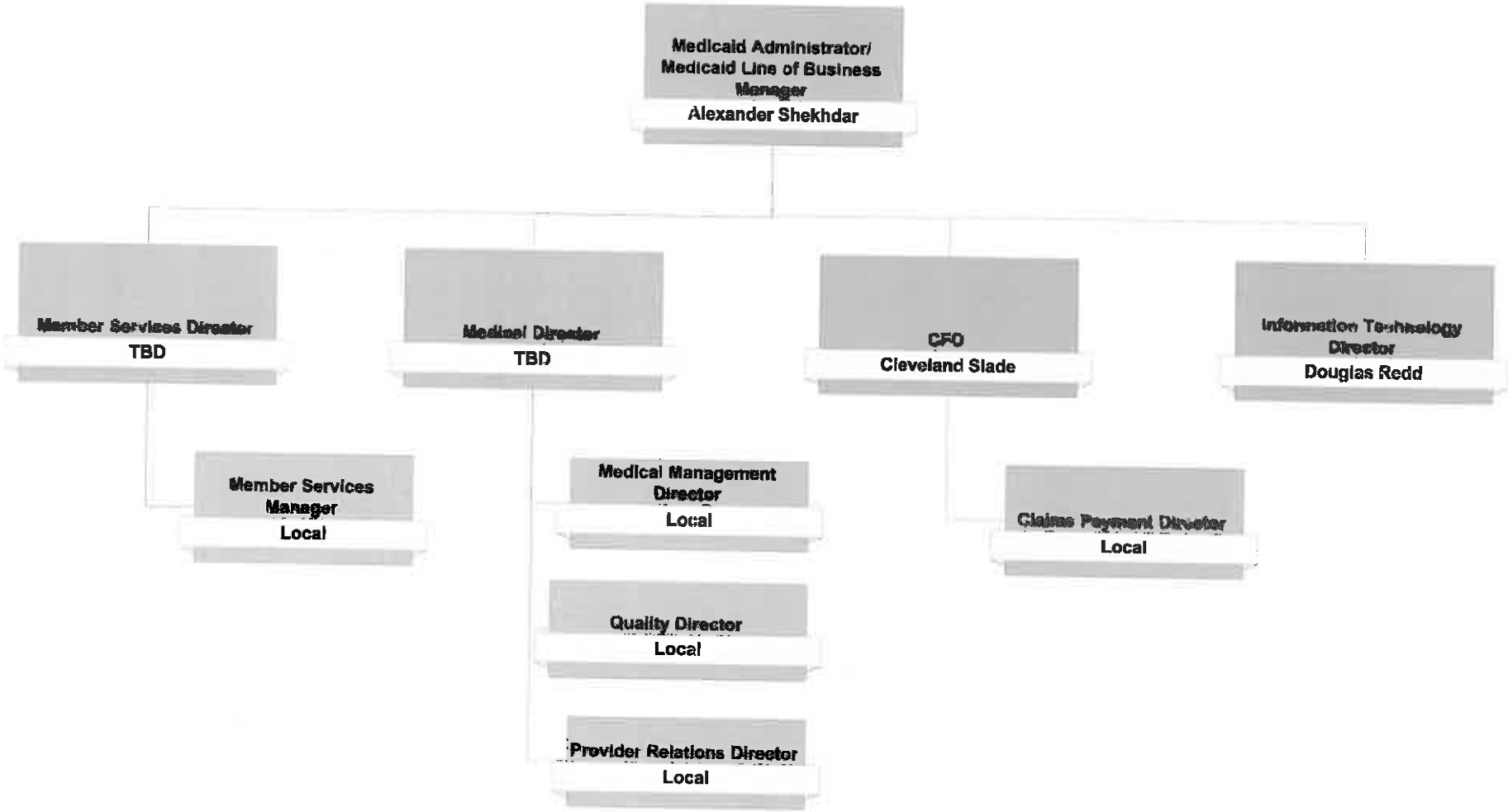
ATTACHMENT C:

WEST VIRGINIA BUREAU FOR MEDICAL SERVICES BEHAVIORAL HEALTH NETWORK STANDARDS SFY16

ATTACHMENT D:

WEST VIRGINIA BUREAU FOR MEDICAL SERVICES

MANAGED CARE PHARMACY NETWORK STANDARDS SFY16


Medicaid Administrator/ Medicaid Line of Business Manager
Alexander Shekhdar
Member Services Director
TBD
Member Services Manager
Local
Medical Director
TBD
Medical Management Director
Local
Quality Director
Local
Provider Relations Director
Local
CFO
Cleveland Slade
Claims Payment Director
Local
Information Technology Director
Douglas Redd

Resource Planning Worksheet

		STAFFING REQUIRED AS MEMBERSHIP GROWS			
[illegible]	QTY	[illegible]	[illegible]	[illegible]	[illegible]
Clinical Staff					
Care Managers (LPN/RN)	9	9.0	15.8	23.6	29.5
Care Coordinators	5	5.0	8.8	13.1	16.4
UR Nurses (RN)	4	4.0	7.0	10.5	13.1
Clinical Intake Coordinators	3	3.0	5.3	7.9	9.8
EPSDT Coordinators	3	3.0	5.3	7.9	9.8
Maternal Health/EPSDT Coordinator	1	1.0	1.8	2.6	3.3
Administrative Assistant	1	1.0	1.8	2.6	3.3
Special Needs Coordinator	3	3.0	5.3	7.9	9.8
G&A Coordinators	2	2.0	3.5	5.3	6.6
Community Health Worker	10	10.0	17.5	26.3	32.8
Clinical Administration	2	2.0	3.5	5.3	6.6
Utilization Management Coordinator	1	1.0	1.8	2.6	3.3
UM Director	1	1.0	1.0	2.0	2.0
Complaint, Grievance and DHS Fair Hearing Coordinator	1	1.0	1.0	2.0	2.0
EPSDT Coordinators	1	1.0	1.0	2.0	2.0
Associate Director of Outreach	1	1.0	1.0	2.0	2.0
Quality Management Coordinator	1	1.0	1.0	2.0	2.0
HEDIS Project Manager	1	1.0	1.0	2.0	2.0
Clinical Quality Manager	1	1.0	1.0	2.0	2.0
Sr. Director of Quality & Accreditation	1	1.0	1.0	2.0	2.0
Pharmacist	1	1.0	1.0	2.0	2.0
Director of Pharmacy	1	1.0	1.0	2.0	2.0
Sr. Director of Clinical Programs	1	1.0	1.0	2.0	2.0
Chief Medical and Quality Officer	1	1.0	1.0	1.0	1.0
[illegible]					
Member Service Representative	6	6.0	10.5	15.8	19.7
Claims Represenative	4	4.0	7.0	10.5	13.1
Enrollment Services Representative	2	2.0	3.5	5.3	6.6
Provider Relations Representative	5	5.0	8.8	13.1	16.4
Credentialing Coordinator	1	1.0	1.0	1.5	1.9
Provider Services Manager	1	1.0	1.0	2.0	2.0
Credentialing Manager	1	1.0	1.0	2.0	2.0
Operations Manager	1	1.0	1.0	2.0	2.0
Member Services Manager	1	1.0	1.8	2.6	3.3
Enrollment Supervisor	1	1.0	1.8	2.6	3.3
Claims/ Operations Supervisor	1	1.0	1.8	2.6	3.3
Claims Administrator	1	1.0	1.0	2.0	2.0
Government Liaison	1	1.0	1.0	1.0	1.0
Director of Operations	1	1.0	1.0	2.0	2.0
VP of Provider Relations	1	1.0	1.0	1.0	1.0
Chief Operations Officer	1	1.0	1.0	1.0	1.0

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[redacted]					
Compliance Investigator	1	1.0	1.8	2.6	3.3
Compliance Auditor	1	1.0	1.8	2.6	3.3
Compliance Officer	1	1.0	1.0	1.0	1.0
Contract Compliance Officer	1	1.0	1.0	2.0	2.0
Human Resources Manager	1	1.0	1.0	2.0	2.0
General Counsel	1	1.0	1.0	1.0	1.0
[redacted]					
SQL Data Analyst	1	1.0	1.8	2.6	3.3
Health Informatic Manager	1	1.0	1.0	2.0	2.0
Chief Information Officer	1	1.0	1.0	1.0	1.0
[redacted]					
Staff Accountant	1	1.0	1.0	2.0	2.0
Controller	1	1.0	1.0	2.0	2.0
Chief Financial Officer	1	1.0	1.0	1.0	1.0
[redacted]					
Corporate Director of Development	1	1.0	1.0	1.0	1.0
Chief Executive Officer	1	1.0	1.0	1.0	1.0
TOTAL EMPLOYEE COUNT	99	99	149	229	274
INCREMENTAL STAFFING (CONSULTANTS)					

Assumes full time to equal 40 hours/week of productive effort

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EFFECTIVE: November 2014 **Exempt** X

POSITION TITLE: Medicaid Line of Business Manager and Administrator (Contract Liaison)

REPORT TO: Chairman

DEPARTMENT: Executive

LOCATION: Charleston, WV

POSITION OVERVIEW

The Medicaid Administrator is responsible for the West Virginia Service Line and provides overall direction for all activities related to administration, personnel, information systems, office management and safety. The administrator is responsible for development and implementation of annual budgets, policies and goals in each of these areas. The administrator works closely with all members of the management team and others to ensure that his or her responsibilities are effectively and consistently discharged.

POSITION DUTIES AND RESPONSIBILITIES

- Develops consistent and fair personnel policies that comply with all federal and state regulations and that reflect management philosophy and culture.
- Develops an ongoing training program for all areas that ensures we remain a "learning organization" and that addresses our critical technical, supervision and management training needs.
- Works with the information systems manager to develop and implement an information systems program that ensures use of appropriate state-of-the-art information systems technology in all areas.
- Develops safety policies and program with the safety program manager. This program must comply with all federal and state regulations and be consistently implemented throughout. The safety program must be closely coordinated with our physical plant operations to ensure the elimination of safety hazards and compliance with OSHA regulations.
- Develops office policies and supervises their implementation. Responsible for ensuring a quiet and productive office work environment. Ensures that all



office personnel (e.g., receptionist) provide superior, customer-oriented responses to all inquiries.

- Negotiates and maintains all corporate insurance policies.
- Compiles and issues payroll on a biweekly basis. Administers all employee benefits programs. Maintains and updates employee files.
- Establishes a library of literature relating to personnel policies and regulations, safety program and regulations, training materials, and information systems manuals and procedures.
- Develops and monitors annual budgets in conjunction with the controller.
- Strives to improve efficiency and reduce costs in those areas that report to him or her.
- Attends weekly staff meeting and monthly management team meetings.

QUALIFICATIONS

- Master's degree in Healthcare/ Management/ Finance/ Legal
- Minimum experience of 5+ years administration/ Project Management/ Human Resources in an MCO environment

ALEXANDER SHEKHDAR – HEALTHCHOICES PROGRAM MANAGER



SPECIALITY:

- Healthcare Law
- Business Development

YEARS OF EXPERIENCE: 18

EDUCATION:

- JD, Health Law, Seton Hall University School of Law, 2002
- Master's Degree, Health Policy, Johns Hopkins University Bloomberg School of Public Health, 1998
- BA, Public Health, Johns Hopkins University, 1996

AWARDS:

Oxford Health Plans Employee of the Quarter/Stock Star Winner

SUMMARY:

Alexander Shekhdar is a strategic business consultant, specializing in Healthcare Law, and Public Health. In his extensive career, he has held responsibilities of developing new State business opportunities, Medicaid expansion, and implementation of government health programs.

EXPERIENCE:

TRUSTED HEALTH PLAN, DC -Business Development Consultant (August 2015 – Present)

- Worked with mid-size Medicaid managed care organization (32K members, $130M annual revenue) on strategic market entry into adjacent and new geographies, as well as product diversification (e.g. products targeting children and young adults with special needs). Performed market research and product assessments.
- Executed Letters of Intent (LOIs) in support of new network development and negotiated provider contracts with health systems and Federally Qualified Health Centers (FQHCs).
- Liaised with Commonwealth of Pennsylvania Department of Human Services Office of Medical Assistance.

MAGELLAN HEALTH SERVICES- Corporate Vice President/ Strategic Business Development (09/01/2011-11/01/2014)

- Responsible for developing new State business opportunities and increasing and expanding Magellan's existing business footprint enterprise-wide in the Mid-Atlantic region, especially as related to behavioral health administrative service organization business, Medicaid managed care, and Section 2703 health homes.
- Worked with business units on evaluating State LOIs related to dual eligible demonstrations. Supported the business unit sales teams in crafting, influencing, and responding to RFIs and RFPS, customer presentations, and collateral materials. Assisted in the development of pharmacy solutions Medicaid managed care sales strategy.
- Provided sales development of potential Medicaid managed care plan PBM business. Worked with business operations to identify and fulfill requirements relating to new product platforms (e.g. health homes, MA-PD SNPs).
- Collaborated with program innovative staff on product development related to intellectual/developmental disability (ID/DD) products and potential State-based pilots.
- Developed and maintained external relationships with various state government decision makers (e.g. Secretary of HHS, Medicaid Director). Directed Federal and State consultants and lobbyists in their support of business

development. Regular attendance at State medical assistance meetings and health exchange stakeholder meetings.

- Provided written testimony and input to State solicitations regarding behavioral health integration, Medicaid expansion, etc. Corporate liaison to multiple State DHS/DOI. Analyzed business impact of Medicaid 1115 waiver, expansion activities, etc. in advancement of business interests.

MEDCO HEALTH SOLUTIONS-Healthcare Reform Business Development, (03/01/2010-08-01-2011)

- Core executive team of health care business opportunity and strategy workgroup with responsibility for Medicaid, health insurance exchanges, and accountable care organizations. The team served as a business accelerator, coordinating with existing business owners and core Medco processes to architect solutions that maximize business opportunities and mitigate risks.
- Conducted corporate business assessments and coordinated account teams to capitalize on immediate business opportunities (e.g. high risk pools, early retiree reinsurance program.) Served as thought leader and subject matter expert on The Accountable Care Act (ACA). Analyzed current and emerging trends in health policy, federal and state budgets, and economics and briefed business leaders on the impact of those trends.
- Provided regulatory responses to multiple HHS/CMS solicitations for proposed and interim rules.

LIBERTY MEDICAL SUPPLY, INC. - Director of Business Development (09/01/2008-08/01/2011)

- Responsible for all aspects associated with determination, development, and implementation of strategies involved in growing Medco corporate subsidiary (Liberty Medical Supply).
- Served as member of senior management team and contribute significantly to the overall and strategic direction of the business from a sales and business development standpoint. Worked with internal business units to outline 3-yr. strategic growth imperatives and coordinated with Finance to develop financial models to evaluate these imperatives.
- Managed investigation of Medicaid market opportunities and the design of pilot projects including the development of core business processes and marketing materials. Spearheaded Company's development of its Competitive Bidding strategy (initially implicating over $600M in revenue across the enterprise) and managed outside consultants on the development of background materials and bid adjudication model.
- Led project management team development of CMS bid form process flows and checklist for bid formulation and assembly. Liaison to Medco Federal and State Government Affairs on health policy developments impacting lines of business.

RETIREE SOLUTIONS, Senior Director of Market Development (01/01/2007-09/01/2008)

- Responsible for analyzing developments in the Medicare marketplace and advising the Medicare book of business on potential business opportunities and risks impacting one-quarter of Medco's overall organizational revenue.
- Served as subject matter expertise on senior/Medicare policy and business strategy for Business Development leadership and senior leadership of internal business units (e.g. Retiree Solutions, Key Accounts, and National Accounts).
- Provided input into development of broader senior product portfolio including potential partnerships on MA-PFFS, MA SNPs, etc. Conducted research on Medicare regulatory environment and profiled business marketplace for senior leadership, as well as Retiree Solutions finance and clinical affairs staff. Drafted memorandum outlining potential business opportunities.

Created product fact sheets, white papers, and training modules for account teams. Coordinated with Medco Federal Affairs on policy and regulatory issues. Managed trade association relationships. Drafted and delivered industry conference presentations.

PHARMACEUTICAL RESEARCH AND MANUFACTURERS OF AMERICA, Director of Public Programs (06/01/2004-12/01/2006)

- Responsible for policy and legislative analysis, especially on issues related to the U.S. pharmaceutical industry and pharmaceutical policy. Portfolio includes issues related to the Medicare Part D, Medicaid, and other public programs.
- Analyzed regulations and guidance promulgated by the Centers for Medicare and Medicaid Services. Drafted comments related to the proposed rules for Title I of the Medicare Prescription Drug, Improvement, and Modernization Act.
- Drafted comments on the proposed designs for the Medicare Advantage PPO and Prescription Drug Plan regions. Provided talking points and analysis on a variety of issues for PhRMA Federal Affairs. Prepared background materials in anticipation of work by the Presidential Advisory Commission on Medicaid.
- Analyzed and summarized Medicaid budget options to be considered as alternatives during the Deficit Reduction Act. Evaluated State waiver programs. Assisted PhRMA Communications with media responses. Developed factual information for op-eds, letters to the editor and editorial boards that demonstrated the value of Part D.
- Coordinated with Policy staff to complete contracted projects on analyses of Part D.

OXFORD HEALTH PLANS, Government Programs Manager, Government Relations/Policy Development (01/01/2002-06/01/2004)

- Monitored and advised on Medicare statutory and regulatory issues advanced by the Centers for Medicare and Medicaid Services, as well as the Office of the Inspector General. Drafted legal opinions for the Director of Medicare Legal Affairs. Provided regulatory interpretation of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 for senior management.
- Responded to interim prescription drug card request-for-proposal and coordinated evaluation for the Company. Submitted comments within the context of proposed rulemaking. Consulted on Medicare legal issues and drafted legal memoranda. Conducted general legal research. Assessed Medicare disease management solicitations.
- In association with the Director of Regulatory Compliance, provided legal review of ancillary business marketing materials. Drafted language for corporate governance agreements and corporate resolutions for Oxford Benefit Management. Researched member complaints.
- Established Washington-based representation. Served as policy architect for Oxford's Medicare reform campaign. Reviewed Medicare legislation and evaluated potential business impact and operational issues for executive management and Chief Executive Officer. Lobbied members of Congress and Congressional staff. Provided briefings to Congressional staff on issues relating to federal health programs.
- Analyzed Congressional bills and public laws relating to private market health insurance issues. Drafted model legislative language. Proposed strategy for impacting National Coverage Decisions (NCDs) processes. Organized grassroots activities. Served as functionary at various political events. Assisted Oxford Chief Executive Officer with formulation and implementation of bioterrorism readiness plan. Acted as liaison between federal and state readiness agencies. Regularly updated Vice President of Government Programs on developments in health law and policy.

- Prepared conference presentations for Chief Executive Officer. Wrote newspaper opinion-editorial pieces fr Chief Executive Officer.
- Outlined operational implications of The Medicare Prescription Drug, Improvement, and Modernization Act of 2003, prepared business memorandum on implementation, and associated business opportunities. Created education and outreach documents (e.g. scripts and Q&A) on the Medicare Modernization Act for customer service and outreach teams. Assisted in launch of ancillary lines of business and expansions of Oxford's service areas.
- Acted as liaison between Oxford Benefits Management operational staff and Oxford Legal. Evaluated streamlining opportunities for Medicare dual eligible on a city and state level. Evaluated alternative government programs opportunities (e.g. Child Health Plus, Family Health Plus, student health insurance).

OXFORD HEALTH PLANS, Research Associate (02/01/2001-12/01/2001)

- Developed business and lobbying strategies in response to the Grijalva settlement. Drafted legal briefs. Investigated and analyzed business opportunities for alternative Medicare products (e.g. Medigap, Medicare SELECT, Medicare private fee-for-service). Crafted multiple policy memoranda for senior management.
- Taught Medicaid eligibility and benefits workshop.
- Conducted legal research and assisted in drafting language related to Oxford's Medicare demonstration project proposal.
- Wrote congressional testimony. Served as industry trade group liaison.

TRUSTED HEALTH PLAN	Effective Date: 07/01/2014	Policy #: HR-2014-003
Department – Human Resources Department	Reviewed Date:	Expiration Date:
Policies and Procedures	Revised Date: 2/12/2016	Page(s): 4

POLICY TITLE: New Hire/ Change/ Termination Policy and Procedure

Policy: The Company should maintain one consistent protocol for hiring practices that complies with legal and governmental requirements and as needed for general business staffing.

Purpose: To provide policies and procedures relative to hiring practices, position changes, and department transfers.

Scope: Applies to all hiring management and executives of Trusted Health Plan.

Responsibilities:

The CEO should be responsible for approval of all incoming hires, newly created company positions, and department transfers.

The Department Chief is responsible for all authorization of department related changes.

The CFO is responsible for authorization of all off cycle salary adjustments.

The HR Manager should be responsible for pre-screening, recruitment, interviews, background/ reference verification, and offers of employment. HR will work with the hiring manager to update an existing job description, if applicable. HR will also ensure job title consistency, companywide.

Hiring Supervisors/ Management/ Executives are responsible for obtaining authorizations from the CEO and Department Executive Officer, prior to discussing a hiring need with HR. The hiring manager is also responsible for communicating their schedule to HR, during the interview and selection process.

Procedure:

1.0 Hiring Procedure

1.1 The Human Resources Manager is the sole authorized personnel for recruiting, screening, and extending offers of employment within Trusted Health Plan. Should a hiring need arise in your department, please fill out a New Hire request form. This form is to be filled in completely, with the approval from the CEO and the department's Chief Executive. NO NEW HIRE REQUESTS WILL BE FILLED, WITHOUT AUTHORIZATION FROM BOTH THE CEO AND DEPARTMENT CHIEF EXECUTIVE OFFICER.

1.2 Upon completion of the New Hire Request form, hiring managers may bring their departmental staffing needs to the attention of HR. In addition to your New Hire Request form, HR should also be provided with a Job Description. This job description should be discussed in detail with HR and revised if needed, to accurately depict the core duties of the position to be filled. It is a best practice to keep all of your direct reports job descriptions updated and on hand, so not to delay the hiring process.

1.3 Upon discussion with HR, and an approved Job Description, the position will be posted externally within 2 business days.

1.4 If you have obtained a resume or have a referral you would like to be considered for the position, please provide the applicant's resume to HR or instruct them to apply to the position via the Trusted website or external posting for consideration. Please do not make implied expressions or promises of employment, even if internally referred, ALL applicants will be subject to the screening process mentioned above.

1.5 All applicants will be pre-screened and selected for in-person interviews at the professional discretion of the HR manager. Plan to communicate your schedule for interviewing with HR for the duration of the interview process.

1.6 Interviews will be conducted with department managers and executives. In addition, one EXTERNAL department's feedback will be considered in the selection process.

1.7 All terms of compensation packages and details, are to be communicated to the selected applicants solely by HR.

2.0 SALARY INCREASES

2.1 All salary increase requests should be reserved the designated review period, the end of the fiscal year.

2.2 Any off cycle salary adjustment requests, should be requested on the change form, and require approval of the department chief, Chief Executive Officer and Chief Financial Officer.

3.0 POSITION UPDATES OR CHANGES

2.1 All changes in status of employment, including department transfers, title changes, should be documented on the Change Request Form and authorized by the department Chief Executive. The Request Form should reflect the effective date, and a copy must be submitted to HR.

2.2 All position updates including title changes and salary adjustments, will be considered with industry standards, and current job description factored.

4.0 TERMINATIONS

4.1 Any employee who expresses the desire to provide their notice to leave the company, should be directed to HR. All documentation of a notice of separation, should be forwarded to HR by same day close of business that the notice is given.

4.2 If an employee is being terminated involuntarily, you should seek counsel with Human Resources and the department Chief Executive, to ensure the employee's performance issue/ reason for being terminated has been sufficiently documented, in compliance with the Employee Handbook. HR will consult with Legal, should there be any potential liability involved in the proposed termination.

4.3 A Change request form should be submitted to HR, to communicate the request for the termination. All terminations require approval of department chief at the counsel of HR.

4.4 Once directed to HR, a formal exit interview will be scheduled between HR and the departing employee. At this time feedback regarding the departing employees

experience at Trusted, appropriate resources and training, will be gauged and shared with the department for operational improvement as applicable.

4.5 Any remaining PTO will be paid out to the departing employee, COBRA eligible benefits, date of final paycheck, updated address and contact information will be discussed and obtained during the exit interview. If applicable, the last date of employment will be discussed and noted for payroll and documentation purposes.

4.6 Departing employees should be prepared to return all Trusted property, Data Watch access entry key to HR on the departing employees' final day.

APPROVED BY:

Human Resources Manager — Date: 2/12/16

Chief Executive Officer — Date: 2/12/16

Chief Financial Officer — Date: 2/12/16

Appendix C

Certificate of Authority

See Binder # 3

TRUSTED Health Plan
THP

2015 Trusted Health Plan Vendor Oversight Activity

Compliance:

- **Monthly Performance Monitoring.**
  - We gather and evaluate contractual and quality metrics on all nine (9) vendors: DentaQuest, EyeQuest, MTM, Beacon, Alere, DST, Meridian Rx, Lab Corp and Centene.
  - We issue corrective action plans (CAPs) based on any deficiencies found during performance monitoring.
- **Internal Audits (Compliance Department).**
  - We conduct audits of vendors periodically. The types of audits range from Claims audits, Enrollment audits, Operational audits, etc.
- **OIG Exclusion List Checking.**
  - Credentialing Manager verifies no OIG exclusion for all participating providers on a monthly basis.
  - Compliance receives monthly attestation from vendors to verify OIG Exclusion List checks for their employees who work on Trusted contract.
- **Compliance and FWA Training.**
  - Compliance receives attestations from all vendors for annual Compliance and FWA training.
  - We provide copies of our trainings and, if applicable, receive copies of each vendor's training.
- **Fraud, Waste and Abuse Reporting.**
  - Compliance receives monthly FWA reports from vendors.
  - Compliance has scheduled bi–monthly calls with all vendors for FWA status.
- **Compliance Committee / Risk Committee.**
  - Vendor performance and compliance routinely discussed at these meetings.
- **Annual Vendor Assessment.**
  - Serves as an annual monitoring and oversight tool for all delegated vendors.



Vendor Oversight:

- **Vendor Oversight Committee.**
  - Internal committee meets once a month and consists of all business owners of Trusted's vendors.
- **Quarterly Oversight Meetings with Vendors.**
  - Quarterly oversight meetings are scheduled with each of Trusted's vendors. Metrics, compliance, performance and open issues are discussed.
- **Weekly Vendor Calls.**
  - Weekly and bi-weekly ongoing calls with DST and DentaQuest.
- **Vendor Reporting.**
  - Review and distribution of all vendor reports.
  - Plans to develop automated reporting distribution system (autosys jobs) in conjunction with IT.

NIA Magellan

Utilization Review Summary for TRUSTED Health Plan
July 1, 2015 - September 30, 2015

TRUSTED Health Plan THP

UTILIZATION RESULTS

Radiology	Total Initial Requests	Certified	% of Total Certified	Clinical Non-Certified	% of Total Clinical Non-Certified	Administrative Non-Certified*	% of Total Admin Non-Cert	Inactivated by Ordering Provider**	% of Total Inactivated by Ordering Provider	Clinical Disapproval Rate***
Q1 2015	482	370	75.20%	105	21.34%	12	2.44%	5	1.02%	22.36%
Q2 2015	539	397	73.65%	124	23.01%	9	1.67%	9	1.67%	24.68%
Q3 2015	529	395	74.66%	108	20.42%	20	3.78%	5	0.96%	21.36

Cardiology	Total Initial Requests	Certified	% of Total Certified	Clinical Non-Certified	% of Total Clinical Non-Certified	Administrative Non-Certified*	% of Total Admin Non-Cert	Inactivated by Ordering Provider**	% of Total Inactivated by Ordering Provider	Clinical Disapproval Rate***
Q1 2015	100	75	75.00%	18	18.00%	6	6.00%	1	1.00%	18.00%
Q2 2015	96	72	75.00%	20	20.83%	4	4.17%	0	0.00%	20.83%
Q3 2015	149	103	69.10%	42	28.19%	4	2.68%	0	0.00%	28.19%

Combined Results	Total Initial Requests	Certified	% of Total Certified	Clinical Non-Certified	% of Total Clinical Non-Certified	Administrative Non-Certified*	% of Total Admin Non-Cert	Inactivated by Ordering Provider**	% of Total Inactivated by Ordering Provider	Clinical Disapproval Rate***
Q1 2015	582	445	75.17%	123	20.78%	18	3.04%	6	1.01%	21.79%
Q2 2015	635	469	73.86%	144	22.68%	13	2.05%	9	1.42%	24.09%
Q3 2015	678	498	73.60%	150	22.12%	24	3.54%	5	0.74%	22.86%

Definitions:
**Administrative Non-Certified* refers to requests that could not be certified due to administrative reasons such as failure to pre certify; lack of information; and benefit eligibility.
***Inactivated by Ordering Provider* refers to requests that were inactivated by the ordering provider during the UM review process.
****Clinical Yield* is a combination of Clinical Non-Certifications and Inactivated by Ordering Provider and is calculated to illustrate NIA's impact from our clinical interventions.

TOP DENIED PROCEDURES - RADIOLOGY

CPT Code	CPT Description	Total Clinical & Retrospective Non-Certifications	% of Total Clinical & Retrospective Non-Certifications
72148	MRI LUMBAR SPINE OR LOW BACK WITHOUT CONTRAST	21	18.92%
73720	MRI LEG OR LOWER EXTREMITY OTHER THAN JOINT	12	10.81%
70450	CT BRAIN, HEAD	10	9.01%
71250	CT CHEST, THORAX	9	8.11%
70551	MRI HEAD, BRAIN, BRAINSTEM WITHOUT CONTRAST	9	8.11%
77058	MRI BREAST WITHOUT AND/OR WITH CONTRAST MATERIAL(S);UNILATERAL	9	8.11%
72141	MRI CERVICAL SPINE OR NECK SPINE WITHOUT CONTRAST	8	7.21%
74150	CT ABDOMEN WITHOUT CONTRAST	7	6.31%
74176	CT ABD & PELVIS W/O CONTRAST	6	5.41%
72192	CT PELVIS WITHOUT CONTRAST	3	2.70%
70540	MRI ORBIT/FACE/NECK W/O DYE	2	1.80%
72131	CT LUMBAR SPINE, LOW BACK	2	1.80%
70544	MR ANGIOGRAPHY HEAD W/O DYE	2	1.80%
73221	MRI JOINT OF UPPER EXTREMITY	2	1.80%
75572	CT HEART	1	0.90%
73721	MRI JOINT OF LOWER EXTREMITY HIP OR KNEE OR ANKLE OR FOOT JOINT	1	0.90%
72128	CT THORACIC SPINE, UPPER BACK NO CONTRAST	1	0.90%
70547	MR ANGIOGRAPHY NECK W/O DYE	1	0.90%
73200	CT ARM OR UPPER EXTREMITY	1	0.90%
78813	PET IMAGING WHOLE BODY	1	0.90%
72196	MRI PELVIS	1	0.90%
S8032	LOW-DOSE COMPUTED TOMOGRAPHY FOR LUNG CANCER SCREENING	1	0.90%
71275	CT ANGIOGRAPHY CHEST W/CONTRAST/NONCONTRAST	1	0.90%
All Others		0	0.00%
TOTAL		111	100.00%

TOP DENIED PROCEDURES - CARDIOLOGY

CPT Code	CPT Description	Total Clinical & Retrospective Non-Certifications	% of Total Clinical & Retrospective Non-Certifications
93307	TTHRC R-T IMG 2D +-M-MODE REC COMPL	22	52.38%
78451	MYOCARDIAL PERFUSION IMAGING, TOMOGRAPHIC (SPECT), SINGLE STUDY	17	40.48%
93350	ECHO TTHRC R-T 2D +M-MODE COMPLETE REST&STRS	2	4.76%
93312	TEE R-T IMG 2D W/PRB IMG ACQUISJ I&R	1	2.38%
All Others		0	0.00%
TOTAL		42	100.00%

APPEALS

	Total Appeals Received	Total Overturned	% of Overturned	Total Upheld	% Upheld	Days From Receipt of Request to Notice
Q1 2015	2	2	100%	0	0%	10.5
Q2 2015	0	0	0	0	0%	n/a
Q3 2015	1	0	0	1	100%	8

UTILIZATION TIMELINESS

	Percent Standard Met	Total Standard Cases Met	Percent Standard Met	Total Retro Cases Processed	Total Retro Cases Met	Percent Retro Met	Total Expedited Cases Processed	Total Expedited Met	Percent Expedited Met	Overall Percent Met
Q1 2015	532	526	99%	1	1	100%	0	0	N/A	99%
Q2 2015	580	569	98%	0	0	n/a	1	1	100%	98%
Q3 2015	601	599	99%	1	1	100%	0	0	N/A	99%

Target for overall timeliness is 95%. NIA exceeded the target in Q3 2015.

TRUSTED HEALTH PLAN	Effective Date: 07/01/2013	Policy #: QM-2013-0006
Department- Quality Management	Reviewed Date:	Expiration Date:
Policies and Procedures	Revised Date:	Pages 3

POLICY TITLE: Delegation to Outside Organizations

PURPOSE: Trusted may delegate certain Quality Improvement activities to a contracted organization. However, Trusted retains ultimate accountability for all delegated services. The purpose of this document is to ensure that quality improvement activities, which Trusted delegates to outside organizations, are properly planned and monitored.

SCOPE: This policy document is applicable to all Medical Management and Quality Management staff, as well as delegated entities

DEFINITIONS:

1. **Delegation:** a formal process by which a managed care organization gives another entity the authority to perform certain functions on its behalf. Although a managed care organization may delegate the authority to perform a function, it cannot delegate the responsibility for ensuring that the function is performed properly.

PROCEDURE:

1. There must be a delegation agreement, signed by both parties, that describes:
   a. the activities that have been delegated;
   b. the responsibilities of both Trusted and the delegated entity;
   c. that the delegate will comply with standards of the contract between Trusted and the applicable state and federal agencies, the National Committee for Quality Assurance (NCQA), as well as requirements of Trusted;
   d. the types of documents and data that are to be reported to Trusted by the delegate and the frequency in which they are to be reported;
   e. the process by which Trusted will monitor and evaluate the delegate's performance;
   f. the remedies, including revocation of the delegation, available to Trusted in the event the delegate does not fulfill its obligations;
   g. Any mutually agreed upon sub-delegate arrangements, and the process by which the sub-delegate will be monitored;

2. Prior to execution of the delegation agreement involving the delegation of quality improvement functions, a Trusted representative(s) must conduct a pre-delegation review of

proposed delegate. A formal written evaluation will be sent to the delegate. If deficiencies are found, the evaluation will include a request for the delegate to respond in writing with a corrective action plan and target implementation date(s).

3. Based on the Trusted pre-delegation evaluation report and any applicable corrective action plan from the delegate, the Trusted Delegation Oversight Committee (DOC) will initially review and propose action to the Quality Executive Committee (QEC) regarding the delegation agreement proposal. Their recommendation may be to approve all or some proposed elements of delegation, to deny delegation entirely, or to pend decision until corrective action plan progress can be evaluated.

4. Delegation agreement, including those involving delegation of quality improvement functions, will not be executed by Trusted unless the delegation has been approved by the DOC and QEC and Trusted legal counsel or the chairperson of the Delegation Oversight Committee has reviewed the agreement.

5. At least annually, Trusted will conduct an audit of any quality improvement delegate to evaluate compliance with Trusted standards and the responsibilities outlined in the delegation arrangement. If the delegated entity is NCQA accredited, Trusted may choose to waive the annual evaluation but must continue oversight of delegate.

6. Trusted's annual evaluation of delegate will be reviewed by DOC for recommendations and approval. The DOC will seek assistance from the Quality Improvement/Utilization Management Committee when appropriate.

7. Trusted's annual evaluation of quality improvement delegates will be reviewed by QEC for recommendations and approval.

8. Prior to re-contracting with the entities to which quality improvement activities have been delegated, the Trusted contracting representative shall seek input from all involved departments.

9. A file will be maintained for each delegated QI arrangement.

TRUSTED HEALTH PLAN	Effective Date: 07/01/2013	Policy #: QM-2013-0006
Department- Quality Management	Reviewed Date:	Expiration Date:
Policies and Procedures	Revised Date:	Pages 3

Definitions: (if necessary)

Delegation: a formal process by which a managed care organization gives another entity the authority to perform certain functions on its behalf. Although a managed care organization may delegate the authority to perform a function, it cannot delegate the responsibility for ensuring that the function is performed properly.

Tracking Form



CQI_Delegated_Annual_Monitoring_Oversig

APPROVED BY:

Patricia R. Miles
Senior Director Quality and Accreditation

7/31/2014
Date

TRUSTED HEALTH PLAN	Effective Date: 7/1/2014	Policy #: CPE-2014-0013
Department - Compliance	Reviewed Date: 7/7/2014	Expiration Date: 9/30/2016
Policies and Procedures	Revised Date: 9/1/2014	Page(s): 4

Policy Title: Compliance Internal Monitoring Policy

Purpose:

To continuously evaluate compliance, rapidly detect potential violations, and establish and implement an effective system for routine monitoring and identification of compliance risks. This includes:

- Routine internal monitoring of compliance risk areas by business units
- Evaluation of overall effectiveness of the Compliance Program

Definitions:

1. **Monitoring** - Monitoring is an ongoing check and measurement of performance directed by management to ensure processes are working as intended. Although auditing techniques may be employed, monitoring is often less structured than auditing. Monitoring is typically performed by department staff and communicated to department management. Monitoring efforts are generally more frequent and closer to real time than audit activities.

Policy:

Trusted will develop and implement an appropriate monitoring process to evaluate compliance with applicable laws, regulations and policies, and rapidly detect potential issues, problems or violations. Trusted will provide proactive, targeted efforts to prevent, detect, and respond to fraud, waste, and abuse issues. Monitoring of first tier, downstream, and related entities will be conducted and may result in programmatic actions. The Compliance Committee is responsible for oversight of Trusted's monitoring efforts and will receive regular reports regarding performance, updates to systems, staffing, etc.

TRUSTED HEALTH PLAN	Effective Date: 7/1/2014	Policy #: CPE-2014-0013
Department - Compliance	Reviewed Date: 7/7/2014	Expiration Date: 9/30/2016
Policies and Procedures	Revised Date: 9/1/2014	Page(s): 4

Procedure:

1. **Internal Risk Assessment** – An effective monitoring program begins with an internal risk assessment. Trusted will conduct a formal baseline assessment of the organization's major compliance and fraud, waste, and abuse areas. Each operational area must be assessed for the types and levels of risks the area presents to the Medicaid program and to Trusted. Factors considered in determining the risks associated with each area include but are not limited to:
    - Size of department
    - Complexity of work
    - Amount of training that has taken place
    - Past compliance issues
    - Budget

    Risks identified by the risk assessment will be ranked to determine which risk areas will have the greatest impact on Trusted and Trusted will prioritize the monitoring plan accordingly. A comprehensive risk assessment will be completed at least once a year, or more often if necessary. There will be an ongoing review of potential risks of non-compliance and fraud, waste, and abuse.

2. **Performance Indicators** – Each department will identify appropriate performance benchmarks or indicators to assess compliance with applicable laws, regulations and company policies. Examples of possible performance indicators include process cycle time, timeliness and appropriateness of member notices, correctness of decisions, compliance of contracted entities, and so on. For processes that involve more than one department, performance indicators must be developed to measure each department's compliance with requirements for its portion of the process.
3. **Monitoring Method** – A suitable monitoring method must be implemented for each performance indicator. Examples of possible monitoring methods include conducing risk

assessments, data review, charts and graphs, spot checks, random sample reviews, staff interviews, and so on.

4. **Frequency** – Monitoring should be performed by all managers/supervisors/Compliance staff on an ongoing basis. One should monitor a performance indicator with a frequency appropriate to the nature of the process and relative risk it represents (e.g., monitoring efforts can be periodic spot checks or tests on a daily/weekly/ monthly basis).
5. **Follow-up and Corrective Action** – Any monitoring result indicative of a potential issue, problem or noncompliance must be adequately addressed. If necessary, the Department Manager should conduct a more thorough review to determine whether the monitoring result accurately reflects reality. Negative monitoring results may be reported to the Compliance Officer, based on the scope and severity of the issue. When there are severe monitoring results, the Compliance Officer and Department Manager will determine appropriate next steps, such as conducting a focused audit. Confirmed problems or cases of noncompliance must be remediated with appropriate corrective action.
6. **Monitoring Plan** – Each department should develop its internal Monitoring Plan detailing its performance indicators, monitoring methods and monitoring frequency. Department managers may seek input from the Compliance Committee or Compliance Officer.
7. **Reporting** – Monitoring activities are directed by and reported back to management as an ongoing feedback mechanism to demonstrate that key controls in a process are working effectively. If completed in relation to the Compliance Work Plan, formal communication should be made to the Compliance Officer and the Compliance Committee.

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TRUSTED Health Plan
THP

TRUSTED HEALTH PLAN	Effective Date: 7/1/2014	Policy #: CPE-2014-0013
Department - Compliance	Reviewed Date: 7/7/2014	Expiration Date: 9/30/2016
Policies and Procedures	Revised Date: 9/1/2014	Page(s): 4

APPROVED BY:

Compliance Officer — Date: 9/1/2014

General Counsel — Date: 9/1/14

CLAIMS PROCESSING SERVICES AGREEMENT

This CLAIMS PROCESSING SERVICES AGREEMENT between MERIDIANRX, LLC, a Michigan limited liability company ("MeridianRx") and TRUSTED HEALTH PLANS, INC., a District of Columbia corporation d/b/a Trusted Health Plan ("Trusted") is effective as of July 1, 2013 ("Effective Date").

Recitals

This Agreement is made with reference to the following facts and circumstances, all of which are true and are incorporated into the Agreement.

1. Trusted is a Medicaid Health Maintenance Organization duly licensed under the laws of the District of Columbia; and

2. MeridianRx provides prescription drug claims processing services to Health Maintenance Organizations and other entities that provide prescription drug benefits, and in connection therewith, has established networks of participating pharmacies and operates a system for the processing, fulfillment and payment of claims for prescription drugs and supplies furnished by such pharmacies; and

4. Trusted desires to engage MeridianRx to provide Claims Processing Services as provided in this Agreement; and

5. MeridianRx desires to perform such services for Trusted in connection with Trusted's Medicaid managed care plan, subject to the terms and conditions herein.

NOW THEREFORE, in consideration of the mutual promises and agreement herein contained, MeridianRx and Trusted hereby agree as follows:

ARTICLE 1 - Definitions

The parties hereby incorporate by reference all Definitions set forth below.

The following definitions shall apply throughout the "Agreement":

1.1 The term "Agreement" means this "Agreement," together with all schedules and other documents or materials attached to, and/or referenced in this "Agreement".

1.2 The term "Implementation Guide" means the written document attached to this "Agreement" as a Schedule, which contains terms, conditions, and provisions and other attributes of the "Plan".

1.3 The term "Business Days" means any day, Monday through Friday, not recognized as a United States Postal Holiday.

1.4 The term "Claims Payment Fund(s)" means monies which Trusted is obligated to pay over to MeridianRx for purposes of enabling MeridianRx to pay "Participating Pharmacies" and/or reimburse "Participants" for "Prescription Drugs" sold to "Participants".

1.5 The term "Trusted" generally refers to the party executing the Claims Processing Services Agreement and includes any listed Trusted Representative (as hereinafter defined) with respect to satisfaction of contractual and administrative rights and responsibilities under the "Agreement". Where Trusted is a "Plan Sponsor", Trusted will generally have primary responsibility for satisfaction of all monetary obligations required in this Agreement. Where Trusted is not the "Plan Sponsor", but acting as a Trusted Representative, an administrator and/or agent for the "Plan Sponsor", Trusted's execution and delivery of the Claims Processing Services Agreement includes a warranty that the Trusted Representative has requisite legal power and authority to bind the "Plan Sponsor" to the claims funding, payment and other "Agreement" obligations.

1.6 The term "Trusted Information" means the input data, files, and any information, in proper format and media, provided by Trusted for use in processing such data, and any data resulting from such processing and "Plan" description documents.

1.7 The term "Trusted Representative" generally refers to a third person or entity who has the right or obligation to perform services and communicate to MeridianRx for or on behalf of the Trusted and/or a "Plan Sponsor", such that MeridianRx may conclusively rely upon statements made and information received from the "Trusted Representative". For purposes of this "Agreement", the nature and/or relationship of the Trusted Representative is specified on the first page. Trusted Representative's responsibility for satisfying claim funding obligations and/or paying "Service Fees" to MeridianRx, if any, is specified on the first page of the "Agreement". The Trusted representative has no personal financial or other liability.

1.8 The term "Covered Employee" means the principal "Participants" whose employment or other affiliation with the "Plan Sponsor" entitles such employee and, if applicable, specified other third persons, to be "Participants" hereunder.

1.9 The term "Default" means a failure on the part of a party to perform as required under this "Agreement". A Trusted "Default" includes the acts or omissions set forth in Section 7 of this "Agreement".

1.10 The term "Fraudulent Claims" means claims fraudulently submitted to MeridianRx. The term "Invalid Claim" means a claim that is not a "Valid Claim".

1.11 The term "Late Fee(s)" means an amount of money equal to fifteen (15%) percent per annum, (or the highest legal rate permissible) applicable to all late, overdue and/or delinquent amounts of money payable and/or owed to MeridianRx under the terms of this "Agreement" which begins to run on the date payment is due. If a "Late Fee(s)" of fifteen (15%) percent per annum would result in a usurious, illegal and/or otherwise unenforceable monetary fee and/or is an amount in excess of amounts which are legally permissible in the relevant jurisdiction(s), the "Late Fee(s)" shall be equal to the highest legal rate (not to exceed fifteen (15%) percent per annum) which may be lawfully charged and paid within the jurisdiction(s) applicable to the Trusted whose payment(s) is/are late. "Late Fee(s)", at shall be billed monthly and/or at any time after a termination for purposes of reconciling and/or adjusting amounts of money which may be owing under the terms of this "Agreement".

1.12 The term "Liability Claims" means any and all claims, demands, actions, causes of action, debts, dues, suits, administrative or similar proceedings, governmental or similar investigation, licensure and/or other governmental regulatory proceedings, audits, arbitration proceedings, costs of repair, modification and/or correction, and all orders, judgments, awards, decisions, writs, remedies, and

other legal process, as well as monetary damages, assessments, fines, penalties, costs, interest, attorney fees, and any and every type and nature of claim whatsoever.

1.13 The term "Overpayment(s)" means an amount of money paid for a claim (1) in excess of correct amounts; (2) which is an "Invalid Claim"; and/or (3) which is improperly submitted and/or otherwise erroneous under the applicable "Plan".

1.14 The term "Participant(s)" means the person(s) who participate(s) in "Plans" and who is/are entitled to receive "Plan Benefits".

1.15 The term "Participating Pharmacies" or "Pharmacy" means those pharmacy(ies) participating in the network of licensed pharmacies in and throughout the United States and territories which participate in various prepaid and/or pharmacy reimbursement programs by providing specified "Prescription Drugs" and related services to "Participants" of prescription benefit programs established by "Plan Sponsors".

1.16 The term "Paying Agent" means MeridianRx acting in the capacity of a third-party agent on behalf of Trusted whose obligation is to pay claims with "Claims Payment Funds" provided by Trusted. Any obligation on MeridianRx's part to pay, however, is strictly contingent upon full compliance by Trusted with this "Agreement" and receipt of all necessary "Claims Payment Funds".

1.17 The terms "Pharmacy Benefit Plan" or "Plan(s)" means the various prepaid and/or prescription drug reimbursement plans administered by, through, or with Trusted. MeridianRx's specific obligations with respect to the "Plan" will generally be set forth in a written "Implementation Guide" from which information will be provided on computer line (or other instrumentalities of communication) by MeridianRx to "Participating Pharmacies".

1.18 The term "Plan Benefits" means the particular "Prescription Drugs" and related services specified and from time to time covered under the "Plan" which "Participating Pharmacies" may properly provide to "Participants" in order to receive payment for "Valid Claims".

1.19 The term "Plan Sponsor(s)" means the party with ultimate legal responsibility for "Plan" administration and/or satisfaction of all monetary obligations, including timely payment of "Claims Payment Fund(s)" and does not generally refer to a "Trusted Representative", Third-Party Administrator, agent, or others acting for or on behalf of a "Plan Sponsor".

1.20 The term "Prescription Drugs" means the "Prescription Drugs" and related service benefits available for proper sale to "Participants" under the terms of a prepaid and/or "Prescription Drug" reimbursement plan(s) or program(s).

1.21 The term "Program(s)" means those computer and related programs developed, implemented and/or used by MeridianRx for Trusted during the term of the "Agreement", including, but not limited to, data processing programs, specifications, applications, routines, sub-routines, procedural manuals, documentation, etc., relative to any data processing and/or claims payment, claims adjudication, or other services to be provided by MeridianRx to Trusted hereunder.

1.22 The terms "MeridianRx Service Fees" and/or "Service Fees" means the fees and charges described in the "Agreement Appendix A", in MeridianRx's Fees, Compensation and Remuneration Schedule, any "Late Fees", charges for services relative to termination as described

in the "Agreement," charges for customized reporting and any and all amounts of interest earned with respect to Trusted funds held by MeridianRx.

1.23 The term "Taxes" includes any and all federal, state and/or local taxes and/or similar charges, present or future, imposed by governmental agencies, entities and/or authorities arising from and/or relating to, directly or indirectly, any and all activities to or for the benefit of Trusted and/or any of its "Participants" within the scope of the "Agreement". Satisfaction for payment of taxes and similar charges is/are the sole and exclusive responsibility of Trusted, regardless of which party has legal responsibility for collecting, holding and/or paying such taxes.

1.24 The term "Terminated Participant" means a "Participant" whose participation in a "Plan" has terminated, and/or who is a "Participant" of a "Plan" which has terminated.

1.25 The term "Valid Claim" shall mean a claim properly submitted by a "Participating Pharmacy" and/or a "Participants" submitting a proper claim on his/her own behalf for payment reimbursement respecting sales of "Prescription Drugs" (which amounts shall not exceed the proper amount of the charge set forth in the Plant to a "Participants", which "Prescription Drugs" are within the scope of the "Plan Benefits", and where the claim submission by the "Participating Pharmacy" or "Participant" otherwise complies with the "Plan".

ARTICLE 2 – Responsibilities of MeridianRx

MeridianRx shall:

2.1 Establish, maintain, and disclose a network of "Participating Pharmacies" for use by "Plan Participants".

2.2 If applicable, issue identification cards for the benefit of "Participants". Unless otherwise specified, MeridianRx will provide Trusted with one (1) card to each new single "Participant", and two (2) cards per new "Participants" with eligible dependents under the terms of the "Plan"; upon MeridianRx's receipt of proper notification relating to updated "Participant" eligibility, MeridianRx will reissue and mail to Trusted the appropriate number of cards for the benefit of "Participants" with change in status, within five (5) "Business Days" from MeridianRx's actual receipt of such written notice.

2.3 Communicate various types of claims, eligibility, "Plan" and related information to and from Trusted, "Participating Pharmacies", and other authorized third persons and entities for purposes of "Plan" administration, exercising rights, and/or enforcing obligations relative to the Plan, this "Agreement", and/or related matters.

2.4 Receive and review requests for payment of claims to compute proper amounts of "Claims Payment Funds"; to pay, as Trusted's "Paying Agent", only, "Valid Claims" with "Claims Payment Funds"; to provide direct reimbursement as Trusted's "Paying Agent" only, to "Participants" with "Claims Payment Funds" for non-participating pharmacy claims, but only to the extent permitted in the "Benefit Implementation Guide", less the allowable co-payment amount specified by the "Plan"; to provide "Participants", upon request, with necessary forms for processing such "Claims".

2.5 Subject to receipt of the required amount of "Claims Payment Funds", to process payment of claims as scheduled.

2.6 Provide any or all of the following standard bi-weekly and monthly reports upon Trusted's request, at no additional charge:

Bi-Weekly Reports

Claims Funding

Monthly Reports

Non Formulary Report
Statistics Report
Drug Ranking Report
Payment Summary

Immediate Access to Online Reporting
MeridianRx Dashboard
Custom reporting suite

2.7 Maintain at its offices or other locations, records which are customarily retained by MeridianRx relative to transactions between MeridianRx and Trusted, in the format and media in which such records are normally maintained, for the greater of three (3) years, or the amount of time required by law.

ARTICLE 3
Responsibilities of Trusted

3.1 Trusted shall ensure MeridianRx receives full payment as set forth in this Agreement for all of the following:

3.1.1 "Claims Payment Funds" must be received by MeridianRx within three (3) business days after MeridianRx transmits an invoice to Trusted, or "Late Fees" (as defined herein) may be assessed. In the event MeridianRx does not receive "Claims Payment Funds" from Trusted within seven (7) business days of invoice, MeridianRx may immediately cease to perform its obligations under this contract, including the cessation of claims processing. Any such cessation of performance shall constitute a suspension of MeridianRx's performance obligations of this "Agreement," and shall not constitute a default by MeridianRx or a termination of this "Agreement." MeridianRx shall invoice Trusted for "Claims Payment Funds" twice each month;

3.1.2 "Service Fees" which must be received in full by MeridianRx within three (3) business days after MeridianRx transmits an invoice to Trusted, or "Late Fees" (as defined herein) may be assessed. MeridianRx shall invoice Trusted for "Service Fees" once each month;

3.1.3 "Taxes" which must be paid in full by Trusted on or before the date when due; Trusted is also responsible for payment of any tax related penalties, fees, and interest where "Taxes" are not timely or otherwise properly paid when due; and

3.1.4 "Late Fees" where Trusted fails to timely satisfy all its monetary obligations. "Late Fees" will become due and payable beginning the day following the date a monetary obligation was due. Payment received by MeridianRx shall be applied to satisfy "Late Fees" first, and the balance shall be applied to satisfy the underlying obligation.

3.2 Trusted understands and acknowledges its duty to cooperate with MeridianRx to allow MeridianRx to satisfy its obligations to Trusted under this Agreement.

3.2.1 Trusted is responsible for the timely provision of all "Trusted Information" to MeridianRx the agreed manner, media and format;

3.2.2 Trusted has exclusive responsibility for the accuracy and completeness of all "Trusted Information" provided to MeridianRx;

3.2.3 Trusted is required to provide such other and further data and/or information as may be reasonably requested by MeridianRx to enable MeridianRx to satisfy its various legal and contractual obligations under the terms of this "Agreement";

3.2.4 Trusted has sole and exclusive responsibility to communicate all required eligibility and coverage information immediately upon request by MeridianRx and to communicate updates and changes to MeridianRx as soon as is practicable after Trusted becomes (or reasonably should have become) aware of changes in eligibility and/or coverage; this obligation is very important as MeridianRx shall have three (3) "Business Days" from its receipt of written notice to effectuate the change, and Trusted shall be and remain solely responsible for any and all monetary obligations that arise due to Trusted's failure to timely transmit eligibility information, or that arise within the three (3) "Business Days";

3.2.5 "Liability Claims" resulting from or relating to any Trusted use, disclosure or dissemination of non-MeridianRx created or approved (in writing) documentation and/or other Trusted or third-party written information or materials relating to any and all pharmacy benefits which Trusted provides to, or for the benefit of its "Participants" is/are Trusted's responsibility;

3.2.6 Trusted is responsible for creating, maintaining and securing in accordance with all applicable law all necessary and/or required records, supporting materials, and copies of all data, information, and other materials sufficient to comply with all governmental requirements and to enable MeridianRx to regenerate such information in data processed form; and

3.2.7 Trusted is responsible for promptly reviewing MeridianRx generated reports and must promptly communicate any and all easily detectable errors to MeridianRx as soon as is practicable after Trusted's receipt of the reports, but in no event later than thirty (30) days after Trusted's receipt of the report. If no written notification of errors is received by MeridianRx within such thirty (30) day time period, the report shall be conclusively acknowledged and deemed by Trusted as accurate.

3.3 Trusted shall fully comply with all laws and regulations during the term of this Agreement.

3.3.1 Trusted is responsible for complying with all laws, federal, state and local, and regulations applicable to Trusted relative to the creation, sponsorship, maintenance of information and/or administration of the "Pharmacy Benefit Plan" or "Program" within the scope of this "Agreement", and as required by law;

3.3.2 If applicable, Trusted is responsible for complying with all ERISA, COBRA, HIPAA, Internal Revenue Service, and all other federal, state and local laws, regulations,

rules, and/or local filing and/or notification requirements , processes, security and maintenance of information relating to the "Pharmacy Benefit Plan" or "Program" within the scope of this "Agreement";

3.3.3 Trusted is responsible for satisfying all requirements relating to the creation and dissemination to "Plan" "Participants" of any and all "Plan" documents, notifications, requirements, as well as Summary Plan Descriptions;

3.3.4 Trusted's responsibility to comply with all applicable notification privacy and security requirements includes at minimum, but is not limited to, providing "Participants" with the following information in writing:

3.3.4.1 The specific benefits provided by the "Plan";

3.3.4.2 Whether "Participants" are insured or uninsured;

3.3.4.3 If the "Plan" is not insured, and neither the "Plan" nor the Trusted pays for "Valid Claims", the individual "Participant(s)" may or will ultimately be responsible for payment of any and all such "Valid Claims"; and

3.3.4.4 **MERIDIANRX, LLC IS <u>NOT</u> A FIDUCIARY, PLAN ADMINISTRATOR, OR NAMED FIDUCIARY OF TRUSTED'S PLAN.**

3.3.5 If Trusted is legally required to post a fiduciary, fidelity, payment performance and/or similar bond, or monetary security including, but not limited to providing such bond in satisfaction of any ERISA and/or licensure requirements, Trusted shall include coverage for MeridianRx under said bond(s) or other monetary arrangements.

3.3.6 Trusted is responsible to fully comply with the terms, provisions, conditions and obligations set forth in the Business Associate Agreement attached hereto.

3.4 Trusted acknowledges and agrees to the following proprietary rights and limitations.

3.4.1 MeridianRx has sole and exclusive proprietary rights in all computer software and/or computer "Programs" which MeridianRx develops and/or implements in connection with any and all services provided to, or for the benefit of Trusted;

3.4.2 All Trusted data, records, information, and/or other "Trusted Information" provided, or becoming available to MeridianRx, will be used by MeridianRx only in conjunction with satisfaction of its obligations hereunder as provided by law, or in the exercise of its rights hereunder;

3.4.3 MeridianRx retains the right to disclose and disseminate non-"Participant"-specific prescription and claims-related information to national and/or other data bases;

3.4.4 Upon MeridianRx's receipt of advance written request from Trusted, MeridianRx will ascertain the appropriate amount of time it will take to approximate cost and supply specified types of "Trusted Information" in MeridianRx's possession for review by Trusted and/or Trusted's auditors, within a reasonable period of time after request, and

Trusted shall be obligated to compensate MeridianRx based upon MeridianRx's rates and charges for time and services in effect at the time the services are performed; and

3.4.5 Trusted allows MeridianRx to use "Participant" specific information for purposes of "Plan" administration.

ARTICLE 4
Limited Warranty; Warranty Exclusions; and Limitation on Liability and Damages

4.1 MeridianRx warrants that it will use reasonable care in providing the selected services in satisfaction of its various contractual obligations and in exercising its various rights under the "Agreement", including, but not limited to, processing MeridianRx's data, computing proper amounts of claims payment obligations on the part of Trusted, and paying, as MeridianRx's "Paying Agent", "Valid Claims".

EXCEPT AS TO THE SPECIFIC REPRESENTATIONS SET FORTH IMMEDIATELY ABOVE, MERIDIANRX MAKES NO OTHER REPRESENTATIONS OR WARRANTIES OF ANY KIND, EXPRESS OR IMPLIED, WITH RESPECT TO ANY OF ITS SERVICES, OBLIGATIONS, RIGHTS AND/OR PERFORMANCE HEREUNDER, AND/OR AS TO THE MERCHANTABILITY, SUITABILITY, AND/OR FITNESS OF MERIDIANRX'S SERVICES FOR ANY PARTICULAR PURPOSE(S).

4.2 In the event of a breach of this "Agreement" by MeridianRx (including, but not limited to, a breach of the foregoing limited warranty, and including, but not limited to, error(s) in performance of its obligations, payment of "Invalid Claims" and/or "Overpayments"), MeridianRx, at its option and discretion, will undertake one or more of the following actions:

4.2.1 Reprocess erroneous and/or defective work, recompute erroneous amount(s) of money(ies) communicated as due and owing, and/or reprocess defective and/or erroneous data, or processing services;

4.2.2 Refund, forgive, and/or credit, as the case may be, the amount of "Service Fees" billed, or billable to Trusted for the performance of the specific services associated with the breach, subject, however, to MeridianRx's absolute maximum monetary liability limit to Trusted as hereinafter specified;

4.2.3 Where MeridianRx pays "Invalid Claims", makes erroneous computations, and/or makes "Overpayments" (hereinafter either or both of such "Invalid Claims", erroneous amounts, and/or "Overpayments" hereinafter sometimes referred to as "Improper Payment(s)"), contact the recipient of the Improper Payment(s) and request a refund from the recipient. If the recipient of the Improper Payment(s) fails to refund the amount of the Improper Payments(s), MeridianRx may elect to offset the amount of the Improper Payment(s) against future payments for "Valid Claims" submitted by the same recipient; in the event of an "Overpayment" by the Trusted as a result of MeridianRx's failure to require the dispensing pharmacy to collect the correct amount of co-pay(s) and/or deductible(s), then subject to the foregoing limitation, MeridianRx will refund the amount of the "Overpayment" to Trusted provided that MeridianRx is not precluded by Trusted or third party contract from recovering past and/or present "Participants" underpayments, and Trusted provides all available address and similar information with respect to past and present "Participants" who benefited from the "Participant" underpayment; and/or

4.2.4 Assist Trusted in pursuing any rights or remedies Trusted has and desired to assert or pursue, at MeridianRx's own cost and expense, against third parties, provided MeridianRx is not required to assume any financial obligations or debts, and/or agree to pay any related costs and/or expenses, or become a named party in any litigation or adversary proceeding.

4.3 MeridianRx's payment of a "Fraudulent Claim" is not a breach of the "Agreement", provided MeridianRx was not aware of the erroneous and/or fraudulent nature of the claim, and it could not discovered its erroneous and/or fraudulent nature with reasonable diligence.

4.4 MeridianRx's monetary liability to Trusted in the event of any breach(es) of this "Agreement" by MeridianRx, and/or any monetary claim by Trusted against MeridianRx relating directly or indirectly to this "Agreement", or the services provided hereunder will be) an amount of money equal to Trusted's out-of-pocket monetary damages incurred as a result of the wrongful acts or omissions on the part of MeridianRx, including, but not limited to, any breaches not cured as provided herein by MeridianRx of its specific obligations under this "Agreement."; provided, however, that as a condition precedent to Thrive's right to recover any such unavoidable loss monetary amounts, Thrive shall have first provided MeridianRx with written notice fully describing any such alleged loss, breach, wrongful act or omission as well as a full and detailed description of the monetary damages incurred, or likely to be incurred as a result of such breach, act, omission, claim, loss, and/or the facts relative to the alleged wrongful conduct upon which the claim loss is based, but in no event longer than six (6) months after the "Agreement" terminates. Payment of damages by a third person or entity, including an insurance company, shall not be considered direct, actual, unavoidable monetary damages by Thrive under any circumstances.

EXCEPT AS SPECIFICALLY SET FORTH ABOVE, THERE SHALL BE NO LIABILITY TO MERIDIANRX UNDER NO CIRCUMSTANCES WILL MERIDIANRX BE RESPONSIBLE TO TRUSTED AND/OR TO ANY THIRD PERSONS OR ENTITIES NOT PARTIES TO THIS "AGREEMENT" FOR ANY CONSEQUENTIAL, INCIDENTAL, OR LOSS(ES) AND/OR DAMAGE(S) WHETHER OR NOT RESULTING FROM ANY OF THE FOREGOING CAUSE(S) OR OTHERWISE.

ARTICLE 5
Force Majeure and Indemnification

5.1 Except as to mandatory timely satisfaction of Trusted's monetary payment obligations, neither party shall be responsible for delays or failures in performance resulting from acts or circumstances beyond the reasonable control of such party which may not be overcome by that party's exercise of due diligence. Such delays or failures include, but are not limited to, those which result from labor strikes or problems, acts of God, material shortages, riots, acts of war, government laws, regulations, orders and/or judgments imposed or entered after the fact; fire, floods, earthquakes, other natural disasters (including inclement weather) and/or any other causes beyond the direct, immediate, and reasonable control of such party. In the event of such failure or delay, the party whose performance is delayed shall give prompt written detailed notice to the other party providing all relevant information. The time for performance by the delayed party shall be extended by the time of the delay, and the party whose performance is delayed shall have a reasonable amount of time to perform after the cause of the delay is removed.

5.2 Each party shall fully and contemporaneously indemnify, protect, defend, save, and hold harmless the other party, from and against any and all claims, demands, losses, liabilities, costs, damages, expenses, and debts (including reasonable attorney fees and legal costs and expenses) of, and by third parties, resulting from the indemnifying party's (as well as that party's agents, servants, employees, representatives, officers, directors, shareholders, and others acting for or on behalf of the applicable party) breach of this "Agreement", error, acts, omissions, and/or negligence of such party.

ARTICLE 6
Term and Termination

6.1 Unless otherwise specified in a writing signed by all parties, the initial term of this "Agreement" is two (2) years from the effective date, provided that Trusted's contrat with the Distrcit of Columbia is renewed for an additional on (1) year term. The Agreement shall automatically renew for additional one (1) year periods on its anniversary each year for four (4) consecutive years. After the first year either party can terminate the contract with or without cause with ninety (90) days written notice.

6.2 Either party has the absolute right to terminate this "Agreement" upon a "Default" by other party. Sections 6.2.1 through 6.2.7 below, describe various "Defaults" by Trusted and any relevant cure periods.

6.2.1 Immediately if Trusted fails to timely satisfy any monetary or funding obligations required in this "Agreement" (alternatively, Trusted may elect to act in accordance with Section 3.1.1 of this "Agreement"); or if Trusted violates any material terms, provisions, conditions, requirements or obligations set forth in the Business Associate Agreement of a material nature as determined by MeridianRx.

6.2.2 At any time seven (7) days after any breach by either party (not included within the scope of Section 6.2.1 above) under this "Agreement" where the breach has not been fully cured within the seven (7) day period; and/or

6.2.3 Immediately where Trusted becomes insolvent or otherwise unable to pay its debts in due course as they mature; makes an assignment for the benefit of creditors; conveys any assets to a trustee for the benefit of Trusted's creditors; conveys all or substantially all of its assets to a third person and/or entity; any proceeding is instituted by or against Trusted alleging that Trusted is insolvent or unable to pay debts as they mature; a petition of any kind is filed under any federal bankruptcy act of law, and/or state insolvency act or law, by or against Trusted; entry of a judgment, order of attachment, execution, sequestration, and/or garnishment relative to Trusted which results in the foregoing or other judicial process in the nature of a writ being served upon Trusted and/or levied on any Trusted funds in the actual and/or constructive possession or control of MeridianRx; where Trusted is a person (as opposed to a legal entity), upon the death of that Trusted; upon the dissolution, merger, consolidation and/or transfer of all or substantial part of the assets or property of Trusted (in circumstances where Trusted is a corporation, partnership, LLC, or other form of business entity or association); and/or upon the occurrence of any circumstances where MeridianRx and/or Trusted become(s) legally precluded from engaging in any of the activities on their respective part(s) required under the terms of this "Agreement".

6.2.4 At MeridianRx's election, any time after MeridianRx receives notification of an assignment of this "Agreement" by Trusted (whether voluntary or involuntary), unless the assignment occurred after Trusted first obtained MeridianRx's prior written consent.

6.2.5 Trusted shall have the right to terminate this "Agreement" upon thirty (30) days advance written notice if at any time after the initial term of this "Agreement" MeridianRx notifies Trusted of an increase in the amount of "Service Fees" and/or in the event MeridianRx fails, refuses and/or neglects to perform under the then current terms, conditions and provisions of the "Plan".

6.2.6 A premature, non-scheduled or other unilateral termination of this "Agreement" by Trusted, with, or without cause, or a "Default" by Trusted which results in a termination of the "Agreement" by MeridianRx, relieved MeridianRx of any and all obligations hereunder, as well as all post-termination obligations and/or responsibilities.

6.2.7 The above-listed specific rights relative to termination are in addition to (and not in lieu of) any other specific rights relative to termination which may be set forth in this "Agreement", or otherwise available to the parties at law or in equity.

ARTICLE 7
General Terms and Conditions

7.1 This "Agreement", together with all the attached and/or referenced schedules, writings, attachments and exhibits, constitutes the complete and entire agreement of the parties, superseding all previous and contemporaneous communications and negotiations, written or oral. This "Agreement" shall prevail over any additional, different, and/or conflicting terms of any other writings or documents submitted by Trusted to MeridianRx. Except as specifically provided herein, no modification shall be binding on a party unless set forth in a writing executed by both parties.

7.2 This "Agreement" shall be governed in accordance with the laws of the District of Columbia. Any and all claims and/or actions brought by Trusted or MeridianRx shall be brought in the courts located in the District of Columbia, or if brought in federal court, in the United States District Court for the District of Columbia.

7.3 All notices and invoices pursuant to this "Agreement" shall reference this "Agreement" and shall be given in writing to the respective party as herein specified, or to such other address as may be substituted in writing by a party to the other. All notices shall be deemed to be properly given and received if sent by hand delivery or by registered or certified mail, postage prepaid, and certified receipt requested. Notices to MeridianRx shall be addressed as follows:

MERIDIANRX, LLC
1001 Woodward Avenue, Suite 700
Detroit, MI 48226
Attn: General Counsel

Notices to Trusted shall be addressed as follows:

TRUSTED HEALTH PLANS, INC.
1100 New Jersey Avenue SE, Suite 840
Washington, D.C. 20003

Attn: Thomas Duncan

7.4 One or more waivers by a party of a breach of any term of this "Agreement" by the other, shall neither constitute nor be construed as a waiver by such party as to any subsequent or continuing breach of such term of the "Agreement". The consent or approval of a party to, or of, any act of the other party requiring such consent and/or approval, shall not be deemed a waiver, or render unnecessary consent to and/or approval of any subsequent and/or similar act or omission.

THE PARTIES HAVE READ THIS ENTIRE AGREEMENT, INCLUDING THE TERMS AND CONDITIONS ABOVE, ON THE PRECEDING PAGES, AND ON THE ATTACHED SCHEDULES AND EXHIBITS, UNDERSTAND AND AGREE TO BE BOUND BY ITS TERMS, AND FURTHER AGREE THAT IT CONSTITUTES THE COMPLETE AND EXCLUSIVE STATEMENT OF THE AGREEMENT BETWEEN THEM WHICH SUPERCEDES ALL PROPOSALS, ORAL OR WRITTEN, AND ALL OTHER COMMUNICATIONS BETWEEN THEM RELATING TO THE SUBJECT MATTER HEREOF. TRUSTED AND/OR TRUSTED REPRESENTATIVE UNDERSTAND(S), AKNOWLEDGE(S), AND AGREE(S) TO BE BOUND BY THE PROVISIONS RELATIVE TO LIMITED WARANTY, WARRANTY EXCLUSIONS, AND LIMITATION OF LIABILITY AND DAMAGES. THIS AGREEMENT IS BINDING UPON EXECUTION BY TRUSTED AND/OR TRUSTED REPRESENTATIVE AND ACCEPTANCE BY MERIDIANRX.

MeridianRx, LLC

By: _____

Print name: Sean P. Cotton

Title: President

Date: 06/28/13

Trusted Health Plans, Inc.

By: _____

Printed name: Thomas Duncan

Title: President

Date: 6/29/13

SCHEDULE OF REQUIRED DISCLOSURES

Various state laws require that all Third-Party Administrator contracts must contain the following information. As used herein, the word "Agreement" shall refer to the MeridianRx Claims Processing Services Agreement.

1. The term of the "Agreement" is set forth in Section 7 of the "Agreement".

2. The services to be provided by MeridianRx are set forth in Section 2 of the "Agreement".

3. The method and rate of compensation which will be paid by Trusted to MeridianRx is set forth in MeridianRx's Pharmacy's Fees, Compensation and Remuneration Schedule of the "Agreement".

4. Provisions for renewal and termination of the Agreement are set forth in Section 7 and 8 of the "Agreement".

5. MeridianRx maintains at its principal offices, customary books and records of all transactions relative to "Participants".

6. MeridianRx is a licensed Third-Party Administrator under applicable law and conducts business in compliance with law.

7. All records and files provided by Trusted to MeridianRx belong to the Trusted, and may be used by MeridianRx consistent with MeridianRx's rights and obligations under the terms of the "Agreement".

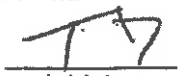
8. MeridianRx shall maintain in effect a fidelity bond in accordance with, and to the extent required by, laws requiring such bonds.

9. MeridianRx is a paying agent, only, and is not an insurer of payment or of any other risks. MeridianRx does not purchase or provide any claims payment insurance and/or stop-loss insurance coverage with respect to its obligations as a Third-Party Administrator and/or with respect to any risks relating thereto.

10. Except with respect to agreements entered into between MeridianRx and the members of its pharmacy network, neither MeridianRx, nor any of its officers, directors, or shareholders has/have any ownership interest or material business relationship with any insurance, reinsurance, risk bearer, or any other business entity with which MeridianRx proposes to contract as a result of MeridianRx's relationship with Trusted with respect to the "Agreement".

11. MeridianRx holds "Claims Payment Funds" received from Trusted in a MeridianRx banking account with "Claims Payment Funds" received from other MeridianRx Trusted.

12. Where a contract is entered into between MeridianRx and a trust, trustee, or trustees of a benefit plan, all trust agreements and any amendments thereto are to be provided to MeridianRx, and upon receipt thereof, MeridianRx will retain copies as part of its records for the duration of the agreement with Trusted, and for at least five (5) years thereafter.



initials

BUSINESS ASSOCIATE AGREEMENT

THIS BUSINESS ASSOCIATE AGREEMENT (the "Agreement") is effective this 29 day of June, 2013 (the "Effective Date") by and between Trusted Health Plans, Inc. whose business address is 888 16th Street NW, Suite 800, Washington, DC 20006 and MeridianRx, LLC whose business address is 1001 Woodward Avenue, Suite 700, Detroit, MI 48226 ("Business Associate").

WITNESSETH:

WHEREAS, Trusted health Plans, Inc. ("Covered Entity") has entered into, or may in the future enter into, one or more written agreements, that may require Business Associate to be provided with, to have access to, and/or to create Protected Health Information (the "Underlying Contract(s)"), that is subject to the federal regulations issued pursuant to the Health Insurance Portability and Accountability Act ("HIPAA") and codified at 45 C.F.R. parts 142 and 160-164 (the "HIPAA Regulations"). Business Associate acknowledges that effective January 1, 2010, as a business associate, it is responsible to comply with the HIPAA Security and Privacy regulations pursuant to Subtitle D of the Health Information Technology for Economic and Clinical Health Act ("HITECH"), including Sections 164.308, 164.310, 164.312 and 164.316 of title 45 of the Code of Federal Regulations; and

WHEREAS, the parties desire to comply with the HIPAA Regulations and HITECH in order to protect the privacy of PHI.

NOW THEREFORE, in consideration of the premises cited above and the mutual observance of the covenants and promises contained herein below, the parties hereby agree as follows:

ARTICLE I – DEFINITIONS

1.1 Definitions. Unless otherwise defined in this Agreement, all capitalized terms used in this Agreement have the meanings ascribed in the HIPAA Regulations, as amended from time to time and construed in accordance with interpretation or guidance on HIPAA, and its regulations, issued by the Department of Health and Human Services, the Office of Civil Rights, or the Centers for Medicare and Medicaid Services, provided, however, that "PHI" and "ePHI" shall mean Protected Health Information and Electronic Protected Health Information, respectively, as defined in 45 C.F.R. § 160.103. "Administrative Safeguards" shall have the same meaning as the term "administrative safeguards" in 45 C.F.R. § 164.304, with the exception that it shall apply to the management of the conduct of Business Associate's workforce, not Covered Entity's workforce, in relation to the protection of that information.

ARTICLE II – OBLIGATIONS OF BUSINESS ASSOCIATE

2.1 With regard to its Use and/or Disclosure of PHI, Business Associate agrees as follows:

a. Business Associate shall not Use or Disclose PHI other than as permitted or required by this Agreement or as Required by Law. Effective January 1, 2010,

Business Associate may Use and Disclose Protected Health Information only if its Use or Disclosure is in compliance with each applicable requirement of section 164.504(e) of title 45 of the Code of Federal Regulations.

b. Business Associate shall use appropriate safeguards to prevent Use or Disclosure of PHI other than as provided for by this Agreement.

c. Business Associate shall report to Covered Entity any Use or Disclosure of PHI not provided for by this Agreement that Business Associate becomes aware of.

d. Business Associate shall ensure that any agents and subcontractors to whom it provides PHI received from, or created or received by Business Associate on behalf of Covered Entity agree to the same restrictions and conditions set forth in the business associate provisions of the HIPAA Regulations that apply through this Agreement to Business Associate with respect to such information.

e. Business Associate shall, within twenty (20) days of receiving a written request from Covered Entity, make available to Covered Entity PHI necessary for Covered Entity to respond to Individuals' requests for access to PHI about them in the event that the PHI in Business Associate's possession constitutes a Designated Record Set. In the event any individual requests access to PHI directly from Business Associate, Business Associate shall within five (5) business days forward such request to Covered Entity. Any denials of access to the PHI requested shall be the responsibility of Covered Entity.

f. Business Associate shall, within thirty (30) days of receiving a written request from Covered Entity, make available to Covered Entity PHI for amendment and incorporate any amendments to the PHI in accordance with 45 C.F.R. Part 164 Subpart E ("Privacy Rule") in the event that the PHI in Business Associate's possession constitutes a Designated Record Set.

g. Business Associate shall, within thirty (30) days of receiving a written request from Covered Entity, make available to Covered Entity the information required for Covered Entity to provide an accounting of disclosures of PHI as required by the Privacy Rule. Business Associate shall provide Covered Entity with the following information: (i) the date of the disclosure, (ii) the name of the entity or person who received the PHI, and if known, the address of such entity or person, (iii) a brief description of the PHI disclosed, and (iv) one of the following, as applicable: (a) a brief statement of the purpose of such disclosure which includes an explanation that reasonably informs the individual of the basis for such disclosure or in lieu of such statement, (b) a copy of a written request from the Secretary of Health and Human Services to investigate or determine compliance with HIPAA; or (c) a copy of the Individual's request for an accounting. In the event the request for an accounting is delivered directly to Business Associate, Business Associate shall within seven (7) business days forward such request to Covered Entity.

h. Business Associate shall make its internal practices, books and records relating to the Use and Disclosure of PHI available to the Secretary of HHS for purposes of determining Covered Entity's compliance with the Privacy Rule.

i. Business Associate shall, upon the expiration or termination of an Underlying Contract, return to Covered Entity or destroy all PHI, including such information in possession of Business Associate's subcontractors, as a result of the Underlying Contract at issue and retain no copies, if it is feasible to do so. If return or destruction is infeasible, Business Associate agrees to extend all protections, limitations and restrictions contained in this Agreement to Business Associate's Use and/or Disclosure of any retained PHI, and to limit further Uses and/or Disclosures to the purposes that make the return or destruction of the PHI infeasible. This provision shall survive the termination or expiration of this Agreement and/or any Underlying Contract.

j. Business Associate shall use reasonable commercial efforts to mitigate any harmful effect that is known to Business Associate of a Use or Disclosure of PHI by Business Associate in violation of the requirements of this Agreement.

k. Business Associate shall implement Administrative Safeguards, Physical Safeguards, and Technical Safeguards ("Safeguards") that reasonably and appropriately protect the Confidentiality, Integrity, and Availability of ePHI as required by 45 C.F.R. Part 164 Subpart C ("Security Rule").

l. Business Associate shall ensure that any agent and subcontractor to whom Business Associate provides ePHI agrees to implement reasonable and appropriate safeguards to protect ePHI.

m. Business Associate shall report promptly to Covered Entity any successful Security Incident of which Business Associate becomes aware; provided, however, that with respect to attempted unauthorized access, Use, Disclosure, modification, or destruction of information or interference with system operations in an information system affecting ePHI, such report to Covered Entity will be made available upon written request.

n. Business Associate shall make its policies, procedures and documentation required by the Security Rule relating to the Safeguards available to the Secretary of HHS for purposes of determining Covered Entity's compliance with the Security Rule.

o. Effective January 1, 2010, if Business Associate accesses, maintains, retains, modifies, records, stores, destroys, or otherwise holds, uses, or discloses Unsecured Protected Health Information (as defined in HITECH Sec. 4402(h)(1)), it shall, following the discovery of a breach of such information, notify Covered Entity of such breach immediately. Such notice shall include the identification of

each Individual whose Unsecured Protected Health Information has been, or is reasonably believed by Business Associate to have been accessed, acquired, or disclosed during such breach.

ARTICLE III - OBLIGATIONS OF COVERED ENTITY

3.1 Covered Entity agrees as follows:

a. Covered Entity shall provide Business Associate with the notice of privacy practices that Covered Entity produces in accordance with 45 CFR 164.520, as well as any changes to such notice.

b. Covered Entity shall provide Business Associate with any changes in, or revocation of, permissions by individual to use or disclose PHI, if such changes affect Business Associate's permitted or required uses and disclosures.

c. Covered Entity shall notify Business Associate of any restrictions to the use or disclosure of PHI that Covered Entity has agreed to in accordance with 45 CFR 164.522.

d. Covered Entity shall not request Business Associate to use or disclose PHI in any manner that would not be permissible under the HIPAA Privacy Rule if done by Covered Entity.

ARTICLE IV – PERMITTED USES AND DISCLOSURES OF PHI BY BUSINESS ASSOCIATE

4.1 Business Associate may use and disclose such PHI as reasonably required or contemplated in connection with the performance of services under the Service Agreement, excluding the use or further disclosure of such PHI in a manner that would violate the requirements of 45 CFR Part 164, if done by Covered Entity; provided, however, Business Associate may use and disclose such PHI for the proper management and administration of Business Associate as provided in 45 CFR §164.504(e)(4), including, without limitation, use and disclosure as required for Business Associate to comply with applicable professional standards and obligations.

ARTICLE V – SECURITY REQUIREMENTS

5.1 Business Associate agrees to:

a. Implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the ePHI that it creates, receives, maintains or transmits on behalf of the covered entity.

b. Insure that any agent, including any subcontractor, to whom it provides ePHI agrees to implement reasonable and appropriate safeguards to protect the

Electronic Protected Health Information.

c. Report to Covered Entity any Security Incident of which Business Associate becomes aware.

ARTICLE VI – AUDIT, INSPECTION AND ENFORCEMENT

6.1 Covered Entity may, upon reasonably notice, inspect the facilities, systems, books and records of Business Associate to monitor compliance with this Agreement. Business Associate shall promptly remedy any violation of any term of this Agreement and shall certify the same to Covered Entity in writing. The fact that Covered Entity inspects, or fails to inspect, or has the right to inspect, Business Associate's facilities, systems and procedures does not relieve Business Associate of its responsibility to comply with this Agreement nor does Covered Entity's (i) failure to detect or (ii) detection, but failure to notify Business Associate or require Business Associate's remediation of any unsatisfactory practices constitute acceptance of such practice or a waiver of Covered Entity's enforcement rights under this Agreement.

ARTICLE VII – TERM AND TERMINATION

7.1 This Agreement shall become effective on the date of execution but not earlier than April 14, 2003 and shall remain in effect during the entire period of the Services Agreement or until terminated as set forth herein.

7.2 Covered Entity may terminate this Agreement and the Services Agreement if, Covered Entity, in its sole discretion, reasonably suspects that Business Associate has improperly used or disclosed PHI in violation of applicable statutes, laws or regulations, in breach of this Agreement, or that Business Associates' security processes and safeguards have materially diminished.

7.3 Upon termination of the Services Agreement for any reason, Business Associate shall return originals and all copies of, or shall destroy, and certify such destruction to Covered Entity, all PHI received from Covered Entity, or created or received by Business Associate on behalf of Covered Entity. This provision also shall apply to PHI that is in the possession of subcontractors or agents of Business Associate.

7.4 If Business Associate reasonably determines that returning or destroying PHI is not feasible, Business Associate shall provide to Covered Entity notification of the conditions that make return or destruction infeasible. If return or destruction of PHI is not feasible, Business Associate shall extend the protections of this Agreement to such PHI and limit further uses and disclosures of such PHI to those purposes and make the return or destruction infeasible, for so long as Business Associate maintains such PHI.

ARTICLE VIII - INDEMNIFICATION

8.1 Each party will indemnify and hold the other harmless from all liabilities, costs and damages arising out of or in any manner connected with any misrepresentation or non-

fulfillment of any undertaking on the part of the party pursuant to this Agreement or any breach of any term or condition of this Agreement.

ARTICLE IX – MISCELLANEOUS

9.1 Regulatory References. A reference in this Agreement to a section in the Privacy Rule means the Section as in effect or amended.

9.2 Amendment. The parties agree to take such action as is necessary to amend this Agreement from time to time as is necessary for Covered Entity to comply with the HIPAA Regulations.

9.3 Survival. The rights and obligations of Business Associate under the termination provisions of this Agreement shall survive the termination of this Agreement.

9.4 Interpretation. Any ambiguity in this Agreement shall be resolved in favor of a meaning that permits Covered Entity to comply with the HIPAA Regulations.

9.5 Previous Agreements. This Agreement supercedes and replaces all previous Business Associate Agreements between Covered Entity and Business Associate.

9.6 Authority. Any person signing on behalf of Business Associate attests that he/she has the authority to bind Business Associate in the manner described herein.

IN WITNESS WHEREOF, the undersigned have placed their hands and seals on the day and date first written above.

TRUSTED HEALTH PLANS, INC.



By: Thomas Duncan
Its: President

MERIDIANRX, LLC



By: Sean P. Cotton
Its: President

APPENDIX A

MERIDIANRX FEES, COMPENSATION AND REMUNERATION SCHEDULE

1. In consideration of services to be provided by MeridianRx, MeridianRx shall receive fees, compensation and remuneration from Trusted Health Plans, Inc. as follows:

a. Per Paid Claim. The per claim fee during the initial term of this "Agreement" (unless otherwise specified herein) is $ 1.45 per paid claim administrative fee. The per claim fee continues for any and all claims processed even after the effective date of termination.

b. Direct member reimbursement. The per claim fee is $ 1.45.

c. Provider Reimbursement Schedule:

	Retail Pharmacy – Post September 26th AWP Adjustment	**Specialty Pharmacy** - Post September 26th AWP Adjustment	**Mail Order** - Post September 26th AWP Adjustment
Brand Name Drugs	AWP-14.5%	AWP-14.5%	AWP-20.88%
Brand Name Drug Dispensing Fee	Range between $1.50 -$2.00	$2.00	$0.00
Generic Cost Basis (MAC)	AWP-83%	[redacted]	AWP-76.5%
Generic Dispensing Fee	Range Between $1.75-$2.25	[redacted]	$0.00

The parties agree that MeridianRx may change the method or metric used to calculate provider reimbursement amounts hereunder in a manner that renders reimbursement amounts that are in the aggregate cost neutral to Trusted.

2. Fees and charges for services not specifically listed in Article 2 of the "Agreement" will be mutually agreed upon by MeridianRx and Trusted prior to performance of the service. Upon request by Trusted, MeridianRx will submit a written estimate of the fees and charges for the service in question, and Trusted will notify MeridianRx in writing whether it will accept or reject MeridianRx's offer for performing the services in question.

3. 100% of Rebates passed on to client - 3% off AWP administration fee for the rebate processing.

4. Interest earned respecting Trusted monies held from time to time by MeridianRx, shall be deemed earned by and shall belong to MeridianRx as part of its overall compensation for various services provided to Trusted.

5. MeridianRx may, from time to time, receive sources of revenues and fees in which MeridianRx is acting on its own behalf, and for the benefit of Trusted, its members, or any employee

benefit plan. Such fees may be derived from, but not limited to, pharmaceutical manufacturers or participating pharmacies. With respect to participating pharmacies, MeridianRx must negotiate with each network participant independently and may accept provider participation at various reimbursement discount and rate schedules.

6. MeridianRx's "Service Fees" are guaranteed not to increase, except as provided in this "Agreement", during the initial term of this "Agreement". Thereafter, MeridianRx has the right to increase the amount of "Service Fees" upon thirty (30) days advance written notice.

TB
Initials

List of Services Included In MeridianRx Base Administrative Fees and Optional Services

MeridianRx - Service Description	Administrative Fee
Eligibility	
- Electronic Eligibility	Included
- On-line access to Eligibility System (2 per account automatically included)	Included
Claim Adjudication	
- Electronic Claims Adjudication	Included
- Direct Member Reimbursement (Paper)	Included
Prior Authorization	
-Online PA System (only available Online)	Included
- E Prescribing	Included
Clinical Programs	
- Generics First Programs	Included
-Step Therapy Programs	Included
-Dose Optimization Programs	Included
- RX to Over The Counter Switch Programs	Included
-Specialty Pharmacy Programs	Included
-Quantity Limits	Included
Drug Utilization Review	
Concurrent DUR	Included
-Low Dose	Included
-High Dose	Included
-Early Refill	Included

-Late Refill	Included
- Early Refill Allowance Calculations	Included
-Pregnancy/Lactation	Included
-Pediatric Precaution	Included
-Gender Check	Included
-Geriatric Precaution	Included
- Duplicate Therapy	Included
-Duplicate Ingredients	Included
- Drug Disease	Included
- Drug to Drug Interaction	Included
-Retrospective DUR	Included
Reporting	
-Standard Monthly Reporting Package	Included
-Quarterly Reports	Included
-Annual Reports	Included
-Eligibility Report (monthly)	Included
-Transaction Report (monthly)	Included
-Access to Online Dashboard Reporting	Included
-Access to Online Reporting Tool For Ad Hoc Reports	Included
-Custom Reports up to 4 a quarter	Included

Data Feeds to 3rd Parties	Included (standard data and layout)
Pharmacy Network	
National Network	Included
-Retail	Included
-Mail Order	Included
-Specialty Pharmacy	Included
Call Centers	Included
-Toll free 24/7 Access For Members	Included
-Toll free 24/7 Access For Pharmacies	Included
-Toll Free For Physician Offices	Included
Auditing	
- Desk Audits	Included
-On Site Audits	Included
-Audit Recovery/Collection	50% of recovery
MeridianRx.com	
Members	
-On-Line Access To Claims History	Included
- Pharmacy Location Finder	Included
- Health News Information	Included
-Mobile Application	Included
- Coverage And Benefit Information	Included
Pharmacies	
-Access National Formulary/Preferred Drug List	Included

Physicians	
-Access National Formulary	Included
- Prior Authorization	Included
-Drug Recalls	Included
- Specialty Pharmacy Program Details	Included
Client	
-Reports (monthly, Quarterly, Annually, Ad Hoc)	Included
- Client Specific OUR Policy	Included
- P&T Policies	Included
-New Drug Reviews	Included
Adherence Programs	
-Compliance Management	Included
-Gaps In Care	Included
Daily Cost Management	
-Compound Drug Management	Included
-Review Drugs Over Agreed Upon$ Threshold On A Daily Basis	Included

Trusted Health Plans
Dental/Vision Services Agreement

This Dental/Vision Services Agreement ("Agreement") between Trusted Health Plans, Inc., ("Plan") and DentaQuest of Maryland, LLC ("DentaQuest"), is effective on _____ 2013 ("Effective Date").

WHEREAS, Plan arranges for the provision of certain health care services to Members pursuant to contracts with various government sponsored health programs. Plan intends to participate in additional government sponsored health programs and offer other health products as the opportunities become available;

WHEREAS, DentaQuest is in the business of arranging for the delivery of dental and/or vision services to Members of healthcare Plans and employer groups contracting with DentaQuest, and to Medicaid recipients;

WHEREAS, DentaQuest and Plan mutually desire to enter into an agreement whereby DentaQuest shall arrange for the provision of certain dental and/or vision services to Members.

AGREEMENT:

NOW, THEREFORE, in consideration of the mutual covenants and agreements contained herein and for other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, Plan and DentaQuest agree as follows:

ARTICLE I
DEFINITIONS

The following terms shall have the meanings set forth below with respect to services furnished under the Medicaid Program.

1.1 Agency. "Agency" means a federal, state or local agency, administration, board or other governing body responsible for the governance or administration of the Program.

1.2 Benefit Contract. "Benefit Contract" means any contract between Agency and Member, which governs the availability and delivery of managed health care services to Program beneficiaries.

1.3 CMS. "CMS" means the Center for Medicare & Medicaid Services, an administrative agency within the United States Department of Health & Human Services ("HHS").

1.4 Clean Claim "Clean Claim" means a request for payment for a service rendered by a Participating Provider, that (a) is accurate and in the format required by DentaQuest, (b) includes all material information required by DentaQuest, including without limitation, all required substantiating documentation and information related to coordination of benefits and

third party liability; (c) is undisputed as to the amount of the claim; and (d) includes no indication of fraudulent content or submission. DentaQuest shall pay Clean Claims within the timeframe required by Agency, in accordance with this Agreement, and the applicable requirements of the DentaQuest Participating Provider Contract.

1.5 Covered Services. "Covered Services" means those health care services that a Member is entitled to receive through Plan pursuant to the Program Contract and Agency.

1.6 DentaQuest Office Reference Manual. The DentaQuest Office Reference Manual ("ORM") describes the office procedures a Participating Provider will follow to administer services following the covered benefit guidelines of the Program.

1.7 Emergency Medical Condition. "Emergency Medical Condition" means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in (a) serious jeopardy to the health of the individual or, in the case of a pregnant woman, the health of the woman or her unborn child; (b) serious impairment to bodily functions; or (c) serious dysfunction of any bodily organ or part.

1.8 Emergency Services. "Emergency Services" mean the medical screening, examination and evaluation by a physician or, to the extent permitted by applicable laws, by other appropriate personnel under the supervision of a physician, to determine whether an Emergency Medical Condition exists. If an Emergency Medical Condition exists, Emergency Services includes the care or treatment that is necessary to relieve or eliminate the Emergency Medical Condition within the service capability of the physician and/or facility rendering such care.

1.9 HIPAA Regulations. "HIPAA Regulations" shall mean those regulations adopted pursuant to the Health Insurance Portability and Accountability Act of 1996 and codified at Title 45 of the Code of Federal Regulations (C.F.R.) relating to the confidentiality, privacy and security of protected health information, and including, without limitation, any amendments or successor laws, rules or regulations thereto.

1.10 Medically Necessary. "Medically Necessary" health care services are health care services that include medical or allied care, goods or services furnished or ordered to meet the following conditions: (a) Be necessary to protect life, to prevent significant illness or significant disability or to alleviate severe pain; (b) Be individualized, specific and consistent with symptoms or confirm diagnosis of the illness or injury under treatment and not in excess of the patient's needs; (c). Be consistent with the generally accepted professional medical standards as determined by the Medicaid program, and not be experimental or investigational; (d) Be reflective of the level of service that can be furnished safely and for which no equally effective and more conservative or less costly treatment is available statewide; and (e) Be furnished in a manner not primarily intended for the convenience of the Member, the Member's caretaker or the provider. Medically Necessary for those services furnished in a hospital or appropriate medical facility on an inpatient basis cannot, consistent with the provisions of appropriate medical care,

be effectively furnished more economically on an outpatient basis or in an inpatient facility of a different type. The fact that a provider has prescribed, recommended or approved medical or allied goods or services does not, in itself, make such care, goods or services Medically Necessary or a Covered Service.

1.11 Member. "Member" means a person who is an eligible Program beneficiary, who is enrolled with Plan in accordance with applicable Program enrollment requirements, and who is eligible to receive Covered Services under a Benefit Contract.

1.12 Member Expenses. "Member Expenses" means co-payments, coinsurance, deductibles, coordination of benefits, amounts paid or to be paid by other liable third parties, and/or other cost-share amounts due from the Member for Covered Services in accordance with **Attachment B (Benefits)** and pursuant to their Benefit Contract.

1.13 Participating Provider. "Participating Provider" includes any person or entity that (a) is licensed to provide the health care services; (b) is party to a participation agreement with DentaQuest to provide Covered Services to Members, or is an employee or subcontractor of a Participating Provider and will be furnishing Covered Services hereunder; and (c) is, if applicable, duly credentialed by DentaQuest in accordance with Plan credentialing requirements for the services the Participating Provider provides.

1.14 Participating Provider Contract. "Participating Provider Contract" is an Agreement between DentaQuest and an appropriately licensed health care provider to render Covered Services to Members in accordance with the Program Contract.

1.15 Program. Program, as defined in this Agreement, shall mean a state Medicaid ("Medicaid", "Medicaid Program") and/or State Child Health Insurance Program ("CHIP"), any successor programs thereto, and any other state or local program related to or administered in conjunction with Medicaid or CHIP, including without limitation, any program providing coverage for eligible family members of CHIP beneficiaries.

1.16 Program Contract. "Program Contract" means any contract between Plan and Agency, which governs the delivery of managed health care services to Program beneficiaries.

1.17 Regulatory Requirements. "Regulatory Requirements" means any requirements imposed by applicable federal, state or local laws, rules, regulations, a Program Contract, or otherwise imposed by the Agency in connection with the operation of the Program or the performance required by either party under this Agreement, and as applicable the Participating Provider Contract(s).

ARTICLE II
PLAN OBLIGATIONS

2.1 Member Identification Cards. Plan, or its designee, will provide Members with identification cards indicating enrollment with Plan. Members shall be required to present their identification cards when seeking Covered Services in accordance with applicable Benefit Contract requirements. Plan will provide access to Member eligibility information through electronic or other means.

2.2 Policies and Procedures. DentaQuest agrees to comply with: (a) all applicable Plan, Program and Regulatory Requirements, policies, procedures and guidance applicable to those Plan products covered under this Agreement; and (b) DentaQuest shall supply to Plan all applicable policies and procedures, including without limitation those addressing quality assurance / improvement, utilization management / review, Plan accreditation, credentialing / re-credentialing, Member / provider grievances and appeals and such other administrative policies as applicable.

2.3 Reports. DentaQuest shall provide to Plan such utilization profiles or other reports, if any, that Plan is required to provide to any Agency under Regulatory Requirements.

2.4 Participating Provider Listing; Marketing/Advertising. For the purposes of enrolling and referring Members, marketing, complying with Program Contract requirements, reporting to CMS, and otherwise carrying out the terms and conditions of this Agreement, Plan shall be entitled to use the name(s), business address(es), and phone number(s) of DentaQuest including any individual Participating Provider employed by or under contract with DentaQuest to provide services hereunder. Plan shall, and shall be entitled to, use information related to any such individual Participating Provider's information including but not limited to education, specialty, subspecialty, licensure, certification and hospital affiliation for the purposes described above.

2.5 Credentialing. Except as mutually agreed by the parties and as evidenced in writing by a Management Services Addendum to this Agreement, DentaQuest shall credential all Participating Providers providing services hereunder pursuant to Plan credentialing criteria applicable to any such Participating Providers.

2.6 Schedule of Benefits and Determination of Covered Services. Plan shall provide DentaQuest with a schedule of Covered Services for the Program, attached at **Attachment B (Benefits)** and incorporated herein, and will notify DentaQuest in a timely manner of any material amendments or modifications to such schedules.

ARTICLE III
DENTAQUEST OBLIGATIONS

3.1 Eligibility Verification. DentaQuest shall require Participating Providers to verify the eligibility of Members prior to rendering non-emergency services using processes made

available by DentaQuest. In the event of Emergency Services, DentaQuest shall allow Participating Providers to verify Member eligibility as soon as reasonably practicable after rendering such Emergency Services. Provider payments are subject to the eligibility information in DentaQuest's System during the time of adjudication.

3.2 DentaQuest Services.

(a) DentaQuest shall require Participating Provider to provide to Members those Covered Services within the scope of Participating Provider's licensure, expertise, and usual and customary range of services pursuant to the terms and conditions of this Agreement and all applicable Regulatory Requirements, and shall be responsible to Plan for its performance hereunder. DentaQuest shall require Participating Providers to provide to Members access to twenty-four (24) hour-per-day, seven (7) day-per-week urgent and Emergency Services as required by applicable Program and Regulatory Requirements. DentaQuest shall allow Participating Providers to render Emergency Services without requiring prior authorization of any kind. DentaQuest may require Participating Providers to submit documentation to support the medical necessity of such Emergency Services prior to remitting payment for such claims.

(b) Hours of Operation. DentaQuest shall require Participating Providers to offer hours of operation that are not less than the hours of operation offered to patients with other insurance coverage including, but not limited to, commercial health plans.

3.3 Licensure/Certification. DentaQuest warrants that it and each of its Participating Providers is and will remain properly licensed, certified and/or accredited to provide Covered Services as provided for in this Agreement throughout its term. DentaQuest shall notify Plan immediately in writing upon the occurrence of any event that could reasonably be expected to impair the ability of DentaQuest and/or Participating Provider to comply with the obligations of this Section 3.2 (DentaQuest Services) including, but not limited to: (a) any suspension, revocation, condition, expiration or other restriction of any licensure, certification or accreditation of DentaQuest or any Provider; (b) the suspension or bar from, or imposition of any sanctions against DentaQuest or Participating Provider(s) relating to any government payor program, or any settlement related thereto; (c) any disciplinary action initiated by any regulatory body against DentaQuest and/or Participating Provider(s); (d) the suspension, limitation, revocation or termination of any Participating Provider's hospital privileges where applicable; (e) any action concerning or brought by an Member against DentaQuest or Provider(s); (f) a conviction of fraud or any felony; and/or (vii) settlement related to any of the foregoing.

3.4 DentaQuest Responsibility. DentaQuest shall not be liable for, nor will it exercise control or direction over, the manner or method by which Participating Provider provides services to Members. Participating Provider shall be solely responsible for all medical advice and services provided by Participating Provider to Members. DentaQuest shall communicate to Participating Providers and require they acknowledges and agree that DentaQuest may deny payment for services rendered to a Member which it determines are not Medically Necessary, are not Covered Services pursuant to an applicable Program Contract, or are not otherwise provided in accordance with this Agreement. Neither such a denial nor any action taken by DentaQuest pursuant to a utilization review, referral, or discharge Planning program shall operate to modify

Participating Provider's obligation to provide appropriate services to a Member under applicable law and any code of professional responsibility. Nothing in this Agreement shall be construed as prohibiting any Participating Provider from discussing treatment or non-treatment options with Members irrespective of whether such treatment options are Covered Services.

3.5 Compliance with Credentialing, Utilization Management, Quality Assurance, Grievance, Coordination of Benefits, and other Rules, Regulations, Policies and Procedures. DentaQuest shall require Participating Providers to comply and cooperate with all Plan, Program and Regulatory Requirements related to credentialing, utilization management, quality assurance, grievances, and coordination of benefits. DentaQuest shall ensure that Medicaid required provisions as applicable to providers of health care services pursuant to statutes and regulations are included in DentaQuest's Participating Provider Contracts. DentaQuest shall also require Participating Providers to comply with the terms of the DentaQuest Office Reference Manual.

3.6 Insurance Coverage.

(b) General Liability. At all times during the term of this Agreement, DentaQuest shall maintain general comprehensive liability insurance from a carrier authorized to conduct business in the jurisdiction in which DentaQuest operates, in amounts appropriate for the size and nature of DentaQuest's activities pursuant to this Agreement but not less than what is required under Regulatory Requirements. Said insurance shall cover DentaQuest's premises, insuring DentaQuest against any claim of loss, liability, or damage caused by or arising out of the condition or alleged condition of said premises, or the furniture, fixtures, appliances, or equipment located therein, together with the standard liability protection against any loss, liability or damage resulting from the operation of a motor vehicle by DentaQuest, DentaQuest's employees or agents.

(c) Workers Compensation. To the extent required by applicable state and federal law, DentaQuest shall maintain workers' compensation insurance for DentaQuest's employees. Said insurance shall be obtained from a carrier authorized to conduct business in the jurisdiction in which DentaQuest operates and shall provide such limits of coverage as required by Regulatory Requirements.

(d) Evidence of Insurance. Upon Plan request, DentaQuest shall provide evidence of such liability insurance coverage. DentaQuest shall provide Plan with at least thirty (30) days prior written notice of any cancellation or non-renewal of any required coverage or any reduction in the amount of DentaQuest's coverage, and shall secure replacement coverage meeting the requirements hereunder so as to ensure no lapse in coverage. DentaQuest shall furnish Plan with a certificate of insurance evidencing such replacement coverage. DentaQuest shall also furnish a certificate of insurance to a requesting Agency upon request. DentaQuest may maintain coverage hereunder through a self-funded insurance Plan, provided that DentaQuest maintains actuarially sound reserves related to such self-funded Plan and provides to Plan on a semi-annual basis an opinion letter from an independent actuarial firm or other proof reasonably acceptable to Plan attesting to the financial adequacy of such reserves.

3.7 Vendor Administrator Requirements. Unless otherwise approved in writing by Plan, DentaQuest and its employees shall perform all the services required hereunder directly and not pursuant to any subcontract between DentaQuest and any other person or entity (a "Vendor Administrator"). In the event that any portion of the services that DentaQuest is responsible for hereunder are performed for or on behalf of DentaQuest by a Vendor Administrator, DentaQuest shall be responsible for ensuring that such Vendor Administrator furnishes such services in compliance with all of DentaQuest's obligations under this Agreement including, without limitation, maintaining required insurance, maintaining medical records, and holding Members harmless for the cost of any services or supplies provided by Participating Providers to such Members.

3.8 Proprietary Information. The parties agree not to share or disclose proprietary information except for the purpose of carrying out their obligations under this Agreement. Neither party shall disclose any proprietary information to any person or entity without the other party's express written consent except to the extent such information is available in the public domain or was acquired by such party from a third party not bound to preserve the confidentiality of such information.

3.9 Representations and Warranties.

(a) DentaQuest Status. DentaQuest hereby represents and warrants that DentaQuest: (i) has the power and authority to enter into this Agreement; (ii) is legally organized and operated to provide the services contemplated hereunder; (iii) is not in violation of any licensure or accreditation requirement applicable to DentaQuest under law, Program Contract or Agency rules; (iv) has not been excluded from participation in the Medicare, Medicaid, and/or SCHIP programs pursuant to Sections 1128 or 1156 of the Social Security Act; (v) is in good standing with CMS; (vi) has not been convicted of bribery or attempted bribery of any official or employee of the jurisdiction in which DentaQuest operates, nor made an admission of guilt of such conduct which is a matter of record; (vi) is not presently disbarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from arranging for Covered Services by any federal or state department or contractor; and (vii) is capable of providing all data related to the services provided hereunder in a timely manner as reasonably required by Plan to satisfy Regulatory Requirements, including, without limitation, data required under the Health Employer Data and Information Set and National Committee for Quality Assurance requirements in accordance with the applicable Regulatory Requirements.

(b) DentaQuest Information and Documentation. DentaQuest represents and warrants that all information provided by DentaQuest to Plan, including without limitation, information relating to insurance coverage, quality assurance, credentialing, change of ownership of DentaQuest and availability of medical care by DentaQuest to Members, is true and correct as of the date such information is furnished, and DentaQuest is unaware of any undisclosed facts or circumstances that would make such information inaccurate or misleading. DentaQuest shall provide Plan with written notice of any changes to such information within five (5) business days of such change.

3.10 Reporting Fraud and Abuse. DentaQuest shall cooperate with Plan's anti-fraud compliance program. If DentaQuest identifies any actual or suspected fraud, abuse or misconduct in connection with the services rendered hereunder, in violation of state or federal law, DentaQuest immediately shall report such activity directly to the Compliance Officer of Plan.

ARTICLE IV
REIMBURSEMENT

4.1 Clean Claim/Encounter Data Submission. DentaQuest shall prepare and submit to Plan, or its designee where applicable, Encounter Data for Covered Services rendered to Members along with all information necessary for Plan to verify Covered Services rendered to Members. For the purposes of this Agreement, "Encounter Data" shall mean data relating to treatment or service rendered by a provider to a patient, regardless of whether the provider was reimbursed on a capitated or fee-for-service basis.

4.1.1 Codes. When submitting Encounter Data to Plan, DentaQuest shall: (a) require Participating Providers to use the most current coding methodologies on all forms (i.e. CDT); (b) abide by all applicable coding rules and associated guidelines, including without limitation inclusive code sets; and (c) agree that regardless of any provision or term in this Agreement and in the event a code is formally retired or replaced, discontinue use of such code and begin use of the new or replacement code within the forty-five (45) day period following the publication date by the appropriate coding entity or government agency and; (d) DentaQuest will implement changes in codes and/or code sets published by the applicable coding entity or government agency within forty-five (45) days of publication.

4.1.2 Electronic Submission. During the term of this Agreement, DentaQuest agrees to submit all Encounter Data electronically in accordance with mutually agreeable standards applicable to the health care industry including but not limited to DentaQuest's and/or Participating Provider's NPI as appropriate.

4.1.3 Timing-Covered Services. DentaQuest shall require Participating Providers to submit Clean Claims for Covered Services rendered to Members, along with all information necessary for DentaQuest to process such claims in accordance with DentaQuest timely filing policies and applicable state Medicaid regulations and applicable CMS standards. Plan, in its sole discretion, may deny payment for any claims received following the above referenced time period(s). In the event payment is denied as described herein, any Member Expenses shall be adjusted accordingly.

4.1.4 Timing-Administrative Services. In exchange for payment for administrative services, performed by DentaQuest pursuant to this Agreement, and identified in **Attachment A (Compensation)**, DentaQuest shall electronically submit complete information and reports to Plan pursuant to the provisions in **Attachment A**

(Compensation) and the separate Management Services Addendum entered into by and between the parties.

4.1.5 Member Expenses. Regardless of any reduction in payment identified in Section 4.1 (Clean Claim/Encounter Data Submission) or its subparts above, in no event will Members be responsible for monies in addition to those Member Expenses due under the applicable Benefits Contract.

4.1.6 Interest Payments. DentaQuest shall pay Participating Provider interest on the unpaid portion of Clean Claims not adjudicated within such period as required under applicable prompt pay Plan, Program and Regulatory Requirements, at a rate equal to the District of Columbia interest rate in effect at the time of such charge.

4.2 Financial Incentives. The parties agree that nothing contained in this Agreement nor any payment made by Plan to DentaQuest or any Participating Provider is a financial incentive or inducement to reduce, limit or withhold Medically Necessary services to Members.

4.3 Plan Payments. Plan shall pay DentaQuest in accordance with the terms and conditions of this Agreement and the compensation schedule set forth in **Attachment A (Compensation)**.

4.4 Claims Review and Audit. DentaQuest acknowledges Plan's right to review DentaQuest and Participating Provider's claims for appropriateness in accordance with industry standard billing rules, including, but not limited to, **(a)** current CDT coding, **(b)** State mandated and CMS billing rules, DentaQuest acknowledges Plan's right to conduct such review and audit on a line-by-line basis for Medical Necessity or on such other basis as Plan deems appropriate, and Plan's right to exclude inappropriate line items to adjust payment and reimburse DentaQuest at the revised allowable level. DentaQuest shall cooperate with Plan's audits of claims and payments by providing access to requested claims information, all supporting medical records, Participating Provider's charging policies, and other related data. Plan shall use established industry claims adjudication and/or clinical practices, state and federal guidelines, and/or Plan's policies and data to determine the appropriateness of the billing, coding and payment.

4.5 Offset. In the event that Plan determines that a claim has been overpaid or paid in duplicate, or that funds were paid which were not provided for under this Agreement, DentaQuest shall make repayment to Plan within thirty (30) working days of written notification by Plan of the overpayment, duplicate payment, or other excess payment. In addition to any other contractual or legal remedy, Plan may recover the amounts owed by way of offset or recoupments from current or future amounts due DentaQuest by giving DentaQuest not less than thirty (30) working days notice in which to exercise DentaQuest's appeal rights under this Agreement. As a material condition to Plan's obligations under this Agreement, DentaQuest agrees that the offset and recoupments rights set forth herein shall be deemed to be and to constitute rights of offset and recoupments authorized in state and federal law or in equity to the maximum extent legally permissible, and that such rights shall not be subject to any requirement of prior or other approval from any court or other governmental authority that may now or hereafter have jurisdiction over Plan and/or DentaQuest.

ARTICLE V
COMPLIANCE WITH REGULATORY REQUIREMENTS

5.1 Compliance with Regulatory Requirements. Plan and DentaQuest shall each comply with all applicable Regulatory Requirements related to this Agreement. DentaQuest shall also maintain such compliance in its Participating Provider Contracts and any other downstream subcontract arrangements related to this Agreement. The failure of this Agreement to expressly reference a Regulatory Requirement applicable to either party in connection with their duties and responsibilities hereunder shall in no way limit such party's obligation to comply with such Regulatory Requirement. Without limiting the foregoing, this Agreement incorporates by reference all applicable federal law and state laws, rules and regulations, consent decrees and court orders. Any amendments to or revisions of such laws, regulations, consent decrees or court orders shall automatically be incorporated into the Agreement, as of their respective effective dates.

5.2 Hold Harmless. Pursuant to 42 C.F.R. §422.502(g)(1)(i), DentaQuest hereby agrees that in no event including, but not limited to, nonpayment by Plan, Plan's determination that services were not Medically Necessary, Plan's insolvency, or Plan's breach of this Agreement, shall DentaQuest and/or any Participating Provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against any Member, or persons other than Plan acting on any Member's behalf, for amounts that are the legal obligation of Plan. This provision does not prohibit collection of Member Expenses for Covered Services from Members.

5.3 Compliance with Program Contract. Nothing in this Agreement shall be construed to terminate or reduce the legal responsibility of Plan to Agency or CMS to ensure that all activities under Program Contract are carried out. Plan shall afford DentaQuest access to all necessary training and information to enable DentaQuest to carry out its responsibilities under the Program Contract. DentaQuest shall require all Participating Providers to obtain and maintain a National Provider Identification number ("NPI") as required by applicable law. DentaQuest shall communicate to Participating Providers that they can obtain their NPIs through the National Plan and Provider numerator System located at: https://nppes.cms.hhs.gov/NPPES/Welcome.do or appropriate successor website.

5.4 Rights of Participating Providers. Nothing in the Agreement shall be construed as prohibiting any Participating Provider from advising or advocating on behalf of a Member who is his or her patient for the following:

(a) The Member's health status, medical or behavioral health care, or treatment options, including alternative treatment that may be self-administered;

(b) Any information the Member needs in order to decide among all relevant treatment options;

(c) The risks, benefits and consequences of treatment or non-treatment; or

(d) 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.

5.5 Fraud and Abuse Audit Requirements. The parties agree to comply with all applicable state and federal laws, rules, and regulations governing the Medicaid Program, CMS instructions, and applicable requirements of the Contract, including without limitation: (a) laws and regulations designed to prevent or ameliorate fraud, waste and abuse, (b) laws, regulations and CMS instructions and guidelines regarding marketing. The alleged failure by either party to comply with applicable state and/or federal laws, rules or regulations shall not be construed as allowing either party a private right of action against the other in any legal or administrative proceeding in matters in which such right is not recognized by such law, rule or regulation.

5.6 Monitoring. Plan shall require DentaQuest to monitor the quality of services delivered by DentaQuest hereunder and may initiate corrective action when necessary. DentaQuest shall cure such said deficiencies within thirty (30) days or receiving notices of such deficiencies from Plan. DentaQuest shall comply, and require Participating Providers to comply, with all applicable quality requirements to which Plan must comply as required by Agency.

5.7 Lobbying. By signing this Agreement, DentaQuest certifies to the best of its knowledge and belief that federal funds have not been used for lobbying in accordance with 45 CFR Part 93 and 31 USC 1352. DentaQuest shall disclose any lobbying activities using non-federal funds in accordance with and to the extent required by 45 CFR Part 93.

5.8 Non-Discrimination. DentaQuest shall abide by the federal Civil Rights Act of 1964, the Federal Rehabilitation Act of 1973, and all other applicable statutes, regulations and orders (including, without limitation, Executive Orders 11246 and 11375, "Equal Employment Opportunities") as amended, and any and all successor statutes, regulations and related orders. DentaQuest shall not exclude any Member from participation in any aid, care, service or other benefit, or deny any Member such services on the grounds of race, color, national origin, sex, age, disability, political beliefs or religion or other applicable protected categories. DentaQuest shall not subject any Member to discrimination due to such Member's status as a Program Contract beneficiary.

5.9 Conformance with Law; Effect of Governmental Action. In addition to and without limiting the applicability of any other sanctions and penalties that may be applicable for DentaQuest's failure to conform with such federal, state and local laws, rules and regulations, DentaQuest acknowledges and agrees that, in connection with the Medicaid Program, DentaQuest's failure to report potential fraud or abuse may result in sanctions, cancellation of contract, or exclusion from participation in the Medicaid Program. DentaQuest agrees to comply with all state and federal laws, rules and regulations that apply to all persons receiving state and federal funds, including without limitation, all applicable Medicaid laws, rules and regulations and all CMS instructions.

ARTICLE VI
RECORDS AND CONFIDENTIALITY

6.1 Records. DentaQuest shall maintain medical, financial and administrative records concerning services provided to Members in accordance with industry standards, Plan, Program and Regulatory Requirements, including without limitation applicable law regarding confidentiality of Member information. Such records shall be retained by DentaQuest for the period of time required under Regulatory Requirements, but in no event less than ten (10) years from the date the service is rendered. DentaQuest shall provide state and federal agencies access to review records related to services provided hereunder in accordance with Regulatory Requirements. DentaQuest shall permit Plan or its designated agent to review records directly related to services provided to Members, either by providing such records to Plan for off-site review, or on-site at DentaQuest's facility, upon reasonable notice from Plan and during regular business hours. DentaQuest shall obtain all necessary releases, consents and authorizations from Members with respect to their medical records to permit Plan access to such records. DentaQuest shall supply the records described above at no charge upon request. The rights and obligations of the parties under this section shall survive the termination of this Agreement.

6.2 Record Transfer. DentaQuest shall require Participating Provider to cooperate in the transfer of Members' medical records to other Participating Providers when required, subject to Program and Regulatory Requirements.

6.3 Confidentiality of Information. DentaQuest and Plan shall each treat all information which is obtained through its respective performance under the Agreement and this Agreement as confidential information to the extent that confidential treatment is required under applicable law and regulations, and shall not use any information so obtained in any manner except as necessary to the proper discharge of its obligations and securing of its rights hereunder. DentaQuest shall have a system in effect, which shall be compliant with all applicable security and recovery requirements, in order to maintain and protect all records and all other documents deemed confidential by law which are maintained in connection with the activities of DentaQuest performed in connection with this Agreement. Any disclosure or transfer of confidential information by DentaQuest will be in accordance with applicable law, Program and Regulatory Requirements.

6.4 HIPAA Compliance. Plan acknowledges its designation as a covered entity under the HIPAA Regulations adopted pursuant to the Health Insurance Portability and Accountability Act of 1996 and codified at Title 45 of the Code of Federal Regulations (C.F.R.) relating to the privacy and security of protected health information, including, without limitation, any amendments or successor laws, rules or regulations thereto. DentaQuest and Plan shall each treat all information which is obtained through its respective performance under the Agreement as confidential information to the extent that confidential treatment is required under applicable law and regulations. DentaQuest and Plan agree to ensure that any agent, including a subcontractor, to whom it provides protected health information ("PHI") that was created, received, maintained or transmitted on behalf of Plan agrees to use reasonable and appropriate safeguards to protect the PHI. DentaQuest and Plan shall not use any information, particularly

protected health information, so obtained in any manner except as necessary to the proper discharge of the obligations and securing of the rights of DentaQuest and Plan hereunder. DentaQuest and Plan shall each have a system in effect, which shall be compliant with all applicable security and recovery requirements, in order to maintain and protect all records and all other documents deemed confidential by law which are maintained in connection with the respective activities of DentaQuest or Plan and performed in connection with this Agreement. Any disclosure or transfer of confidential information by DentaQuest or Plan will be in accordance with applicable law, Program and Regulatory Requirements. Further, the parties will comply with the requirements of HIPAA more specifically set forth in the DentaQuest Office Reference Manual. Notwithstanding the foregoing, the Parties hereby agree to the terms and conditions set forth in **Attachment C (Business Associate Addendum)** referenced hereto and incorporated herein.

ARTICLE VII
COMPLAINT/DISPUTE RESOLUTION

7.1 Grievances and Appeals. DentaQuest agrees to cooperate and participate with Plan: (a) in its grievance and appeals processes to resolve disputes that may arise between Plan and its Members and DentaQuest and its Participating Providers, including without limitation the timely provision of information and/or records and documents required by Plan; and (b) in provider appeals and dispute resolution processes developed and implemented by Plan.

7.2 Negotiation of Disputes.

(a) In the event of a dispute arising out of this Agreement that is not resolved by, or is not within the scope of relationship management set forth in the Agreement, or that is not resolved by informal discussions among the Parties, the Parties shall negotiate the dispute in good faith. Any party may initiate negotiation by sending a written description of the dispute to the other Parties by certified or registered mail or personal delivery. The description shall explain the nature of the dispute in detail and set forth a proposed resolution, including a specific time frame within which the Parties must act. The Party receiving the letter must respond in writing within thirty (30) days with a detailed explanation of its position and a response to the proposed resolution. With in thirty (30) days of the initiating Party receiving this response, principals of the Party who have authority to settle the dispute will meet to discuss the resolution of the dispute. The initiating Party shall initiate the scheduling of this negotiating session.

(b) Any remaining claim or controversy shall be resolved through binding arbitration conducted by a single arbitrator in accordance with the AAA Commercial Arbitration Rules, then in effect, in the city where Plan's principal office is located. If possible, the arbitrator shall be an attorney with at least fifteen (15) years' experience, including at least five (5) years' experience in managed health care. The Parties shall conduct a mandatory settlement conference at the initiation of arbitration, to be administered by AAA. The arbitrator shall have no authority to award damages or provide a remedy that would not be available to such prevailing party in a court of law or award punitive damages. Each Party shall bear its own costs and expenses, including its own attorneys' fees, and shall bear an equal share of the arbitrator's and administrative fees. The parties agree to accept any decision by the arbitrator as a final

determination of the matter in dispute, and judgment on the award rendered by the arbitrator may be entered in any court having jurisdiction. Arbitration must be initiated within (1) one year of the earlier of the date the claim or controversy arose, was discovered, or should have been discovered with reasonable diligence; otherwise it shall be deemed waived. The use of binding arbitration shall not preclude a request for equitable and injunctive relief made to a court of appropriate jurisdiction.

(c) In the event the Parties are unable to resolve the dispute following the negotiation or arbitration provisions set forth above, a Party shall have the right to pursue all available remedies at law or equity, including injunctive relief.

ARTICLE VIII
TERM; TERMINATION

8.1 Initial Term and Renewal. Subject to the terms and conditions otherwise set forth in this Agreement, this Agreement shall have an initial term of two (2) years, commencing as of the Effective Date, and shall renew automatically thereafter for successive terms of one (1) year.

8.2 Termination by Either Partyfor Cause. Either party may terminate this Agreement for Cause, defined as a material breach of this Agreement by the other party hereto, upon thirty (30) days prior written notice to the other party. The notice shall set forth the reasons for termination and provide the breaching party thirty (30) days to cure such material breach or the termination becomes effective.

8.3 Termination by Either Without Cause. Either party may terminate this Agreement without Cause upon ninety (90) days prior written notice to the other party.

Automatic Termination. This Agreement shall automatically and immediately terminate upon the expiration, surrender, revocation, restriction or suspension of any professional license required for DentaQuest to perform the services contemplated hereunder or DentaQuest's participation in any applicable Program. In addition, if DentaQuest is terminated, barred, suspended or otherwise excluded from participation in, or has voluntarily withdrawn as the result of a settlement agreement related to, any program under Titles XVIII, XIX or XX of the Social Security Act, this Agreement shall automatically and immediately terminate.

8.4 Continuation of Care. DentaQuest agrees that, upon termination of this Agreement under **section 8.2, 8.3 or 8.4**, DentaQuest shall continue to arrange for the furnishing of Covered Services to all Members for the period in which premiums were paid to DentaQuest, and DentaQuest shall promptly notify Plan of any services scheduled beyond that point.

8.5 Reassignment of Members. Plan reserves the right to reassign Members from DentaQuest to another provider or to limit or deny the assignment or selection of new Members to DentaQuest during any termination notice period.

ARTICLE IX
MISCELLANEOUS

9.1 Amendment.

(a) This Agreement may be amended by the mutual agreement of the parties as evidenced in a writing signed by the parties.

9.2 Assignment.

(a) DentaQuest may assign this Agreement to any entity which controls, is controlled by, or is under common control with DentaQuest.

(b) In the event of a partial assignment of this Agreement by Plan, the obligations of the DentaQuest shall be performed for Plan with respect to the part retained and shall be performed for Plan assignee with respect to the part assigned, and such assignee shall be solely responsible to perform all obligations of Plan with respect to the part assigned.

(c) The rights and obligations of the parties hereunder shall inure to the benefit of, and shall be binding upon, any permitted successors and assigns of the parties hereto.

9.3 Indemnification of Plan

(a) DentaQuest agrees to indemnify, defend, and hold harmless Plan and its officers, employees and agents from and against any and all liability, loss, claim, damage or expense, including defense costs and legal fees, incurred in connection with (i) DentaQuest's breach of any representation and warranty made by DentaQuest in this Agreement, and (ii) claims for damages of any nature whatsoever, including, but not limited to, bodily injury, death, personal injury or property damage arising from DentaQuest's delivery of health care services or DentaQuest's performance or failure to perform DentaQuest's obligations hereunder.

(b) Plan agrees to indemnify, defend, and hold harmless DentaQuest and, if DentaQuest is an entity, its officers, employees and agents from and against any and all liability, loss, claim, damage or expense, including defense costs and legal fees, incurred in connection with (i) Plan's breach of any representation and warranty made by Plan in this Agreement, and (ii) claims for damages of any nature whatsoever, arising from Plan's performance or failure to perform its obligations hereunder.

(c) Notwithstanding the foregoing subsections (a) and (b), this Section shall be null and void to the extent that it is interpreted to reduce insurance coverage to which either party is otherwise entitled, by way of any exclusion for contractually assumed liability or otherwise.

9.4 Waiver. Either party's waiver of any breach or violation of this Agreement by the other party shall not, nor shall it be construed to, constitute a waiver of any subsequent breach or violation of this Agreement by the other party.

9.5 Severability. The invalidity or unenforceability of any provision contained herein shall not affect the validity of any other provisions of this Agreement, and this Agreement shall be construed in all respects as if such invalid or unenforceable provision were omitted, or, to the extent permitted by applicable law, such invalid or unenforceable paragraph shall be replaced with another paragraph as similar in terms as may be possible and as may be legal, valid and enforceable.

9.6 Construction. This Agreement shall be construed without regard to any presumption or other rule requiring construction against the party causing this Agreement to be drafted.

9.7 Notice. Any notice required to be given under this Agreement shall be sent by certified mail, return receipt requested, postage prepaid; hand delivery; overnight prepaid delivery; or confirmed facsimile to the addresses set forth below, or to such other address designated by a party hereto by notice to the other party pursuant to the terms of this Agreement:

If to PLAN:
Trusted Health Plans, Inc.
Thomas Duncan
888 16th St
Nw Suite 800
Washington, District of Columbia 20006

If to DentaQuest:
DentaQuest, LLC
Steven J. Pollock
Attention: COO
465 Medford St
Boston, MA 02129

9.8 Independent Contractor Status. Nothing contained herein shall, or shall be construed to, create a partnership, joint venture or any other relationship between the parties hereto other than that of independent contractors.

9.9 Entire Agreement. This Agreement, and any exhibits, attachments and amendments hereto, constitute the entire Agreement and understanding between the parties with respect to the subject matter hereof, and supersede any prior understandings and agreements between the parties, whether written or oral, with respect to the subject matter hereof.

9.10 Captions. The section headings in this Agreement are for convenience of reference only, shall not define or limit the provisions hereof, and shall have no legal effect whatsoever.

9.11 Coordination of Defense of Claims. The parties hereto shall make all reasonable efforts, consistent with advice of counsel and their requirements of their respective insurance policies and carriers, to coordinate the defense of claims in which either party is named a defendant, or has a substantial possibility of being named a defendant.

9.12 Governing Law. This Agreement shall be governed by and construed in accordance with the laws of the District of Columbia, excluding and without application of any conflicts of law principles.

9.13 Counterparts. This Agreement and any amendment hereto may be executed in two or more counterparts, each of which shall be deemed to be an original and all of which taken together shall constitute one and the same agreement.

9.14 Non-Performance. Neither party shall be liable, nor deemed to be in default hereunder, for any delay in performance or failure to perform under this Agreement which results directly or indirectly from acts of God, civil or military authority, acts of public enemy, war, accidents, fires, explosions, employee strikes or other work interruptions, earthquakes, floods, failure of transportation, or any cause beyond the reasonable control of such party. DentaQuest acknowledges and agrees that this Agreement and the arrangement contemplated herein is subject to regulation by state and federal governmental authorities. In the event that any action of any such governmental authority impairs, limits, or delays either party's performance of any obligation hereunder, that party shall be excused from such performance, and party's failure to perform such obligation for such reason shall not constitute a breach of this Agreement.

*** * * SIGNATURE PAGE TO FOLLOW * * ***

IN WITNESS WHEREOF, the parties hereto have caused this Agreement to be executed by their duly authorized officers or agents.

Plan:
Trusted Health Plans, Inc.

By: _____
(authorized signature)

Thomas Duncan [Name]

President [Title]

7.25.13 [Date]

DentaQuest:
DentaQuest of Maryland, LLC

By: _____
(authorized signature)

Steven J. Pollock [Name]

President [Title]

465 Medford St [Address]

Boston, MA 02129 [City, State, Zip]

617-886-1568 [Telephone]

July 25, 2013 [Date]

ATTACHMENT A
COMPENSATION

Plan agrees to compensate DentaQuest in accordance with this Agreement and the following terms and conditions:

1. Administrative Fee. Plan shall pay DentaQuest the following per Member per month Administrative Fee for all administrative services set forth in the separate Management Services Addendum to this Agreement, based on the membership reported by the Plan for each month. Plan shall be responsible for issuing the Administrative Fee payments set forth herein by the 15th of the month in which services are provided.

   Adults and Children
   Dental $0.57
   Vision $0.20
   Total Administrative Fee $0.77

2. Participating Provider Payment. DentaQuest will consolidate bills from Participating Providers and submit bi-weekly funding requests to Plan for dental and/or vision Covered Services provided to Members pursuant to this Agreement. Funding requests include a claims detail report submitted electronically, compliant with Section 4.4 (Claims Review and Audit), and provided in a mutually agreeable format. Plan shall remit payment via ACH for funding requests within seventy-two (72) hours of receipt of invoice. DentaQuest shall supply Plan with information in order to process payments via ACH, and promptly notify Plan in the event of any changes to its ACH information. DentaQuest shall release funds to Participating Providers within seventy-two (72) hours or receipt of funds from Plan.

3. Rate Multiplier. For each term following the initial term the Agreement, the Administrative Fee for each successive term shall increase by a maximum of five percent (5%) to be effective on the Effective Date of such successive terms. Parties shall be allowed to negotiate changes to the rate in accordance with Section 9.1 (Amendment) of this Agreement in the event of a material change to the Plan Contract or number of Members enrolled.

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ATTACHMENT B
BENEFITS

1. Routine Dental Benefits as defined by DC Medicaid

2. Routine Vision Benefits as defined by DC Medicaid

BUSINESS ASSOCIATE AGREEMENT

This business associate agreement (the "BAA") is made by and between Trusted Health Plans, LLC ("Company") and DentaQuest of Maryland, LLC ("Business Associate"), each a "Party" and, together, the "Parties."

RECITALS

WHEREAS, Business Associate will provide services to Company pursuant to an underlying arrangement, as set out in the Management Services Agreement and effective on July 1, 2013 (the "Services Agreement");

WHEREAS, Company possesses individually identifiable health information that it may use and disclose only in accordance with and subject to HIPAA, the HITECH Act, and the Privacy, Security, Breach Notification, and Transactions Rules;

WHEREAS, Business Associate may receive such information from Company, or create and receive such information on behalf of Company, in connection with its performance of services for or on behalf of Company pursuant to the Services Agreement (the "Services"); and

WHEREAS, The Privacy and Security Rules require that Company and Business Associate enter into a "business associate agreement";

NOW, THEREFORE, the Parties agree as follows:

1. **Definitions.** Capitalized terms not defined above or in this Section 1 have the meaning of those terms in the Privacy, Security, or Breach Notification Rule, as applicable. *See* 45 C.F.R. §§ 160.103 ("covered entity," "electronic media"), 164.103 ("required by law"), 164.304 ("access," "information systems"), 164.402 ("breach," "unsecured protected health information"), 164.501 ("data aggregation," "designated record set," "health care operations," "marketing").

   a. "*Breach Notification Rule*" means 45 C.F.R. Parts 160 and Part 164, Subparts A and D, ("Notification in the Case of Breach of Unsecured Protected Health Information").

   b. *"Electronic Protected Health Information"* means Protected Health Information that is transmitted by or maintained in Electronic Media.

   c. "*HHS*" means the United States Department of Health and Human Services.

   d. "*HIPAA*" means Title II, Subpart F ("Administrative Simplification") of the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191.

   e. *"HITECH Act"* means Subtitle D of the Health Information Technology for Economic and Clinical Health Act ("HITECH Act"), which is Title XIII of the

American Recovery and Reinvestment Act of 2009 (Public Law 111-5), and any regulations promulgated thereunder.

f. "*Privacy Rule*" means 45 C.F.R. Parts 160 and Part 164, Subparts A and E. ("Privacy of Individually Identifiable Health Information").

g. "*Protected Health Information*" has the meaning of that term established in 45 C.F.R. § 160.103, limited to the Protected Health Information that Business Associate creates or receives on behalf of Company.

h. "*Security Rule*" means 45 C.F.R. Parts 160 and 164, Subparts A and C. ("Security Standards for the Protection of Electronic Protected Health Information").

i. "*Transactions Rule*" means 45 C.F.R. Parts 160 and Part 162. ("Administrative Requirements").

2. Permitted Uses and Disclosures by Business Associate

a. *General Use and Disclosure Provisions.* Business Associate may use and disclose Protected Health Information for the purpose of performing the Services under the Services Agreement, subject to the further limitations set out in Section 4 below.

b. *Use and Disclosure Required By Law.* Business Associate may use and disclose Protected Health Information to the extent Required By Law.

c. *Specific Use and Disclosure Provisions.* Subject to the further limitations set out in Section 4 below, Business Associate may:

(1) Use Protected Health Information for Business Associate's proper management and administration or to meet Business Associate's legal responsibilities.

(2) Disclose Protected Health Information for Business Associate's proper management and administration or to meet Business Associate's legal responsibilities, provided that such disclosure is only permitted if Required By Law or Business Associate obtains reasonable assurances from the person to whom the information is disclosed. The required reasonable assurances are that:

(i) the information will be protected as confidential information;

(ii) the information will be used or further disclosed only as Required By Law or for the purpose for which the information was disclosed to the person; and

(iii) the person will notify Business Associate of any instances of which it is aware in which the confidentiality of the information has been breached.

d. *Data Aggregation.* Subject to the further limitations set out in Section 4 below, Business Associate may use and disclose Protected Health Information to perform Data Aggregation related to Company's Health Care Operations.

3. **Obligations and Activities of Business Associate**

a. *Use or Disclosure.* Business Associate shall not use or disclose Protected Health Information other than as expressly permitted or required by this BAA.

b. *Safeguards.* Business Associate shall have in place:

(1) Appropriate administrative, physical and technical safeguards to protect the privacy of Protected Health Information, including safeguards sufficient to reasonably safeguard Protected Health Information:

(i) From any intentional or unintentional use or disclosure of Protected Health Information other than uses and disclosures expressly permitted or required by this BAA, and

(ii) To limit incidental uses or disclosures made pursuant to an otherwise permitted or required use or disclosure.

(2) Safeguards sufficient to ensure the confidentiality, integrity, and availability of Electronic Protected Health Information, including the Security Rule's requirements for administrative safeguards (45 C.F.R. § 164.308), physical safeguards (45 C.F.R. § 164.310), technical safeguards (45 C.F.R. § 164.312), and policies and procedures and documentation (45 C.F.R. § 164.316).

c. *Reporting.* Business Associate shall report to Company's privacy officer:

(1) Any Breach of Unsecured Protected Health Information within ten (10) days of learning the Breach occurred.

(2) With respect to any incident not subject to reporting under subsection 3.c(1), any use or disclosure of Protected Health Information in violation of this BAA within ten (10) days of becoming aware of the non-permitted use or disclosure.

(3) With respect to any incident not subject to reporting under subsections 3.c(1) or (2), any successful (a) unauthorized Access, use, disclosure, modification, or destruction of Company's Electronic Protected Health Information or (b) unauthorized interference with system operations in Business Associate's Information Systems, within ten (10) days of becoming aware of the incident.

(4) With respect to any incident not subject to reporting under subsections 3.c(1)-(3) but only upon Company's request, any attempted, but unsuccessful (a) unauthorized Access, use, disclosure, modification, or destruction of Company's Electronic Protected Health Information or (b) unauthorized interference with system operations in Business

Associate's Information Systems, of which Business Associate becomes aware.

d. *Subcontractors and Agents.* Business Associate shall ensure that any subcontractors and agents to which Business Associate provides Protected Health Information agree to the same restrictions and conditions that apply through this BAA to Business Associate with respect to such information.

e. *Access.* Business Associate shall, within ten (10) days of receiving a request by Company, provide Company a copy of Protected Health Information that Business Associate maintains in a Designated Record Set (or that Business Associate's subcontractor or agent maintains in a Designated Record Set on Business Associate's behalf) as necessary for Company to comply with a request for access to records under 45 C.F.R. § 164.524.

f. *Amendment.* Within ten (10) days of receiving a written request by Company to amend an individual's Protected Health Information, Business Associate shall confer with Company concerning whether Protected Health Information that Business Associate maintains in a Designated Record Set (or that Business Associate's subcontractor or agent maintains in a Designated Record Set on Business Associate's behalf) should be amended in accordance with 45 C.F.R. § 164.526 and promptly make such amendments to which the parties agree.

g. *Disclosure Accounting.*

(1) *Documentation of Disclosures.* Business Associate shall document disclosures of Protected Health Information and maintain information related to such disclosures as necessary for Company to respond to a request by an individual for an accounting of disclosures of Protected Health Information in accordance with 45 C.F.R. § 164.528.

(2) *Accounting.* Within fifteen (15) days of receipt of notice that Company has received a request for an accounting of disclosures of Protected Health Information for an individual, Business Associate shall make available to Company the information collected under subsection 3.g(1) so that Company may respond to the request in accordance with 45 C.F.R. § 164.528.

h. *Audit and Inspection.* Business Associate shall make its internal practices, books, and records relating to the use and disclosure of Protected Health Information available to HHS or any agent to whom HHS has delegated such authority for purposes of determining Company's compliance with the Privacy Rule. Such information shall be made available in a time and manner designated by HHS.

i. *Compliance with Transactions Rule.* Business Associate shall use the standard format required by the Transactions Rule when using Electronic Media to conduct on Company's behalf any transaction for which HHS has established a standard under the Transactions Rule.

4. **Other Restrictions on Protected Health Information**

a. *Compliance with Privacy Rule and HITECH Act.* Except as permitted by Sections 2.c and 2.d, above, Business Associate shall not use or disclose Protected Health Information in a manner that would violate the Privacy Rule or the HITECH Act if done by Company.

b. *Minimum Necessary.* Business Associate shall use, disclose, or request Protected Health Information in a "limited data set" (as that term is defined in 45 C.F.R. § 164.514(e)(2)) if practicable. Otherwise, Business Associate shall, in the performance of its functions and activities on Company's behalf, make reasonable efforts to use, to disclose, or to request of a Covered Entity only the minimum amount of Protected Health Information necessary to accomplish the intended purpose of the use, the disclosure, or the request when Company would be required to do so by 45 C.F.R. § 164.502(b).

c. *Restriction Requests; Confidential Communications.* Prior to agreeing to an individual's restriction request or confidential communications request, Company shall solicit feedback from Business Associate concerning the impact the request will have on Business Associate. Business Associate shall use and disclose Protected Health Information in compliance with (i) any restriction request to which Business Associate and Company agree pursuant to 45 C.F.R. § 164.522(a) and (ii) any confidential communications request to which Company is required to agree pursuant to 45 C.F.R. § 164.522(b).

d. *Marketing.* Business Associate shall not use or disclose Protected Health Information for Marketing purposes or receive direct or indirect payment for making Marketing communications, except as permitted by the HITECH Act and the Privacy Rule.

e. *Sale of Protected Health Information.* Business Associate shall not sell Protected Health Information, except as permitted by the HITECH Act.

5. **Term and Termination**

a. *Term.* This BAA shall be effective on the date Business Associate first receives Protected Health Information pursuant to the Services Agreement and shall continue until Business Associate has returned or destroyed Protected Health Information pursuant to Section 5.c(1).

b. *Termination for Cause.* In the event of a material breach of this BAA by Business Associate, Company shall provide Business Associate with notice of breach and an opportunity to cure the breach; Company may terminate the Services Agreement if Business Associate fails to cure the breach within a reasonable time of receiving Company's notice of breach. In the event that termination of the Services Agreement is not feasible, Company shall report the breach to HHS.

c. *Effect of Termination.*

(1) Upon termination of the Services Agreement for any reason, Business Associate shall return or destroy all Protected Health Information and shall retain no copies of the Protected Health Information, subject to the provisions of subsection 5.c(2) below. These requirements shall also apply to Protected Health Information that is in the possession of Business Associate's subcontractors and agents.

(2) Notwithstanding the foregoing, in the event that Business Associate determines that the return or destruction of any Protected Health Information (including Protected Health Information in the possession of Business Associate's subcontractors and agents) is not feasible, Business Associate shall extend the protections of this BAA to such Protected Health Information and limit further uses and disclosures of such Protected Health Information to those purposes that make the return or destruction not feasible, for so long as Business Associate maintains such Protected Health Information.

6. Miscellaneous

a. *Regulatory References.* A reference in this BAA to a section in HIPAA, the HITECH Act, or the Privacy, Security, Breach Notification, or Transactions Rules means the section (or its successor section) as in effect and as amended from time to time.

b. *Amendment of Agreement.* Amendment of this BAA may be required to ensure that Company and Business Associate comply with changes in laws and regulations relating to the privacy, security, and confidentiality of Protected Health Information. The Parties therefore agree to negotiate in good faith to make changes to this BAA as necessary to comply with such laws and regulations.

c. *Survival.* The respective rights and obligations of Company and Business Associate under Section 5.c ("Effect of Termination") of this BAA shall survive the termination of this BAA.

d. *Interpretation.* Any ambiguity in this BAA shall be resolved in favor of a meaning that permits Company and Business Associate to comply with HIPAA, the HITECH Act, and the Privacy, Security, Breach Notification, and Transactions Rules.

e. *No Third Party Beneficiaries.* Nothing express or implied in this BAA is intended or shall be deemed to confer upon any person other than Company, Business Associate, and their respective successors and assigns, any rights, obligations, remedies or liabilities.

f. *Primacy.* To the extent that any provisions of this BAA conflict with the provisions of the Services Agreement, this BAA shall control with respect to the subject matter of this BAA.

IN WITNESS WHEREOF, Company and Business Associate execute this BAA effective on the date identified in Section 5.a, above.

Trusted Health Plans, LLC	**DentaQuest of Maryland, LLC.**
Signature of Authorized Representative	Signature of Authorized Representative
Name	Steven J. Pollock Name
Title	President Title

MANAGED BEHAVIORAL HEALTH
ADMINISTRATIVE SERVICES AGREEMENT
Between
Trusted Health Plan
And
BEACON HEALTH STRATEGIES LLC

This Managed Behavioral Health Administrative Services Agreement (the "Agreement") is entered into by and between **Trusted Health Plan**, a District of Columbia Health Maintenance Organization ("Plan"), and **Beacon Health Strategies LLC** ("Beacon") effective as of the **1st day of July, 2013** (the "Effective Date").

WHEREAS, Plan is a Health Maintenance Organization that provides health care services to Medicaid and Alliance members in the District of Columbia; and

WHEREAS, Beacon is a specialty managed behavioral healthcare organization engaged in the business of arranging for and managing mental health and substance abuse services on behalf of plans; and

WHEREAS, Plan wishes Beacon to provide certain administrative services in connection with mental health and substance abuse services for certain enrollees of Plan under the terms of this Agreement.

NOW, THEREFORE, Plan and Beacon hereby agree to be legally bound as follows:

1.0 DEFINITIONS:

For purposes of the Agreement, the following terms shall have the meanings indicated:

Administrative PMPM — shall mean a dollar amount to be paid monthly by Plan to Beacon in consideration for the provision of Administrative Services.

Administrative Services – shall mean the services that Beacon will provide to, and on behalf of, Plan.

Affiliated Entities – shall mean an entity owned by or under common ownership with Beacon or an entity managed by an entity owned by or under common ownership with Beacon.

Agreement — shall mean this Agreement and all exhibits, appendices and attachments attached hereto.

Behavioral Health Services— shall mean the behavioral health benefits and services that Members may be entitled to receive through the Plan that Beacon will arrange for and manage under this Agreement.

Covered Services — shall mean those Behavioral Health Services determined to be Medically Necessary.

Delegated Service Standards/Delegation Agreement — shall mean the standards and terms under which Plan delegates certain Administrative Services to Beacon under this Agreement.

Evidence of Coverage — shall mean any policy, contract, certificate or evidence of benefits entered into or issued by Plan that entitles Members to Behavioral Health Services.

Member – means an individual who is eligible to receive Covered Services from or through the Plan.

Participating Provider — A health care practitioner or entity who/that has agreed to provide Covered Services to Members through a written agreement with Beacon and/or Plan.

Party(ies) — shall mean individually Plan or Beacon and collectively both.

Program Director – shall mean a Beacon staff member with a behavioral health related license or training and experience in managed behavioral health.

2.0 RESPONSIBILITIES OF BEACON

2.1 General Obligations. Beacon shall provide the Administrative Services set forth in Exhibit B, attached hereto and incorporated by reference, in accordance with the terms of this Agreement, including the Delegated Service Standards/Delegation Agreement set forth in Exhibit C, attached hereto and incorporated by reference. Beacon does not directly deliver Behavioral Health Services, but coordinates care through providers.

2.2. Personnel.

2.2.1 Program Director. Beacon shall designate a Program Director who shall have oversight responsibility for the Agreement and will act as a liaison between Plan and Beacon.

2.2.2. Co-Location. The Parties agree that certain Beacon staff shall be co-located at a Plan worksite. Beacon shall provide and support necessary computer equipment for use by such co-located Beacon staff at the Plan site. Beacon will supply co-located staff with a fax, printer and copier machine.

2.3 Access to Behavioral Health Services. Members will have access to Covered Services through Participating Providers.

2.14 Case Collaboration. Beacon shall provide a mutually agreed upon number of Plan staff with read-only access to appropriate screens of Beacon's case management system for the purposes of collaborating between medical and behavioral health issues for Members.

2.15 Reports. Beacon shall provide to Plan certain reports with certain frequency listed in Exhibit E, attached hereto and incorporated by reference.

2.16 Financial Accounting. Beacon shall maintain necessary and appropriate financial and accounting records for the proper administration of this Agreement. Such records shall comply with generally accepted accounting principles and applicable laws, rules and regulations.

2.17 Licensure/Regulatory Compliance. Beacon shall maintain all licensure necessary in connection with this Agreement and shall comply with all state and federal regulatory requirements relevant to the Agreement and the operations of Beacon.

2.18 Documentation/Right to Inspect. Beacon shall provide copies of policies and procedures for Administrative Services as reasonably requested by Plan in writing. During normal business hours, as reasonably required, upon reasonable prior notice and with all confidentiality/privacy protections in place, Beacon shall provide Plan, their duly authorized representatives or applicable governmental agencies, access to inspect

facilities, equipment, documents and records reasonably relating to Administrative Services.

2.19 **Subcontracting.** Beacon may subcontract certain Administrative Services to Affiliated Entities. Subcontractor shall comply with all requirements hereunder applicable to subcontracted obligations. Beacon shall remain responsible hereunder for all subcontracted obligations.

2.20 **Data Collection/Sharing for Reports.** Beacon shall cooperate with collecting and sharing with Plan data pursuant to this Agreement that Plan is required to report to regulators, accreditation entities, and other third parties.

3.0 RESPONSIBILITIES OF PLAN

3.1 **General Obligations.** Plan shall perform all obligations hereunder in accordance with the terms of this Agreement and in compliance with applicable state and federal laws. Plan shall be responsible for paying Beacon the Compensation set forth in Exhibit A.

3.2 **Personnel.**

3.2.1 Liaison. Plan shall designate a Plan staff member to act as liaison between Plan and Beacon. Such staff member shall meet with the Program Director on a periodic or as-needed basis to resolve any issues that may arise in connection with the Agreement, including any programmatic and operational issues.

3.2.2 Co-Location. Plan will provide appropriate work space for any co-located Beacon staff under Section 2.2.2. above. Plan will provide appropriate computer server room space to accommodate Beacon's technological support for any co-located Beacon staff.

3.2 **Member Eligibility.** Plan shall provide Beacon with daily electronic access to a full file of up-to-date and historical eligibility information to enable Beacon to determine the eligibility of Members for Behavioral Health Services and other relevant information, including applicable co-payments, deductibles, and any limitations on coverage of Behavioral Health Services.

Eligibility determinations and updating shall be the sole responsibility of Plan. Beacon shall be entitled to rely on such information and shall be held harmless by Plan with respect to any errors, omissions, or delays in connection with updating of such membership information. Eligibility information shall be provided to Beacon in a format and manner that is mutually agreeable to Beacon and Plan.

3.3 **Medical Data.** Plan shall provide Beacon with at least monthly electronic access to a full file of up-to-date medical utilization data on all Members to enable Beacon to manage and integrate Behavioral Health Services with medical services in the most efficacious manner possible. Medical data information shall be provided to Beacon in a format and manner that is mutually agreeable to Beacon and Plan.

3.4 **Case Collaboration.** Plan shall provide a mutually agreed upon number of Beacon staff with read-only access to appropriate screens of Plan's care management system for the purposes of Member case collaboration.

3.5 **Financial Accounting.** Plan shall maintain necessary and appropriate financial and accounting records for the proper administration of this Agreement. Such records shall comply with generally accepted accounting principles and applicable laws, rules and regulations.

3.6 **Provider Directories.** Plan shall be responsible for creating and distributing provider directories to Members.

3.7 **Licensure/Regulatory Compliance.** Plan shall maintain all licensure necessary in connection with this Agreement and shall comply with all state and federal regulatory requirements relevant to the Agreement and the operations of Plan.

3.8 **Evidence of Coverage.** Plan shall provide Beacon with a copy of each of the Evidence of Coverage agreements applicable to Members. Plan shall notify Beacon as soon as possible, but no later than thirty (30) days in advance, of any change in an Evidence of Coverage that affects Behavioral Health Services and/or Members' rights related to Behavioral Health Services.

3.9 **Data Collection/Sharing for Reports.** Plan shall cooperate with collecting and sharing with Beacon data pursuant to this Agreement that Beacon is required to report to regulators, accreditation entities, and other third parties.

4.0 PAYMENT OF CLAIMS

Plan shall establish a bank account for the payment of all claims for Covered Services as set forth in the Claims Payment section of the Administrative Services in Exhibit B.

5.0 COMPENSATION

5.1 Administrative Fee. Plan shall pay to Beacon the Administrative PMPM set forth in Exhibit A, attached hereto and incorporated by reference as compensation for the provision of Administrative Services. Payments from Plan to Beacon shall be made by wire transfer on a monthly basis no later than the 15th calendar day, or prior business day preceding the 15th calendar day if the 15th calendar day is a weekend or a federal holiday. The Administrative PMPM shall be calculated based on the number of Members for the then current month included in the monthly eligibility file that Plan shall provide Beacon.

5.2 **Retroactive Adjustments/Reconciliation.** It is acknowledged that there may be retroactive adjustment to the number of Members for whom Plan pays Beacon an Administrative PMPM due to retroactive changes in Member eligibility. Every month, the Plan's monthly eligibility file shall reflect any eligibility retroactive adjustments, provided that such retrospective adjustments shall be limited to the prior ninety (90) days. Beacon shall bring to Plan's attention any discrepancy with underpayment or overpayment within sixty (60) days of the receipt of the Administrative PMPM payment or the detailed Member report, whichever is later.

6.0 TERM AND TERMINATION

6.1 **Term.** This Agreement shall remain in effect for an initial term of three (3) years from the Effective Date unless otherwise terminated pursuant to the terms set forth herein. The Parties can mutually agree in writing to extend the initial term or renew the Agreement, provided the Parties agree in writing to the extension or renewal and any changes herein.

6.2 **Termination for Cause.** If one Party reasonably believes there is a material breach of the Agreement, the non-breaching Party may terminate the Agreement upon at least thirty (30) days written notice to the other Party. The Party alleged to be in breach shall have fifteen (15) days from receipt of such notice to cure the breach or provide a reasonable plan for correcting such breach as quickly as possible, otherwise the non-breaching Party may terminate the Agreement at the conclusion of the thirty (30) day notice period.

Notwithstanding the above, this Agreement may be terminated by either Party immediately upon notice to the other in case of any of the following: (a) a suspension or revocation of a Party's license, certificate or other legal credential authorizing the activity contemplated hereunder; or (b) where a party makes a general assignment for the benefit of creditors, suffers or permits the appointment of a receiver and/or avails itself of or becomes subject to any proceeding under the Federal Bankruptcy Act or any other statute of any state relating to insolvency or the protection of the rights of creditors.

6.3 **Termination Without Cause.** Notwithstanding any other provisions to the contrary, either Party may terminate this Agreement upon at least one hundred twenty (120) days prior written notice to the other Party.

6.4 **Upon Termination/Expiration.** In the event that this Agreement expires, is not renewed or is terminated, the Parties shall work together in good faith to effect an orderly transfer of Beacon's obligations hereunder to Plan.

6.4.1. Member Notification. Plan shall at its own expense notify its Members of any termination

6.4.1 Run-out. For up to six months, Beacon shall continue to be responsible for processing claims for Behavioral Health Services rendered to Members prior to the date of termination, provided that Plan continues to fund the cost of the fee for services claims as required herein.

7.0 GENERAL PROVISIONS

7.1 **Performance Review and Oversight.** Plan shall engage in oversight activities and performance reviews to ensure that Beacon is properly performing all delegated functions and meeting all Delegated Service Standards. Both parties agree to meet on a not less than quarterly basis to review and evaluate the delivery of Behavioral Health Services under this Agreement.

7.2 **Insurance.** Both Parties shall maintain commercially reasonable general liability insurance and errors and omissions professional liability insurance and shall provide the other with evidence of such coverage within five (5) business days of request.

7.3 **Indemnification.** Each party, for itself, its legal representatives, its successors and assigns ("Indemnifying Party"), shall indemnify, defend and hold harmless

the other party and its officers, employees and agents (collectively as the "Indemnified Party") from any claims, liability, loss, demands, costs and expenses of any kind, including reasonable attorneys' fees and disbursements, regulatory penalties (collectively as "Loss"), which the Indemnified Party may hereinafter incur, sustain or be required to pay by reason of Indemnifying Party's breach of this Agreement, or from negligent or reckless acts or omissions or the intentional acts of the Indemnifying Party or the Indemnifying Party's officers, employees or agents; provided, however, if the Loss is caused by fault of both parties, the apportionment of the resulting damages shall be shared by the parties based upon the comparative degree of each other's fault and each shall be responsible for its own defense and costs associated therewith.

7.4 Amendments. This Agreement may be amended only by written agreement executed by the Parties. If either Party reasonably believes that amendment of this Agreement is necessary to comply with applicable federal or state law or applicable government pronouncements, it shall notify the other Party and the Parties shall negotiate in good faith an amendment to this Agreement to allow this Agreement to be compliant. If the Parties do not amend this Agreement as necessary, the Party that will be non-compliant may terminate this Agreement for cause pursuant to the termination provisions set forth herein.

7.5 Assignment. Except as provided in this Agreement, neither party may assign its rights under this Agreement without prior written consent of the other party, except that either party may assign this Agreement in whole or part to any entity that it controls, is controlled by or that is under common control with it, or which succeeds to its business through a sale, merger or other similar transaction.

7.6 Governing Law. The validity, enforceability, and interpretation of any of the terms of this Agreement shall be determined and governed by the laws of the District of Columbia, without regard to conflicts.

7.7 Waiver. Waiver of, or failure of either Party to enforce the terms of this Agreement in one instance shall not constitute a waiver of such Party's rights under the Agreement in any other respect.

7.8 No Third-Party Rights. No provision in this Agreement shall create any rights in any person or entity not a party hereto.

7.9 Actions. Each Party shall notify the other as soon as reasonably possible, but no later than fifteen (15) days after receipt, of any legal or regulatory action related to this Agreement or related to the delivery of any Behavioral Health Services to Members.

7.10 Severability. If any part of this Agreement is determined to be invalid, illegal or unenforceable, such part shall be reformed, if possible, to conform with applicable law and the remaining parts of this Agreement shall be in full force and effect so far as reasonably possible to carry out the contractual purposes and terms set forth herein. If the arrangement contemplated by this Agreement is determined impermissible, the Parties shall negotiate in good faith to enter into a new agreement which, to the extent

possible, reflects the arrangement contemplated hereunder while conforming to the applicable laws or regulations deemed violated by the present agreement.

7.11 **Entire Agreement.** This Agreement, with the attached exhibits, is the sole agreement between the Parties relating to the subject matter hereof and supersedes all prior statements, understandings, or agreements, oral or written, relating to the subject matter hereof.

7.12 **Consent of the Parties.** Whenever the consent of either of the Parties hereto is required hereunder, such consent shall not be unreasonably withheld, delayed or conditioned.

7.13 **Notices.** Any notice, demand or communication required, permitted or desired to be given hereunder shall be deemed given when personally delivered or sent by facsimile or the next day if sent by a national overnight delivery service or three (3) days after deposited in the U.S. mail, postage prepaid, to the addresses set forth herein, or to such other address as the parties may designate in writing:

if sent to Plan, to:

Thomas Duncan
Chief Executive Officer
Trusted Health Plan
1100 New Jersey Ave SE, Suite, 800
Washington, DC 20003

if sent to Beacon, to:
President
Beacon Health Strategies LLC
200 State Street Suite 302
Boston, MA 02109
With a copy to its General Counsel at the same address

7.14 **Counterparts.** This Agreement may be executed in counterparts, each of which shall be considered an original and all of which taken together shall constitute a single instrument.

IN WITNESS WHEREOF, the parties have executed this Agreement by their duly authorized representatives as of the Effective Date first written above.

Trusted Health Plan (PLAN)

By: _____
Name: Thomas Duncan
Title: CEO

BEACON HEALTH STRATEGIES LLC

By: _____
Name: James E Spink
Title: President

Exhibits:

Exhibit A	Compensation
Exhibit B	Administrative Services
Exhibit C	Behavioral Health Services
Exhibit D	Reports
Exhibit E	Business Associate Agreement
Exhibit F	Performance Objectives

Exhibit A
Compensation

Plan will pay to Beacon the following amounts as compensation. The amounts set forth herein shall remain in effect unless amended upon the mutual written agreement of the parties.

AID CATEGORY	PMPM ADMIN-ONLY (ASO)
Medicaid Members	$1.95 PMPM
Alliance Members	$. 22 PMPM

The Parties understand that if any of terms and conditions of this Agreement shall change in such a way as to materially affect the Administrative Services or Behavioral Health Services to be provided hereunder, the Parties will renegotiate the compensation to be paid hereunder in good faith.

The Parties agree to work in good faith to convert from an Administrative Services Only (ASO) arrangement in Year 2 (two) of the Agreement to a Full-risk capitation arrangement.

Exhibit B
Administrative Services

Beacon shall provide the following Administrative Services under this Agreement:

1. **Telephone Access and Triage Services.** Beacon shall provide telephone access and triage for Members for Behavioral Health Services. Beacon shall receive and appropriately act upon routine, non-emergent telephone calls and triage such calls during Plan working hours Monday through Friday (except for Plan recognized holidays). Beacon shall receive and appropriately act upon emergent calls and triage such calls, 24 hours per day, 365 days per year basis.

2. **Clinical Review Process.** Beacon shall operate a clinical review process, which shall include verifying the Member's eligibility for Behavioral Health Services with the eligibility information provided to Beacon by Plan, and referring the Member to the appropriate level of care of Behavioral Health Services.

3. **Utilization Management Program.** Beacon shall provide utilization management for Behavioral Health Services for Members. Utilization management shall mean a system for prospective, concurrent or retrospective review of Medical Necessity for and authorization of appropriate Behavioral Health Services for a Member. Beacon's utilization management program shall be provided in accordance with the Member's Evidence of Coverage, other requirements provided by the Plan to Beacon if any, all applicable state and federal laws and regulations, and in accordance with the applicable NCQA Delegated Services Standards/Delegation Agreement set forth in this Contract.

   3.1 Medical Necessity/Level of Care Criteria. Beacon shall share with Participating Providers and Plan the level of care criteria used by Beacon when making Medical Necessity determinations and level of care decisions

4. **Case Management Program.** Beacon shall conduct case management for Behavioral Health Services for Members. Case management or care coordination shall mean assessing, coordinating, monitoring and evaluating the options and services required to meet a Member's health needs and promote quality, cost-effective outcomes. Beacon shall provide the case management program in compliance with URAC accreditation requirements and applicable legal and regulatory requirements.

5. **Quality Management.** Beacon shall maintain a quality management and improvement program that meets the applicable Delegated Services Standards/Delegation Agreement set forth in Exhibit C and all applicable legal and regulatory requirements.

6. **Complaints, Grievances and Appeals.** Beacon shall process all complaints and grievances, and appeals, in accordance with applicable legal and regulatory requirements and pursuant to applicable Delegated Services Standards/Delegation Agreement set forth in Exhibit C.

7. **Reporting and Data Exchange:** Beacon shall provide reporting and data exchange as mutually agreed to between Beacon and Plan as set forth in this contract.

8. **Claims Receipt, Adjudication and Processing:** Beacon shall provide complete, accurate and timely claims adjudication services for all Covered Services provided to Members in accordance with applicable District and federal laws and regulations. Claims adjudication services shall

include verifying eligibility, and providing accepted or disapproved claims adjudication status back to the Participating Provider.

9. **Network Development, Contracting and Maintenance:** Beacon will ensure network adequacy and sufficiency according to District and regulating body requirements.

10. **Credentialing:** Beacon will credential all applicable behavioral health providers according to NCQA and District regulations. Credentialing determination data will be shared with Trusted as requested and as needed to support regulatory reporting requirements.

Exhibit C
Behavioral Health Services

Medicaid

1. Inpatient mental health
2. Inpatient detox
3. Sub-acute care
4. Psychiatric Residential Treatment Facility
5. Day Services
6. Intensive Day Treatment
7. Partial Hospitalization Programs (PHP)
8. Intensive Outpatient Program (IOP)
9. Substance abuse service for pre and post-partum pregnant women
10. Psychiatric Diagnostic Services
11. Psychiatric Evaluation and Management Services
12. Individual Therapy
13. Group Therapy
14. Family Therapy
15. ECT
16. Home Based Therapy Program
17. Court Order Mental Health Evaluations
18. DMH School based therapy not included in IEPs or ISFPs
19. Care Coordination with DMH Mental Health Rehabilitation Services
20. Crisis Services

Alliance

1. Detox on Hospital Med-Surge Unit
2. Care Coordination for substance abuse services and mental health services

Alliance and Medicaid

1. Care Coordination and Case Management Services

Exhibit D
Reports

Reporting index on file

Exhibit E
Business Associate Agreement

On file.

Exhibit F
Performance Objectives

Parties mutually agree to the below referenced Performance Objectives:

	Category	Standard	Performance Penalty Amount
1.	Telephone Access ◦ Access Rate • Abandonment Rate	Average Speed of Answer of 30 seconds or less Abandonment rate of less than 5%	Reported Monthly Measured Quarterly If quarterly performance is below standard, a penalty of $2,500 will be paid by Beacon.
2.	Claims Processing • Processed	95% of clean claims processed within 30 days	Reported Monthly Measured Quarterly If quarterly performance is below standard, a penalty of $2,500 will be paid by Beacon.
3.	% credentialed w/n 30 days	90% of clean credentialing applications will be processed within 30 days	Reported Monthly Measured Quarterly If quarterly performance is below standard, a penalty of $2,500 will be paid by Beacon.
4.	% outpatient follow up post hospitalization w/n 7	7 Day aftercare performance will exceed HEDIS 75 Percentile in Year 1	Measured Annually per HEDIS Technical Specifications and data submission timeline. Beacon to report performance to Trusted in CY 2015 for Measurement Year 2014 no later than June 30th, 2015 If performance is below standard, a penalty of $2,500 will be paid by Beacon.
5.	% outpatient follow up post hospitalization w/n 30 days	30 Day aftercare Performance will exceed HEDIS 75 Percentile in Year 1	Measured Annually per HEDIS Technical Specifications and data submission timeline. Beacon to report performance to Trusted in CY 2015 for Measurement Year 2014 no later than June 30th, 2015 If performance is below standard, a penalty of $2,500

			will be paid by Beacon.
6.	Network data produced by Beacon will be accurate when transmitted to Trusted for Provider Directory purposes	At point of data transmission, data accuracy will be no less than 90%	Annual measurement where inaccuracy will be defined as the incorrect inclusion or exclusion of a provider. If performance is below standard, a penalty of $2,500 will be paid by Beacon.

Execution Final

ADMINISTRATIVE SERVICES AGREEMENT

BY AND BETWEEN

THRIVE HEALTH PLAN

AND

DST HEALTH SOLUTIONS, LLC

By the signatures of their duly authorized representatives below, Thrive Health Plan and DST Health Solutions, LLC, intending to be legally bound, agree to all of the provisions of this Agreement and all Schedules and Exhibits attached hereto.

THRIVE HEALTH PLAN		**DST HEALTH SOLUTIONS, LLC**	
By:	Thomas Pinga	By:	
Print Name:	Thomas Pinga	Print Name:	Stephan Sabino
Print Title:	President	Print Title:	President DST Health Solutions

ADMINISTRATIVE SERVICES AGREEMENT

THIS AGREEMENT (the "Agreement") is made and entered into this 7th day of May, 2013 (the **"Effective Date"**) by and between the **Thrive Health Plan, Inc.**, having its principal place of business at 888 16th St. NW Washington, DC 20006 (**"Customer"**), and **DST Health Solutions, LLC**, having its principal place of business at 2500 Corporate Drive, Birmingham, Alabama 35242 (**"DSTHS"**).

WHEREAS, Customer desires to enter into this Agreement for DSTHS to provide, among other things, for the implementation of DSTHS's PowerMHC product, Integrated Care Management Solution and business outsourcing services and hosting services using DSTHS's PowerMHC product, and

WHEREAS, Customer intends on providing a managed care delivery system to the Department of Health, Medical Assistance Administration ("MAA") Medicaid eligible population enrolled in the District of Columbia Healthy Families Program ("DCHFP") and to District of Columbia Health Care safety Net Program ("Alliance"); and

WHEREAS, Customer has been issued a certificate of authority to operate a health maintenance organization in accordance with Title 31, Chapter 34 ("Health Maintenance Organizations") of the District of Columbia Official Code; and

NOW, THEREFORE, in consideration of the representation, warranties, covenants and agreements herein contained, the parties agree as follows.

1. **INCORPORATION OF RECITALS**. The preceding Recitals are incorporated herein and are a material part of this Agreement.

2. **DEFINITIONS**. The following terms shall have the meanings set forth below for purposes of this Agreement.

"Administrative Services" means, collectively, On-Going Services and On-Demand Services.

"Auto-Adjudication Rate" means the percentage of Claims processed during a calendar month that, once the Claims data is entered into the ISS, as defined below, either manually or electronically, do not suspend for manual adjudication or review.

"Claim" means, for all Customer Products, a written or electronically submitted request for payment of or reimbursement for a specific medical procedure(s), medical service(s), supply(ies), equipment, or any other goods or services; or a notification that such procedure, service, supply, equipment or other good or service was paid or is to be paid by a party other than Customer. Dental and Pharmacy claims will not be accepted under this Agreement.

"Customer Product(s)" means the health care insurance products and related services offered by Customers to its Members, which shall consist of District of Columbia Medicaid, and any other products as mutually agreed to in writing between the parties hereto.

"Enhancements" means any and all refinements, upgrades, expansions, advancements, improvements, updates, modifications, or enhancements made to the ISS or Third Party Products, whenever made, however made or by whomever made, and whether integrated with or interfaced to the ISS.

"EDI Rate" means the percentage of all Claims received in a month by DSTHS that were submitted electronically and in a format agreed to by DSTHS and Customer.

"Go Live Date" means the date that DSTHS commences the performance of the On-Going Services, or any portion thereof.

"Implementation Fee" means DSTHS's fee to Customer for providing the Implementation Services.

"Implementation Services" means those pre-production services provided by DSTHS for and on behalf of Customer as described in Schedule A.

"Integrated Software Solution" or **"ISS"** means the DSTHS owned PowerMHC software, CareAnalyzer, CareConnect, Automated Workflow Distributor (AWD) Workflow, Customer Service and Grievance/Appeals, ePower (Provider web portal) and any other software owned by DSTHS or an affiliate of DSTHS and provided hereunder.

"Interface(s)" means a computer software program specifically designed and developed to provide or allow the exchange of data between the ISS and any other software program or system.

"Major Release" means an update to the ISS, or a component thereof, which is a planned general release and is designed to provide significant additional functionality or architectural improvements or advancements. A Major Release may also contain corrections to inaccuracies in the ISS or a component of the ISS. Major Releases are typically, but not necessarily, designated by whole numbers, e.g., 1.0, 2.0, 3.0, 4.0 and so on.

"Member" or **"Members"** means any individual person provided health care coverage or other services that are administered, or some portion thereof are administered, by the ISS under this Agreement. All Members included under this definition are sometimes referred to as **"Membership"**.

"On-Demand Services" means those services set forth in Schedule B of this Agreement.

"On-Going Services" means those services set forth in Schedule A of this Agreement.

"PMPM" means per Member per month.

"Release" means, collectively, Major Release and Service Pack Release.

"Service Pack Release" means an update to the ISS, or a component thereof, which is designed to provide limited additional functionality and/or corrections to inaccuracies. Service Pack Releases are typically, but not necessarily, denoted by a subset of a Major Release, e.g., 1.1, 2.1, 3.1 or 1.11, 2.11, 3.11 and so on.

"Services" means, collectively, Implementation Services and Administrative Services.

"Third Party Products" means those computer software programs embedded in the ISS or that work in conjunction with the ISS, owned by parties other than DSTHS or its affiliates. Third Party Products include but are not limited to; AMA CPT codes, Johns Hopkins ACGs, MarketProminence and any and all open source code contained in the ISS or any Third Party Product (whether identified herein or not), and may include hardware products, as agreed by the parties prior to finalization and execution of this Agreement.

"Third Party Vendors" means the various owners of the Third Party Products.

"Total Utilization Rate" means the number of Claims per Member per month that DSTHS receives on behalf of Customer, combining all Customer Product lines into a single measurement.

3. RIGHTS, OBLIGATIONS AND APPROVALS

A. **Rights and Obligations.** DSTHS shall provide the Services specified herein to Customer relative to the Customer Products during the term of this Agreement. Customer shall have sole authority to manage the overall operations of Customer's organization and the Customer Products, including, but not limited to, all medical, professional and ethical affairs.

B. **Relationship with Third Party Vendors.**

(1). Customer agrees that all communications to and from Third Party Vendors concerning any matters directly related to this Agreement or to the Services will be conducted by and through DSTHS.

(2). Subject to the obligations set forth in Schedule D and otherwise in this Agreement, Customer is hereby granted, during the term of this Agreement, the right to use the Third Party Products, operated by DSTHS from DSTHS's (or an affiliate of DSTHS's) data center.

(3). Notwithstanding the above grant, Customer acknowledges that the Third Party Products are provided hereunder by DSTHS through various agreements DSTHS holds with such Third Party Vendors. In the event that a Third Party Vendor sunsets or stops supporting a Third Party Product, goes bankrupt or out of business, or the agreement between DSTHS and such Third Party Vendor expires or terminates, DSTHS shall notify Customer as soon as reasonably possible, and work in good faith to help Customer determine a replacement Third Party Product.

4. SERVICES

A. **Services.** During the term of this Agreement, DSTHS shall provide to Customer, with respect to the Customer Products, those On-Going Services as set forth in Schedule A, during the periods of time set forth herein, and access to the On-Demand Services, set forth in Schedule B. DSTHS's fee for the provision of the Services is set forth in Schedule C.

B. **Changes in Scope of On-Going Services**. If Customer introduces new products or substantially revises the Customer Products, changes administrative policies or procedures, or requires any new services or processes, any of which affect the scope of On-Going Services, or cause DSTHS to incur additional costs in any other way (e.g., custom programming), the parties agree to negotiate in good faith any necessary amendment to this Agreement. Customer specifically acknowledges that any programming modifications or other changes to Services based on, directly or indirectly, changes in any laws, association rules or regulations (e.g., Medicare or Medicaid), shall be considered billable Services hereunder and shall be charged to Customer under an executed Work Order as set forth in Schedule G, Sample Work Order. DSTHS shall not be required to perform any Services that increase its costs prior to the finalization of such negotiations.

C. **Performance Standards**. Certain of the Services set forth in Schedule A (On-Going Services) shall be provided subject to the Performance Standards set forth in Schedule E (the "Performance Standards"). With respect to such services, information on DSTHS's performance in relation to the Performance Standards will be reported in writing, or electronically transmitted, to Customer on a monthly basis, within thirty (30) days of the end of each month.

5. LIMITATIONS

A. **Ownership of Records**: All business records and claims data required for the operation of or contained in the ISS on Customer's behalf, including all books of account, enrollment records, general administrative records, and patient records, shall constitute Confidential Information under the terms of Section 5.D of this Agreement and shall be and remain the sole property of Customer. In addition, all data generated under and/or contained in the ISS pertaining to Customer shall constitute Confidential Information under the terms of Section 5.D of this Agreement and shall also be and remain the property of Customer. However, the manner in which this data is organized and/or stored in the ISS is proprietary to DSTHS or Third Party Vendors.

B. **Computer Programs and Documentation**: This Agreement confers no incidents of ownership, interest in title or any other proprietary interest whatsoever to Customer in the ISS or any DSTHS owned or licensed system or any other intellectual property, or any parts thereof, including without limitation, the ISS, Third Party Products, any other product, work product, Enhancements, Interfaces or otherwise resulting from this Agreement. This Agreement only confers a right to Customer to use the ISS and Third Party Products during the Initial and Renewal Terms of this Agreement, and only for so long as Customer complies with all the terms and conditions hereof. Customer further agrees that the ownership of any Enhancement, Interface or modification to a DSTHS system, the ISS or other licensed system provided by DSTHS under this Agreement, including Third Party Products, however made and by whomever made, shall vest in and remain exclusively with DSTHS, its successors or assigns, or its licensor(s). Any and all computer programs, systems and computer software, documentation, and training materials, including the ISS, Third Party Products, Interfaces and Enhancements, developed or utilized by DSTHS in whole or in part, or to fulfill DSTHS's responsibilities specified herein or otherwise provided by DSTHS for the benefit of Customer, shall remain the exclusive property of DSTHS or Third Party Vendors as determined pursuant to agreements between DSTHS and such Third Party Vendors.

Customer shall not attempt to access the source code, as that term is known in the industry, of any programs, systems or software, including the ISS, Third Party Products, Interfaces and Enhancements, made available to Customer through this Agreement, nor will Customer disclose to any other party the ISS, Third Party Products, Interfaces or Enhancements or any information relating to the programs, systems and software without the express written consent of DSTHS. Customer agrees not to contest DSTHS's or Third Party Vendor's title and interest in and to, or the copyright of the ISS, Third Party Products, Interfaces and Enhancements, and Customer agrees not to bring any action to cancel such copyright or contest the validity thereof.

C. **Warranty, Disclaimer and Limitation of Liability**.

(1). DSTHS warrants that the ISS is licensed or owned by DSTHS, that it has the right to make the use of the ISS available to Customer, and that the use of the ISS by Customer in accordance with this Agreement does not and will not infringe or otherwise violate the rights of others. Subject to the limitation contained herein this Section C, DSTHS shall defend and indemnify Customer against any loss, damage or expense arising from any claim of proprietary right infringement upon Customer's use of the ISS in accordance with this Agreement, provided that DSTHS will have sole control over the defense and settlement of such action and that Customer will promptly notify DSTHS in writing of any claims, and cooperate with said defense.

(2). DSTHS warrants that its Services hereunder shall be performed in a good and workmanlike manner.

(3). DSTHS SPECIFICALLY DISCLAIMS ANY WARRANTY OF NONINFRINGEMENT OR OPERATION RELATED TO THIRD PARTY PRODUCTS, AND OPEN SOURCE CODE, CONTAINED IN THE ISS OR THIRD PARTY PRODUCTS.

(4). IN NO EVENT SHALL DSTHS OR ITS THIRD PARTY VENDORS, BE LIABLE FOR INCIDENTAL, CONSEQUENTIAL, LOSS OF BUSINESS, SPECIAL OR INDIRECT DAMAGES OF ANY KIND OR NATURE WHATSOEVER ARISING OUT OF OR IN CONNECTION WITH THIS AGREEMENT.

(5). CUSTOMER'S SOLE REMEDY FOR FAILURE BY DSTHS TO PERFORM ANY SERVICE IN ACCORDANCE WITH THE WARRANTY SET FORTH IN SECTION 5(C)(2) ABOVE SHALL BE FOR DSTHS TO RE-PERFORM THE SERVICES, AT NO CHARGE TO CUSTOMER. FOR ANY OTHER BREACH OR WRONGFUL ACTION UNDER THIS AGREEMENT BY DSTHS, OR IN THE EVENT THAT RE-PERFORMANCE OF THE SERVICE IS NOT AN AVAILABLE REMEDY, DSTHS'S LIABILITY FOR ACTUAL DAMAGES SHALL UNDER NO CIRCUMSTANCES EXCEED THE PMPM FEES ACTUALLY PAID TO DSTHS BY CUSTOMER UNDER THIS AGREEMENT DURING THE THREE (3) MONTH PERIOD PRECEDING CUSTOMER'S NOTIFICATION TO DSTHS OF SUCH BREACH OR WRONGFUL ACTION.

(6). THE LIMITATIONS CONTAINED HEREIN THIS SECTION 5 SHALL APPLY NOTWITHSTANDING ANY FAILURE OF ESSENTIAL PURPOSE OF ANY LIMITED REMEDY.

D. **Confidentiality of Information**. The parties recognize that in the course of carrying out the terms of this Agreement, each party will require access to, will be provided with (verbally or in writing) and will make use of, certain proprietary and confidential information, including without limitation, eligibility and coverage information, eligible person and group information, information concerning Claims approval criteria and procedures, financial terms, utilization data which identifies patients, Customer Products, methodologies, operations and business affairs, financial information, intellectual property and trade secret or sensitive information concerning information, software and systems, including without limitation, the ISS, Third Party Products, Interfaces and Enhancements, (hereinafter individually and collectively referred to as "Confidential Information") which belong to the other party or to third parties. Therefore, in order to properly protect Confidential Information, the parties agree as follows:

(1). Each party agrees that it will not, at any time or for any purpose, whether during or after termination of this Agreement, without the prior written consent of the other party, divulge or disclose to any person, association or company, or use any Confidential Information for its own benefit or for the benefit of any other entity or person other than in accordance with this Agreement. DSTHS shall be allowed to share Confidential Information with its affiliated companies for the purposes of providing Services under this Agreement, including but not limited to, the operation of the data center facility where the ISS resides.

(2). All Confidential Information shall remain the exclusive property of the providing party. No right, title or interest in the Confidential Information shall be conveyed to the receiving party by release, authorized or unauthorized, of such information to it.

(3). Confidential Information shall not include information which: (1) is or has been independently developed by the party receiving the information prior to such receipt or, if subsequent to such receipt, without reference to or use of the information received, as evidenced by documentation in its possession which documentation will be supplied to the other party upon request, or which is lawfully received from another source having the lawful right to so furnish such Confidential Information, or (2) has become generally available to the public in a lawful manner, without breach of this Agreement by the party receiving the Confidential Information or (3) at the time of lawful disclosure to the receiving party was lawfully known by it as evidenced by documentation in the receiving party's possession, which documentation will be supplied to the other party upon

request or (4) is ordered to be released pursuant to a court order issued by a court of competent jurisdiction or otherwise legally required to be disclosed. If either party becomes legally obligated, or receives a subpoena or other legal demand, to disclose any of the other party's Confidential Information, the party subject to the obligation shall notify the other party in writing immediately, shall cooperate with the other party in seeking a protective order or other appropriate remedy, and shall make reasonable efforts to protect the confidential and proprietary status of any disclosed Confidential Information.

(4). Each party agrees to return or destroy all Confidential Information received by it including, without limitation, all copies and/or abstracts thereof upon the other party's written request.

(5). Each party agrees to promptly notify the other party in writing if it becomes aware of any use of the Confidential Information that is not authorized by this Agreement.

(6). DSTHS and Customer agree to the terms and conditions of the Business Associate Agreement attached hereto as Schedule F.

E. **Continuity of Obligations.** Each party further understands and acknowledges that its obligations under this Section 5 shall survive the termination of the Agreement and shall be binding on its subsidiaries, successors and assigns.

F. **Subpoena Materials:** In the event that Customer is or becomes a defendant in a lawsuit or other formal proceeding in which DSTHS is subpoenaed, deposed or otherwise required or asked to participate as a third party, as custodian of records or otherwise. If during or after such participation, DSTHS becomes a named defendant in such lawsuit or other formal proceeding, Customer shall indemnify, defend and hold DSTHS and its parent and affiliated companies harmless from any and all costs, expenses, including reasonable attorney's fees, settlements or judgments arising from or in connection with such lawsuit or other formal proceeding.

G. **Indemnification:** Customer agrees to indemnify and hold DSTHS, and its affiliated companies, employees, officers and directors harmless from and against any and all costs, expenses (including reasonable attorney's fees), lawsuits, claims or allegations arising from or in connection with DSTHS's performance of the Services in accordance with Customer's direction, payment guidelines, policies or procedures under this Agreement, except for any claims that result from the sole negligence or breach of DSTHS subject to the limitations on indemnification set forth above in this Section 5.

6. **SERVICE FEES**

A. **Implementation Services.** Implementation Services, as set forth in Schedule A shall be charged to Customer in accordance with the fees and payment terms set forth in Schedule C.

B. **On-Going Services.** Each calendar month or portion thereof commencing on the Go Live Date, Customer shall pay to DSTHS for those services set forth in Schedule A, the monthly fees set forth in Schedule C. The fees for On-Going Services to be furnished by DSTHS under Schedule A shall be determined based on Membership and Transactions counts as of the first calendar day of the month.

C. **On-Demand Administrative Services.** On-Demand Services, as set forth in Schedule B, shall be estimated in advance by DSTHS and approved by Customer before expended, and charged to Customer in accordance with fees and payment terms set forth in Schedule C.

D. **Timing of Payments.** The fees payable by Customer to DSTHS under this Agreement shall be paid within thirty (30) days of the date of an invoice. Fees which are due, but not received by DSTHS within thirty (30) days of receipt of a monthly invoice, are subject to a late charge which shall accrue at the rate

of one and a half percent (1½ %) per month or fraction thereof. Customer shall remain obligated to pay all amounts on or before the due date notwithstanding any good faith disputes as to a portion of the amount owed.

7. TERM AND TERMINATION

A. Term. This Agreement shall be effective on the Effective Date hereof and shall extend for a period of five (5) years from the Go Live Date (the "Initial Term") and shall be subject to an automatic renewal on the Go Live Date for three (3) additional years ("Renewal Terms").

The Customer shall have the right to terminate this Agreement upon thirty (30) days' notice to DSTHS in the event, the District of Columbia, Department of Health ("DCDOH") revokes or terminates the Customer's certificate of authority to operate a health maintenance organization in accordance with Title 31, Chapter 34 ("Health Maintenance Organizations") of the District of Columbia Official Code. The Customer shall provide such DCDOH notice to DSTHS within ten (10) business days after receipt and shall have the right to terminate the Agreement upon thirty (30) days' notice. In the event of such termination of the Customer's certificate of authority to operate as a Health Maintenance Organization by the District of Columbia, Department of Health ("DCDOH"), the Customer shall pay to DSTHS the following early termination fees (a) if such termination occurs during the 1st year of this Agreement, Customer shall pay to DSTHS the amount of ($414,000); (b) if such termination occurs during the 2nd year of this Agreement, Customer shall pay to DSTHS the amount of ($331,200); (c) if such termination occurs during the 3rd year of this Agreement, Customer shall pay to DSTHS the amount of ($248,400); (d) if such termination occurs during the 4th year of this Agreement, Customer shall pay to DSTHS the amount of ($165,600); and (e) if such termination occurs during the 5th year of this Agreement, Customer shall pay to DSTHS the amount of ($82,800).

The Parties agree nothing herein grants the Customer the right to terminate this Agreement at will, specifically, it is the intent of the Parties that the only events - (a) a default of DSTHS under Section 7(B) (1) and (2) or (b) a termination of the Customer's authority to operate granted by DCDOH – will give rise to Customer's right to terminate this Agreement prior to the end of the fifth year.

B. Event of Default by DSTHS.

Each of the following shall constitute an event of default hereunder by DSTHS:

(1). If DSTHS shall apply for or consent to the appointment of a receiver, trustee or liquidator of DSTHS or of all or a substantial part of its assets, file a voluntary petition in bankruptcy, make a general assignment for the benefit of creditors, file a petition or an answer seeking reorganization or arrangement with creditors or take advantage of any insolvency law, or if any order, judgment or decree shall be entered by any court of competent jurisdiction on the application of a creditor, adjudicating DSTHS bankrupt or insolvent or approving a petition seeking reorganization of DSTHS or of all or a substantial part of its assets, and such order, judgment or decree continues un-stayed and in effect for sixty (60) consecutive days, Customer may terminate this Agreement, at its option, upon ten (10) days written notice to DSTHS.

(2). If DSTHS fails to keep, observe or perform any material covenant, obligation, agreement, term or provision of this Agreement to be kept, observed or performed by DSTHS and such default continues uncured for a period of ninety (90) consecutive days after written notice thereof has been received by DSTHS from Customer, Customer may terminate this Agreement, at its option, upon ten (10) days written notice to DSTHS.

C. Event of Default by Customer.

Each of the following shall constitute an event of default hereunder by Customer.

(1). If Customer shall apply for or consent to the appointment of a receiver, trustee or liquidator of Customer or of all or a substantial part of its assets, file a voluntary petition in bankruptcy, make a general assignment for the benefit of creditors, file a petition or an answer seeking reorganization or arrangement with creditors or take advantage of any insolvency law, or if any order, judgment or decree shall be entered by any court of competent jurisdiction on the application of a creditor, adjudicating Customer bankrupt or insolvent or approving a petition seeking reorganization of Customer or of all or a substantial part of its assets, and such order, judgment or decree continues un-stayed and in effect for sixty (60) consecutive days, DSTHS may terminate this Agreement, at its option, upon ten (10) days written notice to Customer.

(2). If Customer fails to keep, observe or perform any material covenant, obligation, agreement, term or provision of this Agreement to be kept, observed or performed by Customer and such default continues uncured for a period of sixty (60) days after written notice thereof has been received by Customer from DSTHS, DSTHS may terminate this Agreement, at its option, upon ten (10) days written notice to Customer.

D. **Transfer of Records at Termination of Agreement**: Upon expiration or termination of this Agreement:

(1). At Customer's expense, DSTHS shall transfer to Customer all records in such format as DSTHS may use from time to time, including computer records, which are the property of Customer, as provided herein. Upon delivery of such records to Customer, DSTHS shall not retain any records for purposes of HIPAA maintenance, or CMS record retention policies, and all such retention obligations shall solely be Customer's responsibility.

(2). Customer shall return to DSTHS, as applicable, all systems, manuals, procedures, software and equipment provided or developed in whole or in part by DSTHS or its licensor(s), including all originals and copies thereof, except as otherwise specified herein. Both parties agree to cooperate in such removal.

8. MISCELLANEOUS

A. **Assignment**: Neither party shall assign its rights or obligations under the Agreement, in whole or in part, without the prior written consent of the other party, which consent shall not be unreasonably withheld or delayed. Notwithstanding the preceding restriction, either party may assign this Agreement, without the need to obtain prior written consent of the other party, to a parent, affiliate or subsidiary entity, or an entity which shall acquire or succeed to a substantial part of either party's business or assets.

B. **Binding on Successors and Assigns**. The terms, covenants, conditions, provisions and agreements herein contained shall be binding upon and inure to the benefit of the parties hereto and their respective successors and assigns, unless otherwise agreed to in writing.

C. **Negation of Partnership, Joint Venture and Equity Interest**. Nothing in this Agreement shall constitute, be construed to be or create, a partnership, joint venture or lease between Customer and DSTHS. The relationship of DSTHS to Customer under this Agreement is solely that of independent contractors.

D. **Non-Assumption of Liabilities**. Neither party shall, by entering into and performing under this Agreement, become liable for any of the existing or future obligations, liabilities or debts of the other.

E. **Limitation on Duration of Services**. This Agreement establishes an obligation on behalf of DSTHS to provide specified services during the term as defined herein. DSTHS shall not be responsible for providing any services after the effective date of any termination of this Agreement. At Customer's request, DSTHS will in good faith negotiate a separate run-out fee for Claims received following the date of termination.

F. **Rights Cumulative, No Waiver**. No right or remedy herein conferred upon or reserved to either DSTHS or Customer is intended to be exclusive of any other right or remedy, and each and every right and remedy shall be cumulative and in addition to any other right or remedy given hereunder, or now or hereafter legally existing upon the occurrence of any event of default hereunder. The failure of either DSTHS or Customer to insist at any time upon the strict observance or performance of any of the provisions of this Agreement or to exercise any right or remedy as provided in this Agreement shall not impair any such right or remedy or be construed as a waiver or relinquishment thereof. Every right and remedy given by this Agreement to the parties hereto may be exercised from time to time and as often as may be deemed expedient by the parties hereto.

G. **Captions and Headings**. The captions and heading throughout this Agreement are for convenience purposes only, and the words contained therein shall in no way be held or deemed to define, limit, describe, explain, modify, amplify or add to the interpretation, construction or meaning of any provision of or the scope or intent of this Agreement nor in any way affect the Agreement.

H. **Public Announcements**. DSTHS shall not have the right to make any public announcement regarding this Agreement or its relationship with Customer without the prior written consent of Customer, except that DSTHS may use the name of Customer in any list of DSTHS's clients without the prior consent of Customer. Customer shall have the right to refer to its association with DSTHS upon the request and approval of DSTHS, which will not be unreasonably withheld by DSTHS.

I. **Impracticability of Performance.** Nether Customer nor DSTHS shall be deemed to be in violation of this Agreement if prevented from performing any of its obligations hereunder for any circumstance or reason beyond its control, including without limitation, flood, storm, strike, terrorist acts, War (declared or undeclared) acts of God, government or the public enemy, equipment failure only to the extent such equipment failure arises from a terrorist acts, War (declared or undeclared) acts of God, government or the public enemy, flood, strike, or storm.

J. **Severability and Savings**. If any provision of this Agreement is held to be invalid or unenforceable by a court of competent jurisdiction, the other provisions of this Agreement shall remain in full force and effect.

K. **Taxes**. The amounts payable to DSTHS under this Agreement shall not be construed to include local, state or federal sales, use, excise, personal property or other similar taxes or duties on the services provided by DSTHS, and any such taxes imposed on and actually paid by Customer to any governmental or taxing authority shall be assumed and paid by Customer. Customer agrees to reimburse DSTHS for any and all taxes and other fees imposed on DSTHS relative to DSTHS's performance of Services under this Agreement, exclusive of any taxes on DSTHS's income.

L. **Consequences of Violation of Agreement:**

Arbitration. Any claim, dispute, difference or controversy ("Dispute") between DSTHS and Customer, arising out of or relating to this Agreement (the parties to any such dispute being sometimes collectively

referred to herein as the "Disputing Parties" and individually as a "Disputing Party") shall at the written request of any Disputing Party, be fully and finally resolved in binding arbitration as set out below.

(1). Arbitration shall be conducted by a single arbitrator, to be mutually selected by the Disputing Parties, in accordance with the protocols adopted and in effect by the American Arbitration Association. If the parties are unable to agree on a single arbitrator, each party shall appoint one with both arbitrators selecting a third arbitrator. The fees of the arbitrator(s) and the expenses incident to the arbitration proceedings shall be born equally by the Disputing Parties. All other expenses, including but not limited to, legal fees, shall be borne by the party incurring such expenses.

(2). To the maximum extent permitted by applicable law, the provisions of this Section 8.L shall be the exclusive procedure for resolving any Dispute arising out of the provisions of this Agreement and the decision of the arbitrator shall be final and without appeal. If within thirty (30) days after the making of the award by the arbitrator, the award shall not be complied with, a Disputing Party may enter judgment upon, or institute a proceeding to enforce, the award in any court of competent jurisdiction against the other Disputing Party or Parties, and may enforce such judgment by execution or may pursue any other appropriate remedy against such other Disputing Party or Parties for enforcement of the award.

(3). Any such arbitration shall be brought in the Delaware, and shall be held before and be in accordance with the rules of JAMS/Endispute and the Parties agree the arbitrator must have healthcare and software contracts experience. Judgment on the arbitrator's award may be entered in any court which has the jurisdiction to do so.

(4). Pending final determination of any dispute hereunder, the Disputing Parties shall proceed diligently with their performance under this Agreement.

M. Notices. All notices hereunder by either party to the other shall be in writing. All notices, demands and requests shall be deemed given when delivered by hand; when delivered via nationally recognized overnight carrier, with a confirmation of receipt capability, or if sent via U.S. mail, when mailed, postage prepaid, registered or certified mail, return receipt requested, on the date such notice was deposited with the U.S. Post Office, and addressed as follows:

	DST Health Solutions, LLC President 2500 Corporate Drive Birmingham, AL 35242 (205) 437-5246

With a Copy to:

	DST Health Solutions, LLC Legal Counsel 2500 Corporate Drive Birmingham, AL 35242 (205) 437-5922

	Thomas Duncan Chairman Thrive Health Plans, Inc. 1100 New Jersey Avenue, S.E.

	Washington D.C. 20003 Tel: Fax: Email:

or to such other address or to such other person as may be designated by written notice given from time to time during the term of this Agreement by one party to the other.

N. **Authorization of Agreement**. DSTHS and Customer mutually represent and warrant to the other that the person executing this Agreement has the authority to bind the respective company and if required by law, its respective shareholders, and that this Agreement constitutes a valid and enforceable obligation in accordance with its terms.

O. **Governing Law**. All the terms and provisions of this Agreement and the rights and obligations of the parties hereto shall be governed and construed in accordance with the laws of the District of Columbia, without regard to the conflict of laws principles thereof.

P. **Entire Agreement**. This Agreement, together with any Schedules, constitutes the entire agreement between the parties hereto with respect to the subject matter hereof, and no representations or agreement, oral or otherwise, between the parties which are not embodied herein or attached hereto shall be of any force or effect unless in writing and signed by the parties thereto.

Q. **Nondisclosure**. The terms of this Agreement are not to be disclosed by either party without the prior written consent of the other, except as necessary to exercise its rights under this Agreement, or to the extent required by applicable law.

R. **Subcontractors**: DSTHS will, and shall have the right to, subcontract Services under this Agreement, including subcontracting to its onshore and offshore affiliates and other entities; provided, that, DSTHS shall be entirely responsible for the performance of its subcontractors under this Agreement.

S. **Non-Hiring of Employees**. Customer and DSTHS agree to use their best efforts during the term of this Agreement and for one (1) year thereafter not to directly solicit for hire or hire any employee(s) or consultants of the other party without the prior written consent of that party. For the purposes of this provision, an employee or consultant is a person who has been employed or engaged by a party in the six (6) month period prior to the date of solicitation or hire and "directly solicit" shall mean direct contact with the employee and shall not include generally available public advertisements for employment available to the general public, in particular but without limitation, advertisements in local newspapers, national newspapers, internet employment sites such as Monster.com.

T. **Negotiated Terms**: The parties acknowledge and agree that each individual party has had the opportunity to seek the guidance of legal counsel in regard to the terms and conditions of this Agreement, that this Agreement has been entered into voluntarily, and that the terms and conditions herein reflect the parties' mutually negotiated understanding. As such, the parties waive any claim to a contract of adhesion, and further agree that this Agreement shall not be construed in favor of or against any party by reason of the extent to which any party or its professional advisors participated in the preparation of this Agreement.

U. **Survival**. Section 5, Section 6(D), Section 7(B), 7(C), 7(D), Section 8, and any other term, representation, obligation or condition which, by its nature, is meant to survive termination or expiration of this Agreement, shall so survive the termination or expiration of this Agreement.

SCHEDULES

A. Implementation and On-Going Services

B. On-Demand Services

C. Fees

D. Third Party Vendor Pass Through Terms

E. Performance Standards

F. Business Associate Agreement

G. Sample Work Order

H. Travel Policy

SCHEDULE A

IMPLEMENTATION SERVICES AND ON-GOING SERVICES

I. **Implementation Services:** DSTHS will implement the ISS and Third Party solutions set forth in this Schedule A for the fees set forth in Schedule C. Customer's implementation approach will be more fully in the Implementation Scope of Work prepared by DSTHS.

II. **Administrative Services:** During the term of this Agreement, except as otherwise provided herein, DSTHS shall provide Customer with those On-Going Services listed in Section II.A below for the Customer Products, for the PMPM and related fees set forth in Schedule C, and access to the On-Demand Services listed in Schedule B. DSTHS will perform only those Services listed herein, and no service which is not explicitly stated herein shall be the responsibility of DSTHS. To facilitate the performance of the responsibilities hereunder, each party shall coordinate with the other party any activities that affect, or require the input of, the other party.

A. On-Going Administrative Services: Unless otherwise specified in this Agreement, DSTHS will provide the following On-Going Services.

1. Integrated Software Solution and Third Party Products: DSTHS will operate the ISS and Third Party Products for Customer. For purposes of On-Going Services, the capabilities and functionality of the ISS and Third Party Products shall be as they exist at the time Administrative Services are first provided (i.e., the Go Live Date). The ISS shall be subject to the following requirements:

a. DSTHS shall provide Customer with specifications on Third Party Products, such as computer hardware, computer software and telecommunication hardware and systems required at Customer's location for access to the ISS. Customer shall bear all costs associated with its on-site Third Party Products including installation and maintenance of such Third Party Products. Customer and DSTHS shall enter into an independent telecommunications contract that defines the capabilities of the telecommunication lines, and contains separate pricing.

b. To ensure timely connection to the ISS over the term of the Agreement, Customer will provide DSTHS with quarterly projections of access requirements as they pertain to personal computers, or any peripheral equipment. Additionally, on or before September 30th of each year, Customer will provide DSTHS with an annual projection of Membership and system access requirements for the upcoming calendar year.

c. Unless otherwise agreed to in writing, and except as specified in subparagraph e. below, DSTHS shall not be required to maintain historical records on-line for more than thirty six (36) months, provided that DSTHS:

(1) Uses a scheduled and systematic process for transferring such data to storage media; and

(2) Maintains the ability to temporarily restore specific data on-line within forty-eight (48) hours when necessary to process a specific on-line transaction; and

(3) DSTHS performs backups onto storage media for each working day's systems files on the ISS and maintains such backups under DSTHS's data security procedures.

(4) DSTHS will store electronic Claims images on back-ups for a period of ten (10) years. DSTHS will not store paper claims, or other paper documentation, and such paper documents shall either be destroyed within thirty (30) days following imaging, or at Customer's election and expense, returned to Customer.

d. Periodically, Third Party Vendors will issue a new Release of their software. DSTHS will routinely install Service Pack Releases as it deems appropriate to accurately provide Administrative Services to Customer under this Agreement, but shall inform Customer in advance of such installation if the Service Pack Release provides additional or revised functionality.

During the term of this Agreement, either DSTHS or Customer may request a Major Release be installed. In the event DSTHS desires to install a Major Release, DSTHS shall notify Customer for approval: such approval shall not be unreasonably withheld by Customer. All costs and expenses related to implementing Enhancements into such Major Release (or pulling forward previous Enhancements so they will be compatible with the new Release) will be borne by Customer. Any additional training, consulting or project management that Customer requires related to the installed Major Release will also be billable by DSTHS. Customer shall be responsible for its travel or other-related expenses in attending such training.

If Customer requests DSTHS to install a Major Release prior to the time that DSTHS schedules the installation, DSTHS shall charge Customer for such installation on a time and materials basis, after receipt of Customer's written approval of such charge to perform the installation.

In the event that a Major Release contains functionality responsive to a change in laws or regulations (e.g., ICD-10 / 5010 Releases), DSTHS will notify Customer of its installation date, and Customer will use its best efforts to coordinate testing and acceptance of such regulatory release in a prompt and efficient manner.

e. In the event of a disaster that destroys or disables DSTHS's data center, or the destruction or material malfunction of the equipment on which the ISS resides, DSTHS may declare a disaster and recover the ISS and Third Party Products at DSTHS's cold-site disaster recovery center. Customer acknowledges that there will be delays in such event, and that Customer has elected a cold-site disaster recovery option, which does not allow for immediate transfer to redundant equipment and software. DSTHS shall use commercially reasonable efforts to recover the ISS within seventy-two (72) hours of the declaration of a disaster.

f. DSTHS will provide Customer with access and/or licenses (as identified by the number of user log-on ID's) to the components of the ISS as set forth below.

Software System	Number of Customer Users/Licenses
(1) PowerMHC	5
(2) AWD Workflow	5
(3) AWD Customer Service	7
(4) CareAnalyzer	7
(5) Image Repository ID	5
(6) CareConnect	15
(7) ePower (Provider web portal)	N/A
(8) AWD Grievance and Appeals	2

The Image Repository ID may be the same set of log on IDs as the AWD Workflow IDs, as DSTHS transfers the capability onto one internal server.

It is anticipated that Customer will have approximately 40,000 Members as of the Go Live Date. For every additional 5,000 Members, DSTHS will provide Customer one (1) additional PowerMHC license and one (1) additional AWD Workflow license. For every additional 7,500 Members, DSTHS will provide Customer one (1) additional CareConnect, CareAnalyzer, AWD Grievance/Appeals and AWD Customer Service license.

Any additional access/licenses for the above components of the ISS requested by Customer shall be treated as an On-Demand Service at the prices set forth in Schedule C. Any log on IDs to components not shown above shall be licensed on an On-Demand basis.

Network Connectivity is included in this Agreement at the fees set forth in Schedule C.

g. DSTHS shall provide one production environment for the ISS and applicable Third Party Products hosted by DSTHS, and one test environment which shall not be the equivalent of the production environment, but shall be adequate for Customer to perform its testing obligations hereunder. It is the nature of computer hardware and equipment that, from time to time, it must be updated or refreshed (e.g., new or additional memory, new server, new firewalls, etc.). DSTHS standardly refreshes its technology every three years. Customer will be responsible for the costs of such refreshes, which costs will be added to the PMPM fees or otherwise agreed upon.

2. Provider, Membership and Benefits Database Management: DSTHS shall maintain within the ISS provider records, Membership records and benefit designs, including networks, physician panels, contractual arrangements, and pricing records based on timely information provided electronically by Customer in DSTHS compatible formats. DSTHS shall not be responsible to maintain more than one (1) provider network consisting of 5,000 providers, with 2 changes per contract year. DSTHS shall not be responsible for provider credentialing. In the event that DSTHS requires more staff than anticipated to meet the services set forth in the above paragraph, DSTHS shall have the right to increase the PMPM fees hereunder.

DSTHS shall also maintain within the ISS Member records and databases based on timely and accurate information provided electronically by Customer in DSTHS compatible formats. DSTHS shall not be required to maintain more than one (1) base benefit plan.

3. Front End Services: From a designated PO Box, DSTHS shall receive, scan and image paper Claims using imaging technology onto a DSTHS database where such Claim images will be available for viewing by Customer until moved to back-up media according to DSTHS's normal procedures. DSTHS shall capture 47 CMS (HCFA) fields and 188 fields for UB Claims.

4. Claims Processing:

   a. DSTHS shall receive, sort, enter (as necessary for paper Claims) and adjudicate Claims in accordance with Customer's payment guidelines and provider contracts entered into the ISS, and suspend certain Claims, as directed, to Customer for review.

   b. Receive EDI Claims from DSTHS's clearinghouse in a batch basis no less than once each business day, excluding DSTHS's holidays. Submission services may include software developed by DSTHS to enable the receipt and processing of transactions received. DSTHS will utilize only one clearinghouse under this Agreement. Additional clearinghouses requested by Customer shall be implemented as On-Demand Services

      HIPAA Validation Services are included as part of Submission Services based on the HIPAA implementation guidelines and WEDI testing levels 1- 6. DSTHS reserves the right to bill Customer, at DSTHS's then current hourly rate, for any additional training and/or business rule configuration that Customer requires DSTHS to perform based on Customer specific business requirements, or the business requirements of its clearinghouse, including additional testing, training or custom programming..

   c. DSTHS shall produce and mail hardcopy Claim payments and Explanation of Payments ("EOPs") to providers on a weekly basis.

   d. DSTHS shall produce and mail hardcopy Explanation of Benefits ("EOBs") to Members on a weekly basis.

   e. DSTHS shall manage the inventory of EOB and claim check forms, including re-ordering of such forms as necessary.

   f. DSTHS shall process Claim adjustments, check voids and refunds based on written guidelines provided by Customer, or in the event of a request to adjust a specific Claim, based upon the written, or electronically transmitted, request of Customer. Customer shall be primarily responsible for the detection of possible Claim adjustments, such as adjustments required based on Customer's performance of COB processing, but DSTHS shall notify Customer if in the normal course of DSTHS's work, a Claim adjustment is identified.

   g. DSTHS shall flag and pend COB/ OPL opportunities for Customer's review and pursuit (if pay and pursuit).

h. DSTHS shall provide Customer with monthly claims processing performance reports, as set forth in Schedule E.

5. Client Support:

a. Help Desk: DSTHS will provide to Customer a help desk charged with receiving and tracking all calls and problems associated with the ISS. DSTHS's standard business hours are Monday through Friday, 8 AM to 6:30 PM EST, excluding DSTHS observed holidays. Detailed information, such as contacts and phone numbers related to the help desk, will be provided to Customer.

DSTHS will utilize its resources (Help Desk, Account Management, Technical Support Area, as required) beyond normal business hours and exercise commercially reasonable efforts to resolve failures of the ISS to operate in accordance with its Release notes ("Defects"); provided, that, such Defect(s) causes production to stop in the ISS, or an application within the ISS, when no manual process workarounds exist. DSTHS shall continue to work on such Defects until the Defect is fixed or a manual process workaround is developed. The development of manual process workarounds in order to allow Customer to perform functions not inherently present within the ISS shall not be deemed Defects.

All other after hours support shall be billable as an On-Demand Service.

b. Account Manager: DSTHS will provide an Account Manager who shall, among other obligations, coordinate the execution and delivery of Work Orders and On-Demand Services, conduct functional meetings and act as a liaison between Customer and DSTHS staff. Customer acknowledges that DSTHS's Account Manager shall not be solely dedicated to Customer.

c. Technical Support: DSTHS will provide a Technical Support Area consisting of Technical Support Specialists, including Business Analysts, Programmers and other IT professional staff whose responsibility it shall be to track, research and use commercially reasonable efforts to fix (or coordinate the fixing of) Defects, or in the alternative develop manual process workarounds. The Technical Support Area may only be contacted through the Help Desk.

Other than the tracking, researching and fixing of Defects in the ISS and the development of manual process workarounds, the Technical Support Specialists shall be billable personnel under this Agreement. It is understood that if, after researching a Customer-reported Defect, it is determined that the Defect was not a problem in the ISS, the time spent by the Technical Support Area to determine the origin of the problem shall be billable.

In the event that a defect is reported to the Technical Support Area and it is a Defect which DSTHS plans to fix in a future Release (or DSTHS knows a Third Party Vendor or Third Party Vendor is planning on fixing in a future Release), DSTHS shall provide Customer with the option of either having the defect fixed at a billable rate (subject to ISS or Third Party Vendor's approval), or waiting for the future Release.

6. Reporting: Customer shall be entitled to the standard reporting packages available in the ISS and Third Party Products, as may change from time to time pursuant to Releases. The standard reporting package shall mean those reports that can be run from the ISS and Third Party Products without need of customization. Custom reporting packages are available as an On-Demand Service.

7. Inventory of Hours: At the fees set forth in Schedule C under "Inventory of Hours" Customer shall purchase an annual inventory of 500 hours for development work (custom programming), encounter, reporting and EDI services (not including transaction or submission fees themselves). Any services performed in excess of the purchased calendar quarter Inventory of Hours will be billed to Customer pursuant to the executed Work Order under which the excess services were performed.

The inventories of hours shall be subdivided into calendar quarters, such that Customer will purchase and receive 125 hours per calendar quarter. No hours may roll over into a new calendar quarter.

The parties acknowledge that this Agreement is anticipated to Go Live after January 1st of a calendar year. As such, Customer's first year inventory will be pro-rated on an annual basis and, further, Customer's first calendar quarter inventory will be pro-rated on a calendar quarter basis.
All services which draw upon Customer's inventory of hours must be represented by a signed Work Order between the parties.

SCHEDULE B

ON-DEMAND SERVICES

During the term of this Agreement, DSTHS shall use reasonable efforts to provide the following On-Demand Services to Customer, based on a mutually agreed upon Work Order. Any service required or requested by Customer that is not specifically set forth in Schedule A as DSTHS's responsibility shall be considered an On-Demand Service and shall be billable as indicated in Schedule C, Fees. The following is a partial list of such On-Demand Services:

1. Enhancements. During the term of this Agreement, DSTHS shall use reasonable efforts to provide custom Enhancements (including custom ad hoc reports) to the ISS, Third Party Products, Interfaces, or Customer developed software, as may be requested from time to time by Customer, on a time and materials basis, at the prices set forth in Schedule C, Fees. Such custom Enhancements may be performed utilizing the Inventory of Hours set forth herein.

Customer understands and acknowledges that DSTHS's right to perform custom Enhancement work may be governed by DSTHS's agreements with licensor(s) or Third Party Vendors. In the event DSTHS does not have the right to perform any particular custom Enhancement, such custom Enhancement shall be performed by Third Party Vendor, at Third Party Vendor's option, at prices and time estimates as mutually agreed by Customer and DSTHS. DSTHS shall use reasonable efforts to (i) arrange for the Third Party Vendor to perform the custom Enhancements and (ii) to coordinate the delivery of such custom Enhancements performed by the Third Party Vendor.

2. Training and Consulting. DSTHS will make available to Customer training sessions and consulting services in the use of the ISS, the Third Party Products, or a component of either. Such training and/or consulting shall be provided at mutually agreed upon dates, times and charges for such training/consulting.

3. EDI Clearinghouses and Transactions. All new clearinghouse installations and transactions will require a new amendment to the Agreement.

4. Additional Users/Licenses. In the event that Customer requires more than the threshold number of Concurrent or Named Users as identified herein, Customer will compensate DSTHS according to the fees listed in Schedule C, Fees.

SCHEDULE C

FEES

I. Implementation Services

DSTHS has agreed to limit its fee for performance of Implementation Services to two hundred thousand dollars ($200,000) upon execution of the Agreement, and the remainder of Implementation Services Fees are included in the performance of On-Going Services performed under the Services Agreement.

The fixed fee implementation includes: PowerMHC Release 22.1, BPO, AWD Workflow, AWD Customer Service, AWD Image Repository, AWD Grievance/Appeals, ePower (provider web portal), CareConnect, CareAnalyzer, 3i, McKesson's ClaimCheck, and all EDI transactions listed in Schedule C II C.

II. On-Going Services

A. Monthly PMPM Fees. Commencing on the Go Live Date and continuing throughout the remaining Term of this Agreement, DSTHS will charge Customer a monthly fee for the provision of the On-Going Services for the Customer Products as set forth in Schedule A. Pricing subject to change based on further due diligence during the implementation period. This fee will be calculated; (i) based on the Membership in each of the Customer Products for each such month, and (ii) based on the applicable PMPM fees set forth in the following tables.

BPO services for Medicaid: Front End Services, Claims processing, provider & member maintenance, Output Services (checks, EOP/RA), DSTHS claims platform, McKesson ClaimCheck and AWD Workflow. Hosting services for CareConnect, CareAnalyzer, AWD Customer Service and AWD Grievance/Appeals		
Membership		PMPM
1	200,000+	$4.45

B. Minimum Monthly Fee. Each month commencing on the Go Live Date, there shall be a minimum monthly fee for DSTHS' performance of the On-Going Services equal to minimum membership of 25,000 at the $4.45 pmpm equaling the sum of $111,250 the "Minimum Monthly Fee"). In the event that in a given month commencing on the Go Live Date, the monthly fee based on actual Membership is less than the Minimum Monthly Fee, DSTHS shall invoice and Customer shall pay the Minimum Monthly Fee for such month. In the event that On-Going Services begin for an individual Customer Product(s) after the Go Live Date, the Minimum Monthly Fee calculation set forth in this Section C shall not include the minimum Members for such Product(s) until such time that On-Going Services commence for such Product(s).

C. Transaction Fee: DSTHS will charge Customer the following transaction fees for the listed transaction types:

EDI Transaction Type	Transaction	# of Trading Partners
837 Inbound Professional/Institutional	$0.33	1
820 Inbound (product report only)	$0.05	1
835 Inbound/Outbound Remittance (ERA)	$0.08	1
834 Inbound	$0.05	1

834 Outbound (1 map)	$0.05	multiple
270/271	$0.08	1
276/277	$0.08	1
EFT	$0.05	1

A "Transaction" is defined as an individual claim, member enrollment record, vendor payment, premium payment, eligibility request/ response, claim status request / response or authorization request / response. Pricing assumes Emdeon is involved.

D. IT Operations

DSTHS will perform batch jobs run of 500 jobs per month. Any additional jobs over 500 will be on a time and materials basis rate of $99.00/hour. IT Operations include batch processing 24 X5 and specific EDI transactions.

E. Fulfillment Services

See Exhibit 1 to this Schedule C. Postage and fulfillment costs are a pass through charge.

F. Managed Network Connectivity Services

One time set up fee: $3,571.00 (due when network connectivity is ordered).

The Monthly Fee Network Connectivity fee is $2,581. (due upon network installation and every month thereafter).

The network is required for testing purposes and the monthly fee begins upon installation of the network. The monthly fee is reviewed annually and is subject to change.

G. Fees for Subsequent Contract Years. The fees indicated in Section II and V of this Schedule C are for the initial twelve (12) month period commencing on the Go Live Date. Fees for each subsequent twelve (12) month period during the Term of the Agreement shall increase by the percentage increase in the Consumer Price Index (according to the U.S. Bureau of Labor Statistics), All Urban Areas, during the prior twelve (12) month period.

H. Manual claims processing and other DSTHS activities prior to automation

In order to support Customer's required Go Live dates, DSTHS may charge additional fees due to the lack of automation and increased labor costs. These additional fees are temporary, and upon Go Live of AWD Workflow and for front end services would be removed.

III. Anticipated Processing Metrics

A. Claims utilization of 16 claims PMPY.
B. Up to 2% adjustments. Additional adjustments billable on T&M basis.
C. Paper ratio of CMS 85% and 15% UB.
D. Front end services field capture of 44 fields for CMS and 57 fields for UB forms.
E. EDI rate of 60%.
F. Minimum claims auto-adjudication rate of 60%.
G. Maximum of 3 benefit plans.
H. Provider count up to 5,000 providers with an average 2 changes per provider per year.

In the event that the anticipated metrics set forth above are not consistently met, DSTHS reserves the right to renegotiate the PMPM, Transaction or other fees set forth in this Schedule C.

IV. Inventory of Hours

DSTHS shall provide an inventory of 125 hours per quarter at the rate of $95.00 per hour. Hours shall be adjusted and pro-rated according to the process set forth in Schedule A. The Inventory of Hours for each calendar quarter shall be billed by DSTHS at the beginning of each calendar quarter. For purposes of clarity, Customer agrees to purchase a minimum of 125 hours per quarter at the rate of $95.00 per hour.

V. On-Demand Administrative Service

A. For On-Demand Services, as set forth in Schedule B of this Agreement, fees shall be estimated in advance and approved by Customer before expended, and charged based on actual hours at the indicated hourly rate.

	< 1,000 hours	1,000 - 10,000 hours	10,000 + hours
Architect	$135.00	$124.00	$114.00
Business Analyst	$135.00	$124.00	$114.00
Customer Support	$91.00	$84.00	$77.00
Designer	$119.00	$109.00	$100.00
Development Services - Doc	$77.00	$70.00	$65.00
Development Services - Programmer	$95.00	$87.00	$80.00
Development Services-Other	$95.00	$87.00	$80.00
Development Services-Testing	$77.00	$70.00	$65.00
EDI Consultant	$95.00	$87.00	$80.00
IT Operations	$117.00	$107.00	$99.00
Project Manager	$135.00	$124.00	$114.00
Project Administrator	$86.00	$79.00	$73.00
Business Consultant	$128.00	$117.00	$108.00
Application Consultant	$100.00	$92.00	$85.00
Off Shore - Developer	$45.00	$41.00	$38.00
Off Shore - Consultant	$50.00	$45.00	$42.00
Training at DSTHS site		$1,250 per person	
Training at client site		$2,500 a day up to 10 people	

B. DSTHS shall provide Customer thirty (30) days advance written notice of any increase in the fees for On-Demand Services.

C. Fees for additional Third Party Product licenses or log-on IDs will be subject to such Vendors' then-current fee schedules.

D. On-Demand Services Payment Terms

1. Enhancements

Customer shall bear the cost of Enhancements that are requested in writing by Customer and agreed to and performed by DSTHS, its agent or DSTHS' licensor. DSTHS shall invoice Customer based on actual hours worked for work in progress, rounded up to the nearest 0.25 of an hour. Monthly invoices will cover all time spent performing Enhancement work and participating in meetings and discussions regarding the Enhancement work, and will indicate the number of hours worked and expenses incurred.

Customer may terminate an Enhancement project at will (unless otherwise agreed to in the applicable Work Order) upon ten (10) days written notice, but shall be responsible for paying DSTHS' fees up until the time of notification.

2. Other On-Demand Services

For all other On-Demand Services, Customer will be invoiced monthly based upon the terms of payment set forth in the applicable Work Order, or in the case of additional access or licenses, as set forth above.

3. Expenses for On-Demand Services

Customer shall reimburse DSTHS for any and all reasonable out-of-pocket expenses incurred in performing On-Demand Services, including but not necessarily limited to, travel to and from Customer's site, lodging, meals, telephone charges and shipping charges, as may be necessary in connection with the duties performed by DSTHS under this Agreement. In addition, when DSTHS (a) performs work while traveling or (b) Customer requires DSTHS to travel on weekends (from Friday at 7:00 p.m. to Monday at 6:00 a.m. prevailing Central time) or on nationally recognized holidays, Customer will be billed for actual travel time. DSTHS also reserves the right to bill Customer for travel time in other situations or under other circumstances, where billing for such time is reasonable and/or equitable; such circumstances will be agreed upon with Customer in advance. Expenses will be billed monthly, and shall be due and payable by Customer within thirty (30) days of the date of an invoice.

4. Payment Terms

Fees for On-Demand Administrative Services are due and payable with thirty (30) days of the date of invoice. Fees that are due but not received within thirty (30) days of the date of invoice are subject to a late fee as set forth in Section 6.E of this Agreement.

E. Additional licenses/log on IDs shall be licensed by Customer at DSTHS's then current fees.

PowerMHC, including any third party software:

Number of Named Users	Annual Per Named User Fee
6 and above	$1,500

AWD:

Number of Named Users	Annual Per Named User Fee

Workflow - 6 and above	$1,500
Customer Service - 8 and above	$1,644
Grievance/Appeals – 3 and above	$1,644

Integrated Care Management:

Number of Named Users	Annual Per Named User Fee
CareConnect – 16 and above	$1,670
CareAnalyzer – 8 and above	$1,100

Customer is responsible for additional fees for groupers and/or APC specific pricers. Customer is responsible for any additional fees of any new DSTH's software licenses.

VI. Subsequent Upgrades

Major Releases, upgrades, and servers needed subsequent to the Go Live Date and any related travel expenses are not included in the fees set forth in this Agreement and would be billed at DSTHS's then current rates. DSTHS will not implement any such Major Releases or upgrades without the prior written consent of both parties.

VII. Additional Costs and Expenses

Customer shall reimburse DSTHS for any and all out-of-pocket expenses, subject to Section 6.D of the Agreement, incurred in performing the Services, including but not necessarily limited to, travel, lodging, meals, telephone charges and shipping charges, as may be necessary in connection with the duties performed by DSTHS under this Agreement. In addition, when DSTHS (a) performs work while traveling or (b) Customer requires DSTHS to travel on weekends (from Friday at 7:00 p.m. to Monday at 6:00 a.m. Eastern prevailing time) or on nationally recognized holidays, Customer will be billed for actual travel time. DSTHS also reserves the right to bill Customer for travel time in other situations or under other circumstances, where billing for such time is reasonable and/or equitable; such circumstances will be agreed upon with Customer in advance. Expenses will be billed monthly, and shall be due and payable by Customer within thirty (30) days of the date of an invoice.

Additionally, Customer shall bear the cost of all items not specifically included in the fees, including without limitation, postage, paper stock, the cost of forms, check stock and other Customer-specific materials, telecommunication line fees (under separate, mutually agreed upon telecommunications contract with DSTHS), run-out Claims processing, and equipment located at Customer's site or a site requested by Customer.

EXHIBIT 1

NEWKIRK FULFILLMENT FEES

newkirk®
A DST Company

Member Booklets and Provider Directories

Thrive
28-Mar-13

Section A

Member Booklets and Provider Directories Retail Costs

Program, Print, Kit and Mail Services

Processing - Print On Demand		
Laser Printing B/W 8 1/2" x 11" pages	$0.0385	per side/image
Cover Printing		
11" x 17 1/4" Digital Printed Cover 4/0	$0.3520	per cover
Cover File Set-up Fee	$27.50	per file
Finishing		
Perfect Binding	$0.5500	per booklet
Envelopes		
9 x 12 closed faced envelopes	$0.0880	per envelope
Processing Services		
Per file processing fee - uploading a mail file	$27.50	per file
Laser Print Mailing Recipient Data onto envelopes	$0.1650	per envelope

All pricing is exclusive of Postage

Examples	20 page booklet	40 page booklet	60 page booklet
Cover	$0.3520	$0.3520	$0.3520
Page Count varies per booklet	$0.7700	$1.5400	$2.3100
Perfect Binding Fee	$0.5500	$0.5500	$0.5500
Envelope	$0.0880	$0.0880	$0.0880
Envelope Addressing	$0.1650	$0.1650	$0.1650
Total per booklet*	$1.9250	$2.6950	$3.4650

*Pricing does not include postage or $27.50 per file processing fee.

Production Assumptions

3 business day turnaround time
Volume Estimate: TBD

B	Other Services provided as necessary		Unit Price
	Design Services	per hour	$110.00
	Programming – Maintenance	per hour	$165.00
	Bulk Shipping	per request	at actual
	Fulfillment Costs (additional piece sent with booklet)	per insert	$0.1100
	Warehousing for materials produced outside of Newkirk/DST - No cost for materials produced at Newkirk	per skid/per year	$231.00
	File aborts	per file	$27.50

C	Development	Unit	Fee
	Enroll Plus Health Booklet Builder System	One Time	$1,650.00

D Pricing Assumptions

1. Five Year Agreement
2. All pricing is subject to due diligence review
3. Materials to be provided by Newkirk/DST Output
4. Pricing is valid for 90 days from date of proposal
5. Other costs such as Data transmission, Dedicated Lease Lines and artwork creation are not included and will be quoted based upon requirements
6. Prevailing USPS rates apply.
7. These prices are good faith estimates. Although our goal is to keep within the estimate, the actual cost of the printing component of this project will ultimately depend on your actual chosen design. The number of colors, paper stocks used and other production techniques will always vary somewhat from job to job.
8. Provider Directories must be in PDF ready state. If not, Newkirk design/programming services will be needed

Budgetary Fees Schedule - ID Cards

Thrive
21-Mar-13

newkirk
A DST Company

Section A

ID Cards - Retail Cost for the client

Program, Print, Kit and Mail Services

	ID Cards 2-up 20 mil. Laminated	
Processing - Image, Insert,		
Production Cost: (2-up ID Card, Laser, Laminate, Die-Cut, Insert)	$0.8250	
Inserts		
8 1/2" x 11" Generic letter to be printed and inserted with ID card - printed simplex	$0.0600	per letter
Fulfillment Costs - Fee to enclose letter into envelope with ID card	$0.0600	per insert
Envelopes		
#10 Dual window envelope - for use with 2 up ID card and letter (no ink) (50,000 Qty $2,420.00)	$0.0484	per envelope
Processing Services		
Per file processing fee	$27.50	per file

All pricing is exclusive of Postage

Example - at Retail Cost	ID Cards 2-up 20 mil. Laminated
Card, print, process, insert	$0.8250
Letter	$0.0600
Insert Fee	$0.0600
Envelope	$0.0484
Total per package*	$0.9934
*Pricing does not include postage or $27.50 per file processing fee.	

Production Assumptions

3 business day turnaround time

Volume Estimate: 50,000 ID Cards

Reporting includes: return file report, error report.

Digital Printing in Color on Side 1/Black ink on side 2.

B	Other Services provided as necessary	Unit	Retail Price
	Design Services	per hour	$110.00
	Programming - Maintenenace	per hour	$165.00
	Shipping	per request	at actual
	Manual pulls from production	per ID Card	$6.60
	Fulfillment Costs (additional piece sent with ID Card)	per insert	$0.60
	Warehousing for materials produced outside of Newkirk/DST - No cost for materials produced at Newkirk	per skid/per year	$231.00
	File aborts	per file	$27.50

C	Development	Unit	Retail Fee
	Custom System Set-up	One Time	$5,500.00

D Pricing Assumptions

1. Five Year Agreement
2. All pricing is subject to due diligence review
3. Materials to be provided by Newkirk/DST Output
4. Pricing is valid for 90 days from date of proposal
5. Other costs such as Data transmission, Dedicated Lease Lines and artwork creation are not included and will be quoted based upon requirements
6. Prevailing USPS rates apply.
7. These prices are good faith estimates. Although our goal is to keep within the estimate, the actual cost of the printing component of this project will ultimately depend on your actual chosen design.

SCHEDULE D

THIRD PARTY VENDOR PASS THROUGH TERMS

1. Johns Hopkins Pass Through Terms

The following terms and conditions are a pass-thru from Johns Hopkins University for the Johns Hopkins ACG Predictive Models ("Programs") contained in DSTHS's CareAnalyzer software. The Programs are not a substitute for Customer's clinical judgment.

1. Misuse of the Programs (The Johns Hopkins ACG® Predictive Models)

1.1 Estimation and Evaluation - The ACG System (the "Program(s)") produces, as output, ACG assignments ("Assignments") for individuals in a population that can be used in many ways, including adjustment and estimation of expected costs, or expected utilization of healthcare services related to the affected population(s). The Program uses population-based methodology for use at the population or sub-population level. It is not intended to be used or relied upon for conclusive analysis, or have substantive impact on decisions regarding care of affected individual patients. Any reliance on the Assignments to estimate or evaluate any parameter at the individual patient or member level, which may be construed by a provider as having any relevance in determining, estimating or evaluating care of any individual person, shall be deemed Misuse of the Programs under this Section 3.3 of Schedule D and therefore the indemnification shall apply.

1.2 Data Input to the Programs - Any and all Assignments produced by the Programs are based entirely on the data that are processed by the Programs and on the instructions provided to the Customer with the Programs. Therefore, Assignments are only as accurate and complete as the data used and Assignments cannot be relied upon for any purpose if the data are inadequate or inaccurate for Customer's intended purpose. Use of inappropriate or inaccurate data for Customer's intended purpose, or failing to instruct the Programs appropriately for Customer's intended purpose shall be deemed Misuse of the Programs.

1.3 Analyses produced with output of the Programs - In order to produce usable analyses using the Assignments produced by the Programs, the data used (payments, counts of services, RVUs, etc.) to develop analyses or reports must also be appropriate for Customer's intended purpose, and must be sufficiently accurate and complete in order to produce useful information. Use of any data to produce analyses or reports that are not consistent with data use requirements to support the Customer's intended purpose shall be deemed Misuse of the Programs.

1.4 Use of Results - Customer acknowledges and agrees that all use of the Programs, whether the Assignments and analyses are generated by Customer, DSTHS, JHU, or any other person or organization designated by Customer, and all consequences of subsequent use, are the sole responsibility of Customer. Customer agrees to take commercially reasonable care to assure that the data used to assign ACGs or to produce analyses based on the Assignments are suitable for Customer's intended use, and that all analyses produced using the Assignments and subsequently used in any way by any person or entity in the making of decisions are consistent with the requirements for Customer's intended use. DSTHS makes no warranties in relation to the suitability of the data. Failure on Customer's part to do so shall be deemed Misuse of the Programs.

1.5 Decisions Based on Assignments or Analyses - Assignment produced information intended to influence decisions or data interpretation based behavior on the part of providers, patients, managers, or any other person whether developed using Assignments produced by the Programs or any other system or set of parameters is useful only to the degree that; (i) the data used are sufficiently accurate and

appropriate for their intended purpose; (ii) the Programs or other techniques, criteria and methodologies are properly applied; (iii) Program based final reports are appropriately designed; and (iv) interpretation of data results by receiving parties are consistent with Customer's assumptions and expectations. Commercially inconsistent or inappropriate decisions regarding the accuracy and appropriateness of data used, use of the Programs, design and implementation of analyses developed, or inaccurate interpretation of data out-put by receiving parties resulting from Customer's nonconformance of any provision of this Section 1 shall be deemed Misuse of the Programs.

2. Title to and Ownership of Programs, Modifications

2.1 Customer acknowledges that certain Programs licensed hereunder are the commercially valuable, proprietary products and property of The Johns Hopkins University. Customer further acknowledges that The Johns Hopkins University has invested substantial time and economic resources in the design and development of its Programs, which required the efforts of skilled development experts, and that The Johns Hopkins University treats its Programs as confidential and that the Programs constitute trade secrets of The Johns Hopkins University, regardless of whether the Programs are or may be copyrighted or patented. Title, full ownership and all proprietary rights to its Programs shall remain with The Johns Hopkins University. Customer shall neither receive nor retain any interest in the Programs (other than the right to use the Programs in accordance with the provisions of this Agreement) nor will any right be vested in Customer to transfer use of the Programs to any other entity.

2.2 Customer agrees that modifications, customizations and enhancements of the Programs whether made by Customer, a third party, DSTHS or The Johns Hopkins University shall belong solely and exclusively to The Johns Hopkins University. Any such modifications, customizations, and enhancements made by DSTHS or The Johns Hopkins University at the request of and paid for by Customer shall be licensed to Customer by DSTHS under the same terms and conditions of this Agreement as are applicable to the Programs.

3. Indemnification

3.1 The Johns Hopkins University has warranted to DSTHS that The Johns Hopkins University will defend any action brought against Customer to the extent that such action is based on a claim that its Programs or any related documentation licensed by DSTHS infringes upon any U.S. patent or copyright when used as provided in the Agreement. The Johns Hopkins University will pay any settlement or any award against Customer based upon such infringement only if Customer notifies The Johns Hopkins University promptly in writing of such claim, permits The Johns Hopkins University to control the defense and any settlement of such claim, and provides reasonable assistance in the defense thereof. The foregoing states The Johns Hopkins University's entire liability and obligation for patent, copyright or other intellectual property infringement. Customer acknowledges and agrees that DSTHS shall have no liability or obligation for patent, copyright or other intellectual property infringement of the Programs.

3.2 In the event of settling or defending a claim of infringement, The Johns Hopkins University shall, at its reasonable expense and option, (i) obtain the right of continued use of the Programs or part thereof, which is alleged to be infringing, by Customer, or (ii) replace or modify the Programs, or part thereof, so as to make the Programs non-infringing. If The Johns Hopkins University is unable, for a commercially reasonable cost, to either acquire the rights of continued use, or replace or modify the Programs so as to make the Programs non-infringing, then DSTHS shall refund all or a pro-rata share of the licensee fees paid by Customer.

3.3 Except as provided in this Section 3, Customer hereby absolutely and unconditionally agrees, to the maximum extent allowable by law, to indemnify and defend DSTHS and The Johns Hopkins University and to hold DSTHS and The Johns Hopkins University harmless from and against any and all claims, liabilities, costs, expenses, losses, suits, damages or causes of action (including reasonable attorney fees) arising, made,

incurred, or suffered, directly or indirectly, by any person from or in connection with Customer's use of any of the Programs, and to indemnify DSTHS and The Johns Hopkins University for any liability resulting from: (i) whether, and under what circumstances, any person is or is not entitled to be reimbursed or compensated for medical treatment or care administered or received, or proposed to be administered or received, in a hospital or other medical facility (whether inpatient or outpatient); (ii) whether, and under what circumstances, any person is or is not entitled to be admitted to a hospital, or other medical facility (whether inpatient or outpatient); and (iii) Misuse of the Programs as set forth in Section 1 of this Schedule D.

2. AMA PASS THROUGH TERMS

Customer's use of the CPT codes contemplated by this Agreement is subject to the following terms and conditions.

The American Medical Association ("AMA") owns all right, title and interest in the CPT codes and all editorial content contained therein ("AMA IP"). "CPT" is copyrighted and a registered trademark of the AMA. Customer accepts a non-transferable, non-exclusive license to use the CPT codes and editorial content during the term of this Agreement, solely for Customer's internal use, within the continental United States. Customer specifically acknowledges that it shall have no right to any updates of the AMA IP following termination of the Agreement.

Customer is prohibited from publishing, distributing via the internet or other public computer based information system, creating derivative works (including translating), transferring, selling, leasing, licensing or otherwise making available to any unauthorized party the AMA IP, or a copy or portion thereof.

Customer shall ensure that anyone with authorized access to the AMA IP shall comply with the provisions of these pass through terms and conditions. In the event that Customer is allowed to make copies of the AMA IP, Customer may only make copies for back-up purposes, and must reproduce all trademark and copyright notices on such back-up copies.

To the maximum extent possible under applicable law, the AMA IP is accepted by Customer "AS IS" without any liability to the AMA, including without limitation, no liability for consequential or special damages, or lost profits for sequence, accuracy, completeness of data, or that it will meet Customer's requirements. The AMA's sole responsibility is to make available to DSTHS replacement copies of the AMA IP if the data is not intact. The AMA disclaims any liability for any consequences due to use, misuse, or interpretation of information contained or not contained in the AMA IP.

The AMA IP is commercial technical data and/or computer data based and/or commercial computer software, and /or commercial computer software documentation, as applicable, which was developed exclusively at private expense by the America Medical Association, 515 North State Street, Chicago, Illinois 60610. U.S. Government rights to use, modify, reproduce, release, perform, display or disclose these technical data and/or computer data bases and/or computer software and /or computer software documentation are subject to the limited rights restrictions of DFARS 252.227-7015(b)(2) (November 1995) and/or subject to the restrictions of DFARS 227.7202-1(a) (June 1995) and DFARS 227.7202-3(a) (June 1995), as applicable, for U.S. Department of Defense procurements and the limited rights restrictions of FAR 52.227-14 (June 1987) and FAR 52.227-19 (June 1987), as applicable, and any applicable agency FAR Supplements, for non-Department of Defense Federal procurements.

In the event that any provision herein is found to be in violation of any law, or is unenforceable the remainder of these pass through terms shall remain in full force and effect.

3. AWD PASS THROUGH TERMS

DST TECHNOLOGIES, INC. ("DST")
PASS THROUGH TERMS AND CONDITIONS

1. Definitions for Purposes of the Following Terms and Conditions

A. **"AWD Data Center"** shall mean the data center(s) owned and operated by DST Systems, Inc. ("Parent") which data center(s) are currently located at (i) the Poindexter Building, 330 West 9th Street, Kansas City, Missouri 64105, U.S.A.; or (ii) the Winchester Building, 7201 E. 64th Court, Kansas City, Missouri 64133. The terms "AWD Data Center" and "DSTHS Data Center" shall mean the same Data Center.

B. **"AWD Server Software"** shall mean that part of the AWD software that resides on a server.

C. **"Customer"** means CCHP. Thanks gm

D. **"System"** shall mean collectively the computer software AWD System, including the Workflow and Customer Services modules of the AWD System (the "Licensed Software"),all related user and system documentation (the "Documentation"), provided, however, the term "System" shall not include any software or software code, including freeware, computer code, or other items or materials that are subject to the GNU General Public License or any other open source license agreement, that is created or provided by a third party and is incorporated into the Licensed Software, as well as the AWD Server Software and other software hosted and operated at the AWD Data Center.

E. "Version" shall mean a set of object code and associated documentation of the Licensed Software that is associated with a specific hardware platform, operating system or other technology, which distinguishes it from other forms of the Licensed Software.

2. During the Term of the Agreement, DST hereby grants to Customer, and Customer accepts from DST a non-exclusive, non-transferable license (the "License") to Access the machine executable (object code) copy of the Licensed Software and the Documentation in accordance with the terms and conditions of the Agreement. This License grants Customer no title or rights of ownership in the System or any components thereof, or any right to use, copy, transfer or disclose all or any portions of the System except as expressly provided in the Agreement. All changes, additions, and updates in the Licensed Software or Documentation that may be provided by DST or DSTHS or other work product of DST or DSTHS provided by DST or DSTHS pursuant to the Agreement; shall remain proprietary to DST and shall be received by the Customer for its use pursuant to all of the restrictions and other terms and conditions of the Agreement, including, but not limited to, use limitations, the exclusion and limitation of warranties, limitation of liability, and undertakings of confidentiality and non-disclosure. The Agreement does not grant Customer a license to the AWD Server Software or the AWD database being operated at the AWD Data Center and no such software will be delivered to Customer hereunder. The Licensed Software may be accessed from any workstation owned or operated by Customer or its Affiliates in the United States without regard to location. The Customer shall not (i) permit any third party to use the Licensed Software, or any part thereof, or access the System or any part thereof or (ii) use the System or the AWD Server Software or the AWD database to process the documents or data of any third party except as permitted by the Agreement. All documents and data processed by the System and output produced by the System shall be the property of and owned by Customer or Customer's Affiliates.

3. Customer shall not reverse engineer, decompile, or disassemble the System or the Licensed Software or any portion thereof, or otherwise attempt to create or derive the source code (including, but not limited to, review of data structures or similar materials, produced by the System.)

4. Customer shall immediately cease any use of the System (in any form) or any part thereof upon termination of the Agreement for any reason. In such an event, Customer shall deliver to DST within ten (10) business days all Licensed Software and Documentation in the form provided by DST or as modified by Customer and all copies thereof, in whole or in part, made by Customer or certify to DST that such Licensed Software or Documentation has been destroyed.

5. Customer acknowledges that there may be third party software applications embedded in the System. The use of such third party software is limited to the use as integrated into the Licensed Software. Such third party applications may include source code which such licensors may provide as part of the standard shipment and such source code is subject to the terms of this Agreement.

6. Third party technology that may be appropriate or necessary for use with the System is specified in the application package documentation or as otherwise notified by DST or DSTHS such third party technology is licensed to Customer under the terms of a third party license agreement specified in the Documentation or as otherwise notified by DST or DSTHS and not under the terms of the Agreement.

7. Customer shall inform DSTHS in writing of any modification in the applicable Licensed Software made by others than DST.

8. Customer, with computer equipment and through transmission facilities installed on its premises, shall transmit such information and data that Customer determines is to be input and that is required to use the Server Software to the AWD Data Center.

9. To the extent sufficient communication circuits are not already provided to Customer under the Agreement, Customer shall be responsible for and pay the costs of all communication circuits necessary to enable Customer to utilize the DST AWD Server, the peripheral servers and image storage systems. However, if, at Customer's election, DST or DSTHS obtains communications circuits, on Customer's behalf, DSTHS shall bill the costs of the communications circuits and related network costs and expenses, including DST's and DSTHS' monitoring and problem resolution services described below, to Customer as a reimbursable expense. In such event, DST and DSTHS shall also utilize communications network control and monitoring capabilities to assist Customer with the identification and resolution of any problems which appear to be related to the communications circuits obtained by DST or DSTHS on Customer's behalf, but DST and DSTHS are not responsible and shall have no liability for inadequacies or failures to perform related to or arising out of such communications circuits prior to their entry into the AWD Data Center. In the event Customer elects to engage a third party directly to provide the communications circuits, Customer shall be responsible for (i) providing connectivity between Customer's locations and the AWD Data Center reasonably necessary for Customer to access the DST AWD Server, the peripheral servers and image storage systems; and (ii) for the provision of communications network control and monitoring capabilities to identify and to resolve any problems which occur prior to the entry of such circuits to DST. DST or DSTHS shall, as reasonably possible, assist Customer with the identification and resolution of problems with the communication lines to the extent DST or DSTHS have personnel available and free to do so or as otherwise agreed by the parties.

10. In the event DST ceases to provide maintenance and support for the Versions of the System then being hosted under the Agreement, Customer will license supported Versions as soon as practicable after the announcement by DST of the sunset of the prior Version. The timing of the migration to the supported Version shall be as mutually agreed, but not later than a time that is commercially reasonable for such conversion to be completed prior to the sunset of the prior Version.

11. Customer shall transmit or cause to be transmitted to the AWD Data Center, in the formats and form specified by DST, DSTHS or its Affiliates, all information, data or other documentation required or desirable in connection with Customer's use of the DST AWD Server, the peripheral servers, or the AWD Data Center so that the input shall be complete and accurate when it is received by the AWD Data Center. Customer shall advise

DSTHS of any (i) errors or mistakes in the data, information or documentation transmitted to the AWD Data Center, (ii) errors or mistakes in the records maintained (or intended to be maintained) on the DST AWD Servers, and/or the related image storage systems, (iii) errors or mistakes in the output generated by the AWD Server Software or (iv) any other issues with respect to Customer's use of the DST AWD Server, the AWD Data Center, any third party software operated by or hosted by the AWD Data Center and/or the operation of the AWD Server Software. Using normal audit and control procedures, Customer shall verify (i) that all data, information and documentation transmitted to the AWD Data Center hereunder is properly input into the System and is accessible by Customer hereunder and (ii) all output received hereunder. Notification of any errors or mistakes or other issues shall be provided promptly under the circumstance (but no later than 24 hours after Customer knows or reasonably should know of such error or mistake or other issue). Customer shall be responsible and liable for any resulting losses and the cost or expense of regenerating any output if Customer shall have (i) failed to utilize and employ a reasonable control procedure available on the System, (ii) failed to transmit properly any information, data or documentation, (iii) transmitted erroneous or incorrect information, data, or documentation, or (iv) failed or delayed to notify DST or DSTHS of any error or mistake in (x) any record, report, data or information sent to DST, (y) the records maintained or supposed to be maintained on the DST AWD Server and/or the related image storage systems or (z) the output provided by DST or DSTHS.

12. Upon written notice to Customer, DST shall be entitled to audit, where installed and during normal business hours (which shall include any hours during which Customer or any User is using the Licensed Software), the number and location of (a) workstations on which the Licensed Software is installed or accessed, (b) Users who are capable of accessing or using the Licensed Software, and (c) workstations which have access to the AWD Data Center. DSTHS shall be entitled to bill retroactively for any previously undisclosed workstations, servers or users from the month in which they were first installed or able to access or use the Licensed Software. DST may provide the results of any such audit to its licensors solely to the extent the results pertain to such licensor's software applications.

13. For a period of ninety (90) days from the date of installation, DST warrants that the Licensed Software shall perform in all material respects in the manner specified in the Documentation provided to Customer as of the date hereof, provided that (i) Customer has not modified or altered the Licensed Software and (ii) the malfunctions of the System are not due to (x) the failure to install promptly an Update provided by DST, or (y) conflicts or non-compliance with any non-Licensed Software installed by Customer on an affected workstation or system. DST's sole obligation and liability under the preceding sentence is to use its commercially reasonable efforts to promptly correct any such failure to perform. DST does not warrant that: (i) the System will run properly on all hardware; (ii) the System will operate in the combination of hardware/software which may be independently selected by Customer; (iii) the use of the System will be uninterrupted or error-free; or (iv) the System will run properly following unauthorized modifications by Customer or a third-party.

14. The Customer further represents and warrants that, to the extent that it is using the Licensed Software on equipment not provided to Customer by DST or DSTHS, Customer has obtained a license or the right to use the operating software which is included in the equipment.

15. Neither DST nor DSTHS or their Parent company shall be responsible for, and Customer shall indemnify and hold DST, DSTHS and their Parent company harmless from and against, any and all costs, expenses, losses, damages, charges, counsel fees, payments and liability, which may be asserted against DST, DSTHS or their Parent company for which it may be liable, arising out of or attributable to:

(i) All actions of DST, DSTHS and their Parent company required to be taken pursuant to this Agreement provided that DST, DSTHS and their Parent company have acted in good faith and with due diligence;

(ii) Customer's failure to use and employ the System and the AWD Data Center in accordance with this Agreement or the Licensed Software in accordance with the Documentation delivered to Customer or Customer's failure to utilize the control procedures set forth and described therein;

(iii) Customer's errors and mistakes in the use of the the System, the AWD Data Center and control procedures;

(iv) DST's reasonable reliance on, or reasonable use of, in performing its duties and obligations hereunder, information, data, records and documents received by DST, DSTHS and their Parent company from Customer;

(v) The reliance on, or the carrying out of, any instructions or requests of Customer; and

(vi) Customer's refusal or failure to comply with the terms of this Agreement, or which arise out of the breach of any representation or warranty or covenant of Customer hereunder.

16. DST and DSTHS are not and shall not be responsible for the following: (i) any changes to Customer's database caused by Customer or any unauthorized third-party; or (ii) in the event that Customer makes modifications to the System, any repair of database, support of Licensed Software or compatibility of the modified Licensed Software with any equipment, with the unmodified System or with any future Licensed Software releases.

17. Any termination of the Agreement shall terminate Customer's license provided herein. Upon any expiration or termination of this Agreement and the License herein granted for any reason, Customer shall deliver to DST or DSTHS all copies of the Licensed Software and Documentation, and including all magnetic tape and other materials furnished by DST or DSTHS and pertaining to the System, and Customer shall also represent and warrant to DST or DSTHS in writing that to Customer's knowledge, all copies thereof have been returned to DST or destroyed.

18. Customer agrees to serve as a reference for DST and AWD. This will involve Customer participating in reference calls and hosting a reasonable number of prospect visits. Customer also agrees to allow DST to publish pre-approved press releases and case studies, which approval may not be unreasonably withheld.

19. AWD Users.

(i) An AWD/Contact User license and an AWD User license are required for each user accessing AWD via the *AWD/NetServer with AWD/Contact Extensions.*

(ii) An AWD User license is required for each user accessing the AWD Server via *AWD/NetServer.*

(iii) AWD BPM Named User – An AWD BPM Named User can be configured for access to all view, inquiry, update, lookup, and work select functionality in the System. Such users may access AWD via either the AWD 3.x Client or a custom-built interface (including an interface based on the AWD Thin Client). Each such user will be identified by an independent entry on the W06 (or equivalent) AWD User Security table.

SCHEDULE E

PERFORMANCE STANDARDS

Certain of the On-Going Services set forth in Schedule A of this Agreement are subject to an expected level of performance, referred to herein as a "Performance Standard" or the "Performance Standards". DSTHS will use commercially reasonable efforts to meet the following Performance Standards, but makes no warranties or representations that such Performance Standards can be met or will be met consistently.

DSTHS shall track its performance relative to the Performance Standards set forth herein this Schedule E on a monthly basis and report such performance to each other in writing, or by electronic mail, within thirty (30) days of the end of each calendar month, but shall not be reported or effective for the first three (3) full months following the first date on which DSTHS runs its first payment cycle.

All accuracy rates shall be determined by DSTHS based on one statistically valid random sample of finalized Claims. Such Claim sample shall be selected to provide a confidence level of 95% or greater, and a tolerance level of no greater than plus or minus 3%. Adjusted claims, per Schedule A, shall be eligible for inclusion in the sample.

I. Claims Processing Timeliness

Claims shall be categorized as "Clean Claims" or "Unclean Claims". A Clean Claim is one with no defect or impropriety, which would require information or intervention external to DSTHS or Customer.

A defect or impropriety shall include any circumstance requiring special treatment that prevents timely payment from being made on the Claim (such as missing or invalid information on the Claim which cannot be determined with certainty from information available in the ISS). A Claim which does not meet the definition of a Clean Claim is categorized as an Unclean Claim.

Processing Timeliness is a measurement of the number of days to process a new Claim, from the date the Claim is received at DSTHS to the date the Claim is posted on the ISS for payment, or the date the Claim is posted on the ISS for rejection.

Performance Standards:

Clean Claims

i) 95% in 30 calendar days for paper Claims

All Other Claims

i) 99% of all Pended Claims in 60 calendar days

For purposes of measuring DSTHS's performance relative to the Processing Timeliness Performance Standard, processing time for claims routed to Customer, at the request or consent of Customer, COB "claims" and Claims contained in rejected files or files requiring manual manipulation shall always be excluded from the calculation of performance.

II. Claim Accuracy

Claim Accuracy is a measurement of the projected percentage of claims processed by DSTHS during a given period of time, that were processed accurately, based on benefit information and processing

policies and guidelines in the ISS at such time that the claim was processed. Claim Accuracy shall be measured relative to two Performance Standards; Financial Accuracy and Payment Accuracy. Errors caused by Customer's failure to perform its assigned functions to maintain and update the provider files shall not be considered DSTHS's error.

Performance Standards:

i) Financial Accuracy: ≥ 98% Accurate

ii) Payment Accuracy: ≥ 98% Accurate

Financial Accuracy is the projected percent of total dollars paid on all claims processed during a given period of time that were paid accurately, i.e. a percentage of dollars paid. Financial Accuracy shall be calculated as follows:

1- $\frac{\text{Absolute Value of Projected Overpayment + Absolute Value of Projected Underpayment}}{\text{Population \$'s minus Projected Overpayment plus Projected Underpayment}}$

"Projected Overpayment" means the overpayment in sample divided by the claims in sample multiplied by the claim volume of the population.

"Projected Underpayment" means the underpayment in sample divided by the claims in sample multiplied by the volume of the population.

ii) Payment Accuracy is the projected percent of all claims processed during a given period of time that were paid accurately, i.e. a percentage of claims processed. Payment Accuracy shall be calculated as follows:

1- $\frac{\text{Number of Sample Claims Containing Payment Errors}}{\text{Number of Sample Claims}}$

iii) Procedural Accuracy

Procedural Accuracy is a measure of the total number of claims processed correctly divided by the total number of claims reviewed.

Performance Standard:

Procedural Accuracy: 95% Accurate

1- $\frac{\text{Number of Sample Claims Containing Non-Monetary Errors}}{\text{Number of Sample Claims}}$

DSTHS shall not be responsible for the financial or procedural accuracy of any claim edited, corrected or updated by Customer after delivery of such claim to DSTHS.

III. Customer Audit Rights and Responsibility

Notwithstanding the above Performance Standard measurements reported by DSTHS, or any other services provided by DSTHS under this Agreement, Customer shall be ultimately responsible for the accuracy of the Claims paid and the processes performed hereunder, including the verification at

intervals of Customer's election, of the accuracy of Member and provider fees / files information contained in the ISS and the testing of paid Claims against expected results.

Customer shall have the right, upon reasonable written notice, during normal business hours and at Customer's sole expense, to audit DSTHS's (or its affiliates') performance hereunder, including without limitation, DSTHS's Performance Standard calculations for purposes of such verification. DSTHS will reasonably cooperate with such audit. Such audits shall not in any way allow Customer to view confidential information of other clients, or interfere with the performance of work for other clients. In the event a third party conducts the audit, DSTHS (or its affiliates) may request that the third party enter into a nondisclosure agreement, outlining the confidentiality of DSTHS's services and software, and limiting such auditor's ability to disclose information obtained during the audit (though not to Customer). Customer will share the results of any such audit with DSTHS.

To the extent that DSTHS or its affiliated entities performing Services hereunder complete a SSAE 16 audit of controls during any annual period, DSTHS will provide such audit to Customer.

SCHEDULE F

BUSINESS ASSOCIATE AGREEMENT

In connection with the performance of its obligations under this Agreement, DSTHS agrees to the following provisions, restrictions and requirements contained in the HIPAA Privacy and Security Rules regulations, as currently promulgated and as they may hereafter be amended. In furtherance thereof, DSTHS covenants and agrees:

PRIVACY/SECURITY REGULATORY

I. PROTECTED INFORMATION. In rendering the services described herein, DSTHS may receive from or transmit to Customer individually identifiable health information of Members which is "protected health information" ("PHI") or "electronic protected health information" ("EPHI") within the meaning of the regulations promulgated pursuant to the Health Insurance Portability and Accountability Act ("HIPAA") and codified at 45 CFR Parts 160 and 164 as amended from time to time (the "HIPAA Privacy and Security Rules") or which is non-public personal information ("NPPI") within the meaning of the regulations promulgated by a state with jurisdiction over this Agreement in response to the privacy provisions of the Gramm Leach Bliley Act ("GLBA Privacy Rules"). For purposes of this Amendment, any HIPAA PHI, EPHI, and NPPI created or received by DSTHS from or on behalf of Customer shall be referred to collectively as Protected Information ("PI" or "the PI").

II. BREACH. Consistent with the American Recovery and Reinvestment Act of 2009 ("ARRA"), if either party engages in a pattern of activity or practice that constitutes a material breach of this Amendment and the breach is not cured under the procedures set forth in the Agreement, the non-breaching party may report the violation to the Department of Health and Human Services Secretary. Upon making such report, the non-breaching party shall also provide the breaching party with a copy of such report. Any breach of this Amendment shall not affect the parties' rights and obligations pursuant to the Agreement.

III. USE and DISCLOSURE OF PI. DSTHS agrees not to use or disclose the PI, which the parties agree is the minimum necessary for DSTHS to perform its services, except (i) in conjunction with the services described in the Agreement when in accordance with any minimum necessary policies adopted by DSTHS; (ii) as covered entities are permitted with or without consent by the HIPAA and GLBA Privacy Rules; (iii) to provide data aggregation related to the healthcare operations of Customer; (iv) to fulfill its present or future legal responsibilities; (v) to, after de-identification pursuant to 45 CFR § 164.514, use the de-identified PI for, inter alia, its own operations provided, however, that DSTHS shall not sell the de-identified PI; or (vi) for its proper management or administration. DSTHS's policies with respect to minimum necessary disclosure shall apply until such time as there is guidance provided by the Secretary pursuant to the ARRA and that, at such time, such guidance shall control provided that any material adverse effect that such guidance may have is subject to satisfactory negotiation of compensation.

To the extent that DSTHS accesses, maintains, retains, modifies, records, destroys or otherwise holds, uses or discloses unsecured PI, it will notify Customer of any breach (within the meaning of Section 13400 of the ARRA) with respect to such information with the content set forth in Section 13402 of the ARRA and any implementing regulations consistent with any time frames set forth in the ARRA and any implementing regulations.

IV. ACCOUNTING OF DISCLOSURES. DSTHS agrees to document such disclosures of the PHI and information related to such disclosures as would be required for Customer to respond to a request by a

Member for an accounting of disclosures of PHI in accordance with 45 CFR § 164.528. The parties agree that DSTHS does not maintain PHI in an Electronic Health Record and, therefore, DSTHS is not required to account for disclosures for treatment, payment and health care operations purposes.

DSTHS shall, in the time and manner mutually agreed, provide Customer information documented in this section IV to permit Customer to respond to a request by a Member for an accounting of disclosures of PHI in accordance with 45 CFR § 164.528.

V. SAFEGUARDS. DSTHS agrees to use reasonable and appropriate safeguards to prevent the use or disclosure of PI that is contrary to the uses or disclosures authorized in Section III of this Amendment.

VI. SUBCONTRACTORS. DSTHS agrees to hold agents and subcontractors that have access to PHI to substantially similar standards as set forth in this Amendment. DSTHS agrees to enter into written agreements imposing substantially similar requirements on any non-affiliate subcontractors that have access to PHI.

VII. RECORDS. Upon reasonable notice and during normal business hours, DSTHS agrees, pursuant to 45 CFR 164.504(e)(2)(ii)(H), to make its internal practices, books, and records relating to the use and disclosure of PI received from, or created on behalf of, Customer available to the Department of Health and Human Services Secretary for purposes of determining Customer's compliance with the HIPAA Privacy Rules.

VIII. INFORMATION SECURITY. DSTHS shall maintain an information security program to implement, maintain, and use administrative, technical, and physical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of EPHI that DSTHS creates, receives, maintains, or transmits on Customer's behalf.

IX. TERMINATION OR EXPIRATION. DSTHS will, at termination or expiration of the Agreement, if feasible and in compliance with the recordkeeping provisions of any exhibit or addendum to the Agreement, return or destroy all PI received from, or created by DSTHS on behalf of, Customer which DSTHS still maintains in any form, and, if feasible and in compliance with the recordkeeping provisions of the Agreement, will not retain any copies of such information. If, in DSTHS's reasonable judgment, such return or destruction is not feasible or is not in accordance with the recordkeeping provisions of the Agreement, DSTHS will extend the protections of this Amendment to the PI and will limit further uses and disclosures to those purposes that make the return or destruction of the PI infeasible.

X. EPHI. Pursuant to the following parameters, or, if different as provided in any regulations implementing ARRA sections 13400 and 13402 that may be applicable, DSTHS will report, either verbally or in written form, to Customer any successful unauthorized access, use, disclosure, modification, or destruction of Customer's EPHI of which DSTHS becomes aware:

- Not more than fifteen (15) business days after DSTHS learns of any such incident, DSTHS will use reasonable efforts to provide a report to Customer's Privacy Office (or Privacy Official). The report will identify actions DSTHS will take to prevent future incidents. (NOTE: If Customer uses Emdeon or RelayHealth for its EDI processing services, DSTHS makes no guarantees or warranties about such vendors' turnaround times for notification, and will not be responsible if Emdeon or RelayHealth do not meet state, HIPAA or HITECH notification standards).
- DSTHS will, in a reasonable time, provide such other information, including a written report, as Customer may reasonably request in writing.
- For the purposes of this Amendment, contact with Customer will be on normal business days, Monday through Friday, 8:00 a.m. through 5:00 p.m. of Customer's time zone, unless Customer provides emergency contact information to the DSTHS Privacy Officer.

At Customer's request, DSTHS shall report, to the extent reasonably practicable, any unsuccessful unauthorized attempts to access, use, disclose, modify, or destroy Customer's EPHI to the extent such information is available to DSTHS.

Customer acknowledges and agrees that to the extent DSTHS is managing or subcontracting EDI claims transmissions through clearinghouses, such as Emdeon or RelayHealth, DSTHS will use good faith efforts to provide notification of the above disclosures within 30 calendar days of their discovery.

XI. REQUEST FOR MEMBER INFORMATION. In the time and manner mutually agreed, DSTHS shall, at Customer's cost if the data is archived, make available to Customer a Member's HIPAA PHI contained in any non-duplicative portion of the Customer's Designated Record Set. In the event any Member requests access to HIPAA PHI directly from DSTHS, DSTHS shall, as soon as reasonably practicable, forward such request to Customer. Any responses to or denials of access to the HIPAA PHI requested shall be the responsibility of Customer.

XII. AMENDMENT REQUEST. When DSTHS maintains a non-duplicative portion of the Customer's Designated Record Set, DSTHS agrees to make any amendment(s) to PHI in such portion of the Designated Record Set that the Customer directs or agrees to pursuant to 45 CFR § 164.526 at the request of Customer and at a time and manner mutually agreed.

XIII. OBLIGATIONS OF CUSTOMER. Customer shall notify DSTHS of the following which shall modify the obligations of DSTHS if DSTHS does not notify Customer of a material cost impact associated with such a limitation, change or restriction in which case such limitation, change or restriction shall take effect following the parties' negotiation of funding for same:

- Any limitation(s) in its notice of privacy practices in accordance with 45 CFR § 164.520, to the extent that such limitation may affect DSTHS's use or disclosure of PHI.
- Any changes in, or revocation of, permission by a Member to use or disclose PHI, to the extent that such changes may affect DSTHS's use or disclosure of PHI.
- Any restriction to the use or disclosure of PHI that Customer has agreed to in accordance with 45 CFR § 164.522, to the extent that such restriction may affect DSTHS's use or disclosure of PHI.

XIV. PERMISSIBLE REQUESTS BY CUSTOMER. Except as otherwise allowed by HIPAA, Customer shall not request DSTHS to use or disclose PHI in any manner that would not be permissible under HIPAA if done by Customer.

XV. GENERAL. This Amendment contains the complete and final agreement of the parties on the subject matter. All prior negotiations, representations and understandings are expressly superseded and may not be relied upon. This Amendment may be amended only in a written document, signed by both parties. All claims regarding this Amendment are governed by and construed in accordance with the laws of the state as indicated in the applicable Agreement, notwithstanding any choice or conflict of law principles. This Amendment binds and inures to the benefit of the parties' successors and assigns.

XVI. RENEGOTIATION. The parties agree to negotiate in good faith any modification to this Amendment, and to the extent necessary the Agreement, that may be necessary or required to ensure consistency with amendments to and changes in applicable federal and state laws and regulations, including but not limited to, regulations promulgated pursuant to HIPAA and ARRA.

SCHEDULE G

SAMPLE WORK ORDER

This Work Order, prepared on _____, is incorporated herein by this reference and made an integral part of the Administrative Service Agreement, by and between DST Health Solutions, LLC ("DSTHS") and _____ ("Customer"), dated _____.

Enhancement or services to be performed (refer to project proposal, if appropriate):

Deliverables:

Estimated number of hours required to complete performance of the Enhancement or services:

Project schedule, including start date, estimated completion date, due dates for deliverables, as applicable:

Professional classification and rate of personnel performance Enhancement or services:

Person coordinating administrative and technical issues related to this Work Order:

- DSTHS:
- Customer:

Location where work will be performed:

Other Special Terms and Conditions:

DST HEALTH SOLUTIONS, LLC		**THRIVE HEALTH PLAN**	
By:	_____	By:	Thomas Dorcy
Name:	_____	Name:	Thomas Dorcy
Title:	_____	Title:	President
Date:	_____	Date:	5.9.13

SCHEDULE H

TRAVEL POLICY

The purpose is to set forth policies for expenditure and accountability of DST (the "Company") funds while engaged in Company business travel and entertainment. While travel and entertainment expenditures are necessary business activities, prudent use of Company funds for travel and entertainment is expected. It is our responsibility to exercise proper judgment when incurring travel and entertainment expenditures and to ensure expenses are incurred on the most cost efficient basis to DST and our Clients, consistent with reasonable schedules, safe accommodations, and comfortable service.

These policies govern both domestic and international travel. (Note: If an international assignment of more than three months duration is accepted, the DST Expatriate Policy will be followed.) The Company will pay for business travel and entertainment expenditures incurred that are considered necessary for the proper conduct of our business, included within the Policies set forth in this document, and properly documented and reported. The associate is also personally liable for any amount in excess of the substantiated expenses.

There may be situations when an officer may want to augment these policies with specific guidelines for the officer's area. This is acceptable; however, under no condition can these officer guidelines be less restrictive than the corporate policies. If an officer does choose to set specific guidelines for his or her area, they should forward a copy to the Company Controller or Chief Accounting Officer.

GENERAL POLICIES

All associates expecting to travel or periodically incur entertainment expenses should carry a Corporate Travel and Entertainment ("T&E") Card. A Corporate T&E Card generally provides the safest and most convenient means of paying for travel and entertainment expenses. On approval of the supervising officer, a Company sponsored Corporate T&E Card will be issued to an associate. DST sponsors the Corporate T&E Card, but individual associates are responsible for documenting all business charges incurred. This card is to be used only for Company expenses. Using the card for personal use may result in cancellation of card privileges. As DST provides for issuance of a Corporate T&E Card, the company will not reimburse fees associated with personal credit cards.

Company financed group functions should be coordinated through Corporate Marketing with airline, hotel, and transportation service agreements negotiated by DST's Corporate Procurement Department. This includes conferences and trade shows attended by Company associates, Company-sponsored client conferences, meetings, training sessions, and all sporting and special events such as golf outings and other similar activities. A group is defined as ten (10) or more people traveling to a common destination for a common purpose. They need not depart from the same point of origin, but travel must occur within a predetermined span of time. (Note: some airlines now require that a group depart from the same city on the same dates.)

Travel Corner, located at MyWorkPortal, houses all travel related information. DST's on-line booking tool should be used to make travel arrangements. It can be accessed on MyWorkPortal or at *www.Travelport.net*. All phone numbers for the on-line tool, including after-hours, can be found on the on-line tool under Traveler Support. These regular and toll free assistance numbers can be used for assistance when out of town, during regular business hours. The after hour service should be utilized for needs that occur at night, on weekends or holidays. Travel Corner also details all preferred vendor information, discount vendors, and airline details.

SPECIFIC TRAVEL AND ENTERTAINMENT POLICIES

The following policies address specific categories of permitted travel and entertainment expenditures.

Air Travel

All air travel is to be booked via the approved on-line tool or through the travel management company. Instructions and information regarding the on-line tool and the Travel Management Company are available in the Travel Corner.

The Company will pay for the cost of air travel incurred which is necessary to conduct its business that is within the Policy. In general, Company associates are expected to plan their air travel so that the **"lowest available airfare"** is achieved. Lowest Available Airfare is generally defined as an advance purchase (fourteen days or more), non-refundable fare, which does not require a Saturday night stay. If travel requirements do not allow an advanced purchase option, the lowest available coach fare should be obtained. Upgrades for domestic travel within Coach Class or Business Class, First Class or other airline classes **will not be reimbursed.**

An unused ticket list is located within the Travel Corner. The list should be reviewed before booking air fare to ensure unused tickets are utilized. If the ticket was already expensed to another department, the financial contact for the area can assist with re-classing to the appropriate department. If you have questions about the tickets listed or how to use an unused ticket, please contact DST's Travel Management Company.

Connecting flights should be used if:

- They do not add more than ninety (90) minutes to the total trip **and**
- They result in a fare savings of $200 or more

Alternate airports should be used when:

- They do not add significantly to your total travel time.
- The fare savings is greater than $200, **and**
- They do not result in greater additional ground transportation.

When flying both domestically and internationally, coach class seating will be used except under the following circumstances when business or first class may be selected:

All associates including Managers and Directors will fly economy/tourist to all destinations with the following exceptions:

- On international flights in excess of six hours, subject to approval by a vice president, associates may travel Business class. Otherwise, associates may travel Premium Economy or equivalent.
- Associates accompanying a client may travel in the same class as the client.
- Associates may upgrade if, by using any special discount structure or concession, they can do so as economically as the lowest available fare.

If business reasons cause the travel schedule to change, the Company will pay transfer fees and other such charges, which result from the change. It is expected that associates schedule air travel during non-business hours where possible. Generally, associates may return home on weekends unless business needs require otherwise. Though not required, if the associate is willing to stay over or into a weekend and significantly decrease the cost of airfare by booking "over Friday or Saturday night stay" tickets, the Company will pay for reasonable hotel and meal expenses during this weekend period. These expenses are not to exceed the cost savings realized by the purchase of the aforementioned ticket. Prior approval from the associate's Officer is required before purchase of the ticket.

All associates traveling internationally are required to complete an "International Travel Request" form and have it signed by the officer over their area. This form must be submitted to the Travel Management Company before they will complete an international reservation.

When a trip is cancelled, full or in part, the associate must notify the Travel Management Company as quickly as possible. Most airlines require cancellation of the reservation prior to the departure date to retain the value of the ticket.

Membership fees for air travel clubs **will not be reimbursed**.

Discount Parking at Airports

Certain DST locations have negotiated rates with their local airport parking vendors. Please see Travel Corner for specific details regarding discounts by location. It is expected that the associate use the most economical parking option.

Car Service

It is expected that associates will use the most economical means of transportation when traveling in other cities. Use of public transportation systems in major metropolitan cities (domestic and international) is encouraged; as such systems are often significantly less expensive than car rentals or taxis for extended trips. Car service to and from the airport may be used, provided it is less expensive than reimbursement for mileage charges. Public transit expenses are reimbursed when the use of public transportation is required or more efficient. Receipts are to be obtained whenever possible and are required for any expenditure over $25.

Rental Cars

Use of a rental car is permitted when other methods of transportation are not available or feasible, or when a rental represents the least expensive mode of transportation (including parking fees) available. Preferred rental car agencies are listed in the Travel Corner. Reservations for car rentals must be made via the on-line tool or through our Travel Management Company. Navigation services **will not be reimbursed**. Corporate agreements include free mileage and insurance at most locations. You should **decline all optional insurance** offered in the contiguous 48 states. The Company's corporate card includes primary collision coverage for the car and the Company's corporate insurance program provides liability protection. The Company will pay for refueling charges, supported by a receipt. When returning rented cars, every effort should be made to refill at a local gas station (usually cheaper) rather than at the rental agency return area. Original receipts for car rental are required.

Reservations should be made for intermediate (mid-size) cars. Requests for a larger vehicle must have a reasonable business explanation. Passenger vans that seat more than eight (8) people are **not covered** by our corporate insurance agreements and should not be rented unless specifically required by an officer. If no other vehicle or reasonable form of transportation is available and such vans are rented, the associate must accept optional insurance offered by the car agency.

A proof-of-insurance document is available on MyWorkPortal at Travel Corner. The associate must keep this documentation at all times while representing the Company on business travel. This document lists the Company's insurance providers and proof that the traveler, an associate of the Company, is covered. In the event of an accident, following these instructions will provide the associate with maximum protection while minimizing the Company's risk.

If an accident occurs, (in addition to following the procedures that accompanied your Corporate Card), the Company's Risk Insurance Administrator (Karen Hanaway @ 816-435-8750) should be contacted within 24 hours to discuss the proper procedures for handling any claims.

International Car Rental

Weekly rates abroad may afford substantial savings over the daily rates for two to three days and should be utilized when appropriate. When traveling outside the contiguous 48 states, it is recommended (at the minimum) Collision or Loss Damage Waiver and Liability supplemental insurance be accepted.

Lodging Expense

The Company has negotiated rates with certain hotels in selected cities. The associate is expected to take advantage of these special rates. These hotels can be found both on the MyWorkPortal and the on-line tool. **The associate will be required to select a standard room rate at one of the preferred domestic hotels or be considered out of policy and any cost over the preferred rate will be considered a personal expense.** There are some situations where it is not possible to stay at a preferred hotel (the preferred hotel is sold out, DST does not have a preferred hotel property in a less traveled city, client directed travel and hotels associated with meetings). In these instances, a hotel of comparable quality and no greater cost should be selected. Hotel reservations should be made through our Travel Management Company or the on-line tool. Use of in room minibars should be avoided and any charges from use of the minibar will generally be treated as personal charges to the associate. Charges incurred in exceptional circumstances may be submitted if reasonable in amount and clearly documented. An example of an exceptional circumstance for which reimbursement would be allowed would be a traveler arriving at his or her room after other usual facilities such as the hotel restaurant (including room service) are closed. In this situation reasonable charges for food or snacks and beverages available from the hotel minibar would be allowable as valid travel expenses. All lodging expenses should be charged on the Corporate Card, not directly billed to the Company. If an associate fails to timely cancel a reservation, he/she may be personally responsible for any non-cancellation charges incurred and not be reimbursed for them. Detailed receipts are always required for lodging expense. Internet usage in the hotel room is considered an allowable expense as part of lodging expenses.

Food Expense

In some cases, room rates at hotels include breakfast. Always verify at check-in whether or not breakfast is included in the room rate. Whenever possible, this amenity should be utilized. The ranking officer/manager/supervisor is to pay for all meals and entertainment when dining with other associates.

Entertaining Clients

The Company will pay for reasonable expenses (including meals and refreshments) incurred when entertaining individuals from whom the company expects to derive specific business benefits. The nature and extent of the entertainment should be in line with the image and appropriate representation desired by the Company. The Company has access to tickets for certain sporting and other special events and these should be used when available.

Use of Personal Automobile

Associates who are authorized to use their automobiles when on Company business will be reimbursed for mileage at the IRS approved allowance to the extent mileage incurred exceeds mileage for commuting to and from the associate's usual place of work. For example, you drive from your home to the airport to leave on a business flight: To calculate mileage, take the total miles from your home to the airport – less the miles from your home to the office – that is your reimbursable mileage. Parking and tolls in excess of those incurred in commuting to an associates' primary place of employment will also be reimbursed. Mileage incurred on regular business days commuting between your primary place of employment and your home is not considered a business expense and is not reimbursable.

Dues, Subscriptions, Books and Publications

Dues, subscriptions, books and publications/manuals should be pre-approved by the associate's management and purchased on the associate's Corporate T&E Card.

Seminars/Conferences

A purchase requisition should be submitted for all seminars/conferences. If the seminar or conference is approved, you will be notified to purchase this on the associate's Corporate T&E Card.

Laundry/Dry Cleaning

Laundry and dry cleaning expenses will not be reimbursed unless an associate is on a business trip that is six (6) or more consecutive days in duration. If the business trip meets the time-test and the need arises during that trip for the associate to have dry cleaning and/or laundry done by the hotel, DST will pay for that service. Other tipping for certain travel services may be appropriate but should be reasonable in amount.

Domestic Gratuities

Gratuities are reimbursable when confined to reasonable limits as determined by services required and received. Generally, a 15%-20% gratuity for restaurant services and 10% for taxi service are appropriate.

International Gratuities

Gratuity standards differ from country to country. Please check with a local company contact regarding the standard of the country.

Communication Expenses

The Company will pay for all business calls made while out of town. Communication with an associate's immediate family is important when traveling and the Company will reimburse the expense for reasonable personal calls made while out of town on business. The associate should always attempt to use the least expensive mode of communication available.

If the associate has a corporate cellular phone with a plan that includes long distance, the cell phone should be used to make calls while out of town. If the associate does not have a corporate cellular phone, the Company toll free phone mail number, **800-444-DSTS (3787)** should be utilized when calling the office and checking voice mail. Once in phone mail, the associate can be transferred to another extension, but not to an outside number.

If a cell phone is not an option, a corporate calling card application can be found on MyWorkPortal on Travel Corner. The calling card should be utilized by associates whom seldom travel for business expenses or for personal calls made while out of town on business.

When connecting to DST from a hotel room, the associate should use the toll free number **(800-423-8602)** except when traveling internationally.

Permanent home based associates are allowed **$40** a month for internet/broadband services.

Airtime rates for calls made from hotel phones are very expensive and should be avoided except in cases of emergency.

Personal Cellular Phones

The incremental charges for business use of personal cellular phones will be reimbursed. The company will not reimburse monthly fees associated with personal cell phones. If the personal cell phones are used extensively for business purposes, telecom should be contacted for a company provided cell phone. If you are traveling abroad, provisions should be made for a loaner phone from Telecomm.

On-Line Services

On-line services such as NetZero, America On-Line, and Reality On-Line will not be reimbursed. (Contact Data Security at 816-936-2938 for business related requirement for this type of service.)

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Trusted Health Plan

Building a powerful team of talent, best ideas, focus, and hard work.

January 2015

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VINCENT C. GRAY, MAYOR

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Fraud, Waste and Abuse Training
&
General Compliance Training

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Introduction

This training module consists of two parts:

(1)Fraud, Waste, and Abuse (FWA) Training

(2)General Compliance Training

All persons who provide health or administrative services to Medicaid enrollees must satisfy general compliance and FWA training requirements. This module *may* be used to satisfy both requirements.

Part 1

Fraud, Waste and Abuse (FWA)Training

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FWA

Every year *millions* of dollars are improperly spent because of fraud, waste, and abuse.

It affects everyone.

Including YOU.

This training will help you detect, correct, and prevent fraud, waste, and abuse.

YOU are part of the solution.

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FWA - Objectives

- Meet the regulatory requirement for training and education
- Provide information on the scope of fraud, waste, and abuse
- Explain obligation of everyone to detect, prevent, and correct fraud, waste, and abuse
- Provide information on how to report fraud, waste, and abuse
- Provide information on laws pertaining to fraud, waste, and abuse

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FWA - Responsibilities

You are a vital part of the effort to prevent, detect, and report Medicaid non-compliance as well as possible fraud, waste, and abuse.

- **FIRST** you are required to comply with all applicable statutory, regulatory, and other Medicaid requirements, including adopting and implementing an effective compliance program.
- **SECOND** you have a duty to the Medicaid Program to report any violations of laws that you may be aware of.
- **THIRD** you have a duty to follow Trusted's Code of Conduct that articulates your and Trusted's commitment to standards of conduct and ethical rules of behavior.

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FWA - Prevention

How Do I Prevent Fraud, Waste, and Abuse?

- Ensure data/billing is both accurate and timely.
- Verify information provided to you.
- Be on the lookout for suspicious activity.
- Make sure you are familiar with Trusted's policies and procedures.

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FWA - Definitions

Fraud:

Knowingly and willfully executing, or attempting to execute, a scheme or artifice to defraud any health care benefit program; or to obtain, by means of false or fraudulent pretenses, representations, or promises, any of the money or property owned by, or under the custody or control of, any health care benefit program.

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FWA - Definitions

Waste:

Overutilization of services, or other practices that, directly or indirectly, result in unnecessary costs to the Medicaid Program. Waste is generally not considered to be caused by criminally negligent actions but rather the misuse of resources.

Abuse:

Includes actions that may, directly or indirectly, result in unnecessary costs to the Medicaid Program. Abuse involves payment for items or services when there is not legal entitlement to that payment and the provider has not knowingly and or/intentionally misrepresented facts to obtain payment.

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FWA - Differences

There are differences between fraud, waste, and abuse. One of the primary differences is intent and knowledge.

Fraud requires the person to have an intent to obtain payment and the knowledge that their actions are wrong. Waste and abuse may involve obtaining an improper payment, but does not require the same intent and knowledge.

Waste and Abuse may involve obtaining an improper payment, but does not require the same intent and knowledge.

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FWA - Reporting

Do not be concerned about whether it is fraud, waste, or abuse. Just report any concerns to your Compliance Officer. The Compliance Department area will investigate and make the proper determination.

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FWA – Corrections

Once fraud, waste, or abuse has been detected it must be promptly corrected. Correcting the problem saves the government money and ensures you are in compliance with Trusted Health Plan's requirements.

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Laws

The following slides provide very high level information about specific laws. For details about the specific laws, such as safe harbor provisions, consult the applicable statute and regulations concerning the law.

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Civil Fraud
Civil False Claims Act

Prohibits:

- Presenting a false claim for payment or approval;
- Making or using a false record or statement in support of a false claim;
- Conspiring to violate the False Claims Act;
- Falsely certifying the type/amount of property to be used by the Government;
- Certifying receipt of property without knowing if it's true;
- Buying property from an unauthorized Government officer; and
- Knowingly concealing or knowingly and improperly avoiding or decreasing an obligation to pay the Government.

31 United States Code § 3729-3733

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Civil False Claims Act Damages and Penalties

The damages may be tripled. Civil Money Penalty between $5,000 and $10,000 for each claim.

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Criminal Fraud Penalties

If convicted, the individual shall be fined, imprisoned, or both. If the violations resulted in death, the individual may be imprisoned for any term of years or for life, or both.

18 United States Code §1347

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Exclusion

No Federal health care program payment may be made for any item or service furnished, ordered, or prescribed by an individual or entity excluded by the Office of Inspector General.

42 U.S.C. §1395(e)(1)

42 C.F.R. §1001.1901

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HIPAA

Health Insurance Portability and Accountability Act of 1996 (P.L. 104-191)

Created greater access to health care insurance, protection of privacy of health care data, and promoted standardization and efficiency in the health care industry.

Safeguards to prevent unauthorized access to protected health care information.

As a individual who has access to protected health care information, you are responsible for adhering to HIPAA.

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Consequences of Committing Fraud, Waste, or Abuse

The following are potential penalties. The actual consequence depends on the violation:

- Civil Money Penalties
- Criminal Conviction/Fines
- Civil Prosecution
- Imprisonment
- Loss of Provider License
- Exclusion from Federal Health Care program

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Scenario Q & A

You are in charge of payment of claims submitted from providers. You notice a certain diagnostic provider ("Doe Diagnostics") has requested a substantial payment for a large number of members. Many of these claims are for a certain procedure. You review the same type of procedure for other diagnostic providers and realize that Doe Diagnostics' claims far exceed any other provider that you reviewed.

What do you do?

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Scenario Q & A

A. Call Doe Diagnostics and request additional information for the claims

B. Consult with your immediate supervisor for next steps

C. Contact the compliance department

D. Reject the claims

E. Pay the claims

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Scenario Q & A

Answers B or C
Consult with your immediate supervisor for next steps or Contact the compliance department.

Either of these answers would be acceptable. You do not want to contact the provider. This may jeopardize an investigation. Nor do you want to pay or reject the claims until further discussions with your supervisor or the compliance department have occurred, including whether additional documentation is necessary.

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COMPLIANCE REPORTING

855 – 228 – 1700

The THP Compliance Program offers a confidential and anonymous telephone hotline available 24/7 to voice your concerns about any situation that may conflict with Compliance Program principles. If you want to report concerns or suspicions regarding:

- ✓ Compliance with federal or district law
- ✓ Compliance with THP policies
- ✓ Suspected fraud, waste or abuse
- ✓ Possible ethical or code of conduct violations

You may also send a message to our inbox:

ReportFraud@TrustedHP.com

You may also come speak to our Compliance Officer, George Aloth, directly.

Your report will remain confidential and your privacy will be respected! No individual who reports Compliance Plan violations or suspected fraud and abuse is retaliated against by anyone who is employed by or contracts with THP. Anyone who believes that he or she has been retaliated against may report this violation to the DC Office of Program Integrity and/or the U.S. Office of Inspector General.

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CONGRATULATIONS!!!

You have completed the Fraud, Waste and Abuse (FWA) Training

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Part 2

General Compliance Training

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General Compliance

Compliance is EVERYONE'S responsibility!

At a minimum, a compliance program must include the 7 core requirements:

1. Written Policies, Procedures and Standards of Conduct;
2. Compliance Officer, Compliance Committee and High Level Oversight;
3. Effective Training and Education;
4. Effective Lines of Communication;
5. Well Publicized Disciplinary Standards;
6. Effective System for Routine Monitoring and Identification of Compliance Risks; and
7. Procedures and System for Prompt Response to Compliance Issue

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Compliance Training

- CMS expects that all Sponsors will apply their training requirements and "effective lines of communication" to the entities with which they partner.
- Having "effective lines of communication" means that employees of the organization and the partnering entities have several avenues through which to report compliance concerns.

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Ethics – Do the Right Thing!

- Act Fairly and Honest
- Comply with letter and Spirit of the Law
- Adhere to high ethical standards in All that you do
- Report Suspected Violations
- As a part of the MCO program, it is important that you conduct yourself in an ethical and legal manner.

It's about doing the right thing!

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What's Expected?!?

Standards of Conduct (or Code of Conduct) state compliance expectations and the principles and values by which our organization operates.

Everyone is required to report violations of Standards of Conduct and suspected noncompliance.

An organization's Standards of Conduct and Policies and Procedures should identify this obligation and tell you how to report.

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What Is Noncompliance?

Noncompliance is conduct that does not conform to the law, and Federal health care program requirements, or to an organization's ethical and business policies

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Noncompliance Harms Enrollees

Without programs to prevent, detect and correct noncompliance there are:

- Delayed Services
- Denial of Benefits
- Hurdles to Care
- Difficulty in using Providers of Choice

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Noncompliance Costs Money

Noncompliance affects EVERYBODY!

Without programs to prevent, detect, and correct noncompliance you risk:

- Higher Premiums
- Lower Profits
- Lower benefits for individuals and Employers
- Lower Ratings

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THP

Report Noncompliance

There can be NO retaliation against you for reporting suspected noncompliance in good faith.

Each Sponsor must offer reporting methods that are:

- Anonymous
- Confidential
- Non- Retaliatory

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THP

What Happens Next?

After noncompliance has been detected, it must be investigated immediately and then promptly corrected for any noncompliance.

Correcting Noncompliance:

- Avoids the recurrence of the same noncompliance
- Promotes efficiency and effective internal controls
- Protects enrollees
- Ensures ongoing compliance with THP requirements

- Once noncompliance is detected and corrected, an ongoing evaluation process is critical to ensure the noncompliance does not recur.
- Monitoring activities are regular reviews which confirm ongoing compliance and ensure that corrective actions are undertaken and effective.
- Auditing is a formal review of compliance with a particular set of standards (e.g., policies and procedures, laws and regulations) used as base measures.

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Consequences of Noncompliance

THP is required to have disciplinary standards in place for noncompliant behavior. Those who engage in noncompliant behavior may be subject to any of the following:

- Mandatory Training or Re-Training
- Disciplinary Action
- Termination

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Scenario Q & A

You have discovered an unattended email address or fax machine in your office which receives beneficiary appeals requests. You suspect that no one is processing the appeals.

What should you do?

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Scenario Q & A

A) Contact Law Enforcement

B) Nothing

C) Contact your Compliance Department

D) Wait to confirm someone is processing the appeals before taking further action

E) Contact your supervisor

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Scenario Q & A

The correct answer is: C – Contact your Compliance Department.

Suspected or actual noncompliance should be reported immediately upon discovery. It is best to report anything that is suspected rather than wait and let the situation play out.

THP's compliance department will have properly trained individuals who can investigate the situation and then, as needed, take steps to correct the situation according to the Standards of Conduct and Policies and Procedures.

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What Governs Compliance?

- Social Security Act:
- Title 18
- Code of Federal Regulations*:
- 42 CFR Parts 422 (Part C) and 423 (Part D)
- CMS Guidance:
- Manuals
- HPMS Memos
- CMS Contracts:
- Private entities apply and contracts are renewed/non-renewed each year
- Other Sources:
- OIG/DOJ (fraud, waste and abuse (FWA))
- HHS (HIPAA privacy)
- State Laws:
- Licensure
- Financial Solvency
- Sales Agents

* 42 C.F.R. §§ 422.503(b)(4)(vi) and 423.504(b)(4)(vi)

TRUSTED Health Plan
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COMPLIANCE REPORTING

855 – 228 – 1700

The THP Compliance Program offers a confidential and anonymous telephone hotline available 24/7 to voice your concerns about any situation that may conflict with Compliance Program principles. If you want to report concerns or suspicions regarding:

- ✓ Compliance with federal or district law
- ✓ Compliance with THP policies
- ✓ Suspected fraud, waste or abuse
- ✓ Possible ethical or code of conduct violations

You may also send a message to our inbox:

ReportFraud@TrustedHP.com

You may also come speak to our Compliance Officer, George Aloth, directly.

Your report will remain confidential and your privacy will be respected! No individual who reports Compliance Plan violations or suspected fraud and abuse is retaliated against by anyone who is employed by or contracts with THP. Anyone who believes that he or she has been retaliated against may report this violation to the DC Office of Program Integrity and/or the U.S. Office of Inspector General.

GOVERNMENT OF THE DISTRICT OF COLUMBIA
VINCENT C. GRAY, MAYOR

This program is funded in part by the Government of the District of Columbia Department of Health Care Finance

DHCF

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CONGRATULATIONS!!!

You have completed the General Compliance Training

GOVERNMENT OF THE DISTRICT OF COLUMBIA
VINCENT C. GRAY, MAYOR

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DHCF

ONE CITY

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MultiPlan.

State	Estimated Eligibles	Provider Group	Total Providers
Southeast Zone	85,900	PHCS-MPI: HOSPITALS	47
		PHCS-MPI: NURSING FACILITY	32
		PHCS-MPI: PRIMARY CARE PHYSICIAN	1,897
		PHCS-MPI: PCP - FAMILY PRACTICE	1,030
		PHCS-MPI: PCP - GENERAL PRACTICE	67
		PHCS-MPI: PCP - INTERNAL MEDICINE	800
		PHCS-MPI: CARDIOLOGY	179
		PHCS-MPI: DERMATOLOGY	46
		PHCS-MPI: GENERAL SURGERY	246
		PHCS-MPI: NEUROLOGY	63
		PHCS-MPI: OBSTETRICS & GYNECOLOGY	304
		PHCS-MPI: ONCOLOGY	102
		PHCS-MPI: ORAL SURGERY	11
		PHCS-MPI: ORTHOPEDIC SURGERY	157
		PHCS-MPI: OTOLARYNGOLOGY	81
		PHCS-MPI: PEDIATRICIAN	386
		PHCS-MPI: PHYSICAL THERAPY	540
		PHCS-MPI: RADIOLOGY	409
		PHCS-MPI: UROLOGY	65

Networ

Pl

Tc

# With Access	% With Access	# Without Access	% Without Access	Average Time to 1	Average Time to 2
85,074	99	826	1	14.9	25.1
83,480	97.2	2,420	2.8	23.1	34.4
85,900	100	0	0	5.7	7
85,900	100	0	0	6.4	7.6
78,476	91.4	7,424	8.6	19.3	24.9
85,900	100	0	0	10	12.8
83,253	96.9	2,647	3.1	19.9	23.5
80,123	93.3	5,777	6.7	27.2	35.2
85,032	99	868	1	16.9	20.8
79,073	92.1	6,827	7.9	28.1	34.3
84,856	98.8	1,044	1.2	15.5	20.5
77,846	90.6	8,054	9.4	23.8	30.9
35,216	41	50,684	59	63.8	106.7
81,834	95.3	4,066	4.7	23.3	25.3
83,443	97.1	2,457	2.9	21.7	29.2
85,900	100	0	0	10.3	14.4
85,368	99.4	532	0.6	17.5	19.7
83,245	96.9	2,655	3.1	16.6	21.5
77,819	90.6	8,081	9.4	26.5	32.6

k Access Scorecard

State of West Virginia

HCS/MPI Commercial Providers

otal Estimated Eligibles: 85,900* *100 lives per zip code state wide

Report Created: March 3, 2016

Maximum Time to 1	Maximum Time to 2	Urban Standard (Minutes)	Suburban Standard (Minutes)	Rural Standard (Minutes)
50	64.2	1 in 30	1 in 45	1 in 60
80.4	85.2	1 in 30	1 in 45	1 in 60
22.9	26.7	2 in 30	2 in 45	2 in 60
24.8	26.7	2 in 30	2 in 45	2 in 60
91.5	91.5	2 in 30	2 in 45	2 in 60
57.9	58	2 in 30	2 in 45	2 in 60
69.7	74	2 in 30	2 in 45	2 in 60
78	93.1	1 in 30	1 in 45	1 in 60
67.2	67.2	2 in 30	2 in 45	2 in 60
88.8	157	1 in 30	1 in 45	1 in 60
58.9	67.2	2 in 30	2 in 45	2 in 60
75.9	77.1	2 in 30	2 in 45	2 in 60
187.1	187.1	1 in 30	1 in 45	1 in 60
73.9	76.3	2 in 30	2 in 45	2 in 60
72	89.7	1 in 30	1 in 45	1 in 60
46	48.1	2 in 30	2 in 45	2 in 60
56.2	61.2	2 in 30	2 in 45	2 in 60
66.2	91.5	2 in 30	2 in 45	2 in 60
74.2	79.7	1 in 30	1 in 45	1 in 60

Access Score > 85%	All Provider Access %
PASS	93.0
PASS	
PASS	
PASS	
PASS	
PASS	
PASS	
PASS	
PASS	
PASS	
PASS	
PASS	
FAIL	
PASS	
PASS	
PASS	
PASS	
PASS	
PASS	



County, State	Estimated Eligibles	Provider Group	Total Providers
Barbour, WV	602	PHCS-MPI: HOSPITALS	1
		PHCS-MPI: NURSING FACILITY	0
		PHCS-MPI: PRIMARY CARE PHYSICIAN	11
		PHCS-MPI: PCP - FAMILY PRACTICE	9
		PHCS-MPI: PCP - GENERAL PRACTICE	1
		PHCS-MPI: PCP - INTERNAL MEDICINE	1
		PHCS-MPI: CARDIOLOGY	1
		PHCS-MPI: DERMATOLOGY	0
		PHCS-MPI: GENERAL SURGERY	0
		PHCS-MPI: NEUROLOGY	0
		PHCS-MPI: OBSTETRICS & GYNECOLOGY	0
		PHCS-MPI: ONCOLOGY	0
		PHCS-MPI: ORAL SURGERY	0
		PHCS-MPI: ORTHOPEDIC SURGERY	0
		PHCS-MPI: OTOLARYNGOLOGY	0
		PHCS-MPI: PEDIATRICIAN	0
		PHCS-MPI: PHYSICAL THERAPY	0
		PHCS-MPI: RADIOLOGY	0
		PHCS-MPI: UROLOGY	0
Berkeley, WV	1,199	PHCS-MPI: HOSPITALS	1
		PHCS-MPI: NURSING FACILITY	1
		PHCS-MPI: PRIMARY CARE PHYSICIAN	67
		PHCS-MPI: PCP - FAMILY PRACTICE	32
		PHCS-MPI: PCP - GENERAL PRACTICE	0
		PHCS-MPI: PCP - INTERNAL MEDICINE	35
		PHCS-MPI: CARDIOLOGY	7
		PHCS-MPI: DERMATOLOGY	2
		PHCS-MPI: GENERAL SURGERY	12
		PHCS-MPI: NEUROLOGY	1
		PHCS-MPI: OBSTETRICS & GYNECOLOGY	14
		PHCS-MPI: ONCOLOGY	6
		PHCS-MPI: ORAL SURGERY	0
		PHCS-MPI: ORTHOPEDIC SURGERY	7
		PHCS-MPI: OTOLARYNGOLOGY	4
		PHCS-MPI: PEDIATRICIAN	14

		PHCS-MPI: PHYSICAL THERAPY	2
		PHCS-MPI: RADIOLOGY	0
		PHCS-MPI: UROLOGY	5
Boone, WV	2,613	PHCS-MPI: HOSPITALS	1
		PHCS-MPI: NURSING FACILITY	0
		PHCS-MPI: PRIMARY CARE PHYSICIAN	1
		PHCS-MPI: PCP - FAMILY PRACTICE	1
		PHCS-MPI: PCP - GENERAL PRACTICE	0
		PHCS-MPI: PCP - INTERNAL MEDICINE	0
		PHCS-MPI: CARDIOLOGY	0
		PHCS-MPI: DERMATOLOGY	0
		PHCS-MPI: GENERAL SURGERY	0
		PHCS-MPI: NEUROLOGY	0
		PHCS-MPI: OBSTETRICS & GYNECOLOGY	2
		PHCS-MPI: ONCOLOGY	0
		PHCS-MPI: ORAL SURGERY	0
		PHCS-MPI: ORTHOPEDIC SURGERY	0
		PHCS-MPI: OTOLARYNGOLOGY	0
		PHCS-MPI: PEDIATRICIAN	3
		PHCS-MPI: PHYSICAL THERAPY	0
		PHCS-MPI: RADIOLOGY	0
		PHCS-MPI: UROLOGY	0
Braxton, WV	1,172	PHCS-MPI: HOSPITALS	0
		PHCS-MPI: NURSING FACILITY	0
		PHCS-MPI: PRIMARY CARE PHYSICIAN	24
		PHCS-MPI: PCP - FAMILY PRACTICE	23
		PHCS-MPI: PCP - GENERAL PRACTICE	0
		PHCS-MPI: PCP - INTERNAL MEDICINE	1
		PHCS-MPI: CARDIOLOGY	0
		PHCS-MPI: DERMATOLOGY	0
		PHCS-MPI: GENERAL SURGERY	0
		PHCS-MPI: NEUROLOGY	0
		PHCS-MPI: OBSTETRICS & GYNECOLOGY	1
		PHCS-MPI: ONCOLOGY	0
		PHCS-MPI: ORAL SURGERY	0
		PHCS-MPI: ORTHOPEDIC SURGERY	0
		PHCS-MPI: OTOLARYNGOLOGY	0
		PHCS-MPI: PEDIATRICIAN	0
		PHCS-MPI: PHYSICAL THERAPY	0
		PHCS-MPI: RADIOLOGY	14
		PHCS-MPI: UROLOGY	0
Brooke, WV	705	PHCS-MPI: HOSPITALS	0
		PHCS-MPI: NURSING FACILITY	1
		PHCS-MPI: PRIMARY CARE PHYSICIAN	8
		PHCS-MPI: PCP - FAMILY PRACTICE	3
		PHCS-MPI: PCP - GENERAL PRACTICE	1
		PHCS-MPI: PCP - INTERNAL MEDICINE	4
		PHCS-MPI: CARDIOLOGY	1

		PHCS-MPI: DERMATOLOGY	0
		PHCS-MPI: GENERAL SURGERY	0
		PHCS-MPI: NEUROLOGY	0
		PHCS-MPI: OBSTETRICS & GYNECOLOGY	0
		PHCS-MPI: ONCOLOGY	0
		PHCS-MPI: ORAL SURGERY	0
		PHCS-MPI: ORTHOPEDIC SURGERY	0
		PHCS-MPI: OTOLARYNGOLOGY	0
		PHCS-MPI: PEDIATRICIAN	3
		PHCS-MPI: PHYSICAL THERAPY	15
		PHCS-MPI: RADIOLOGY	0
		PHCS-MPI: UROLOGY	0
Cabell, WV	4,480	PHCS-MPI: HOSPITALS	3
		PHCS-MPI: NURSING FACILITY	1
		PHCS-MPI: PRIMARY CARE PHYSICIAN	222
		PHCS-MPI: PCP - FAMILY PRACTICE	107
		PHCS-MPI: PCP - GENERAL PRACTICE	9
		PHCS-MPI: PCP - INTERNAL MEDICINE	106
		PHCS-MPI: CARDIOLOGY	23
		PHCS-MPI: DERMATOLOGY	4
		PHCS-MPI: GENERAL SURGERY	25
		PHCS-MPI: NEUROLOGY	8
		PHCS-MPI: OBSTETRICS & GYNECOLOGY	61
		PHCS-MPI: ONCOLOGY	10
		PHCS-MPI: ORAL SURGERY	1
		PHCS-MPI: ORTHOPEDIC SURGERY	22
		PHCS-MPI: OTOLARYNGOLOGY	8
		PHCS-MPI: PEDIATRICIAN	70
		PHCS-MPI: PHYSICAL THERAPY	12
		PHCS-MPI: RADIOLOGY	73
		PHCS-MPI: UROLOGY	6
Calhoun, WV	881	PHCS-MPI: HOSPITALS	1
		PHCS-MPI: NURSING FACILITY	0
		PHCS-MPI: PRIMARY CARE PHYSICIAN	4
		PHCS-MPI: PCP - FAMILY PRACTICE	2
		PHCS-MPI: PCP - GENERAL PRACTICE	0
		PHCS-MPI: PCP - INTERNAL MEDICINE	2
		PHCS-MPI: CARDIOLOGY	0
		PHCS-MPI: DERMATOLOGY	0
		PHCS-MPI: GENERAL SURGERY	0
		PHCS-MPI: NEUROLOGY	0
		PHCS-MPI: OBSTETRICS & GYNECOLOGY	0
		PHCS-MPI: ONCOLOGY	0
		PHCS-MPI: ORAL SURGERY	0
		PHCS-MPI: ORTHOPEDIC SURGERY	0
		PHCS-MPI: OTOLARYNGOLOGY	0
		PHCS-MPI: PEDIATRICIAN	3

		PHCS-MPI: PHYSICAL THERAPY	0
		PHCS-MPI: RADIOLOGY	0
		PHCS-MPI: UROLOGY	0
Clay, WV	1,379	PHCS-MPI: HOSPITALS	0
		PHCS-MPI: NURSING FACILITY	0
		PHCS-MPI: PRIMARY CARE PHYSICIAN	14
		PHCS-MPI: PCP - FAMILY PRACTICE	14
		PHCS-MPI: PCP - GENERAL PRACTICE	0
		PHCS-MPI: PCP - INTERNAL MEDICINE	0
		PHCS-MPI: CARDIOLOGY	0
		PHCS-MPI: DERMATOLOGY	0
		PHCS-MPI: GENERAL SURGERY	0
		PHCS-MPI: NEUROLOGY	0
		PHCS-MPI: OBSTETRICS & GYNECOLOGY	0
		PHCS-MPI: ONCOLOGY	0
		PHCS-MPI: ORAL SURGERY	0
		PHCS-MPI: ORTHOPEDIC SURGERY	0
		PHCS-MPI: OTOLARYNGOLOGY	0
		PHCS-MPI: PEDIATRICIAN	1
		PHCS-MPI: PHYSICAL THERAPY	0
		PHCS-MPI: RADIOLOGY	0
		PHCS-MPI: UROLOGY	0
Doddridge, WV	420	PHCS-MPI: HOSPITALS	0
		PHCS-MPI: NURSING FACILITY	0
		PHCS-MPI: PRIMARY CARE PHYSICIAN	8
		PHCS-MPI: PCP - FAMILY PRACTICE	4
		PHCS-MPI: PCP - GENERAL PRACTICE	2
		PHCS-MPI: PCP - INTERNAL MEDICINE	2
		PHCS-MPI: CARDIOLOGY	0
		PHCS-MPI: DERMATOLOGY	0
		PHCS-MPI: GENERAL SURGERY	0
		PHCS-MPI: NEUROLOGY	0
		PHCS-MPI: OBSTETRICS & GYNECOLOGY	0
		PHCS-MPI: ONCOLOGY	0
		PHCS-MPI: ORAL SURGERY	0
		PHCS-MPI: ORTHOPEDIC SURGERY	0
		PHCS-MPI: OTOLARYNGOLOGY	0
		PHCS-MPI: PEDIATRICIAN	2
		PHCS-MPI: PHYSICAL THERAPY	0
		PHCS-MPI: RADIOLOGY	0
		PHCS-MPI: UROLOGY	0
Fayette, WV	4,002	PHCS-MPI: HOSPITALS	1
		PHCS-MPI: NURSING FACILITY	0
		PHCS-MPI: PRIMARY CARE PHYSICIAN	23
		PHCS-MPI: PCP - FAMILY PRACTICE	14
		PHCS-MPI: PCP - GENERAL PRACTICE	1
		PHCS-MPI: PCP - INTERNAL MEDICINE	8
		PHCS-MPI: CARDIOLOGY	2

		PHCS-MPI: DERMATOLOGY	0
		PHCS-MPI: GENERAL SURGERY	1
		PHCS-MPI: NEUROLOGY	0
		PHCS-MPI: OBSTETRICS & GYNECOLOGY	0
		PHCS-MPI: ONCOLOGY	0
		PHCS-MPI: ORAL SURGERY	0
		PHCS-MPI: ORTHOPEDIC SURGERY	0
		PHCS-MPI: OTOLARYNGOLOGY	0
		PHCS-MPI: PEDIATRICIAN	2
		PHCS-MPI: PHYSICAL THERAPY	0
		PHCS-MPI: RADIOLOGY	1
		PHCS-MPI: UROLOGY	1
Gilmer, WV	841	PHCS-MPI: HOSPITALS	0
		PHCS-MPI: NURSING FACILITY	1
		PHCS-MPI: PRIMARY CARE PHYSICIAN	3
		PHCS-MPI: PCP - FAMILY PRACTICE	3
		PHCS-MPI: PCP - GENERAL PRACTICE	0
		PHCS-MPI: PCP - INTERNAL MEDICINE	0
		PHCS-MPI: CARDIOLOGY	0
		PHCS-MPI: DERMATOLOGY	0
		PHCS-MPI: GENERAL SURGERY	0
		PHCS-MPI: NEUROLOGY	0
		PHCS-MPI: OBSTETRICS & GYNECOLOGY	0
		PHCS-MPI: ONCOLOGY	0
		PHCS-MPI: ORAL SURGERY	0
		PHCS-MPI: ORTHOPEDIC SURGERY	0
		PHCS-MPI: OTOLARYNGOLOGY	0
		PHCS-MPI: PEDIATRICIAN	1
		PHCS-MPI: PHYSICAL THERAPY	0
		PHCS-MPI: RADIOLOGY	0
		PHCS-MPI: UROLOGY	0
Grant, WV	700	PHCS-MPI: HOSPITALS	1
		PHCS-MPI: NURSING FACILITY	0
		PHCS-MPI: PRIMARY CARE PHYSICIAN	2
		PHCS-MPI: PCP - FAMILY PRACTICE	0
		PHCS-MPI: PCP - GENERAL PRACTICE	0
		PHCS-MPI: PCP - INTERNAL MEDICINE	2
		PHCS-MPI: CARDIOLOGY	0
		PHCS-MPI: DERMATOLOGY	0
		PHCS-MPI: GENERAL SURGERY	0
		PHCS-MPI: NEUROLOGY	0
		PHCS-MPI: OBSTETRICS & GYNECOLOGY	1
		PHCS-MPI: ONCOLOGY	0
		PHCS-MPI: ORAL SURGERY	0
		PHCS-MPI: ORTHOPEDIC SURGERY	0
		PHCS-MPI: OTOLARYNGOLOGY	0
		PHCS-MPI: PEDIATRICIAN	0

		PHCS-MPI: PHYSICAL THERAPY	2
		PHCS-MPI: RADIOLOGY	2
		PHCS-MPI: UROLOGY	0
Greenbrier, WV	1,939	PHCS-MPI: HOSPITALS	1
		PHCS-MPI: NURSING FACILITY	3
		PHCS-MPI: PRIMARY CARE PHYSICIAN	51
		PHCS-MPI: PCP - FAMILY PRACTICE	38
		PHCS-MPI: PCP - GENERAL PRACTICE	1
		PHCS-MPI: PCP - INTERNAL MEDICINE	12
		PHCS-MPI: CARDIOLOGY	6
		PHCS-MPI: DERMATOLOGY	0
		PHCS-MPI: GENERAL SURGERY	10
		PHCS-MPI: NEUROLOGY	2
		PHCS-MPI: OBSTETRICS & GYNECOLOGY	3
		PHCS-MPI: ONCOLOGY	4
		PHCS-MPI: ORAL SURGERY	0
		PHCS-MPI: ORTHOPEDIC SURGERY	1
		PHCS-MPI: OTOLARYNGOLOGY	2
		PHCS-MPI: PEDIATRICIAN	10
		PHCS-MPI: PHYSICAL THERAPY	14
		PHCS-MPI: RADIOLOGY	2
		PHCS-MPI: UROLOGY	3
Hampshire, WV	1,544	PHCS-MPI: HOSPITALS	1
		PHCS-MPI: NURSING FACILITY	0
		PHCS-MPI: PRIMARY CARE PHYSICIAN	9
		PHCS-MPI: PCP - FAMILY PRACTICE	2
		PHCS-MPI: PCP - GENERAL PRACTICE	0
		PHCS-MPI: PCP - INTERNAL MEDICINE	7
		PHCS-MPI: CARDIOLOGY	0
		PHCS-MPI: DERMATOLOGY	1
		PHCS-MPI: GENERAL SURGERY	2
		PHCS-MPI: NEUROLOGY	0
		PHCS-MPI: OBSTETRICS & GYNECOLOGY	1
		PHCS-MPI: ONCOLOGY	0
		PHCS-MPI: ORAL SURGERY	0
		PHCS-MPI: ORTHOPEDIC SURGERY	0
		PHCS-MPI: OTOLARYNGOLOGY	0
		PHCS-MPI: PEDIATRICIAN	1
		PHCS-MPI: PHYSICAL THERAPY	0
		PHCS-MPI: RADIOLOGY	0
		PHCS-MPI: UROLOGY	0
Hancock, WV	490	PHCS-MPI: HOSPITALS	1
		PHCS-MPI: NURSING FACILITY	1
		PHCS-MPI: PRIMARY CARE PHYSICIAN	49
		PHCS-MPI: PCP - FAMILY PRACTICE	8
		PHCS-MPI: PCP - GENERAL PRACTICE	2
		PHCS-MPI: PCP - INTERNAL MEDICINE	39
		PHCS-MPI: CARDIOLOGY	6

		PHCS-MPI: DERMATOLOGY	1
		PHCS-MPI: GENERAL SURGERY	9
		PHCS-MPI: NEUROLOGY	0
		PHCS-MPI: OBSTETRICS & GYNECOLOGY	7
		PHCS-MPI: ONCOLOGY	10
		PHCS-MPI: ORAL SURGERY	0
		PHCS-MPI: ORTHOPEDIC SURGERY	3
		PHCS-MPI: OTOLARYNGOLOGY	3
		PHCS-MPI: PEDIATRICIAN	8
		PHCS-MPI: PHYSICAL THERAPY	3
		PHCS-MPI: RADIOLOGY	0
		PHCS-MPI: UROLOGY	5
Hardy, WV	817	PHCS-MPI: HOSPITALS	0
		PHCS-MPI: NURSING FACILITY	0
		PHCS-MPI: PRIMARY CARE PHYSICIAN	5
		PHCS-MPI: PCP - FAMILY PRACTICE	5
		PHCS-MPI: PCP - GENERAL PRACTICE	0
		PHCS-MPI: PCP - INTERNAL MEDICINE	0
		PHCS-MPI: CARDIOLOGY	0
		PHCS-MPI: DERMATOLOGY	2
		PHCS-MPI: GENERAL SURGERY	0
		PHCS-MPI: NEUROLOGY	0
		PHCS-MPI: OBSTETRICS & GYNECOLOGY	0
		PHCS-MPI: ONCOLOGY	0
		PHCS-MPI: ORAL SURGERY	0
		PHCS-MPI: ORTHOPEDIC SURGERY	0
		PHCS-MPI: OTOLARYNGOLOGY	0
		PHCS-MPI: PEDIATRICIAN	0
		PHCS-MPI: PHYSICAL THERAPY	0
		PHCS-MPI: RADIOLOGY	0
		PHCS-MPI: UROLOGY	0
Harrison, WV	2,113	PHCS-MPI: HOSPITALS	1
		PHCS-MPI: NURSING FACILITY	2
		PHCS-MPI: PRIMARY CARE PHYSICIAN	124
		PHCS-MPI: PCP - FAMILY PRACTICE	84
		PHCS-MPI: PCP - GENERAL PRACTICE	1
		PHCS-MPI: PCP - INTERNAL MEDICINE	39
		PHCS-MPI: CARDIOLOGY	7
		PHCS-MPI: DERMATOLOGY	5
		PHCS-MPI: GENERAL SURGERY	11
		PHCS-MPI: NEUROLOGY	3
		PHCS-MPI: OBSTETRICS & GYNECOLOGY	12
		PHCS-MPI: ONCOLOGY	3
		PHCS-MPI: ORAL SURGERY	0
		PHCS-MPI: ORTHOPEDIC SURGERY	4
		PHCS-MPI: OTOLARYNGOLOGY	2
		PHCS-MPI: PEDIATRICIAN	12

		PHCS-MPI: PHYSICAL THERAPY	20
		PHCS-MPI: RADIOLOGY	0
		PHCS-MPI: UROLOGY	2
Jackson, WV	1,099	PHCS-MPI: HOSPITALS	1
		PHCS-MPI: NURSING FACILITY	0
		PHCS-MPI: PRIMARY CARE PHYSICIAN	32
		PHCS-MPI: PCP - FAMILY PRACTICE	19
		PHCS-MPI: PCP - GENERAL PRACTICE	3
		PHCS-MPI: PCP - INTERNAL MEDICINE	10
		PHCS-MPI: CARDIOLOGY	6
		PHCS-MPI: DERMATOLOGY	0
		PHCS-MPI: GENERAL SURGERY	0
		PHCS-MPI: NEUROLOGY	0
		PHCS-MPI: OBSTETRICS & GYNECOLOGY	0
		PHCS-MPI: ONCOLOGY	0
		PHCS-MPI: ORAL SURGERY	0
		PHCS-MPI: ORTHOPEDIC SURGERY	3
		PHCS-MPI: OTOLARYNGOLOGY	1
		PHCS-MPI: PEDIATRICIAN	1
		PHCS-MPI: PHYSICAL THERAPY	34
		PHCS-MPI: RADIOLOGY	0
		PHCS-MPI: UROLOGY	0
Jefferson, WV	1,082	PHCS-MPI: HOSPITALS	1
		PHCS-MPI: NURSING FACILITY	1
		PHCS-MPI: PRIMARY CARE PHYSICIAN	43
		PHCS-MPI: PCP - FAMILY PRACTICE	31
		PHCS-MPI: PCP - GENERAL PRACTICE	0
		PHCS-MPI: PCP - INTERNAL MEDICINE	12
		PHCS-MPI: CARDIOLOGY	1
		PHCS-MPI: DERMATOLOGY	2
		PHCS-MPI: GENERAL SURGERY	5
		PHCS-MPI: NEUROLOGY	0
		PHCS-MPI: OBSTETRICS & GYNECOLOGY	5
		PHCS-MPI: ONCOLOGY	0
		PHCS-MPI: ORAL SURGERY	0
		PHCS-MPI: ORTHOPEDIC SURGERY	1
		PHCS-MPI: OTOLARYNGOLOGY	3
		PHCS-MPI: PEDIATRICIAN	7
		PHCS-MPI: PHYSICAL THERAPY	4
		PHCS-MPI: RADIOLOGY	1
		PHCS-MPI: UROLOGY	2
Kanawha, WV	7,824	PHCS-MPI: HOSPITALS	5
		PHCS-MPI: NURSING FACILITY	3
		PHCS-MPI: PRIMARY CARE PHYSICIAN	191
		PHCS-MPI: PCP - FAMILY PRACTICE	61
		PHCS-MPI: PCP - GENERAL PRACTICE	1
		PHCS-MPI: PCP - INTERNAL MEDICINE	129
		PHCS-MPI: CARDIOLOGY	26

		PHCS-MPI: DERMATOLOGY	2
		PHCS-MPI: GENERAL SURGERY	41
		PHCS-MPI: NEUROLOGY	6
		PHCS-MPI: OBSTETRICS & GYNECOLOGY	35
		PHCS-MPI: ONCOLOGY	7
		PHCS-MPI: ORAL SURGERY	0
		PHCS-MPI: ORTHOPEDIC SURGERY	11
		PHCS-MPI: OTOLARYNGOLOGY	8
		PHCS-MPI: PEDIATRICIAN	44
		PHCS-MPI: PHYSICAL THERAPY	29
		PHCS-MPI: RADIOLOGY	145
		PHCS-MPI: UROLOGY	0
Lewis, WV	732	PHCS-MPI: HOSPITALS	1
		PHCS-MPI: NURSING FACILITY	0
		PHCS-MPI: PRIMARY CARE PHYSICIAN	22
		PHCS-MPI: PCP - FAMILY PRACTICE	18
		PHCS-MPI: PCP - GENERAL PRACTICE	0
		PHCS-MPI: PCP - INTERNAL MEDICINE	4
		PHCS-MPI: CARDIOLOGY	1
		PHCS-MPI: DERMATOLOGY	0
		PHCS-MPI: GENERAL SURGERY	3
		PHCS-MPI: NEUROLOGY	0
		PHCS-MPI: OBSTETRICS & GYNECOLOGY	4
		PHCS-MPI: ONCOLOGY	0
		PHCS-MPI: ORAL SURGERY	0
		PHCS-MPI: ORTHOPEDIC SURGERY	3
		PHCS-MPI: OTOLARYNGOLOGY	1
		PHCS-MPI: PEDIATRICIAN	2
		PHCS-MPI: PHYSICAL THERAPY	5
		PHCS-MPI: RADIOLOGY	20
		PHCS-MPI: UROLOGY	1
Lincoln, WV	1,473	PHCS-MPI: HOSPITALS	0
		PHCS-MPI: NURSING FACILITY	0
		PHCS-MPI: PRIMARY CARE PHYSICIAN	25
		PHCS-MPI: PCP - FAMILY PRACTICE	23
		PHCS-MPI: PCP - GENERAL PRACTICE	0
		PHCS-MPI: PCP - INTERNAL MEDICINE	2
		PHCS-MPI: CARDIOLOGY	0
		PHCS-MPI: DERMATOLOGY	0
		PHCS-MPI: GENERAL SURGERY	0
		PHCS-MPI: NEUROLOGY	0
		PHCS-MPI: OBSTETRICS & GYNECOLOGY	5
		PHCS-MPI: ONCOLOGY	0
		PHCS-MPI: ORAL SURGERY	0
		PHCS-MPI: ORTHOPEDIC SURGERY	0
		PHCS-MPI: OTOLARYNGOLOGY	0
		PHCS-MPI: PEDIATRICIAN	2

		PHCS-MPI: PHYSICAL THERAPY	2
		PHCS-MPI: RADIOLOGY	0
		PHCS-MPI: UROLOGY	0
Logan, WV	3,149	PHCS-MPI: HOSPITALS	0
		PHCS-MPI: NURSING FACILITY	0
		PHCS-MPI: PRIMARY CARE PHYSICIAN	30
		PHCS-MPI: PCP - FAMILY PRACTICE	24
		PHCS-MPI: PCP - GENERAL PRACTICE	2
		PHCS-MPI: PCP - INTERNAL MEDICINE	4
		PHCS-MPI: CARDIOLOGY	0
		PHCS-MPI: DERMATOLOGY	0
		PHCS-MPI: GENERAL SURGERY	1
		PHCS-MPI: NEUROLOGY	0
		PHCS-MPI: OBSTETRICS & GYNECOLOGY	0
		PHCS-MPI: ONCOLOGY	1
		PHCS-MPI: ORAL SURGERY	0
		PHCS-MPI: ORTHOPEDIC SURGERY	0
		PHCS-MPI: OTOLARYNGOLOGY	1
		PHCS-MPI: PEDIATRICIAN	2
		PHCS-MPI: PHYSICAL THERAPY	2
		PHCS-MPI: RADIOLOGY	21
		PHCS-MPI: UROLOGY	0
Marion, WV	1,702	PHCS-MPI: HOSPITALS	0
		PHCS-MPI: NURSING FACILITY	0
		PHCS-MPI: PRIMARY CARE PHYSICIAN	45
		PHCS-MPI: PCP - FAMILY PRACTICE	25
		PHCS-MPI: PCP - GENERAL PRACTICE	2
		PHCS-MPI: PCP - INTERNAL MEDICINE	18
		PHCS-MPI: CARDIOLOGY	2
		PHCS-MPI: DERMATOLOGY	1
		PHCS-MPI: GENERAL SURGERY	4
		PHCS-MPI: NEUROLOGY	0
		PHCS-MPI: OBSTETRICS & GYNECOLOGY	1
		PHCS-MPI: ONCOLOGY	1
		PHCS-MPI: ORAL SURGERY	0
		PHCS-MPI: ORTHOPEDIC SURGERY	2
		PHCS-MPI: OTOLARYNGOLOGY	2
		PHCS-MPI: PEDIATRICIAN	13
		PHCS-MPI: PHYSICAL THERAPY	39
		PHCS-MPI: RADIOLOGY	7
		PHCS-MPI: UROLOGY	2
Marshall, WV	736	PHCS-MPI: HOSPITALS	1
		PHCS-MPI: NURSING FACILITY	0
		PHCS-MPI: PRIMARY CARE PHYSICIAN	13
		PHCS-MPI: PCP - FAMILY PRACTICE	4
		PHCS-MPI: PCP - GENERAL PRACTICE	3
		PHCS-MPI: PCP - INTERNAL MEDICINE	6
		PHCS-MPI: CARDIOLOGY	2

		PHCS-MPI: DERMATOLOGY	0
		PHCS-MPI: GENERAL SURGERY	5
		PHCS-MPI: NEUROLOGY	0
		PHCS-MPI: OBSTETRICS & GYNECOLOGY	3
		PHCS-MPI: ONCOLOGY	4
		PHCS-MPI: ORAL SURGERY	0
		PHCS-MPI: ORTHOPEDIC SURGERY	1
		PHCS-MPI: OTOLARYNGOLOGY	0
		PHCS-MPI: PEDIATRICIAN	2
		PHCS-MPI: PHYSICAL THERAPY	1
		PHCS-MPI: RADIOLOGY	1
		PHCS-MPI: UROLOGY	1
Mason, WV	1,392	PHCS-MPI: HOSPITALS	1
		PHCS-MPI: NURSING FACILITY	0
		PHCS-MPI: PRIMARY CARE PHYSICIAN	31
		PHCS-MPI: PCP - FAMILY PRACTICE	10
		PHCS-MPI: PCP - GENERAL PRACTICE	1
		PHCS-MPI: PCP - INTERNAL MEDICINE	20
		PHCS-MPI: CARDIOLOGY	4
		PHCS-MPI: DERMATOLOGY	0
		PHCS-MPI: GENERAL SURGERY	8
		PHCS-MPI: NEUROLOGY	2
		PHCS-MPI: OBSTETRICS & GYNECOLOGY	5
		PHCS-MPI: ONCOLOGY	1
		PHCS-MPI: ORAL SURGERY	0
		PHCS-MPI: ORTHOPEDIC SURGERY	3
		PHCS-MPI: OTOLARYNGOLOGY	3
		PHCS-MPI: PEDIATRICIAN	10
		PHCS-MPI: PHYSICAL THERAPY	0
		PHCS-MPI: RADIOLOGY	12
		PHCS-MPI: UROLOGY	0
McDowell, WV	3,630	PHCS-MPI: HOSPITALS	1
		PHCS-MPI: NURSING FACILITY	0
		PHCS-MPI: PRIMARY CARE PHYSICIAN	11
		PHCS-MPI: PCP - FAMILY PRACTICE	7
		PHCS-MPI: PCP - GENERAL PRACTICE	1
		PHCS-MPI: PCP - INTERNAL MEDICINE	3
		PHCS-MPI: CARDIOLOGY	0
		PHCS-MPI: DERMATOLOGY	0
		PHCS-MPI: GENERAL SURGERY	1
		PHCS-MPI: NEUROLOGY	0
		PHCS-MPI: OBSTETRICS & GYNECOLOGY	1
		PHCS-MPI: ONCOLOGY	0
		PHCS-MPI: ORAL SURGERY	0
		PHCS-MPI: ORTHOPEDIC SURGERY	0
		PHCS-MPI: OTOLARYNGOLOGY	0
		PHCS-MPI: PEDIATRICIAN	1

		PHCS-MPI: PHYSICAL THERAPY	0
		PHCS-MPI: RADIOLOGY	7
		PHCS-MPI: UROLOGY	0
Mercer, WV	1,958	PHCS-MPI: HOSPITALS	2
		PHCS-MPI: NURSING FACILITY	1
		PHCS-MPI: PRIMARY CARE PHYSICIAN	58
		PHCS-MPI: PCP - FAMILY PRACTICE	26
		PHCS-MPI: PCP - GENERAL PRACTICE	4
		PHCS-MPI: PCP - INTERNAL MEDICINE	28
		PHCS-MPI: CARDIOLOGY	12
		PHCS-MPI: DERMATOLOGY	2
		PHCS-MPI: GENERAL SURGERY	9
		PHCS-MPI: NEUROLOGY	3
		PHCS-MPI: OBSTETRICS & GYNECOLOGY	10
		PHCS-MPI: ONCOLOGY	6
		PHCS-MPI: ORAL SURGERY	1
		PHCS-MPI: ORTHOPEDIC SURGERY	8
		PHCS-MPI: OTOLARYNGOLOGY	3
		PHCS-MPI: PEDIATRICIAN	12
		PHCS-MPI: PHYSICAL THERAPY	3
		PHCS-MPI: RADIOLOGY	23
		PHCS-MPI: UROLOGY	7
Mineral, WV	825	PHCS-MPI: HOSPITALS	1
		PHCS-MPI: NURSING FACILITY	1
		PHCS-MPI: PRIMARY CARE PHYSICIAN	10
		PHCS-MPI: PCP - FAMILY PRACTICE	5
		PHCS-MPI: PCP - GENERAL PRACTICE	2
		PHCS-MPI: PCP - INTERNAL MEDICINE	3
		PHCS-MPI: CARDIOLOGY	0
		PHCS-MPI: DERMATOLOGY	0
		PHCS-MPI: GENERAL SURGERY	2
		PHCS-MPI: NEUROLOGY	0
		PHCS-MPI: OBSTETRICS & GYNECOLOGY	0
		PHCS-MPI: ONCOLOGY	0
		PHCS-MPI: ORAL SURGERY	0
		PHCS-MPI: ORTHOPEDIC SURGERY	0
		PHCS-MPI: OTOLARYNGOLOGY	0
		PHCS-MPI: PEDIATRICIAN	1
		PHCS-MPI: PHYSICAL THERAPY	0
		PHCS-MPI: RADIOLOGY	2
		PHCS-MPI: UROLOGY	0
Mingo, WV	2,164	PHCS-MPI: HOSPITALS	1
		PHCS-MPI: NURSING FACILITY	0
		PHCS-MPI: PRIMARY CARE PHYSICIAN	14
		PHCS-MPI: PCP - FAMILY PRACTICE	11
		PHCS-MPI: PCP - GENERAL PRACTICE	1
		PHCS-MPI: PCP - INTERNAL MEDICINE	2
		PHCS-MPI: CARDIOLOGY	1

		PHCS-MPI: DERMATOLOGY	0
		PHCS-MPI: GENERAL SURGERY	1
		PHCS-MPI: NEUROLOGY	0
		PHCS-MPI: OBSTETRICS & GYNECOLOGY	0
		PHCS-MPI: ONCOLOGY	0
		PHCS-MPI: ORAL SURGERY	0
		PHCS-MPI: ORTHOPEDIC SURGERY	0
		PHCS-MPI: OTOLARYNGOLOGY	0
		PHCS-MPI: PEDIATRICIAN	2
		PHCS-MPI: PHYSICAL THERAPY	0
		PHCS-MPI: RADIOLOGY	0
		PHCS-MPI: UROLOGY	0
Monongalia, WV	1,737	PHCS-MPI: HOSPITALS	2
		PHCS-MPI: NURSING FACILITY	2
		PHCS-MPI: PRIMARY CARE PHYSICIAN	202
		PHCS-MPI: PCP - FAMILY PRACTICE	87
		PHCS-MPI: PCP - GENERAL PRACTICE	3
		PHCS-MPI: PCP - INTERNAL MEDICINE	112
		PHCS-MPI: CARDIOLOGY	22
		PHCS-MPI: DERMATOLOGY	13
		PHCS-MPI: GENERAL SURGERY	39
		PHCS-MPI: NEUROLOGY	21
		PHCS-MPI: OBSTETRICS & GYNECOLOGY	42
		PHCS-MPI: ONCOLOGY	28
		PHCS-MPI: ORAL SURGERY	9
		PHCS-MPI: ORTHOPEDIC SURGERY	36
		PHCS-MPI: OTOLARYNGOLOGY	28
		PHCS-MPI: PEDIATRICIAN	79
		PHCS-MPI: PHYSICAL THERAPY	89
		PHCS-MPI: RADIOLOGY	19
		PHCS-MPI: UROLOGY	12
Monroe, WV	1,086	PHCS-MPI: HOSPITALS	0
		PHCS-MPI: NURSING FACILITY	1
		PHCS-MPI: PRIMARY CARE PHYSICIAN	6
		PHCS-MPI: PCP - FAMILY PRACTICE	6
		PHCS-MPI: PCP - GENERAL PRACTICE	0
		PHCS-MPI: PCP - INTERNAL MEDICINE	0
		PHCS-MPI: CARDIOLOGY	0
		PHCS-MPI: DERMATOLOGY	0
		PHCS-MPI: GENERAL SURGERY	0
		PHCS-MPI: NEUROLOGY	0
		PHCS-MPI: OBSTETRICS & GYNECOLOGY	0
		PHCS-MPI: ONCOLOGY	0
		PHCS-MPI: ORAL SURGERY	0
		PHCS-MPI: ORTHOPEDIC SURGERY	0
		PHCS-MPI: OTOLARYNGOLOGY	0
		PHCS-MPI: PEDIATRICIAN	0

		PHCS-MPI: PHYSICAL THERAPY	1
		PHCS-MPI: RADIOLOGY	0
		PHCS-MPI: UROLOGY	0
Morgan, WV	286	PHCS-MPI: HOSPITALS	1
		PHCS-MPI: NURSING FACILITY	1
		PHCS-MPI: PRIMARY CARE PHYSICIAN	14
		PHCS-MPI: PCP - FAMILY PRACTICE	8
		PHCS-MPI: PCP - GENERAL PRACTICE	0
		PHCS-MPI: PCP - INTERNAL MEDICINE	6
		PHCS-MPI: CARDIOLOGY	2
		PHCS-MPI: DERMATOLOGY	1
		PHCS-MPI: GENERAL SURGERY	2
		PHCS-MPI: NEUROLOGY	0
		PHCS-MPI: OBSTETRICS & GYNECOLOGY	0
		PHCS-MPI: ONCOLOGY	0
		PHCS-MPI: ORAL SURGERY	0
		PHCS-MPI: ORTHOPEDIC SURGERY	0
		PHCS-MPI: OTOLARYNGOLOGY	0
		PHCS-MPI: PEDIATRICIAN	1
		PHCS-MPI: PHYSICAL THERAPY	0
		PHCS-MPI: RADIOLOGY	0
		PHCS-MPI: UROLOGY	0
Nicholas, WV	1,932	PHCS-MPI: HOSPITALS	1
		PHCS-MPI: NURSING FACILITY	1
		PHCS-MPI: PRIMARY CARE PHYSICIAN	4
		PHCS-MPI: PCP - FAMILY PRACTICE	3
		PHCS-MPI: PCP - GENERAL PRACTICE	0
		PHCS-MPI: PCP - INTERNAL MEDICINE	1
		PHCS-MPI: CARDIOLOGY	0
		PHCS-MPI: DERMATOLOGY	0
		PHCS-MPI: GENERAL SURGERY	0
		PHCS-MPI: NEUROLOGY	0
		PHCS-MPI: OBSTETRICS & GYNECOLOGY	0
		PHCS-MPI: ONCOLOGY	0
		PHCS-MPI: ORAL SURGERY	0
		PHCS-MPI: ORTHOPEDIC SURGERY	0
		PHCS-MPI: OTOLARYNGOLOGY	0
		PHCS-MPI: PEDIATRICIAN	3
		PHCS-MPI: PHYSICAL THERAPY	0
		PHCS-MPI: RADIOLOGY	1
		PHCS-MPI: UROLOGY	1
Ohio, WV	398	PHCS-MPI: HOSPITALS	2
		PHCS-MPI: NURSING FACILITY	2
		PHCS-MPI: PRIMARY CARE PHYSICIAN	77
		PHCS-MPI: PCP - FAMILY PRACTICE	37
		PHCS-MPI: PCP - GENERAL PRACTICE	3
		PHCS-MPI: PCP - INTERNAL MEDICINE	37
		PHCS-MPI: CARDIOLOGY	8

		PHCS-MPI: DERMATOLOGY	3
		PHCS-MPI: GENERAL SURGERY	12
		PHCS-MPI: NEUROLOGY	7
		PHCS-MPI: OBSTETRICS & GYNECOLOGY	21
		PHCS-MPI: ONCOLOGY	10
		PHCS-MPI: ORAL SURGERY	0
		PHCS-MPI: ORTHOPEDIC SURGERY	9
		PHCS-MPI: OTOLARYNGOLOGY	5
		PHCS-MPI: PEDIATRICIAN	14
		PHCS-MPI: PHYSICAL THERAPY	24
		PHCS-MPI: RADIOLOGY	10
		PHCS-MPI: UROLOGY	3
Pendleton, WV	847	PHCS-MPI: HOSPITALS	0
		PHCS-MPI: NURSING FACILITY	0
		PHCS-MPI: PRIMARY CARE PHYSICIAN	6
		PHCS-MPI: PCP - FAMILY PRACTICE	6
		PHCS-MPI: PCP - GENERAL PRACTICE	0
		PHCS-MPI: PCP - INTERNAL MEDICINE	0
		PHCS-MPI: CARDIOLOGY	0
		PHCS-MPI: DERMATOLOGY	1
		PHCS-MPI: GENERAL SURGERY	0
		PHCS-MPI: NEUROLOGY	0
		PHCS-MPI: OBSTETRICS & GYNECOLOGY	0
		PHCS-MPI: ONCOLOGY	0
		PHCS-MPI: ORAL SURGERY	0
		PHCS-MPI: ORTHOPEDIC SURGERY	0
		PHCS-MPI: OTOLARYNGOLOGY	0
		PHCS-MPI: PEDIATRICIAN	1
		PHCS-MPI: PHYSICAL THERAPY	0
		PHCS-MPI: RADIOLOGY	0
		PHCS-MPI: UROLOGY	0
Pleasants, WV	290	PHCS-MPI: HOSPITALS	0
		PHCS-MPI: NURSING FACILITY	0
		PHCS-MPI: PRIMARY CARE PHYSICIAN	7
		PHCS-MPI: PCP - FAMILY PRACTICE	3
		PHCS-MPI: PCP - GENERAL PRACTICE	2
		PHCS-MPI: PCP - INTERNAL MEDICINE	2
		PHCS-MPI: CARDIOLOGY	0
		PHCS-MPI: DERMATOLOGY	0
		PHCS-MPI: GENERAL SURGERY	0
		PHCS-MPI: NEUROLOGY	0
		PHCS-MPI: OBSTETRICS & GYNECOLOGY	0
		PHCS-MPI: ONCOLOGY	0
		PHCS-MPI: ORAL SURGERY	0
		PHCS-MPI: ORTHOPEDIC SURGERY	0
		PHCS-MPI: OTOLARYNGOLOGY	0
		PHCS-MPI: PEDIATRICIAN	1

		PHCS-MPI: PHYSICAL THERAPY	1
		PHCS-MPI: RADIOLOGY	0
		PHCS-MPI: UROLOGY	0
Pocahontas, WV	1,173	PHCS-MPI: HOSPITALS	1
		PHCS-MPI: NURSING FACILITY	0
		PHCS-MPI: PRIMARY CARE PHYSICIAN	14
		PHCS-MPI: PCP - FAMILY PRACTICE	12
		PHCS-MPI: PCP - GENERAL PRACTICE	2
		PHCS-MPI: PCP - INTERNAL MEDICINE	0
		PHCS-MPI: CARDIOLOGY	0
		PHCS-MPI: DERMATOLOGY	0
		PHCS-MPI: GENERAL SURGERY	0
		PHCS-MPI: NEUROLOGY	0
		PHCS-MPI: OBSTETRICS & GYNECOLOGY	0
		PHCS-MPI: ONCOLOGY	0
		PHCS-MPI: ORAL SURGERY	0
		PHCS-MPI: ORTHOPEDIC SURGERY	0
		PHCS-MPI: OTOLARYNGOLOGY	0
		PHCS-MPI: PEDIATRICIAN	0
		PHCS-MPI: PHYSICAL THERAPY	3
		PHCS-MPI: RADIOLOGY	0
		PHCS-MPI: UROLOGY	0
Preston, WV	1,422	PHCS-MPI: HOSPITALS	1
		PHCS-MPI: NURSING FACILITY	1
		PHCS-MPI: PRIMARY CARE PHYSICIAN	25
		PHCS-MPI: PCP - FAMILY PRACTICE	19
		PHCS-MPI: PCP - GENERAL PRACTICE	0
		PHCS-MPI: PCP - INTERNAL MEDICINE	6
		PHCS-MPI: CARDIOLOGY	0
		PHCS-MPI: DERMATOLOGY	0
		PHCS-MPI: GENERAL SURGERY	1
		PHCS-MPI: NEUROLOGY	0
		PHCS-MPI: OBSTETRICS & GYNECOLOGY	0
		PHCS-MPI: ONCOLOGY	0
		PHCS-MPI: ORAL SURGERY	0
		PHCS-MPI: ORTHOPEDIC SURGERY	0
		PHCS-MPI: OTOLARYNGOLOGY	0
		PHCS-MPI: PEDIATRICIAN	3
		PHCS-MPI: PHYSICAL THERAPY	5
		PHCS-MPI: RADIOLOGY	2
		PHCS-MPI: UROLOGY	0
Putnam, WV	1,253	PHCS-MPI: HOSPITALS	1
		PHCS-MPI: NURSING FACILITY	1
		PHCS-MPI: PRIMARY CARE PHYSICIAN	47
		PHCS-MPI: PCP - FAMILY PRACTICE	34
		PHCS-MPI: PCP - GENERAL PRACTICE	0
		PHCS-MPI: PCP - INTERNAL MEDICINE	13
		PHCS-MPI: CARDIOLOGY	4

		PHCS-MPI: DERMATOLOGY	0
		PHCS-MPI: GENERAL SURGERY	2
		PHCS-MPI: NEUROLOGY	1
		PHCS-MPI: OBSTETRICS & GYNECOLOGY	24
		PHCS-MPI: ONCOLOGY	0
		PHCS-MPI: ORAL SURGERY	0
		PHCS-MPI: ORTHOPEDIC SURGERY	2
		PHCS-MPI: OTOLARYNGOLOGY	0
		PHCS-MPI: PEDIATRICIAN	14
		PHCS-MPI: PHYSICAL THERAPY	11
		PHCS-MPI: RADIOLOGY	28
		PHCS-MPI: UROLOGY	0
Raleigh, WV	4,758	PHCS-MPI: HOSPITALS	2
		PHCS-MPI: NURSING FACILITY	3
		PHCS-MPI: PRIMARY CARE PHYSICIAN	65
		PHCS-MPI: PCP - FAMILY PRACTICE	24
		PHCS-MPI: PCP - GENERAL PRACTICE	2
		PHCS-MPI: PCP - INTERNAL MEDICINE	39
		PHCS-MPI: CARDIOLOGY	14
		PHCS-MPI: DERMATOLOGY	1
		PHCS-MPI: GENERAL SURGERY	16
		PHCS-MPI: NEUROLOGY	3
		PHCS-MPI: OBSTETRICS & GYNECOLOGY	14
		PHCS-MPI: ONCOLOGY	1
		PHCS-MPI: ORAL SURGERY	0
		PHCS-MPI: ORTHOPEDIC SURGERY	10
		PHCS-MPI: OTOLARYNGOLOGY	2
		PHCS-MPI: PEDIATRICIAN	11
		PHCS-MPI: PHYSICAL THERAPY	0
		PHCS-MPI: RADIOLOGY	1
		PHCS-MPI: UROLOGY	6
Randolph, WV	1,642	PHCS-MPI: HOSPITALS	1
		PHCS-MPI: NURSING FACILITY	0
		PHCS-MPI: PRIMARY CARE PHYSICIAN	32
		PHCS-MPI: PCP - FAMILY PRACTICE	24
		PHCS-MPI: PCP - GENERAL PRACTICE	0
		PHCS-MPI: PCP - INTERNAL MEDICINE	8
		PHCS-MPI: CARDIOLOGY	2
		PHCS-MPI: DERMATOLOGY	1
		PHCS-MPI: GENERAL SURGERY	4
		PHCS-MPI: NEUROLOGY	0
		PHCS-MPI: OBSTETRICS & GYNECOLOGY	2
		PHCS-MPI: ONCOLOGY	3
		PHCS-MPI: ORAL SURGERY	0
		PHCS-MPI: ORTHOPEDIC SURGERY	3
		PHCS-MPI: OTOLARYNGOLOGY	1
		PHCS-MPI: PEDIATRICIAN	3

		PHCS-MPI: PHYSICAL THERAPY	3
		PHCS-MPI: RADIOLOGY	4
		PHCS-MPI: UROLOGY	1
Ritchie, WV	978	PHCS-MPI: HOSPITALS	0
		PHCS-MPI: NURSING FACILITY	0
		PHCS-MPI: PRIMARY CARE PHYSICIAN	8
		PHCS-MPI: PCP - FAMILY PRACTICE	3
		PHCS-MPI: PCP - GENERAL PRACTICE	2
		PHCS-MPI: PCP - INTERNAL MEDICINE	3
		PHCS-MPI: CARDIOLOGY	0
		PHCS-MPI: DERMATOLOGY	0
		PHCS-MPI: GENERAL SURGERY	0
		PHCS-MPI: NEUROLOGY	0
		PHCS-MPI: OBSTETRICS & GYNECOLOGY	0
		PHCS-MPI: ONCOLOGY	0
		PHCS-MPI: ORAL SURGERY	0
		PHCS-MPI: ORTHOPEDIC SURGERY	0
		PHCS-MPI: OTOLARYNGOLOGY	0
		PHCS-MPI: PEDIATRICIAN	2
		PHCS-MPI: PHYSICAL THERAPY	18
		PHCS-MPI: RADIOLOGY	0
		PHCS-MPI: UROLOGY	0
Roane, WV	850	PHCS-MPI: HOSPITALS	0
		PHCS-MPI: NURSING FACILITY	0
		PHCS-MPI: PRIMARY CARE PHYSICIAN	2
		PHCS-MPI: PCP - FAMILY PRACTICE	2
		PHCS-MPI: PCP - GENERAL PRACTICE	0
		PHCS-MPI: PCP - INTERNAL MEDICINE	0
		PHCS-MPI: CARDIOLOGY	0
		PHCS-MPI: DERMATOLOGY	0
		PHCS-MPI: GENERAL SURGERY	0
		PHCS-MPI: NEUROLOGY	0
		PHCS-MPI: OBSTETRICS & GYNECOLOGY	0
		PHCS-MPI: ONCOLOGY	0
		PHCS-MPI: ORAL SURGERY	0
		PHCS-MPI: ORTHOPEDIC SURGERY	2
		PHCS-MPI: OTOLARYNGOLOGY	0
		PHCS-MPI: PEDIATRICIAN	0
		PHCS-MPI: PHYSICAL THERAPY	0
		PHCS-MPI: RADIOLOGY	1
		PHCS-MPI: UROLOGY	0
Summers, WV	1,243	PHCS-MPI: HOSPITALS	1
		PHCS-MPI: NURSING FACILITY	0
		PHCS-MPI: PRIMARY CARE PHYSICIAN	10
		PHCS-MPI: PCP - FAMILY PRACTICE	8
		PHCS-MPI: PCP - GENERAL PRACTICE	0
		PHCS-MPI: PCP - INTERNAL MEDICINE	2
		PHCS-MPI: CARDIOLOGY	0

		PHCS-MPI: DERMATOLOGY	0
		PHCS-MPI: GENERAL SURGERY	0
		PHCS-MPI: NEUROLOGY	0
		PHCS-MPI: OBSTETRICS & GYNECOLOGY	0
		PHCS-MPI: ONCOLOGY	0
		PHCS-MPI: ORAL SURGERY	0
		PHCS-MPI: ORTHOPEDIC SURGERY	0
		PHCS-MPI: OTOLARYNGOLOGY	0
		PHCS-MPI: PEDIATRICIAN	0
		PHCS-MPI: PHYSICAL THERAPY	0
		PHCS-MPI: RADIOLOGY	0
		PHCS-MPI: UROLOGY	0
Taylor, WV	481	PHCS-MPI: HOSPITALS	1
		PHCS-MPI: NURSING FACILITY	0
		PHCS-MPI: PRIMARY CARE PHYSICIAN	10
		PHCS-MPI: PCP - FAMILY PRACTICE	8
		PHCS-MPI: PCP - GENERAL PRACTICE	1
		PHCS-MPI: PCP - INTERNAL MEDICINE	1
		PHCS-MPI: CARDIOLOGY	0
		PHCS-MPI: DERMATOLOGY	0
		PHCS-MPI: GENERAL SURGERY	1
		PHCS-MPI: NEUROLOGY	1
		PHCS-MPI: OBSTETRICS & GYNECOLOGY	0
		PHCS-MPI: ONCOLOGY	0
		PHCS-MPI: ORAL SURGERY	0
		PHCS-MPI: ORTHOPEDIC SURGERY	1
		PHCS-MPI: OTOLARYNGOLOGY	0
		PHCS-MPI: PEDIATRICIAN	0
		PHCS-MPI: PHYSICAL THERAPY	0
		PHCS-MPI: RADIOLOGY	0
		PHCS-MPI: UROLOGY	0
Tucker, WV	781	PHCS-MPI: HOSPITALS	0
		PHCS-MPI: NURSING FACILITY	0
		PHCS-MPI: PRIMARY CARE PHYSICIAN	9
		PHCS-MPI: PCP - FAMILY PRACTICE	6
		PHCS-MPI: PCP - GENERAL PRACTICE	0
		PHCS-MPI: PCP - INTERNAL MEDICINE	3
		PHCS-MPI: CARDIOLOGY	0
		PHCS-MPI: DERMATOLOGY	1
		PHCS-MPI: GENERAL SURGERY	0
		PHCS-MPI: NEUROLOGY	0
		PHCS-MPI: OBSTETRICS & GYNECOLOGY	0
		PHCS-MPI: ONCOLOGY	0
		PHCS-MPI: ORAL SURGERY	0
		PHCS-MPI: ORTHOPEDIC SURGERY	0
		PHCS-MPI: OTOLARYNGOLOGY	0
		PHCS-MPI: PEDIATRICIAN	0

		PHCS-MPI: PHYSICAL THERAPY	0
		PHCS-MPI: RADIOLOGY	0
		PHCS-MPI: UROLOGY	0
Tyler, WV	489	PHCS-MPI: HOSPITALS	1
		PHCS-MPI: NURSING FACILITY	0
		PHCS-MPI: PRIMARY CARE PHYSICIAN	7
		PHCS-MPI: PCP - FAMILY PRACTICE	2
		PHCS-MPI: PCP - GENERAL PRACTICE	0
		PHCS-MPI: PCP - INTERNAL MEDICINE	5
		PHCS-MPI: CARDIOLOGY	7
		PHCS-MPI: DERMATOLOGY	0
		PHCS-MPI: GENERAL SURGERY	2
		PHCS-MPI: NEUROLOGY	0
		PHCS-MPI: OBSTETRICS & GYNECOLOGY	0
		PHCS-MPI: ONCOLOGY	0
		PHCS-MPI: ORAL SURGERY	0
		PHCS-MPI: ORTHOPEDIC SURGERY	2
		PHCS-MPI: OTOLARYNGOLOGY	0
		PHCS-MPI: PEDIATRICIAN	0
		PHCS-MPI: PHYSICAL THERAPY	0
		PHCS-MPI: RADIOLOGY	0
		PHCS-MPI: UROLOGY	0
Upshur, WV	1,133	PHCS-MPI: HOSPITALS	1
		PHCS-MPI: NURSING FACILITY	0
		PHCS-MPI: PRIMARY CARE PHYSICIAN	24
		PHCS-MPI: PCP - FAMILY PRACTICE	21
		PHCS-MPI: PCP - GENERAL PRACTICE	0
		PHCS-MPI: PCP - INTERNAL MEDICINE	3
		PHCS-MPI: CARDIOLOGY	1
		PHCS-MPI: DERMATOLOGY	0
		PHCS-MPI: GENERAL SURGERY	4
		PHCS-MPI: NEUROLOGY	0
		PHCS-MPI: OBSTETRICS & GYNECOLOGY	4
		PHCS-MPI: ONCOLOGY	0
		PHCS-MPI: ORAL SURGERY	0
		PHCS-MPI: ORTHOPEDIC SURGERY	1
		PHCS-MPI: OTOLARYNGOLOGY	0
		PHCS-MPI: PEDIATRICIAN	1
		PHCS-MPI: PHYSICAL THERAPY	23
		PHCS-MPI: RADIOLOGY	0
		PHCS-MPI: UROLOGY	1
Wayne, WV	1,446	PHCS-MPI: HOSPITALS	0
		PHCS-MPI: NURSING FACILITY	0
		PHCS-MPI: PRIMARY CARE PHYSICIAN	32
		PHCS-MPI: PCP - FAMILY PRACTICE	25
		PHCS-MPI: PCP - GENERAL PRACTICE	1
		PHCS-MPI: PCP - INTERNAL MEDICINE	6
		PHCS-MPI: CARDIOLOGY	0

		PHCS-MPI: DERMATOLOGY	0
		PHCS-MPI: GENERAL SURGERY	0
		PHCS-MPI: NEUROLOGY	0
		PHCS-MPI: OBSTETRICS & GYNECOLOGY	15
		PHCS-MPI: ONCOLOGY	0
		PHCS-MPI: ORAL SURGERY	0
		PHCS-MPI: ORTHOPEDIC SURGERY	0
		PHCS-MPI: OTOLARYNGOLOGY	0
		PHCS-MPI: PEDIATRICIAN	9
		PHCS-MPI: PHYSICAL THERAPY	3
		PHCS-MPI: RADIOLOGY	0
		PHCS-MPI: UROLOGY	0
Webster, WV	880	PHCS-MPI: HOSPITALS	1
		PHCS-MPI: NURSING FACILITY	0
		PHCS-MPI: PRIMARY CARE PHYSICIAN	11
		PHCS-MPI: PCP - FAMILY PRACTICE	9
		PHCS-MPI: PCP - GENERAL PRACTICE	0
		PHCS-MPI: PCP - INTERNAL MEDICINE	2
		PHCS-MPI: CARDIOLOGY	0
		PHCS-MPI: DERMATOLOGY	0
		PHCS-MPI: GENERAL SURGERY	0
		PHCS-MPI: NEUROLOGY	0
		PHCS-MPI: OBSTETRICS & GYNECOLOGY	0
		PHCS-MPI: ONCOLOGY	0
		PHCS-MPI: ORAL SURGERY	0
		PHCS-MPI: ORTHOPEDIC SURGERY	0
		PHCS-MPI: OTOLARYNGOLOGY	0
		PHCS-MPI: PEDIATRICIAN	2
		PHCS-MPI: PHYSICAL THERAPY	3
		PHCS-MPI: RADIOLOGY	0
		PHCS-MPI: UROLOGY	0
Wetzel, WV	1,305	PHCS-MPI: HOSPITALS	1
		PHCS-MPI: NURSING FACILITY	2
		PHCS-MPI: PRIMARY CARE PHYSICIAN	19
		PHCS-MPI: PCP - FAMILY PRACTICE	7
		PHCS-MPI: PCP - GENERAL PRACTICE	2
		PHCS-MPI: PCP - INTERNAL MEDICINE	10
		PHCS-MPI: CARDIOLOGY	1
		PHCS-MPI: DERMATOLOGY	1
		PHCS-MPI: GENERAL SURGERY	5
		PHCS-MPI: NEUROLOGY	1
		PHCS-MPI: OBSTETRICS & GYNECOLOGY	3
		PHCS-MPI: ONCOLOGY	2
		PHCS-MPI: ORAL SURGERY	0
		PHCS-MPI: ORTHOPEDIC SURGERY	3
		PHCS-MPI: OTOLARYNGOLOGY	1
		PHCS-MPI: PEDIATRICIAN	1

		PHCS-MPI: PHYSICAL THERAPY	18
		PHCS-MPI: RADIOLOGY	0
		PHCS-MPI: UROLOGY	1
Wirt, WV	421	PHCS-MPI: HOSPITALS	0
		PHCS-MPI: NURSING FACILITY	0
		PHCS-MPI: PRIMARY CARE PHYSICIAN	5
		PHCS-MPI: PCP - FAMILY PRACTICE	3
		PHCS-MPI: PCP - GENERAL PRACTICE	1
		PHCS-MPI: PCP - INTERNAL MEDICINE	1
		PHCS-MPI: CARDIOLOGY	2
		PHCS-MPI: DERMATOLOGY	0
		PHCS-MPI: GENERAL SURGERY	0
		PHCS-MPI: NEUROLOGY	0
		PHCS-MPI: OBSTETRICS & GYNECOLOGY	0
		PHCS-MPI: ONCOLOGY	0
		PHCS-MPI: ORAL SURGERY	0
		PHCS-MPI: ORTHOPEDIC SURGERY	0
		PHCS-MPI: OTOLARYNGOLOGY	0
		PHCS-MPI: PEDIATRICIAN	0
		PHCS-MPI: PHYSICAL THERAPY	0
		PHCS-MPI: RADIOLOGY	0
		PHCS-MPI: UROLOGY	0
Wood, WV	1,602	PHCS-MPI: HOSPITALS	1
		PHCS-MPI: NURSING FACILITY	2
		PHCS-MPI: PRIMARY CARE PHYSICIAN	93
		PHCS-MPI: PCP - FAMILY PRACTICE	46
		PHCS-MPI: PCP - GENERAL PRACTICE	6
		PHCS-MPI: PCP - INTERNAL MEDICINE	41
		PHCS-MPI: CARDIOLOGY	8
		PHCS-MPI: DERMATOLOGY	2
		PHCS-MPI: GENERAL SURGERY	8
		PHCS-MPI: NEUROLOGY	4
		PHCS-MPI: OBSTETRICS & GYNECOLOGY	8
		PHCS-MPI: ONCOLOGY	5
		PHCS-MPI: ORAL SURGERY	0
		PHCS-MPI: ORTHOPEDIC SURGERY	19
		PHCS-MPI: OTOLARYNGOLOGY	3
		PHCS-MPI: PEDIATRICIAN	12
		PHCS-MPI: PHYSICAL THERAPY	151
		PHCS-MPI: RADIOLOGY	12
		PHCS-MPI: UROLOGY	5
Wyoming, WV	3,804	PHCS-MPI: HOSPITALS	0
		PHCS-MPI: NURSING FACILITY	0
		PHCS-MPI: PRIMARY CARE PHYSICIAN	18
		PHCS-MPI: PCP - FAMILY PRACTICE	14
		PHCS-MPI: PCP - GENERAL PRACTICE	4
		PHCS-MPI: PCP - INTERNAL MEDICINE	0
		PHCS-MPI: CARDIOLOGY	0

PHCS-MPI: DERMATOLOGY	0
PHCS-MPI: GENERAL SURGERY	0
PHCS-MPI: NEUROLOGY	0
PHCS-MPI: OBSTETRICS & GYNECOLOGY	0
PHCS-MPI: ONCOLOGY	0
PHCS-MPI: ORAL SURGERY	0
PHCS-MPI: ORTHOPEDIC SURGERY	0
PHCS-MPI: OTOLARYNGOLOGY	0
PHCS-MPI: PEDIATRICIAN	0
PHCS-MPI: PHYSICAL THERAPY	0
PHCS-MPI: RADIOLOGY	0
PHCS-MPI: UROLOGY	0

Ratio of Providers to Members	# With Access	% With Access	# Without Access	% Without Access	Average Time to 1
0.00200	602	100	0	0	9.4
0.00000	602	100	0	0	30.7
0.01800	602	100	0	0	5.9
0.01500	602	100	0	0	5.9
0.00200	602	100	0	0	11.1
0.00200	602	100	0	0	9
0.00200	602	100	0	0	9.4
0.00000	602	100	0	0	16.1
0.00000	602	100	0	0	12.6
0.00000	602	100	0	0	20.5
0.00000	602	100	0	0	14.9
0.00000	602	100	0	0	17.8
0.00000	602	100	0	0	46.9
0.00000	602	100	0	0	13.2
0.00000	602	100	0	0	17.4
0.00000	602	100	0	0	14.7
0.00000	602	100	0	0	13.7
0.00000	602	100	0	0	19.7
0.00000	602	100	0	0	15.5
0.00100	1,199	100	0	0	10.7
0.00100	1,199	100	0	0	10.4
0.05600	1,199	100	0	0	4.5
0.02700	1,199	100	0	0	4.6
0.00000	464	38.7	735	61.3	63.2
0.02900	1,199	100	0	0	8.9
0.00600	1,199	100	0	0	10.6
0.00200	1,199	100	0	0	9.3
0.01000	1,199	100	0	0	10.3
0.00100	1,199	100	0	0	10.9
0.01200	1,199	100	0	0	9.5
0.00500	1,199	100	0	0	11
0.00000	0	0	1,199	100	140
0.00600	1,199	100	0	0	10.6
0.00300	1,199	100	0	0	10.7
0.01200	1,199	100	0	0	9.5

0.00200	1,199	100	0	0	10.7
0.00000	464	38.7	735	61.3	21.6
0.00400	1,199	100	0	0	9.6
0.00000	2,613	100	0	0	11.4
0.00000	2,613	100	0	0	30.6
0.00000	2,613	100	0	0	9.9
0.00000	2,613	100	0	0	9.9
0.00000	2,613	100	0	0	21.2
0.00000	2,613	100	0	0	16.8
0.00000	2,613	100	0	0	30
0.00000	2,613	100	0	0	32.6
0.00000	2,613	100	0	0	22.7
0.00000	2,613	100	0	0	30.6
0.00100	2,613	100	0	0	11.9
0.00000	2,613	100	0	0	24.2
0.00000	7	0.3	2,606	99.7	71.7
0.00000	2,613	100	0	0	31
0.00000	2,613	100	0	0	23.5
0.00100	2,613	100	0	0	10.3
0.00000	2,613	100	0	0	20
0.00000	2,613	100	0	0	21.6
0.00000	2,613	100	0	0	33.4
0.00000	1,172	100	0	0	26
0.00000	1,172	100	0	0	23.1
0.02000	1,172	100	0	0	7.9
0.02000	1,172	100	0	0	7.9
0.00000	1,172	100	0	0	42.8
0.00100	1,172	100	0	0	12.7
0.00000	1,172	100	0	0	31.6
0.00000	710	60.6	462	39.4	58.5
0.00000	1,172	100	0	0	31.5
0.00000	571	48.7	601	51.3	60.6
0.00100	1,172	100	0	0	10.8
0.00000	670	57.2	502	42.8	58.8
0.00000	0	0	1,172	100	96.3
0.00000	1,172	100	0	0	30.4
0.00000	1,172	100	0	0	33.2
0.00000	1,172	100	0	0	20.5
0.00000	1,172	100	0	0	30.7
0.01200	1,172	100	0	0	12.7
0.00000	1,172	100	0	0	26.7
0.00000	705	100	0	0	14.8
0.00100	705	100	0	0	5.5
0.01100	705	100	0	0	3.5
0.00400	705	100	0	0	3.6
0.00100	705	100	0	0	4.3
0.00600	705	100	0	0	7.3
0.00100	705	100	0	0	7.7

0.00000	705	100	0	0	12.6
0.00000	705	100	0	0	13
0.00000	595	84.4	110	15.6	27.4
0.00000	705	100	0	0	12.6
0.00000	705	100	0	0	13.7
0.00000	0	0	705	100	81.4
0.00000	705	100	0	0	13
0.00000	705	100	0	0	14.7
0.00400	705	100	0	0	3.7
0.02100	705	100	0	0	4.9
0.00000	595	84.4	110	15.6	30.3
0.00000	705	100	0	0	13.4
0.00100	4,480	100	0	0	5.5
0.00000	4,480	100	0	0	6.3
0.05000	4,480	100	0	0	1.6
0.02400	4,480	100	0	0	2.2
0.00200	4,480	100	0	0	3.3
0.02400	4,480	100	0	0	1.9
0.00500	4,480	100	0	0	3.4
0.00100	4,480	100	0	0	4.8
0.00600	4,480	100	0	0	4.5
0.00200	4,480	100	0	0	4.5
0.01400	4,480	100	0	0	1.7
0.00200	4,433	99	47	1	5.4
0.00000	4,413	98.5	67	1.5	5.9
0.00500	4,480	100	0	0	5.5
0.00200	4,480	100	0	0	3.2
0.01600	4,480	100	0	0	2.5
0.00300	4,480	100	0	0	2.8
0.01600	4,480	100	0	0	5
0.00100	4,413	98.5	67	1.5	6.1
0.00100	881	100	0	0	10.1
0.00000	881	100	0	0	23.3
0.00500	881	100	0	0	8.9
0.00200	881	100	0	0	8.9
0.00000	881	100	0	0	28.4
0.00200	881	100	0	0	10
0.00000	881	100	0	0	35.1
0.00000	174	19.8	707	80.2	65.7
0.00000	881	100	0	0	44.8
0.00000	399	45.3	482	54.7	60.3
0.00000	881	100	0	0	33.6
0.00000	245	27.8	636	72.2	60.3
0.00000	0	0	881	100	107.8
0.00000	881	100	0	0	21.2
0.00000	881	100	0	0	38.6
0.00300	881	100	0	0	9.7

0.00000	881	100	0	0	30.6
0.00000	881	100	0	0	20.3
0.00000	881	100	0	0	41.4
0.00000	1,379	100	0	0	31
0.00000	1,379	100	0	0	36.3
0.01000	1,379	100	0	0	8.2
0.01000	1,379	100	0	0	8.2
0.00000	1,379	100	0	0	42
0.00000	1,379	100	0	0	22.1
0.00000	1,379	100	0	0	41.6
0.00000	891	64.6	488	35.4	54.4
0.00000	1,379	100	0	0	42.9
0.00000	1,020	74	359	26	47.5
0.00000	1,379	100	0	0	32.2
0.00000	996	72.2	383	27.8	48.1
0.00000	0	0	1,379	100	93.6
0.00000	1,379	100	0	0	36.9
0.00000	1,379	100	0	0	45.8
0.00100	1,379	100	0	0	10.6
0.00000	1,379	100	0	0	32.8
0.00000	1,379	100	0	0	22
0.00000	1,379	100	0	0	24.1
0.00000	420	100	0	0	27.2
0.00000	420	100	0	0	13.6
0.01900	420	100	0	0	6.1
0.01000	420	100	0	0	6.3
0.00500	420	100	0	0	6.6
0.00500	420	100	0	0	7.8
0.00000	420	100	0	0	27.3
0.00000	420	100	0	0	32.2
0.00000	420	100	0	0	25.2
0.00000	420	100	0	0	33.7
0.00000	420	100	0	0	24.9
0.00000	420	100	0	0	32.7
0.00000	100	23.8	320	76.2	66.2
0.00000	420	100	0	0	27.2
0.00000	420	100	0	0	29.2
0.00500	420	100	0	0	7.5
0.00000	420	100	0	0	13.9
0.00000	420	100	0	0	28.4
0.00000	420	100	0	0	28.4
0.00000	4,002	100	0	0	14.9
0.00000	4,002	100	0	0	18.4
0.00600	4,002	100	0	0	5.9
0.00300	4,002	100	0	0	7.3
0.00000	4,002	100	0	0	15.3
0.00200	4,002	100	0	0	9
0.00000	4,002	100	0	0	14.8

0.00000	4,002	100	0	0	26.6
0.00000	4,002	100	0	0	15.3
0.00000	4,002	100	0	0	25.9
0.00000	4,002	100	0	0	21.7
0.00000	2,663	66.5	1,339	33.5	27.3
0.00000	1,023	25.6	2,979	74.4	62.4
0.00000	4,002	100	0	0	26.3
0.00000	4,002	100	0	0	26.6
0.00000	4,002	100	0	0	9.2
0.00000	4,002	100	0	0	28.4
0.00000	4,002	100	0	0	15.4
0.00000	4,002	100	0	0	15.4
0.00000	841	100	0	0	17.7
0.00100	841	100	0	0	10.9
0.00400	841	100	0	0	9.5
0.00400	841	100	0	0	9.5
0.00000	841	100	0	0	27.8
0.00000	841	100	0	0	16.7
0.00000	841	100	0	0	29.1
0.00000	516	61.4	325	38.6	56.6
0.00000	841	100	0	0	29.2
0.00000	440	52.3	401	47.7	59.9
0.00000	841	100	0	0	21.6
0.00000	444	52.8	397	47.2	59.7
0.00000	0	0	841	100	96.6
0.00000	841	100	0	0	24.6
0.00000	841	100	0	0	30.7
0.00100	841	100	0	0	10.4
0.00000	841	100	0	0	32.4
0.00000	841	100	0	0	20.3
0.00000	841	100	0	0	28
0.00100	700	100	0	0	17.2
0.00000	700	100	0	0	31.5
0.00300	700	100	0	0	10
0.00000	700	100	0	0	13.8
0.00000	700	100	0	0	32.1
0.00300	700	100	0	0	11.8
0.00000	646	92.3	54	7.7	48.1
0.00000	700	100	0	0	19.2
0.00000	700	100	0	0	31
0.00000	499	71.3	201	28.7	53.3
0.00100	700	100	0	0	17
0.00000	602	86	98	14	51.8
0.00000	9	1.3	691	98.7	74.3
0.00000	649	92.7	51	7.3	46.5
0.00000	602	86	98	14	51.9
0.00000	700	100	0	0	24.1

0.00300	700	100	0	0	16
0.00300	700	100	0	0	15.9
0.00000	600	85.7	100	14.3	52.1
0.00100	1,939	100	0	0	15.1
0.00200	1,939	100	0	0	10.2
0.02600	1,939	100	0	0	6.4
0.02000	1,939	100	0	0	6.9
0.00100	1,939	100	0	0	14.8
0.00600	1,939	100	0	0	11.8
0.00300	1,939	100	0	0	13.2
0.00000	1,862	96	77	4	46.7
0.00500	1,939	100	0	0	14.2
0.00100	1,939	100	0	0	15
0.00200	1,939	100	0	0	16.4
0.00200	1,939	100	0	0	14.9
0.00000	246	12.7	1,693	87.3	68.2
0.00100	1,869	96.4	70	3.6	16.4
0.00100	1,939	100	0	0	16.6
0.00500	1,939	100	0	0	8.8
0.00700	1,939	100	0	0	8.4
0.00100	1,939	100	0	0	15.3
0.00200	1,939	100	0	0	15.3
0.00100	1,544	100	0	0	15.1
0.00000	1,544	100	0	0	28.8
0.00600	1,544	100	0	0	11.5
0.00100	1,544	100	0	0	11.5
0.00000	1,544	100	0	0	31.1
0.00500	1,544	100	0	0	15.1
0.00000	1,544	100	0	0	37.1
0.00100	1,544	100	0	0	14.3
0.00100	1,544	100	0	0	14.8
0.00000	1,437	93.1	107	6.9	46.8
0.00100	1,544	100	0	0	15.3
0.00000	1,426	92.4	118	7.6	47
0.00000	0	0	1,544	100	96.5
0.00000	1,418	91.8	126	8.2	45.5
0.00000	1,475	95.5	69	4.5	45.2
0.00100	1,544	100	0	0	15.2
0.00000	1,544	100	0	0	39.5
0.00000	1,544	100	0	0	30.2
0.00000	1,516	98.2	28	1.8	42.7
0.00200	490	100	0	0	19.6
0.00200	490	100	0	0	19.2
0.10000	490	100	0	0	2.1
0.01600	490	100	0	0	15.7
0.00400	490	100	0	0	17.9
0.08000	490	100	0	0	2.1
0.01200	490	100	0	0	16

0.00200	490	100	0	0	20.5
0.01800	490	100	0	0	19.6
0.00000	300	61.2	190	38.8	56.3
0.01400	490	100	0	0	16.6
0.02000	490	100	0	0	19.6
0.00000	0	0	490	100	98.7
0.00600	490	100	0	0	19.6
0.00600	490	100	0	0	19.6
0.01600	490	100	0	0	4.3
0.00600	490	100	0	0	16.8
0.00000	298	60.8	192	39.2	58.3
0.01000	490	100	0	0	19.6
0.00000	817	100	0	0	19
0.00000	817	100	0	0	34.7
0.00600	817	100	0	0	6.6
0.00600	817	100	0	0	6.6
0.00000	817	100	0	0	34.6
0.00000	817	100	0	0	26.3
0.00000	378	46.3	439	53.7	60.1
0.00200	817	100	0	0	10.8
0.00000	817	100	0	0	28
0.00000	17	2.1	800	97.9	70.9
0.00000	817	100	0	0	19.6
0.00000	201	24.6	616	75.4	64.2
0.00000	0	0	817	100	96.2
0.00000	191	23.4	626	76.6	62.6
0.00000	280	34.3	537	65.7	62.8
0.00000	817	100	0	0	26.8
0.00000	817	100	0	0	21
0.00000	817	100	0	0	19.8
0.00000	341	41.7	476	58.3	60.3
0.00000	2,113	100	0	0	10.1
0.00100	2,113	100	0	0	7.8
0.05900	2,113	100	0	0	2.1
0.04000	2,113	100	0	0	2.2
0.00000	2,113	100	0	0	10
0.01800	2,113	100	0	0	5.7
0.00300	2,113	100	0	0	10.2
0.00200	2,113	100	0	0	11.2
0.00500	2,113	100	0	0	6.5
0.00100	2,113	100	0	0	11.1
0.00600	2,113	100	0	0	6.8
0.00100	2,113	100	0	0	10
0.00000	1,064	50.4	1,049	49.6	50.7
0.00200	2,113	100	0	0	12.1
0.00100	2,113	100	0	0	10.4
0.00600	2,113	100	0	0	4.9

0.00900	2,113	100	0	0	6.5
0.00000	2,113	100	0	0	17.3
0.00100	2,113	100	0	0	9.8
0.00100	1,099	100	0	0	12.1
0.00000	1,099	100	0	0	38.6
0.02900	1,099	100	0	0	9
0.01700	1,099	100	0	0	9.1
0.00300	1,099	100	0	0	10.1
0.00900	1,099	100	0	0	10.5
0.00500	1,099	100	0	0	12
0.00000	1,099	100	0	0	43.3
0.00000	1,099	100	0	0	26.5
0.00000	1,099	100	0	0	26.7
0.00000	1,099	100	0	0	24.8
0.00000	1,099	100	0	0	26.5
0.00000	0	0	1,099	100	80.6
0.00300	1,099	100	0	0	11.3
0.00100	1,099	100	0	0	12.1
0.00100	1,099	100	0	0	16.1
0.03100	1,099	100	0	0	8.6
0.00000	1,099	100	0	0	21.1
0.00000	1,068	97.2	31	2.8	48.9
0.00100	1,082	100	0	0	7.7
0.00100	1,082	100	0	0	7.2
0.04000	1,082	100	0	0	4.1
0.02900	1,082	100	0	0	4.2
0.00000	3	0.3	1,079	99.7	69.9
0.01100	1,082	100	0	0	5.7
0.00100	1,082	100	0	0	7.7
0.00200	1,082	100	0	0	7.1
0.00500	1,082	100	0	0	7.7
0.00000	1,082	100	0	0	20.1
0.00500	1,082	100	0	0	6.3
0.00000	1,082	100	0	0	20.7
0.00000	0	0	1,082	100	142.9
0.00100	1,082	100	0	0	7.7
0.00300	1,082	100	0	0	7.7
0.00600	1,082	100	0	0	6.1
0.00400	1,082	100	0	0	6.2
0.00100	3	0.3	1,079	99.7	7.8
0.00200	1,082	100	0	0	7
0.00100	7,003	89.5	821	10.5	12.9
0.00000	7,824	100	0	0	12.2
0.02400	7,824	100	0	0	3.7
0.00800	7,824	100	0	0	4.6
0.00000	2,702	34.5	5,122	65.5	31.4
0.01600	7,824	100	0	0	5.3
0.00300	7,239	92.5	585	7.5	11.7

0.00000	6,738	86.1	1,086	13.9	21.7
0.00500	6,995	89.4	829	10.6	12
0.00100	7,479	95.6	345	4.4	11.7
0.00400	6,918	88.4	906	11.6	6.9
0.00100	6,865	87.7	959	12.3	13.2
0.00000	165	2.1	7,659	97.9	85.1
0.00100	6,903	88.2	921	11.8	13.6
0.00100	6,886	88	938	12	14.7
0.00600	7,824	100	0	0	4.6
0.00400	7,485	95.7	339	4.3	11.2
0.01900	7,485	95.7	339	4.3	6.4
0.00000	3,451	44.1	4,373	55.9	33.5
0.00100	732	100	0	0	11.5
0.00000	732	100	0	0	20.8
0.03000	732	100	0	0	8
0.02500	732	100	0	0	8
0.00000	732	100	0	0	30
0.00500	732	100	0	0	11.4
0.00100	732	100	0	0	11.6
0.00000	732	100	0	0	33.2
0.00400	732	100	0	0	10.7
0.00000	732	100	0	0	37.7
0.00500	732	100	0	0	8.7
0.00000	732	100	0	0	37.1
0.00000	3	0.4	729	99.6	75.2
0.00400	732	100	0	0	11.5
0.00100	732	100	0	0	11.8
0.00300	732	100	0	0	11
0.00700	732	100	0	0	15
0.02700	732	100	0	0	11.9
0.00100	732	100	0	0	11.5
0.00000	1,473	100	0	0	21.7
0.00000	1,473	100	0	0	30.4
0.01700	1,473	100	0	0	5.4
0.01600	1,473	100	0	0	5.4
0.00000	1,473	100	0	0	16.2
0.00100	1,473	100	0	0	9.7
0.00000	1,473	100	0	0	26.7
0.00000	1,473	100	0	0	27.1
0.00000	1,473	100	0	0	23.5
0.00000	1,473	100	0	0	29.4
0.00300	1,473	100	0	0	9.4
0.00000	1,470	99.8	3	0.2	26.3
0.00000	1,442	97.9	31	2.1	47.2
0.00000	1,473	100	0	0	29.6
0.00000	1,473	100	0	0	22.9
0.00100	1,473	100	0	0	9.5

0.00100	1,473	100	0	0	10.3
0.00000	1,473	100	0	0	22.9
0.00000	1,470	99.8	3	0.2	41.4
0.00000	3,149	100	0	0	21.7
0.00000	3,149	100	0	0	47.6
0.01000	3,149	100	0	0	4.3
0.00800	3,149	100	0	0	4.3
0.00100	3,149	100	0	0	8.6
0.00100	3,149	100	0	0	6.3
0.00000	3,149	100	0	0	29.5
0.00000	3,149	100	0	0	49.2
0.00000	3,149	100	0	0	8.6
0.00000	3,149	100	0	0	48.8
0.00000	3,149	100	0	0	20.7
0.00000	3,149	100	0	0	8.9
0.00000	13	0.4	3,136	99.6	72.9
0.00000	3,149	100	0	0	48.8
0.00000	3,149	100	0	0	8.5
0.00100	3,149	100	0	0	7.1
0.00100	3,149	100	0	0	8.3
0.00700	3,149	100	0	0	8.5
0.00000	3,147	99.9	2	0.1	49.3
0.00000	1,702	100	0	0	18.5
0.00000	1,702	100	0	0	24.5
0.02600	1,702	100	0	0	3.6
0.01500	1,702	100	0	0	3.6
0.00100	1,702	100	0	0	5.7
0.01100	1,702	100	0	0	4.5
0.00100	1,702	100	0	0	8.2
0.00100	1,702	100	0	0	8.4
0.00200	1,702	100	0	0	7.8
0.00000	1,702	100	0	0	19.2
0.00100	1,702	100	0	0	8.4
0.00100	1,702	100	0	0	8.2
0.00000	1,702	100	0	0	27.9
0.00100	1,702	100	0	0	8.2
0.00100	1,702	100	0	0	7.9
0.00800	1,702	100	0	0	4.6
0.02300	1,702	100	0	0	6.3
0.00400	1,702	100	0	0	11.6
0.00100	1,702	100	0	0	8
0.00100	736	100	0	0	9.3
0.00000	736	100	0	0	17.6
0.01800	736	100	0	0	4.1
0.00500	736	100	0	0	7.6
0.00400	736	100	0	0	8.7
0.00800	736	100	0	0	5.7
0.00300	736	100	0	0	9.1

0.00000	736	100	0	0	12.9
0.00700	736	100	0	0	8.3
0.00000	736	100	0	0	16
0.00400	736	100	0	0	8.8
0.00500	736	100	0	0	9.3
0.00000	325	44.2	411	55.8	65.8
0.00100	736	100	0	0	9.3
0.00000	736	100	0	0	16.8
0.00300	736	100	0	0	9.1
0.00100	736	100	0	0	9.9
0.00100	736	100	0	0	12.5
0.00100	736	100	0	0	9.4
0.00100	1,392	100	0	0	14.7
0.00000	1,192	85.6	200	14.4	40.7
0.02200	1,392	100	0	0	7.5
0.00700	1,392	100	0	0	7.7
0.00100	1,392	100	0	0	12.9
0.01400	1,392	100	0	0	9.5
0.00300	1,392	100	0	0	14.6
0.00000	1,192	85.6	200	14.4	40.6
0.00600	1,392	100	0	0	15
0.00100	1,392	100	0	0	15
0.00400	1,392	100	0	0	11.6
0.00100	1,106	79.5	286	20.5	15.2
0.00000	676	48.6	716	51.4	61.7
0.00200	1,392	100	0	0	14.7
0.00200	1,392	100	0	0	14.6
0.00700	1,392	100	0	0	12.9
0.00000	1,392	100	0	0	17.4
0.00900	1,392	100	0	0	15
0.00000	992	71.3	400	28.7	51.7
0.00000	3,630	100	0	0	10.9
0.00000	3,630	100	0	0	30.9
0.00300	3,630	100	0	0	4.1
0.00200	3,630	100	0	0	7.4
0.00000	3,630	100	0	0	10.5
0.00100	3,630	100	0	0	6.1
0.00000	3,630	100	0	0	29.3
0.00000	3,630	100	0	0	30.1
0.00000	3,630	100	0	0	10.9
0.00000	3,630	100	0	0	30.5
0.00000	3,630	100	0	0	10.9
0.00000	3,630	100	0	0	29.2
0.00000	3,630	100	0	0	36.5
0.00000	3,630	100	0	0	30.4
0.00000	3,630	100	0	0	29.1
0.00000	3,630	100	0	0	9.7

0.00000	3,630	100	0	0	29.1
0.00200	3,630	100	0	0	10.9
0.00000	3,630	100	0	0	30.3
0.00100	1,958	100	0	0	9.5
0.00100	1,958	100	0	0	11.3
0.03000	1,958	100	0	0	3.7
0.01300	1,958	100	0	0	4.8
0.00200	1,958	100	0	0	9.3
0.01400	1,958	100	0	0	5.1
0.00600	1,958	100	0	0	9.3
0.00100	1,958	100	0	0	9.4
0.00500	1,958	100	0	0	8.8
0.00200	1,958	100	0	0	9.6
0.00500	1,958	100	0	0	9
0.00300	1,958	100	0	0	9.1
0.00100	1,958	100	0	0	12.6
0.00400	1,958	100	0	0	9.4
0.00200	1,958	100	0	0	9.4
0.00600	1,958	100	0	0	5.2
0.00200	1,958	100	0	0	9.4
0.01200	1,958	100	0	0	9.5
0.00400	1,958	100	0	0	9.3
0.00100	825	100	0	0	13
0.00100	825	100	0	0	13.8
0.01200	825	100	0	0	4.6
0.00600	825	100	0	0	6.3
0.00200	825	100	0	0	13.7
0.00400	825	100	0	0	10.7
0.00000	725	87.9	100	12.1	45.2
0.00000	825	100	0	0	23.9
0.00200	825	100	0	0	12
0.00000	564	68.4	261	31.6	56.6
0.00000	725	87.9	100	12.1	22.5
0.00000	266	32.2	559	67.8	61.5
0.00000	2	0.2	823	99.8	73.7
0.00000	541	65.6	284	34.4	56.5
0.00000	266	32.2	559	67.8	61.5
0.00100	825	100	0	0	13.1
0.00000	725	87.9	100	12.1	38.3
0.00200	825	100	0	0	12.7
0.00000	265	32.1	560	67.9	61.4
0.00000	2,164	100	0	0	13.2
0.00000	674	31.1	1,490	68.9	61.6
0.00600	2,164	100	0	0	6
0.00500	2,164	100	0	0	6
0.00000	2,164	100	0	0	15.4
0.00100	2,164	100	0	0	8.7
0.00000	733	33.9	1,431	66.1	13.6

0.00000	1,616	74.7	548	25.3	54.8
0.00000	2,164	100	0	0	12.5
0.00000	728	33.6	1,436	66.4	62
0.00000	2,164	100	0	0	24
0.00000	734	33.9	1,430	66.1	20.6
0.00000	349	16.1	1,815	83.9	69.2
0.00000	728	33.6	1,436	66.4	61.6
0.00000	2,164	100	0	0	22.5
0.00100	2,164	100	0	0	8.3
0.00000	2,164	100	0	0	22.1
0.00000	2,164	100	0	0	22.3
0.00000	664	30.7	1,500	69.3	62.4
0.00100	1,737	100	0	0	10.9
0.00100	1,737	100	0	0	10.8
0.11600	1,737	100	0	0	3
0.05000	1,737	100	0	0	3.5
0.00200	1,737	100	0	0	8
0.06400	1,737	100	0	0	5.1
0.01300	1,737	100	0	0	8.8
0.00700	1,737	100	0	0	7.7
0.02200	1,737	100	0	0	8.9
0.01200	1,737	100	0	0	8.6
0.02400	1,737	100	0	0	8.2
0.01600	1,737	100	0	0	9.1
0.00500	1,737	100	0	0	9.4
0.02100	1,737	100	0	0	8.6
0.01600	1,737	100	0	0	9.2
0.04500	1,737	100	0	0	6.3
0.05100	1,737	100	0	0	3.2
0.01100	1,737	100	0	0	9.1
0.00700	1,737	100	0	0	9.3
0.00000	1,086	100	0	0	17.7
0.00100	1,086	100	0	0	11.5
0.00600	1,086	100	0	0	7.5
0.00600	1,086	100	0	0	7.5
0.00000	1,086	100	0	0	23.6
0.00000	1,086	100	0	0	18.1
0.00000	1,086	100	0	0	20.7
0.00000	1,041	95.9	45	4.1	43.3
0.00000	1,086	100	0	0	20.2
0.00000	1,086	100	0	0	22.2
0.00000	1,086	100	0	0	21
0.00000	1,086	100	0	0	20.5
0.00000	977	90	109	10	45.1
0.00000	1,038	95.6	48	4.4	21.3
0.00000	1,086	100	0	0	21.1
0.00000	1,086	100	0	0	20.9

0.00100	1,086	100	0	0	11.9
0.00000	1,086	100	0	0	21.3
0.00000	1,086	100	0	0	19.8
0.00300	286	100	0	0	10.1
0.00300	286	100	0	0	9.9
0.04900	286	100	0	0	9.5
0.02800	286	100	0	0	9.5
0.00000	286	100	0	0	43
0.02100	286	100	0	0	9.7
0.00700	286	100	0	0	10.1
0.00300	286	100	0	0	10.2
0.00700	286	100	0	0	10.1
0.00000	286	100	0	0	27.6
0.00000	286	100	0	0	25.8
0.00000	286	100	0	0	26.4
0.00000	0	0	286	100	107.8
0.00000	286	100	0	0	26.9
0.00000	286	100	0	0	26.3
0.00300	286	100	0	0	11.7
0.00000	286	100	0	0	27
0.00000	286	100	0	0	39.6
0.00000	286	100	0	0	26.3
0.00100	1,932	100	0	0	19.7
0.00100	1,932	100	0	0	20.1
0.00200	1,932	100	0	0	9.4
0.00200	1,932	100	0	0	10.2
0.00000	1,932	100	0	0	29.7
0.00100	1,932	100	0	0	13.3
0.00000	1,932	100	0	0	35.6
0.00000	1,315	68.1	617	31.9	53.4
0.00000	1,932	100	0	0	36.2
0.00000	1,893	98	39	2	43.3
0.00000	1,932	100	0	0	33.5
0.00000	1,898	98.2	34	1.8	44.1
0.00000	0	0	1,932	100	80.8
0.00000	1,723	89.2	209	10.8	43.4
0.00000	1,932	100	0	0	43.7
0.00200	1,932	100	0	0	13.1
0.00000	1,932	100	0	0	25.4
0.00100	1,932	100	0	0	13.4
0.00100	1,932	100	0	0	14
0.00500	398	100	0	0	13
0.00500	398	100	0	0	10
0.19300	398	100	0	0	5.7
0.09300	398	100	0	0	5.9
0.00800	398	100	0	0	9.1
0.09300	398	100	0	0	11.7
0.02000	398	100	0	0	11.5

0.00800	398	100	0	0	6.6
0.03000	398	100	0	0	12.1
0.01800	398	100	0	0	12.7
0.05300	398	100	0	0	12.7
0.02500	398	100	0	0	12.7
0.00000	4	1	394	99	80.4
0.02300	398	100	0	0	13
0.01300	398	100	0	0	12.7
0.03500	398	100	0	0	9.1
0.06000	398	100	0	0	8.7
0.02500	398	100	0	0	15.7
0.00800	398	100	0	0	13
0.00000	847	100	0	0	30.4
0.00000	428	50.5	419	49.5	60.1
0.00700	847	100	0	0	9.9
0.00700	847	100	0	0	9.9
0.00000	393	46.4	454	53.6	56.8
0.00000	847	100	0	0	35.4
0.00000	809	95.5	38	4.5	44.1
0.00100	847	100	0	0	14.3
0.00000	809	95.5	38	4.5	44
0.00000	104	12.3	743	87.7	71.8
0.00000	809	95.5	38	4.5	31.3
0.00000	809	95.5	38	4.5	44.1
0.00000	0	0	847	100	92.7
0.00000	805	95	42	5	44.1
0.00000	809	95.5	38	4.5	44.1
0.00100	847	100	0	0	11.6
0.00000	847	100	0	0	30.3
0.00000	847	100	0	0	30.4
0.00000	809	95.5	38	4.5	44.4
0.00000	290	100	0	0	22.4
0.00000	290	100	0	0	28.7
0.02400	290	100	0	0	6.2
0.01000	290	100	0	0	6.2
0.00700	290	100	0	0	6.3
0.00700	290	100	0	0	6.2
0.00000	290	100	0	0	22.1
0.00000	290	100	0	0	30.2
0.00000	290	100	0	0	17.1
0.00000	290	100	0	0	30
0.00000	290	100	0	0	30
0.00000	290	100	0	0	31.7
0.00000	0	0	290	100	88.9
0.00000	290	100	0	0	21.6
0.00000	290	100	0	0	28.9
0.00300	290	100	0	0	8.8

0.00300	290	100	0	0	8.1
0.00000	290	100	0	0	33.5
0.00000	290	100	0	0	30.1
0.00100	1,173	100	0	0	22.2
0.00000	1,001	85.3	172	14.7	45.7
0.01200	1,173	100	0	0	9.9
0.01000	1,173	100	0	0	9.9
0.00200	1,173	100	0	0	23.9
0.00000	1,173	100	0	0	31.5
0.00000	1,173	100	0	0	40
0.00000	893	76.1	280	23.9	47.9
0.00000	1,173	100	0	0	42.2
0.00000	567	48.3	606	51.7	56.6
0.00000	1,173	100	0	0	42.1
0.00000	1,173	100	0	0	42.6
0.00000	0	0	1,173	100	102.9
0.00000	920	78.4	253	21.6	43.1
0.00000	1,173	100	0	0	43.3
0.00000	1,173	100	0	0	31.5
0.00300	1,173	100	0	0	19.9
0.00000	1,173	100	0	0	42.5
0.00000	1,173	100	0	0	42.5
0.00100	1,422	100	0	0	12.5
0.00100	1,422	100	0	0	13.1
0.01800	1,422	100	0	0	3.6
0.01300	1,422	100	0	0	4.3
0.00000	1,422	100	0	0	22.3
0.00400	1,422	100	0	0	6
0.00000	1,422	100	0	0	22.7
0.00000	1,422	100	0	0	15.8
0.00100	1,422	100	0	0	12.5
0.00000	1,422	100	0	0	19.3
0.00000	1,422	100	0	0	22.9
0.00000	1,422	100	0	0	28.3
0.00000	1,422	100	0	0	29.6
0.00000	1,422	100	0	0	19.2
0.00000	1,422	100	0	0	28.3
0.00200	1,422	100	0	0	7.7
0.00400	1,422	100	0	0	9.7
0.00100	1,422	100	0	0	12.9
0.00000	1,422	100	0	0	28.1
0.00100	1,253	100	0	0	13.2
0.00100	1,253	100	0	0	13.8
0.03800	1,253	100	0	0	5
0.02700	1,253	100	0	0	5.1
0.00000	1,234	98.5	19	1.5	13.4
0.01000	1,253	100	0	0	9.5
0.00300	1,253	100	0	0	12.7

0.00000	1,034	82.5	219	17.5	27.8
0.00200	1,252	99.9	1	0.1	13.7
0.00100	1,252	99.9	1	0.1	14.4
0.01900	1,253	100	0	0	5.5
0.00000	925	73.8	328	26.2	28.9
0.00000	634	50.6	619	49.4	54
0.00200	1,253	100	0	0	13
0.00000	1,035	82.6	218	17.4	25.7
0.01100	1,253	100	0	0	9.7
0.00900	1,253	100	0	0	6.3
0.02200	1,253	100	0	0	12.4
0.00000	750	59.9	503	40.1	49.9
0.00000	4,758	100	0	0	11.5
0.00100	4,758	100	0	0	11.7
0.01400	4,758	100	0	0	5.4
0.00500	4,758	100	0	0	5.7
0.00000	4,758	100	0	0	10.3
0.00800	4,758	100	0	0	7.5
0.00300	4,758	100	0	0	11.5
0.00000	4,758	100	0	0	13.7
0.00300	4,758	100	0	0	10.4
0.00100	4,758	100	0	0	12.3
0.00300	4,758	100	0	0	12.2
0.00000	4,503	94.6	255	5.4	12.7
0.00000	4,147	87.2	611	12.8	41.6
0.00200	4,758	100	0	0	11.3
0.00000	4,758	100	0	0	12.8
0.00200	4,758	100	0	0	9.3
0.00000	4,758	100	0	0	33.6
0.00000	4,758	100	0	0	12.7
0.00100	4,758	100	0	0	12.5
0.00100	1,642	100	0	0	16.6
0.00000	1,503	91.5	139	8.5	49.9
0.01900	1,642	100	0	0	7.9
0.01500	1,642	100	0	0	8
0.00000	1,627	99.1	15	0.9	32.3
0.00500	1,642	100	0	0	15.9
0.00100	1,642	100	0	0	18.1
0.00100	1,642	100	0	0	19.1
0.00200	1,642	100	0	0	18
0.00000	1,530	93.2	112	6.8	45.8
0.00100	1,642	100	0	0	17
0.00200	1,642	100	0	0	19.6
0.00000	167	10.2	1,475	89.8	73
0.00200	1,642	100	0	0	18
0.00100	1,642	100	0	0	19.5
0.00200	1,642	100	0	0	14

0.00200	1,642	100	0	0	16.4
0.00200	1,642	100	0	0	19
0.00100	1,642	100	0	0	18.2
0.00000	978	100	0	0	21.7
0.00000	978	100	0	0	24.8
0.00800	978	100	0	0	8.5
0.00300	978	100	0	0	8.6
0.00200	978	100	0	0	9.7
0.00300	978	100	0	0	9
0.00000	978	100	0	0	23.5
0.00000	978	100	0	0	41.3
0.00000	978	100	0	0	28.8
0.00000	978	100	0	0	40.6
0.00000	978	100	0	0	33.5
0.00000	978	100	0	0	40.9
0.00000	0	0	978	100	87.8
0.00000	978	100	0	0	27.4
0.00000	978	100	0	0	33.6
0.00200	978	100	0	0	9.4
0.01800	978	100	0	0	12.4
0.00000	978	100	0	0	32.5
0.00000	978	100	0	0	33.5
0.00000	850	100	0	0	26.4
0.00000	850	100	0	0	40.8
0.00200	850	100	0	0	13
0.00200	850	100	0	0	13
0.00000	850	100	0	0	30.2
0.00000	850	100	0	0	25 8
0.00000	850	100	0	0	32.4
0.00000	725	85.3	125	14.7	52.9
0.00000	850	100	0	0	46.4
0.00000	850	100	0	0	46.4
0.00000	850	100	0	0	37.3
0.00000	834	98.1	16	1.9	46.7
0.00000	0	0	850	100	95.4
0.00200	850	100	0	0	16.6
0.00000	850	100	0	0	32.7
0.00000	850	100	0	0	21.9
0.00000	850	100	0	0	26.3
0.00100	850	100	0	0	16.4
0.00000	850	100	0	0	40.7
0.00100	1,243	100	0	0	11
0.00000	1,243	100	0	0	18.8
0.00800	1,243	100	0	0	6.5
0.00600	1,243	100	0	0	6.5
0.00000	1,243	100	0	0	24.3
0.00200	1,243	100	0	0	11
0.00000	1,243	100	0	0	23.4

0.00000	1,243	100	0	0	27.1
0.00000	1,243	100	0	0	22.1
0.00000	1,243	100	0	0	23.9
0.00000	1,243	100	0	0	23.3
0.00000	1,243	100	0	0	23.7
0.00000	1,243	100	0	0	39.4
0.00000	1,243	100	0	0	22.9
0.00000	1,243	100	0	0	22.9
0.00000	1,243	100	0	0	17.3
0.00000	1,243	100	0	0	18.2
0.00000	1,243	100	0	0	24.7
0.00000	1,243	100	0	0	23.6
0.00200	481	100	0	0	7.5
0.00000	481	100	0	0	17.3
0.02100	481	100	0	0	6
0.01700	481	100	0	0	6
0.00200	481	100	0	0	6.6
0.00200	481	100	0	0	6.4
0.00000	481	100	0	0	11.4
0.00000	481	100	0	0	14.2
0.00200	481	100	0	0	6.4
0.00200	481	100	0	0	6.7
0.00000	481	100	0	0	12
0.00000	481	100	0	0	13.2
0.00000	481	100	0	0	33.5
0.00200	481	100	0	0	7.2
0.00000	481	100	0	0	13.2
0.00000	481	100	0	0	10.6
0.00000	481	100	0	0	12.4
0.00000	481	100	0	0	16.9
0.00000	481	100	0	0	12.5
0.00000	781	100	0	0	22.8
0.00000	781	100	0	0	34.8
0.01200	781	100	0	0	6.3
0.00800	781	100	0	0	9
0.00000	781	100	0	0	32.2
0.00400	781	100	0	0	7.9
0.00000	781	100	0	0	26.7
0.00100	781	100	0	0	18.4
0.00000	781	100	0	0	26.3
0.00000	781	100	0	0	42.1
0.00000	781	100	0	0	23.4
0.00000	781	100	0	0	27.9
0.00000	362	46.4	419	53.6	61.6
0.00000	781	100	0	0	27.7
0.00000	781	100	0	0	28
0.00000	781	100	0	0	15.4

0.00000	781	100	0	0	22.3
0.00000	781	100	0	0	23
0.00000	781	100	0	0	28.1
0.00200	489	100	0	0	13.7
0.00000	489	100	0	0	17.9
0.01400	489	100	0	0	5.6
0.00400	489	100	0	0	6.7
0.00000	489	100	0	0	12.3
0.01000	489	100	0	0	8.3
0.01400	489	100	0	0	13.7
0.00000	489	100	0	0	21.6
0.00400	489	100	0	0	13.7
0.00000	489	100	0	0	21.4
0.00000	489	100	0	0	21.4
0.00000	489	100	0	0	21.4
0.00000	27	5.5	462	94.5	65.5
0.00400	489	100	0	0	13.7
0.00000	489	100	0	0	19.5
0.00000	489	100	0	0	13.2
0.00000	489	100	0	0	16.7
0.00000	454	92.8	35	7.2	45.6
0.00000	489	100	0	0	21.3
0.00100	1,133	100	0	0	13.4
0.00000	1,133	100	0	0	34.2
0.02100	1,133	100	0	0	3.7
0.01900	1,133	100	0	0	3.7
0.00000	1,133	100	0	0	30.2
0.00300	1,133	100	0	0	13.3
0.00100	1,133	100	0	0	13.7
0.00000	1,133	100	0	0	30.4
0.00400	1,133	100	0	0	13.2
0.00000	1,133	100	0	0	37.2
0.00400	1,133	100	0	0	6.3
0.00000	1,133	100	0	0	30.9
0.00000	69	6.1	1,064	93.9	71.9
0.00100	1,133	100	0	0	13.7
0.00000	1,133	100	0	0	20.9
0.00100	1,133	100	0	0	13.5
0.02000	1,133	100	0	0	13.3
0.00000	1,133	100	0	0	23
0.00100	1,133	100	0	0	13.7
0.00000	1,446	100	0	0	23.3
0.00000	1,446	100	0	0	29.4
0.02200	1,446	100	0	0	5.4
0.01700	1,446	100	0	0	5.4
0.00100	1,446	100	0	0	19
0.00400	1,446	100	0	0	11.1
0.00000	1,446	100	0	0	23.2

0.00000	1,446	100	0	0	24.4
0.00000	1,446	100	0	0	23
0.00000	1,446	100	0	0	28.5
0.01000	1,446	100	0	0	6
0.00000	1,446	100	0	0	24.5
0.00000	1,446	100	0	0	29.4
0.00000	1,446	100	0	0	28.5
0.00000	1,446	100	0	0	21.3
0.00600	1,446	100	0	0	9.7
0.00200	1,446	100	0	0	14.2
0.00000	1,446	100	0	0	23.9
0.00000	1,446	100	0	0	30.1
0.00100	880	100	0	0	10.4
0.00000	880	100	0	0	27.5
0.01300	880	100	0	0	5.6
0.01000	880	100	0	0	5.6
0.00000	880	100	0	0	31.9
0.00200	880	100	0	0	10.8
0.00000	880	100	0	0	40.1
0.00000	282	32	598	68	63.4
0.00000	880	100	0	0	39.7
0.00000	847	96.2	33	3.8	52.2
0.00000	880	100	0	0	22.6
0.00000	877	99.7	3	0.3	50.7
0.00000	0	0	880	100	98.2
0.00000	880	100	0	0	40.6
0.00000	880	100	0	0	41.1
0.00200	880	100	0	0	8.5
0.00300	880	100	0	0	10.9
0.00000	880	100	0	0	24.6
0.00000	880	100	0	0	28.9
0.00100	1,305	100	0	0	18.6
0.00200	1,305	100	0	0	16
0.01500	1,305	100	0	0	6.5
0.00500	1,305	100	0	0	10.6
0.00200	1,305	100	0	0	9
0.00800	1,305	100	0	0	14.6
0.00100	1,305	100	0	0	18.1
0.00100	1,305	100	0	0	18.1
0.00400	1,305	100	0	0	17.2
0.00100	1,305	100	0	0	19.5
0.00200	1,305	100	0	0	18.5
0.00200	1,305	100	0	0	18.6
0.00000	1,140	87.4	165	12.6	47.5
0.00200	1,305	100	0	0	18.1
0.00100	1,305	100	0	0	17.7
0.00100	1,305	100	0	0	16.4

0.01400	1,305	100	0	0	12.8
0.00000	1,140	87.4	165	12.6	35.8
0.00100	1,305	100	0	0	18.5
0.00000	421	100	0	0	17.7
0.00000	421	100	0	0	27.1
0.01200	421	100	0	0	11.8
0.00700	421	100	0	0	11.8
0.00200	421	100	0	0	16.6
0.00200	421	100	0	0	12
0.00500	421	100	0	0	16.8
0.00000	421	100	0	0	42.5
0.00000	421	100	0	0	38.7
0.00000	421	100	0	0	40.3
0.00000	421	100	0	0	38.6
0.00000	421	100	0	0	40.7
0.00000	0	0	421	100	106.8
0.00000	421	100	0	0	19.4
0.00000	421	100	0	0	31.7
0.00000	421	100	0	0	16.5
0.00000	421	100	0	0	21.7
0.00000	421	100	0	0	19.4
0.00000	421	100	0	0	38.7
0.00100	1,597	99.7	5	0.3	12.5
0.00100	1,602	100	0	0	10.5
0.05800	1,602	100	0	0	4.5
0.02900	1,602	100	0	0	4.7
0.00400	1,602	100	0	0	6.3
0.02600	1,602	100	0	0	5.8
0.00500	1,602	100	0	0	8.7
0.00100	1,602	100	0	0	14.3
0.00500	1,602	100	0	0	10.5
0.00200	1,602	100	0	0	11.8
0.00500	1,602	100	0	0	11.6
0.00300	1,595	99.6	7	0.4	12.2
0.00000	0	0	1,602	100	124.7
0.01200	1,602	100	0	0	11.6
0.00200	1,602	100	0	0	10.3
0.00700	1,602	100	0	0	9.2
0.09400	1,602	100	0	0	5.3
0.00700	1,602	100	0	0	11.5
0.00300	1,602	100	0	0	11.6
0.00000	3,804	100	0	0	19.7
0.00000	3,804	100	0	0	31.7
0.00500	3,804	100	0	0	6.3
0.00400	3,804	100	0	0	6.4
0.00100	3,804	100	0	0	6.9
0.00000	3,804	100	0	0	14.8
0.00000	3,804	100	0	0	29.9

0.00000	3,804	100	0	0	33.8
0.00000	3,804	100	0	0	19.5
0.00000	3,804	100	0	0	32.2
0.00000	3,804	100	0	0	19.8
0.00000	3,804	100	0	0	27.7
0.00000	3,631	95.5	173	4.5	44.4
0.00000	3,804	100	0	0	31.1
0.00000	3,804	100	0	0	29.5
0.00000	3,804	100	0	0	17
0.00000	3,711	97.6	93	2.4	32.6
0.00000	3,804	100	0	0	19.7
0.00000	3,804	100	0	0	32.2

Network Access Scorecard

State of West Virginia

PHCS/MPI Commercial Providers

Total Estimated Eligibles: 85,900** *100 lives per zip code state wide

Report Created: March 3, 2016

Average Time to 2	Maximum Time to 1	Maximum Time to 2	Urban Standard (Minutes)	Suburban Standard (Minutes)
15.4	19.3	21.6	1 in 30	1 in 45
37.7	46	49.2	1 in 30	1 in 45
6.1	12.9	13.4	2 in 30	2 in 45
6.1	12.9	13.4	2 in 30	2 in 45
20.7	19.7	30.3	2 in 30	2 in 45
12.8	14.8	18.5	2 in 30	2 in 45
15.8	21.6	27.1	2 in 30	2 in 45
23.6	26.2	35.6	1 in 30	1 in 45
15.2	21.2	25.6	2 in 30	2 in 45
28.4	30.3	43	1 in 30	1 in 45
15.1	26.8	27.1	2 in 30	2 in 45
17.8	27.1	27.1	2 in 30	2 in 45
46.9	57.6	57.6	1 in 30	1 in 45
17.6	21.6	27.3	2 in 30	2 in 45
24.7	27.1	37.6	1 in 30	1 in 45
16.8	24.3	25.4	2 in 30	2 in 45
14.1	25.6	25.6	2 in 30	2 in 45
19.7	29.1	29.1	2 in 30	2 in 45
19.9	27	31	1 in 30	1 in 45
19.5	25.6	30.1	1 in 30	1 in 45
19.1	23.3	30.7	1 in 30	1 in 45
4.9	13.6	16.2	2 in 30	2 in 45
5.2	13.6	16.2	2 in 30	2 in 45
63.2	91.5	91.5	2 in 30	2 in 45
9.5	23	25.1	2 in 30	2 in 45
11.1	25.6	25.6	2 in 30	2 in 45
14.4	20.7	25.4	1 in 30	1 in 45
10.3	25.1	25.1	2 in 30	2 in 45
120.1	26.2	157	1 in 30	1 in 45
9.5	23.5	23.5	2 in 30	2 in 45
11.3	25.1	25.7	2 in 30	2 in 45
140	187.1	187.1	1 in 30	1 in 45
11.3	25.1	25.1	2 in 30	2 in 45
10.8	25.6	25.9	1 in 30	1 in 45
10.3	23.5	24.8	2 in 30	2 in 45

11.4	25.1	25.2	2 in 30	2 in 45
63.2	37.2	91.5	2 in 30	2 in 45
9.8	25.4	25.6	1 in 30	1 in 45
32.6	25.4	45.5	1 in 30	1 in 45
33.4	46.5	47.7	1 in 30	1 in 45
14.3	18.2	21.7	2 in 30	2 in 45
14.5	18.2	21.7	2 in 30	2 in 45
25.5	34.4	35.7	2 in 30	2 in 45
21	25.5	29.8	2 in 30	2 in 45
30.3	43.1	45.8	2 in 30	2 in 45
34.1	46.2	53	1 in 30	1 in 45
30.3	31.4	43.1	2 in 30	2 in 45
31	46.1	49.1	1 in 30	1 in 45
11.9	26.8	26.8	2 in 30	2 in 45
31.3	34.4	49.2	2 in 30	2 in 45
85.6	81	98.8	1 in 30	1 in 45
31.2	46.4	46.5	2 in 30	2 in 45
32.5	35.8	46.5	1 in 30	1 in 45
11.6	23.7	25.8	2 in 30	2 in 45
23.4	33.8	35	2 in 30	2 in 45
22.1	31.2	33.1	2 in 30	2 in 45
48.6	50.2	61.4	1 in 30	1 in 45
31.4	33.9	44.7	1 in 30	1 in 45
40.8	34.4	56.4	1 in 30	1 in 45
8	15.3	15.6	2 in 30	2 in 45
8	15.3	15.6	2 in 30	2 in 45
44.5	53.1	55.4	2 in 30	2 in 45
25.4	22	33.4	2 in 30	2 in 45
40.7	53.1	57.7	2 in 30	2 in 45
58.6	76.3	76.3	1 in 30	1 in 45
31.6	53.1	53.1	2 in 30	2 in 45
60.8	75.4	75.6	1 in 30	1 in 45
26.5	24	47.5	2 in 30	2 in 45
58.8	74.2	75.7	2 in 30	2 in 45
97	111.6	116.4	1 in 30	1 in 45
30.4	45.9	45.9	2 in 30	2 in 45
56.5	54.8	66.3	1 in 30	1 in 45
25.3	27	33.4	2 in 30	2 in 45
30.7	43.2	43.2	2 in 30	2 in 45
12.7	22	22	2 in 30	2 in 45
37.1	36.8	52.4	1 in 30	1 in 45
28.1	22.2	53.2	1 in 30	1 in 45
15.1	12.2	21.8	1 in 30	1 in 45
3.6	12	12.1	2 in 30	2 in 45
4.5	12	12.1	2 in 30	2 in 45
13.5	12.2	20.1	2 in 30	2 in 45
7.7	17.7	17.7	2 in 30	2 in 45
14.1	17.7	21.1	2 in 30	2 in 45

19.8	16.4	36	1 in 30	1 in 45
13.4	20.8	21.1	2 in 30	2 in 45
27.4	55.8	55.8	1 in 30	1 in 45
13.9	21.1	21.8	2 in 30	2 in 45
14.7	21.4	21.8	2 in 30	2 in 45
81.4	113.3	113.3	1 in 30	1 in 45
14.7	20.8	22.2	2 in 30	2 in 45
14.7	21.8	21.8	1 in 30	1 in 45
7.5	12.2	17.8	2 in 30	2 in 45
4.9	11.8	11.8	2 in 30	2 in 45
30.3	59.4	59.4	2 in 30	2 in 45
13.4	21.1	21.1	1 in 30	1 in 45
8.4	26.7	40.6	1 in 30	1 in 45
51.9	28.5	61.2	1 in 30	1 in 45
2.2	11.6	11.6	2 in 30	2 in 45
2.2	12.2	12.2	2 in 30	2 in 45
4.4	13.7	21.2	2 in 30	2 in 45
3	12.7	15.6	2 in 30	2 in 45
4.7	24.9	24.9	2 in 30	2 in 45
7.5	22.5	34.4	1 in 30	1 in 45
4.6	24.9	24.9	2 in 30	2 in 45
4.9	24.9	34.4	1 in 30	1 in 45
2	12.2	12.5	2 in 30	2 in 45
5.5	34.4	34.4	2 in 30	2 in 45
174.6	43.4	182.4	1 in 30	1 in 45
5.5	24.9	24.9	2 in 30	2 in 45
5.2	22.2	34.4	1 in 30	1 in 45
3	12.9	15.6	2 in 30	2 in 45
8.3	13	15.3	2 in 30	2 in 45
5	24.9	24.9	2 in 30	2 in 45
6.1	40.4	40.4	1 in 30	1 in 45
37.9	22.5	45.6	1 in 30	1 in 45
55.2	36.7	64	1 in 30	1 in 45
8.9	18.1	18.1	2 in 30	2 in 45
8.9	18.1	18.1	2 in 30	2 in 45
30.9	43.3	43.7	2 in 30	2 in 45
10.1	21.9	22.5	2 in 30	2 in 45
35.1	45.9	45.9	2 in 30	2 in 45
65.7	77	77	1 in 30	1 in 45
44.8	57.2	58.4	2 in 30	2 in 45
60.4	69.6	69.8	1 in 30	1 in 45
43.5	44.7	52.1	2 in 30	2 in 45
63.6	69.6	74.2	2 in 30	2 in 45
109.3	114.9	118.9	1 in 30	1 in 45
21.2	30.8	30.8	2 in 30	2 in 45
47.5	45.9	59.3	1 in 30	1 in 45
10.1	19.9	22.5	2 in 30	2 in 45

30.6	42.2	42.2	2 in 30	2 in 45
31.7	30.8	43.6	2 in 30	2 in 45
50.3	52.1	56.5	1 in 30	1 in 45
38.4	38.4	45.2	1 in 30	1 in 45
45	45.5	57.8	1 in 30	1 in 45
8.3	17.6	18.5	2 in 30	2 in 45
8.3	18.5	18.6	2 in 30	2 in 45
49.2	52.8	54.6	2 in 30	2 in 45
26.6	32.6	35.3	2 in 30	2 in 45
42.3	53.5	54.6	2 in 30	2 in 45
55.7	71.4	74.1	1 in 30	1 in 45
46	56.2	58.9	2 in 30	2 in 45
48.6	66.8	66.8	1 in 30	1 in 45
44.7	42.3	55.2	2 in 30	2 in 45
48.7	66.1	66.2	2 in 30	2 in 45
106.8	109.3	121.4	1 in 30	1 in 45
36.9	50.7	50.7	2 in 30	2 in 45
48	59.6	63.6	1 in 30	1 in 45
23.4	18.3	32.7	2 in 30	2 in 45
32.8	42.6	42.6	2 in 30	2 in 45
25.1	31.5	33.2	2 in 30	2 in 45
36.9	34.9	52	1 in 30	1 in 45
32	31.2	36.4	1 in 30	1 in 45
26.6	20.5	30.9	1 in 30	1 in 45
6.3	16	16	2 in 30	2 in 45
6.5	16.1	16.4	2 in 30	2 in 45
8.8	18.6	21.8	2 in 30	2 in 45
8	21.8	22.3	2 in 30	2 in 45
30.6	31.2	38.1	2 in 30	2 in 45
33.2	39.6	41.6	1 in 30	1 in 45
27.1	28.4	31.2	2 in 30	2 in 45
34.1	43.8	43.8	1 in 30	1 in 45
24.9	34.4	34.4	2 in 30	2 in 45
33.6	43.8	43.8	2 in 30	2 in 45
66.2	81.8	81.8	1 in 30	1 in 45
27.2	31.2	31.2	2 in 30	2 in 45
33.8	33.1	43.8	1 in 30	1 in 45
9	19.8	21.8	2 in 30	2 in 45
20.2	24.1	29.7	2 in 30	2 in 45
28.4	37.3	37.3	2 in 30	2 in 45
33	34.6	40.4	1 in 30	1 in 45
25.7	30.1	38.9	1 in 30	1 in 45
26.1	30.9	41.4	1 in 30	1 in 45
8.1	14.7	16.5	2 in 30	2 in 45
8.7	16.5	18.9	2 in 30	2 in 45
26.9	30	42.6	2 in 30	2 in 45
13	23.1	25.9	2 in 30	2 in 45
15.6	30	30.1	2 in 30	2 in 45

55.4	42.4	67.6	1 in 30	1 in 45
25.5	30.5	40.4	2 in 30	2 in 45
27.7	41	43.6	1 in 30	1 in 45
26.3	41	42.1	2 in 30	2 in 45
46.1	44.2	56.2	2 in 30	2 in 45
117	83.2	144.2	1 in 30	1 in 45
26.3	41.1	41.1	2 in 30	2 in 45
28.6	42.4	43.6	1 in 30	1 in 45
14.8	21.2	23.6	2 in 30	2 in 45
28.4	41.7	41.7	2 in 30	2 in 45
29.5	29.4	38	2 in 30	2 in 45
25.7	29.4	38	1 in 30	1 in 45
31	23.6	46	1 in 30	1 in 45
40.2	24.3	57.1	1 in 30	1 in 45
9.9	17	17	2 in 30	2 in 45
9.9	17	17	2 in 30	2 in 45
30.1	37.8	42.1	2 in 30	2 in 45
17.6	21.4	23.6	2 in 30	2 in 45
38.1	46.5	48.6	2 in 30	2 in 45
56.6	76.3	76.3	1 in 30	1 in 45
29.2	47.8	47.8	2 in 30	2 in 45
59.9	73.7	73.9	1 in 30	1 in 45
27.8	34.2	41.8	2 in 30	2 in 45
60.7	72.6	77.1	2 in 30	2 in 45
96.6	112.6	112.6	1 in 30	1 in 45
24.6	32.7	32.7	2 in 30	2 in 45
50.8	46.6	59.1	1 in 30	1 in 45
17.5	20.2	23.6	2 in 30	2 in 45
32.4	42.1	42.1	2 in 30	2 in 45
20.3	30.8	32.7	2 in 30	2 in 45
38	41.4	47.7	1 in 30	1 in 45
31.4	30.9	45	1 in 30	1 in 45
45.2	48.5	65.4	1 in 30	1 in 45
12.1	21.4	21.4	2 in 30	2 in 45
16.6	21.4	22.4	2 in 30	2 in 45
32.1	48.7	49.2	2 in 30	2 in 45
15.7	29.3	34.2	2 in 30	2 in 45
50.6	62.9	63.2	2 in 30	2 in 45
30.5	28.8	36.3	1 in 30	1 in 45
31.2	45	45.1	2 in 30	2 in 45
64.8	72.3	83	1 in 30	1 in 45
38.2	30.6	48.9	2 in 30	2 in 45
51.9	66.4	66.4	2 in 30	2 in 45
74.3	95.6	95.6	1 in 30	1 in 45
50.8	62.4	65.3	2 in 30	2 in 45
69	66.6	81.4	1 in 30	1 in 45
30.5	32.1	36.3	2 in 30	2 in 45

17.9	27.2	31.2	2 in 30	2 in 45
17.5	29.7	30.9	2 in 30	2 in 45
62.8	66.7	72.5	1 in 30	1 in 45
28.4	28.3	36.9	1 in 30	1 in 45
16.1	37.8	38.4	1 in 30	1 in 45
6.9	21.6	21.7	2 in 30	2 in 45
7.2	21.7	22.1	2 in 30	2 in 45
31.8	31.9	44.7	2 in 30	2 in 45
13.8	26.7	31.6	2 in 30	2 in 45
15.2	34.9	36.4	2 in 30	2 in 45
68.2	76.4	91.5	1 in 30	1 in 45
14.8	34.9	39.7	2 in 30	2 in 45
16.3	40	41.5	1 in 30	1 in 45
16.4	40.4	40.4	2 in 30	2 in 45
15.3	41.7	42.2	2 in 30	2 in 45
151.6	96	169	1 in 30	1 in 45
46.3	40.4	76.3	2 in 30	2 in 45
16.6	40.9	41.1	1 in 30	1 in 45
8.8	32.7	32.7	2 in 30	2 in 45
8.6	27.8	27.8	2 in 30	2 in 45
16.4	36.7	38.7	2 in 30	2 in 45
16.5	36.8	38.8	1 in 30	1 in 45
29	26.8	42.5	1 in 30	1 in 45
37.5	45.4	55.4	1 in 30	1 in 45
14.5	21	23.7	2 in 30	2 in 45
15.3	21	23.7	2 in 30	2 in 45
31.1	47.8	47.8	2 in 30	2 in 45
15.2	26.8	26.8	2 in 30	2 in 45
37.1	58.6	58.6	2 in 30	2 in 45
23	24.5	32.8	1 in 30	1 in 45
17.9	26.8	31	2 in 30	2 in 45
82.8	67.5	94.5	1 in 30	1 in 45
39.2	26.8	48.5	2 in 30	2 in 45
47	69.2	69.2	2 in 30	2 in 45
96.5	109.2	109.2	1 in 30	1 in 45
47.4	67.8	69.2	2 in 30	2 in 45
45.3	69.2	69.7	1 in 30	1 in 45
29.9	26.8	48	2 in 30	2 in 45
40.3	48.9	49	2 in 30	2 in 45
31.5	43.5	44.1	2 in 30	2 in 45
45.2	65.3	69.1	1 in 30	1 in 45
53.1	30.4	58.8	1 in 30	1 in 45
22.2	27.7	30.4	1 in 30	1 in 45
7.7	7.8	13.5	2 in 30	2 in 45
16.3	24.8	24.8	2 in 30	2 in 45
19	28.3	29	2 in 30	2 in 45
7.8	7.8	13.5	2 in 30	2 in 45
19.6	25.2	30.4	2 in 30	2 in 45

41.4	31.1	47.8	1 in 30	1 in 45
19.6	30.4	30.4	2 in 30	2 in 45
56.3	64.5	64.5	1 in 30	1 in 45
19	24.8	29.8	2 in 30	2 in 45
19.6	30.4	30.4	2 in 30	2 in 45
98.7	115.9	115.9	1 in 30	1 in 45
19.6	30.4	30.4	2 in 30	2 in 45
19.6	30.4	30.4	1 in 30	1 in 45
16.8	12.3	27.2	2 in 30	2 in 45
16.8	27.2	27.2	2 in 30	2 in 45
58.3	66.2	66.2	2 in 30	2 in 45
20.5	30.4	31.1	1 in 30	1 in 45
30.8	28.4	51.1	1 in 30	1 in 45
61.2	50.8	79	1 in 30	1 in 45
10.8	20.8	24.2	2 in 30	2 in 45
10.8	20.8	24.2	2 in 30	2 in 45
34.6	51.1	51.1	2 in 30	2 in 45
27.9	45.8	45.9	2 in 30	2 in 45
60.1	69.7	69.7	2 in 30	2 in 45
21.9	24.2	34.3	1 in 30	1 in 45
29	51.1	51.2	2 in 30	2 in 45
80.8	85.5	94.8	1 in 30	1 in 45
33	29.5	53.8	2 in 30	2 in 45
64.3	75.9	75.9	2 in 30	2 in 45
96.2	111.6	111.6	1 in 30	1 in 45
64.6	72	76	2 in 30	2 in 45
73.2	72	87.7	1 in 30	1 in 45
35.2	39.4	48.1	2 in 30	2 in 45
21	37.8	37.8	2 in 30	2 in 45
20.7	37.5	38.2	2 in 30	2 in 45
68.2	69.9	78.8	1 in 30	1 in 45
21.1	24.9	31.9	1 in 30	1 in 45
17.6	18.2	28.2	1 in 30	1 in 45
2.2	12.4	12.4	2 in 30	2 in 45
2.3	12.4	12.4	2 in 30	2 in 45
18.7	25	26.8	2 in 30	2 in 45
6.6	21	22	2 in 30	2 in 45
10.5	25.4	27.7	2 in 30	2 in 45
12.1	26.7	30.6	1 in 30	1 in 45
8.9	22.4	23.4	2 in 30	2 in 45
11.1	28.2	28.2	1 in 30	1 in 45
7	22	22	2 in 30	2 in 45
11	28.2	28.2	2 in 30	2 in 45
50.7	68.5	68.5	1 in 30	1 in 45
12.1	25	25	2 in 30	2 in 45
11	25.5	28.2	1 in 30	1 in 45
8.2	15.8	21.7	2 in 30	2 in 45

7.6	17.2	24.3	2 in 30	2 in 45
17.3	24.3	24.3	2 in 30	2 in 45
11.2	23.2	27.7	1 in 30	1 in 45
26.2	25.9	36.9	1 in 30	1 in 45
42.6	48.2	52.5	1 in 30	1 in 45
9.7	22.9	22.9	2 in 30	2 in 45
9.8	22.9	22.9	2 in 30	2 in 45
12	23.2	23.6	2 in 30	2 in 45
10.8	25.4	25.9	2 in 30	2 in 45
12.1	25.9	25.9	2 in 30	2 in 45
43.4	55.2	55.7	1 in 30	1 in 45
26.5	39.4	39.4	2 in 30	2 in 45
26.8	39.4	39.7	1 in 30	1 in 45
24.8	37.2	37.2	2 in 30	2 in 45
40.9	39.6	55.8	2 in 30	2 in 45
126.1	105	138.9	1 in 30	1 in 45
12	24.1	24.5	2 in 30	2 in 45
26.5	25.9	39.6	1 in 30	1 in 45
25.7	31.7	36.9	2 in 30	2 in 45
8.6	18.4	18.4	2 in 30	2 in 45
26.4	33	39.6	2 in 30	2 in 45
51.1	62.2	64	1 in 30	1 in 45
21.8	16.3	31.9	1 in 30	1 in 45
20.6	15.3	30.4	1 in 30	1 in 45
5.2	10.2	11.6	2 in 30	2 in 45
5.3	10.3	11.6	2 in 30	2 in 45
69.9	76.5	76.5	2 in 30	2 in 45
7.4	12	15.7	2 in 30	2 in 45
21.5	16.3	31.6	2 in 30	2 in 45
8.1	15.9	16.3	1 in 30	1 in 45
7.7	16.2	16.3	2 in 30	2 in 45
124.2	30.3	135.9	1 in 30	1 in 45
6.3	12.7	12.7	2 in 30	2 in 45
21.5	30.9	31.6	2 in 30	2 in 45
142.9	157.8	157.8	1 in 30	1 in 45
20.8	16.3	30.9	2 in 30	2 in 45
7.7	16.2	16.2	1 in 30	1 in 45
6.4	12.7	12.9	2 in 30	2 in 45
9.2	13.2	19.2	2 in 30	2 in 45
69.9	19.8	76.5	2 in 30	2 in 45
7.9	15.4	15.7	1 in 30	1 in 45
14.7	41.3	46.2	1 in 30	1 in 45
24.3	36	53.1	1 in 30	1 in 45
4.7	22.1	22.1	2 in 30	2 in 45
5.4	22.1	22.1	2 in 30	2 in 45
40.1	53.1	57.4	2 in 30	2 in 45
7	31.3	37.1	2 in 30	2 in 45
11.9	40.5	40.6	2 in 30	2 in 45

22.2	55	66.4	1 in 30	1 in 45
12.6	41.1	47	2 in 30	2 in 45
13.5	46.6	48.8	1 in 30	1 in 45
13.6	36	48.2	2 in 30	2 in 45
15.3	47	52.8	2 in 30	2 in 45
115.9	109.1	143.6	1 in 30	1 in 45
13.6	49.9	49.9	2 in 30	2 in 45
15.9	51.8	53.6	1 in 30	1 in 45
7	26	31.3	2 in 30	2 in 45
11.4	47.8	47.8	2 in 30	2 in 45
10.6	26.5	44.4	2 in 30	2 in 45
56.1	63.4	75.7	1 in 30	1 in 45
21	22.3	31	1 in 30	1 in 45
27.8	33.7	42.8	1 in 30	1 in 45
8.1	16.4	16.5	2 in 30	2 in 45
8.1	16.4	16.5	2 in 30	2 in 45
31.6	46	47.2	2 in 30	2 in 45
11.5	22.2	22.3	2 in 30	2 in 45
21.2	23.7	31	2 in 30	2 in 45
33.2	45.7	45.7	1 in 30	1 in 45
11.5	22.1	23.7	2 in 30	2 in 45
37.7	49.6	49.6	1 in 30	1 in 45
10.6	16.9	18.1	2 in 30	2 in 45
37.2	49.1	49.1	2 in 30	2 in 45
75.2	85.6	85.6	1 in 30	1 in 45
11.9	23.7	23.7	2 in 30	2 in 45
37.2	22	49.1	1 in 30	1 in 45
12.1	21.9	22.8	2 in 30	2 in 45
15	26.8	26.8	2 in 30	2 in 45
11.9	23.4	23.4	2 in 30	2 in 45
21.2	23.7	31	1 in 30	1 in 45
30.4	33.4	44.6	1 in 30	1 in 45
35.1	54.2	58.7	1 in 30	1 in 45
6.1	11.1	12.6	2 in 30	2 in 45
6.3	11.1	12.6	2 in 30	2 in 45
22.8	23.7	34	2 in 30	2 in 45
12	19.6	20.8	2 in 30	2 in 45
27.8	39.1	50	2 in 30	2 in 45
32.8	42.6	53.1	1 in 30	1 in 45
28.1	32.5	40.4	2 in 30	2 in 45
32.9	50.1	53.1	1 in 30	1 in 45
12.7	16.3	20.6	2 in 30	2 in 45
32.9	37	53.1	2 in 30	2 in 45
103.3	64.7	150.9	1 in 30	1 in 45
29.8	50.1	50.1	2 in 30	2 in 45
30.5	30	42.4	1 in 30	1 in 45
14.5	16.3	20.8	2 in 30	2 in 45

13.9	19.7	22.1	2 in 30	2 in 45
23.5	32.6	32.6	2 in 30	2 in 45
46.7	56.5	61.5	1 in 30	1 in 45
30.3	27.8	42.2	1 in 30	1 in 45
47.8	57.4	60.9	1 in 30	1 in 45
4.5	12.6	15.1	2 in 30	2 in 45
4.5	12.6	15.1	2 in 30	2 in 45
14.5	15.4	29.7	2 in 30	2 in 45
11.3	17.4	26.7	2 in 30	2 in 45
48.4	42.6	58.5	2 in 30	2 in 45
55.9	58.9	63.3	1 in 30	1 in 45
29.4	25.4	42.7	2 in 30	2 in 45
49.2	58.8	59.4	1 in 30	1 in 45
21	32.4	33	2 in 30	2 in 45
47.8	22.6	58.3	2 in 30	2 in 45
85.2	81.3	103.5	1 in 30	1 in 45
48.9	58.6	58.8	2 in 30	2 in 45
49.2	25.3	59	1 in 30	1 in 45
10.3	24.1	27.1	2 in 30	2 in 45
15.9	25.8	34.6	2 in 30	2 in 45
8.5	25.3	25.3	2 in 30	2 in 45
49.7	61	62.2	1 in 30	1 in 45
24.6	30.7	35.1	1 in 30	1 in 45
29.3	31	36.1	1 in 30	1 in 45
3.7	10.7	10.7	2 in 30	2 in 45
3.9	10.7	10.7	2 in 30	2 in 45
10.5	16.9	19.9	2 in 30	2 in 45
7.5	18	24	2 in 30	2 in 45
8.2	27.1	27.1	2 in 30	2 in 45
19.6	26.5	31	1 in 30	1 in 45
8.4	27.1	27.1	2 in 30	2 in 45
20.6	32.2	34	1 in 30	1 in 45
18.5	27.2	30.1	2 in 30	2 in 45
19.5	27.1	30.7	2 in 30	2 in 45
27.9	39.8	39.8	1 in 30	1 in 45
8.2	27.1	27.1	2 in 30	2 in 45
8.7	27.1	27.1	1 in 30	1 in 45
4.8	18	18	2 in 30	2 in 45
7.1	15.7	23.6	2 in 30	2 in 45
11.6	29.6	29.7	2 in 30	2 in 45
11.8	27.1	29.7	1 in 30	1 in 45
16.5	21.2	31	1 in 30	1 in 45
18.3	31	32.5	1 in 30	1 in 45
8.1	13.5	19.9	2 in 30	2 in 45
8.7	19.9	20	2 in 30	2 in 45
10.1	20.2	20.2	2 in 30	2 in 45
9.2	15.7	21.2	2 in 30	2 in 45
9.4	21.2	21.2	2 in 30	2 in 45

18.1	22.5	34	1 in 30	1 in 45
9.4	20.2	21.2	2 in 30	2 in 45
17.7	31	37.2	1 in 30	1 in 45
9.3	21	21.2	2 in 30	2 in 45
9.3	21.2	21.2	2 in 30	2 in 45
65.8	91.7	91.7	1 in 30	1 in 45
16	21.2	31	2 in 30	2 in 45
19.2	32.5	37.8	1 in 30	1 in 45
9.6	21.2	21.7	2 in 30	2 in 45
16.3	20.8	23.8	2 in 30	2 in 45
18.6	31	37.4	2 in 30	2 in 45
17.9	21.2	31	1 in 30	1 in 45
25.5	24.5	34.3	1 in 30	1 in 45
51.1	60.4	65.6	1 in 30	1 in 45
9.2	15.6	17.3	2 in 30	2 in 45
12.3	15.6	18.9	2 in 30	2 in 45
18.5	24.2	28.8	2 in 30	2 in 45
12.4	20.7	20.7	2 in 30	2 in 45
14.7	24.5	24.5	2 in 30	2 in 45
50.4	59.4	68.4	1 in 30	1 in 45
15	29	29	2 in 30	2 in 45
15.3	29	29.1	1 in 30	1 in 45
13	21.8	21.8	2 in 30	2 in 45
49.2	29	64.2	2 in 30	2 in 45
139.6	88	164.6	1 in 30	1 in 45
14.7	24.5	24.5	2 in 30	2 in 45
15.3	24.5	29	1 in 30	1 in 45
13.4	23.1	24.8	2 in 30	2 in 45
18.6	27.9	28.2	2 in 30	2 in 45
15	28	28	2 in 30	2 in 45
51.8	64.5	64.5	1 in 30	1 in 45
29.4	24.9	42.5	1 in 30	1 in 45
52.9	51.4	72.2	1 in 30	1 in 45
7.4	13.9	18.1	2 in 30	2 in 45
9.5	22.1	25.2	2 in 30	2 in 45
18.2	25.2	32.6	2 in 30	2 in 45
12.9	18.7	23	2 in 30	2 in 45
30.4	42.5	51.3	2 in 30	2 in 45
36.1	50.9	58.4	1 in 30	1 in 45
29.1	24.9	40.9	2 in 30	2 in 45
35.7	51.6	58.2	1 in 30	1 in 45
29.9	24.9	46.8	2 in 30	2 in 45
34.8	39.8	51.8	2 in 30	2 in 45
128.2	58.9	144.4	1 in 30	1 in 45
30.4	51.4	51.4	2 in 30	2 in 45
34.9	40.9	51.4	1 in 30	1 in 45
22.9	24.9	32.8	2 in 30	2 in 45

34	40.9	46.8	2 in 30	2 in 45
10.9	24.9	24.9	2 in 30	2 in 45
30.5	51.3	51.6	1 in 30	1 in 45
17	19	24.4	1 in 30	1 in 45
34.2	22.6	46.6	1 in 30	1 in 45
5.9	12.9	14.4	2 in 30	2 in 45
6.2	13.4	14.4	2 in 30	2 in 45
14.6	18.9	30.5	2 in 30	2 in 45
7.7	16.2	17.4	2 in 30	2 in 45
9.3	20	20	2 in 30	2 in 45
16.3	19.9	28.6	1 in 30	1 in 45
9.4	18.1	20	2 in 30	2 in 45
12.3	20.4	20.4	1 in 30	1 in 45
9.1	18.9	18.9	2 in 30	2 in 45
11.9	20.2	20.5	2 in 30	2 in 45
154.2	21.2	182.4	1 in 30	1 in 45
9.9	20.7	21.5	2 in 30	2 in 45
12.3	20.4	20.4	1 in 30	1 in 45
7.9	16.3	17.6	2 in 30	2 in 45
12.5	20.4	22	2 in 30	2 in 45
15.5	20.5	32.4	2 in 30	2 in 45
9.5	20.1	20.1	1 in 30	1 in 45
23.2	26.8	32	1 in 30	1 in 45
37.9	30.3	49.6	1 in 30	1 in 45
11.9	12.9	26.7	2 in 30	2 in 45
13	18.3	26.7	2 in 30	2 in 45
13.7	29.6	29.6	2 in 30	2 in 45
13.9	26.8	26.8	2 in 30	2 in 45
45.5	59.7	59.7	2 in 30	2 in 45
31.1	33.9	37.3	1 in 30	1 in 45
13.1	23.8	26.8	2 in 30	2 in 45
63.8	65.2	72.9	1 in 30	1 in 45
41.7	32	61.5	2 in 30	2 in 45
61.5	71.4	71.4	2 in 30	2 in 45
73.7	88.2	88.2	1 in 30	1 in 45
57.3	65.5	68	2 in 30	2 in 45
61.5	71.4	73	1 in 30	1 in 45
23	26.6	31.9	2 in 30	2 in 45
42.2	56.2	61.2	2 in 30	2 in 45
15.6	29.6	33.3	2 in 30	2 in 45
61.8	71.4	71.4	1 in 30	1 in 45
39.4	27.8	50.8	1 in 30	1 in 45
63.6	73	79.4	1 in 30	1 in 45
6.4	15	15	2 in 30	2 in 45
7	15	15.6	2 in 30	2 in 45
22	31.3	36.4	2 in 30	2 in 45
13.1	21.3	23.6	2 in 30	2 in 45
61.8	30.6	74	2 in 30	2 in 45

63.8	64.4	74.7	1 in 30	1 in 45
23.2	25.7	28.9	2 in 30	2 in 45
62.3	74.2	74.2	1 in 30	1 in 45
29.3	36.2	42.2	2 in 30	2 in 45
61.3	26.2	73	2 in 30	2 in 45
89.2	78.4	103.8	1 in 30	1 in 45
62	73.9	74.2	2 in 30	2 in 45
54.8	28.9	64.4	1 in 30	1 in 45
17.6	22.1	25.7	2 in 30	2 in 45
28.5	28.6	35.7	2 in 30	2 in 45
22.3	28.9	28.9	2 in 30	2 in 45
62.5	74.2	74.2	1 in 30	1 in 45
12.3	33	36	1 in 30	1 in 45
11.8	32.1	33	1 in 30	1 in 45
3.5	11.2	11.2	2 in 30	2 in 45
3.6	11.6	11.6	2 in 30	2 in 45
9.2	21.9	27.2	2 in 30	2 in 45
7.1	20	22.3	2 in 30	2 in 45
9.2	30.2	30.7	2 in 30	2 in 45
7.8	28.4	28.4	1 in 30	1 in 45
9.1	30.1	30.2	2 in 30	2 in 45
9.1	30	30.3	1 in 30	1 in 45
8.8	30	30	2 in 30	2 in 45
9.3	30.2	30.2	2 in 30	2 in 45
9.4	30.7	30.7	1 in 30	1 in 45
8.8	30.2	30.2	2 in 30	2 in 45
9.2	30.7	30.7	1 in 30	1 in 45
6.4	21.9	21.9	2 in 30	2 in 45
3.5	12.1	12.7	2 in 30	2 in 45
9.2	30.4	30.7	2 in 30	2 in 45
9.4	30.3	30.7	1 in 30	1 in 45
26.8	28.2	38.4	1 in 30	1 in 45
20.7	22.6	33.3	1 in 30	1 in 45
8.2	15.7	18.2	2 in 30	2 in 45
8.2	15.7	18.2	2 in 30	2 in 45
41.9	34.6	52.4	2 in 30	2 in 45
18.9	29.7	30.1	2 in 30	2 in 45
22.1	33.3	34.1	2 in 30	2 in 45
48.3	65.7	66.3	1 in 30	1 in 45
20.8	31.9	33	2 in 30	2 in 45
23.9	34.1	35.6	1 in 30	1 in 45
21	32.6	32.6	2 in 30	2 in 45
23	31.9	33.8	2 in 30	2 in 45
170.5	66.1	186.7	1 in 30	1 in 45
43	33.7	64.2	2 in 30	2 in 45
21.2	33.3	33.3	1 in 30	1 in 45
21	31.8	32.4	2 in 30	2 in 45

21	25.2	32.9	2 in 30	2 in 45
22.4	33.4	38.5	2 in 30	2 in 45
21.1	32.5	33.3	1 in 30	1 in 45
25.3	18	33.9	1 in 30	1 in 45
27.6	16.9	35	1 in 30	1 in 45
9.8	18	18	2 in 30	2 in 45
9.8	18	18	2 in 30	2 in 45
43	59	59	2 in 30	2 in 45
10.1	18	18	2 in 30	2 in 45
10.1	18	18	2 in 30	2 in 45
26.2	18.5	33.4	1 in 30	1 in 45
10.1	18	18	2 in 30	2 in 45
92.2	35.5	107.3	1 in 30	1 in 45
27	34.5	34.8	2 in 30	2 in 45
26.4	34.1	34.1	2 in 30	2 in 45
107.8	124.6	124.6	1 in 30	1 in 45
26.9	34.5	34.5	2 in 30	2 in 45
26.4	33.9	34.1	1 in 30	1 in 45
25.3	21	33.9	2 in 30	2 in 45
27.1	34.6	34.8	2 in 30	2 in 45
44.6	47.2	59	2 in 30	2 in 45
26.8	33.9	34.4	1 in 30	1 in 45
31.3	33	39.6	1 in 30	1 in 45
29.2	37.8	42	1 in 30	1 in 45
11.8	16.6	19.3	2 in 30	2 in 45
12.3	16.6	20.1	2 in 30	2 in 45
38.4	49.6	55.6	2 in 30	2 in 45
26.5	24.4	37.3	2 in 30	2 in 45
37.2	52	57.9	2 in 30	2 in 45
70.9	78	93.1	1 in 30	1 in 45
42.5	51.9	55	2 in 30	2 in 45
44.6	63	63.7	1 in 30	1 in 45
42.8	45.3	54.5	2 in 30	2 in 45
45.4	62.7	62.7	2 in 30	2 in 45
121.6	103.3	142.6	1 in 30	1 in 45
50	55.7	71.2	2 in 30	2 in 45
45	56.1	63.7	1 in 30	1 in 45
14	22	24.4	2 in 30	2 in 45
25.5	39	39	2 in 30	2 in 45
27.8	24.4	42	2 in 30	2 in 45
34.7	25.2	51.9	1 in 30	1 in 45
16	25	28.8	1 in 30	1 in 45
13.3	16.2	24.6	1 in 30	1 in 45
8.1	11.7	14.5	2 in 30	2 in 45
8.4	13.7	15.8	2 in 30	2 in 45
12.3	15.8	18.4	2 in 30	2 in 45
12.3	22	22.8	2 in 30	2 in 45
12.5	22	23.2	2 in 30	2 in 45

15.2	15.5	27.6	1 in 30	1 in 45
12.9	24	24.6	2 in 30	2 in 45
12.9	24.6	24.6	1 in 30	1 in 45
12.7	24.6	24.6	2 in 30	2 in 45
12.7	24.6	24.6	2 in 30	2 in 45
80.4	102.4	102.4	1 in 30	1 in 45
13	25	25	2 in 30	2 in 45
13	24.6	24.6	1 in 30	1 in 45
12.2	16.1	22.2	2 in 30	2 in 45
8.7	15.9	15.9	2 in 30	2 in 45
15.7	28.8	28.8	2 in 30	2 in 45
13.1	24.6	24.6	1 in 30	1 in 45
43.9	50	64.2	1 in 30	1 in 45
67.3	80.4	85.2	1 in 30	1 in 45
10.2	22.1	23.2	2 in 30	2 in 45
10.2	22.1	23.2	2 in 30	2 in 45
60.5	67.5	70.9	2 in 30	2 in 45
37	57.9	58	2 in 30	2 in 45
44.1	67.3	67.3	2 in 30	2 in 45
37	23.3	58.2	1 in 30	1 in 45
44	67.2	67.2	2 in 30	2 in 45
81.8	88.8	96.5	1 in 30	1 in 45
44.1	51	67.2	2 in 30	2 in 45
44.2	67.2	67.4	2 in 30	2 in 45
92.7	113.5	113.5	1 in 30	1 in 45
44.8	67.2	68	2 in 30	2 in 45
73.4	67.3	89.7	1 in 30	1 in 45
26.4	23.3	44.4	2 in 30	2 in 45
30.3	48.7	48.7	2 in 30	2 in 45
30.9	50.1	50.6	2 in 30	2 in 45
61.3	67.6	79.7	1 in 30	1 in 45
33.5	32	39.2	1 in 30	1 in 45
34.4	36.2	40.5	1 in 30	1 in 45
6.2	14	14	2 in 30	2 in 45
7.2	14	14	2 in 30	2 in 45
9.8	14	18.4	2 in 30	2 in 45
9.5	14	16.9	2 in 30	2 in 45
22.1	30.6	30.6	2 in 30	2 in 45
33.5	38	47.4	1 in 30	1 in 45
21.6	27.2	30.3	2 in 30	2 in 45
33.4	37.4	47.5	1 in 30	1 in 45
31.8	37.4	39	2 in 30	2 in 45
32.6	39	39.4	2 in 30	2 in 45
88.9	108.1	108.1	1 in 30	1 in 45
21.6	30.3	30.3	2 in 30	2 in 45
33.3	36.4	46.4	1 in 30	1 in 45
16.8	17.5	22.5	2 in 30	2 in 45

13.5	16.1	18.3	2 in 30	2 in 45
33.5	47.4	47.4	2 in 30	2 in 45
35.2	37.4	46.7	1 in 30	1 in 45
32.4	41	50	1 in 30	1 in 45
61.8	69.8	79.8	1 in 30	1 in 45
10.2	19.6	19.7	2 in 30	2 in 45
10.2	19.6	19.7	2 in 30	2 in 45
30.5	55.2	55.8	2 in 30	2 in 45
32.1	43.6	45	2 in 30	2 in 45
42.5	53.1	57.2	2 in 30	2 in 45
50.5	73.9	81.2	1 in 30	1 in 45
42.4	57.4	57.4	2 in 30	2 in 45
60.3	74.9	81.4	1 in 30	1 in 45
43.2	58.9	58.9	2 in 30	2 in 45
42.6	57.4	57.4	2 in 30	2 in 45
108.3	118	136.3	1 in 30	1 in 45
48.6	58.9	72.5	2 in 30	2 in 45
58.4	58.9	76.3	1 in 30	1 in 45
33.5	46	46	2 in 30	2 in 45
19.9	39.1	39.2	2 in 30	2 in 45
43.2	56.5	58.8	2 in 30	2 in 45
50.3	56.5	63.4	1 in 30	1 in 45
24	28	37.5	1 in 30	1 in 45
30.4	27.7	42.9	1 in 30	1 in 45
5	11.5	21.7	2 in 30	2 in 45
6.8	11.5	21.7	2 in 30	2 in 45
25.9	35.5	37.8	2 in 30	2 in 45
8.2	25.8	27.3	2 in 30	2 in 45
27.7	41.1	46.3	2 in 30	2 in 45
23.2	32.5	43.3	1 in 30	1 in 45
22.5	28	35.5	2 in 30	2 in 45
26.3	35.5	48	1 in 30	1 in 45
27.9	41.7	46.3	2 in 30	2 in 45
28.5	49.1	49.6	2 in 30	2 in 45
29.6	57.6	57.6	1 in 30	1 in 45
23	35.8	45.8	2 in 30	2 in 45
28.7	49.1	50.8	1 in 30	1 in 45
13.6	20.9	26.5	2 in 30	2 in 45
11.5	24	26.5	2 in 30	2 in 45
12.9	28	28	2 in 30	2 in 45
28.6	48.4	50.5	1 in 30	1 in 45
31.4	29.2	45.8	1 in 30	1 in 45
26.5	31.2	42	1 in 30	1 in 45
5.2	15.9	15.9	2 in 30	2 in 45
5.2	15.9	15.9	2 in 30	2 in 45
19.4	24.4	22.2	2 in 30	2 in 45
9.8	19.6	19.6	2 in 30	2 in 45
16	29.2	29.2	2 in 30	2 in 45

30.6	38.7	44.2	1 in 30	1 in 45
15.9	32.8	32.8	2 in 30	2 in 45
28.9	32.8	39.2	1 in 30	1 in 45
5.6	20.5	20.5	2 in 30	2 in 45
30.9	39.2	44.2	2 in 30	2 in 45
129	78.8	158.4	1 in 30	1 in 45
13.3	29.2	29.2	2 in 30	2 in 45
30.4	33	39.2	1 in 30	1 in 45
10.2	23.5	25.5	2 in 30	2 in 45
11.5	16	21	2 in 30	2 in 45
12.4	27.7	27.7	2 in 30	2 in 45
50.4	73	74.4	1 in 30	1 in 45
14	26.9	29	1 in 30	1 in 45
12.8	30.9	31.9	1 in 30	1 in 45
6.8	17.4	17.4	2 in 30	2 in 45
8.1	17.4	17.5	2 in 30	2 in 45
11.9	25.2	26.1	2 in 30	2 in 45
9.9	21.6	23.8	2 in 30	2 in 45
11.7	27.8	29	2 in 30	2 in 45
39.1	34.6	54.7	1 in 30	1 in 45
11.5	28.2	32.5	2 in 30	2 in 45
12.8	33.8	33.9	1 in 30	1 in 45
12.2	27.7	27.8	2 in 30	2 in 45
36.1	31.8	50.1	2 in 30	2 in 45
128.3	65.5	150.4	1 in 30	1 in 45
11.8	33.8	33.8	2 in 30	2 in 45
14.7	33	34.6	1 in 30	1 in 45
10.5	22.4	26.2	2 in 30	2 in 45
34.9	42.8	43.5	2 in 30	2 in 45
33	30.7	42.2	2 in 30	2 in 45
12.7	31.6	33.8	1 in 30	1 in 45
29	34.3	47.5	1 in 30	1 in 45
57.2	66.4	75.8	1 in 30	1 in 45
8.3	20.4	20.4	2 in 30	2 in 45
8.3	20.4	20.4	2 in 30	2 in 45
41.9	54.4	61.6	2 in 30	2 in 45
16.4	33.3	34.2	2 in 30	2 in 45
19.5	43.6	50.8	2 in 30	2 in 45
35.9	54.1	57	1 in 30	1 in 45
18.2	43.6	43.6	2 in 30	2 in 45
55.5	62.9	78.3	1 in 30	1 in 45
18.2	39	43.6	2 in 30	2 in 45
19.6	53.8	53.8	2 in 30	2 in 45
73	104.2	104.2	1 in 30	1 in 45
19.6	43.6	53.5	2 in 30	2 in 45
44.6	52.2	65.7	1 in 30	1 in 45
17.3	31.8	34.3	2 in 30	2 in 45

16.7	34.4	34.6	2 in 30	2 in 45
19	44.4	44.4	2 in 30	2 in 45
33	43.6	53	1 in 30	1 in 45
30.6	30.5	42.4	1 in 30	1 in 45
32.3	34.2	44.8	1 in 30	1 in 45
8.6	17.1	17.1	2 in 30	2 in 45
10.6	17.1	17.2	2 in 30	2 in 45
12.7	20.1	23.4	2 in 30	2 in 45
11.3	19.4	19.7	2 in 30	2 in 45
24.9	30.8	37.9	2 in 30	2 in 45
42.4	57.8	57.8	1 in 30	1 in 45
28.8	43.7	43.7	2 in 30	2 in 45
42.2	58.2	58.7	1 in 30	1 in 45
33.5	43.7	43.7	2 in 30	2 in 45
41	58.1	58.1	2 in 30	2 in 45
87.8	104.1	104.1	1 in 30	1 in 45
27.4	35.6	35.6	2 in 30	2 in 45
41	43	51.2	1 in 30	1 in 45
12.3	19.7	22.5	2 in 30	2 in 45
12.4	25.6	25.6	2 in 30	2 in 45
34.1	44.5	44.5	2 in 30	2 in 45
40.3	43.7	51.8	1 in 30	1 in 45
35.1	38.4	46.4	1 in 30	1 in 45
47.6	47.4	59.7	1 in 30	1 in 45
13	22.9	22.9	2 in 30	2 in 45
13	22.9	22.9	2 in 30	2 in 45
30.9	44.7	45.1	2 in 30	2 in 45
26.3	35	37.7	2 in 30	2 in 45
32.4	46.6	46.6	2 in 30	2 in 45
52.9	68.4	68.4	1 in 30	1 in 45
46.6	58.8	59	2 in 30	2 in 45
47.1	59.8	60	1 in 30	1 in 45
41.2	46.2	51.8	2 in 30	2 in 45
47.8	59.8	63.1	2 in 30	2 in 45
110.8	108.8	126.2	1 in 30	1 in 45
16.6	29.8	29.8	2 in 30	2 in 45
46.5	46.6	59.4	1 in 30	1 in 45
28.5	35.3	37.8	2 in 30	2 in 45
26.3	39.3	39.3	2 in 30	2 in 45
34.4	28.9	45.7	2 in 30	2 in 45
46.4	54	59.3	1 in 30	1 in 45
23.6	18.8	33.6	1 in 30	1 in 45
24.1	28.2	32.7	1 in 30	1 in 45
6.7	13.5	13.7	2 in 30	2 in 45
6.7	13.5	13.7	2 in 30	2 in 45
28.3	35	39.1	2 in 30	2 in 45
11.2	18.9	19	2 in 30	2 in 45
23.8	33.2	34.1	2 in 30	2 in 45

40.7	39.6	53.2	1 in 30	1 in 45
23	31.9	32.9	2 in 30	2 in 45
25.1	34.1	35.7	1 in 30	1 in 45
23.3	32.7	32.7	2 in 30	2 in 45
25.4	32	34.2	2 in 30	2 in 45
148.4	53.1	163	1 in 30	1 in 45
26	33.3	36.9	2 in 30	2 in 45
23.7	33.3	33.4	1 in 30	1 in 45
18.7	30.1	30.4	2 in 30	2 in 45
21.2	30.2	32.5	2 in 30	2 in 45
26.9	33.6	38.6	2 in 30	2 in 45
24	32.5	33.2	1 in 30	1 in 45
14.1	13.3	21.8	1 in 30	1 in 45
26.8	27	31.9	1 in 30	1 in 45
6.1	10.1	10.4	2 in 30	2 in 45
6.1	10.1	10.4	2 in 30	2 in 45
14.2	12.7	24.1	2 in 30	2 in 45
9.1	10.6	13.8	2 in 30	2 in 45
12.2	21.7	23.5	2 in 30	2 in 45
14.7	21.4	23.2	1 in 30	1 in 45
12.5	12.7	23.1	2 in 30	2 in 45
13.3	13.4	25.3	1 in 30	1 in 45
12.3	22.6	23.5	2 in 30	2 in 45
13.3	25.5	25.6	2 in 30	2 in 45
33.5	43.4	43.4	1 in 30	1 in 45
13.3	13.4	23	2 in 30	2 in 45
13.2	25.4	25.5	1 in 30	1 in 45
12.1	20.1	21.3	2 in 30	2 in 45
12.4	22.6	22.6	2 in 30	2 in 45
16.9	25.5	25.5	2 in 30	2 in 45
12.9	24	25.5	1 in 30	1 in 45
27.6	30.5	38	1 in 30	1 in 45
49.8	46.5	58.5	1 in 30	1 in 45
9	14.1	14.8	2 in 30	2 in 45
9	14.8	14.8	2 in 30	2 in 45
41.9	44.8	53.5	2 in 30	2 in 45
11.6	18.1	18.4	2 in 30	2 in 45
28.1	38	42.4	2 in 30	2 in 45
27	28.9	39.2	1 in 30	1 in 45
27.6	37.9	40.9	2 in 30	2 in 45
52.7	55.7	65.3	1 in 30	1 in 45
27.9	35.3	42.3	2 in 30	2 in 45
28	42.3	42.4	2 in 30	2 in 45
61.6	75.6	75.6	1 in 30	1 in 45
28.2	40.9	42.3	2 in 30	2 in 45
51.6	42.4	63.9	1 in 30	1 in 45
25.1	24.4	33.2	2 in 30	2 in 45

23.3	28.1	30.4	2 in 30	2 in 45
23.4	30.5	30.8	2 in 30	2 in 45
41.8	42.6	52	1 in 30	1 in 45
21.4	27.2	31.8	1 in 30	1 in 45
20.8	30	31.8	1 in 30	1 in 45
6.2	12.9	17.1	2 in 30	2 in 45
7.7	17.1	17.1	2 in 30	2 in 45
15	18.3	19.9	2 in 30	2 in 45
8.5	19.8	19.9	2 in 30	2 in 45
13.7	27.2	27.2	2 in 30	2 in 45
45.4	32.4	54.1	1 in 30	1 in 45
13.7	27.2	27.2	2 in 30	2 in 45
47.6	31.8	62.1	1 in 30	1 in 45
21.4	31.8	31.8	2 in 30	2 in 45
21.4	31.8	31.8	2 in 30	2 in 45
65.5	77.8	77.8	1 in 30	1 in 45
13.7	27.2	27.2	2 in 30	2 in 45
45.8	30.1	58.6	1 in 30	1 in 45
16.7	19.8	28.8	2 in 30	2 in 45
17.4	22.5	28.6	2 in 30	2 in 45
46	55.6	59.8	2 in 30	2 in 45
38.6	31.8	47.1	1 in 30	1 in 45
21.9	23.1	31.5	1 in 30	1 in 45
38.8	47.7	48.4	1 in 30	1 in 45
5.5	12	13.2	2 in 30	2 in 45
5.5	12	13.2	2 in 30	2 in 45
36.2	43.6	45.8	2 in 30	2 in 45
13.4	23	23.1	2 in 30	2 in 45
23.2	26.2	33.9	2 in 30	2 in 45
33.5	44.4	45.4	1 in 30	1 in 45
13.6	25	25.5	2 in 30	2 in 45
37.4	49.8	49.8	1 in 30	1 in 45
13.1	17.4	22.6	2 in 30	2 in 45
30.9	44.5	44.5	2 in 30	2 in 45
71.9	85	85	1 in 30	1 in 45
23.3	26.2	34.1	2 in 30	2 in 45
32	33.4	44.5	1 in 30	1 in 45
21.4	22.9	31.6	2 in 30	2 in 45
13.3	23.4	23.4	2 in 30	2 in 45
23	34.1	34.1	2 in 30	2 in 45
23.3	26.2	34.1	1 in 30	1 in 45
29.4	39	44.6	1 in 30	1 in 45
63.5	56	80.4	1 in 30	1 in 45
5.7	14.1	14.1	2 in 30	2 in 45
5.8	14.1	14.1	2 in 30	2 in 45
25.7	33.7	43.9	2 in 30	2 in 45
12.8	24.1	24.6	2 in 30	2 in 45
28.7	39	56.2	2 in 30	2 in 45

28.6	43.7	54.5	1 in 30	1 in 45
23.8	39.1	39.1	2 in 30	2 in 45
28.5	55.8	55.8	1 in 30	1 in 45
9.6	14.5	26.7	2 in 30	2 in 45
28.6	41	56	2 in 30	2 in 45
131.1	56.2	186	1 in 30	1 in 45
28.5	55.8	55.8	2 in 30	2 in 45
24.6	37.4	43.8	1 in 30	1 in 45
11.4	24.1	25.2	2 in 30	2 in 45
18.2	29.3	33.9	2 in 30	2 in 45
23.9	39.4	39.4	2 in 30	2 in 45
30.1	56.5	56.5	1 in 30	1 in 45
25.1	21.7	35.6	1 in 30	1 in 45
44.4	47.5	57.3	1 in 30	1 in 45
6.1	14.1	15.1	2 in 30	2 in 45
6.1	14.1	15.1	2 in 30	2 in 45
39.1	43	49.9	2 in 30	2 in 45
10.9	21.7	21.7	2 in 30	2 in 45
43.3	49.5	52.5	2 in 30	2 in 45
64.8	75.6	79.4	1 in 30	1 in 45
40.1	49.5	49.5	2 in 30	2 in 45
53.4	61.3	62.8	1 in 30	1 in 45
31	32.1	44.6	2 in 30	2 in 45
50.7	61.4	61.4	2 in 30	2 in 45
103.6	106.8	118.9	1 in 30	1 in 45
42.8	49.6	55.9	2 in 30	2 in 45
52.5	49.9	62.1	1 in 30	1 in 45
13.8	22	26.8	2 in 30	2 in 45
10.9	21.7	21.7	2 in 30	2 in 45
26.5	35.2	37.7	2 in 30	2 in 45
42	39.3	49.8	1 in 30	1 in 45
24.1	30.4	36	1 in 30	1 in 45
19.2	29.8	31.3	1 in 30	1 in 45
10.9	14.6	18.3	2 in 30	2 in 45
11.2	18.3	18.3	2 in 30	2 in 45
17.7	23.3	26.8	2 in 30	2 in 45
16.9	22.8	25.5	2 in 30	2 in 45
22.4	29.8	33.2	2 in 30	2 in 45
34.1	29.1	50.8	1 in 30	1 in 45
17.9	29.8	29.8	2 in 30	2 in 45
41.2	33.1	60.8	1 in 30	1 in 45
18.8	30	30.3	2 in 30	2 in 45
19.2	30.6	31.8	2 in 30	2 in 45
47.5	71.6	71.6	1 in 30	1 in 45
18.1	29.8	29.8	2 in 30	2 in 45
36.7	30.6	58.4	1 in 30	1 in 45
23.1	25.6	30	2 in 30	2 in 45

15.8	22.5	27.4	2 in 30	2 in 45
37.9	54.1	59.7	2 in 30	2 in 45
28.5	29.8	35.8	1 in 30	1 in 45
33	27.7	41.3	1 in 30	1 in 45
38.5	36	48	1 in 30	1 in 45
11.8	15.7	15.8	2 in 30	2 in 45
11.8	15.9	15.9	2 in 30	2 in 45
21.5	24.5	29.7	2 in 30	2 in 45
16.3	18	26	2 in 30	2 in 45
16.8	24.5	24.5	2 in 30	2 in 45
42.5	52	52	1 in 30	1 in 45
38.8	49.2	49.2	2 in 30	2 in 45
40.3	49.8	49.8	1 in 30	1 in 45
38.8	47.5	49.2	2 in 30	2 in 45
40.7	50.2	50.4	2 in 30	2 in 45
109.8	112.9	122	1 in 30	1 in 45
19.4	26.5	26.5	2 in 30	2 in 45
37.8	42.3	46.7	1 in 30	1 in 45
17.6	26.8	27.3	2 in 30	2 in 45
21.7	29.5	29.5	2 in 30	2 in 45
38.4	26.5	47	2 in 30	2 in 45
40.6	49.2	50.2	1 in 30	1 in 45
40.6	30.6	56.1	1 in 30	1 in 45
15.4	25	35.2	1 in 30	1 in 45
5	15.3	15.5	2 in 30	2 in 45
6.1	15.3	20	2 in 30	2 in 45
8.3	20.2	22.8	2 in 30	2 in 45
7.7	16.9	19.4	2 in 30	2 in 45
8.7	28.4	28.4	2 in 30	2 in 45
14.3	31.7	31.7	1 in 30	1 in 45
11.7	28.1	28.2	2 in 30	2 in 45
11.8	28.8	28.8	1 in 30	1 in 45
12.3	28.1	29.2	2 in 30	2 in 45
12.6	29	30.8	2 in 30	2 in 45
126.7	156.6	156.6	1 in 30	1 in 45
11.6	25.8	25.8	2 in 30	2 in 45
14.2	23.6	28.1	1 in 30	1 in 45
11.1	21.8	26.7	2 in 30	2 in 45
5.4	15.8	15.9	2 in 30	2 in 45
11.7	28.2	28.2	2 in 30	2 in 45
12.2	28.1	29.2	1 in 30	1 in 45
29.8	26.8	41.8	1 in 30	1 in 45
32.6	49.7	54	1 in 30	1 in 45
6.7	15	16.4	2 in 30	2 in 45
6.3	16.5	16.5	2 in 30	2 in 45
10.7	16.9	19	2 in 30	2 in 45
20.2	20.5	25.7	2 in 30	2 in 45
32.2	42	51.1	2 in 30	2 in 45

40.6	51.6	58.4	1 in 30	1 in 45
28.1	25.9	41	2 in 30	2 in 45
32.7	51.3	52.8	1 in 30	1 in 45
30.6	27.3	42.5	2 in 30	2 in 45
35.3	39.8	51.6	2 in 30	2 in 45
119.7	63.4	143	1 in 30	1 in 45
32.2	51.1	51.2	2 in 30	2 in 45
34.1	41.2	51.4	1 in 30	1 in 45
22.2	26	27.4	2 in 30	2 in 45
37.4	41.5	48	2 in 30	2 in 45
20.2	25.8	29.7	2 in 30	2 in 45
32.3	51.1	51.3	1 in 30	1 in 45

Rural Standard (Minutes)	Required P to M Ratio	Access Score > 85%	P to M Ratio Score	All Provider Access %
1 in 60	1 : 1,000	PASS	PASS	
1 in 60	1 : 1,000	PASS	*FAIL*	
2 in 60	1 : 1,000	PASS	PASS	
2 in 60	1 : 1,000	PASS	PASS	
2 in 60	1 : 1,000	PASS	PASS	
2 in 60	1 : 1,000	PASS	PASS	
2 in 60	1 : 5,000	PASS	PASS	
1 in 60	1 : 5,000	PASS	*FAIL*	
2 in 60	1 : 5,000	PASS	*FAIL*	
1 in 60	1 : 5,000	PASS	*FAIL*	**100.0**
2 in 60	1 : 1,000	PASS	*FAIL*	
2 in 60	1 : 5,000	PASS	*FAIL*	
1 in 60	1 : 5,000	PASS	*FAIL*	
2 in 60	1 : 5,000	PASS	*FAIL*	
1 in 60	1 : 5,000	PASS	*FAIL*	
2 in 60	1 : 1,000	PASS	*FAIL*	
2 in 60	1 : 5,000	PASS	*FAIL*	
2 in 60	1 : 5,000	PASS	*FAIL*	
1 in 60	1 : 5,000	PASS	*FAIL*	
1 in 60	1 : 1,000	PASS	*FAIL*	
1 in 60	1 : 1,000	PASS	*FAIL*	
2 in 60	1 : 1,000	PASS	PASS	
2 in 60	1 : 1,000	PASS	PASS	
2 in 60	1 : 1,000	*FAIL*	*FAIL*	
2 in 60	1 : 1,000	PASS	PASS	
2 in 60	1 : 5,000	PASS	PASS	
1 in 60	1 : 5,000	PASS	PASS	
2 in 60	1 : 5,000	PASS	PASS	
1 in 60	1 : 5,000	PASS	PASS	**89.9**
2 in 60	1 : 1,000	PASS	PASS	
2 in 60	1 : 5,000	PASS	PASS	
1 in 60	1 : 5,000	*FAIL*	*FAIL*	
2 in 60	1 : 5,000	PASS	PASS	
1 in 60	1 : 5,000	PASS	PASS	
2 in 60	1 : 1,000	PASS	PASS	

2 in 60	1 : 5,000	PASS	PASS	
2 in 60	1 : 5,000	FAIL	FAIL	
1 in 60	1 : 5,000	PASS	PASS	
1 in 60	1 : 1,000	PASS	FAIL	
1 in 60	1 : 1,000	PASS	FAIL	
2 in 60	1 : 1,000	PASS	FAIL	
2 in 60	1 : 1,000	PASS	FAIL	
2 in 60	1 : 1,000	PASS	FAIL	
2 in 60	1 : 1,000	PASS	FAIL	
2 in 60	1 : 5,000	PASS	FAIL	
1 in 60	1 : 5,000	PASS	FAIL	
2 in 60	1 : 5,000	PASS	FAIL	
1 in 60	1 : 5,000	PASS	FAIL	93.8
2 in 60	1 : 1,000	PASS	FAIL	
2 in 60	1 : 5,000	PASS	FAIL	
1 in 60	1 : 5,000	FAIL	FAIL	
2 in 60	1 : 5,000	PASS	FAIL	
1 in 60	1 : 5,000	PASS	FAIL	
2 in 60	1 : 1,000	PASS	FAIL	
2 in 60	1 : 5,000	PASS	FAIL	
2 in 60	1 : 5,000	PASS	FAIL	
1 in 60	1 : 5,000	PASS	FAIL	
1 in 60	1 : 1,000	PASS	FAIL	
1 in 60	1 : 1,000	PASS	FAIL	
2 in 60	1 : 1,000	PASS	PASS	
2 in 60	1 : 1,000	PASS	PASS	
2 in 60	1 : 1,000	PASS	FAIL	
2 in 60	1 : 1,000	PASS	FAIL	
2 in 60	1 : 5,000	PASS	FAIL	
1 in 60	1 : 5,000	FAIL	FAIL	
2 in 60	1 : 5,000	PASS	FAIL	
1 in 60	1 : 5,000	FAIL	FAIL	85.4
2 in 60	1 : 1,000	PASS	FAIL	
2 in 60	1 : 5,000	FAIL	FAIL	
1 in 60	1 : 5,000	FAIL	FAIL	
2 in 60	1 : 5,000	PASS	FAIL	
1 in 60	1 : 5,000	PASS	FAIL	
2 in 60	1 : 1,000	PASS	FAIL	
2 in 60	1 : 5,000	PASS	FAIL	
2 in 60	1 : 5,000	PASS	PASS	
1 in 60	1 : 5,000	PASS	FAIL	
1 in 60	1 : 1,000	PASS	FAIL	
1 in 60	1 : 1,000	PASS	FAIL	
2 in 60	1 : 1,000	PASS	PASS	
2 in 60	1 : 1,000	PASS	PASS	
2 in 60	1 : 1,000	PASS	FAIL	
2 in 60	1 : 1,000	PASS	PASS	
2 in 60	1 : 5,000	PASS	PASS	

1 in 60	1 : 5,000	PASS	FAIL	
2 in 60	1 : 5,000	PASS	FAIL	
1 in 60	1 : 5,000	FAIL	FAIL	**91.8**
2 in 60	1 : 1,000	PASS	FAIL	
2 in 60	1 : 5,000	PASS	FAIL	
1 in 60	1 : 5,000	FAIL	FAIL	
2 in 60	1 : 5,000	PASS	FAIL	
1 in 60	1 : 5,000	PASS	FAIL	
2 in 60	1 : 1,000	PASS	PASS	
2 in 60	1 : 5,000	PASS	PASS	
2 in 60	1 : 5,000	FAIL	FAIL	
1 in 60	1 : 5,000	PASS	FAIL	
1 in 60	1 : 1,000	PASS	FAIL	
1 in 60	1 : 1,000	PASS	FAIL	
2 in 60	1 : 1,000	PASS	PASS	
2 in 60	1 : 1,000	PASS	PASS	
2 in 60	1 : 1,000	PASS	PASS	
2 in 60	1 : 1,000	PASS	PASS	
2 in 60	1 : 5,000	PASS	PASS	
1 in 60	1 : 5,000	PASS	PASS	
2 in 60	1 : 5,000	PASS	PASS	
1 in 60	1 : 5,000	PASS	PASS	**99.8**
2 in 60	1 : 1,000	PASS	PASS	
2 in 60	1 : 5,000	PASS	PASS	
1 in 60	1 : 5,000	PASS	FAIL	
2 in 60	1 : 5,000	PASS	PASS	
1 in 60	1 : 5,000	PASS	PASS	
2 in 60	1 : 1,000	PASS	PASS	
2 in 60	1 : 5,000	PASS	PASS	
2 in 60	1 : 5,000	PASS	PASS	
1 in 60	1 : 5,000	PASS	PASS	
1 in 60	1 : 1,000	PASS	FAIL	
1 in 60	1 : 1,000	PASS	FAIL	
2 in 60	1 : 1,000	PASS	PASS	
2 in 60	1 : 1,000	PASS	PASS	
2 in 60	1 : 1,000	PASS	FAIL	
2 in 60	1 : 1,000	PASS	PASS	
2 in 60	1 : 5,000	PASS	FAIL	
1 in 60	1 : 5,000	FAIL	FAIL	
2 in 60	1 : 5,000	PASS	FAIL	
1 in 60	1 : 5,000	FAIL	FAIL	**80.8**
2 in 60	1 : 1,000	PASS	FAIL	
2 in 60	1 : 5,000	FAIL	FAIL	
1 in 60	1 : 5,000	FAIL	FAIL	
2 in 60	1 : 5,000	PASS	FAIL	
1 in 60	1 : 5,000	PASS	FAIL	
2 in 60	1 : 1,000	PASS	PASS	

2 in 60	1 : 5,000	PASS	FAIL	
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1 in 60	1 : 1,000	PASS	FAIL	
1 in 60	1 : 1,000	PASS	FAIL	
2 in 60	1 : 1,000	PASS	PASS	
2 in 60	1 : 1,000	PASS	PASS	
2 in 60	1 : 1,000	PASS	FAIL	
2 in 60	1 : 1,000	PASS	FAIL	
2 in 60	1 : 5,000	PASS	FAIL	
1 in 60	1 : 5,000	FAIL	FAIL	
2 in 60	1 : 5,000	PASS	FAIL	
1 in 60	1 : 5,000	FAIL	FAIL	88.2
2 in 60	1 : 1,000	PASS	FAIL	
2 in 60	1 : 5,000	FAIL	FAIL	
1 in 60	1 : 5,000	FAIL	FAIL	
2 in 60	1 : 5,000	PASS	FAIL	
1 in 60	1 : 5,000	PASS	FAIL	
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1 in 60	1 : 1,000	PASS	FAIL	
2 in 60	1 : 1,000	PASS	PASS	
2 in 60	1 : 1,000	PASS	PASS	
2 in 60	1 : 1,000	PASS	PASS	
2 in 60	1 : 1,000	PASS	PASS	
2 in 60	1 : 5,000	PASS	FAIL	
1 in 60	1 : 5,000	PASS	FAIL	
2 in 60	1 : 5,000	PASS	FAIL	
1 in 60	1 : 5,000	PASS	FAIL	95.2
2 in 60	1 : 1,000	PASS	FAIL	
2 in 60	1 : 5,000	PASS	FAIL	
1 in 60	1 : 5,000	FAIL	FAIL	
2 in 60	1 : 5,000	PASS	FAIL	
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2 in 60	1 : 1,000	PASS	PASS	
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2 in 60	1 : 1,000	PASS	FAIL	
2 in 60	1 : 1,000	PASS	PASS	
2 in 60	1 : 5,000	PASS	FAIL	

1 in 60	1 : 5,000	PASS	FAIL	
2 in 60	1 : 5,000	PASS	FAIL	
1 in 60	1 : 5,000	PASS	FAIL	93.3
2 in 60	1 : 1,000	PASS	FAIL	
2 in 60	1 : 5,000	FAIL	FAIL	
1 in 60	1 : 5,000	FAIL	FAIL	
2 in 60	1 : 5,000	PASS	FAIL	
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2 in 60	1 : 1,000	PASS	PASS	
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2 in 60	1 : 1,000	PASS	FAIL	
2 in 60	1 : 1,000	PASS	FAIL	
2 in 60	1 : 5,000	PASS	FAIL	
1 in 60	1 : 5,000	FAIL	FAIL	
2 in 60	1 : 5,000	PASS	FAIL	
1 in 60	1 : 5,000	FAIL	FAIL	85.4
2 in 60	1 : 1,000	PASS	FAIL	
2 in 60	1 : 5,000	FAIL	FAIL	
1 in 60	1 : 5,000	FAIL	FAIL	
2 in 60	1 : 5,000	PASS	FAIL	
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2 in 60	1 : 1,000	PASS	PASS	
2 in 60	1 : 5,000	PASS	FAIL	
1 in 60	1 : 5,000	PASS	FAIL	
2 in 60	1 : 5,000	PASS	FAIL	
1 in 60	1 : 5,000	FAIL	FAIL	88.5
2 in 60	1 : 1,000	PASS	FAIL	
2 in 60	1 : 5,000	PASS	FAIL	
1 in 60	1 : 5,000	FAIL	FAIL	
2 in 60	1 : 5,000	PASS	FAIL	
1 in 60	1 : 5,000	PASS	FAIL	
2 in 60	1 : 1,000	PASS	FAIL	

2 in 60	1 : 5,000	PASS	PASS	
2 in 60	1 : 5,000	PASS	PASS	
1 in 60	1 : 5,000	PASS	FAIL	
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1 in 60	1 : 1,000	PASS	PASS	
2 in 60	1 : 1,000	PASS	PASS	
2 in 60	1 : 1,000	PASS	PASS	
2 in 60	1 : 1,000	PASS	FAIL	
2 in 60	1 : 1,000	PASS	PASS	
2 in 60	1 : 5,000	PASS	PASS	
1 in 60	1 : 5,000	PASS	FAIL	
2 in 60	1 : 5,000	PASS	PASS	
1 in 60	1 : 5,000	PASS	PASS	94.1
2 in 60	1 : 1,000	PASS	PASS	
2 in 60	1 : 5,000	PASS	PASS	
1 in 60	1 : 5,000	FAIL	FAIL	
2 in 60	1 : 5,000	PASS	PASS	
1 in 60	1 : 5,000	PASS	PASS	
2 in 60	1 : 1,000	PASS	PASS	
2 in 60	1 : 5,000	PASS	PASS	
2 in 60	1 : 5,000	PASS	PASS	
1 in 60	1 : 5,000	PASS	PASS	
1 in 60	1 : 1,000	PASS	FAIL	
1 in 60	1 : 1,000	PASS	FAIL	
2 in 60	1 : 1,000	PASS	PASS	
2 in 60	1 : 1,000	PASS	FAIL	
2 in 60	1 : 1,000	PASS	FAIL	
2 in 60	1 : 1,000	PASS	PASS	
2 in 60	1 : 5,000	PASS	FAIL	
1 in 60	1 : 5,000	PASS	PASS	
2 in 60	1 : 5,000	PASS	PASS	
1 in 60	1 : 5,000	PASS	FAIL	91.9
2 in 60	1 : 1,000	PASS	FAIL	
2 in 60	1 : 5,000	PASS	FAIL	
1 in 60	1 : 5,000	FAIL	FAIL	
2 in 60	1 : 5,000	PASS	FAIL	
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2 in 60	1 : 1,000	PASS	PASS	
2 in 60	1 : 1,000	PASS	PASS	
2 in 60	1 : 1,000	PASS	PASS	
2 in 60	1 : 1,000	PASS	PASS	
2 in 60	1 : 5,000	PASS	PASS	

1 in 60	1 : 5,000	PASS	PASS	
2 in 60	1 : 5,000	PASS	PASS	
1 in 60	1 : 5,000	FAIL	FAIL	88.9
2 in 60	1 : 1,000	PASS	PASS	
2 in 60	1 : 5,000	PASS	PASS	
1 in 60	1 : 5,000	FAIL	FAIL	
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1 in 60	1 : 5,000	PASS	PASS	
2 in 60	1 : 1,000	PASS	PASS	
2 in 60	1 : 5,000	PASS	PASS	
2 in 60	1 : 5,000	FAIL	FAIL	
1 in 60	1 : 5,000	PASS	PASS	
1 in 60	1 : 1,000	PASS	FAIL	
1 in 60	1 : 1,000	PASS	FAIL	
2 in 60	1 : 1,000	PASS	PASS	
2 in 60	1 : 1,000	PASS	PASS	
2 in 60	1 : 1,000	PASS	FAIL	
2 in 60	1 : 1,000	PASS	FAIL	
2 in 60	1 : 5,000	FAIL	FAIL	
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2 in 60	1 : 5,000	PASS	FAIL	
1 in 60	1 : 5,000	FAIL	FAIL	67.0
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2 in 60	1 : 5,000	FAIL	FAIL	
1 in 60	1 : 5,000	FAIL	FAIL	
2 in 60	1 : 5,000	FAIL	FAIL	
1 in 60	1 : 5,000	FAIL	FAIL	
2 in 60	1 : 1,000	PASS	FAIL	
2 in 60	1 : 5,000	PASS	FAIL	
2 in 60	1 : 5,000	PASS	FAIL	
1 in 60	1 : 5,000	FAIL	FAIL	
1 in 60	1 : 1,000	PASS	FAIL	
1 in 60	1 : 1,000	PASS	FAIL	
2 in 60	1 : 1,000	PASS	PASS	
2 in 60	1 : 1,000	PASS	PASS	
2 in 60	1 : 1,000	PASS	FAIL	
2 in 60	1 : 1,000	PASS	PASS	
2 in 60	1 : 5,000	PASS	PASS	
1 in 60	1 : 5,000	PASS	PASS	
2 in 60	1 : 5,000	PASS	PASS	
1 in 60	1 : 5,000	PASS	PASS	96.9
2 in 60	1 : 1,000	PASS	PASS	
2 in 60	1 : 5,000	PASS	PASS	
1 in 60	1 : 5,000	FAIL	FAIL	
2 in 60	1 : 5,000	PASS	PASS	
1 in 60	1 : 5,000	PASS	PASS	
2 in 60	1 : 1,000	PASS	PASS	

2 in 60	1 : 5,000	PASS	PASS	
2 in 60	1 : 5,000	PASS	*FAIL*	
1 in 60	1 : 5,000	PASS	PASS	
1 in 60	1 : 1,000	PASS	*FAIL*	
1 in 60	1 : 1,000	PASS	*FAIL*	
2 in 60	1 : 1,000	PASS	PASS	
2 in 60	1 : 1,000	PASS	PASS	
2 in 60	1 : 1,000	PASS	PASS	
2 in 60	1 : 1,000	PASS	PASS	
2 in 60	1 : 5,000	PASS	PASS	
1 in 60	1 : 5,000	PASS	*FAIL*	
2 in 60	1 : 5,000	PASS	*FAIL*	
1 in 60	1 : 5,000	PASS	*FAIL*	**93.6**
2 in 60	1 : 1,000	PASS	*FAIL*	
2 in 60	1 : 5,000	PASS	*FAIL*	
1 in 60	1 : 5,000	*FAIL*	*FAIL*	
2 in 60	1 : 5,000	PASS	PASS	
1 in 60	1 : 5,000	PASS	PASS	
2 in 60	1 : 1,000	PASS	*FAIL*	
2 in 60	1 : 5,000	PASS	PASS	
2 in 60	1 : 5,000	PASS	*FAIL*	
1 in 60	1 : 5,000	PASS	*FAIL*	
1 in 60	1 : 1,000	PASS	*FAIL*	
1 in 60	1 : 1,000	PASS	*FAIL*	
2 in 60	1 : 1,000	PASS	PASS	
2 in 60	1 : 1,000	PASS	PASS	
2 in 60	1 : 1,000	*FAIL*	*FAIL*	
2 in 60	1 : 1,000	PASS	PASS	
2 in 60	1 : 5,000	PASS	PASS	
1 in 60	1 : 5,000	PASS	PASS	
2 in 60	1 : 5,000	PASS	PASS	
1 in 60	1 : 5,000	PASS	*FAIL*	**87.5**
2 in 60	1 : 1,000	PASS	PASS	
2 in 60	1 : 5,000	PASS	*FAIL*	
1 in 60	1 : 5,000	*FAIL*	*FAIL*	
2 in 60	1 : 5,000	PASS	PASS	
1 in 60	1 : 5,000	PASS	PASS	
2 in 60	1 : 1,000	PASS	PASS	
2 in 60	1 : 5,000	PASS	PASS	
2 in 60	1 : 5,000	*FAIL*	PASS	
1 in 60	1 : 5,000	PASS	PASS	
1 in 60	1 : 1,000	PASS	*FAIL*	
1 in 60	1 : 1,000	PASS	*FAIL*	
2 in 60	1 : 1,000	PASS	PASS	
2 in 60	1 : 1,000	PASS	PASS	
2 in 60	1 : 1,000	*FAIL*	*FAIL*	
2 in 60	1 : 1,000	PASS	PASS	
2 in 60	1 : 5,000	PASS	PASS	

1 in 60	1 : 5,000	PASS	FAIL	
2 in 60	1 : 5,000	PASS	PASS	
1 in 60	1 : 5,000	PASS	PASS	83.9
2 in 60	1 : 1,000	PASS	PASS	
2 in 60	1 : 5,000	PASS	PASS	
1 in 60	1 : 5,000	FAIL	FAIL	
2 in 60	1 : 5,000	PASS	PASS	
1 in 60	1 : 5,000	PASS	PASS	
2 in 60	1 : 1,000	PASS	PASS	
2 in 60	1 : 5,000	PASS	PASS	
2 in 60	1 : 5,000	PASS	PASS	
1 in 60	1 : 5,000	FAIL	FAIL	
1 in 60	1 : 1,000	PASS	FAIL	
1 in 60	1 : 1,000	PASS	FAIL	
2 in 60	1 : 1,000	PASS	PASS	
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2 in 60	1 : 1,000	PASS	FAIL	
2 in 60	1 : 1,000	PASS	PASS	
2 in 60	1 : 5,000	PASS	PASS	
1 in 60	1 : 5,000	PASS	FAIL	
2 in 60	1 : 5,000	PASS	PASS	
1 in 60	1 : 5,000	PASS	FAIL	93.8
2 in 60	1 : 1,000	PASS	PASS	
2 in 60	1 : 5,000	PASS	FAIL	
1 in 60	1 : 5,000	FAIL	FAIL	
2 in 60	1 : 5,000	PASS	PASS	
1 in 60	1 : 5,000	PASS	PASS	
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2 in 60	1 : 5,000	PASS	PASS	
2 in 60	1 : 5,000	PASS	PASS	
1 in 60	1 : 5,000	PASS	PASS	
1 in 60	1 : 1,000	PASS	FAIL	
1 in 60	1 : 1,000	PASS	FAIL	
2 in 60	1 : 1,000	PASS	PASS	
2 in 60	1 : 1,000	PASS	PASS	
2 in 60	1 : 1,000	PASS	FAIL	
2 in 60	1 : 1,000	PASS	FAIL	
2 in 60	1 : 5,000	PASS	FAIL	
1 in 60	1 : 5,000	PASS	FAIL	
2 in 60	1 : 5,000	PASS	FAIL	
1 in 60	1 : 5,000	PASS	FAIL	99.8
2 in 60	1 : 1,000	PASS	PASS	
2 in 60	1 : 5,000	PASS	FAIL	
1 in 60	1 : 5,000	PASS	FAIL	
2 in 60	1 : 5,000	PASS	FAIL	
1 in 60	1 : 5,000	PASS	FAIL	
2 in 60	1 : 1,000	PASS	FAIL	

2 in 60	1 : 5,000	PASS	PASS	
2 in 60	1 : 5,000	PASS	*FAIL*	
1 in 60	1 : 5,000	PASS	*FAIL*	
1 in 60	1 : 1,000	PASS	*FAIL*	
1 in 60	1 : 1,000	PASS	*FAIL*	
2 in 60	1 : 1,000	PASS	PASS	
2 in 60	1 : 1,000	PASS	PASS	
2 in 60	1 : 1,000	PASS	*FAIL*	
2 in 60	1 : 1,000	PASS	*FAIL*	
2 in 60	1 : 5,000	PASS	*FAIL*	
1 in 60	1 : 5,000	PASS	*FAIL*	
2 in 60	1 : 5,000	PASS	*FAIL*	
1 in 60	1 : 5,000	PASS	*FAIL*	**93.8**
2 in 60	1 : 1,000	PASS	*FAIL*	
2 in 60	1 : 5,000	PASS	*FAIL*	
1 in 60	1 : 5,000	*FAIL*	*FAIL*	
2 in 60	1 : 5,000	PASS	*FAIL*	
1 in 60	1 : 5,000	PASS	*FAIL*	
2 in 60	1 : 1,000	PASS	*FAIL*	
2 in 60	1 : 5,000	PASS	PASS	
2 in 60	1 : 5,000	PASS	PASS	
1 in 60	1 : 5,000	PASS	*FAIL*	
1 in 60	1 : 1,000	PASS	*FAIL*	
1 in 60	1 : 1,000	PASS	*FAIL*	
2 in 60	1 : 1,000	PASS	PASS	
2 in 60	1 : 1,000	PASS	PASS	
2 in 60	1 : 1,000	PASS	*FAIL*	
2 in 60	1 : 1,000	PASS	PASS	
2 in 60	1 : 5,000	PASS	PASS	
1 in 60	1 : 5,000	PASS	PASS	
2 in 60	1 : 5,000	PASS	PASS	
1 in 60	1 : 5,000	PASS	*FAIL*	**100.0**
2 in 60	1 : 1,000	PASS	*FAIL*	
2 in 60	1 : 5,000	PASS	PASS	
1 in 60	1 : 5,000	PASS	*FAIL*	
2 in 60	1 : 5,000	PASS	PASS	
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2 in 60	1 : 1,000	PASS	PASS	
2 in 60	1 : 5,000	PASS	PASS	
2 in 60	1 : 5,000	PASS	PASS	
1 in 60	1 : 5,000	PASS	PASS	
1 in 60	1 : 1,000	PASS	*FAIL*	
1 in 60	1 : 1,000	PASS	*FAIL*	
2 in 60	1 : 1,000	PASS	PASS	
2 in 60	1 : 1,000	PASS	PASS	
2 in 60	1 : 1,000	PASS	PASS	
2 in 60	1 : 1,000	PASS	PASS	
2 in 60	1 : 5,000	PASS	PASS	

1 in 60	1 : 5,000	PASS	FAIL	
2 in 60	1 : 5,000	PASS	PASS	
1 in 60	1 : 5,000	PASS	FAIL	96.5
2 in 60	1 : 1,000	PASS	PASS	
2 in 60	1 : 5,000	PASS	PASS	
1 in 60	1 : 5,000	FAIL	FAIL	
2 in 60	1 : 5,000	PASS	PASS	
1 in 60	1 : 5,000	PASS	FAIL	
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2 in 60	1 : 5,000	PASS	PASS	
1 in 60	1 : 5,000	PASS	PASS	
1 in 60	1 : 1,000	PASS	FAIL	
1 in 60	1 : 1,000	PASS	FAIL	
2 in 60	1 : 1,000	PASS	PASS	
2 in 60	1 : 1,000	PASS	PASS	
2 in 60	1 : 1,000	PASS	FAIL	
2 in 60	1 : 1,000	PASS	PASS	
2 in 60	1 : 5,000	PASS	PASS	
1 in 60	1 : 5,000	PASS	FAIL	
2 in 60	1 : 5,000	PASS	PASS	
1 in 60	1 : 5,000	PASS	PASS	91.9
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2 in 60	1 : 5,000	PASS	PASS	
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1 in 60	1 : 1,000	PASS	FAIL	
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1 in 60	1 : 5,000	PASS	FAIL	
2 in 60	1 : 5,000	PASS	FAIL	
1 in 60	1 : 5,000	PASS	FAIL	100.0
2 in 60	1 : 1,000	PASS	FAIL	
2 in 60	1 : 5,000	PASS	FAIL	
1 in 60	1 : 5,000	PASS	FAIL	
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2 in 60	1 : 1,000	PASS	FAIL	

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1 in 60	1 : 5,000	PASS	PASS	
2 in 60	1 : 5,000	PASS	PASS	
1 in 60	1 : 5,000	PASS	PASS	100.0
2 in 60	1 : 1,000	PASS	PASS	
2 in 60	1 : 5,000	PASS	PASS	
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2 in 60	1 : 5,000	PASS	PASS	
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2 in 60	1 : 5,000	PASS	PASS	
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1 in 60	1 : 1,000	PASS	FAIL	
2 in 60	1 : 1,000	PASS	PASS	
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1 in 60	1 : 5,000	FAIL	FAIL	74.7
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2 in 60	1 : 5,000	PASS	FAIL	
2 in 60	1 : 5,000	PASS	PASS	
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1 in 60	1 : 1,000	FAIL	FAIL	
2 in 60	1 : 1,000	PASS	PASS	
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2 in 60	1 : 1,000	PASS	FAIL	
2 in 60	1 : 1,000	PASS	FAIL	
2 in 60	1 : 5,000	FAIL	FAIL	

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1 in 60	1 : 5,000	FAIL	FAIL	68.0
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1 in 60	1 : 5,000	PASS	PASS	100.0
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2 in 60	1 : 5,000	PASS	PASS	
1 in 60	1 : 5,000	PASS	PASS	
2 in 60	1 : 5,000	PASS	PASS	
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2 in 60	1 : 5,000	PASS	PASS	
2 in 60	1 : 5,000	PASS	PASS	
1 in 60	1 : 5,000	PASS	PASS	
1 in 60	1 : 1,000	PASS	FAIL	
1 in 60	1 : 1,000	PASS	FAIL	
2 in 60	1 : 1,000	PASS	PASS	
2 in 60	1 : 1,000	PASS	PASS	
2 in 60	1 : 1,000	PASS	FAIL	
2 in 60	1 : 1,000	PASS	FAIL	
2 in 60	1 : 5,000	PASS	FAIL	
1 in 60	1 : 5,000	PASS	FAIL	
2 in 60	1 : 5,000	PASS	FAIL	
1 in 60	1 : 5,000	PASS	FAIL	98.8
2 in 60	1 : 1,000	PASS	FAIL	
2 in 60	1 : 5,000	PASS	FAIL	
1 in 60	1 : 5,000	PASS	FAIL	
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2 in 60	1 : 1,000	PASS	FAIL	

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2 in 60	1 : 5,000	PASS	FAIL	
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1 in 60	1 : 1,000	PASS	PASS	
2 in 60	1 : 1,000	PASS	PASS	
2 in 60	1 : 1,000	PASS	PASS	
2 in 60	1 : 1,000	PASS	FAIL	
2 in 60	1 : 1,000	PASS	PASS	
2 in 60	1 : 5,000	PASS	PASS	
1 in 60	1 : 5,000	PASS	PASS	
2 in 60	1 : 5,000	PASS	PASS	
1 in 60	1 : 5,000	PASS	FAIL	93.8
2 in 60	1 : 1,000	PASS	FAIL	
2 in 60	1 : 5,000	PASS	FAIL	
1 in 60	1 : 5,000	FAIL	FAIL	
2 in 60	1 : 5,000	PASS	FAIL	
1 in 60	1 : 5,000	PASS	FAIL	
2 in 60	1 : 1,000	PASS	PASS	
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2 in 60	1 : 1,000	PASS	FAIL	
2 in 60	1 : 1,000	PASS	FAIL	
2 in 60	1 : 5,000	PASS	FAIL	
1 in 60	1 : 5,000	FAIL	FAIL	
2 in 60	1 : 5,000	PASS	FAIL	
1 in 60	1 : 5,000	PASS	FAIL	90.8
2 in 60	1 : 1,000	PASS	FAIL	
2 in 60	1 : 5,000	PASS	FAIL	
1 in 60	1 : 5,000	FAIL	FAIL	
2 in 60	1 : 5,000	PASS	FAIL	
1 in 60	1 : 5,000	PASS	FAIL	
2 in 60	1 : 1,000	PASS	PASS	
2 in 60	1 : 5,000	PASS	FAIL	
2 in 60	1 : 5,000	PASS	PASS	
1 in 60	1 : 5,000	PASS	PASS	
1 in 60	1 : 1,000	PASS	PASS	
1 in 60	1 : 1,000	PASS	PASS	
2 in 60	1 : 1,000	PASS	PASS	
2 in 60	1 : 1,000	PASS	PASS	
2 in 60	1 : 1,000	PASS	PASS	
2 in 60	1 : 1,000	PASS	PASS	
2 in 60	1 : 5,000	PASS	PASS	

1 in 60	1 : 5,000	PASS	PASS	
2 in 60	1 : 5,000	PASS	PASS	
1 in 60	1 : 5,000	PASS	PASS	**93.8**
2 in 60	1 : 1,000	PASS	PASS	
2 in 60	1 : 5,000	PASS	PASS	
1 in 60	1 : 5,000	*FAIL*	*FAIL*	
2 in 60	1 : 5,000	PASS	PASS	
1 in 60	1 : 5,000	PASS	PASS	
2 in 60	1 : 1,000	PASS	PASS	
2 in 60	1 : 5,000	PASS	PASS	
2 in 60	1 : 5,000	PASS	PASS	
1 in 60	1 : 5,000	PASS	PASS	
1 in 60	1 : 1,000	PASS	*FAIL*	
1 in 60	1 : 1,000	*FAIL*	*FAIL*	
2 in 60	1 : 1,000	PASS	PASS	
2 in 60	1 : 1,000	PASS	PASS	
2 in 60	1 : 1,000	*FAIL*	*FAIL*	
2 in 60	1 : 1,000	PASS	*FAIL*	
2 in 60	1 : 5,000	PASS	*FAIL*	
1 in 60	1 : 5,000	PASS	PASS	
2 in 60	1 : 5,000	PASS	*FAIL*	
1 in 60	1 : 5,000	*FAIL*	*FAIL*	**83.2**
2 in 60	1 : 1,000	PASS	*FAIL*	
2 in 60	1 : 5,000	PASS	*FAIL*	
1 in 60	1 : 5,000	*FAIL*	*FAIL*	
2 in 60	1 : 5,000	PASS	*FAIL*	
1 in 60	1 : 5,000	PASS	*FAIL*	
2 in 60	1 : 1,000	PASS	*FAIL*	
2 in 60	1 : 5,000	PASS	*FAIL*	
2 in 60	1 : 5,000	PASS	*FAIL*	
1 in 60	1 : 5,000	PASS	*FAIL*	
1 in 60	1 : 1,000	PASS	*FAIL*	
1 in 60	1 : 1,000	PASS	*FAIL*	
2 in 60	1 : 1,000	PASS	PASS	
2 in 60	1 : 1,000	PASS	PASS	
2 in 60	1 : 1,000	PASS	PASS	
2 in 60	1 : 1,000	PASS	PASS	
2 in 60	1 : 5,000	PASS	*FAIL*	
1 in 60	1 : 5,000	PASS	*FAIL*	
2 in 60	1 : 5,000	PASS	*FAIL*	
1 in 60	1 : 5,000	PASS	*FAIL*	**93.8**
2 in 60	1 : 1,000	PASS	*FAIL*	
2 in 60	1 : 5,000	PASS	*FAIL*	
1 in 60	1 : 5,000	*FAIL*	*FAIL*	
2 in 60	1 : 5,000	PASS	*FAIL*	
1 in 60	1 : 5,000	PASS	*FAIL*	
2 in 60	1 : 1,000	PASS	PASS	

2 in 60	1 : 5,000	PASS	PASS	
2 in 60	1 : 5,000	PASS	FAIL	
1 in 60	1 : 5,000	PASS	FAIL	
1 in 60	1 : 1,000	PASS	FAIL	
1 in 60	1 : 1,000	PASS	FAIL	
2 in 60	1 : 1,000	PASS	PASS	
2 in 60	1 : 1,000	PASS	PASS	
2 in 60	1 : 1,000	PASS	PASS	
2 in 60	1 : 1,000	PASS	FAIL	
2 in 60	1 : 5,000	PASS	FAIL	
1 in 60	1 : 5,000	FAIL	FAIL	
2 in 60	1 : 5,000	PASS	FAIL	
1 in 60	1 : 5,000	FAIL	FAIL	86.8
2 in 60	1 : 1,000	PASS	FAIL	
2 in 60	1 : 5,000	PASS	FAIL	
1 in 60	1 : 5,000	FAIL	FAIL	
2 in 60	1 : 5,000	FAIL	FAIL	
1 in 60	1 : 5,000	PASS	FAIL	
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2 in 60	1 : 5,000	PASS	FAIL	
1 in 60	1 : 5,000	PASS	FAIL	
2 in 60	1 : 5,000	PASS	PASS	
1 in 60	1 : 5,000	PASS	FAIL	100.0
2 in 60	1 : 1,000	PASS	FAIL	
2 in 60	1 : 5,000	PASS	FAIL	
1 in 60	1 : 5,000	PASS	FAIL	
2 in 60	1 : 5,000	PASS	FAIL	
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2 in 60	1 : 1,000	PASS	PASS	
2 in 60	1 : 1,000	PASS	PASS	
2 in 60	1 : 1,000	PASS	FAIL	
2 in 60	1 : 1,000	PASS	PASS	
2 in 60	1 : 5,000	PASS	PASS	

1 in 60	1 : 5,000	FAIL	FAIL	
2 in 60	1 : 5,000	PASS	PASS	
1 in 60	1 : 5,000	PASS	PASS	**90.6**
2 in 60	1 : 1,000	PASS	PASS	
2 in 60	1 : 5,000	FAIL	FAIL	
1 in 60	1 : 5,000	FAIL	FAIL	
2 in 60	1 : 5,000	PASS	PASS	
1 in 60	1 : 5,000	FAIL	FAIL	
2 in 60	1 : 1,000	PASS	PASS	
2 in 60	1 : 5,000	PASS	PASS	
2 in 60	1 : 5,000	PASS	PASS	
1 in 60	1 : 5,000	FAIL	FAIL	
1 in 60	1 : 1,000	PASS	FAIL	
1 in 60	1 : 1,000	PASS	FAIL	
2 in 60	1 : 1,000	PASS	PASS	
2 in 60	1 : 1,000	PASS	PASS	
2 in 60	1 : 1,000	PASS	FAIL	
2 in 60	1 : 1,000	PASS	PASS	
2 in 60	1 : 5,000	PASS	PASS	
1 in 60	1 : 5,000	PASS	FAIL	
2 in 60	1 : 5,000	PASS	PASS	
1 in 60	1 : 5,000	PASS	PASS	**98.9**
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2 in 60	1 : 1,000	PASS	FAIL	
2 in 60	1 : 1,000	PASS	PASS	
2 in 60	1 : 5,000	PASS	PASS	
1 in 60	1 : 5,000	PASS	PASS	
2 in 60	1 : 5,000	PASS	PASS	
1 in 60	1 : 5,000	PASS	FAIL	**93.4**
2 in 60	1 : 1,000	PASS	FAIL	
2 in 60	1 : 5,000	PASS	PASS	
1 in 60	1 : 5,000	FAIL	FAIL	
2 in 60	1 : 5,000	PASS	PASS	
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2 in 60	1 : 5,000	PASS	PASS	
2 in 60	1 : 5,000	PASS	PASS	
1 In 60	1 : 5,000	PASS	PASS	
1 in 60	1 : 1,000	PASS	FAIL	
1 in 60	1 : 1,000	PASS	FAIL	
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2 in 60	1 : 1,000	PASS	PASS	
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1 in 60	1 : 5,000	PASS	FAIL	
2 in 60	1 : 5,000	PASS	FAIL	
1 in 60	1 : 5,000	PASS	FAIL	93.8
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2 in 60	1 : 5,000	PASS	FAIL	
1 in 60	1 : 5,000	PASS	FAIL	92.7
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2 in 60	1 : 5,000	PASS	FAIL	

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2 in 60	1 : 5,000	PASS	FAIL	
1 in 60	1 : 5,000	PASS	FAIL	100.0
2 in 60	1 : 1,000	PASS	FAIL	
2 in 60	1 : 5,000	PASS	FAIL	
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2 in 60	1 : 5,000	PASS	FAIL	
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2 in 60	1 : 5,000	PASS	FAIL	
1 in 60	1 : 5,000	PASS	FAIL	96.7
2 in 60	1 : 1,000	PASS	FAIL	
2 in 60	1 : 5,000	PASS	FAIL	
1 in 60	1 : 5,000	FAIL	FAIL	
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2 in 60	1 : 1,000	PASS	PASS	
2 in 60	1 : 5,000	PASS	PASS	
1 in 60	1 : 5,000	PASS	FAIL	
2 in 60	1 : 5,000	PASS	PASS	
1 in 60	1 : 5,000	PASS	FAIL	93.6
2 in 60	1 : 1,000	PASS	FAIL	
2 in 60	1 : 5,000	PASS	FAIL	
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2 in 60	1 : 1,000	PASS	FAIL	
2 in 60	1 : 1,000	PASS	PASS	
2 in 60	1 : 5,000	PASS	PASS	
1 in 60	1 : 5,000	PASS	FAIL	
2 in 60	1 : 5,000	PASS	PASS	
1 in 60	1 : 5,000	PASS	FAIL	94.1
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2 in 60	1 : 1,000	PASS	PASS	
2 in 60	1 : 5,000	PASS	FAIL	

1 in 60	1 : 5,000	PASS	FAIL	
2 in 60	1 : 5,000	PASS	FAIL	
1 in 60	1 : 5,000	PASS	FAIL	**100.0**
2 in 60	1 : 1,000	PASS	PASS	
2 in 60	1 : 5,000	PASS	FAIL	
1 in 60	1 : 5,000	PASS	FAIL	
2 in 60	1 : 5,000	PASS	FAIL	
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2 in 60	1 : 1,000	PASS	PASS	
2 in 60	1 : 1,000	PASS	PASS	
2 in 60	1 : 1,000	PASS	FAIL	
2 in 60	1 : 1,000	PASS	PASS	
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1 in 60	1 : 5,000	FAIL	FAIL	
2 in 60	1 : 5,000	PASS	FAIL	
1 in 60	1 : 5,000	PASS	FAIL	**89.2**
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2 in 60	1 : 5,000	PASS	FAIL	
1 in 60	1 : 5,000	FAIL	FAIL	
2 in 60	1 : 5,000	PASS	FAIL	
1 in 60	1 : 5,000	PASS	FAIL	
2 in 60	1 : 1,000	PASS	PASS	
2 in 60	1 : 5,000	PASS	PASS	
2 in 60	1 : 5,000	PASS	FAIL	
1 in 60	1 : 5,000	PASS	FAIL	
1 in 60	1 : 1,000	PASS	FAIL	
1 in 60	1 : 1,000	PASS	PASS	
2 in 60	1 : 1,000	PASS	PASS	
2 in 60	1 : 1,000	PASS	PASS	
2 in 60	1 : 1,000	PASS	PASS	
2 in 60	1 : 1,000	PASS	PASS	
2 in 60	1 : 5,000	PASS	PASS	
1 in 60	1 : 5,000	PASS	PASS	
2 in 60	1 : 5,000	PASS	PASS	
1 in 60	1 : 5,000	PASS	PASS	**98.4**
2 in 60	1 : 1,000	PASS	PASS	
2 in 60	1 : 5,000	PASS	PASS	
1 in 60	1 : 5,000	PASS	FAIL	
2 in 60	1 : 5,000	PASS	PASS	
1 in 60	1 : 5,000	PASS	PASS	
2 in 60	1 : 1,000	PASS	FAIL	

2 in 60	1 : 5,000	PASS	PASS	
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2 in 60	1 : 1,000	PASS	PASS	
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2 in 60	1 : 1,000	PASS	PASS	
2 in 60	1 : 1,000	PASS	PASS	
2 in 60	1 : 5,000	PASS	PASS	
1 in 60	1 : 5,000	PASS	FAIL	
2 in 60	1 : 5,000	PASS	FAIL	
1 in 60	1 : 5,000	PASS	FAIL	93.8
2 in 60	1 : 1,000	PASS	FAIL	
2 in 60	1 : 5,000	PASS	FAIL	
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2 in 60	1 : 5,000	PASS	FAIL	
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1 in 60	1 : 1,000	PASS	FAIL	
1 in 60	1 : 1,000	PASS	FAIL	
2 in 60	1 : 1,000	PASS	PASS	
2 in 60	1 : 1,000	PASS	PASS	
2 in 60	1 : 1,000	PASS	FAIL	
2 in 60	1 : 1,000	PASS	FAIL	
2 in 60	1 : 5,000	PASS	FAIL	

1 in 60	1 : 5,000	PASS	*FAIL*	
2 in 60	1 : 5,000	PASS	*FAIL*	
1 in 60	1 : 5,000	PASS	*FAIL*	**99.6**
2 in 60	1 : 1,000	PASS	*FAIL*	
2 in 60	1 : 5,000	PASS	*FAIL*	
1 in 60	1 : 5,000	PASS	*FAIL*	
2 in 60	1 : 5,000	PASS	*FAIL*	
1 in 60	1 : 5,000	PASS	*FAIL*	
2 in 60	1 : 1,000	PASS	*FAIL*	
2 in 60	1 : 5,000	PASS	*FAIL*	
2 in 60	1 : 5,000	PASS	*FAIL*	
1 in 60	1 : 5,000	PASS	*FAIL*	



Network Analysis

State of West Virginia

Created by...

MultiPlan

March 2, 2016

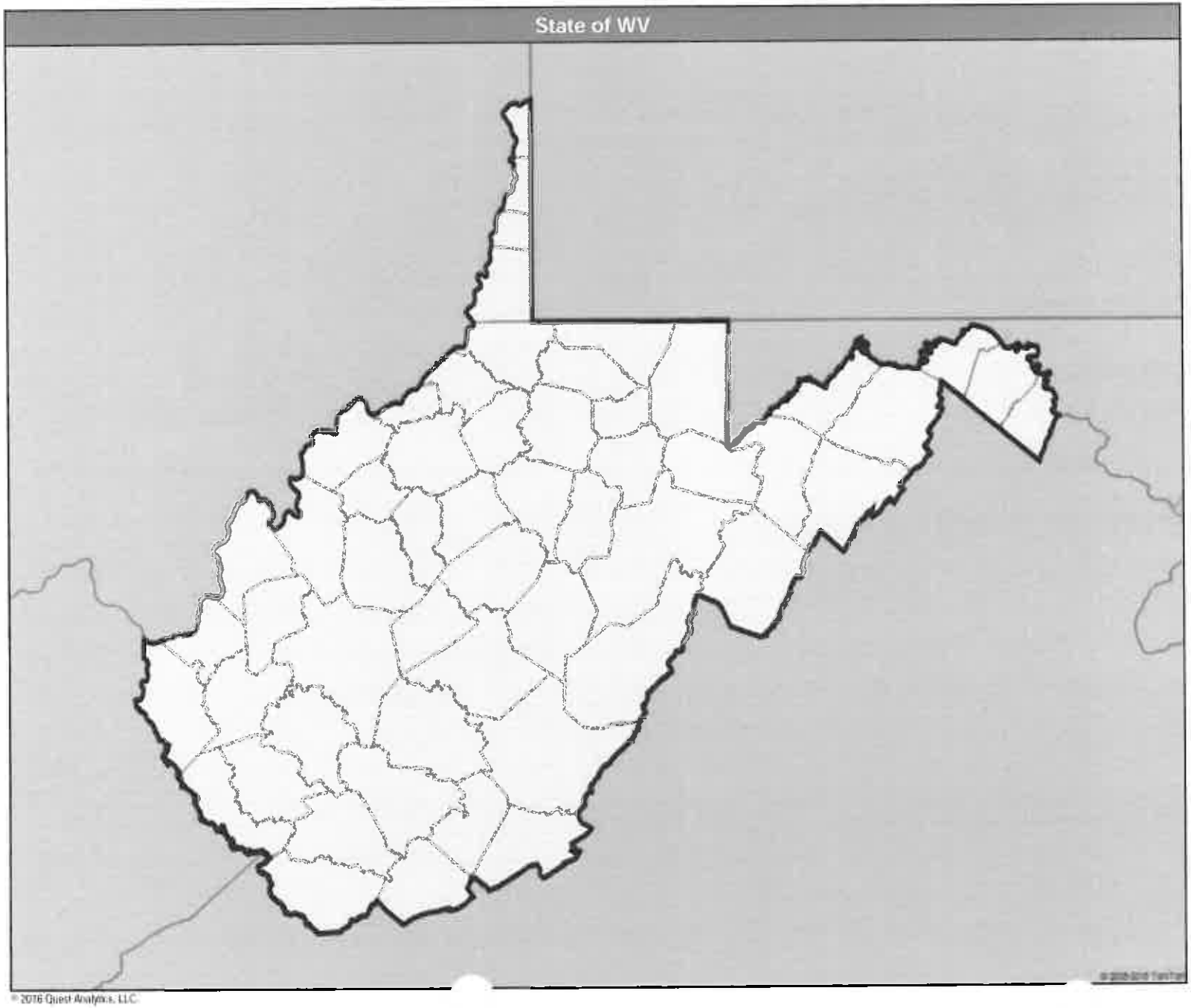
Created with the Quest Analytics Suite
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Map

March 2, 2016

Created by...
MultiPlan

1 in = 39.35 miles



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March 2, 2016

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Access Analysis

South ..st Access Summary

March 2, 2016

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General Access

[1] The Access Standard is defined as (State of WV) employees accessing in:

Urban areas...

1 (PHCS-MPI: HOSPITALS) provider in 30 minutes, 1 (PHCS-MPI: NURSING FACILITY) provider in 30 minutes, 2 (PHCS-MPI: CARDIOLOGY) providers in 30 minutes, 1 (PHCS-MPI: DERMATOLOGY) provider in 30 minutes, 2 (PHCS-MPI: GENERAL SURGERY) providers in 30 minutes, 1 (PHCS-MPI: NEUROLOGY) provider in 30 minutes, 2 (PHCS-MPI: OBSTETRICS & GYNECOLOGY) providers in 30 minutes, 2 (PHCS-MPI: ONCOLOGY) providers in 30 minutes, 1 (PHCS-MPI: ORAL SURGERY) provider in 30 minutes, 2 (PHCS-MPI: ORTHOPEDIC SURGERY) providers in 30 minutes, 1 (PHCS-MPI: OTOLARYNGOLOGY) provider in 30 minutes, 2 (PHCS-MPI: PEDIATRICIAN) providers in 30 minutes, 2 (PHCS-MPI: PHYSICAL THERAPY) providers in 30 minutes, 2 (PHCS-MPI: PRIMARY CARE PHYSICIAN) providers in 30 minutes, 2 (PHCS-MPI: RADIOLOGY) providers in 30 minutes, 1 (PHCS-MPI: UROLOGY) provider in 30 minutes

Suburban areas...

All Employees										
State	Provider		With Access[2]		Without Access[2]		Average Time		Maximum Time	
	Name	#	#	%	#	%	1	2	1	2
West Virginia	PHCS-MPI: HOSPITALS	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
	PHCS-MPI: NURSING FACILITY	32	83,480	97.2	2,420	2.8	23.1	34.4	80.4	85.2
	PHCS-MPI: CARDIOLOGY	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
	PHCS-MPI: DERMATOLOGY	46	80,123	93.3	5,777	6.7	27.2	35.2	78.0	93.1
	PHCS-MPI: GENERAL SURGERY	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
	PHCS-MPI: NEUROLOGY	63	79,073	92.1	6,827	7.9	28.1	34.3	88.8	157.0
	PHCS-MPI: OBSTETRICS & GYNECOLOGY	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
	PHCS-MPI: ONCOLOGY	102	77,846	90.6	8,054	9.4	23.8	30.9	75.9	77.1
	PHCS-MPI: ORAL SURGERY	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
	PHCS-MPI: ORTHOPEDIC SURGERY	157	81,834	95.3	4,066	4.7	23.3	25.3	73.9	76.3
	PHCS-MPI: OTOLARYNGOLOGY	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
	PHCS-MPI: PEDIATRICIAN	386	85,900	100.0	0	0.0	10.3	14.4	46.0	48.1
	PHCS-MPI: PHYSICAL THERAPY	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
	PHCS-MPI: PRIMARY CARE PHYSICIAN	1,897	85,900	100.0	0	0.0	5.7	7.0	22.9	26.7
	PHCS-MPI: RADIOLOGY	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
	PHCS-MPI: UROLOGY	65	77,819	90.6	8,081	9.4	26.5	32.6	74.2	79.7

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Southeast Access Detail By County

March 2, 2016

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[1] The Access Standard is defined as (State of WV) employees accessing in:

Urban areas...

1 (PHCS-MPI: HOSPITALS) provider in 30 minutes, 1 (PHCS-MPI: NURSING FACILITY) provider in 30 minutes, 2 (PHCS-MPI: CARDIOLOGY) providers in 30 minutes, 1 (PHCS-MPI: DERMATOLOGY) provider in 30 minutes, 2 (PHCS-MPI: GENERAL SURGERY) providers in 30 minutes, 1 (PHCS-MPI: NEUROLOGY) provider in 30 minutes, 2 (PHCS-MPI: OBSTETRICS & GYNECOLOGY) providers in 30 minutes, 2 (PHCS-MPI: ONCOLOGY) providers in 30 minutes, 1 (PHCS-MPI: ORAL SURGERY) provider in 30 minutes, 2 (PHCS-MPI: ORTHOPEDIC SURGERY) providers in 30 minutes, 1 (PHCS-MPI: OTOLARYNGOLOGY) provider in 30 minutes, 2 (PHCS-MPI: PEDIATRICIAN) providers in 30 minutes, 2 (PHCS-MPI: PHYSICAL THERAPY) providers in 30 minutes, 2 (PHCS-MPI: PRIMARY CARE PHYSICIAN) providers in 30 minutes, 2 (PHCS-MPI: RADIOLOGY) providers in 30 minutes, 1 (PHCS-MPI: UROLOGY) provider in 30 minutes

Suburban areas...

All Employees										
County	Provider		With Access[1]		Without Access[1]		Average Time		Maximum Time	
	Name	#	#	%	#	%	1	2	1	2
Barbour, WV	PHCS-MPI: HOSPITALS	1	602	100.0	0	0.0	9.4	15.4	19.3	21.6
	PHCS-MPI: NURSING FACILITY	0	602	100.0	0	0.0	30.7	37.7	46.0	49.2
	PHCS-MPI: CARDIOLOGY	1	602	100.0	0	0.0	9.4	15.4	21.6	27.3
	PHCS-MPI: DERMATOLOGY	0	602	100.0	0	0.0	16.1	23.6	26.2	35.6
	PHCS-MPI: GENERAL SURGERY	0	602	100.0	0	0.0	12.6	16.7	21.2	25.6
	PHCS-MPI: NEUROLOGY	0	602	100.0	0	0.0	20.5	28.4	30.3	43.0
	PHCS-MPI: OBSTETRICS & GYNECOLOGY	0	602	100.0	0	0.0	14.6	18.1	26.6	27.1
	PHCS-MPI: ONCOLOGY	0	602	100.0	0	0.0	17.8	17.8	27.1	27.1
	PHCS-MPI: ORAL SURGERY	0	602	100.0	0	0.0	46.0	46.0	57.6	57.6
	PHCS-MPI: ORTHOPEDIC SURGERY	0	602	100.0	0	0.0	13.2	17.6	21.6	27.3
	PHCS-MPI: OTOLARYNGOLOGY	0	602	100.0	0	0.0	13.4	20.7	27.1	37.6
	PHCS-MPI: PEDIATRICIAN	0	602	100.0	0	0.0	14.7	16.8	24.3	25.4
	PHCS-MPI: PHYSICAL THERAPY	0	602	100.0	0	0.0	13.7	14.9	23.6	25.6
	PHCS-MPI: PRIMARY CARE PHYSICIAN	11	602	100.0	0	0.0	5.9	6.1	12.9	13.4
	PHCS-MPI: RADIOLOGY	0	602	100.0	0	0.0	16.3	16.7	23.1	25.1
	PHCS-MPI: UROLOGY	0	602	100.0	0	0.0	15.5	19.9	27.0	31.0
Berkeley, WV	PHCS-MPI: HOSPITALS	1	1,199	100.0	0	0.0	10.7	19.0	25.6	30.1
	PHCS-MPI: NURSING FACILITY	1	1,199	100.0	0	0.0	10.4	19.1	23.3	30.7
	PHCS-MPI: CARDIOLOGY	7	1,199	100.0	0	0.0	10.8	11.7	23.6	25.5
	PHCS-MPI: DERMATOLOGY	2	1,199	100.0	0	0.0	9.3	14.4	20.7	25.4
	PHCS-MPI: GENERAL SURGERY	12	1,199	100.0	0	0.0	10.3	19.3	25.1	25.1
	PHCS-MPI: NEUROLOGY	1	1,199	100.0	0	0.0	10.9	120.1	26.2	157.0
	PHCS-MPI: OBSTETRICS & GYNECOLOGY	14	1,199	100.0	0	0.0	9.5	9.6	23.6	23.9
	PHCS-MPI: ONCOLOGY	6	1,199	100.0	0	0.0	11.0	11.3	25.1	25.7
	PHCS-MPI: ORAL SURGERY	0	0	0.0	1,199	100.0	100.0	100.0	107.1	107.1
	PHCS-MPI: ORTHOPEDIC SURGERY	7	1,199	100.0	0	0.0	10.6	11.3	25.1	25.1
	PHCS-MPI: OTOLARYNGOLOGY	4	1,199	100.0	0	0.0	10.7	19.0	23.6	23.9
	PHCS-MPI: PEDIATRICIAN	14	1,199	100.0	0	0.0	9.5	10.3	23.5	24.8
	PHCS-MPI: PHYSICAL THERAPY	2	1,199	100.0	0	0.0	10.7	11.4	25.1	25.2
	PHCS-MPI: PRIMARY CARE PHYSICIAN	67	1,199	100.0	0	0.0	4.5	4.9	13.6	16.2
	PHCS-MPI: RADIOLOGY	0	468	28.7	731	61.3	21.6	69.2	37.2	91.5
	PHCS-MPI: UROLOGY	5	1,199	100.0	0	0.0	9.6	9.8	25.4	25.6
Boone, WV	PHCS-MPI: HOSPITALS	1	2,613	100.0	0	0.0	11.4	32.0	39.4	46.8
	PHCS-MPI: NURSING FACILITY	0	2,613	100.0	0	0.0	30.6	33.4	46.5	47.7
	PHCS-MPI: CARDIOLOGY	0	2,613	100.0	0	0.0	30.0	30.9	46.1	46.9
	PHCS-MPI: DERMATOLOGY	0	2,613	100.0	0	0.0	32.6	34.1	46.2	53.0
	PHCS-MPI: GENERAL SURGERY	0	2,613	100.0	0	0.0	22.7	30.6	31.4	46.1
	PHCS-MPI: NEUROLOGY	0	2,613	100.0	0	0.0	30.6	31.0	46.1	49.1
	PHCS-MPI: OBSTETRICS & GYNECOLOGY	2	2,613	100.0	0	0.0	11.0	11.3	23.6	25.6
	PHCS-MPI: ONCOLOGY	0	2,613	100.0	0	0.0	24.2	31.3	34.4	49.2

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Southeast Access Detail By County

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Urban areas...

1 (PHCS-MPI: HOSPITALS) provider in 30 minutes, 1 (PHCS-MPI: NURSING FACILITY) provider in 30 minutes, 2 (PHCS-MPI: CARDIOLOGY) providers in 30 minutes, 1 (PHCS-MPI: DERMATOLOGY) provider in 30 minutes, 2 (PHCS-MPI: GENERAL SURGERY) providers in 30 minutes, 1 (PHCS-MPI: NEUROLOGY) provider in 30 minutes, 2 (PHCS-MPI: OBSTETRICS & GYNECOLOGY) providers in 30 minutes, 2 (PHCS-MPI: ONCOLOGY) providers in 30 minutes, 1 (PHCS-MPI: ORAL SURGERY) provider in 30 minutes, 2 (PHCS-MPI: ORTHOPEDIC SURGERY) providers in 30 minutes, 1 (PHCS-MPI: OTOLARYNGOLOGY) provider in 30 minutes, 2 (PHCS-MPI: PEDIATRICIAN) providers in 30 minutes, 2 (PHCS-MPI: PHYSICAL THERAPY) providers in 30 minutes, 2 (PHCS-MPI: PRIMARY CARE PHYSICIAN) providers in 30 minutes, 2 (PHCS-MPI: RADIOLOGY) providers in 30 minutes, 1 (PHCS-MPI: UROLOGY) provider in 30 minutes

Suburban areas...

All Employees										
County	Provider		With Access[2]		Without Access[2]		Average Time		Maximum Time	
	Name	#	#	%	#	%	1	2	1	2
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
	PHCS-MPI: ORTHOPEDIC SURGERY	0	2,613	100.0	0	0.0	31.0	31.2	46.4	46.5
	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
	PHCS-MPI: PEDIATRICIAN	3	2,613	100.0	0	0.0	10.3	11.6	23.7	25.8
	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
	PHCS-MPI: PRIMARY CARE PHYSICIAN	1	2,613	100.0	0	0.0	9.9	14.3	18.2	21.7
	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
	PHCS-MPI: UROLOGY	0	2,613	100.0	0	0.0	33.4	48.6	50.2	61.4
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
	PHCS-MPI: NURSING FACILITY	0	1,172	100.0	0	0.0	23.1	40.8	34.4	56.4
	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
	PHCS-MPI: DERMATOLOGY	0	710	60.6	462	39.4	58.5	58.6	76.3	76.3
	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
	PHCS-MPI: NEUROLOGY	0	571	48.7	601	51.3	60.6	60.8	75.4	75.6
	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
	PHCS-MPI: ONCOLOGY	0	670	57.2	502	42.8	58.8	58.8	74.2	75.7
	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
	PHCS-MPI: ORTHOPEDIC SURGERY	0	1,172	100.0	0	0.0	30.4	30.4	45.9	45.9
	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
	PHCS-MPI: PEDIATRICIAN	0	1,172	100.0	0	0.0	20.5	25.3	27.0	33.4
	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
	PHCS-MPI: PRIMARY CARE PHYSICIAN	24	1,172	100.0	0	0.0	7.9	8.0	15.3	15.6
	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
	PHCS-MPI: UROLOGY	0	1,172	100.0	0	0.0	26.7	37.1	36.8	52.4
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
	PHCS-MPI: NURSING FACILITY	1	705	100.0	0	0.0	5.5	15.1	12.2	21.8
	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
	PHCS-MPI: DERMATOLOGY	0	705	100.0	0	0.0	12.6	19.8	16.4	36.0
	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
	PHCS-MPI: NEUROLOGY	0	595	84.4	110	15.6	27.4	27.4	55.8	55.8
	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
	PHCS-MPI: ONCOLOGY	0	705	100.0	0	0.0	13.7	14.7	21.4	21.8
	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
	PHCS-MPI: ORTHOPEDIC SURGERY	0	705	100.0	0	0.0	13.0	14.7	20.8	22.2
	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
	PHCS-MPI: PEDIATRICIAN	3	705	100.0	0	0.0	3.7	7.5	12.2	17.8
	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
	PHCS-MPI: PRIMARY CARE PHYSICIAN	8	705	100.0	0	0.0	3.5	3.6	12.0	12.1
	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
	PHCS-MPI: UROLOGY	0	705	100.0	0	0.0	13.4	13.4	21.1	21.1

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Southeast Access Detail By County

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Urban areas...

1 (PHCS-MPI: HOSPITALS) provider in 30 minutes, 1 (PHCS-MPI: NURSING FACILITY) provider in 30 minutes, 2 (PHCS-MPI: CARDIOLOGY) providers in 30 minutes, 1 (PHCS-MPI: DERMATOLOGY) provider in 30 minutes, 2 (PHCS-MPI: GENERAL SURGERY) providers in 30 minutes, 1 (PHCS-MPI: NEUROLOGY) provider in 30 minutes, 2 (PHCS-MPI: OBSTETRICS & GYNECOLOGY) providers in 30 minutes, 2 (PHCS-MPI: ONCOLOGY) providers in 30 minutes, 1 (PHCS-MPI: ORAL SURGERY) provider in 30 minutes, 2 (PHCS-MPI: ORTHOPEDIC SURGERY) providers in 30 minutes, 1 (PHCS-MPI: OTOLARYNGOLOGY) provider in 30 minutes, 2 (PHCS-MPI: PEDIATRICIAN) providers in 30 minutes, 2 (PHCS-MPI: PHYSICAL THERAPY) providers in 30 minutes, 2 (PHCS-MPI: PRIMARY CARE PHYSICIAN) providers in 30 minutes, 2 (PHCS-MPI: RADIOLOGY) providers in 30 minutes, 1 (PHCS-MPI: UROLOGY) provider in 30 minutes

Suburban areas...

All Employees										
County	Provider		With Access[1]		Without Access[1]		Average Time		Maximum Time	
	Name	#	#	%	#	%	1	2	1	2
Cabell, WV	PHCS-MPI: HOSPITALS	3	4,480	100.0	0	0.0	6.5	8.4	26.7	40.6
	PHCS-MPI: NURSING FACILITY	1	4,480	100.0	0	0.0	6.3	51.9	28.5	61.2
	PHCS-MPI: CARDIOLOGY	25	4,480	100.0	0	0.0	3.4	4.7	20.9	24.9
	PHCS-MPI: DERMATOLOGY	4	4,480	100.0	0	0.0	4.8	7.5	22.5	34.4
	PHCS-MPI: GENERAL SURGERY	15	4,480	100.0	0	0.0	4.5	4.8	24.9	34.9
	PHCS-MPI: NEUROLOGY	8	4,480	100.0	0	0.0	4.5	4.9	24.9	34.4
	PHCS-MPI: OBSTETRICS & GYNECOLOGY	61	4,480	100.0	0	0.0	1.7	5.0	12.2	12.5
	PHCS-MPI: ONCOLOGY	10	4,433	99.0	47	1.0	5.4	5.5	34.4	34.4
	PHCS-MPI: ORAL SURGERY	1	4,433	99.0	47	1.0	5.0	174.0	49.9	182.4
	PHCS-MPI: ORTHOPEDIC SURGERY	22	4,480	100.0	0	0.0	5.5	5.5	24.9	24.9
	PHCS-MPI: OTOLARYNGOLOGY	8	4,480	100.0	0	0.0	3.6	8.2	25.2	34.4
	PHCS-MPI: PEDIATRICIAN	70	4,480	100.0	0	0.0	2.5	3.0	12.9	15.6
	PHCS-MPI: PHYSICAL THERAPY	12	4,480	100.0	0	0.0	2.8	8.3	19.0	19.3
	PHCS-MPI: PRIMARY CARE PHYSICIAN	222	4,480	100.0	0	0.0	1.6	2.2	11.6	11.6
	PHCS-MPI: RADIOLOGY	73	4,480	100.0	0	0.0	5.0	5.0	24.9	24.9
	PHCS-MPI: UROLOGY	6	4,413	98.5	67	1.5	6.1	6.1	40.4	40.4
Calhoun, WV	PHCS-MPI: HOSPITALS	1	881	100.0	0	0.0	10.1	22.8	22.5	45.8
	PHCS-MPI: NURSING FACILITY	0	881	100.0	0	0.0	23.3	55.2	36.7	64.0
	PHCS-MPI: CARDIOLOGY	0	881	100.0	0	0.0	28.1	28.7	45.8	45.8
	PHCS-MPI: DERMATOLOGY	0	174	19.8	707	80.2	65.7	65.7	77.0	77.0
	PHCS-MPI: GENERAL SURGERY	0	881	100.0	0	0.0	44.8	44.8	57.2	58.4
	PHCS-MPI: NEUROLOGY	0	399	45.3	482	54.7	60.3	60.4	69.6	69.8
	PHCS-MPI: OBSTETRICS & GYNECOLOGY	0	881	100.0	0	0.0	39.6	43.6	44.7	62.1
	PHCS-MPI: ONCOLOGY	0	245	27.8	636	72.2	60.3	63.6	69.6	74.2
	PHCS-MPI: ORAL SURGERY	0	0	0.0	881	100.0	102.8	109.3	114.0	116.8
	PHCS-MPI: ORTHOPEDIC SURGERY	0	881	100.0	0	0.0	21.2	21.2	30.8	30.8
	PHCS-MPI: OTOLARYNGOLOGY	0	881	100.0	0	0.0	39.6	43.6	44.8	58.3
	PHCS-MPI: PEDIATRICIAN	3	881	100.0	0	0.0	9.7	10.1	19.9	22.5
	PHCS-MPI: PHYSICAL THERAPY	0	881	100.0	0	0.0	30.6	30.6	42.2	42.2
	PHCS-MPI: PRIMARY CARE PHYSICIAN	4	881	100.0	0	0.0	8.9	8.9	18.1	18.1
	PHCS-MPI: RADIOLOGY	0	881	100.0	0	0.0	20.3	31.7	30.8	45.6
	PHCS-MPI: UROLOGY	0	881	100.0	0	0.0	41.4	50.3	52.1	56.5
Clay, WV	PHCS-MPI: HOSPITALS	0	1,379	100.0	0	0.0	31.0	39.4	39.4	65.2
	PHCS-MPI: NURSING FACILITY	0	1,379	100.0	0	0.0	36.3	45.0	45.5	57.8
	PHCS-MPI: CARDIOLOGY	0	1,379	100.0	0	0.0	41.8	42.3	45.5	58.0
	PHCS-MPI: DERMATOLOGY	0	891	64.6	488	35.4	54.4	55.7	71.4	74.1
	PHCS-MPI: GENERAL SURGERY	0	1,379	100.0	0	0.0	46.8	48.0	66.2	66.8
	PHCS-MPI: NEUROLOGY	0	1,020	74.0	359	26.0	47.5	48.6	66.8	66.8
	PHCS-MPI: OBSTETRICS & GYNECOLOGY	0	1,379	100.0	0	0.0	38.2	44.7	42.3	65.2
	PHCS-MPI: ONCOLOGY	0	996	72.2	383	27.8	48.1	48.7	66.1	66.2

[1]nued on next page...

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[1] The Access Standard is defined as (State of WV) employees accessing in:

Urban areas...

1 (PHCS-MPI: HOSPITALS) provider in 30 minutes, 1 (PHCS-MPI: NURSING FACILITY) provider in 30 minutes, 2 (PHCS-MPI: CARDIOLOGY) providers in 30 minutes, 1 (PHCS-MPI: DERMATOLOGY) provider in 30 minutes, 2 (PHCS-MPI: GENERAL SURGERY) providers in 30 minutes, 1 (PHCS-MPI: NEUROLOGY) provider in 30 minutes, 2 (PHCS-MPI: OBSTETRICS & GYNECOLOGY) providers in 30 minutes, 2 (PHCS-MPI: ONCOLOGY) providers in 30 minutes, 1 (PHCS-MPI: ORAL SURGERY) provider in 30 minutes, 2 (PHCS-MPI: ORTHOPEDIC SURGERY) providers in 30 minutes, 1 (PHCS-MPI: OTOLARYNGOLOGY) provider in 30 minutes, 2 (PHCS-MPI: PEDIATRICIAN) providers in 30 minutes, 2 (PHCS-MPI: PHYSICAL THERAPY) providers in 30 minutes, 2 (PHCS-MPI: PRIMARY CARE PHYSICIAN) providers in 30 minutes, 2 (PHCS-MPI: RADIOLOGY) providers in 30 minutes, 1 (PHCS-MPI: UROLOGY) provider in 30 minutes

Suburban areas...

All Employees										
County	Provider		With Access[2]		Without Access[2]		Average Time		Maximum Time	
	Name	#	#	%	#	%	1	2	1	2
Clay, WV	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	100	[illegible]	[illegible]	[illegible]	[illegible]
	PHCS-MPI: ORTHOPEDIC SURGERY	0	1,379	100.0	0	0.0	36.9	36.9	50.7	50.7
	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
	PHCS-MPI: PEDIATRICIAN	1	1,379	100.0	0	0.0	10.6	23.4	18.3	32.7
	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
	PHCS-MPI: PRIMARY CARE PHYSICIAN	14	1,379	100.0	0	0.0	8.2	8.3	17.6	18.5
	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
	PHCS-MPI: UROLOGY	0	1,379	100.0	0	0.0	24.1	36.9	34.9	52.0
Dodridge, WV	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
	PHCS-MPI: NURSING FACILITY	0	420	100.0	0	0.0	13.6	26.6	20.5	30.9
	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
	PHCS-MPI: DERMATOLOGY	0	420	100.0	0	0.0	32.2	33.2	39.6	41.6
	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
	PHCS-MPI: NEUROLOGY	0	420	100.0	0	0.0	33.7	34.1	43.8	43.8
	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
	PHCS-MPI: ONCOLOGY	0	420	100.0	0	0.0	32.7	33.6	43.8	43.8
	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
	PHCS-MPI: ORTHOPEDIC SURGERY	0	420	100.0	0	0.0	27.2	27.2	31.2	31.2
	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
	PHCS-MPI: PEDIATRICIAN	2	420	100.0	0	0.0	7.5	9.0	19.8	21.8
	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
	PHCS-MPI: PRIMARY CARE PHYSICIAN	8	420	100.0	0	0.0	6.1	6.3	16.0	16.0
	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
	PHCS-MPI: UROLOGY	0	420	100.0	0	0.0	28.4	33.0	34.6	40.4
Fayette, WV	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
	PHCS-MPI: NURSING FACILITY	0	4,002	100.0	0	0.0	18.4	26.1	30.9	41.4
	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
	PHCS-MPI: DERMATOLOGY	0	4,002	100.0	0	0.0	26.6	55.4	42.4	67.6
	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
	PHCS-MPI: NEUROLOGY	0	4,002	100.0	0	0.0	25.9	27.7	41.0	43.6
	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
	PHCS-MPI: ONCOLOGY	0	2,663	66.5	1,339	33.5	27.3	46.1	44.2	56.2
	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
	PHCS-MPI: ORTHOPEDIC SURGERY	0	4,002	100.0	0	0.0	26.3	26.3	41.1	41.1
	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
	PHCS-MPI: PEDIATRICIAN	2	4,002	100.0	0	0.0	9.2	14.8	21.2	23.6
	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
	PHCS-MPI: PRIMARY CARE PHYSICIAN	23	4,002	100.0	0	0.0	5.9	8.1	14.7	16.5
	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
	PHCS-MPI: UROLOGY	1	4,002	100.0	0	0.0	15.4	25.7	29.4	38.0

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Continued on next page...

Southeast Access Detail By County

March 2, 2016

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MultiPlan

General Access

[1] The Access Standard is defined as (State of WV) employees accessing in:

Urban areas...

1 (PHCS-MPI: HOSPITALS) provider in 30 minutes, 1 (PHCS-MPI: NURSING FACILITY) provider in 30 minutes, 2 (PHCS-MPI: CARDIOLOGY) providers in 30 minutes, 1 (PHCS-MPI: DERMATOLOGY) provider in 30 minutes, 2 (PHCS-MPI: GENERAL SURGERY) providers in 30 minutes, 1 (PHCS-MPI: NEUROLOGY) provider in 30 minutes, 2 (PHCS-MPI: OBSTETRICS & GYNECOLOGY) providers in 30 minutes, 2 (PHCS-MPI: ONCOLOGY) providers in 30 minutes, 1 (PHCS-MPI: ORAL SURGERY) provider in 30 minutes, 2 (PHCS-MPI: ORTHOPEDIC SURGERY) providers in 30 minutes, 1 (PHCS-MPI: OTOLARYNGOLOGY) provider in 30 minutes, 2 (PHCS-MPI: PEDIATRICIAN) providers in 30 minutes, 2 (PHCS-MPI: PHYSICAL THERAPY) providers in 30 minutes, 2 (PHCS-MPI: PRIMARY CARE PHYSICIAN) providers in 30 minutes, 2 (PHCS-MPI: RADIOLOGY) providers in 30 minutes, 1 (PHCS-MPI: UROLOGY) provider in 30 minutes

Suburban areas...

All Employees										
County	Provider		With Access[1]		Without Access[1]		Average Time		Maximum Time	
	Name	#	#	%	#	%	1	2	1	2
Gilmer, WV	PHCS-MPI: HOSPITALS	0	841	100.0	0	0.0	17.7	31.0	33.6	46.0
	PHCS-MPI: NURSING FACILITY	1	841	100.0	0	0.0	10.9	40.2	24.3	57.1
	PHCS-MPI: CARDIOLOGY	0	841	100.0	0	0.0	28.1	36.1	40.5	48.5
	PHCS-MPI: DERMATOLOGY	0	516	61.4	325	38.6	56.6	56.6	76.3	76.3
	PHCS-MPI: GENERAL SURGERY	0	841	100.0	0	0.0	28.2	36.2	47.8	47.8
	PHCS-MPI: NEUROLOGY	0	440	52.3	401	47.7	59.9	59.9	73.7	73.9
	PHCS-MPI: OBSTETRICS & GYNECOLOGY	0	841	100.0	0	0.0	31.5	37.5	34.2	41.3
	PHCS-MPI: ONCOLOGY	0	444	52.8	397	47.2	59.7	60.7	72.6	77.1
	PHCS-MPI: ORAL SURGERY	0	0	0.0	841	100.0	96.6	96.6	112.6	112.6
	PHCS-MPI: ORTHOPEDIC SURGERY	0	841	100.0	0	0.0	24.6	24.6	32.7	32.7
	PHCS-MPI: OTOLARYNGOLOGY	0	841	100.0	0	0.0	30.7	40.3	48.6	58.1
	PHCS-MPI: PEDIATRICIAN	1	841	100.0	0	0.0	10.4	17.5	20.2	23.6
	PHCS-MPI: PHYSICAL THERAPY	0	841	100.0	0	0.0	32.4	33.4	42.1	42.1
	PHCS-MPI: PRIMARY CARE PHYSICIAN	3	841	100.0	0	0.0	9.5	9.9	17.0	17.0
	PHCS-MPI: RADIOLOGY	0	841	100.0	0	0.0	23.0	29.3	30.5	32.7
	PHCS-MPI: UROLOGY	0	841	100.0	0	0.0	28.0	38.0	41.4	47.7
Grant, WV	PHCS-MPI: HOSPITALS	1	700	100.0	0	0.0	17.2	33.4	30.6	45.0
	PHCS-MPI: NURSING FACILITY	0	700	100.0	0	0.0	31.5	45.2	48.5	65.4
	PHCS-MPI: CARDIOLOGY	0	636	92.9	64	7.7	46.1	58.6	62.8	69.2
	PHCS-MPI: DERMATOLOGY	0	700	100.0	0	0.0	19.2	30.5	28.8	36.3
	PHCS-MPI: GENERAL SURGERY	0	700	100.0	0	0.0	31.2	38.2	40.0	46.1
	PHCS-MPI: NEUROLOGY	0	499	71.3	201	28.7	53.3	64.8	72.3	83.0
	PHCS-MPI: OBSTETRICS & GYNECOLOGY	1	700	100.0	0	0.0	27.0	39.6	39.0	46.9
	PHCS-MPI: ONCOLOGY	0	602	86.0	98	14.0	51.8	51.9	66.4	66.4
	PHCS-MPI: ORAL SURGERY	0	9	1.3	691	98.7	74.3	74.3	95.6	95.6
	PHCS-MPI: ORTHOPEDIC SURGERY	0	649	92.7	51	7.3	46.5	50.8	62.4	65.3
	PHCS-MPI: OTOLARYNGOLOGY	0	602	86.0	98	14.0	51.8	59.6	66.6	81.4
	PHCS-MPI: PEDIATRICIAN	0	700	100.0	0	0.0	24.1	30.5	32.1	36.3
	PHCS-MPI: PHYSICAL THERAPY	2	700	100.0	0	0.0	19.0	19.3	27.2	31.2
	PHCS-MPI: PRIMARY CARE PHYSICIAN	2	700	100.0	0	0.0	10.0	12.1	21.4	21.4
	PHCS-MPI: RADIOLOGY	2	700	100.0	0	0.0	19.9	27.6	29.7	30.9
	PHCS-MPI: UROLOGY	0	600	85.7	100	14.3	52.1	62.8	66.7	72.5
Greenbrier, WV	PHCS-MPI: HOSPITALS	1	1,939	100.0	0	0.0	16.1	28.4	28.3	39.8
	PHCS-MPI: NURSING FACILITY	3	1,939	100.0	0	0.0	10.2	16.1	37.8	38.4
	PHCS-MPI: CARDIOLOGY	5	1,939	100.0	0	0.0	19.2	19.2	34.9	38.4
	PHCS-MPI: DERMATOLOGY	0	1,862	96.0	77	4.0	46.7	68.2	76.4	91.5
	PHCS-MPI: GENERAL SURGERY	10	1,939	100.0	0	0.0	14.3	14.8	34.9	38.4
	PHCS-MPI: NEUROLOGY	2	1,939	100.0	0	0.0	15.0	16.3	40.0	41.5
	PHCS-MPI: OBSTETRICS & GYNECOLOGY	3	1,939	100.0	0	0.0	19.4	19.4	40.4	41.4
	PHCS-MPI: ONCOLOGY	4	1,939	100.0	0	0.0	14.9	15.3	41.7	42.2

...nued on next page...

[2] 2016 Quest Analytics, LLC.

Southeast Access Detail By County

March 2, 2016

Created by...
MultiPlan

General Access

[1] The Access Standard is defined as (State of WV) employees accessing in:

Urban areas...

1 (PHCS-MPI: HOSPITALS) provider in 30 minutes, 1 (PHCS-MPI: NURSING FACILITY) provider in 30 minutes, 2 (PHCS-MPI: CARDIOLOGY) providers in 30 minutes, 1 (PHCS-MPI: DERMATOLOGY) provider in 30 minutes, 2 (PHCS-MPI: GENERAL SURGERY) providers in 30 minutes, 1 (PHCS-MPI: NEUROLOGY) provider in 30 minutes, 2 (PHCS-MPI: OBSTETRICS & GYNECOLOGY) providers in 30 minutes, 2 (PHCS-MPI: ONCOLOGY) providers in 30 minutes, 1 (PHCS-MPI: ORAL SURGERY) provider in 30 minutes, 2 (PHCS-MPI: ORTHOPEDIC SURGERY) providers in 30 minutes, 1 (PHCS-MPI: OTOLARYNGOLOGY) provider in 30 minutes, 2 (PHCS-MPI: PEDIATRICIAN) providers in 30 minutes, 2 (PHCS-MPI: PHYSICAL THERAPY) providers in 30 minutes, 2 (PHCS-MPI: PRIMARY CARE PHYSICIAN) providers in 30 minutes, 2 (PHCS-MPI: RADIOLOGY) providers in 30 minutes, 1 (PHCS-MPI: UROLOGY) provider in 30 minutes

Suburban areas...

All Employees										
County	Provider		With Access[2]		Without Access[2]		Average Time		Maximum Time	
	Name	#	#	%	#	%	1	2	1	2
[illegible]	[illegible]	0	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
	PHCS-MPI: ORTHOPEDIC SURGERY	1	1,869	96.4	70	3.6	16.4	46.3	40.4	76.3
	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
	PHCS-MPI: PEDIATRICIAN	10	1,939	100.0	0	0.0	8.8	8.8	32.7	32.7
	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
	PHCS-MPI: PRIMARY CARE PHYSICIAN	51	1,939	100.0	0	0.0	6.4	6.9	21.6	21.7
	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
	PHCS-MPI: UROLOGY	3	1,939	100.0	0	0.0	15.3	16.5	36.8	38.8
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
	PHCS-MPI: NURSING FACILITY	0	1,544	100.0	0	0.0	28.8	37.5	45.4	55.4
	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
	PHCS-MPI: DERMATOLOGY	1	1,544	100.0	0	0.0	14.3	23.0	24.5	32.8
	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
	PHCS-MPI: NEUROLOGY	0	1,437	93.1	107	6.9	46.8	82.8	67.5	94.5
	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
	PHCS-MPI: ONCOLOGY	0	1,426	92.4	118	7.6	47.0	47.0	69.2	69.2
	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
	PHCS-MPI: ORTHOPEDIC SURGERY	0	1,418	91.8	126	8.2	45.5	47.4	67.8	69.2
	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
	PHCS-MPI: PEDIATRICIAN	1	1,544	100.0	0	0.0	15.2	29.9	26.8	48.0
	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
	PHCS-MPI: PRIMARY CARE PHYSICIAN	9	1,544	100.0	0	0.0	11.5	14.5	21.0	23.7
	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
	PHCS-MPI: UROLOGY	0	1,516	98.2	28	1.8	42.7	45.2	65.3	69.1
Hancock, WV	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
	PHCS-MPI: NURSING FACILITY	1	490	100.0	0	0.0	19.2	22.2	27.7	30.4
	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
	PHCS-MPI: DERMATOLOGY	1	490	100.0	0	0.0	20.5	41.4	31.1	47.8
	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
	PHCS-MPI: NEUROLOGY	0	300	61.2	190	38.8	56.3	56.3	64.5	64.5
	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
	PHCS-MPI: ONCOLOGY	10	490	100.0	0	0.0	19.6	19.6	30.4	30.4
	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
	PHCS-MPI: ORTHOPEDIC SURGERY	3	490	100.0	0	0.0	19.6	19.6	30.4	30.4
	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
	PHCS-MPI: PEDIATRICIAN	8	490	100.0	0	0.0	4.3	16.8	12.3	27.2
	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
	PHCS-MPI: PRIMARY CARE PHYSICIAN	49	490	100.0	0	0.0	2.1	7.7	7.8	13.5
	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
	PHCS-MPI: UROLOGY	5	490	100.0	0	0.0	19.6	20.5	30.4	31.1

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Continued on next page...

Southeast Access Detail By County

March 2, 2016

Created by...
MultiPlan

General Access

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Urban areas...

1 (PHCS-MPI: HOSPITALS) provider in 30 minutes, 1 (PHCS-MPI: NURSING FACILITY) provider in 30 minutes, 2 (PHCS-MPI: CARDIOLOGY) providers in 30 minutes, 1 (PHCS-MPI: DERMATOLOGY) provider in 30 minutes, 2 (PHCS-MPI: GENERAL SURGERY) providers in 30 minutes, 1 (PHCS-MPI: NEUROLOGY) provider in 30 minutes, 2 (PHCS-MPI: OBSTETRICS & GYNECOLOGY) providers in 30 minutes, 2 (PHCS-MPI: ONCOLOGY) providers in 30 minutes, 1 (PHCS-MPI: ORAL SURGERY) provider in 30 minutes, 2 (PHCS-MPI: ORTHOPEDIC SURGERY) providers in 30 minutes, 1 (PHCS-MPI: OTOLARYNGOLOGY) provider in 30 minutes, 2 (PHCS-MPI: PEDIATRICIAN) providers in 30 minutes, 2 (PHCS-MPI: PHYSICAL THERAPY) providers in 30 minutes, 2 (PHCS-MPI: PRIMARY CARE PHYSICIAN) providers in 30 minutes, 2 (PHCS-MPI: RADIOLOGY) providers in 30 minutes, 1 (PHCS-MPI: UROLOGY) provider in 30 minutes

Suburban areas...

All Employees										
County	Provider		With Access[1]		Without Access[1]		Average Time		Maximum Time	
	Name	#	#	%	#	%	1	2	1	2
Hardy, WV	PHCS-MPI: HOSPITALS	0	817	100.0	0	0.0	19.0	30.6	28.4	51.1
	PHCS-MPI: NURSING FACILITY	0	817	100.0	0	0.0	34.7	61.2	50.8	79.0
	PHCS-MPI: CARDIOLOGY	0	379	46.4	438	53.6	48.1	69.1	69.7	88.7
	PHCS-MPI: DERMATOLOGY	2	817	100.0	0	0.0	10.8	21.9	24.2	34.3
	PHCS-MPI: GENERAL SURGERY	0	817	100.0	0	0.0	29.0	29.0	51.1	51.1
	PHCS-MPI: NEUROLOGY	0	17	2.1	800	97.9	70.9	80.8	85.5	94.8
	PHCS-MPI: OBSTETRICS & GYNECOLOGY	0	817	100.0	0	0.0	19.5	29.0	28.5	53.0
	PHCS-MPI: ONCOLOGY	0	201	24.6	616	75.4	64.2	64.3	75.9	75.9
	PHCS-MPI: ORAL SURGERY	0	0	0.0	817	100.0	96.2	96.2	111.8	111.8
	PHCS-MPI: ORTHOPEDIC SURGERY	0	191	23.4	626	76.6	62.6	64.6	72.0	76.0
	PHCS-MPI: OTOLARYNGOLOGY	0	280	34.3	537	65.7	62.6	73.2	76.0	87.7
	PHCS-MPI: PEDIATRICIAN	0	817	100.0	0	0.0	26.8	35.2	39.4	48.1
	PHCS-MPI: PHYSICAL THERAPY	0	817	100.0	0	0.0	21.9	21.9	37.8	37.8
	PHCS-MPI: PRIMARY CARE PHYSICIAN	5	817	100.0	0	0.0	6.6	10.8	20.8	24.2
	PHCS-MPI: RADIOLOGY	0	817	100.0	0	0.0	16.8	20.7	37.8	38.2
	PHCS-MPI: UROLOGY	0	341	41.7	476	58.3	60.3	68.2	69.9	78.8
Harrison, WV	PHCS-MPI: HOSPITALS	1	2,113	100.0	0	0.0	19.1	25.1	24.8	31.9
	PHCS-MPI: NURSING FACILITY	2	2,113	100.0	0	0.0	7.8	17.6	18.2	28.2
	PHCS-MPI: CARDIOLOGY	7	2,113	100.0	0	0.0	15.8	19.1	23.4	27.7
	PHCS-MPI: DERMATOLOGY	5	2,113	100.0	0	0.0	11.2	12.1	26.7	30.6
	PHCS-MPI: GENERAL SURGERY	11	2,113	100.0	0	0.0	6.5	8.5	22.4	23.1
	PHCS-MPI: NEUROLOGY	3	2,113	100.0	0	0.0	11.1	11.1	28.2	28.2
	PHCS-MPI: OBSTETRICS & GYNECOLOGY	12	2,113	100.0	0	0.0	9.0	11.0	22.0	25.0
	PHCS-MPI: ONCOLOGY	3	2,113	100.0	0	0.0	10.0	11.0	28.2	28.2
	PHCS-MPI: ORAL SURGERY	0	1,064	50.4	1,049	49.6	80.7	88.7	88.8	96.8
	PHCS-MPI: ORTHOPEDIC SURGERY	4	2,113	100.0	0	0.0	12.1	12.1	25.0	25.0
	PHCS-MPI: OTOLARYNGOLOGY	2	2,113	100.0	0	0.0	10.4	11.0	25.8	26.2
	PHCS-MPI: PEDIATRICIAN	12	2,113	100.0	0	0.0	4.9	8.2	15.8	21.7
	PHCS-MPI: PHYSICAL THERAPY	20	2,113	100.0	0	0.0	6.5	7.5	17.2	24.3
	PHCS-MPI: PRIMARY CARE PHYSICIAN	124	2,113	100.0	0	0.0	2.1	2.2	12.4	12.4
	PHCS-MPI: RADIOLOGY	0	2,113	100.0	0	0.0	17.3	17.3	24.3	24.3
	PHCS-MPI: UROLOGY	2	2,113	100.0	0	0.0	9.8	11.2	23.2	27.7
Jackson, WV	PHCS-MPI: HOSPITALS	1	1,099	100.0	0	0.0	18.1	30.2	28.9	39.6
	PHCS-MPI: NURSING FACILITY	0	1,099	100.0	0	0.0	38.6	42.6	48.2	52.5
	PHCS-MPI: CARDIOLOGY	6	1,099	100.0	0	0.0	12.1	12.1	28.9	28.9
	PHCS-MPI: DERMATOLOGY	0	1,099	100.0	0	0.0	43.3	43.4	55.2	55.7
	PHCS-MPI: GENERAL SURGERY	3	1,099	100.0	0	0.0	29.3	29.6	39.4	39.4
	PHCS-MPI: NEUROLOGY	0	1,099	100.0	0	0.0	26.7	26.8	39.4	39.7
	PHCS-MPI: OBSTETRICS & GYNECOLOGY	0	1,099	100.0	0	0.0	25.0	29.0	37.2	37.2
	PHCS-MPI: ONCOLOGY	0	1,099	100.0	0	0.0	26.5	40.9	39.6	55.8

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Continued on next page...

South[illegible]st Access Detail By County

March 2, 2016

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MultiPlan

General Access

[1] The Access Standard is defined as (State of WV) employees accessing in:

Urban areas...

1 (PHCS-MPI: HOSPITALS) provider in 30 minutes, 1 (PHCS-MPI: NURSING FACILITY) provider in 30 minutes, 2 (PHCS-MPI: CARDIOLOGY) providers in 30 minutes, 1 (PHCS-MPI: DERMATOLOGY) provider in 30 minutes, 2 (PHCS-MPI: GENERAL SURGERY) providers in 30 minutes, 1 (PHCS-MPI: NEUROLOGY) provider in 30 minutes, 2 (PHCS-MPI: OBSTETRICS & GYNECOLOGY) providers in 30 minutes, 2 (PHCS-MPI: ONCOLOGY) providers in 30 minutes, 1 (PHCS-MPI: ORAL SURGERY) provider in 30 minutes, 2 (PHCS-MPI: ORTHOPEDIC SURGERY) providers in 30 minutes, 1 (PHCS-MPI: OTOLARYNGOLOGY) provider in 30 minutes, 2 (PHCS-MPI: PEDIATRICIAN) providers in 30 minutes, 2 (PHCS-MPI: PHYSICAL THERAPY) providers in 30 minutes, 2 (PHCS-MPI: PRIMARY CARE PHYSICIAN) providers in 30 minutes, 2 (PHCS-MPI: RADIOLOGY) providers in 30 minutes, 1 (PHCS-MPI: UROLOGY) provider in 30 minutes

Suburban areas...

All Employees										
County	Provider		With Access[1]		Without Access[1]		Average Time		Maximum Time	
	Name	#	#	%	#	%	1	2	1	2
Jefferson, WV	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
	PHCS-MPI: ORTHOPEDIC SURGERY	3	1,099	100.0	0	0.0	11.3	12.0	24.1	24.5
	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
	PHCS-MPI: PEDIATRICIAN	1	1,099	100.0	0	0.0	16.1	25.7	31.7	36.9
	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
	PHCS-MPI: PRIMARY CARE PHYSICIAN	32	1,099	100.0	0	0.0	9.0	9.7	22.9	22.9
	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
	PHCS-MPI: UROLOGY	0	1,068	97.2	31	2.8	48.9	51.1	62.2	64.0
Jefferson, WV	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
	PHCS-MPI: NURSING FACILITY	1	1,082	100.0	0	0.0	7.2	20.6	15.3	30.4
	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
	PHCS-MPI: DERMATOLOGY	2	1,082	100.0	0	0.0	7.1	8.1	15.9	16.3
	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
	PHCS-MPI: NEUROLOGY	0	1,082	100.0	0	0.0	20.1	124.2	30.3	135.9
	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
	PHCS-MPI: ONCOLOGY	0	1,082	100.0	0	0.0	20.7	21.5	30.9	31.6
	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
	PHCS-MPI: ORTHOPEDIC SURGERY	1	1,082	100.0	0	0.0	7.7	20.8	16.3	30.9
	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
	PHCS-MPI: PEDIATRICIAN	7	1,082	100.0	0	0.0	6.1	6.4	12.7	12.9
	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
	PHCS-MPI: PRIMARY CARE PHYSICIAN	43	1,082	100.0	0	0.0	4.1	5.2	10.2	11.6
	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
	PHCS-MPI: UROLOGY	2	1,082	100.0	0	0.0	7.0	7.9	15.4	15.7
Kanawha, WV	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
	PHCS-MPI: NURSING FACILITY	3	7,824	100.0	0	0.0	12.2	24.3	36.0	53.1
	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
	PHCS-MPI: DERMATOLOGY	2	6,738	86.1	1,086	13.9	21.7	22.2	55.0	66.4
	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
	PHCS-MPI: NEUROLOGY	6	7,479	95.6	345	4.4	11.7	13.5	46.6	48.8
	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
	PHCS-MPI: ONCOLOGY	7	6,865	87.7	959	12.3	13.2	15.3	47.0	52.8
	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
	PHCS-MPI: ORTHOPEDIC SURGERY	11	6,903	88.2	921	11.8	13.6	13.6	49.9	49.9
	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
	PHCS-MPI: PEDIATRICIAN	44	7,824	100.0	0	0.0	4.6	7.0	26.0	31.3
	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
	PHCS-MPI: PRIMARY CARE PHYSICIAN	191	7,824	100.0	0	0.0	3.7	4.7	22.1	22.1
	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
	PHCS-MPI: UROLOGY	0	3,451	44.1	4,373	55.9	33.5	56.1	63.4	75.7

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Continued on next page...

Southeast Access Detail By County

March 2, 2016

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MultiPlan

General Access

[1] The Access Standard is defined as (State of WV) employees accessing in:

Urban areas...

1 (PHCS-MPI: HOSPITALS) provider in 30 minutes, 1 (PHCS-MPI: NURSING FACILITY) provider in 30 minutes, 2 (PHCS-MPI: CARDIOLOGY) providers in 30 minutes, 1 (PHCS-MPI: DERMATOLOGY) provider in 30 minutes, 2 (PHCS-MPI: GENERAL SURGERY) providers in 30 minutes, 1 (PHCS-MPI: NEUROLOGY) provider in 30 minutes, 2 (PHCS-MPI: OBSTETRICS & GYNECOLOGY) providers in 30 minutes, 2 (PHCS-MPI: ONCOLOGY) providers in 30 minutes, 1 (PHCS-MPI: ORAL SURGERY) provider in 30 minutes, 2 (PHCS-MPI: ORTHOPEDIC SURGERY) providers in 30 minutes, 1 (PHCS-MPI: OTOLARYNGOLOGY) provider in 30 minutes, 2 (PHCS-MPI: PEDIATRICIAN) providers in 30 minutes, 2 (PHCS-MPI: PHYSICAL THERAPY) providers in 30 minutes, 2 (PHCS-MPI: PRIMARY CARE PHYSICIAN) providers in 30 minutes, 2 (PHCS-MPI: RADIOLOGY) providers in 30 minutes, 1 (PHCS-MPI: UROLOGY) provider in 30 minutes

Suburban areas...

All Employees										
County	Provider		With Access[2]		Without Access[2]		Average Time		Maximum Time	
	Name	#	#	%	#	%	1	2	1	2
Lewis, WV	PHCS-MPI: HOSPITALS	1	732	100.0	0	0.0	11.5	21.0	23.3	31.0
	PHCS-MPI: NURSING FACILITY	0	732	100.0	0	0.0	20.8	27.8	33.7	42.8
	PHCS-MPI: CARDIOLOGY	1	732	100.0	0	0.0	11.6	21.3	23.7	31.0
	PHCS-MPI: DERMATOLOGY	0	732	100.0	0	0.0	33.2	33.2	45.7	45.7
	PHCS-MPI: GENERAL SURGERY	1	732	100.0	0	0.0	11.3	11.5	22.1	23.7
	PHCS-MPI: NEUROLOGY	0	732	100.0	0	0.0	37.7	37.7	49.6	49.6
	PHCS-MPI: OBSTETRICS & GYNECOLOGY	1	732	100.0	0	0.0	8.7	16.8	16.9	18.1
	PHCS-MPI: ONCOLOGY	0	732	100.0	0	0.0	37.1	37.2	49.1	49.1
	PHCS-MPI: ORAL SURGERY	0	3	0.4	729	99.6	76.2	75.8	86.6	86.6
	PHCS-MPI: ORTHOPEDIC SURGERY	3	732	100.0	0	0.0	11.5	11.9	23.7	23.7
	PHCS-MPI: OTOLARYNGOLOGY	1	732	100.0	0	0.0	11.8	37.2	22.8	49.1
	PHCS-MPI: PEDIATRICIAN	2	732	100.0	0	0.0	11.0	12.1	21.9	22.8
	PHCS-MPI: PHYSICAL THERAPY	2	732	100.0	0	0.0	15.0	15.0	25.6	25.6
	PHCS-MPI: PRIMARY CARE PHYSICIAN	22	732	100.0	0	0.0	8.0	8.1	16.4	16.5
	PHCS-MPI: RADIOLOGY	20	732	100.0	0	0.0	11.2	11.3	23.4	23.4
	PHCS-MPI: UROLOGY	1	732	100.0	0	0.0	11.5	21.2	23.7	31.0
Lincoln, WV	PHCS-MPI: HOSPITALS	0	1,473	100.0	0	0.0	30.7	39.4	33.4	44.6
	PHCS-MPI: NURSING FACILITY	0	1,473	100.0	0	0.0	30.4	35.1	54.2	58.7
	PHCS-MPI: CARDIOLOGY	0	1,473	100.0	0	0.0	28.7	42.0	38.1	60.0
	PHCS-MPI: DERMATOLOGY	0	1,473	100.0	0	0.0	27.1	32.8	42.6	53.1
	PHCS-MPI: GENERAL SURGERY	0	1,473	100.0	0	0.0	29.0	33.1	39.5	40.4
	PHCS-MPI: NEUROLOGY	0	1,473	100.0	0	0.0	29.4	32.9	50.1	53.1
	PHCS-MPI: OBSTETRICS & GYNECOLOGY	0	1,473	100.0	0	0.0	9.4	18.7	19.2	20.6
	PHCS-MPI: ONCOLOGY	0	1,470	99.8	3	0.2	26.3	32.9	37.0	53.1
	PHCS-MPI: ORAL SURGERY	0	1,392	97.9	81	2.1	47.2	103.3	84.7	160.0
	PHCS-MPI: ORTHOPEDIC SURGERY	0	1,473	100.0	0	0.0	29.6	29.8	50.1	50.1
	PHCS-MPI: OTOLARYNGOLOGY	0	1,473	100.0	0	0.0	28.8	30.5	30.0	42.4
	PHCS-MPI: PEDIATRICIAN	2	1,473	100.0	0	0.0	9.5	14.5	16.3	20.8
	PHCS-MPI: PHYSICAL THERAPY	2	1,473	100.0	0	0.0	10.2	13.8	19.7	22.1
	PHCS-MPI: PRIMARY CARE PHYSICIAN	25	1,473	100.0	0	0.0	5.4	6.1	11.1	12.6
	PHCS-MPI: RADIOLOGY	0	1,473	100.0	0	0.0	22.0	23.6	32.6	32.6
	PHCS-MPI: UROLOGY	0	1,470	99.8	3	0.2	41.4	46.7	56.5	61.5
Logan, WV	PHCS-MPI: HOSPITALS	0	3,149	100.0	0	0.0	31.7	39.3	27.8	42.2
	PHCS-MPI: NURSING FACILITY	0	3,149	100.0	0	0.0	47.6	47.8	57.4	60.9
	PHCS-MPI: CARDIOLOGY	0	3,149	100.0	0	0.0	29.6	48.4	42.6	66.6
	PHCS-MPI: DERMATOLOGY	0	3,149	100.0	0	0.0	49.2	55.9	58.9	63.3
	PHCS-MPI: GENERAL SURGERY	1	3,149	100.0	0	0.0	0.0	28.4	30.4	42.7
	PHCS-MPI: NEUROLOGY	0	3,149	100.0	0	0.0	48.8	49.2	58.8	59.4
	PHCS-MPI: OBSTETRICS & GYNECOLOGY	0	3,149	100.0	0	0.0	29.7	29.0	32.4	33.0
	PHCS-MPI: ONCOLOGY	1	3,149	100.0	0	0.0	8.9	47.8	22.6	58.3

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South[illegible]st Access Detail By County

March 2, 2016

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General Access

[1] The Access Standard is defined as (State of WV) employees accessing in:

Urban areas...

1 (PHCS-MPI: HOSPITALS) provider in 30 minutes, 1 (PHCS-MPI: NURSING FACILITY) provider in 30 minutes, 2 (PHCS-MPI: CARDIOLOGY) providers in 30 minutes, 1 (PHCS-MPI: DERMATOLOGY) provider in 30 minutes, 2 (PHCS-MPI: GENERAL SURGERY) providers in 30 minutes, 1 (PHCS-MPI: NEUROLOGY) provider in 30 minutes, 2 (PHCS-MPI: OBSTETRICS & GYNECOLOGY) providers in 30 minutes, 2 (PHCS-MPI: ONCOLOGY) providers in 30 minutes, 1 (PHCS-MPI: ORAL SURGERY) provider in 30 minutes, 2 (PHCS-MPI: ORTHOPEDIC SURGERY) providers in 30 minutes, 1 (PHCS-MPI: OTOLARYNGOLOGY) provider in 30 minutes, 2 (PHCS-MPI: PEDIATRICIAN) providers in 30 minutes, 2 (PHCS-MPI: PHYSICAL THERAPY) providers in 30 minutes, 2 (PHCS-MPI: PRIMARY CARE PHYSICIAN) providers in 30 minutes, 2 (PHCS-MPI: RADIOLOGY) providers in 30 minutes, 1 (PHCS-MPI: UROLOGY) provider in 30 minutes

Suburban areas...

All Employees										
County	Provider		With Access[2]		Without Access[2]		Average Time		Maximum Time	
	Name	#	#	%	#	%	1	2	1	2
Logan, WV	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
	PHCS-MPI: ORTHOPEDIC SURGERY	0	3,149	100.0	0	0.0	48.8	48.9	58.6	58.8
	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
	PHCS-MPI: PEDIATRICIAN	2	3,149	100.0	0	0.0	7.1	10.3	24.1	27.1
	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
	PHCS-MPI: PRIMARY CARE PHYSICIAN	30	3,149	100.0	0	0.0	4.3	4.5	12.6	15.1
	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
	PHCS-MPI: UROLOGY	0	3,147	99.9	2	0.1	49.3	49.7	61.0	62.2
Mason, WV	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
	PHCS-MPI: NURSING FACILITY	0	1,702	100.0	0	0.0	24.5	29.3	31.0	36.1
	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
	PHCS-MPI: DERMATOLOGY	1	1,702	100.0	0	0.0	8.4	19.6	26.5	31.0
	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
	PHCS-MPI: NEUROLOGY	0	1,702	100.0	0	0.0	19.2	20.6	32.2	34.0
	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
	PHCS-MPI: ONCOLOGY	1	1,702	100.0	0	0.0	8.2	19.5	27.1	30.7
	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
	PHCS-MPI: ORTHOPEDIC SURGERY	2	1,702	100.0	0	0.0	8.2	8.2	27.1	27.1
	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
	PHCS-MPI: PEDIATRICIAN	13	1,702	100.0	0	0.0	4.6	4.8	18.0	18.0
	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
	PHCS-MPI: PRIMARY CARE PHYSICIAN	45	1,702	100.0	0	0.0	3.6	3.7	10.7	10.7
	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
	PHCS-MPI: UROLOGY	2	1,702	100.0	0	0.0	8.0	11.8	27.1	29.7
Marshall, WV	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
	PHCS-MPI: NURSING FACILITY	0	736	100.0	0	0.0	17.6	18.3	31.0	32.5
	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
	PHCS-MPI: DERMATOLOGY	0	736	100.0	0	0.0	12.9	18.1	22.5	34.0
	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
	PHCS-MPI: NEUROLOGY	0	736	100.0	0	0.0	16.0	17.7	31.0	37.2
	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
	PHCS-MPI: ONCOLOGY	4	736	100.0	0	0.0	9.3	9.3	21.2	21.2
	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
	PHCS-MPI: ORTHOPEDIC SURGERY	1	736	100.0	0	0.0	9.3	16.0	21.2	31.0
	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
	PHCS-MPI: PEDIATRICIAN	2	736	100.0	0	0.0	9.1	9.6	21.2	21.7
	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
	PHCS-MPI: PRIMARY CARE PHYSICIAN	13	736	100.0	0	0.0	4.1	8.1	13.5	19.9
	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
	PHCS-MPI: UROLOGY	1	736	100.0	0	0.0	9.4	17.9	21.2	31.0

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Continued on next page...

Southeast Access Detail By County

March 2, 2016

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General Access

[1] The Access Standard is defined as (State of WV) employees accessing in:

Urban areas...

1 (PHCS-MPI: HOSPITALS) provider in 30 minutes, 1 (PHCS-MPI: NURSING FACILITY) provider in 30 minutes, 2 (PHCS-MPI: CARDIOLOGY) providers in 30 minutes, 1 (PHCS-MPI: DERMATOLOGY) provider in 30 minutes, 2 (PHCS-MPI: GENERAL SURGERY) providers in 30 minutes, 1 (PHCS-MPI: NEUROLOGY) provider in 30 minutes, 2 (PHCS-MPI: OBSTETRICS & GYNECOLOGY) providers in 30 minutes, 2 (PHCS-MPI: ONCOLOGY) providers in 30 minutes, 1 (PHCS-MPI: ORAL SURGERY) provider in 30 minutes, 2 (PHCS-MPI: ORTHOPEDIC SURGERY) providers in 30 minutes, 1 (PHCS-MPI: OTOLARYNGOLOGY) provider in 30 minutes, 2 (PHCS-MPI: PEDIATRICIAN) providers in 30 minutes, 2 (PHCS-MPI: PHYSICAL THERAPY) providers in 30 minutes, 2 (PHCS-MPI: PRIMARY CARE PHYSICIAN) providers in 30 minutes, 2 (PHCS-MPI: RADIOLOGY) providers in 30 minutes, 1 (PHCS-MPI: UROLOGY) provider in 30 minutes

Suburban areas...

All Employees										
County	Provider		With Access[2]		Without Access[1]		Average Time		Maximum Time	
	Name	#	#	%	#	%	1	2	1	2
Mason, WV	PHCS-MPI: HOSPITALS	1	1,392	100.0	0	0.0	14.7	26.6	24.5	34.3
	PHCS-MPI: NURSING FACILITY	0	1,192	85.6	200	14.4	40.7	51.1	60.4	65.6
	PHCS-MPI: CARDIOLOGY	4	1,392	100.0	0	0.0	14.7	14.7	24.5	24.5
	PHCS-MPI: DERMATOLOGY	0	1,192	85.6	200	14.4	40.6	50.4	59.4	68.4
	PHCS-MPI: GENERAL SURGERY	8	1,392	100.0	0	0.0	14.8	15.0	29.0	29.0
	PHCS-MPI: NEUROLOGY	2	1,392	100.0	0	0.0	15.0	15.3	29.0	29.1
	PHCS-MPI: OBSTETRICS & GYNECOLOGY	5	1,392	100.0	0	0.0	11.8	13.6	21.8	21.8
	PHCS-MPI: ONCOLOGY	1	1,106	79.5	286	20.5	15.2	49.2	29.0	64.2
	PHCS-MPI: ORAL SURGERY	0	676	48.6	716	51.4	69.7	139.8	89.0	140.0
	PHCS-MPI: ORTHOPEDIC SURGERY	3	1,392	100.0	0	0.0	14.7	14.7	24.5	24.5
	PHCS-MPI: OTOLARYNGOLOGY	3	1,392	100.0	0	0.0	14.8	15.3	24.8	29.0
	PHCS-MPI: PEDIATRICIAN	10	1,392	100.0	0	0.0	12.9	13.4	23.1	24.8
	PHCS-MPI: PHYSICAL THERAPY	0	1,392	100.0	0	0.0	11.4	15.8	21.8	29.0
	PHCS-MPI: PRIMARY CARE PHYSICIAN	31	1,392	100.0	0	0.0	7.5	9.2	15.6	17.3
	PHCS-MPI: RADIOLOGY	12	1,392	100.0	0	0.0	15.0	15.0	29.0	29.0
	PHCS-MPI: UROLOGY	0	992	71.3	400	28.7	51.7	51.8	64.5	64.5
McDowell, WV	PHCS-MPI: HOSPITALS	1	3,630	100.0	0	0.0	30.9	52.9	51.4	72.2
	PHCS-MPI: NURSING FACILITY	0	3,630	100.0	0	0.0	30.9	52.9	51.4	72.2
	PHCS-MPI: CARDIOLOGY	0	3,630	100.0	0	0.0	29.3	38.4	42.8	51.3
	PHCS-MPI: DERMATOLOGY	0	3,630	100.0	0	0.0	30.1	36.1	50.9	58.4
	PHCS-MPI: GENERAL SURGERY	1	3,630	100.0	0	0.0	30.5	35.7	51.6	58.2
	PHCS-MPI: NEUROLOGY	0	3,630	100.0	0	0.0	30.5	35.7	51.6	58.2
	PHCS-MPI: OBSTETRICS & GYNECOLOGY	1	3,630	100.0	0	0.0	29.2	34.8	39.8	51.8
	PHCS-MPI: ONCOLOGY	0	3,630	100.0	0	0.0	29.2	34.8	39.8	51.8
	PHCS-MPI: ORAL SURGERY	0	3,630	100.0	0	0.0	30.8	52.9	51.4	72.2
	PHCS-MPI: ORTHOPEDIC SURGERY	0	3,630	100.0	0	0.0	30.4	30.4	51.4	51.4
	PHCS-MPI: OTOLARYNGOLOGY	0	3,630	100.0	0	0.0	29.1	36.6	40.8	51.4
	PHCS-MPI: PEDIATRICIAN	1	3,630	100.0	0	0.0	9.7	22.9	24.9	32.8
	PHCS-MPI: PHYSICAL THERAPY	0	3,630	100.0	0	0.0	29.1	34.0	40.8	46.8
	PHCS-MPI: PRIMARY CARE PHYSICIAN	11	3,630	100.0	0	0.0	4.1	7.4	13.9	18.1
	PHCS-MPI: RADIOLOGY	7	3,630	100.0	0	0.0	15.0	15.0	29.0	29.0
	PHCS-MPI: UROLOGY	0	3,630	100.0	0	0.0	30.3	30.5	51.3	51.6
Mercer, WV	PHCS-MPI: HOSPITALS	2	1,958	100.0	0	0.0	9.6	12.6	19.9	24.4
	PHCS-MPI: NURSING FACILITY	1	1,958	100.0	0	0.0	11.3	34.2	22.6	46.6
	PHCS-MPI: CARDIOLOGY	12	1,958	100.0	0	0.0	9.8	9.8	20.0	20.0
	PHCS-MPI: DERMATOLOGY	2	1,958	100.0	0	0.0	9.4	16.3	19.9	28.6
	PHCS-MPI: GENERAL SURGERY	6	1,958	100.0	0	0.0	9.6	12.4	19.9	20.0
	PHCS-MPI: NEUROLOGY	3	1,958	100.0	0	0.0	9.6	12.3	20.4	20.4
	PHCS-MPI: OBSTETRICS & GYNECOLOGY	10	1,958	100.0	0	0.0	9.6	9.6	19.9	19.9
	PHCS-MPI: ONCOLOGY	6	1,958	100.0	0	0.0	9.1	11.9	20.2	20.5

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Southeast Access Detail By County

March 2, 2016

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General Access

[1] The Access Standard is defined as (State of WV) employees accessing in:

Urban areas...

1 (PHCS-MPI: HOSPITALS) provider in 30 minutes, 1 (PHCS-MPI: NURSING FACILITY) provider in 30 minutes, 2 (PHCS-MPI: CARDIOLOGY) providers in 30 minutes, 1 (PHCS-MPI: DERMATOLOGY) provider in 30 minutes, 2 (PHCS-MPI: GENERAL SURGERY) providers in 30 minutes, 1 (PHCS-MPI: NEUROLOGY) provider in 30 minutes, 2 (PHCS-MPI: OBSTETRICS & GYNECOLOGY) providers in 30 minutes, 2 (PHCS-MPI: ONCOLOGY) providers in 30 minutes, 1 (PHCS-MPI: ORAL SURGERY) provider in 30 minutes, 2 (PHCS-MPI: ORTHOPEDIC SURGERY) providers in 30 minutes, 1 (PHCS-MPI: OTOLARYNGOLOGY) provider in 30 minutes, 2 (PHCS-MPI: PEDIATRICIAN) providers in 30 minutes, 2 (PHCS-MPI: PHYSICAL THERAPY) providers in 30 minutes, 2 (PHCS-MPI: PRIMARY CARE PHYSICIAN) providers in 30 minutes, 2 (PHCS-MPI: RADIOLOGY) providers in 30 minutes, 1 (PHCS-MPI: UROLOGY) provider in 30 minutes

Suburban areas...

All Employees										
County	Provider		With Access[1]		Without Access[1]		Average Time		Maximum Time	
	Name	#	#	%	#	%	1	2	1	2
[illegible], WV	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
	PHCS-MPI: ORTHOPEDIC SURGERY	8	1,958	100.0	0	0.0	9.4	9.9	20.7	21.5
	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
	PHCS-MPI: PEDIATRICIAN	12	1,958	100.0	0	0.0	5.2	7.9	16.3	17.6
	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
	PHCS-MPI: PRIMARY CARE PHYSICIAN	58	1,958	100.0	0	0.0	3.7	5.9	12.9	14.4
	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
	PHCS-MPI: UROLOGY	7	1,958	100.0	0	0.0	9.3	9.5	20.1	20.1
[illegible], WV	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
	PHCS-MPI: NURSING FACILITY	1	825	100.0	0	0.0	13.8	37.9	30.3	49.6
	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
	PHCS-MPI: DERMATOLOGY	0	825	100.0	0	0.0	23.9	31.1	33.9	37.3
	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
	PHCS-MPI: NEUROLOGY	0	564	68.4	261	31.6	56.6	63.8	65.2	72.9
	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
	PHCS-MPI: ONCOLOGY	0	266	32.2	559	67.8	61.5	61.5	71.4	71.4
	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
	PHCS-MPI: ORTHOPEDIC SURGERY	0	541	65.6	284	34.4	56.5	57.3	65.5	68.0
	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
	PHCS-MPI: PEDIATRICIAN	1	825	100.0	0	0.0	13.1	23.0	26.6	31.9
	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
	PHCS-MPI: PRIMARY CARE PHYSICIAN	10	825	100.0	0	0.0	4.6	11.9	12.9	26.7
	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
	PHCS-MPI: UROLOGY	0	265	32.1	560	67.9	61.4	61.8	71.4	71.4
Mingo, WV	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
	PHCS-MPI: NURSING FACILITY	0	674	31.1	1,490	68.9	61.6	63.6	73.0	79.4
	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
	PHCS-MPI: DERMATOLOGY	0	1,616	74.7	548	25.3	54.8	63.8	64.4	74.7
	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
	PHCS-MPI: NEUROLOGY	0	728	33.6	1,436	66.4	62.0	62.3	74.2	74.2
	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
	PHCS-MPI: ONCOLOGY	0	734	33.9	1,430	66.1	20.6	61.3	26.2	73.0
	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
	PHCS-MPI: ORTHOPEDIC SURGERY	0	728	33.6	1,436	66.4	61.6	62.0	73.9	74.2
	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
	PHCS-MPI: PEDIATRICIAN	2	2,164	100.0	0	0.0	8.3	17.6	22.1	25.7
	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
	PHCS-MPI: PRIMARY CARE PHYSICIAN	14	2,164	100.0	0	0.0	6.0	6.4	15.0	15.0
	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
	PHCS-MPI: UROLOGY	0	664	30.7	1,500	69.3	62.4	62.5	74.2	74.2

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Southeast Access Detail By County

March 2, 2016

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General Access

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Urban areas...

1 (PHCS-MPI: HOSPITALS) provider in 30 minutes, 1 (PHCS-MPI: NURSING FACILITY) provider in 30 minutes, 2 (PHCS-MPI: CARDIOLOGY) providers in 30 minutes, 1 (PHCS-MPI: DERMATOLOGY) provider in 30 minutes, 2 (PHCS-MPI: GENERAL SURGERY) providers in 30 minutes, 1 (PHCS-MPI: NEUROLOGY) provider in 30 minutes, 2 (PHCS-MPI: OBSTETRICS & GYNECOLOGY) providers in 30 minutes, 2 (PHCS-MPI: ONCOLOGY) providers in 30 minutes, 1 (PHCS-MPI: ORAL SURGERY) provider in 30 minutes, 2 (PHCS-MPI: ORTHOPEDIC SURGERY) providers in 30 minutes, 1 (PHCS-MPI: OTOLARYNGOLOGY) provider in 30 minutes, 2 (PHCS-MPI: PEDIATRICIAN) providers in 30 minutes, 2 (PHCS-MPI: PHYSICAL THERAPY) providers in 30 minutes, 2 (PHCS-MPI: PRIMARY CARE PHYSICIAN) providers in 30 minutes, 2 (PHCS-MPI: RADIOLOGY) providers in 30 minutes, 1 (PHCS-MPI: UROLOGY) provider in 30 minutes

Suburban areas...

All Employees										
County	Provider		With Access[2]		Without Access[2]		Average Time		Maximum Time	
	Name	#	#	%	#	%	1	2	1	2
Monongalia, WV	PHCS-MPI: HOSPITALS	2	1,737	100.0	0	0.0	10.0	12.2	32.0	36.0
	PHCS-MPI: NURSING FACILITY	2	1,737	100.0	0	0.0	10.8	11.8	32.1	33.0
	PHCS-MPI: CARDIOLOGY	2	1,737	100.0	0	0.0	7.8	8.8	30.2	30.7
	PHCS-MPI: DERMATOLOGY	13	1,737	100.0	0	0.0	7.7	7.8	28.4	28.4
	PHCS-MPI: GENERAL SURGERY	2	1,737	100.0	0	0.0	8.8	9.8	30.1	30.2
	PHCS-MPI: NEUROLOGY	21	1,737	100.0	0	0.0	8.6	9.1	30.0	30.3
	PHCS-MPI: OBSTETRICS & GYNECOLOGY	2	1,737	100.0	0	0.0	8.2	8.8	30.0	30.0
	PHCS-MPI: ONCOLOGY	28	1,737	100.0	0	0.0	9.1	9.3	30.2	30.2
	PHCS-MPI: ORAL SURGERY	9	1,737	100.0	0	0.0	9.6	9.4	30.7	30.7
	PHCS-MPI: ORTHOPEDIC SURGERY	36	1,737	100.0	0	0.0	8.6	8.8	30.2	30.2
	PHCS-MPI: OTOLARYNGOLOGY	2	1,737	100.0	0	0.0	9.1	9.7	30.7	30.7
	PHCS-MPI: PEDIATRICIAN	79	1,737	100.0	0	0.0	6.3	6.4	21.9	21.9
	PHCS-MPI: PHYSICAL THERAPY	13	1,737	100.0	0	0.0	9.2	9.8	32.1	32.7
	PHCS-MPI: PRIMARY CARE PHYSICIAN	202	1,737	100.0	0	0.0	3.0	3.5	11.2	11.2
	PHCS-MPI: RADIOLOGY	16	1,737	100.0	0	0.0	9.1	9.2	30.4	30.7
	PHCS-MPI: UROLOGY	12	1,737	100.0	0	0.0	9.3	9.4	30.3	30.7
Monroe, WV	PHCS-MPI: HOSPITALS	0	1,086	100.0	0	0.0	17.7	25.0	29.2	33.4
	PHCS-MPI: NURSING FACILITY	1	1,086	100.0	0	0.0	11.5	20.7	22.6	33.3
	PHCS-MPI: CARDIOLOGY	0	1,086	100.0	0	0.0	20.7	32.1	30.3	34.1
	PHCS-MPI: DERMATOLOGY	0	1,041	95.9	45	4.1	43.3	48.3	65.7	66.3
	PHCS-MPI: GENERAL SURGERY	0	1,086	100.0	0	0.0	20.2	28.8	31.9	33.0
	PHCS-MPI: NEUROLOGY	0	1,086	100.0	0	0.0	22.2	23.9	34.1	35.6
	PHCS-MPI: OBSTETRICS & GYNECOLOGY	0	1,086	100.0	0	0.0	21.0	29.0	32.8	32.6
	PHCS-MPI: ONCOLOGY	0	1,086	100.0	0	0.0	20.5	23.0	31.9	33.8
	PHCS-MPI: ORAL SURGERY	0	977	90.0	109	10.0	48.1	118.5	86.1	105.7
	PHCS-MPI: ORTHOPEDIC SURGERY	0	1,038	95.6	48	4.4	21.3	43.0	33.7	64.2
	PHCS-MPI: OTOLARYNGOLOGY	0	1,086	100.0	0	0.0	21.1	21.3	30.3	32.3
	PHCS-MPI: PEDIATRICIAN	0	1,086	100.0	0	0.0	20.9	21.0	31.8	32.4
	PHCS-MPI: PHYSICAL THERAPY	1	1,086	100.0	0	0.0	11.0	25.0	26.2	32.9
	PHCS-MPI: PRIMARY CARE PHYSICIAN	6	1,086	100.0	0	0.0	7.5	8.2	15.7	18.2
	PHCS-MPI: RADIOLOGY	0	1,086	100.0	0	0.0	21.2	22.4	33.4	33.5
	PHCS-MPI: UROLOGY	0	1,086	100.0	0	0.0	19.8	21.1	32.5	33.3
Morgan, WV	PHCS-MPI: HOSPITALS	1	286	100.0	0	0.0	16.1	28.3	33.0	33.5
	PHCS-MPI: NURSING FACILITY	1	286	100.0	0	0.0	9.9	27.6	16.9	35.0
	PHCS-MPI: CARDIOLOGY	2	286	100.0	0	0.0	10.1	10.1	18.0	18.0
	PHCS-MPI: DERMATOLOGY	1	286	100.0	0	0.0	10.2	26.2	18.5	33.4
	PHCS-MPI: GENERAL SURGERY	2	286	100.0	0	0.0	10.7	10.1	18.0	18.0
	PHCS-MPI: NEUROLOGY	0	286	100.0	0	0.0	27.6	92.2	35.5	107.3
	PHCS-MPI: OBSTETRICS & GYNECOLOGY	0	286	100.0	0	0.0	28.0	27.0	34.0	34.0
	PHCS-MPI: ONCOLOGY	0	286	100.0	0	0.0	26.4	26.4	34.1	34.1

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Southeast Access Detail By County

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[1] The Access Standard is defined as (State of WV) employees accessing in:

Urban areas...

1 (PHCS-MPI: HOSPITALS) provider in 30 minutes, 1 (PHCS-MPI: NURSING FACILITY) provider in 30 minutes, 2 (PHCS-MPI: CARDIOLOGY) providers in 30 minutes, 1 (PHCS-MPI: DERMATOLOGY) provider in 30 minutes, 2 (PHCS-MPI: GENERAL SURGERY) providers in 30 minutes, 1 (PHCS-MPI: NEUROLOGY) provider in 30 minutes, 2 (PHCS-MPI: OBSTETRICS & GYNECOLOGY) providers in 30 minutes, 2 (PHCS-MPI: ONCOLOGY) providers in 30 minutes, 1 (PHCS-MPI: ORAL SURGERY) provider in 30 minutes, 2 (PHCS-MPI: ORTHOPEDIC SURGERY) providers in 30 minutes, 1 (PHCS-MPI: OTOLARYNGOLOGY) provider in 30 minutes, 2 (PHCS-MPI: PEDIATRICIAN) providers in 30 minutes, 2 (PHCS-MPI: PHYSICAL THERAPY) providers in 30 minutes, 2 (PHCS-MPI: PRIMARY CARE PHYSICIAN) providers in 30 minutes, 2 (PHCS-MPI: RADIOLOGY) providers in 30 minutes, 1 (PHCS-MPI: UROLOGY) provider in 30 minutes

Suburban areas...

All Employees										
County	Provider		With Access[1]		Without Access[1]		Average Time		Maximum Time	
	Name	#	#	%	#	%	1	2	1	2
Morgan, WV	[illegible]	0	[illegible]							
	PHCS-MPI: ORTHOPEDIC SURGERY	0	286	100.0	0	0.0	26.9	26.9	34.5	34.5
	[illegible]	0	[illegible]							
	PHCS-MPI: PEDIATRICIAN	1	286	100.0	0	0.0	11.7	25.3	21.0	33.9
	[illegible]	0	[illegible]							
	PHCS-MPI: PRIMARY CARE PHYSICIAN	14	286	100.0	0	0.0	9.5	9.8	18.0	18.0
	[illegible]	0	[illegible]							
	PHCS-MPI: UROLOGY	0	286	100.0	0	0.0	26.3	26.8	33.9	34.4
Nicholas, WV	[illegible]	1	[illegible]							
	PHCS-MPI: NURSING FACILITY	1	1,932	100.0	0	0.0	20.1	29.2	37.8	42.0
	[illegible]	0	[illegible]							
	PHCS-MPI: DERMATOLOGY	0	1,315	68.1	617	31.9	53.4	70.9	78.0	93.1
	[illegible]	0	[illegible]							
	PHCS-MPI: NEUROLOGY	0	1,893	98.0	39	2.0	43.3	44.6	63.0	63.7
	[illegible]	0	[illegible]							
	PHCS-MPI: ONCOLOGY	0	1,898	98.2	34	1.8	44.1	45.4	62.7	62.7
	[illegible]	0	[illegible]							
	PHCS-MPI: ORTHOPEDIC SURGERY	0	1,723	89.2	209	10.8	43.4	50.0	55.7	71.2
	[illegible]	0	[illegible]							
	PHCS-MPI: PEDIATRICIAN	3	1,932	100.0	0	0.0	13.1	14.0	22.0	24.4
	[illegible]	0	[illegible]							
	PHCS-MPI: PRIMARY CARE PHYSICIAN	4	1,932	100.0	0	0.0	9.4	11.8	16.6	19.3
	[illegible]	0	[illegible]							
	PHCS-MPI: UROLOGY	1	1,932	100.0	0	0.0	14.0	34.7	25.2	51.9
Ohio, WV	[illegible]	2	[illegible]							
	PHCS-MPI: NURSING FACILITY	2	398	100.0	0	0.0	10.0	13.3	16.2	24.6
	[illegible]	0	[illegible]							
	PHCS-MPI: DERMATOLOGY	3	398	100.0	0	0.0	6.6	15.2	15.5	27.6
	[illegible]	0	[illegible]							
	PHCS-MPI: NEUROLOGY	7	398	100.0	0	0.0	12.7	12.9	24.6	24.6
	[illegible]	0	[illegible]							
	PHCS-MPI: ONCOLOGY	10	398	100.0	0	0.0	12.7	12.7	24.6	24.6
	[illegible]	0	[illegible]							
	PHCS-MPI: ORTHOPEDIC SURGERY	9	398	100.0	0	0.0	13.0	13.0	25.0	25.0
	[illegible]	0	[illegible]							
	PHCS-MPI: PEDIATRICIAN	14	398	100.0	0	0.0	9.1	12.2	16.1	22.2
	[illegible]	0	[illegible]							
	PHCS-MPI: PRIMARY CARE PHYSICIAN	77	398	100.0	0	0.0	5.7	8.1	11.7	14.5
	[illegible]	0	[illegible]							
	PHCS-MPI: UROLOGY	3	398	100.0	0	0.0	13.0	13.1	24.6	24.6

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Southeast Access Detail By County

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Urban areas...

1 (PHCS-MPI: HOSPITALS) provider in 30 minutes, 1 (PHCS-MPI: NURSING FACILITY) provider in 30 minutes, 2 (PHCS-MPI: CARDIOLOGY) providers in 30 minutes, 1 (PHCS-MPI: DERMATOLOGY) provider in 30 minutes, 2 (PHCS-MPI: GENERAL SURGERY) providers in 30 minutes, 1 (PHCS-MPI: NEUROLOGY) provider in 30 minutes, 2 (PHCS-MPI: OBSTETRICS & GYNECOLOGY) providers in 30 minutes, 2 (PHCS-MPI: ONCOLOGY) providers in 30 minutes, 1 (PHCS-MPI: ORAL SURGERY) provider in 30 minutes, 2 (PHCS-MPI: ORTHOPEDIC SURGERY) providers in 30 minutes, 1 (PHCS-MPI: OTOLARYNGOLOGY) provider in 30 minutes, 2 (PHCS-MPI: PEDIATRICIAN) providers in 30 minutes, 2 (PHCS-MPI: PHYSICAL THERAPY) providers in 30 minutes, 2 (PHCS-MPI: PRIMARY CARE PHYSICIAN) providers in 30 minutes, 2 (PHCS-MPI: RADIOLOGY) providers in 30 minutes, 1 (PHCS-MPI: UROLOGY) provider in 30 minutes

Suburban areas...

All Employees										
County	Provider Name	#	With Access[2] #	With Access[2] %	Without Access[2] #	Without Access[2] %	Average Time 1	Average Time 2	Maximum Time 1	Maximum Time 2
Pendleton, WV	PHCS-MPI: HOSPITALS	0	847	100.0	0	0.0	30.4	43.0	50.0	64.2
	PHCS-MPI: NURSING FACILITY	0	428	50.5	419	49.5	60.1	67.3	80.4	85.2
	PHCS-MPI: CARDIOLOGY	0	809	95.5	38	4.5	44.1	44.2	67.2	67.4
	PHCS-MPI: DERMATOLOGY	1	847	100.0	0	0.0	14.3	37.0	23.3	58.2
	PHCS-MPI: GENERAL SURGERY	0	805	95.0	42	5.0	44.1	44.8	67.2	68.0
	PHCS-MPI: NEUROLOGY	0	104	12.3	743	87.7	71.8	81.8	88.8	96.5
	PHCS-MPI: OBSTETRICS & GYNECOLOGY	0	809	95.5	38	4.5	44.1	44.2	67.2	67.4
	PHCS-MPI: ONCOLOGY	0	809	95.5	38	4.5	44.1	44.2	67.2	67.4
	PHCS-MPI: ORAL SURGERY	0	0	0.0	847	100.0	82.7	82.7	113.0	113.0
	PHCS-MPI: ORTHOPEDIC SURGERY	0	805	95.0	42	5.0	44.1	44.8	67.2	68.0
	PHCS-MPI: OTOLARYNGOLOGY	0	809	95.5	38	4.5	44.1	73.4	67.2	89.7
	PHCS-MPI: PEDIATRICIAN	1	847	100.0	0	0.0	11.6	26.4	23.3	44.4
	PHCS-MPI: PHYSICAL THERAPY	0	847	100.0	0	0.0	30.3	30.3	46.7	46.7
	PHCS-MPI: PRIMARY CARE PHYSICIAN	6	847	100.0	0	0.0	9.9	10.2	22.1	23.2
	PHCS-MPI: RADIOLOGY	0	847	100.0	0	0.0	30.4	30.9	50.1	50.8
	PHCS-MPI: UROLOGY	0	809	95.5	38	4.5	44.4	61.3	67.6	79.7
Pleasants, WV	PHCS-MPI: HOSPITALS	0	290	100.0	0	0.0	28.4	33.6	32.0	39.2
	PHCS-MPI: NURSING FACILITY	0	290	100.0	0	0.0	28.7	34.4	36.2	40.5
	PHCS-MPI: CARDIOLOGY	0	290	100.0	0	0.0	22.1	22.1	30.6	30.6
	PHCS-MPI: DERMATOLOGY	0	290	100.0	0	0.0	30.2	33.5	38.0	47.4
	PHCS-MPI: GENERAL SURGERY	0	290	100.0	0	0.0	17.1	21.6	27.2	30.3
	PHCS-MPI: NEUROLOGY	0	290	100.0	0	0.0	30.0	33.4	37.4	47.5
	PHCS-MPI: OBSTETRICS & GYNECOLOGY	0	290	100.0	0	0.0	30.0	33.4	39.4	39.4
	PHCS-MPI: ONCOLOGY	0	290	100.0	0	0.0	31.7	32.6	39.0	39.4
	PHCS-MPI: ORAL SURGERY	0	0	0.0	290	100.0	82.9	82.9	105.1	105.1
	PHCS-MPI: ORTHOPEDIC SURGERY	0	290	100.0	0	0.0	21.6	21.6	30.3	30.3
	PHCS-MPI: OTOLARYNGOLOGY	0	290	100.0	0	0.0	28.6	30.3	30.4	45.4
	PHCS-MPI: PEDIATRICIAN	1	290	100.0	0	0.0	8.8	16.8	17.5	22.5
	PHCS-MPI: PHYSICAL THERAPY	1	290	100.0	0	0.0	8.1	19.6	19.1	18.3
	PHCS-MPI: PRIMARY CARE PHYSICIAN	7	290	100.0	0	0.0	6.2	6.2	14.0	14.0
	PHCS-MPI: RADIOLOGY	0	290	100.0	0	0.0	30.6	30.6	47.4	47.4
	PHCS-MPI: UROLOGY	0	290	100.0	0	0.0	30.1	35.2	37.4	46.7
Pocahontas, WV	PHCS-MPI: HOSPITALS	1	1,173	100.0	0	0.0	28.7	28.4	46.0	46.0
	PHCS-MPI: NURSING FACILITY	0	1,001	85.3	172	14.7	45.7	61.8	69.8	79.8
	PHCS-MPI: CARDIOLOGY	0	1,173	100.0	0	0.0	40.0	42.6	56.1	57.2
	PHCS-MPI: DERMATOLOGY	0	893	76.1	280	23.9	47.9	50.5	73.9	81.2
	PHCS-MPI: GENERAL SURGERY	0	1,173	100.0	0	0.0	42.6	42.6	57.4	57.4
	PHCS-MPI: NEUROLOGY	0	567	48.3	606	51.7	56.6	60.3	74.9	81.4
	PHCS-MPI: OBSTETRICS & GYNECOLOGY	0	1,173	100.0	0	0.0	42.6	42.6	57.4	57.4
	PHCS-MPI: ONCOLOGY	0	1,173	100.0	0	0.0	42.6	42.6	57.4	57.4

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...ued on next page...

Southeast Access Detail By County

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[1] The Access Standard is defined as (State of WV) employees accessing in:

Urban areas...

1 (PHCS-MPI: HOSPITALS) provider in 30 minutes, 1 (PHCS-MPI: NURSING FACILITY) provider in 30 minutes, 2 (PHCS-MPI: CARDIOLOGY) providers in 30 minutes, 1 (PHCS-MPI: DERMATOLOGY) provider in 30 minutes, 2 (PHCS-MPI: GENERAL SURGERY) providers in 30 minutes, 1 (PHCS-MPI: NEUROLOGY) provider in 30 minutes, 2 (PHCS-MPI: OBSTETRICS & GYNECOLOGY) providers in 30 minutes, 2 (PHCS-MPI: ONCOLOGY) providers in 30 minutes, 1 (PHCS-MPI: ORAL SURGERY) provider in 30 minutes, 2 (PHCS-MPI: ORTHOPEDIC SURGERY) providers in 30 minutes, 1 (PHCS-MPI: OTOLARYNGOLOGY) provider in 30 minutes, 2 (PHCS-MPI: PEDIATRICIAN) providers in 30 minutes, 2 (PHCS-MPI: PHYSICAL THERAPY) providers in 30 minutes, 2 (PHCS-MPI: PRIMARY CARE PHYSICIAN) providers in 30 minutes, 2 (PHCS-MPI: RADIOLOGY) providers in 30 minutes, 1 (PHCS-MPI: UROLOGY) provider in 30 minutes

Suburban areas...

All Employees										
County	Provider		With Access[2]		Without Access[2]		Average Time		Maximum Time	
	Name	#	#	%	#	%	1	2	1	2
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
	PHCS-MPI: ORTHOPEDIC SURGERY	0	920	78.4	253	21.6	43.1	48.6	58.9	72.5
	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
	PHCS-MPI: PEDIATRICIAN	0	1,173	100.0	0	0.0	31.5	33.5	46.0	46.0
	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
	PHCS-MPI: PRIMARY CARE PHYSICIAN	14	1,173	100.0	0	0.0	9.9	10.2	19.6	19.7
	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
	PHCS-MPI: UROLOGY	0	1,173	100.0	0	0.0	42.5	50.3	56.5	63.4
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
	PHCS-MPI: NURSING FACILITY	1	1,422	100.0	0	0.0	13.1	30.4	27.7	42.9
	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
	PHCS-MPI: DERMATOLOGY	0	1,422	100.0	0	0.0	15.8	23.2	32.5	43.3
	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
	PHCS-MPI: NEUROLOGY	0	1,422	100.0	0	0.0	19.3	26.3	35.5	48.0
	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
	PHCS-MPI: ONCOLOGY	0	1,422	100.0	0	0.0	28.3	28.5	49.1	49.6
	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
	PHCS-MPI: ORTHOPEDIC SURGERY	0	1,422	100.0	0	0.0	19.2	23.0	35.8	45.8
	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
	PHCS-MPI: PEDIATRICIAN	3	1,422	100.0	0	0.0	7.7	13.6	20.9	26.5
	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
	PHCS-MPI: PRIMARY CARE PHYSICIAN	25	1,422	100.0	0	0.0	3.6	5.0	11.5	21.7
	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
	PHCS-MPI: UROLOGY	0	1,422	100.0	0	0.0	28.1	28.6	48.4	50.5
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
	PHCS-MPI: NURSING FACILITY	1	1,253	100.0	0	0.0	13.8	26.5	31.2	42.0
	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
	PHCS-MPI: DERMATOLOGY	0	1,034	82.5	219	17.5	27.8	30.6	38.7	44.2
	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
	PHCS-MPI: NEUROLOGY	1	1,252	99.9	1	0.1	14.4	28.9	32.8	39.2
	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
	PHCS-MPI: ONCOLOGY	0	925	73.8	328	26.2	28.9	30.9	39.2	44.2
	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
	PHCS-MPI: ORTHOPEDIC SURGERY	2	1,253	100.0	0	0.0	13.0	13.3	29.2	29.2
	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
	PHCS-MPI: PEDIATRICIAN	14	1,253	100.0	0	0.0	9.7	10.2	23.5	25.5
	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
	PHCS-MPI: PRIMARY CARE PHYSICIAN	47	1,253	100.0	0	0.0	5.0	5.2	15.9	15.9
	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
	PHCS-MPI: UROLOGY	0	750	59.9	503	40.1	49.9	50.4	73.0	74.4

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Southeast Access Detail By County

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1 (PHCS-MPI: HOSPITALS) provider in 30 minutes, 1 (PHCS-MPI: NURSING FACILITY) provider in 30 minutes, 2 (PHCS-MPI: CARDIOLOGY) providers in 30 minutes, 1 (PHCS-MPI: DERMATOLOGY) provider in 30 minutes, 2 (PHCS-MPI: GENERAL SURGERY) providers in 30 minutes, 1 (PHCS-MPI: NEUROLOGY) provider in 30 minutes, 2 (PHCS-MPI: OBSTETRICS & GYNECOLOGY) providers in 30 minutes, 2 (PHCS-MPI: ONCOLOGY) providers in 30 minutes, 1 (PHCS-MPI: ORAL SURGERY) provider in 30 minutes, 2 (PHCS-MPI: ORTHOPEDIC SURGERY) providers in 30 minutes, 1 (PHCS-MPI: OTOLARYNGOLOGY) provider in 30 minutes, 2 (PHCS-MPI: PEDIATRICIAN) providers in 30 minutes, 2 (PHCS-MPI: PHYSICAL THERAPY) providers in 30 minutes, 2 (PHCS-MPI: PRIMARY CARE PHYSICIAN) providers in 30 minutes, 2 (PHCS-MPI: RADIOLOGY) providers in 30 minutes, 1 (PHCS-MPI: UROLOGY) provider in 30 minutes

Suburban areas...

All Employees										
County	Provider		With Access[1]		Without Access[1]		Average Time		Maximum Time	
	Name	#	#	%	#	%	1	2	1	2
Raleigh, WV	PHCS-MPI: HOSPITALS	2	4,758	100.0	0	0.0	11.5	14.0	29.9	29.0
	PHCS-MPI: NURSING FACILITY	3	4,758	100.0	0	0.0	11.7	12.8	30.9	31.9
	PHCS-MPI: CARDIOLOGY	14	4,758	100.0	0	0.0	11.3	11.7	27.8	29.0
	PHCS-MPI: DERMATOLOGY	1	4,758	100.0	0	0.0	13.7	39.1	34.6	54.7
	PHCS-MPI: GENERAL SURGERY	16	4,758	100.0	0	0.0	10.4	11.8	28.2	32.5
	PHCS-MPI: NEUROLOGY	3	4,758	100.0	0	0.0	12.3	12.8	33.8	33.9
	PHCS-MPI: OBSTETRICS & GYNECOLOGY	14	4,758	100.0	0	0.0	12.5	12.5	27.7	27.8
	PHCS-MPI: ONCOLOGY	1	4,503	94.6	255	5.4	12.7	36.1	31.8	50.1
	PHCS-MPI: ORAL SURGERY	0	4,147	87.2	611	12.8	41.0	130.0	69.4	150.4
	PHCS-MPI: ORTHOPEDIC SURGERY	10	4,758	100.0	0	0.0	11.3	11.8	33.8	33.8
	PHCS-MPI: OTOLARYNGOLOGY	2	4,758	100.0	0	0.0	12.8	14.7	38.0	34.6
	PHCS-MPI: PEDIATRICIAN	11	4,758	100.0	0	0.0	9.3	10.5	22.4	26.2
	PHCS-MPI: PHYSICAL THERAPY	0	4,758	100.0	0	0.0	33.8	36.8	42.8	43.6
	PHCS-MPI: PRIMARY CARE PHYSICIAN	65	4,758	100.0	0	0.0	5.4	6.8	17.4	17.4
	PHCS-MPI: RADIOLOGY	1	4,758	100.0	0	0.0	12.7	16.0	30.7	42.2
	PHCS-MPI: UROLOGY	6	4,758	100.0	0	0.0	12.5	12.7	31.6	33.8
Randolph, WV	PHCS-MPI: HOSPITALS	1	1,642	100.0	0	0.0	19.6	29.0	34.3	47.5
	PHCS-MPI: NURSING FACILITY	0	1,503	91.5	139	8.5	49.9	57.2	66.4	75.8
	PHCS-MPI: CARDIOLOGY	2	1,642	100.0	0	0.0	19.1	19.6	43.6	53.5
	PHCS-MPI: DERMATOLOGY	1	1,642	100.0	0	0.0	19.1	35.9	54.1	57.0
	PHCS-MPI: GENERAL SURGERY	4	1,642	100.0	0	0.0	18.0	18.2	43.6	43.6
	PHCS-MPI: NEUROLOGY	0	1,530	93.2	112	6.8	45.8	55.5	62.9	78.3
	PHCS-MPI: OBSTETRICS & GYNECOLOGY	2	1,642	100.0	0	0.0	17.0	18.2	39.6	43.6
	PHCS-MPI: ONCOLOGY	3	1,642	100.0	0	0.0	19.6	19.6	53.8	53.8
	PHCS-MPI: ORAL SURGERY	0	167	10.2	1,475	89.8	73.0	73.0	104.2	104.2
	PHCS-MPI: ORTHOPEDIC SURGERY	3	1,642	100.0	0	0.0	18.0	19.6	43.6	53.5
	PHCS-MPI: OTOLARYNGOLOGY	1	1,642	100.0	0	0.0	15.5	44.0	62.3	65.7
	PHCS-MPI: PEDIATRICIAN	3	1,642	100.0	0	0.0	14.0	17.3	31.8	34.3
	PHCS-MPI: PHYSICAL THERAPY	3	1,642	100.0	0	0.0	19.1	19.7	34.4	34.8
	PHCS-MPI: PRIMARY CARE PHYSICIAN	32	1,642	100.0	0	0.0	7.9	8.3	20.4	20.4
	PHCS-MPI: RADIOLOGY	4	1,642	100.0	0	0.0	19.6	19.6	44.4	44.4
	PHCS-MPI: UROLOGY	1	1,642	100.0	0	0.0	18.2	33.0	43.6	53.0
Ritchie, WV	PHCS-MPI: HOSPITALS	0	978	100.0	0	0.0	21.7	30.0	30.5	42.4
	PHCS-MPI: NURSING FACILITY	0	978	100.0	0	0.0	24.8	32.3	34.2	44.8
	PHCS-MPI: CARDIOLOGY	0	978	100.0	0	0.0	23.3	29.0	30.5	37.9
	PHCS-MPI: DERMATOLOGY	0	978	100.0	0	0.0	41.3	42.4	57.8	57.8
	PHCS-MPI: GENERAL SURGERY	0	978	100.0	0	0.0	28.3	29.0	43.7	43.7
	PHCS-MPI: NEUROLOGY	0	978	100.0	0	0.0	40.6	42.2	58.2	58.7
	PHCS-MPI: OBSTETRICS & GYNECOLOGY	0	978	100.0	0	0.0	35.5	35.5	43.7	43.7
	PHCS-MPI: ONCOLOGY	0	978	100.0	0	0.0	40.9	41.0	58.1	58.1

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South[illegible]st Access Detail By County

March 2, 2016

Created by...
MultiPlan

General Access

[1] The Access Standard is defined as (State of WV) employees accessing in:

Urban areas...

1 (PHCS-MPI: HOSPITALS) provider in 30 minutes, 1 (PHCS-MPI: NURSING FACILITY) provider in 30 minutes, 2 (PHCS-MPI: CARDIOLOGY) providers in 30 minutes, 1 (PHCS-MPI: DERMATOLOGY) provider in 30 minutes, 2 (PHCS-MPI: GENERAL SURGERY) providers in 30 minutes, 1 (PHCS-MPI: NEUROLOGY) provider in 30 minutes, 2 (PHCS-MPI: OBSTETRICS & GYNECOLOGY) providers in 30 minutes, 2 (PHCS-MPI: ONCOLOGY) providers in 30 minutes, 1 (PHCS-MPI: ORAL SURGERY) provider in 30 minutes, 2 (PHCS-MPI: ORTHOPEDIC SURGERY) providers in 30 minutes, 1 (PHCS-MPI: OTOLARYNGOLOGY) provider in 30 minutes, 2 (PHCS-MPI: PEDIATRICIAN) providers in 30 minutes, 2 (PHCS-MPI: PHYSICAL THERAPY) providers in 30 minutes, 2 (PHCS-MPI: PRIMARY CARE PHYSICIAN) providers in 30 minutes, 2 (PHCS-MPI: RADIOLOGY) providers in 30 minutes, 1 (PHCS-MPI: UROLOGY) provider in 30 minutes

Suburban areas...

All Employees										
County	Provider		With Access[2]		Without Access[2]		Average Time		Maximum Time	
	Name	#	#	%	#	%	1	2	1	2
[illegible], WV	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	104.1
	PHCS-MPI: ORTHOPEDIC SURGERY	0	978	100.0	0	0.0	27.4	27.4	35.6	35.6
	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
	PHCS-MPI: PEDIATRICIAN	2	978	100.0	0	0.0	9.4	12.3	19.7	22.5
	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
	PHCS-MPI: PRIMARY CARE PHYSICIAN	8	978	100.0	0	0.0	8.5	8.6	17.1	17.1
	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
	PHCS-MPI: UROLOGY	0	978	100.0	0	0.0	33.5	40.3	43.7	51.8
Rowle, WV	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
	PHCS-MPI: NURSING FACILITY	0	850	100.0	0	0.0	40.8	47.6	47.4	59.7
	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
	PHCS-MPI: DERMATOLOGY	0	725	85.3	125	14.7	52.9	52.9	68.4	68.4
	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
	PHCS-MPI: NEUROLOGY	0	850	100.0	0	0.0	46.4	47.1	59.8	60.0
	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
	PHCS-MPI: ONCOLOGY	0	834	98.1	16	1.9	46.7	47.8	59.8	63.1
	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
	PHCS-MPI: ORTHOPEDIC SURGERY	2	850	100.0	0	0.0	16.6	16.6	29.8	29.8
	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
	PHCS-MPI: PEDIATRICIAN	0	850	100.0	0	0.0	21.9	28.5	35.3	37.8
	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
	PHCS-MPI: PRIMARY CARE PHYSICIAN	2	850	100.0	0	0.0	13.0	13.0	22.9	22.9
	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
	PHCS-MPI: UROLOGY	0	850	100.0	0	0.0	40.7	46.4	54.0	59.3
Summers, WV	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
	PHCS-MPI: NURSING FACILITY	0	1,243	100.0	0	0.0	18.8	24.1	28.2	32.7
	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
	PHCS-MPI: DERMATOLOGY	0	1,243	100.0	0	0.0	27.1	40.7	39.6	53.2
	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
	PHCS-MPI: NEUROLOGY	0	1,243	100.0	0	0.0	23.9	25.1	34.1	35.7
	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
	PHCS-MPI: ONCOLOGY	0	1,243	100.0	0	0.0	23.7	25.4	32.0	34.2
	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	148.4	[illegible]	[illegible]
	PHCS-MPI: ORTHOPEDIC SURGERY	0	1,243	100.0	0	0.0	22.9	26.0	33.3	36.9
	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
	PHCS-MPI: PEDIATRICIAN	0	1,243	100.0	0	0.0	17.3	18.7	30.1	30.4
	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
	PHCS-MPI: PRIMARY CARE PHYSICIAN	10	1,243	100.0	0	0.0	6.5	6.7	13.5	13.7
	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
	PHCS-MPI: UROLOGY	0	1,243	100.0	0	0.0	23.6	24.0	32.5	33.2

[2] 2016 Quest Analytics, LLC.

Continued on next page...

Southeast Access Detail By County

March 2, 2016

Created by...
MultiPlan

General Access

[1] The Access Standard is defined as (State of WV) employees accessing in:

Urban areas...

1 (PHCS-MPI: HOSPITALS) provider in 30 minutes, 1 (PHCS-MPI: NURSING FACILITY) provider in 30 minutes, 2 (PHCS-MPI: CARDIOLOGY) providers in 30 minutes, 1 (PHCS-MPI: DERMATOLOGY) provider in 30 minutes, 2 (PHCS-MPI: GENERAL SURGERY) providers in 30 minutes, 1 (PHCS-MPI: NEUROLOGY) provider in 30 minutes, 2 (PHCS-MPI: OBSTETRICS & GYNECOLOGY) providers in 30 minutes, 2 (PHCS-MPI: ONCOLOGY) providers in 30 minutes, 1 (PHCS-MPI: ORAL SURGERY) provider in 30 minutes, 2 (PHCS-MPI: ORTHOPEDIC SURGERY) providers in 30 minutes, 1 (PHCS-MPI: OTOLARYNGOLOGY) provider in 30 minutes, 2 (PHCS-MPI: PEDIATRICIAN) providers in 30 minutes, 2 (PHCS-MPI: PHYSICAL THERAPY) providers in 30 minutes, 2 (PHCS-MPI: PRIMARY CARE PHYSICIAN) providers in 30 minutes, 2 (PHCS-MPI: RADIOLOGY) providers in 30 minutes, 1 (PHCS-MPI: UROLOGY) provider in 30 minutes

Suburban areas...

All Employees										
County	Provider		With Access[2]		Without Access[2]		Average Time		Maximum Time	
	Name	#	#	%	#	%	1	2	1	2
Taylor, WV	PHCS-MPI: HOSPITALS	1	481	100.0	0	0.0	7.5	14.1	13.3	21.8
	PHCS-MPI: NURSING FACILITY	0	481	100.0	0	0.0	17.3	26.8	27.0	31.9
	PHCS-MPI: CARDIOLOGY	0	481	100.0	0	0.0	11.4	12.4	21.7	23.8
	PHCS-MPI: DERMATOLOGY	0	481	100.0	0	0.0	14.2	14.7	21.4	23.2
	PHCS-MPI: GENERAL SURGERY	1	481	100.0	0	0.0	6.4	12.5	12.7	23.1
	PHCS-MPI: NEUROLOGY	1	481	100.0	0	0.0	6.7	13.3	13.4	25.3
	PHCS-MPI: OBSTETRICS & GYNECOLOGY	0	481	100.0	0	0.0	10.0	10.8	22.6	23.3
	PHCS-MPI: ONCOLOGY	0	481	100.0	0	0.0	13.2	13.3	25.5	25.6
	PHCS-MPI: ORAL SURGERY	0	481	100.0	0	0.0	23.6	23.6	43.4	43.4
	PHCS-MPI: ORTHOPEDIC SURGERY	1	481	100.0	0	0.0	7.2	13.3	13.4	23.0
	PHCS-MPI: OTOLARYNGOLOGY	0	481	100.0	0	0.0	13.2	13.2	23.4	23.5
	PHCS-MPI: PEDIATRICIAN	0	481	100.0	0	0.0	10.6	12.1	20.1	21.3
	PHCS-MPI: PHYSICAL THERAPY	0	481	100.0	0	0.0	12.4	12.4	22.6	22.6
	PHCS-MPI: PRIMARY CARE PHYSICIAN	10	481	100.0	0	0.0	6.0	6.1	10.1	10.4
	PHCS-MPI: RADIOLOGY	0	481	100.0	0	0.0	10.0	10.0	23.5	23.5
	PHCS-MPI: UROLOGY	0	481	100.0	0	0.0	12.5	12.9	24.0	25.5
Tucker, WV	PHCS-MPI: HOSPITALS	0	781	100.0	0	0.0	32.0	37.0	30.5	39.0
	PHCS-MPI: NURSING FACILITY	0	781	100.0	0	0.0	34.8	49.8	46.5	58.5
	PHCS-MPI: CARDIOLOGY	0	781	100.0	0	0.0	29.7	29.1	38.0	42.4
	PHCS-MPI: DERMATOLOGY	1	781	100.0	0	0.0	18.4	27.0	28.9	39.2
	PHCS-MPI: GENERAL SURGERY	0	781	100.0	0	0.0	32.0	37.0	37.9	40.0
	PHCS-MPI: NEUROLOGY	0	781	100.0	0	0.0	42.1	52.7	55.7	65.3
	PHCS-MPI: OBSTETRICS & GYNECOLOGY	0	781	100.0	0	0.0	33.4	37.0	36.5	49.2
	PHCS-MPI: ONCOLOGY	0	781	100.0	0	0.0	27.9	28.0	42.3	42.4
	PHCS-MPI: ORAL SURGERY	0	302	48.4	499	59.8	61.8	61.8	78.8	78.8
	PHCS-MPI: ORTHOPEDIC SURGERY	0	781	100.0	0	0.0	27.7	28.2	40.9	42.3
	PHCS-MPI: OTOLARYNGOLOGY	0	781	100.0	0	0.0	30.0	31.5	42.4	63.9
	PHCS-MPI: PEDIATRICIAN	0	781	100.0	0	0.0	15.4	25.1	24.4	33.2
	PHCS-MPI: PHYSICAL THERAPY	0	781	100.0	0	0.0	22.3	23.3	28.1	30.4
	PHCS-MPI: PRIMARY CARE PHYSICIAN	9	781	100.0	0	0.0	6.3	9.0	14.1	14.8
	PHCS-MPI: RADIOLOGY	0	781	100.0	0	0.0	23.0	23.4	30.5	30.6
	PHCS-MPI: UROLOGY	0	781	100.0	0	0.0	28.1	41.8	42.6	52.0
Tyler, WV	PHCS-MPI: HOSPITALS	1	489	100.0	0	0.0	13.7	21.4	27.2	31.8
	PHCS-MPI: NURSING FACILITY	0	489	100.0	0	0.0	17.9	20.8	30.0	31.8
	PHCS-MPI: CARDIOLOGY	7	489	100.0	0	0.0	13.7	13.7	27.2	27.2
	PHCS-MPI: DERMATOLOGY	0	489	100.0	0	0.0	21.6	45.4	32.4	54.1
	PHCS-MPI: GENERAL SURGERY	2	489	100.0	0	0.0	13.7	13.7	27.2	27.2
	PHCS-MPI: NEUROLOGY	0	489	100.0	0	0.0	21.4	47.6	31.8	62.1
	PHCS-MPI: OBSTETRICS & GYNECOLOGY	0	489	100.0	0	0.0	21.4	21.4	31.8	31.8
	PHCS-MPI: ONCOLOGY	0	489	100.0	0	0.0	21.4	21.4	31.8	31.8

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Southeast Access Detail By County

March 2, 2016

Created by...
MultiPlan

General Access

[1] The Access Standard is defined as (State of WV) employees accessing in:

Urban areas...

1 (PHCS-MPI: HOSPITALS) provider in 30 minutes, 1 (PHCS-MPI: NURSING FACILITY) provider in 30 minutes, 2 (PHCS-MPI: CARDIOLOGY) providers in 30 minutes, 1 (PHCS-MPI: DERMATOLOGY) provider in 30 minutes, 2 (PHCS-MPI: GENERAL SURGERY) providers in 30 minutes, 1 (PHCS-MPI: NEUROLOGY) provider in 30 minutes, 2 (PHCS-MPI: OBSTETRICS & GYNECOLOGY) providers in 30 minutes, 2 (PHCS-MPI: ONCOLOGY) providers in 30 minutes, 1 (PHCS-MPI: ORAL SURGERY) provider in 30 minutes, 2 (PHCS-MPI: ORTHOPEDIC SURGERY) providers in 30 minutes, 1 (PHCS-MPI: OTOLARYNGOLOGY) provider in 30 minutes, 2 (PHCS-MPI: PEDIATRICIAN) providers in 30 minutes, 2 (PHCS-MPI: PHYSICAL THERAPY) providers in 30 minutes, 2 (PHCS-MPI: PRIMARY CARE PHYSICIAN) providers in 30 minutes, 2 (PHCS-MPI: RADIOLOGY) providers in 30 minutes, 1 (PHCS-MPI: UROLOGY) provider in 30 minutes

Suburban areas...

All Employees										
County	Provider		With Access[1]		Without Access[1]		Average Time		Maximum Time	
	Name	#	#	%	#	%	1	2	1	2
Tyler, WV	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
	PHCS-MPI: ORTHOPEDIC SURGERY	2	489	100.0	0	0.0	13.7	13.7	27.2	27.2
	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
	PHCS-MPI: PEDIATRICIAN	0	489	100.0	0	0.0	13.2	16.7	19.8	28.8
	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
	PHCS-MPI: PRIMARY CARE PHYSICIAN	7	489	100.0	0	0.0	5.6	6.2	12.9	17.1
	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
	PHCS-MPI: UROLOGY	0	489	100.0	0	0.0	21.3	38.6	31.8	47.1
Upshur, WV	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
	PHCS-MPI: NURSING FACILITY	0	1,133	100.0	0	0.0	34.2	38.8	47.7	48.4
	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
	PHCS-MPI: DERMATOLOGY	0	1,133	100.0	0	0.0	30.4	33.5	44.4	45.4
	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
	PHCS-MPI: NEUROLOGY	0	1,133	100.0	0	0.0	37.2	37.4	49.8	49.8
	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
	PHCS-MPI: ONCOLOGY	0	1,133	100.0	0	0.0	30.9	30.9	44.5	44.5
	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
	PHCS-MPI: ORTHOPEDIC SURGERY	1	1,133	100.0	0	0.0	13.7	23.3	26.2	34.1
	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
	PHCS-MPI: PEDIATRICIAN	1	1,133	100.0	0	0.0	13.5	21.4	22.9	31.6
	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
	PHCS-MPI: PRIMARY CARE PHYSICIAN	24	1,133	100.0	0	0.0	3.7	5.5	12.0	13.2
	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
	PHCS-MPI: UROLOGY	1	1,133	100.0	0	0.0	13.7	23.3	26.2	34.1
Wayne, WV	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
	PHCS-MPI: NURSING FACILITY	0	1,446	100.0	0	0.0	29.4	63.5	56.0	80.4
	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
	PHCS-MPI: DERMATOLOGY	0	1,446	100.0	0	0.0	24.4	28.6	43.7	54.5
	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
	PHCS-MPI: NEUROLOGY	0	1,446	100.0	0	0.0	28.5	28.5	55.8	55.8
	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
	PHCS-MPI: ONCOLOGY	0	1,446	100.0	0	0.0	24.5	28.6	41.0	56.0
	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
	PHCS-MPI: ORTHOPEDIC SURGERY	0	1,446	100.0	0	0.0	28.5	28.5	55.8	55.8
	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
	PHCS-MPI: PEDIATRICIAN	9	1,446	100.0	0	0.0	9.7	11.4	24.1	25.2
	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
	PHCS-MPI: PRIMARY CARE PHYSICIAN	32	1,446	100.0	0	0.0	5.4	5.7	14.1	14.1
	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
	PHCS-MPI: UROLOGY	0	1,446	100.0	0	0.0	30.1	30.1	56.5	56.5

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Continued on next page...

Southeast Access Detail By County

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General Access

[1] The Access Standard is defined as (State of WV) employees accessing in:

Urban areas...

1 (PHCS-MPI: HOSPITALS) provider in 30 minutes, 1 (PHCS-MPI: NURSING FACILITY) provider in 30 minutes, 2 (PHCS-MPI: CARDIOLOGY) providers in 30 minutes, 1 (PHCS-MPI: DERMATOLOGY) provider in 30 minutes, 2 (PHCS-MPI: GENERAL SURGERY) providers in 30 minutes, 1 (PHCS-MPI: NEUROLOGY) provider in 30 minutes, 2 (PHCS-MPI: OBSTETRICS & GYNECOLOGY) providers in 30 minutes, 2 (PHCS-MPI: ONCOLOGY) providers in 30 minutes, 1 (PHCS-MPI: ORAL SURGERY) provider in 30 minutes, 2 (PHCS-MPI: ORTHOPEDIC SURGERY) providers in 30 minutes, 1 (PHCS-MPI: OTOLARYNGOLOGY) provider in 30 minutes, 2 (PHCS-MPI: PEDIATRICIAN) providers in 30 minutes, 2 (PHCS-MPI: PHYSICAL THERAPY) providers in 30 minutes, 2 (PHCS-MPI: PRIMARY CARE PHYSICIAN) providers in 30 minutes, 2 (PHCS-MPI: RADIOLOGY) providers in 30 minutes, 1 (PHCS-MPI: UROLOGY) provider in 30 minutes

Suburban areas...

All Employees										
County	Provider		With Access[2]		Without Access[2]		Average Time		Maximum Time	
	Name	#	#	%	#	%	1	2	1	2
Webster, WV	PHCS-MPI: HOSPITALS	1	880	100.0	0	0.0	10.4	26.1	21.7	35.6
	PHCS-MPI: NURSING FACILITY	0	880	100.0	0	0.0	27.5	44.4	47.5	57.3
	PHCS-MPI: CARDIOLOGY	0	880	100.0	0	0.0	42.1	46.8	49.5	52.5
	PHCS-MPI: DERMATOLOGY	0	282	32.0	598	68.0	63.4	64.8	75.6	79.4
	PHCS-MPI: GENERAL SURGERY	0	880	100.0	0	0.0	29.7	40.1	49.5	49.5
	PHCS-MPI: NEUROLOGY	0	847	96.2	33	3.8	52.2	53.4	61.3	62.8
	PHCS-MPI: OBSTETRICS & GYNECOLOGY	0	880	100.0	0	0.0	32.6	37.0	32.1	46.0
	PHCS-MPI: ONCOLOGY	0	877	99.7	3	0.3	50.7	50.7	61.4	61.4
	PHCS-MPI: ORAL SURGERY	0	0	0.0	880	100.0	66.6	103.6	106.5	116.9
	PHCS-MPI: ORTHOPEDIC SURGERY	0	880	100.0	0	0.0	40.6	42.8	49.6	55.9
	PHCS-MPI: OTOLARYNGOLOGY	0	880	100.0	0	0.0	41.1	52.5	49.9	62.1
	PHCS-MPI: PEDIATRICIAN	2	880	100.0	0	0.0	8.5	13.8	22.0	26.8
	PHCS-MPI: PHYSICAL THERAPY	3	880	100.0	0	0.0	15.8	19.8	21.7	21.7
	PHCS-MPI: PRIMARY CARE PHYSICIAN	11	880	100.0	0	0.0	5.6	6.1	14.1	15.1
	PHCS-MPI: RADIOLOGY	0	880	100.0	0	0.0	24.9	28.8	39.2	37.7
	PHCS-MPI: UROLOGY	0	880	100.0	0	0.0	28.9	42.0	39.3	49.8
Wetzel, WV	PHCS-MPI: HOSPITALS	1	1,305	100.0	0	0.0	10.8	24.1	20.4	36.0
	PHCS-MPI: NURSING FACILITY	2	1,305	100.0	0	0.0	16.0	19.2	29.8	31.3
	PHCS-MPI: CARDIOLOGY	1	1,305	100.0	0	0.0	16.6	22.4	29.8	33.2
	PHCS-MPI: DERMATOLOGY	1	1,305	100.0	0	0.0	18.1	34.1	29.1	50.8
	PHCS-MPI: GENERAL SURGERY	0	1,305	100.0	0	0.0	11.2	27.3	29.8	29.8
	PHCS-MPI: NEUROLOGY	1	1,305	100.0	0	0.0	19.5	41.2	33.1	60.8
	PHCS-MPI: OBSTETRICS & GYNECOLOGY	0	1,305	100.0	0	0.0	18.6	18.6	30.6	30.7
	PHCS-MPI: ONCOLOGY	2	1,305	100.0	0	0.0	18.6	19.2	30.6	31.8
	PHCS-MPI: ORAL SURGERY	0	1,149	87.4	156	12.6	42.5	41.5	71.6	71.6
	PHCS-MPI: ORTHOPEDIC SURGERY	3	1,305	100.0	0	0.0	18.1	18.1	29.8	29.8
	PHCS-MPI: OTOLARYNGOLOGY	1	1,305	100.0	0	0.0	17.7	38.7	30.6	68.4
	PHCS-MPI: PEDIATRICIAN	1	1,305	100.0	0	0.0	16.4	23.1	25.6	30.0
	PHCS-MPI: PHYSICAL THERAPY	16	1,305	100.0	0	0.0	12.6	18.8	22.6	27.4
	PHCS-MPI: PRIMARY CARE PHYSICIAN	19	1,305	100.0	0	0.0	6.5	10.9	14.6	18.3
	PHCS-MPI: RADIOLOGY	0	1,149	87.4	156	12.0	32.6	37.0	34.0	39.7
	PHCS-MPI: UROLOGY	1	1,305	100.0	0	0.0	18.5	28.5	29.8	35.8
Wirt, WV	PHCS-MPI: HOSPITALS	0	421	100.0	0	0.0	17.7	33.0	27.7	41.5
	PHCS-MPI: NURSING FACILITY	0	421	100.0	0	0.0	27.1	38.5	36.0	48.0
	PHCS-MPI: CARDIOLOGY	2	421	100.0	0	0.0	16.8	19.8	24.5	24.5
	PHCS-MPI: DERMATOLOGY	0	421	100.0	0	0.0	42.5	42.5	52.0	52.0
	PHCS-MPI: GENERAL SURGERY	0	421	100.0	0	0.0	32.7	32.7	49.2	49.2
	PHCS-MPI: NEUROLOGY	0	421	100.0	0	0.0	40.3	40.3	49.8	49.8
	PHCS-MPI: OBSTETRICS & GYNECOLOGY	0	421	100.0	0	0.0	38.9	38.9	47.5	49.2
	PHCS-MPI: ONCOLOGY	0	421	100.0	0	0.0	40.7	40.7	50.2	50.4

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Southeast Access Detail By County

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General Access

[1] The Access Standard is defined as (State of WV) employees accessing in:

Urban areas...

1 (PHCS-MPI: HOSPITALS) provider in 30 minutes, 1 (PHCS-MPI: NURSING FACILITY) provider in 30 minutes, 2 (PHCS-MPI: CARDIOLOGY) providers in 30 minutes, 1 (PHCS-MPI: DERMATOLOGY) provider in 30 minutes, 2 (PHCS-MPI: GENERAL SURGERY) providers in 30 minutes, 1 (PHCS-MPI: NEUROLOGY) provider in 30 minutes, 2 (PHCS-MPI: OBSTETRICS & GYNECOLOGY) providers in 30 minutes, 2 (PHCS-MPI: ONCOLOGY) providers in 30 minutes, 1 (PHCS-MPI: ORAL SURGERY) provider in 30 minutes, 2 (PHCS-MPI: ORTHOPEDIC SURGERY) providers in 30 minutes, 1 (PHCS-MPI: OTOLARYNGOLOGY) provider in 30 minutes, 2 (PHCS-MPI: PEDIATRICIAN) providers in 30 minutes, 2 (PHCS-MPI: PHYSICAL THERAPY) providers in 30 minutes, 2 (PHCS-MPI: PRIMARY CARE PHYSICIAN) providers in 30 minutes, 2 (PHCS-MPI: RADIOLOGY) providers in 30 minutes, 1 (PHCS-MPI: UROLOGY) provider in 30 minutes

Suburban areas...

All Employees										
County	Provider		With Access[1]		Without Access[1]		Average Time		Maximum Time	
	Name	#	#	%	#	%	1	2	1	2
Wirt, WV	PHCS-MPI: ORAL SURGERY	0	[illegible]							
	PHCS-MPI: ORTHOPEDIC SURGERY	0	421	100.0	0	0.0	19.4	19.4	26.5	26.5
	PHCS-MPI: OTOLARYNGOLOGY	0	[illegible]							
	PHCS-MPI: PEDIATRICIAN	0	421	100.0	0	0.0	16.5	17.6	26.8	27.3
	PHCS-MPI: PHYSICAL THERAPY	0	[illegible]							
	PHCS-MPI: PRIMARY CARE PHYSICIAN	5	421	100.0	0	0.0	11.8	11.8	15.7	15.8
	PHCS-MPI: RADIOLOGY	0	[illegible]							
	PHCS-MPI: UROLOGY	0	421	100.0	0	0.0	38.7	40.6	49.2	50.2
Wood, WV	PHCS-MPI: HOSPITALS	1	[illegible]							
	PHCS-MPI: NURSING FACILITY	2	1,602	100.0	0	0.0	10.5	15.4	25.0	35.2
	PHCS-MPI: CARDIOLOGY	0	[illegible]							
	PHCS-MPI: DERMATOLOGY	2	1,602	100.0	0	0.0	14.3	14.3	31.7	31.7
	PHCS-MPI: GENERAL SURGERY	0	[illegible]							
	PHCS-MPI: NEUROLOGY	4	1,602	100.0	0	0.0	11.8	11.8	28.8	28.8
	PHCS-MPI: OBSTETRICS & GYNECOLOGY	0	[illegible]							
	PHCS-MPI: ONCOLOGY	5	1,595	99.6	7	0.4	12.2	12.6	29.0	30.8
	PHCS-MPI: ORAL SURGERY	0	[illegible]							
	PHCS-MPI: ORTHOPEDIC SURGERY	19	1,602	100.0	0	0.0	11.6	11.6	25.8	25.8
	PHCS-MPI: OTOLARYNGOLOGY	1	[illegible]							
	PHCS-MPI: PEDIATRICIAN	12	1,602	100.0	0	0.0	9.2	11.1	21.8	26.7
	PHCS-MPI: PHYSICAL THERAPY	0	[illegible]							
	PHCS-MPI: PRIMARY CARE PHYSICIAN	93	1,602	100.0	0	0.0	4.5	5.0	15.3	15.5
	PHCS-MPI: RADIOLOGY	12	[illegible]							
	PHCS-MPI: UROLOGY	5	1,602	100.0	0	0.0	11.6	12.2	28.1	29.2
Wyoming, WV	PHCS-MPI: HOSPITALS	0	[illegible]							
	PHCS-MPI: NURSING FACILITY	0	3,804	100.0	0	0.0	31.7	32.6	49.7	54.0
	PHCS-MPI: CARDIOLOGY	0	[illegible]							
	PHCS-MPI: DERMATOLOGY	0	3,804	100.0	0	0.0	33.8	40.6	51.6	58.4
	PHCS-MPI: GENERAL SURGERY	0	[illegible]							
	PHCS-MPI: NEUROLOGY	0	3,804	100.0	0	0.0	32.2	32.7	51.3	52.8
	PHCS-MPI: OBSTETRICS & GYNECOLOGY	0	[illegible]							
	PHCS-MPI: ONCOLOGY	0	3,804	100.0	0	0.0	27.7	35.3	39.8	51.6
	PHCS-MPI: ORAL SURGERY	0	[illegible]							
	PHCS-MPI: ORTHOPEDIC SURGERY	0	3,804	100.0	0	0.0	31.1	32.2	51.1	51.2
	PHCS-MPI: OTOLARYNGOLOGY	0	[illegible]							
	PHCS-MPI: PEDIATRICIAN	0	3,804	100.0	0	0.0	17.0	22.2	26.0	27.4
	PHCS-MPI: PHYSICAL THERAPY	0	[illegible]							
	PHCS-MPI: PRIMARY CARE PHYSICIAN	18	3,804	100.0	0	0.0	6.3	6.7	15.0	16.4
	PHCS-MPI: RADIOLOGY	0	[illegible]							
	PHCS-MPI: UROLOGY	0	3,804	100.0	0	0.0	32.2	32.3	51.1	51.3

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Provider Maps

Map - [illegible]ospital

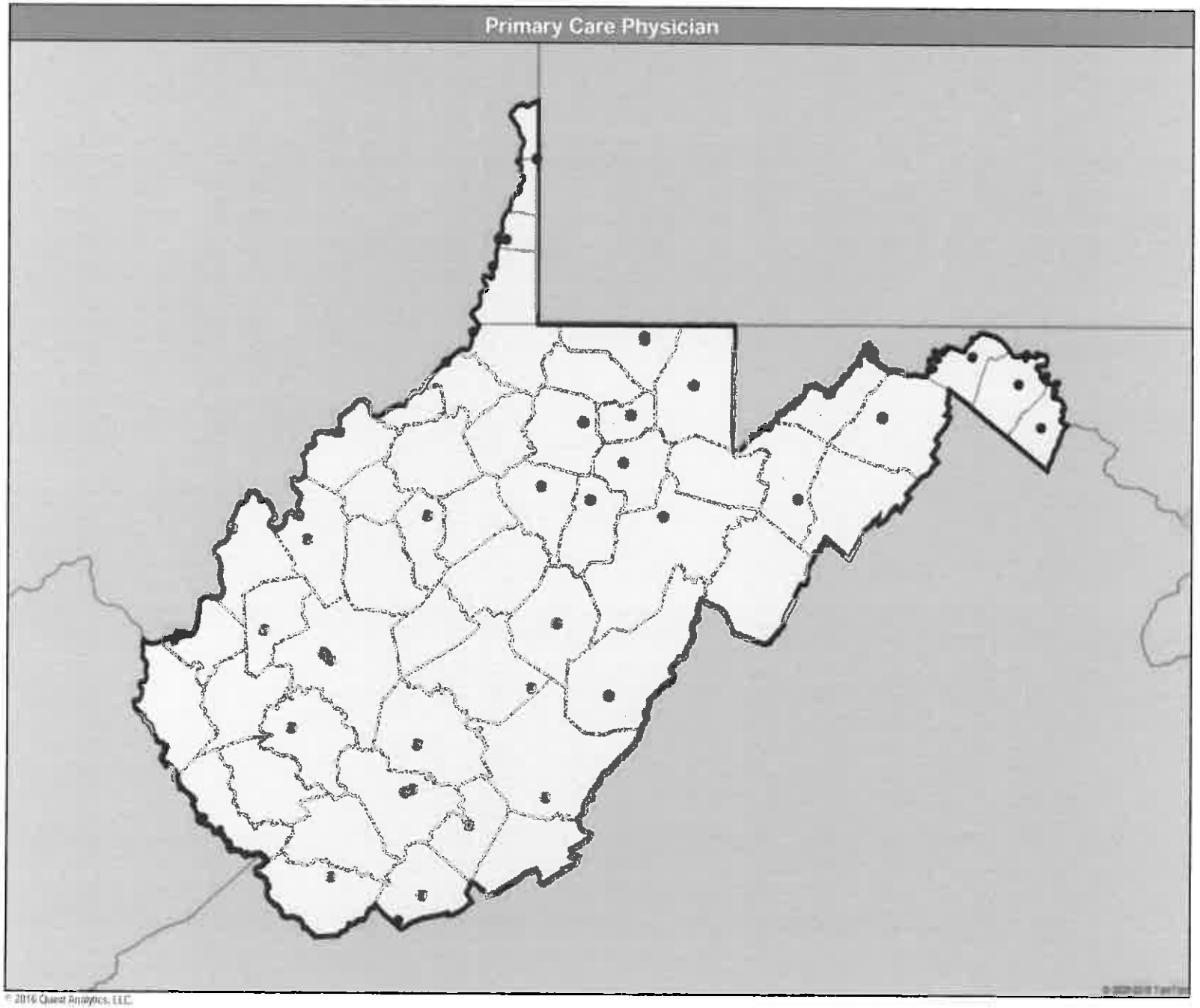
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MultiPlan

PHCS-MPI: HOSPITALS

47 providers at 45 locations
* All providers

1 in = 39.35 miles



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Map - Nursing Facility

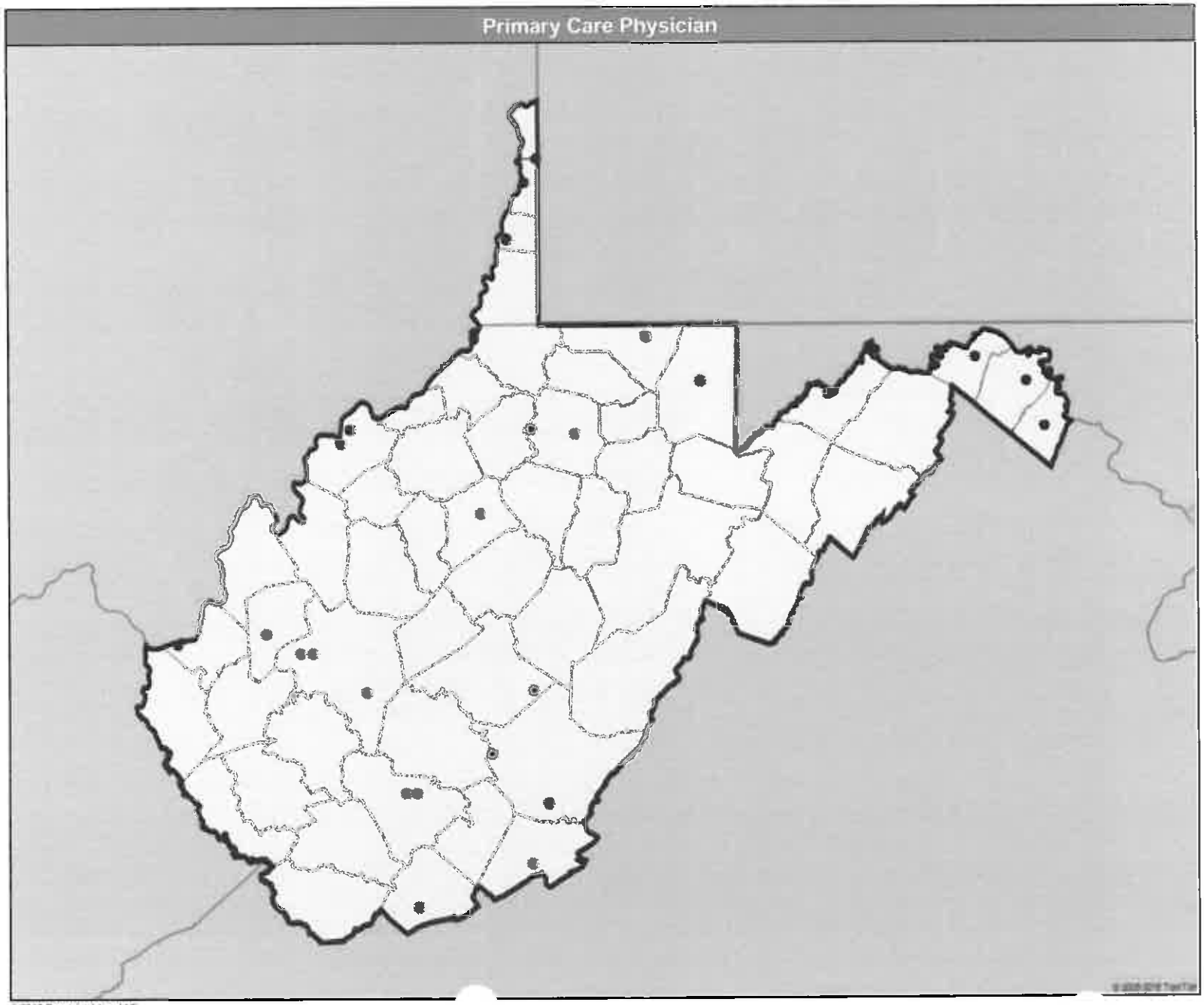
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PHCS-MPI: NURSING FACILITY

31 providers at 30 locations
All providers

1 in = 39.35 miles



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Map - Primary Care Physician

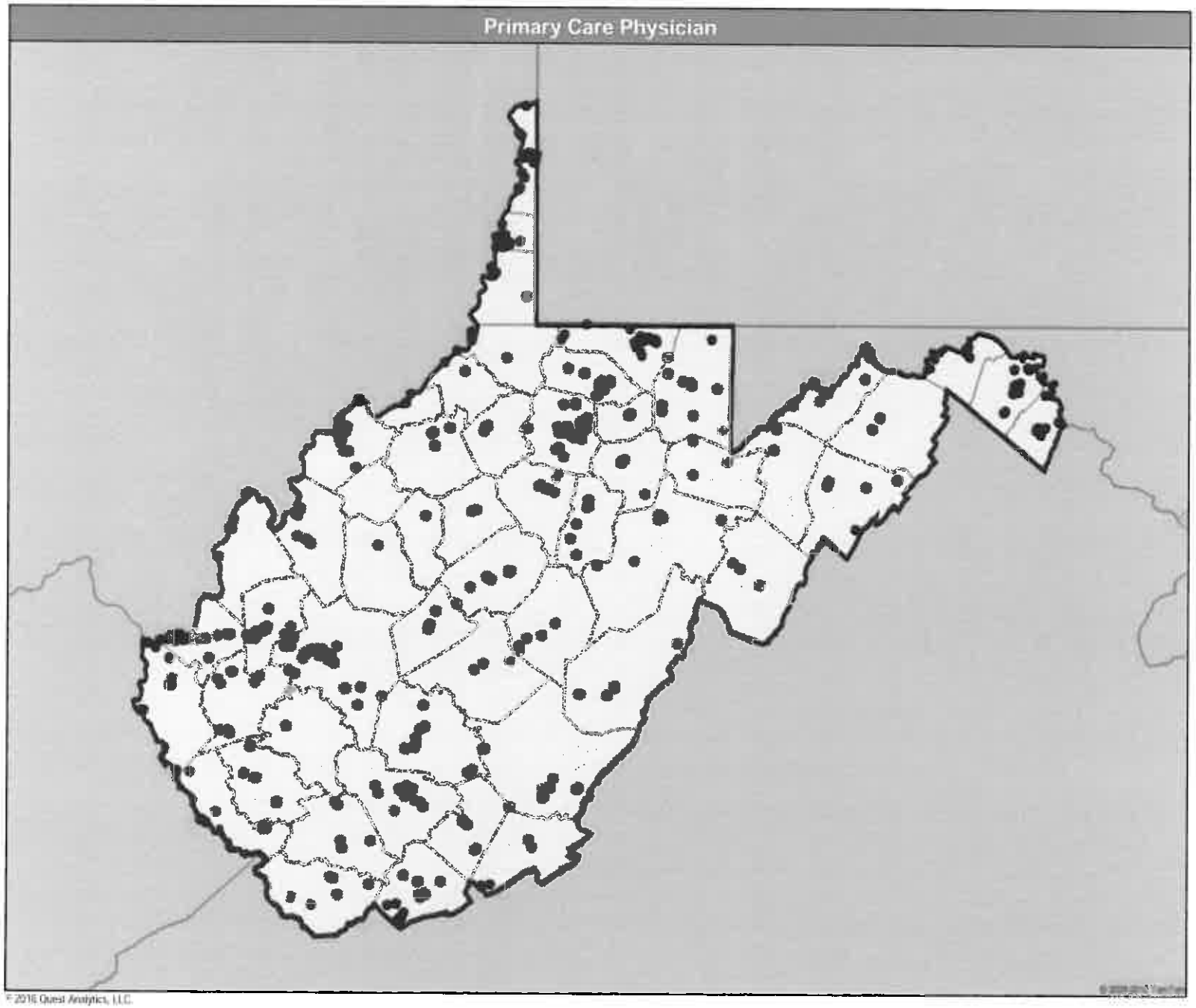
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PHCS-MPI: PRIMARY CARE PHYSICIAN

1,122 providers at 762 locations
All providers

1 in = 39.35 miles



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Map - Cardiology

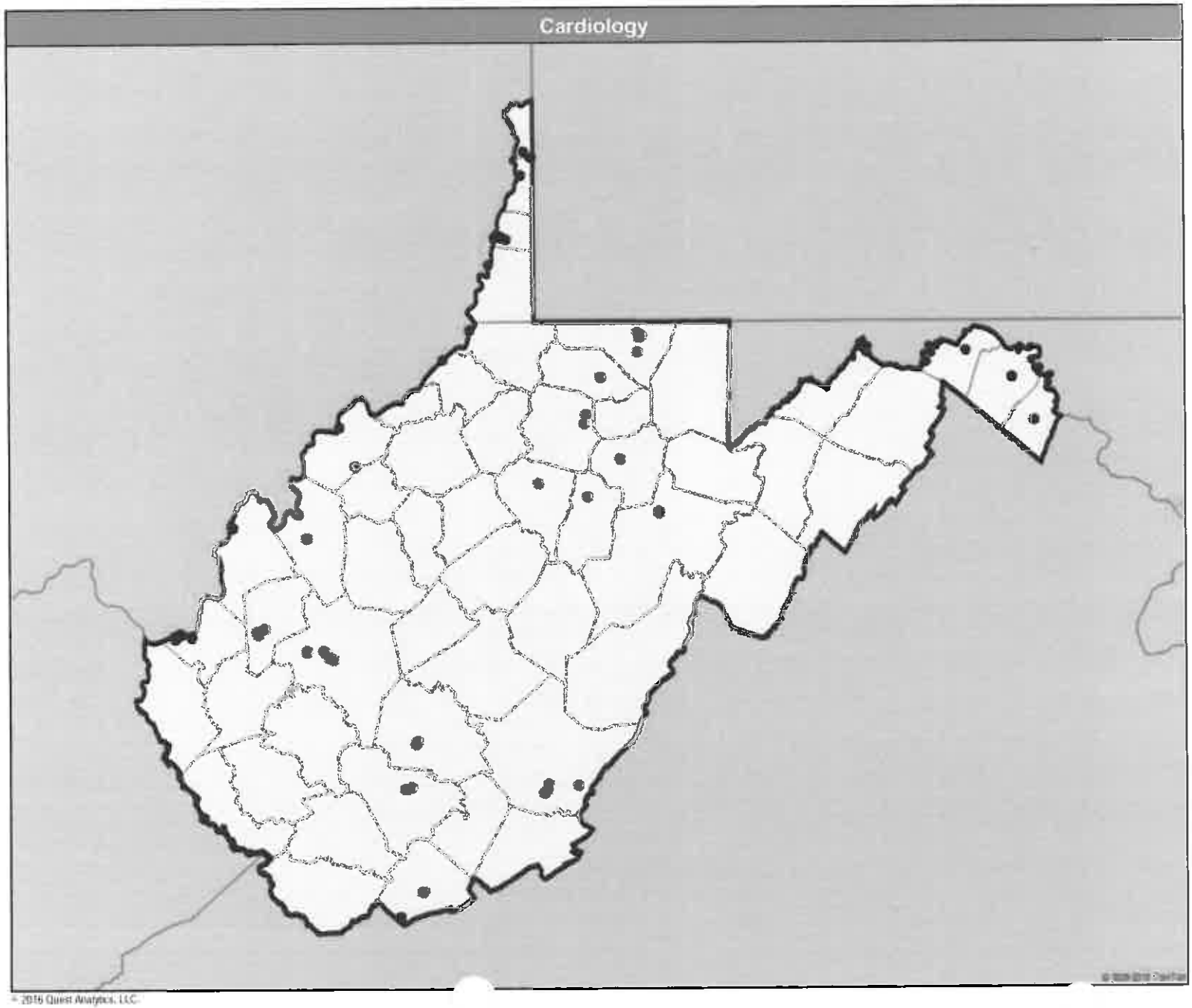
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PHCS-MPI: CARDIOLOGY

115 providers at 88 locations
● All providers

1 in = 39.35 miles



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Map - Dermatology

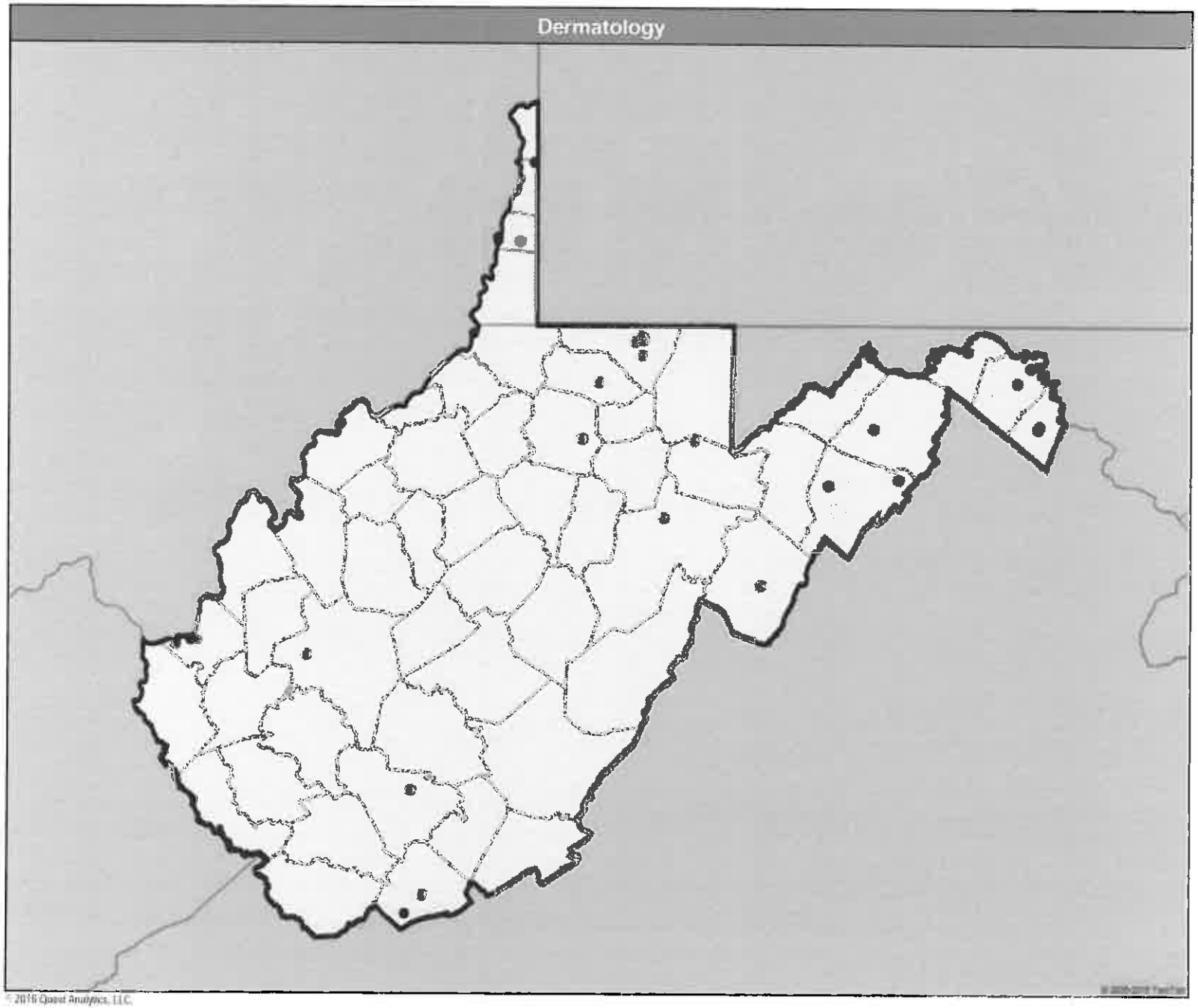
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PHCS-MPI: DERMATOLOGY

30 providers at 35 locations
● All providers

1 in = 39.35 miles



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Map - General Surgery

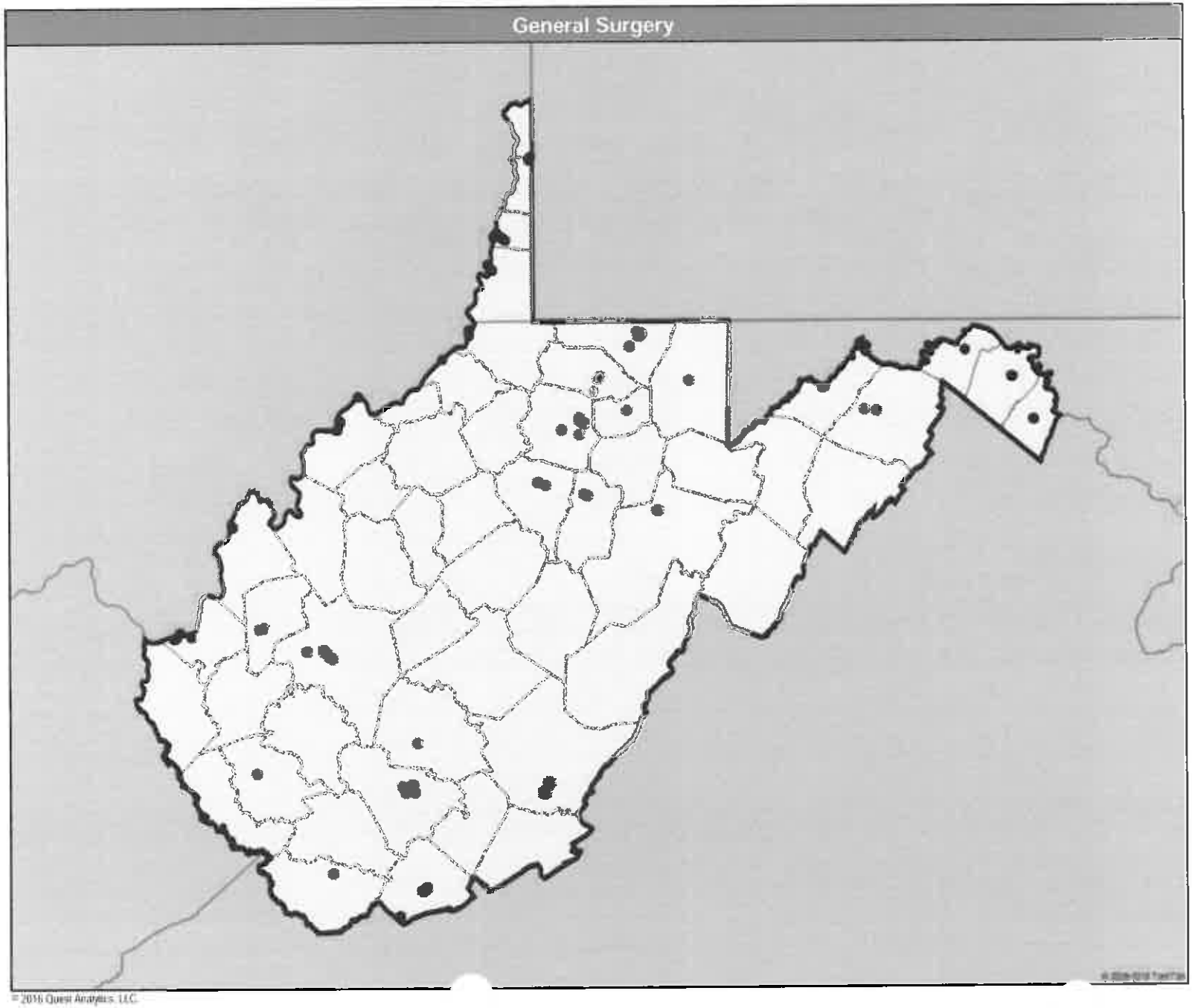
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PHCS-MPI: GENERAL SURGERY

184 providers at 129 locations
● All providers

1 in = 39.35 miles



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Map - Neurology

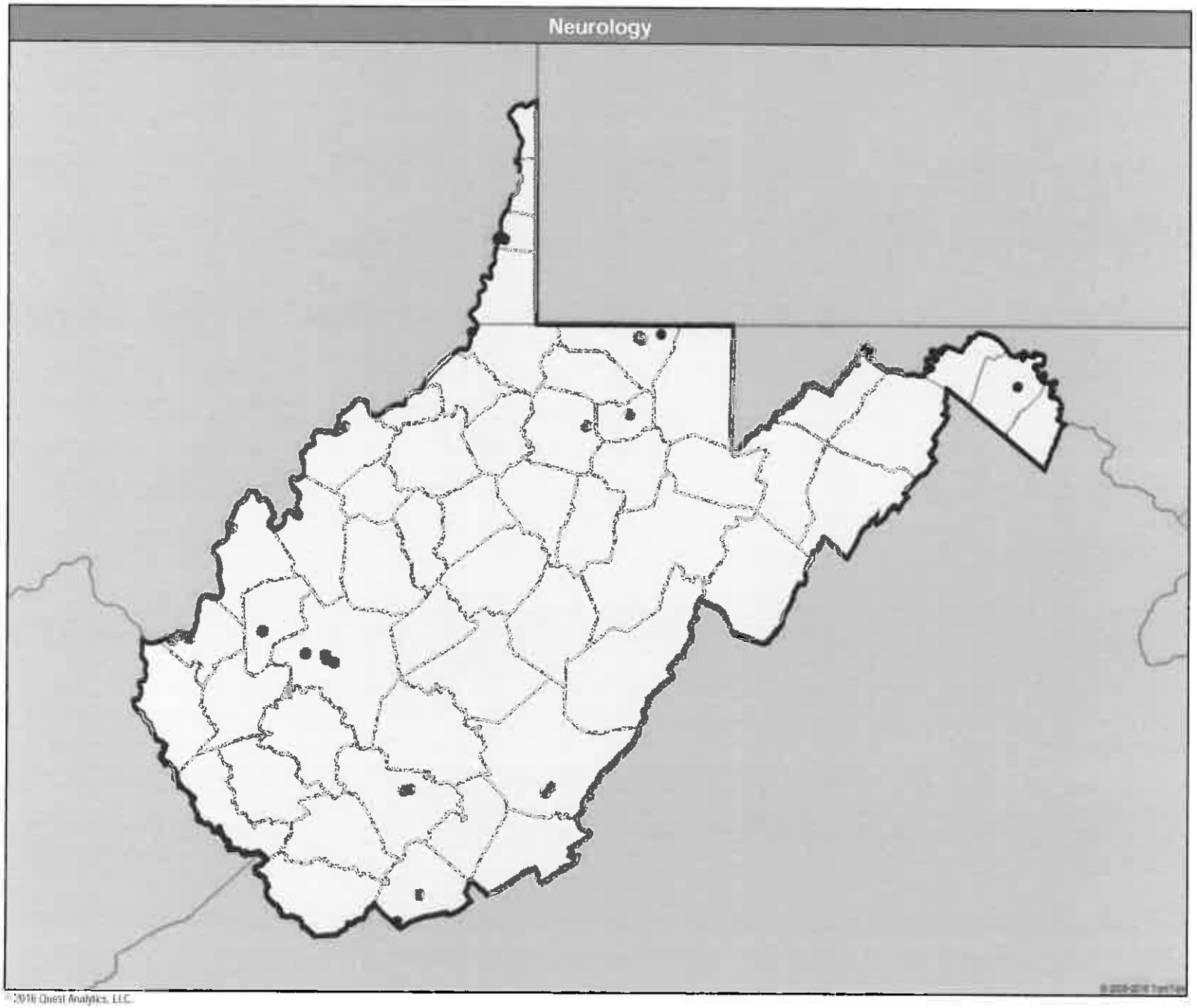
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PHCS-MPI: NEUROLOGY

57 providers at 38 locations
All providers

1 in = 39.35 miles



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Map - Obstetrics & Gynecology

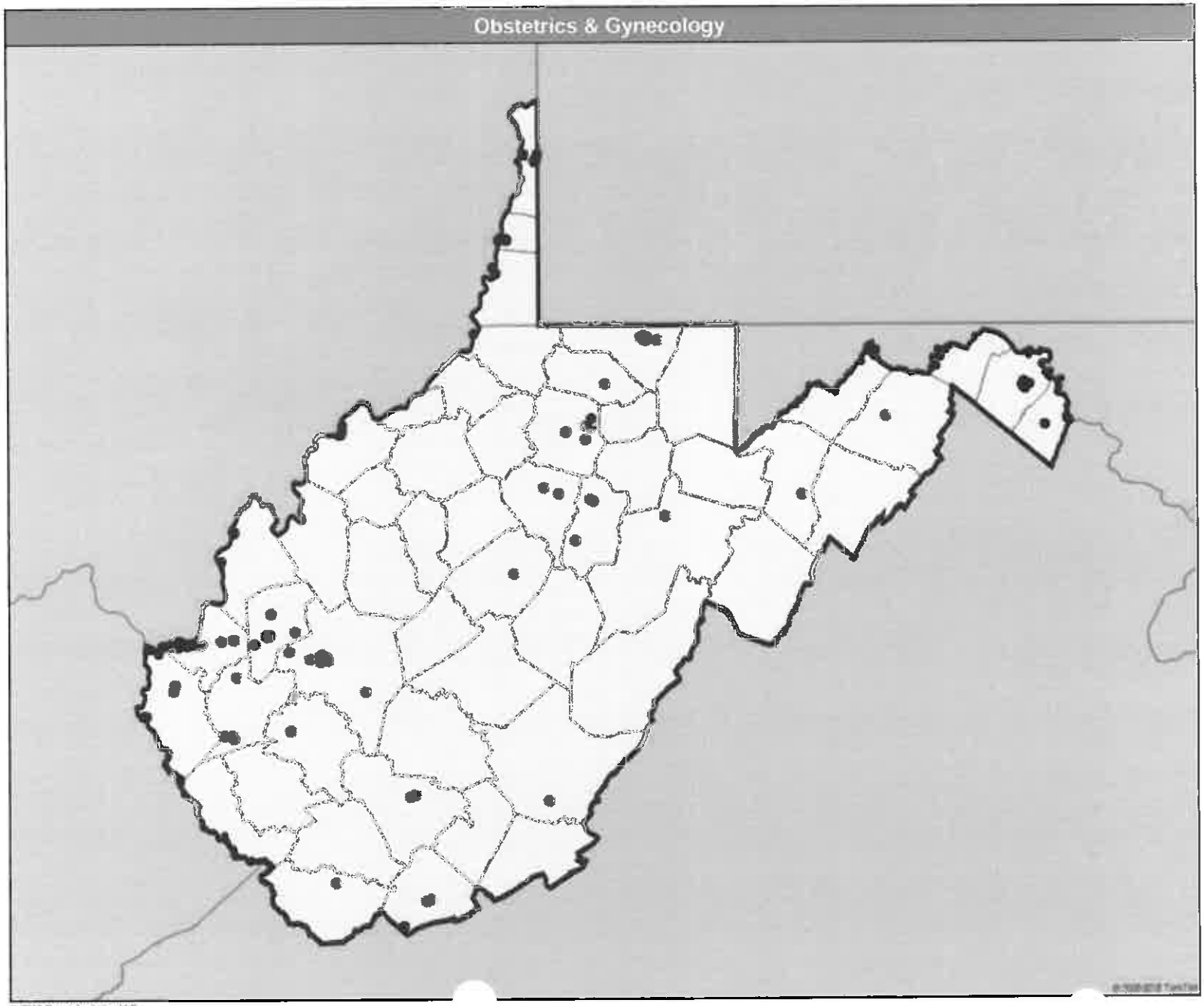
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PHCS-MPI: OBSTETRICS & GYNECOLOGY

164 providers at 145 locations
● All providers

1 in = 39.35 miles



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Map - [illegible]ncology

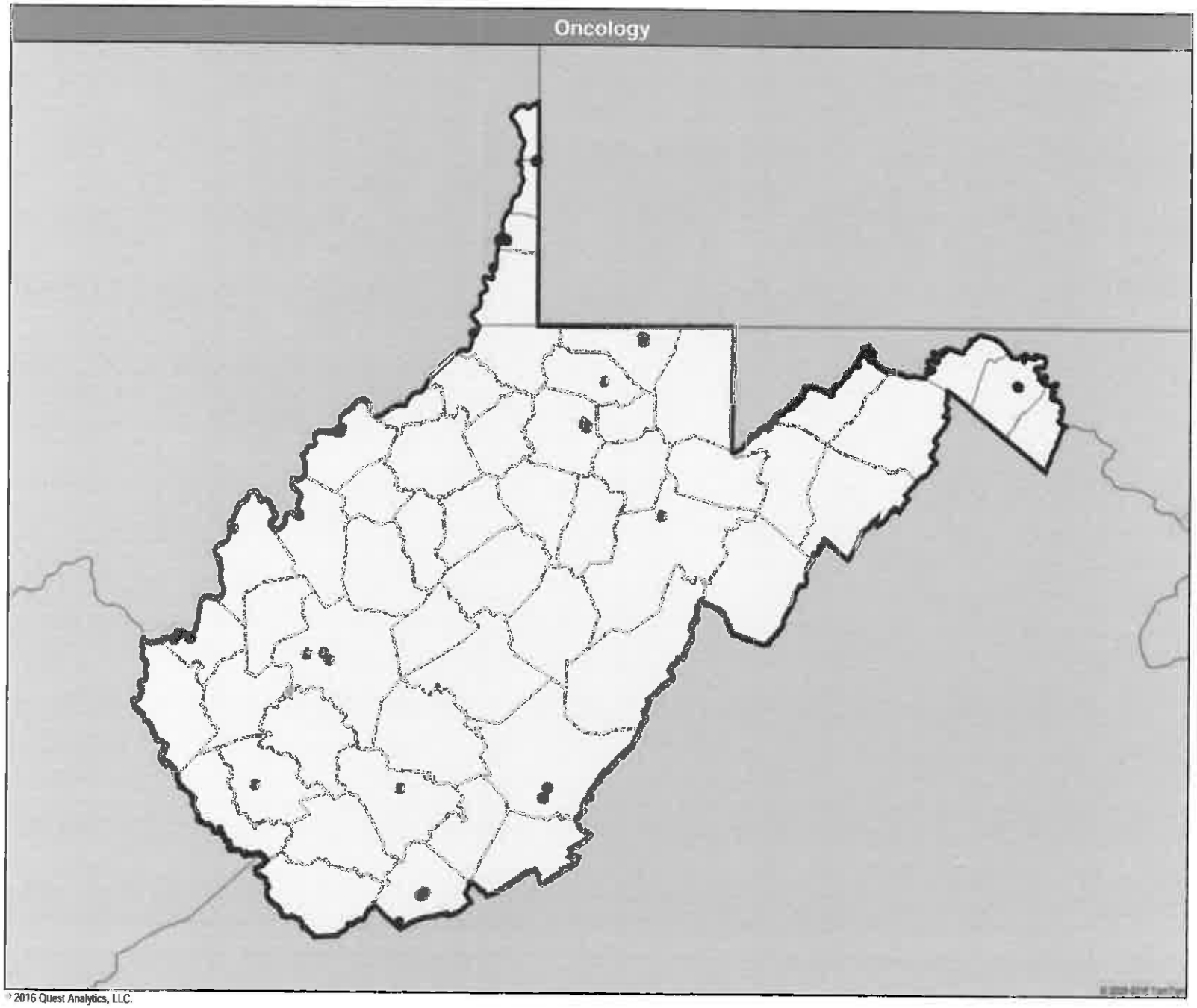
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PHCS-MPI: ONCOLOGY

83 providers at 48 locations
● All providers

1 in = 39.35 miles



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Map - Oral Surgery

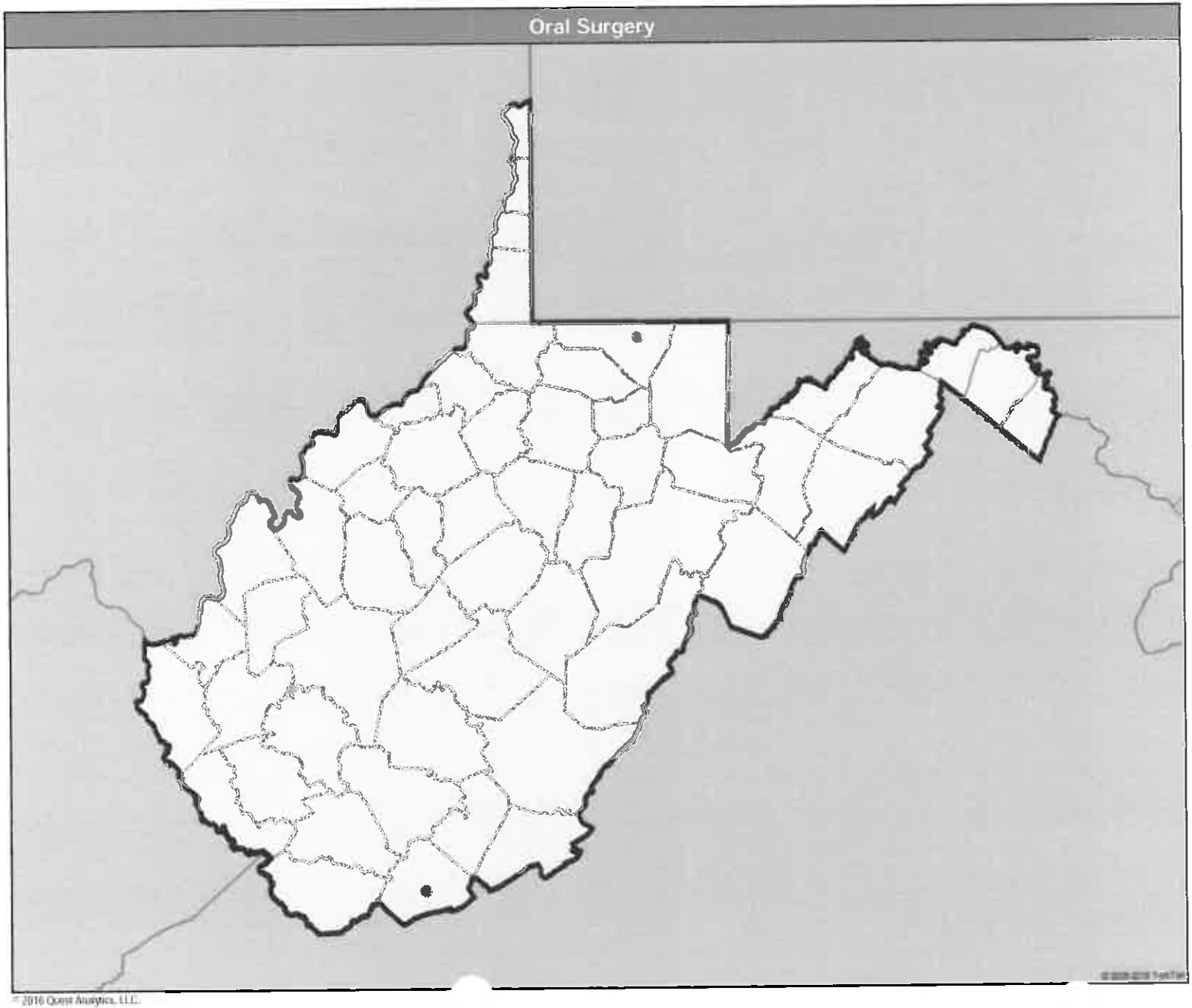
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PHCS-MPI: ORAL SURGERY

11 providers at 3 locations
All providers

1 in = 39.35 miles



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Map - [illegible]thopedic Surgery

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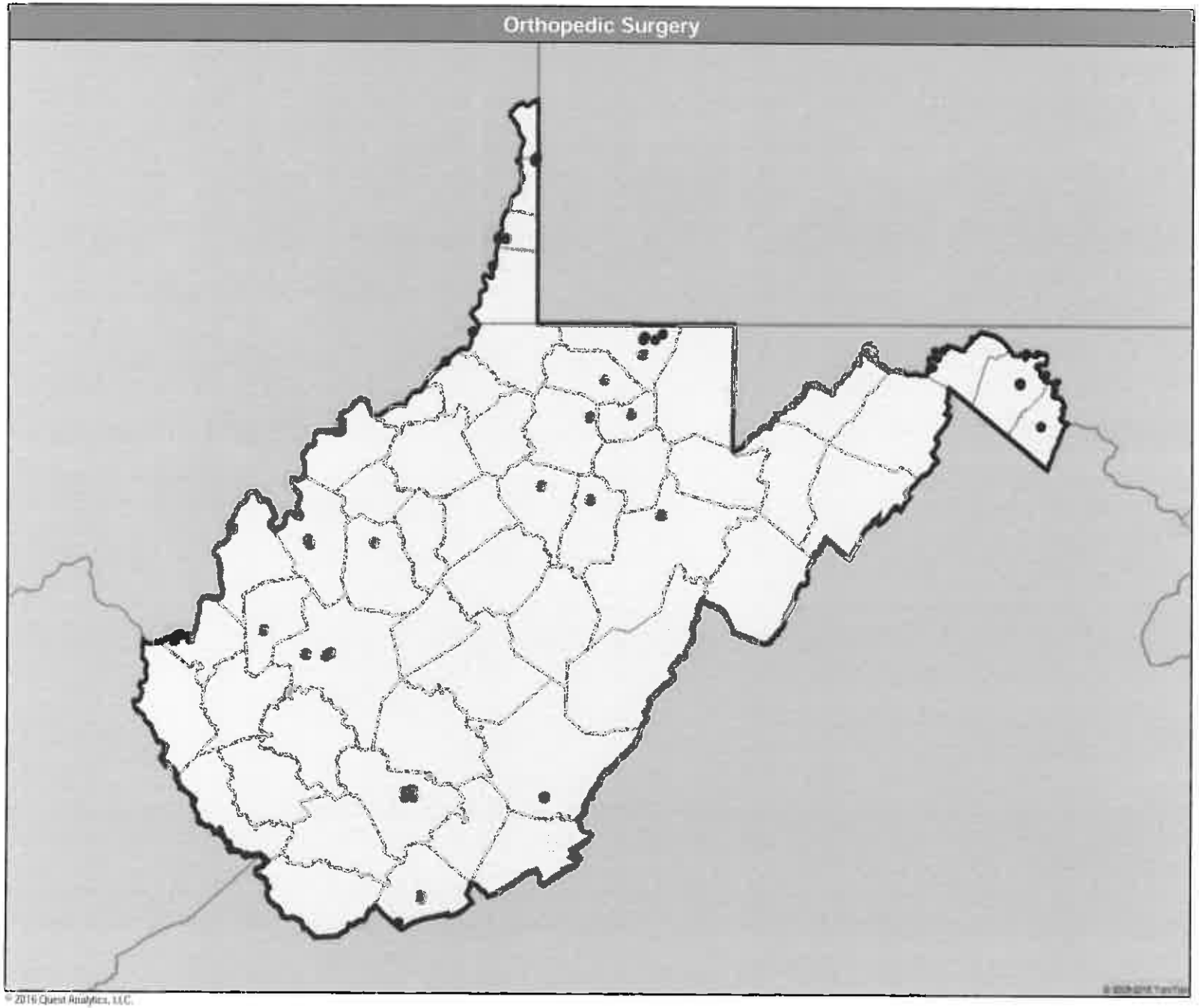
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PHCS-MPI: ORTHOPEDIC SURGERY

114 providers at 67 locations

● All providers

1 in = 39.35 miles



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Map - Otolaryngology

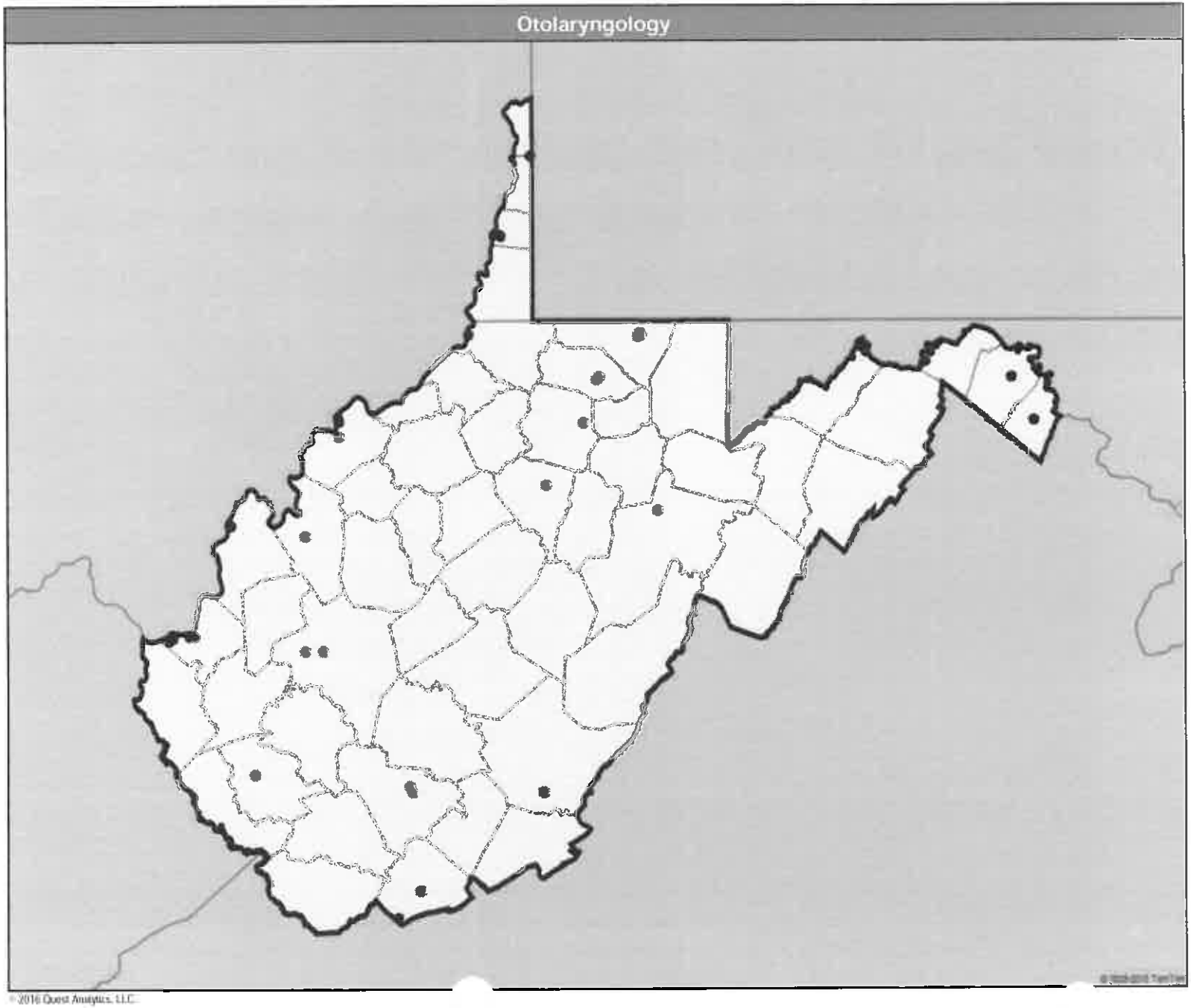
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PHCS-MPI: OTOLARYNGOLOGY

55 providers at 41 locations
All providers

1 in = 39.35 miles



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Map - ediatrician

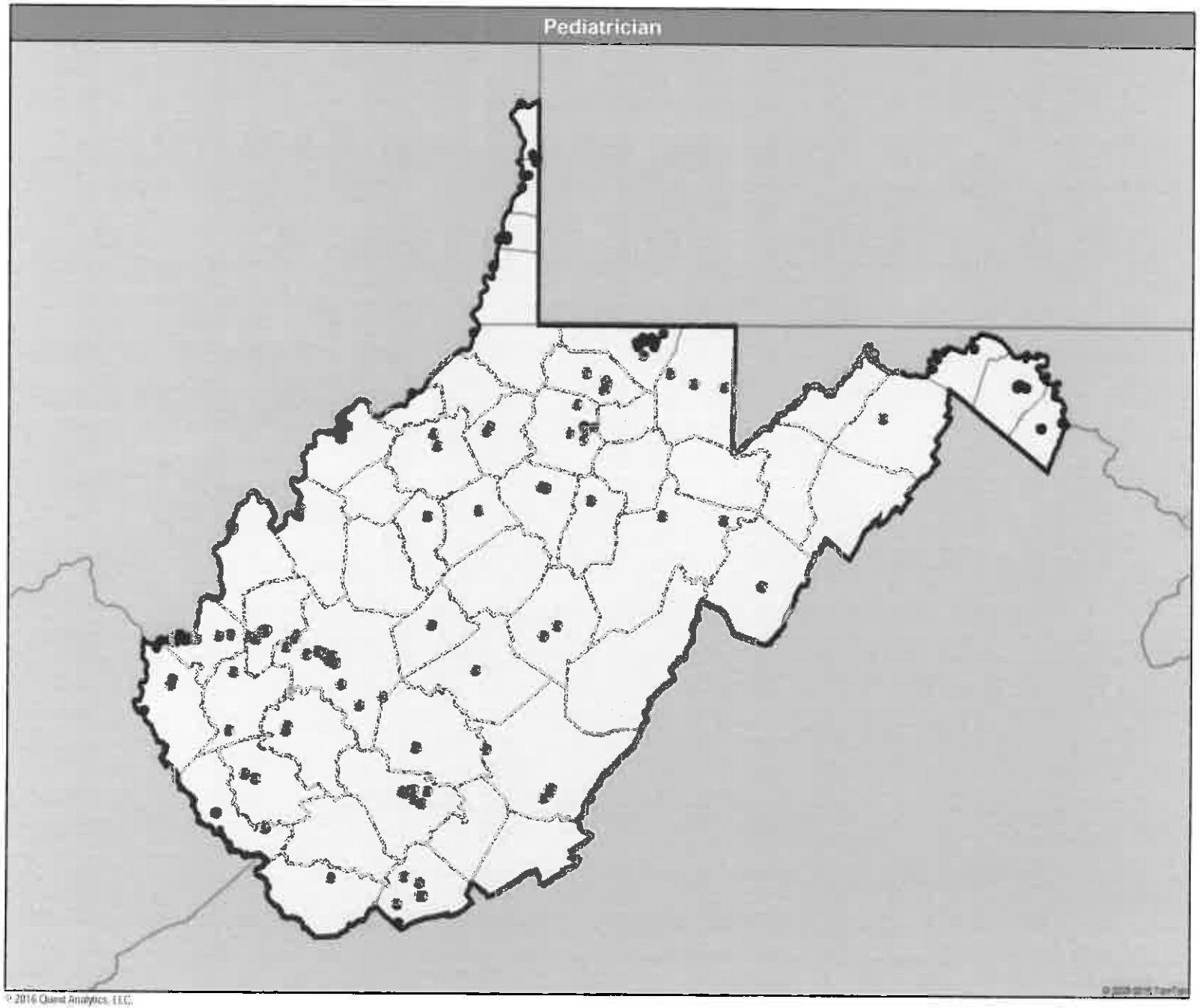
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PHCS-MPI: PEDIATRICIAN

271 providers at 202 locations
● All providers

1 in = 39.35 miles



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Map - Physical Therapy

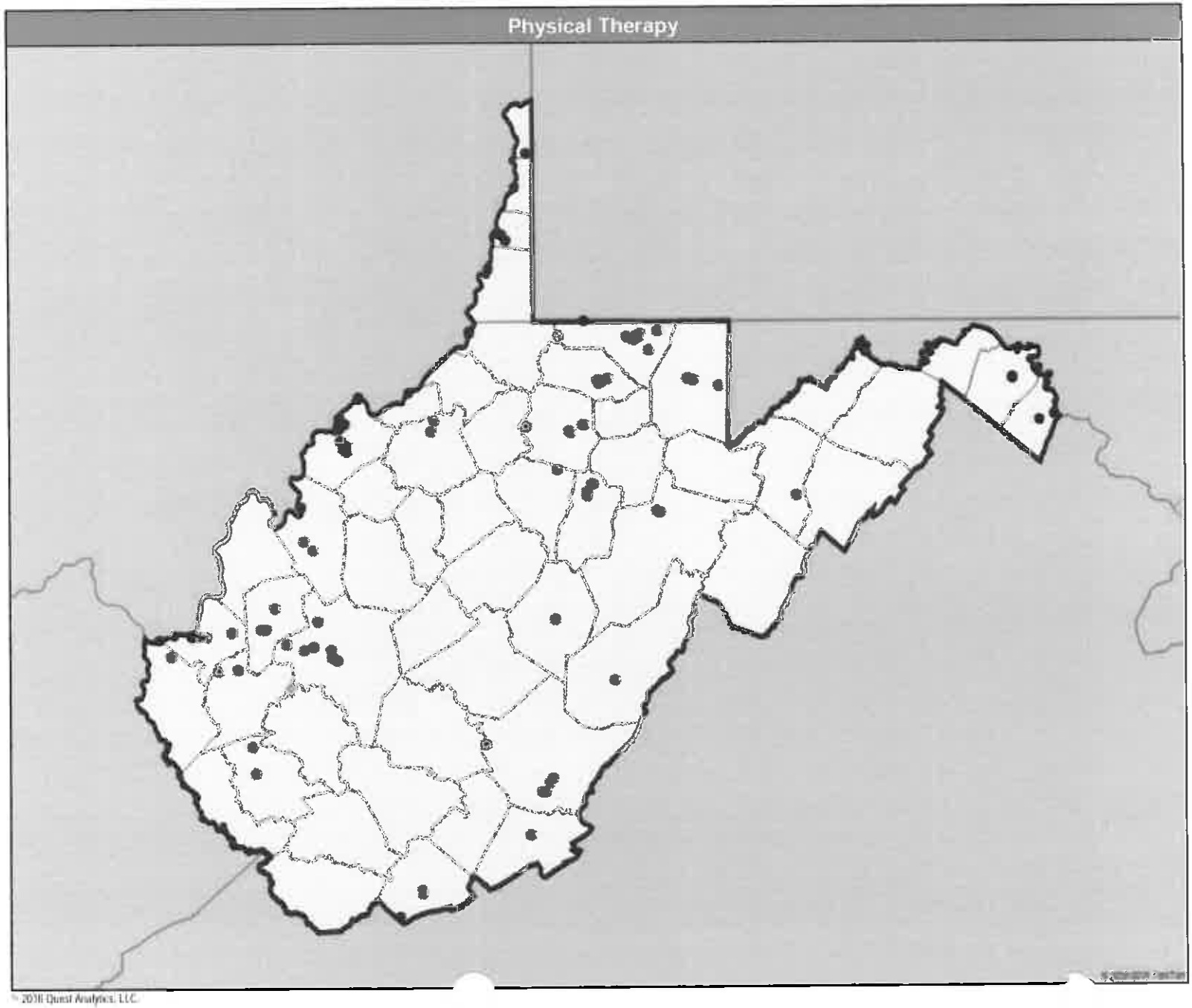
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PHCS-MPI: PHYSICAL THERAPY

211 providers at 132 locations
All providers

1 in = 39.35 miles



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Map - Radiology

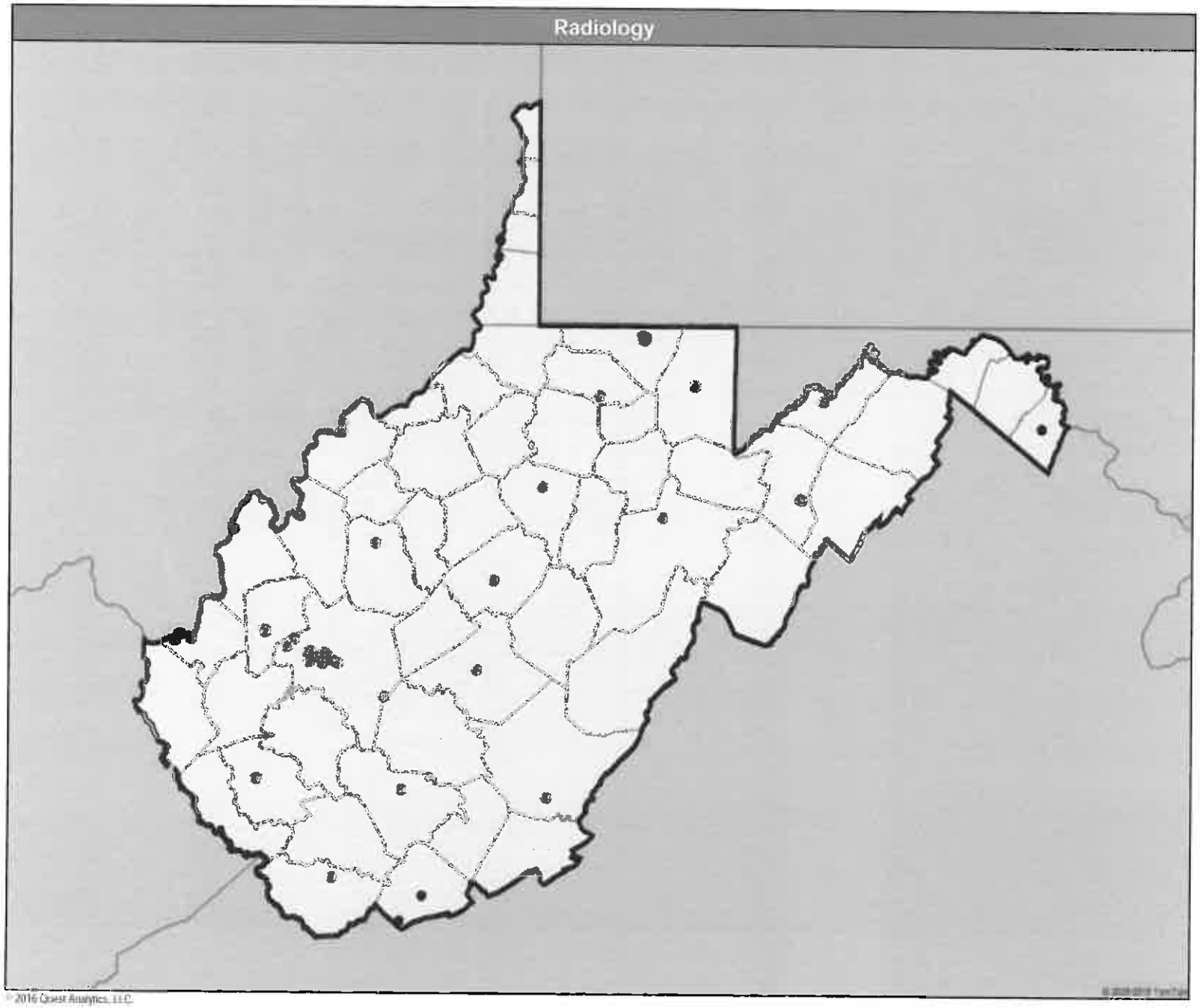
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PHCS-MPI: RADIOLOGY

136 providers at 67 locations
● All providers

1 in = 39.35 miles



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Map - Urology

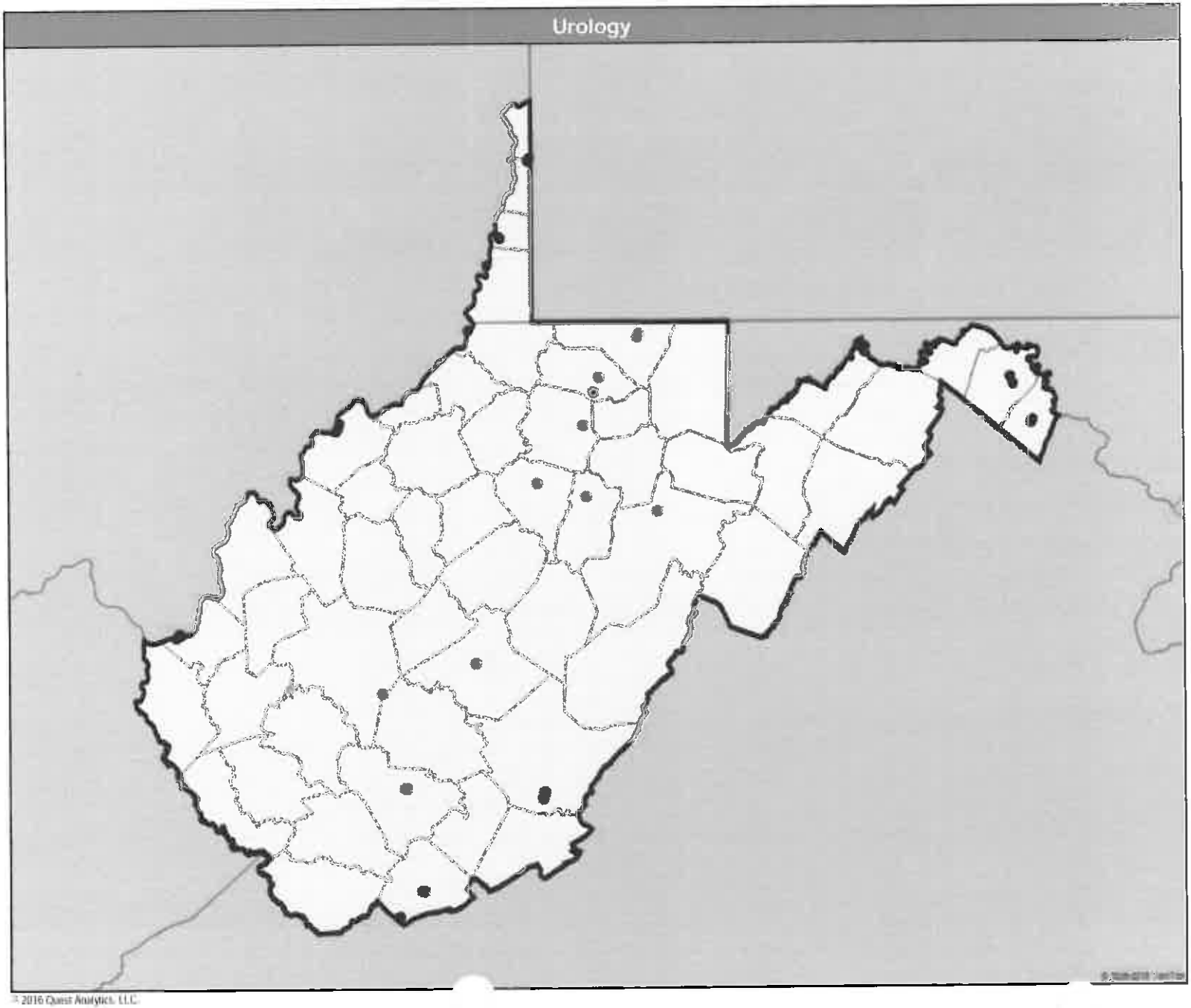
March 2, 2016

Created by...
MultiPlan

PHCS-MPI: UROLOGY

48 providers at 43 locations
● All providers

1 in = 39.35 miles



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Contracts

9/13/2013

MSRA	Agreement	LOI	Grand Total
Central	405	42	447
A	38	15	53
F	3	7	10
G	88	4	92
P	296	16	312
Northeast	817	50	867
A	110	14	124
F	6	10	16
G	141	9	150
P	560	17	577
West	332	107	439
A	79	34	113
F	10	24	34
G	83	7	90
P	420	42	462
Other	1,995	53	2,048
A	185	20	205
F	11	7	18
G	288	4	290
P	1,513	22	1,535
Grand Total	3,629	252	4,081
	93.8%	6.2%	

3/3/2014

MSRA	Agreement	LOI	Grand Total
Central	453	24	477
A	46	8	54
F	6	6	12
G	90	2	92
P	310	8	318
Northeast	868	39	907
A	124	7	131
F	12	4	16
G	148	4	152
P	584	5	589
West	712	52	764
A	112	14	126
F	36	12	48
G	100	4	104
P	464	22	486
Other	2,009	52	2,061
A	198	13	211
F	15	4	19
G	298	2	300
P	1,518	13	1,531
Grand Total	4,041	128	4,169
	96.9%	3.1%	

Providers

9/13/2013

MSRA	Agreement	LOI	Grand Total
Central	685	318	1,003
A	46	27	73
F	3	7	10
G	90	59	149
P	546	225	771
Northeast	1,375	1,017	2,392
A	126	50	176
F	6	22	28
G	144	95	239
P	899	850	1,749
West	629	604	1,233
A	93	55	148
F	10	24	34
G	83	48	131
P	653	537	1,190
Other	2,605	279	2,884
A	212	32	244
F	11	7	18
G	301	18	319
P	2,081	221	2,302
Grand Total	5,304	2,277	7,581
	70.0%	30.0%	

3/3/2014

MSRA	Agreement	LOI	Grand Total
Central	787	184	971
A	60	14	74
F	6	6	12
G	95	33	128
P	626	130	756
Northeast	1,644	606	2,250
A	154	17	171
F	23	5	28
G	168	37	205
P	1,699	147	1,846
West	1,143	341	1,484
A	137	22	159
F	36	12	48
G	103	44	147
P	867	463	1,330
Other	2,882	212	3,094
A	226	24	250
F	15	4	19
G	330	12	342
P	2,311	172	2,483
Grand Total	6,456	1,143	7,599
	85.7%	14.3%	



Provider Services: (202) 821-1145 (202) 905-0178 (EFax)

Member Services: (202) 821-1100 (855) 326-4831 (toll free)

TRUSTED HEALTH PLAN	Effective Date: 08/29/2014	Policy #: PR-2014-14
Department: Provider Relations	Reviewed Date:	Expiration Date:
Policies and Procedures	Revised Date:	Page(s): 2

POLICY TITLE: **SELECTION AND RETENTION OF PRACTITIONER**

SCOPE: **TRUSTED HEALTH PLAN**

UNIT: **NETWORK DEVELOPMENT**

PURPOSE:

This Policy and Procedure outlines TRUSTED Health Plan's (TRUSTED) process for identifying, recruiting and retaining practitioners.

POLICY:

TRUSTED ensures that its network has sufficient numbers and types of primary care, specialty care and behavioral health practitioners. TRUSTED has an established methodology to formally analyze and monitor availability and the adequacy of its practitioner network by providing support mainly from its Provider Network Development/Management, Credentialing, Member Services, Medical Management and Performance Analytics Department.

PROCEDURE:

I. **Practitioner Selection** Process

A. Practitioner Availability is assessed and monitored on a quarterly basis via the following activities:

1. High Volume Specialists (HVS) are identified using annual reports of encounter data by specialist type.
2. GeoAccess reports for Primary Care Providers (PCPs), OB/Gyns, Behavioral Health and HVS are measured using the 30-minute travel time by public transportation or a 5-mile radius of member's residence standard.
3. PCP to member ratio is determined and measured against the 2:1 ratio guideline.
4. Practitioners providing services via Letters of Agreement will be pursued for contracting.

B. The Vice President of Provider Services reviews findings and identify opportunities for improvement.
C. Provider recruitment action plans are developed and implemented.
D. Areas identified for improvement are re-measured to monitor effectiveness of action plan(s).
E. GeoAccess is used quarterly to help identify gaps in the provider network.
F. Claims data is used quarterly to identify recruitment opportunities.
G. Action plans are modified as necessary following quarterly or annual reviews.
H. Results of the evaluation are reported quarterly to the District of Columbia Department of HealthCare Financing and annually to the Quality Management Committee (QMC) and Oversight Operations Committee (OOC). The analysis is a part of the Quality Improvement Work Plan, which is evaluated on an annual basis.

II. Provider Retention Process

A. TRUSTED's Provider Network Management/Development Department provides daily support relative to assistance with reimbursement, panel support and providing liaison function with TRUSTED's Utilization Management (UM), Claims and Member Services Departments.
B. Provider profiling and performance monitoring support is provided by the Performance Analytics Department
C. TRUSTED's Medical Management Department provides key support with disease management and outreach activities.

APPROVED BY:

VP of Provider Relations

8/29/2014
Date

CREDENTIALING PLAN

Trusted Health Plan

PR-2015-0001

Rachel DelPriore
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Updated August 5th, 2015

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CREDENTIALING AND RECREDENTIALING PLAN

Section 1.0
INTRODUCTION

Section 1.1 – Purpose. The purpose of this Credentialing and Recredentialing Plan ("Credentialing Plan") is to explain the policy of Trusted Health Plan, Inc. and its affiliates (Trusted Health Plan) for credentialing and recredentialing. All Licensed Independent Practitioners and Facilities that are part of the Network are subject to the Credentialing Plan. Licensed Independent Practitioners and Facilities that provide health care services to Covered Persons under their out-of-network benefits or an emergency basis are not subject to this Credentialing Plan.

Credentialing is a peer-review process designed to review certain information pertinent to the decision to contract with any Licensed Independent Practitioners and Facility, either initially or on an ongoing basis. The process described in the Credentialing Plan will be initiated only after the Trusted makes a preliminary determination that it wishes to pursue contracting or re-contracting with the Applicant.

No portion of this Credentialing Plan grants rights to Covered Persons, Licensed Independent Practitioners or Facilities, nor is it intended to establish a standard of care or to be used as evidence relevant to establishing a standard of care.

Section 1.2 – Credentialing Policy. The Trusted credentialing policy consists of this Credentialing Plan and any Credentialing Authority's standards. To the extent this Credentialing Plan may vary from any Credentialing Authority's standards the applicable Credentialing Authority's standards will control. To the extent this Credentialing Plan may vary from any Credentialing Authority's credentialing standards, Trusted Health Plan will adopt the revised or clarified standard unless otherwise amended in this Credentialing Plan.

Section 1.3 – Authority of Trusted and Changes to Credentialing Plan. To the extent permitted by any Credentialing Authority's standards and this Credentialing Plan, Trusted has the sole right to determine which Licensed Independent Practitioners and Facilities it will accept and maintain within its Network, and the terms on which it will allow participation.

The Quality Executive Committee has the authority to approve this Credentialing Plan. This Credentialing Plan does not limit Trusted Health Plan's rights under the pertinent Participation Agreements that govern their relationships with Licensed Independent Practitioners and Facilities.

Section 2.0
DEFINITIONS

For the purposes of this Credentialing Plan, the terms listed below have the meanings described below and are capitalized throughout this Plan.

"Appeal" has the meaning given to it by any governing Credentialing Authorities or the pertinent Participation Agreement.

"Applicant" means a Licensed Independent Practitioner or a Facility that has submitted an Application to Trusted for credentialing or recredentialing.

"Application" means the document provided by Trusted (or its designee) to a LIP or a Facility which, when completed, will contain information for Credentialing Committee to review as part of its determination whether Applicant meets the Credentialing Criteria. Health Maintenance Organizations (HMOs) and Preferred Provider Organizations (PPOs) are required to accept the District of Columbia uniform

credentialing form for credentialing and recredentialing (D.C. Code sections 31-3252 and 31-3251; Code of D.C. Municipal Regulations sections 26-4201 and 26- 4299.)

"Application Date" means the date on which the Trusted receives the signed, dated and complete Application for Network participation from a LIP or a Facility.

"Benefit Plan" means an employee health benefits plan that: (1) is underwritten, issued and/or administered by Trusted, and (2) contains the terms and conditions of a Covered Person's health benefits coverage.

"Board of Directors" means the Trusted's Board of Directors.

"CMS" means the Center for Medicare and Medicaid Services.

"Covered Person" means a person who is covered by a Benefit Plan (i.e., members, subscribers, insured's, participants, enrollees, or other Covered Persons).

"Credentialing Authorities" means the Committee for Quality Assurance ("NCQA"), other accrediting body as applicable to Trusted Health Plan, the Center for Medicare and Medicaid Services ("CMS"), as applicable, and other state and federal regulatory authorities; to the extent such authorities dictate Credentialing requirements.

"Credential", "Credentialing", or "Recredentialing" means the process of assessing and validating the applicable criteria and qualifications of Licensed Independent Practitioners and Facilities to become or continue as Participating LIPs and Participating Facilities, as set forth in the Credentialing Plan and pursuant to Credentialing Authorities

"Credentialing Criteria" are those found in Section 4.2, 5.0 and 7.0 as applicable, and Attachment A of this Credentialing Plan, as it may be amended from time to time.

"Trusted" is Trusted Health Plan Services, Inc. or its affiliates that adopts this Credentialing Plan. When "Trusted" is required to take some action by this Credentialing Plan, it may do so through delegation to the extent permitted by any Credentialing Authorities.

"Decision Date" is the date on which the Credentialing Committee makes its decision to indicate approval or denial of credentialing or recredentialing for an Applicant.

"Delegated Entity" is a hospital, group practice, credentials verification organization (CVO), or other entity to which Trusted has delegated specific credentialing and recredentialing responsibilities under a Delegation Agreement.

"Delegation Agreement" is a mutually agreed upon contract, memorandum of understanding, letter of intent, or other document by which Trusted delegates specified credentialing responsibilities to Delegated Entity, and requires Delegated Entity to meet certain standards related to its credentialing and recredentialing responsibilities.

"Facility" includes but is not limited to hospitals and ancillary providers such as home health agencies, skilled nursing facilities, behavioral health centers providing mental health and substance abuse services (inpatient, residential and ambulatory) and freestanding surgical centers, and multispecialty outpatient surgical centers, or as otherwise defined by Credentialing Authority.

"Hearing Panel" means a committee created by the Trusted to provide Appeals as required by Credentialing Authorities or the pertinent Participation Agreement.

"High Volume Behavioral Specialist" means any LIP engaged in providing mental health care and determined by Trusted (THP) through analysis of claims data to meet a "high volume" threshold established by Beacon Health or Trusted.

"HIPDB" means the Healthcare Integrity and Protection Data Bank.

"Leased Network" means an existing organization of physicians, hospitals and other healthcare professionals that Trusted Health Plan contracts to allow member access and to which THP has delegated credentialing functions.

"Material Restriction" mean a restriction that includes but is not limited to the following: a requirement to obtain a second opinion from another practitioner prior to patient diagnosis or treatment; a limitation on prescription drug writing; a limitation on providing examination, diagnosis or procedure without a second person present or approving the procedure; or restriction, suspension or involuntary termination of hospital staff privileges if the LIP's specialty normally admits patients to a hospital. The restrictions listed above are not exclusive. There may be other restrictions or conditions, not specifically identified in the definition above, that rise to the level of a material restriction

"NCQA" means The Committee for Quality Assurance.

"Credentialing Committee" means a standing committee that implements the Credentialing Plan.

"Network" means LIP's and Facilities contracted with by Trusted Health Plan to provide or arrange for the provision of health care services to Covered Persons.

"Notice" means: (1) depositing correspondence in the United States mail, using first class or certified mail, postage prepaid, addressed to the other party at the last known office address given by the party to the other party; or (2) delivering the correspondence to an overnight courier, delivery to the other party prepaid, addressed to the other party at the last known office address given by the other party; or (3) sending a facsimile transmission to the other party at the last known office facsimile number given by the party to the other party, or (4) personally hand-delivering written notice to the other party.

"NPDB" means the National Practitioner Data Bank.

"NTIS" is the National Technical Information Service.

"Participating LIP/Facility" means a Licensed Independent Practitioner or Facility who has entered into a Participation Agreement with the Trusted or as an employee of a Delegated Entity.

"Participation Agreement" means a direct or indirect (such as an IPA or PHO) agreement between the Trusted and a LIP or a Facility that sets forth the terms and conditions under which the LIP or Facility participates in Trusted's Network.

"PCP" means primary care physician, and always includes family practice, geriatrician, internal medicine, pediatric general practice and general practice physicians. In some states and for some Credentialing Entities, "PCP's" may also include OB/GYNs and certified registered nurse practitioners.

"Peer Review" is the evaluation or review of the performance of Physicians, Health Care Professionals or Facilities by professionals with similar types and degrees of expertise (e.g., the evaluation of one physician's practice by another physician).

"Peer Review Committee (PRC)" is responsible for investigating and evaluating Enrollee/Member Quality of Care (QOC) Complaints and determining, or recommending to the Peer Review Committee, whether and what type of disciplinary action should be taken in relation to such QOC Complaints between the

credentialing or recredentialing cycle. Complaints requiring investigation may involve a Physician, Health Care Professional or Facility that delivers health care to Enrollees/Members. The PRC shall comply with applicable state peer review requirements and is comprised of Medical Directors, participating physicians and QOC clinical staff.

"Primary Source Verify" means to verify directly with an educational, accrediting, licensing, other entity, or NCQA approved entity that the information provided by Applicant is correct and current.

"Quality Executive Committee (QEC)" means the Trusted committee that may review and approve changes to the Credentialing Plan required to meet regulatory requirements or other organizational and business needs.

"Quality of Care (QOC)" means the degree to which health services for Enrollees/Members increase the likelihood of desired health outcomes and are consistent with current professional knowledge. Dimensions of performance include, but are not limited to, the following: member perspective issues, safety of the health care environment, accessibility, appropriateness, continuity, effectiveness, efficacy and timeliness of care.

"Protected Health Information" has the same meaning it has under the Health Insurance Portability and Accountability Act and its implementing and interpretative regulations.'

"With Issues" means the Applicant has not met all of the Trusted's criteria for participation as a LIP.

"Without Issues" means the Applicant has met all of the Trusted's criteria for participation as a LIP

"Trusted Health Plan Quality of Management" (QOM) means the department within Trusted Health Plan Health Services that receives logs, investigates and documents resolution of quality of care and quality of service complaints.

Section 3.0
RESPONSIBILITIES OF BOARD OF DIRECTORS COMMITTEES, MEDICAL DIRECTORS, HEARING PANELS AND APPLICANTS

Section 3.1 – Trusted Board of Directors (Board of Directors). The Board of Directors is responsible for the administration of the Credentialing Plan and has delegated to the QEC the overall responsibility and authority for credentialing and recredentialing.

Section 3.2 – Medical Director. The Medical Director (or designee) has overall responsibility for the credentialing process and implementing this credentialing plan. S/he reviews the names of all network applicants. The Medical Director may approve initial or recredentialing files that meet all Trusted credentialing criteria ("clean files") or may determine that additional review by the Credentialing Committee is required. The medical director chairs the credentialing committee. S/he is involved with cases where a practitioner or provider denied participation status or is subsequently de-credentialed. The Medical Director may delegate these functions to a peer as appropriate.

Section 3.3 – Credentialing Committee. The credentialing committee has the responsibility to implement this Credentialing Plan. The Credentialing Committee has the authority to interpret the terms of this Credentialing Plan and make any necessary professional judgments about medical practice and clinical issues.

The Credentialing Committee also recommends appropriate action if they determine that any LIP or Facility (Facility only where required by Credentialing Authorities) has violated the terms of this Credentialing Plan. The Credentialing Committee has the responsibility to report adverse credentialing decisions or other issues that come to their attention to the Trusted, which will make any required reports as described in Section 9.

The Credentialing Committee is comprised of a range of Participating Licensed Independent Practitioners (LIPs) and a designated Medical Director, unless a different committee composition is otherwise required by applicable Credentialing Authorities. The Medical Director shall serve as chairperson of the Credentialing Committee. The committee members provide advice and expertise for credentialing decisions.

Section 3.4 – Process for Initial Credentialing and Recredentialing of LIPs. Trusted staff will collect information to assess whether an Applicant meets Trusted's minimum requirements for practice location, specialty and any other business needs. All "clean" applications will be processed within one-hundred twenty (120) days from the time of receipt.

A list of LIPs who meet criteria is submitted to the Medical Director for review and approval. Lists of applicants will be distributed by email and approved by electronic or manual signature.

LIPs who do not meet Trusted's established criteria are presented to the Credentialing Committee. The information provided to the Credentialing Committee includes the LIP's profile and all documentation related to the issue or issues in question. The information provided to the Credentialing Committees does not include references to age, gender, race, sexual orientation or type of procedure or patients so decisions are made in a nondiscriminatory manner. The Credentialing Committee may request further information from any persons or organizations, including the LIP, in order to assist the committee with the evaluation process.

The Credentialing Committees will not make any decision on an Applicant without a completed Application, except in those cases where the Credentialing Entity has documented multiple attempts to obtain a complete application with no response. The Credentialing Committee has the discretion and authority to recommend contract termination for any LIPs who have not, after multiple documented requests, submitted a recredentialing application. The Credentialing Committee has discretion to ask for missing information or to deny the Application as incomplete. The Credentialing Committees may request further information not covered by the Application, if necessary to fulfill its obligations under applicable Credentialing Authorities.

Upon receipt of a complete Application, the Credentialing Committee will make a decision in accordance to the timeframes as specified by the Credentialing Authority.

The Credentialing Committee may delay action on an Application pending the outcome of an investigation of the Applicant by a hospital, licensing board, government agency, Trusted or any other organization or institution.

Section 3.5 – Hearing Panel. The Peer Review Committee establishes the Hearing Panel when the Peer Review Committee grants an appeal of an adverse action based on quality of care concerns. The Hearing Panel's responsibility is to conduct hearings or reviews and make determinations:

1. to uphold, reject, or modify decisions of the National Peer Review Committee to suspend, restrict or terminate an LIP's participation, or
2. to uphold, reject or modify a decision by a Medical Director, Peer Review Committee chairperson and Chief Medical Officer to take summary action to suspend, restrict or terminate an LIP's participation per the Quality of Care Investigation, Improvement Action Plans and Disciplinary Actions Policy & Procedure

The hearing is held before a Hearing Panel comprised of three (3) clinicians who are appointed by THP, who are not in direct economic competition with the LIP, and who have not acted as accuser, investigator, fact-finder, or initial decision-maker in the matter. The majority of persons on the Hearing Panel must be clinical peers in the same discipline and the same or similar specialty of the LIP under review.

Section 3.6 – Disclosing Reasons for Non-Acceptance or Termination. When a LIP's or Facility's application is not accepted or participation is terminated, the non-acceptance or termination letter generally should include the reason(s) for the decision. Trusted should contact its legal representative if it

has questions about any specific Credentialing Authority that may require it to disclose reasons for non-acceptance or termination, or if it is not accepting an Applicant or is terminating participation for reasons relating to professional competence or conduct

Trusted will notify the LIP and document action taken by the Peer Review Committee, Peer Review Committee or Hearing Panel, including, but not limited to:

- Decisions to accept, deny, restrict or terminate participation
- Decisions to offer or deny a hearing to an Applicant
- Decisions regarding Peer Review Committee reconsideration
- Decisions regarding corrective action

Section 3.7 – Applicant. Applicant is responsible for timely completion of the Application, providing all requested information, and disclosing all facts that are requested and that a Credentialing Entity would consider in making a reasonable credentialing decision. Applicant or a Participating LIP or Participating Facility must inform Trusted of any material change to the information on the Application. Trusted must be informed of any change in staff privileges, prescribing ability, accreditation, ability to perform professional duties, change in OIG sanction or GSA debarment status or Material Restrictions on licensure. Failure to inform Trusted immediately of a status change is a violation of this Credentialing Plan and the Participation Agreement, and may result in immediate suspension or termination from the Network.

Section 4.0
INITIAL CREDENTIALING OF LICENSED INDEPENDENT PRACTITIONER APPLICANTS

Section 4.1 – Scope of Licensed Independent Practitioner (LIP) Credentialing. Credentialing is required for all LIPs to whom Trusted Health Plan directs Covered Persons to receive care under a Benefit Plan as part of Trusted Health Plan's Network of Participating LIPs. "Licensed Independent Practitioner" or "LIP" means any health care professional who is permitted by law to practice independently within the scope of the individual's license or certification, and includes but is not limited to medical doctors (MDs), doctors of osteopathy (DOs), dentists (DDS or DMD), chiropractors (DCs), doctors of podiatric medicine (DPM), psychiatrists, (MDs) psychologists (PhDs), social workers, certified registered nurse practitioners (CRNPs), certified nurse midwives (CNMs), physical, speech, occupational therapists and all other non-physician practitioners who have an independent relationship with the Trusted and provide care under the Trusted's medical benefit. This credentialing plan addresses credentialing and recredentialing of these provider types. Except as otherwise required by Credentialing Authorities, Trusted considers Applications from LIPs with an expressed interest in Network participation if Trusted determines: (1) it needs additional LIPs; and/or (2) that other organizational or business needs may be satisfied by including additional LIPs or a particular LIP in the Network. In addition to the practitioners eligible for credentialing mentioned above, the following types of practitioners fall under the scope of practitioners eligible for credentialing:

1) Hospital-based practitioners who have an independent relationship with the organization:.

   - Anesthesiologists with pain-management practices
   - Cardiologists
   - University faculty who are hospital based and who also have private practices

2) Dentists providing care under medical benefits:

   - Oral surgeons

3) Non-physician practitioners who have an independent relationship with the organization and provide care under the organization's medical benefits:.

   - Behavioral healthcare practitioners

- Nurse practitioners
- Nurse midwives
- Optometrists
- Physical therapists
- Occupational therapists
- Speech and language therapists

Credentialing may be delegated and will be subject to the requirements of Section 11 of this Plan. Credentialing is generally not required for health care professionals who are permitted to furnish services only under the direct supervision of another LIP or for hospital-based or Facility-based health care professionals who provide service to Covered Persons incidental to hospital or Facility services. However, credentialing is required for hospital or Facility-based LIPs to whom Trusted Health Plan directs Covered Persons to receive care under a Benefit Plan or if mandated by Credentialing Authorities.

Practitioners who do not need to be credentialed

Practitioners who practice exclusively within the inpatient setting and provide care for organization members only as a result of members being directed to the hospital or another inpatient setting.

- Pathologists
- Radiologists
- Anesthesiologists
- Neonatologists
- Emergency room physicians
- Hospitalists
- Telemedicine consultants
- Locum tenens

Practitioners who practice exclusively within free-standing facilities may practice exclusively and provide care for organization members only as a result of members being directed to the facility. Free-standing facilities include:

- Mammography centers
- Urgent-care centers
- Surgicenters
- Ambulatory behavioral healthcare facilities
- Psychiatric and addiction disorder clinics
- Community mental health centers

Section 4.2 – Credentialing Process and Criteria Verification Sources. Each LIP must complete an Application with a signed attestation, which may be in an electronic format, within accordance of the time frame as specified by Credentialing Authority. The following steps are taken at the time of credentialing:

1. The application data are reviewed for completion by the credentialing staff
2. Primary Source Verification of the elements below is conducted by Trusted's credentialing staff
3. Upon completion of the primary source verification:
    a. If the application meets all Trusted credentialing requirements, and there is a network need for the service, the name and specialty of the provider is forwarded to the medical director for review.
    b.a. The medical director reviews the names on a list of "clean" files and may approve the provider/s for network participation. Files are considered "clean" if all information is present, up to date, favorable for approval, and compliant with Trusted criteria. Files with adverse reports or questionable findings shall be presented to the Credentialing Committee for discussion and determination of approval status. Adverse events must be five (5) years or older for file to be considered clean. Adverse events with monetary

values of under $200,000.00 will be considered "clean". However, the Credentialing Committee will be notified of providers with such events. The Credentialing Staff will review all applications and identify those practitioner's that may be forwarded to the CMO as "clean" files.

~~i.~~

~~c.~~ b. The medical director forwards the approved providers' names to the credentialing manager, who proceeds with the contracting process.

~~d.~~ c. If the application fails to meet all Trusted credentialing requirements, the information is prepared for Credentialing committee review.

i. The file is provided to the committee at its next meeting

ii. The committee discusses the case and makes a decision to:

1. Approve for network participation
2. Deny network participation
3. Pend for more information
4. Conditionally approve network participation. In this case the committee may require certain actions of the applicant prior or during network participation (for example, acquiring more insurance, practicing under the supervision of another qualified practitioner, etc.)

~~e.~~ d. Each credentialing decision is communicated to the applicant in writing.

4. Credentialing approvals are sent back to the provider relations department, which notifies the provider directory coordinator:
   a. Credentialing effective date is loaded into the database and a provider number generated and sent to Credentialing
   b. Credentialing Coordinator generates approval letter to applicant with provider number and date of credentialing. The letter is mailed to the practitioner or provider within 60 days of the decision of the credentialing committee.
   c. Provider contracting sends the provider the welcome package which includes a signed contract, credentialing approval letter, and provider number. They are notified of the on-line provider handbook and any upcoming provider meetings. At this time practitioner is considered a member of the network and may treat Trusted's members and bill in-network rates.
5. Applicants not approved through credentialing will be notified in writing within 60 days of the credentialing committee's decision by the credentialing specialist.
   a. The applicant's appeal rights are communicated at the time of the denial notice.
   b. Provider relations will hold their contract until their appeal rights have been exhausted or the application is approved.
6. Provider relations will maintain a spreadsheet tracking the progress and disposition of the application.

Each LIP must meet the following criteria, which must be verified and approved within accordance of the time frame as specified by Credentialing Authority from the Application Date to the Decision Date, to be eligible to become a Participating LIP:

1. Required medical or professional education and training. MD's and DO's must graduate from medical school and successfully complete a residency program or other clinical training and experience as appropriate for specialty and scope of practice as determined by the Credentialing Committee. D.C.'s must graduate from Chiropractic College; D.D.S.'s must graduate from dental school; and D.P.M.'s must graduate from podiatry school and successfully complete a hospital residency program. All mid-level practitioners must graduate from an accredited professional school and successfully complete a training program. If Applicant claims to be board certified, Trusted will Primary Source Verify board certification from the most current edition of the ABMS or other NCQA approved source within accordance of the time frame as specified by Credentialing Authority from the Application Date to the Decision Date but need not Primary Source Verify each level of education and training if the certifying board has already Primary Source Verified it. If Applicant is not board certified, then Primary Source Verification of the highest level of education listed on the Application is required, except that each level of education must be primary source verified for dentists. Verification and approval within accordance of the

time frame as specified by Credentialing Authority from the Application Date to the Decision Date is not required for this element, however, verification must be completed prior to the decision date.

2. Verification of post-graduate education or training not listed in (1) above. Trusted will Primary Source Verify any post-graduate education or training disclosed in the Application and not considered in (1) above if relevant to LIP's scope of practice (for example Fellowship). Verification and approval within accordance of the time frame as specified by Credentialing Authority from the Application Date to the Decision Date is not required for this element however verification must be completed prior to the decision date.

3. Current licensure or certification. The Trusted will Primary Source Verify with the appropriate state medical board that the Applicant maintains current licensure or certification, without Material Restrictions, conditions, or other disciplinary action in all states where the applicant practices. Any finding that results in sanctions or restrictions on the LIP from CMS or any state licensing authority will result in denial of credentialing. If a restriction was placed on a provider's licensure, the provider must wait at least twenty-four months after the restriction has been lifted before applying for participation in the Trusted's network. A committee may recommend accepting a LIP to the Network if the restriction does not limit or impact the LIP's practice.

4. Valid DEA or Controlled Substance Certificate or Acceptable Substitute. Unless the Applicant's practice does not require it, the Applicant must have a valid DEA or Controlled Dangerous Substance Certificate in each state where the Applicant intends to practice, or, if the Applicant has a pending DEA application, an agreement with a Participating LIP with a valid DEA certificate in each state where the Applicant intends to practice to write prescriptions of the Applicant with the pending DEA application. The Trusted will verify that the Applicant meets this requirement by obtaining a copy of the Applicant's DEA or CDS Certificate in each state where the Applicant intends to practice, visually inspecting the certificate, or confirming with CDS or NTIS that the certificate is in force at the Decision Date. Verification and approval within accordance of the time frame as specified by Credentialing Authority from the Application Date to the Decision Date is not required for this element.

5. Medicare/Medicaid Program Participation Eligibility. The Applicant must not be ineligible, excluded or debarred from participation in the Medicare and/or Medicaid and related state and federal programs, and must be without any conditions, restrictions or sanctions levied by the Office of Inspector General (OIG) or the General Services Administration (GSA) or other disciplinary action by any federal or state entities identified by CMS or State Medical or Pharmacy Boards and must not participate in the Medicare Opt Out program. Trusted will verify reported sanction information from the NPDB or OIG and CMS.

6. Work History. The Trusted will obtain a five-year work history that does not contain any unacceptable gaps of longer than six months in duration and is current to within accordance of the time frame as specified by Credentialing Authority prior to the Decision Date. Gaps longer than six months must be explained by the LIP and found acceptable by the Credentialing Committee.

7. Insurance or state-approved alternative. The Applicant must maintain errors and omissions (malpractice) insurance through insurers licensed in their State that exceeds the minimum established coverage levels of 1 million per incident and 3 million per aggregate established by this Credentialing Plan. Trusted requires a copy of the Applicant's current Certificate of Coverage or may allow the Applicant's attestation within accordance of the time frame as specified by Credentialing Authority prior to the decision date to meet this requirement.

8. Malpractice History. Trusted must obtain written confirmation of the past five years of history of malpractice settlements from the malpractice carrier or must query the NPDB. Any LIP with a malpractice history exceeding an established threshold (defined in the policy below) may be referred to Committee for review.

9. Passing score on site visit. If required by Credentialing Authorities, Applicant must agree to allow Trusted to conduct an office site visit of Applicant's practice, including staff interviews, and medical record-keeping assessments, as further documented in Attachment B, and must receive a passing score for the site assessment and medical record keeping assessment. Verification and approval within accordance of the time frame as specified by Credentialing Authority from the Application Date to the Decision Date is not required for this element however verification must be completed prior to the Decision Date.

   Any failed site visit will result in the Applicant being required to re-apply for credentialing after at least six months have passed. The Trusted or Delegated Entity may agree to permit an Applicant to re-apply for credentialing prior to the six month wait period if the Applicant can first demonstrate improvements in the areas found deficient by providing documentation of such improvements in an improvement action plan. If the Trusted or Delegated Entity accepts the improvement action plan, the Applicant must agree to allow the Trusted or Delegated Entity to conduct an office site visit of Applicant's practice as further documented in Attachment B, and must receive a passing score for the site visit as part of the initial credentialing criteria.

10. Sanction and Limitation on Licensure. Trusted will obtain information about the Applicant through a review of NPDB or HIPDB or FSMB and State Medical Board reports. Any finding that demonstrates a current sanction or restriction on the LIP from CMS or any state licensing authority will result in review and may result in denial of credentialing.

11. No prior denials or terminations. At the discretion of the Trusted, the Applicant must not have been denied initial participation or had participation terminated (for reasons other than network need) by Trusted within the preceding 24 months.

12. Hospital Staff Privileges. Applicant (physicians) must have full hospital admitting privileges, without Material Restrictions, conditions or other disciplinary actions, at a Participating (Network) hospital, or arrangements with a Participating LIP to admit and provide hospital coverage to Covered Persons at a Participating (Network) hospital, if the Trusted determines that Applicant's practice requires such privileges. The Applicant's attestation is sufficient verification of this requirement. A committee may recommend accepting a LIP to the Network if the restriction does not limit or impact the LIP's practice.

13. Other credentialing requirements such as AMA profile or criminal history review as required by Credentialing Authorities.

14. No affirmative responses to Disclosure Questions on the Credentialing Application. Applicant is required to provide details on all affirmative responses to Disclosure Questions on the Credentialing Application (listed below), which is reviewed by a medical director, and at the discretion of the medical director, may be reviewed by Credentialing Committee for a determination of LIP's acceptance into Trusted's Network.

    a. Reasons for inability to perform the essential functions of the position
    b. Lack of present illegal drug use
    c. History of loss of license and felony convictions
    d. History of loss or limitation of privileges or disciplinary actions
    e. Current malpractice insurance coverage
    f. Current and signed attestation confirming the correctness and completeness of the application

Section 4.3 – Status of Applicant after Credentialing Committee Decision Date. Acceptance of an Applicant into the Trusted's Network is conditioned upon the Applicant's signature on the pertinent Participation Agreement. Indication by the Credentialing Committee that the Applicant meets the Credentialing Criteria does not create a contract between the Applicant and the Trusted. The Applicant is not considered a Participating LIP on the Decision Date and is not entitled to treat Covered Persons or

receive payment from Trusted until the Participation Agreement is signed by both parties with a specified Effective Date, and the Applicant's Agreement and demographic information are entered into all pertinent information systems.

Section 4.4 – Consequences of License Suspension. During any time period in which the Participating LIP's license is suspended Trusted will initiate immediate action to terminate provider from the Network in accordance with the Participation Agreement.

Section 5.0
RECREDENTIALING OF PARTICIPATING LICENSED INDEPENDENT PRACTITIONERS

Section 5.1 – Recredentialing Participating LIPs: Application. LIPs will be recredentialed at least every 36 months. Participating LIPs must complete an Application. The process replicates the initial credentialing process described in Section 4, above.

Section 5.2 – Recredentialing Criteria of Participating LIPs. Each Participating LIP must continue to meet the following criteria to be considered for continued participation:

1. Applicants must meet all initial Credentialing Criteria as set forth in Section 4 at the time of the recredentialing Decision Date, with the exception that education and work history need not be re-verified.

2. An Applicant for recredentialing must have demonstrated compliance with all terms of the Participation Agreement, specifically including completion of Individual Improvement Plans requested by Trusted.

3. An applicant for recredentialing is subject to review of license status, insurance status, malpractice and sanctions history and history of potential quality of care/quality of service concerns within the recredentialing cycle. If a history of malpractice claims and substantiated quality concerns are found, the Credentialing Committee will conduct a clinical review of these findings.

4. Specialty change. A LIP who requests a specialty change must provide documentation of training and/or education in that specialty that conforms to the requirements by the Trusted for other specialists in the same area, and that information will be Primary Source Verified by the Trusted. Trusted is not required to accept a request for specialty change unless there is a Network need.

Section 6.0
PRACTITIONER OFFICE SITE ASSESSMENT

If required by Credentialing Authority Trusted conducts a Site Assessment for locations serving enrolled members, including Medical Record Keeping Practices Assessment, as outlined below. Trusted's office site performance standards address the following domains:

- Physical accessibility to the building, exam rooms, and bathrooms including accommodations for the handicapped
- Physical appearance to provide a safe clean environment for patients, visitors and staff
- Adequacy of waiting room space to accommodate the average number of patients seen per LIP per hour
- Adequacy of exam room space including provisions for privacy during examinations or procedures
- Adequacy of medical/treatment record-keeping
- Availability of appointments if applicable

1. Quality department staff continually monitors the number and type of complaints received by Trusted about network providers. Complaints are totaled by provider as they are received.

2. If one provider or provider site receives three (3) or more complaints within a six month period, OR if any one complaint is received regarding the physical accessibility, physical appearance or adequacy of waiting- and examining-room space, an office site evaluation is conducted.
    a. The quality coordinator notifies the director of the quality department that the provider/provider site exceeded the complaint threshold of three (3).
    b. The director notifies the medical director and director of network and provider relations that a site visit with the provider will be scheduled.
    c. Within 60 calendar days of determining that the complaint threshold was exceeded, a site visit is conducted.
    d. A provider relations representative, with the assistance of a nurse from the UM or quality department, conducts the assessment at a mutually agreed-upon date and time, at the provider's office.
    e. The tool in Attachment A is used for the assessment.
3. The site visit tool results are scored and any deficiencies are reported to the provider at the time of the site visit.
4. Results are summarized in a report by the provider relations staff member, which includes recommendations for next steps / corrective action plan (CAP). If the office site failed to meet a threshold in any of the categories in the assessment tool, a corrective action plan is required of the provider. (Note: the total points required for "passing" each category are recorded in the tool).
5. The report is forwarded in writing to the provider, as well as any follow-up requirements, such as a CAP.
6. The results are reported at the next meeting of the Quality Executive Committee.
7. If a corrective action plan is required of the provider, the provider is required to submit the plan within 20 working days of the date of the written notification.
8. The corrective action plan is received and reviewed by the provider relations representative and quality director.
9. Assessment of the progress and effectiveness of the CAP is conducted every six (6) months until the deficiencies are resolved. Follow-up includes repeating the site visits for the items not in compliance with Trusted office site standards. The site visit tool is used as the assessment tool for subsequent site visits. Results are reported through the management chain and to the QEC and credentialing committee, as described in this procedure.
10. When the provider meets the threshold scores for all categories, follow-up visits cease.
11. All site visit results are documented stored in the provider's credentialing file and results are reviewed by the credentialing committee at the time of recredentialing.

Trusted will conduct an assessment of the medical record-keeping practices on all provider types as specified by applicable law or regulation or pursuant to Participation Agreement unless the office is located in an accredited or certified facility acceptable to the Trusted. Trusted must verify accreditation or certification, if applicable. A medical record-keeping assessment of one blinded medical record, one Trusted member record or one model medical record is reviewed to address the extent to which medical record-keeping practices support the following:

- Confidentiality of the record
- Consistent organization of the record

The office site assessment tool questions and minimum performance thresholds are listed in Attachment A.

Section 7.0

CREDENTIALING AND RECREDENTIALING OF FACILITIES

Section 7.1 – Criteria for Credentialing and Recredentialing Facilities. The following types of providers are subject to initial and recredentialing under this policy:

- Hospitals
- Home health agencies
- Skilled nursing facilities
- Free-standing surgical centers
- Inpatient BH facilities
- Residential BH facilities
- Ambulatory BH facilities

The following describes the Organizational Provider credentialing criteria, as well as the implementation procedures.

1. Current required license(s). The credentialing coordinator verifies that the facility is licensed by the District of Columbia (or other state authority) and any applicable federal regulatory body. See Attachment B for a list of the acceptable accrediting organizations used as verification sources for provider applicants.

2. Insurance. The Applicant must maintain errors and omissions (malpractice) insurance for at least the "per occurrence" and aggregate limits established by Trusted Health Plan, with an insurer licensed to provide medical malpractice insurance in the Applicant's state of practice, or show similar financial commitments made through an appropriate State approved alternative, as determined by the Trusted. The pertinent Participation Agreement may require coverage that exceeds the minimum established by this Credentialing Plan. The credentialing coordinator obtains a copy of the insurance certificate and verifies that the policy limits meet Trusted requirements.

3. Confirmation that the organization is in good standing with state and federal regulatory bodies. The Applicant must not be ineligible, excluded or debarred from participation in the Medicare and/or Medicaid and related state and federal programs, and must be without any, conditions, restrictions or sanctions levied by the Office of Inspector General (OIG) or the General Services Administration (GSA) or other disciplinary action by any federal or state entities identified by CMS or State Medical or Pharmacy Boards and must not participate in the Medicare Opt Out program. The credentialing coordinator verifies that the provider is in good standing with state and federal regulatory bodies by querying these sources electronically or telephonically.

4. Appropriate Accreditation or Satisfactory Alternative. Trusted must verify the facility's accreditation status by: viewing or obtaining the accreditation report or verifying the accreditation status from the issuing body either on-line or telephonically. If the Applicant is not accredited by an agency recognized by Trusted in Attachment B, a site visit of the organization is required and results must be found to be satisfactory as defined by Trusted. Evidence of Medicare/Medicaid certification will serve as evidence of an acceptable site visit.

Organizations Not Accredited

If the Organization is not accredited by an agency recognized by the Trusted, a site visit of the organization prior to contracting is required by the Credentialing Entity. Results must be found to be satisfactory as defined by the Trusted.

In lieu of a site visit by the Trusted, the organization must have been reviewed or received certification by CMS or State Agency within the past three years. The Trusted by virtue of approval of this Credentialing Plan has certified that CMS requirements for facilities fully meet the Credentialing Entities facility site requirements. The Credentialing Entity must obtain a copy of the CMS or State Agency's report from the Facility

5. Compliance with Participation Agreement. An Applicant for recredentialing must have demonstrated compliance with all terms of the Participation Agreement, specifically including

successful participation in quality improvement initiatives or completion of individual improvement plans requested by Trusted.

Section 7.2 – Recredentialing Periodically Required. Facilities will be recredentialed at least every 36 months. Participating Facilities must complete an Application in a timely manner.

Section 7.3 – Status of Applicant after Credentialing Committee Decision. Any acceptance of an Applicant into the Trusted's Network is conditioned upon the Applicant's agreement to accept the Trusted's terms and conditions of participation and sign the pertinent Participation Agreement. Indication that the Applicant meets the credentialing criteria does not create a contract between the Applicant and the Trusted. The Applicant is not considered a Participating Facility on the Decision Date and is not entitled to treat Covered Persons or receive payment from Trusted until the Participation Agreement is signed by both parties with a specified Effective Date, and the Applicant's Agreement and demographic information are entered into all pertinent information systems. (Note: For those facilities seeking Medicare participation the timeframe from verification of credentialing information to presentation at credentialing committee will be no longer than 180 days.)

Section 7.4 Facility Site Visit Requirements for Credentialing/Recredentialing. If the Facility is not accredited or certified by an agency recognized by the Credentialing Entity, a site visit is required and the Facility must pass with at least 85% of the possible score. Any failed site assessment (defined as a less than 85% score) will result in the Applicant being required to reapply for credentialing after a waiting period of at least six months or the Facility can demonstrate improvements in the areas previously found deficient.

The following minimum criteria must be reviewed:

- Physical accessibility to the building, exam rooms, and bathrooms including accommodations for the handicapped
- Physical appearance to provide a safe clean environment for patients, visitors and staff
- Adequacy of waiting and exam room space including provisions for privacy during examinations or procedures
- Presence of medical equipment logs
- Safety of medication administration including assessing expiration dates of medications and drugs including samples are inaccessible to patients or other unauthorized personnel
- Office or facility staffing including the numbers, qualifications, competence and training of clinical staff
- Acceptable verification of licensure for all licensed clinical staff with applicable licensing board
- CLIA and/or appropriate radiology certification/licensure, if lab and or radiology services performed in the facility
- Medical Staff Services or other credentialing and privileging policies for the Facility's LIPs

Section 8.0
CONFIDENTIALITY AND APPLICANT RIGHTS

Section 8.1 – Confidentiality of Applicant Information. Information obtained in the credentialing process is to be protected by the peer review privilege. Trusted will therefore maintain mechanisms to appropriately limit review of confidential credentialing information.

1. All paper credentialing information is kept in locked files with access only by those with a need-to-know for their job.
2. All electronic credentialing information is password-protected with access provided to only those with a need-to-know for their job. Credentialing department supervisors grant employee access to the appropriate levels of electronic access.
3. Trusted's office building has key card access and is not open to the general public.
4. Any confidential information on a staff person's desk is covered or otherwise not readable when the employee is not in his or her workspace.
5. Any confidential emails or other electronic transfer of information is encrypted by Barracuda privacy software. Electronic files are stored in a password-protected location on Trusted's network.

Trusted will also contractually require Delegated Entities to maintain the confidentiality of credentialing information. Each applicant/practitioner is notified of their practitioner rights within 30 days of receipt of their application via the application acknowledgement letter.

Section 8.2 – Applicant Rights.

Applicants have the right to review information submitted in connection with their credentialing or recredentialing Application, including information received from any primary source.

1. Practitioners may notify the credentialing department or network representative of their desire to review this information.
2. A mutually convenient time is established. All reviews must be done in person in the Trusted Credentialing Department.
3. A member of the credentialing staff will accompany the practitioner during the file review.

Peer review documents and references or other information that is peer review protected will not be shared with the applicant. Trusted is not required to allow an Applicant to review personal or professional references, or other information that is peer review protected. In addition, Trusted Health Plan is not required to reveal the source of information that is not obtained to meet the primary source verification requirements or when law prohibits disclosure.

Applicants have the right to be notified of instances where the Credentialing Department discovers information received varies substantially from that which the provider has submitted in the credentialing application. Upon discovery of such, the Credentialing Specialist will:

1. Notify the provider in writing of such discrepancy, requesting formal written clarification.
2. The letter to the practitioner will include a summary of the information in question and a request to have the clarification returned in writing within 15 business days.
3. Upon receipt of the practitioner's clarification, it will be included in the practitioner's credentialing file and presented to the Committee or designee at the next scheduled meeting.

Applicants have the right to correct erroneous information that has been obtained by Trusted in the credentialing and recredentialing process.

1. Trusted will notify Applicant in writing within 30 days of identification of any information that varies substantially from the information provided by the Applicant.
2. Applicant must submit any corrections in writing to the Trusted within 30 days of the Applicant's notification of the discrepancy.

Applicants also have the right to obtain information about the status of their Application upon their request.

1. The practitioner may phone or email the credentialing specialist for this information.
2. The credentialing specialist contacts the practitioner and explains current status of the application.

3. The credentialing specialist may share other information with the practitioner regarding his or her file except for any information that which is peer protected.

Applicants have the right to be notified of the credentialing decision within 60 calendar days of the Credentialing Committee's decision and recredentialing denials within 60 days of decision date. Notwithstanding this provision, credentialing timeframes and notification will not exceed timelines required by the Credentialing Authority. Trusted Credentialing Staff will compose the letter and mail it to the corresponding provider.

Section 8.3 – Appeal Rights. The Trusted will permit Appeals from adverse credentialing decisions only to the extent required by Credentialing Authority. The Credentialing Authority requirements will govern any Appeal. The rights related to the termination due to Quality of Care concerns will be communicated to the affected in the notice of Termination.

Section 9.0
ON-GOING MONITORING AND REPORTING

Section 9.1 – Peer Review Committee Review. Trusted monitors it's practitioner and provider network on an ongoing basis using the following data sources:

- Medicare and Medication sanctions
- State sanctions or limitation on licensure
- Collecting and reviewing member complaints
- Collecting and reviewing adverse events

1. Collecting and reviewing Medicare and Medicaid sanctions and state sanctions or limitations on licensure.
    a. Trusted employs the NPDB's Proactive Disclosure Service (PDS) for monitoring Medicare, Medicaid and state sanctions of network providers on an ongoing basis.
    b. Under this service any action by these governmental sources is forwarded to Trusted by the PDS electronically. The credentialing coordinator receives, checks and tracks these reports.
    c. In addition, State and Federal reports are reviewed within thirty days of their release in order to identify Participating LIPs or Facilities who have had OIG sanctions on Medicare or Medicaid participation, GSA debarments, or other sanctions against their license or certification.
        i. The Credentialing Department pulls the reports on the 15th of every month for the previous month.
        ii. The data is compared with THP's network using the NPI as the unique identifier.
        iii. If there is a match, THP Credentialing Staff will initiate the next steps in conjunction with the Quality Department.
    d. If Trusted identifies a professional license that is not valid, an OIG sanction on Medicare or Medicaid participation, GSA debarment, or other sanction against a license or certification, action shall be taken as outlined in the pertinent Participation Agreement.
    e. Reports are placed in the provider's file and the file is forwarded to the medical director for review.
    f. The medical director determines if the issue is actionable. If the issue is actionable, the case is brought to the credentialing committee for discussion and action.

2. Collecting and reviewing complaints about an office site and facilities are recorded, investigated and appropriate follow-up is conducted to assure that members receive care in a clean, accessible and appropriate environment.
    a. If three or more complaints about a provider or provider site are received within a six month period a site visit review is conducted by the network department. See the procedure in Section 6, above, for details.
    b. Complaints are tracked, trended, and analyzed by provider at the time of recredentialing.

i. At least one month prior to each provider's recredentialing date, the credentialing specialist notifies the quality department of the providers whose complaint totals are needed.
ii. The quality department provides the total number of complaints received by Trusted to the providers eligible for recredentialing the next month. For individuals with greater than five (5) complaints in the three years prior to the request, the quality coordinator provides the categorical reasons for the complaints.
iii. The credentialing committee reviews the providers' credentialing files and makes a determination on how to proceed with each provider.

3. Collecting and reviewing adverse events.
   a. Whenever Trusted's staff receives information suggesting a potential Quality of Care concern, it compiles all pertinent information and refers the matter to the medical director for review.
   b. If the medical director determines that a failure to take action may present an imminent threat to patient safety of any enrollee/member, the medical director may summarily restrict or suspend the LIP's participation status in the network as set out in the Patient Safety, Incident Reporting Sentinel Events Policy & Procedure.
   c. If the medical director determines that immediate action is not warranted, the information is referred to the Peer Review Committee. A Peer Review Committee meeting is scheduled at the earliest possible time by the Medical Director.
   d. After review of all the relevant information available, if the Peer Review Committee decides that further information is needed, the committee obtains it from the LIP or from any other relevant and accessible source.
   e. Following its deliberations, if the Peer Review Committee decides that no corrective action needs to occur, the meeting minutes should reflect the reasons for this decision.
   f. Alternatively, if the Peer Review Committee in its sole discretion decides to recommend to the Medical Director or credentialing committee a specific compliance improvement work plan or the termination of a LIP's participation, the meeting minutes should reflect this recommendation and the reasons for it.
   g. After receiving recommendations from the Peer Review Committee, the credentialing committee decides whether or not to approve the recommendations.
   h. The LIP may appeal the decision by the credentialing committee. See Section 3 of the Plan for a description of the appeal process.

Section 9.2 – Fair Process Considerations. To encourage and support the professional review activities of physicians and dentists and other practitioners, the Health Care Quality Improvement Act of 1986 ("HCQIA") was enacted. The HCQIA provides that the professional review bodies of health care entities (such as the Peer Review Committee and Peer Review Committee) and persons serving on or otherwise assisting such bodies are generally offered immunity from private damages in a civil lawsuit when they conduct professional review activities in the reasonable belief that they are furthering the quality of health care and with proper regard for fair process. HMOs and PPOs fall within the definition of "health care entity."

To receive immunity protection, a professional review action regarding the professional competence or professional conduct of a physician or dentist or other practitioner must be taken in accordance with all of the following standards:

- In the reasonable belief that the action is in the furtherance of quality health care;
- After a reasonable effort to obtain the facts of the matter;
- After adequate notice and hearing procedures are afforded to the LIP involved or after such other procedures are afforded as are fair to the LIP under the circumstances; and

- In the reasonable belief that the action is warranted after exercising a reasonable effort to obtain facts and after meeting the adequate notice and hearing requirement.

Although a health care entity may immediately suspend a LIP's privileges pending an investigation of the LIP's professional competence or conduct, the health care entity can take advantage of the HCQIA's immunity protection only by affording the LIP involved adequate notice and hearing procedures, unless the suspension lasts fewer than 30 days.

The Act sets forth sample notice and hearing criteria, including time frames, that are deemed to satisfy the adequate notice and hearing requirement. These criteria are incorporated into the Plan. Failure to follow the criteria will not, in itself, constitute failure to meet the notice and hearing requirement; provided that the procedures afforded the LIP under review are reasonable under the circumstances.

1. An applicant (appellant) has the right to appeal the decision from the Credentialing Committee or Chief Medical Officer denying credentialing status for cause. Denials due to failure to complete the application, failure to meet criteria, or failure to pass Primary Source Verification inquiries are not appealable.
2. The applicant will be notified of the basis for the denial and notified of their right to correct erroneous information. Trusted must receive written notice of appeal within thirty (30) calendar days of the date of Trusted's denial notification (i.e. the date Trusted sent the certified letter).
3. The notice of appeal should include any relevant material the appellant would like considered on their behalf. The notice of appeal should include the appellant's request for a hearing, if so desired.
4. Upon receipt of the notice of appeal, the Credentialing staff will schedule a meeting of the Credentialing Appeals committee. Every effort will be made to schedule the meeting within ten (10) calendar days unless a hearing is requested.
5. Trusted will provide the applicant with a written notification of the appeal decision that contains specific reasons for the decision.

Hearing

1. The appellant may request a hearing. The hearing will be scheduled within fifteen (15) calendar days after the receipt of the appellant's request for a hearing (Except under circumstances beyond the control of the Credentialing Appeals Committee),
    a. If the appellant is unable to attend on the date or at the time scheduled by the Credentialing Appeals Committee, the appellant may request that the hearing be rescheduled. Every effort will be made to schedule the hearing as soon as possible thereafter.
2. The appellant and/or Trusted may elect to be represented by legal counsel or other person(s) of their choice.
3. Upon the request of the appellant or Trusted, the Credentialing Appeals Committee will arrange for the hearing to be recorded and/or transcribed. The cost of recording and/or transcription will be borne equally by the appellant and Trusted.
4. Trusted and the appellant will have the opportunity to present oral and written evidence in support of their respective positions and both parties may examine any witnesses called to testify.
5. Disclosure of evidence to be submitted and witnesses to be presented should be shared between parties at least five (5) business days before the scheduled hearing.
6. The Credentialing Appeals committee will consider all relevant material; including any additional information and/or statements provided by the appellant.
    a. Any relevant information, including hearsay, may be considered if it is the sort of information on which responsible persons are accustomed to rely in the conduct of serious affairs.
7. The Credentialing Appeals Committee will review and discuss all such information.

8. The Credentialing Staff will maintain the file and any correspondence, record minutes of the meeting, and provide any additional administrative support necessary.
9. The Credentialing Appeals committee is an ad hoc committee. Membership includes:
    a. Chief Medical Officer of Trusted
    b. At least two (2) other practitioners in the field of practice of the appellant. These practitioners may be members of the Quality Management Committee (QMC) or an outside peer review agency contracted to Trusted. These practitioners should not be practitioners in direct competition with the appellant, associated with the appellant or be related by blood or marriage, or otherwise have a conflict of interest as defined by Trusted .
10. The Chief Medical Officer will act as the presiding officer or appoint one of the committee members.

Decision

1. The range of decisions available to the Credentialing Appeals committee include:
    a. Network suspension
    b. No new members assigned to the PCP panel
    c. Network termination
    d. Continued network participation
    e. Continued network participation, with modification
    f. Continued network participation, with supervision
2. The Credentialing Appeals committee will discuss the evidence presented and render a decision via majority vote at the time of the hearing.
3. Under exceptional circumstances the hearing may be continued if relevant evidence or testimony is not available at the time of the initial proceeding.
4. If the appellant is under suspension, the time clock for reporting to NPDB continues.
5. The Credentialing Appeals committee will issue a written report of the decision with a statement of the basis for such recommendations.
6. This report will be sent to the appellant via certified mail within ten (10) business days of the Committee's decision.
7. If approved, the date of the Credentialing Appeals committee vote is considered the "credentialing decision date".
8. The determination of the Credentialing Appeals committee will be final.
9. Suspensions, terminations and/or other decisions will be reported to federal, state, and local agencies and/or the National Physicians Data Bank, as appropriate and required.

Section 9.3 – Reporting to Authorities.

Trusted is required to report various credentialing actions to the DC licensure boards and to the NPDB.

A. NPDB Reporting
The HCQIA requires health care entities to report to the NPDB certain professional review actions ("Adverse Action Reports"). Health care entities are required to report such actions for physicians and dentists. Health care entities may report such actions on other health care practitioners. It is Trusted Health Plan's policy to file NPDB reports, as appropriate, on all LIPs as required.

1. Reportable Actions

Actions taken by the Peer Review Committee or Peer Review Committee that fit into either of the following categories must be reported:

- A professional review action based on the LIP's professional competence or professional conduct that adversely affects his or her clinical privileges for a period of more than 30 days.

- Acceptance of the surrender or restriction of clinical privileges (1) while the LIP is under investigation or (2) in exchange for the health care entity not conducting an investigation relating to possible professional incompetence or improper professional conduct.

- Revisions to any such actions described above.

If the action being taken is solely because of the LIP's failure to meet the minimum administrative requirements for credentialing and recredentialing or the termination is solely based on contractual noncompliance or breach, the action is not reportable to NPDB, However, HIPDB reporting may still be required. Even if the action is being taken because of professional competence or conduct, the action is only reportable if the action or recommendation will reduce, restrict, suspend, revoke, or deny the LIP's status as a participant for a period longer than 30 days.

Before taking a final action and submitting a report, the Trusted should contact the legal representative about offering the LIP an opportunity for a hearing and to determine if reporting is required. The penalty for failing to make a required report is loss of immunity protection for three years.

After final review by Trusted's legal counsel, the Adverse Action Report is submitted electronically by the medical director or director of the network department to the NPDB with a hard copy sent to the applicable state licensing agency.

B. HIPDB Reporting

The Healthcare Integrity and Protection Data Bank ("HIPDB"), which was created under the Health Insurance Portability and Accountability Act (HIPAA) of 1996, was established to create a national fraud and abuse data collection program and it places certain reporting requirements on the public and private sectors alike to report certain final adverse actions against health care providers, suppliers and practitioners. Note that HIPDB does not replace NPDB reporting. Instead, it expands the reporting obligations to a broader range of determinations and events.

1. Required Reports

Credentialing Entities have two primary reporting requirements under the HIPDB rules: plans must report civil judgments and other adjudicated actions or decisions relating to the delivery of a health care item or service.

- Civil Judgments

Credentialing Entities must report "civil judgments" against "health care providers, suppliers, or practitioners" that are related to the delivery of a health care item or service. Plans are not required to report civil settlements in which there was no finding or admission of liability.

When a civil action involves more than one Trusted as claimant, the plan receiving the largest award is responsible for reporting. The report must be made even if the judgment is the subject of a pending appeal.

- Other Adjudicated Actions or Decisions

Plans must report "other adjudicated actions or decisions related to the delivery, payment or provision of a health care item or service." The rule covers: 1) formal or official final actions; 2) that include the availability of a due process mechanism (the right to be heard and the right to appeal the decision); and 3) that are based on acts or omissions that affect or could affect

the payment, provision or delivery of a health care item or service. The rule specifically excludes "clinical privileging actions and similar paneling decisions" and "denial of claims determinations" made by Trusted.

This rule appears to require reporting of a broad range of decisions. For example, agent and broker terminations for cause may be reportable. For cause terminations of provider agreements may also be reportable. A case-by-case evaluation will be necessary to determine whether the action falls within the language of the rule. The Trusted should contact its legal representative for advice regarding the need to report specific actions to HIPDB.

2. Timing of Report

Under the regulations, reportable actions must be submitted to HIPDB: 1) within 30 calendar days from the date the final adverse action was taken; or 2) by the close of the Trusted's next monthly reporting cycle, whichever is later.

3. Sanctions for Failing to Report

The regulations provide for up to a $25,000 penalty for each adverse action not reported.

C. NPDB and HIPDB Dual Reporting

As noted above, the HIPDB supplements do not replace the NPDB or state medical board reporting requirements.

D. Reporting to the District of Columbia and other States

After a decision by the credentialing committee to suspend or terminate a practitioner's network participation in accordance with the above, a written notification statement is sent to the appropriate professional state board notifying them of the action. The notification is prepared by the network department and is signed by the medial director, Notification is sent via certified, returned receipt mail within five (5) business days.

E. Making the appeal process known to practitioners. At the time of the initial contracting, all network practitioners are provided a copy of the Provider Manual, which contains a summary of the appeal process. In addition, at that time a practitioner/provider is denied network participation (other than for administrative reasons), a description of the appeal process is provided to him or her. The process is also available on-line, through Trusted's provider web portal.

Section 10.0
DELEGATED CREDENTIALING

Section 10.1 – Delegated Credentialing Authorized. Trusted may delegate responsibility for specific credentialing and recredentialing functions to another entity, although Trusted retains the ultimate right to sign a Participation Agreement with, reject, terminate or suspend LIPs or Facilities from participation in the Network

Section 10.2 – Delegation Agreement. Any delegation of responsibility by the Trusted must be evidenced by a Delegation Agreement that requires compliance with Credentialing Authorities and includes, but is not limited to:

- The responsibilities of the Trusted and Delegated Entity;
- The activities delegated, including the responsibilities for any sub-delegated activities;
- A requirement for at least semi-annual reporting to the Trusted;
- The process by which the Trusted evaluates the performance of the

- Delegated Entity;
- The remedies, including revocation of the delegation, available to the Credentialing
- Entity if the Delegated Entity does not fulfill its obligations.

If the delegated activities include the use of Protected Health Information by the Delegated Entity, the Delegation Agreement must also include the necessary provisions as defined by Credentialing Authorities and the Health Insurance Portability and Accountability Act, including:

Section 10.3 – Sub delegation. Under certain circumstances, Trusted may allow Delegated Entity to sub-delegate all or part of its credentialing activities to another entity. Prior to any sub-delegation arrangement, Delegated Entity must enter into a Delegation Agreement with the subdelegate. The Delegation Agreement must meet the requirements of Credentialing Authorities and all credentialing criteria of this Credentialing Plan, including Trusted's right of final approval on any recommendations by the sub-delegate. The Delegated Entity must complete a preassessment, annual assessment and other audits of the sub-delegate for those activities it has sub-delegated to another entity in accordance with the requirements of this Credentialing Plan and Credentialing Authorities. Delegated Entity is responsible for receiving and reviewing reports on LIPs and Facilities credentialed and recredentialed by the sub-delegate for the delegated activities outlined in the Delegation Agreement.
Trusted retains its responsibilities for conducting oversight of its Delegated Entities in accordance with Credentialing Authorities requirements.

Section 10.4 – Preassessment Responsibilities of Trusted. Trusted reviews an entity being considered for delegation through a predelegation evaluation process. Trusted shall complete a preassessment to assess the potential Delegated Entity's ability to meet Trusted's standards for the functions being delegated must be completed prior to signing the Delegation Agreement. The preassessment will be completed within twelve (12) months prior to the implementing the delegation. Trusted's preassessment process is outlined below:

1) Review of the potential Delegated Entity's ability to meet Credentialing Authorities and Trusted's standards, including, but not limited to: credentialing and recredentialing policies and procedures, credentialing and recredentialing application and attestation, and other relevant credentialing and recredentialing documents or files, including those related to ongoing monitoring of sanctions, complaints and quality issues, suspension and/or restriction actions, termination and notification to authorities, confidentiality, provision for the protection of Protected Health Information, if applicable, and appeals.

2) Review of the potential Delegated Entity's methods and sources for collecting and verifying credentials.

3) Review of the potential Delegated Entity's blinded Credentialing Committee minutes.

4) Policies and Procedures related to office site assessment and medical record-keeping assessment, if required by Credentialing Authorities.

5) A file review of up to 30 credentialing and 30 recredentialing files using the 8/30 rule and NCQA's credentialing file review form.

6) A report summarizing the findings of the predelegation assessment is compiled by the network department and forwarded to the Credentialing Committee for approval or denial of delegation.

Section 10.5 – Annual Evaluation. For Delegation Agreements that have been in effect for 12 months or longer, the Trusted will perform an assessment of 1) policy and procedure 2) file review and 3) receipt of reports as specified in the delegation agreement. A summary report is prepared by the network department, which includes a recommendation to continue with the delegated arrangement, alter the

arrangement or terminate the arrangement. Corrective actions are also identified if performance expectations are not met. The report is forwarded to the Credentialing Committee for review and approval.

Section 10. 6 - For NCQA accredited or certified Delegated Entities, the preassessment evaluation and annual evaluation Trusted may choose to waive assessment of functions covered under the delegate's NCQA accreditation or certification. Trusted will include an evaluation of any elements not included in the Delegated Entity's accreditation or certification, in accordance with NCQA requirements. An audit of the Delegated Entity's documents and files for the credentialing elements that have been NCQA certified or accredited is not required; however, credentialing elements not accredited or certified by NCQA may require oversight for additional Trusted, state, federal, or other requirements.

Section 10.8 – Review of Oversight and Monitoring Reports. Trusted will review and analyze reports that are designed to provide oversight and monitoring of the Delegated Entity, at least semi-annually as specified in the delegation agreement. At a minimum, reports include a listing of newly credentialed, recredentialed and terminated LIPs and Facilities and LIP and Facility demographic changes. A listing of newly credentialed, recredentialed, terminated LIPs and Facilities as well LIP and Facility demographic changes will be presented to the Trusted Health Plan CMO for signature approval at least semi-annually. Information about LIPs and Facilities must meet Trusted's minimum database requirements.

Section 10.9 – Required Follow-up. When Trusted's preassessment or annual evaluations, or periodic monitoring identify opportunities for Delegated Entity to improve its compliance with the Delegation Agreement or Credentialing Authorities and Trusted's expectations, Delegated Entity will develop a plan for its improvement ("Corrective Action Plan" or CAP) that includes deliverables and time frames to achieve them. The plan is forwarded to the QEC for approval as appropriate. Network staff monitor plan implementation.

Section 10.10 – Process for Acceptance/Rejection of Delegated Entity's Approved LIPs and Facilities. Acceptance of the Delegated Entities' approved LIPs and Facilities into the Trusted's Network is contingent upon the Applicant signing a Participation Agreement or otherwise participating in the Network under another Participation Agreement as required by the Trusted.

Section 10.11 – Credentialing and Recredentialing after Termination of Delegation Agreement. Upon termination of a Delegation Agreement, Trusted will place the LIPs or Facilities in a queue for recredentialing if the Delegated Entity provides Participating LIP and Facility credentialing and recredentialing files to the Trusted and the files are found to be compliant with Trusted requirements. If the Delegated Entity does not provide credentialing and recredentialing files or the files do not meet Trusted requirements, LIPs or Facilities will be placed in a queue for initial credentialing by the Trusted to be completed within six months of the Delegation Agreement termination date. Acceptance of LIPs and Facilities from terminated Delegation Agreements will be accepted into the Network, when applicable, to meet the Trusted's Network needs and the LIP's or Facilities willingness to sign a Participation Agreement.

Section 10.12 – Procedure when LIP or Facility has Contracts with both Trusted and Delegated Entity. In cases where a LIP or Facility is contracted with a Delegated Entity and also has a Participation Agreement with Trusted Health Plan, Trusted may accept the credentialing of the Delegated Entity if Delegated Entity's credentialing meets all the requirements of Trusted and Credentialing Authorities for the Covered Persons outlined in the Participation Agreements. The Delegated Entity maintains a credentialing file and the Trusted maintains a participation contract file on that LIP or Facility.

Section 11
NONDISCRIMINATION

Section 11.1 – Procedure for ensuring that credentialing and recredentialing are conducted in a nondiscriminatory manner. Trusted does not make credentialing and recredentialing decisions based on a Licensed Independent Practitioner's race, ethnic/national identity, gender, age, sexual orientation or the types of procedures (e.g., abortions) or patients (e.g., Medicaid) in which the Licensed Independent Practitioner or Facility specializes and is acting within the scope of the applicable license or certification under State law, solely on the basis of the license or certification. (Note: This does not preclude the Trusted from including in its Network Licensed Independent Practitioners who meet certain demographic or specialty needs such as but not limited to the cultural needs of its covered persons.)

1. For each network denial that occurs by the Trusted credentialing committee, the reason/s for denial is documented in the committee minutes.
2. On an annual basis, the reasons for denial are reviewed by the chief medical officer (CMO), or designee. The form used to review the denied applicants is in Attachment D.
3. The CMO or designee determines if any network denial decision was made using discriminatory practices, as indicated in the attached form.
4. The findings of the annual review are reported to the credentialing committee and the quality committee.
5. The committee and CEO follow-up on any discriminatory practices found, as appropriate.

Section 12
ENSURING PRACTITIONER AND PROVIDER LISTINGS ARE CORRECT

The following procedure ensures that the information provided by practitioner/provider during the credentialing and recredentialing process is reflected correctly in Trusted documents and on-line directories. The information in the paper and on-line provider directories should match the information gathered during the credentialing process, or reflects more recent updates provided by the practitioner or provider.

1. After initial credentialing is complete, the credentialing specialist enters the following practitioner/provider information into a data entry screen for the on-line and printed provider directory:
    - Name/s
    - Addresses/Location/s
    - Phone number/s
    - Gender
    - Education
    - Training
    - Board certification/s
    - Group affiliation
    - Specialty (including primary care discipline)
    - Facility affiliation
    - Languages spoken

    a. The data are uploaded to the provider database daily.
    b. The information is uploaded to the on-line directory each night, and is stored in the database for the next printing of the provider directory.

2. At recredentialing, this information is requested to be updated by the practitioner/provider. Upon recredentialing approval, the quality specialist checks each of the above fields and determines if the information is correct.
    a. If not correct, the correct information is added into the data entry form.
    b. The information is uploaded to the on-line directory each night, and is stored in the database for the next printing of the provider directory.
3. When a practitioner/provider changes any current practice information (such as location, telephone number, etc.), S/he is required to notify Trusted's provider relations department.
    a. After notification of a change to any directory information, a credentialing specialist accesses the electronic data form for the practitioner/provider.
    b. The credentialing specialist inputs the new information into the form
    c. The information is uploaded to the on-line directory each night, and is stored in the database for the next printing of the provider directory.

Attachment A

Site Assessment and Medical Record Keeping Assessment and Tool

Practitioner Name (s):	Check One: ☐ Group ☐ Private Practice
Practice Name:	Check One: ☐ PCP ☐ OB/GYN ☐ Specialist
Office Address:	Specialty:
	Provider Relations Representative:
Facility Contact Person:	Date:

Trusted Provider Office Site Visit Tool	Points	Points Earned
A. Physical Accessibility:	**10**	
Threshold:	**8**	
1. Is there accessibility for people with disabilities? (First floor access, ramps or elevator access) If not, does staff have an alternative plan of action? Access throughout the office including bathrooms)?	2	
2. Is accessible parking clearly marked? (Sign/painted symbol on pavement.) Only applies to off-street parking: N/A if parking is street-side only.	2	
3. All doorways and stairways that provide access are free from obstructions at all times and allow easy access by wheelchair or stretcher?	2	
4. Are exits clearly marked and is there emergency lighting in instances of power failure?	2	
5. Are the building and office suite clearly identifiable (clearly marked office sign)?	2	
B. Physical Appearance:	**10**	
Threshold:	**8**	
1. Is the office clean and well kept (Neat appearance, no trash on floor, furniture in good repair? No significant spills/stains on floors/ furnishings.)?	2	

2. Is treatment area clean and well kept (Neat appearance, no trash on floor, furniture in good repair? No significant spills on floors, counters or furnishings.)?	2	
3. Does office have smoke detector(s)	2	
4. Easy access to a clean, supplied bathroom (Soap, toilet paper, hand towels and hand washing instructions)?	2	
5. Fire extinguishers clearly present and fully charged and recently inspected (even if office has sprinkler system)?	2	
C. Adequacy of Waiting and Examining Room Space:	**12**	
Threshold:	**10**	
1. Is there adequate seating in the waiting are (based on number of physicians/ practitioners)?	2	
2. Does the staff provide extra seating when the waiting room is full?	1	
3. Is there a minimum of 2 exam rooms per scheduled provider (2 consultation rooms for Behavioral Health (BH) Providers)?	2	
4. Is there privacy of exam/ consultation rooms (Doors or curtain closures: rooms cannot be visualized from waiting room)?	2	
5. Are exam/ consultation rooms reasonably sound proof (Conversations cannot be heard from waiting room or other exam rooms)?	2	
6. Are an otoscope, ophthalmoscope, blood pressure cuff and scale readily accessible (N/A for BH Providers)?	1	
7. For OB/GYNs or any physicians/practitioner providing OB Care: Does the office have the following readily accessible: (If not OB/GYN, Check N/A)	1	
7a. A fetal scope (Delee and /or Dopler) and a measuring tape for fundal height measurement?	1	
7b. Supplies for dipstick urine analysis (glucose, protein)?	1	
D. Adequacy of Medical Records:	**16**	
Threshold:	**10**	
1. Does the office maintain an organized medical record keeping system?	1	
2. Are records stored in a manner that ensures confidentiality- are they kept in an area not accessible by patients?	1	
3. Are all items secured in the chart?	1	
4. Does the office maintain a filing system to ensure new information is filed in individual records in a timely manner?	1	
A. Does each page of the medical record include patient identification?	1	
B. Does the office use a standard organizational format for medical records?	1	
C. Does the office use any standard medical record forms (if yes, describe type)?	1	
5. Does the office use an electronic medical record (this is for tracking only; not scored)?	0	

A.*Is written authorization obtained for the release of medical records?	1	
B.*Is there a confidentiality policy for medical records?	1	
6. Are medical records readily available? (Within 15 minutes of request) Ask them if they are.	1	
7. Medical recordkeeping practices:		
7a. Is there a place to document allergies?	1	
7b. Is there a place to document current medication list?	1	
7c. Is there a place to document current chronic problems list?	1	
7d. Is there an immunization record on pediatric charts? N/A for BH Providers	1	
7e. Is there a growth chart on pediatric charts? N/A for BH Providers	1	
7f. Is there a place to document presence/absence and discussion of a patient self-determination/advance directive? (if not appropriate, check N/A)	1	
E. Appointment Availability: Is the physician/practitioner available:	**11**	
Threshold:	**8**	
1. Are patients routinely seen within 45 minutes of check in (ask office manager)?	2	
2. Is the physician/practitioner available: At least 4 days or 20 hours per week?	2	
3. 24 hour call coverage for emergencies (by themselves or by covering provider)?	2	
4. Are urgent care appointments available within 24 hours?	1	
5. Are routine/problem care appointments available within 10 days of appointment request?	1	
6. Are phone lines adequate to handle volume of total patient population?	2	
7. Physical/wellness exams for children within 30 days of request?	1	
F. Documentation Evaluation: Does the office have the following:	**15**	
Threshold:	**10**	
1. No-show follow-up procedure/policy? (If not written, can the staff verbally explain the process?	1	
2. Is there a procedure to remind patients of their appointments?	1	
3. Is there a chaperon policy? (If provider does not have written chaperone policy, office must provide statement on letterhead indicating chaperone will be in exam room.)	1	
4. Is the Patient Bill of Rights posted?	1	
5. Is medical license/occupational license displayed?	1	
6. Is there a written policy for hand washing, gloved procedures, and disposal of shape, etc.? May not be applicable for BH Providers in private practice setting.	2	

7. Is there a written OSHA Exposure Control Plan which includes Universal Precautions & Blood Born Pathogen exposure procedures for staff?	1	
8. If provider employs NP's, Pas or other mid-level providers that will assess health care needs of members, do they have written policies that describe duties and supervision of such providers?	1	
9. Does the office require CLIA certification?	2	
9.A. if Yes, verify the following: Level: Cert.# ; Exp. Date:	2	
9.B. if no, is there a waiver? Cert.#	2	
G. HIPPA Requirements/ Regulations:	**7**	
Threshold:	**5**	
1. Is there a written P & P addressing permitted uses/disclosures and required disclosures of patient PHI/IIHI	2	
2. Does Provider have authorization forms available to designate Personal Representative(s) to which PHI/IIHI may be released and / or disclosed?	2	
3. Are there physical safeguards in place to protect the privacy of patient PHI/IIHI?	2	
4. Is there a designated Compliance & Privacy person? Name:	1	
H. Office Evaluation:	**12**	
Threshold:	**10**	
1. Is there an approved process for biohazards disposal?	2	
2. Are pharmaceutical supplies and medication stored in a locked area that is not readily accessible to patients?	2	
3. Is there a plan/ procedures for narcotic inventory, control and disposal?	2	
4. Are vaccines and other biologicals refrigerated, as appropriate?	2	
4A.Is there a working thermometer in the refrigerator?	2	
5. Observe 2-3 office staff interactions: Are they professional and helpful?	1	
6. Is emergency equipment available (an oral airway and ambu bag)? If not, note how staff accommodates emergency situations.	1	
I. EPSDT AVAILABILITY CHECK LIST	**7**	
Threshold:	**5**	
EPSDT Equipment List		
1. What equipment is used to check Vital Signs - Thermometer - Stethoscope - Blood Pressure Cuff (age/weight appropriate)?	1	
2. What Visual Hearing equipment is used in your office? Wall Mounted eye chart (age appropriate) - Occluder - Occlusive eye patch- Audiometer- Tympanometer	1	
3. Identify the lab test performed in the office: Hemocue- Microcuvertes- Specimen collection tubes- Specimen collection cups- Syringes- Needles - Alcohol Swabs- Uri-Sticks- Disposable gloves	1	

4. What equipment is used to perform the growth Assessment? Recumbent Board- Wall mounted height Chart- Tape Measure- Adult weight scale- Table model beam scale	1	
5. Are the Following items used to perform the physical examination? Ophthalmoscope-otoscope- Tuning Fork- Disposable gown (age/size appropriate)- Tongue depressors- Disposable Gloves	1	
6. Are the following items used to administer immunizations? Syringes- Needles-Alcohol Swabs-Band- Aids Disposable gloves	1	
7. Which screening tool is used to perform the Developmental Assessment? Denver DST- Developmental Profile II- Project Memphis DST- Minneapolis Preschool Screening Instrument	1	
To complete the form, answer every question, then total the number of points and record here		
***These critical elements must be met, in addition to receiving an average score of 70% to achieve an acceptable rating on the Site Assessment and Medical Records Keeping Assessment and Tool**		

Provider/ Facility issues / concerns

_____

_____

Resolution:

_____

_____

_____

Follow up needed:

_____

_____

_____

THP Representative Signature: _____

Title: _____ **Date:** _____

Attachment B

FACILITY ACCREDITING BODIES

FACILITY TYPE	ACCREDITING BODY
Hospitals	JC, AOA, HFAP, AAAHC, DNV NIAHO
Skilled Nursing Facility, Nursing Home	CARF, CHAPS, JC
Home Health Care	CHAPS, JC, ACHC
Surgi-Care Centers	AAAASF, AOA, HFAP, AAAHC, JC
Hospice	ACHC,
Clinical laboratories	COLA,
Comprehensive outpatient rehabilitation facilities (CORF)	CARF
Outpatient physical therapy providers	*
Speech pathology providers	JC
End-stage renal disease services providers	JC, AAAHC
Outpatient diabetes self-management training providers	*
Portable x-ray suppliers	ACR
Rural health clinics (RHC)	*
Federally qualified health centers (FQHC)	*

**Individual physicians/providers will be credentialed rather than the facility*

Acceptable Accreditation Entities:

- *AAAASF*..... American Association for Accreditation of Ambulatory Surgery Facilities
- *AAAHC* .... Accreditation Association for Ambulatory Health Care
- *ABCPO* ..... American Board for Certification of Prosthetics and Orthotics
- *ACHC*..... Accreditation Commission for Health Care, Inc.
- *ACR* ..... American College of Radiology
- *AOA* ..... American Osteopathic Association
- *HFAP* ..... Healthcare Facilities Accreditation Program
- *CAP* ..... College of American Pathologists
- *CARF*..... Commission on Accreditation of Rehabilitation Facilities
- *CHAPS* ..... Community Health Accreditation Program
- *COLA* ..... Commission on Office Laboratory Accreditation
- *JC* ..... Joint Commission
- *DNV NIAHO*.....National Integrated Accreditation for Healthcare organizations

Attachment C

Trusted Health Plan Peer Review Addendum

Trusted Health Plan has the right to restrict, suspend or terminate any Licensed Independent Practitioner's or Facility's participation in the network for issues relating to the Quality Management Program, including Quality of Care Concerns (as defined in Section 2.0).

The Quality Management (QM) staff will refer all potential Quality of Care Concerns to a Trusted Health Plan Medical Director and/or designee. When a Quality of Care Concern is identified, the QM staff notifies the appropriate provider(s), including where appropriate the Medical Group for practitioners who participate under a Medical Group Agreement, and requests a response, along with any supporting documentation, within a specified period of time in accordance with the relevant State requirements.

Trusted Health Plan may terminate a provider's (See Section 2.0 for definitions of Provider) participation in the network for failure to comply with certain contractual obligations or Quality Management requirements. Depending on the circumstances, termination may be immediate or allow for an appeals process.

Trusted Health may immediately terminate a provider's participation in the network if it determines that immediate termination of the Provider's agreement with Trusted Health is in the best medical interest of the members as in instances of imminent threat to an enrollee/member's safety.

Trusted may also initiate termination proceedings for the provider's failure to implement and comply with his/her corrective action plan or refusal to make medical records available for examination.

In the case of immediate termination and terminations for failure to comply with Quality Management requirements, a Medical Director will send the provider a certified letter notifying him/her of the intent to terminate his/her network participation privileges. Terminations, suspensions and restrictions due to competence or professional conduct will be reported to the appropriate federal and state authorities, as required, including the Healthcare Integrity and Protection Data Bank (HIPDB) and the National Practitioner Data Bank (NPDB), as appropriate and as outlined in Section 9.4.

Attachment D

Trusted Network Antidiscrimination Monitoring Report Template

Review Period:	
1. Number of network denials in the review period:	
2. Reasons for network denials:	
Race	
Ethnic/national identity	
Gender	
Age	
Sexual orientation	
Types of patients serviced (e.g., Medicaid, AIDS patients, etc.)	
Practitioner did not meet PNA credentialing criteria	
Other	
3. Total number of cases where discriminatory decisions took place:	

These results are reported to the quality/credentialing committee and CEO annually.

Attachment E

HealthCheck Provider Training Requirement

TRUSTED's Credentialing Program requires verification or confirmation of HealthCheck training for all Primary Care Providers who render services to patients between the ages of 0 – 21. Providers are expected to complete the web-based HealthCheck training within thirty (30) days of joining the Trusted network and at at least every two (2) years therafter. TRUSTED will satisfy the requirement of C.9.4.6.1.13 and C.9.4.8.4.1.1 by ensuring the providers complete the training.

1. **Upon receipt of confirmation of training, the document will be stored in the credentialing file.**
2. **TRUSTED will audit all internal Credentialing Approvals and verify all providers have the doucments proving completion of training in the Credentialing file.**
3. **Trusted will esnure the provider completes the training every two (2) years.**
4. **TRUSTED will report on a quarterly basis to the CA of all compliant and non-complaint providers.**

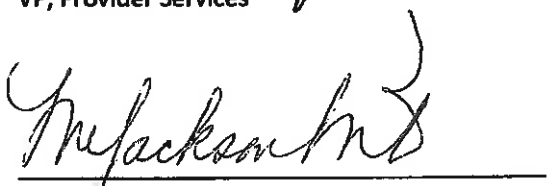
All providers who do not meet or fail to complete the HealthCheck training requirement will not be eligible to join the Trusted Provider Network and their pending contract will be void.



Credentialing Manager — 8/5/2015 — Date



VP, Provider Services — 8/5/2015 — Date



Chief Medical Officer — 8/5/2015 — Date

SAMPLE

This Ancillary Provider Services Agreement ("Agreement") is made and entered into this [DATE] between Trusted Health Plan (District of Columbia), Inc. ("Plan"), a Washington, D.C. corporation licensed as a health maintenance organization and whose business address is 1100 New Jersey Avenue, S.E., Suite 840, Washington, D.C. 20003, and [PROVIDER NAME] ("Provider"), a [TYPE OF ANCILLARY PROVIDER] ancillary provider, whose business address is [PROVIDER BUSINES ADDRESS].

In consideration of their mutual covenants and promises contained in this Agreement, the parties agree as follows:

RECITALS

WHEREAS Plan is a managed care entity and prepaid health plan operating in accordance with the laws of the District of Columbia.

WHEREAS Plan arranges for the provision of health care services to Members (as defined herein) in Plan's Health Products (as defined herein).

WHEREAS, Plan desires for Provider to arrange for or provide [TYPE OF ANCILLARY SERVICE] (as defined herein) for Members of Plan's Health Products, subject to the terms and conditions set forth below.

NOW, THEREFORE, in consideration of the promises and mutual covenants contained herein, the parties agree as follows:

1. DEFINITIONS

Agreement - is this Ancillary Provider Services Agreement and any Attachments hereto.

Clean Claim: A claim that can be processed without obtaining additional information from the provider of the service or from a third party. It does not include a claim from a provider who is under investigation for fraud or abuse, or a claim under review for medical necessity.

Copayment - charges under the Plan Health Products which may be charged to the Member at the time a non-Covered Service is provided.

Covered Services - Primary Care Services, Referral Services, and other health care services set forth in the Plan Health Products.

Emergency Services - those health care services that are rendered by hospitals, physicians, or any other health care professionals after the sudden onset of a medical condition that manifests itself by acute symptoms of sufficient severity (including severe pain), such that the absence of immediate medical attention could reasonably be expected to result in (a) placing the health of the individual

(or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; (b) serious impairment to bodily functions; or (c) serious dysfunction of any body organ or part.

Medically Necessary Services - Covered Services that are all of the following: (i) necessary and appropriate for the symptoms, diagnosis or treatment of a Member's condition; (ii) provide for the diagnosis, direct care, and treatment of a medical condition; and (iii) are not primarily for the convenience of the Member, the Member's attending or consulting physician, or another health care provider. Determinations regarding medical necessity shall be made, after review, by Plan's medical director or his or her designee.

Member - any person who meets the eligibility requirements for membership in any of Plan's Health Products, who is enrolled with Plan, and for whom the applicable premiums have been paid and received by Plan.

Participating Hospital - licensed acute care hospitals that have entered into contracts with Plan for the provision of Covered Services.

Physician - any duly licensed doctors of medicine or osteopathy.

Plan Health Product – Medicare Advantage, the District of Columbia Healthy Families Program and the Health Care Alliance Program.

Primary Care Physician - a duly licensed internist, general practitioner, family practitioner or pediatrician who has entered into a contract with Plan for the provision of Covered Services and who has agreed to supervise, coordinate and be responsible for the management of care with respect to Covered Services provided to Members who have selected or been assigned to the Primary Care Physician as their primary provider of health care.

Primary Care Services - those Medically Necessary Services provided by a Primary Care Physician identified as Primary Care Services in the relevant Plan Health Products.

Provider - a duly licensed or certified health care professional or health care facility.

Provider Manual – Plan's manual that includes the rules, policies, and procedures applicable to Covered Services provided under this Agreement, including, but not limited to, medical management, utilization review, quality assurance, case management, disease management, quality improvement, provider and member grievance procedures, appeals processes, reimbursement policies, preauthorization and referral requirement, and credentialing and re-credentialing standards and policies.

Quality Management Program - the program established by Plan that shall establish, maintain, and perform quality management reviews of Covered Services provided to Members.

Referral - a form used by a Primary Care Physician or a process used by Plan's Utilization Management Program to authorize specialty services, ancillary services, or other Covered Services.

Referral Services - Covered Services other than Primary Care Services.

Urgent Care - Covered Services required to prevent deterioration of a Member's health that results from an unforeseen illness or injury.

Utilization Management Program - a Plan program outlining procedures for the efficient use of resources for the provision of Covered Services. The program shall include the review of elective admissions, referrals and hospital admissions on a concurrent and prospective basis and Emergency Services on a prospective and retrospective basis. The program shall also include the use of care management teams comprised of utilization management nurse coordinators, nurse case management coordinators, medical outreach representatives and social workers, working in coordination with Primary Care Physicians to provide multi-disciplinary and comprehensive coordinated care to Members.

2. RELATIONSHIP OF PARTIES

a. **Independent Contractor** - The relationship between Plan and Provider is an independent contractor relationship. Neither Provider nor any employees or agents of Provider are employees or agents of Plan and neither Plan nor any employee or agent of Plan is an employee or agent of Provider. As such, all medical decisions regarding [TYPE OF ANCILLARY SERVICES] Services are rendered solely by Provider, and not by Plan. None of the provisions of this Agreement shall be construed to create a relationship of agency, representation, joint venture, ownership, control, or employment between the parties.

b. **Duty to Defend and Indemnify** - Provider shall be solely responsible for and agrees to defend, indemnify, and hold Plan free and harmless from any claim, judgment, or liability arising from the arrangement and provision of [TYPE OF ANCILLARY SERVICE] services by Provider, and Provider's employees, agents and contractors to Members under this Agreement. The indemnification obligation set forth in this section does not require Provider to indemnify Plan for Plan's negligence, willful misconduct or breach of this Agreement. This Section 2(b) shall survive termination of this Agreement.

c. **Medical Decision Making** - The Utilization Management Program and the authorization and approval procedures a part thereof are used to make benefit and authorization decisions. Provider is free to discuss medical treatment options with a Member and pursue his or her recommendations provided that the Member is notified that the Provider's recommended course of treatment may not be a Covered Service. Provider may bill a Member for non-Covered Services only after a Member's written consent to receive such non-Covered Services, but may not bill a Member for Covered Services which are not Medically Necessary, as provided under Section 3(i). All authorization decisions are appealable by the Member pursuant to the grievance process

and, to the extent applicable, by Provider pursuant to the procedures set forth in the Provider Manual.

3. DUTIES OF PROVIDER

a. Provider Duties and Standards - During the Term of this Agreement, Provider shall perform the duties and comply with the standards set forth under this Section 3 and in Attachment A to this Agreement.

b. Collection of Charges from Members - Provider hereby agrees that in no event, including, but not limited to, nonpayment by Plan or Provider, insolvency of Plan or Provider, or breach of this Agreement, shall Provider or subcontractor bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against Members (including subscribers) or persons other than Plan for services provided pursuant to this Agreement. This provision shall not prohibit collection of any applicable Copayments or deductibles from Members (including subscribers) billed in accordance with the terms of the applicable subscriber agreement or the health plan documents offered in a Plan Health Product. Provider agrees that: (1) this provision shall survive the termination of this Agreement regardless of the cause giving rise to such termination and shall be construed to be for the benefit of Plan's Members (including subscribers); and (2) this provision supersedes any oral or written agreement to the contrary now existing or hereafter entered into between Provider and the Member (including subscribers) or persons acting on Member's (including subscriber's) behalf.

c. Administrative Guidelines - Provider shall perform their duties under this Agreement in a manner consistent with the reasonable administrative guidelines provided by Plan in its Provider Manual. In the event of conflict between such manual and this Agreement, the terms of this Agreement shall prevail.

d. Quality and Utilization Management - Provider shall cooperate with and participate in Plan's compliance and fraud, waste, and abuse efforts, including Plan's Utilization Management and Quality Management Programs. These programs shall include, among other things, concurrent and retrospective review. Provider shall provide on-site access to Plan representatives upon reasonable notice and shall furnish pertinent sections of a Member's medical records as may be required to implement such programs. Provider shall comply with all final determinations rendered by the Utilization Management and Quality Management Programs. Final determinations may include monetary or other sanctions against Provider as provided for in Plan's policies, procedures, rules, and regulations, including, but not limited to, the sanction provisions in Plan's Provider Manual.

e. Grievance and Complaint Process - Provider shall cooperate with Plan in resolving any Member grievances or complaints related to the provision of [TYPE OF ANCILLARY SERVICES] and shall provide Plan with notice of any Member complaints involving Provider. Provider shall participate in and cooperate with Plan's

Member grievance and complaint procedures, as set forth in the Provider Manual, and to comply with all final determinations rendered in accordance with that procedure.

f. **Disclosure of Information** - Plan may use the names, addresses, and telephone number(s) of Provider in Plan materials including Plan's provider directory. In the event Provider wants to use Plan's name in any context or for any purpose other than general administrative purposes as specified by Plan, Provider shall obtain the prior written consent of Plan, which consent shall not be unreasonably withheld. To the extent applicable, Provider may post a notice in its offices and acknowledge to its patients that Provider participates with Plan.

g. **Nondiscrimination** - Provider represents that they shall not discriminate against any Plan Members on the basis of race, color, creed, national origin, ancestry, sex, age, disability, sexual orientation, personal appearance, family responsibilities, income, Medicaid or Medicare status, political affiliation, religion, place of residence, marital status, health status, lawful occupation, source of payment, or frequency of utilization of Covered Services.

h. **Protection of Member** - Provider shall agree not to impose any limitations on the acceptance of Members for care or treatment that they do not impose on other patients. Provider may not require the transfer, discharge, or removal of any Member because of the Member's need for, or utilization of, Medically Necessary Services.

i. **Billing for Non-Covered Services** - If any services provided by Provider are not Covered Services, Provider may bill Members at a rate not in excess of the rate which Provider bills the general public after first notifying the Member in writing in advance of rendering the service that the service is not covered and obtaining the Member's written consent to be billed. Provider agrees to provide Plan with such documentation upon request. Provider shall, in no event, charge or attempt to recover from Plan or the Member for any Covered Services which are not Medically Necessary. Prior to billing Members for non-Covered Services, Provider agrees to verify with Plan that the claim is the Member's responsibility.

j. **Plan Health Products** - Provider shall acknowledge its participation in each Plan Health Product and agrees to be bound by the terms and conditions of each Plan Health Product upon execution of this Agreement and upon execution of the Cover Sheet by Provider, included herein as Attachment B. Plan may add to or delete from the list of Plan Health Products in which Provider is participating upon at least sixty (60) days prior written notice to Provider. Provider agrees to participate in additional Plan Health Products by executing the relevant cover sheet for the Plan Health Product and returning it to Plan within thirty (30) days after the date of notice from Plan. Provider may object to participating in those additional Plan Health Products by sending written notice to Plan within thirty (30) days after the date of notice from Plan.

k. **Communication with Members** - Provider agrees that in connection with all actions taken on behalf of Members, and in all communications with Members in connection

with this Agreement, Provider shall avoid actions and communications that could or shall undermine the confidence of the Member, a potential Member, employers, unions or the public, in Plan or in the quality of care Plan provides. Notwithstanding the foregoing, nothing in this Agreement shall limit the rights of Provider to: (1) communicate with patients, including Members, regarding medical treatment options; (2) recommend a course of treatment to a Member, even if the course of treatment is not covered or approved by Plan; or (3) advocate on behalf of the Member in any grievance, appeal, or utilization review or individual authorization process. If a recommended course of treatment is not covered, e.g., not approved by Plan, Provider must notify the Member in accordance with Section 3(i), if Provider intends to charge the Member for such non-Covered Services. The obligations set forth in this Section shall survive termination of this Agreement.

l. **Notice of Operational Changes** - Provider shall provide Plan with at least thirty (30) days prior written notice of any changes in office locations, addresses, hours of operation, telephone numbers and other relevant information relating to Provider's operations. In the event Provider terminates this Agreement as provided in Section 7, Provider shall provide thirty (30) days written notice to those Members receiving [TYPE OF ANCILLARY SERVICES] from Provider.

m. **Access** – Provider shall meet Plan's access standards as defined in Provider Manual

n. **Marketing** – Provider shall adhere to the below marketing conditions:

i. Any marketing information distributed by Provider directed at Plan's Members shall be limited to general information about Plan and notification that Provider participates in Plan's network. Any such materials must be submitted to Plan for review and approval prior to distribution to Members (Plan will ultimately submit such materials to DHCF for review and approval).

ii. Provider will not utilize written information that is false or misleading in any material respect, including information regarding the Provider's network, the availability of services, the Provider's qualifications, hours, and location of services.

iii. Provider shall not host marketing events within the Provider's office.

iv. Provider shall not offer to Members gifts of more than a de minimus value or other insurance products designed to induce persons to enroll in Plan.

v. Provider shall not enter into compensation agreements with marketing personnel that utilize any type of payment structure in which compensation is tied to the number (or classes) of persons who enroll in Plan.

o. **Member Notice** – If this Agreement terminates for any reason, within fifteen (15) days of the notice of termination or thirty (30) days before the effective date of

termination, whichever is sooner, Provider will notify its Members in writing of such termination. The notice will include:

i. the effective date of termination;

ii. instructions to the Member(s) to contact the Plan regarding securing a new Provider;

iii. a brief description of the Provider's process for transferring the Member's Protected Health Information ("PHI"); and if applicable

iv. future contact information for the Provider.

4. **DUTIES OF PLAN:**

a. **Administration and Benefit Determination** - Plan shall perform the following duties under this Agreement and in accordance with the applicable Plan Health Product: (1) develop, communicate, and promote policies and procedures to enhance the quality, efficiency and coordination of care by ancillary health care providers; (2) administer Provider claims, as necessary; (3) conduct the Quality Management Program and Utilization Management Program; (4) apprise all Members concerning the type, scope, and duration of benefits and services to which Members are entitled under the applicable Plan Health Product; (5) comply with all applicable Federal and State legal and regulatory requirements; and (6) to the extent possible, assist Provider in the development and initial implementation of procedures necessary to carry out the terms of this Agreement and in orientation to the policies and procedures of Plan.

b. **Transfer of Member** – Plan reserves the right to immediately transfer Members to another Provider if it reasonably determines that Provider is jeopardizing the health or safety of a Member(s).

5. **COMPENSATION**

a. **Payments** - Plan shall provide compensation to Provider as set forth in Attachment C, which shall be full compensation for [TYPE OF ANCILLARY SERVICES] provided under this Agreement.

b. **Collection of Charges from Third Parties** - Provider agrees to accept payment from Plan, together with any authorized Copayments as provided herein, as full payment for Covered Services, and shall not pursue or collect charges for such services from third parties. However, Provider shall agree to cooperate with and use best efforts in the effective implementation of any coordination of benefits procedures and other procedures for handling third party claims, as set forth in the Provider Manual, including, collecting information from Members regarding other health coverage. In the event Provider receives payment for Covered Services from third parties, Provider shall make appropriate adjustments and issue payment(s) due Plan no later than thirty (30) days after

receiving payment from the relevant third party. Notwithstanding the foregoing, in the event Provider receives payment for Covered Services from a third party who is the primary payor, Plan shall pay Provider as full compensation for the Covered Services, such amount, if any, by which Plan's fees for Covered Services, as set forth in Attachment C to this Agreement, exceed the amount actually received from or payable by the primary payor.

c. **Payment of Claims** - For those [TYPE OF ANCILLARY SERVICES] to be provided to Members by Provider, Provider agrees to submit claims to Plan within one hundred eighty (180) days after the [TYPE OF ANCILLARY SERVICES] are rendered on the appropriate reporting forms or in computer readable form as Plan may require. Such bills shall include all diagnostic and/or procedure codes applicable to services performed for each Member's encounters. Plan may deny claims that are not submitted within one hundred eighty (180) days of the date of service. In the event the billed amount for a claim submitted by Provider as provided in this section is less than the contract amount set forth in Attachment C, Plan shall pay Provider the billed amount. Plan shall pay Provider within thirty (30) calendar days of Plan's receipt of a Clean Claim from Provider, or other specified time frames as may be required by the District of Columbia Department of Health Care Finance ("DHCF") or as may be required by Plan in the event additional information is needed to process the claim. Provider must submit a request for an appeal of an adverse claims determination made by Plan within thirty (30) days after the date of Plan's written notice. Plan may deny appeals that are not submitted within thirty (30) days of the date of Plan's written notice.

To the extent necessary, payments to [NAME OF ANCILLARY SERVICES PROVIDER] may be retroactively denied or adjusted during the one hundred eighty (180) period after the date the claim was originally paid, provided that Plan, as the case may be, may retroactively deny or adjust reimbursement for services subject to coordination of benefits with another payor, the District of Columbia Medical Assistance Program, or the Medicare program during the eighteen (18) month period after the date the claim was originally paid. [NAME OF ANCILLARY SERVICES PROVIDER] shall recognize Plan's immediate right to recovery for retroactively denied or adjusted claims and shall repay contested paid claims within twenty (20) days of notice from Plan. The time limits under this Section 5(c) shall apply if Plan retroactively adjusts or denies a claim because (i) the information submitted to the Plan, upon which the claim was approved was fraudulent; (ii) the information submitted to the Plan was improperly coded; or (iii) the claim submitted to the Plan was a duplicate claim.

d. **Payment Suspension** – In the event DHCF fails to pay or delays payment to Plan for the provision of Covered Services to Members, Plan shall temporarily suspend payment to Provider until such time as Plan receives payment from DHCF. Plan shall pay Provider for previously submitted Clean Claims within thirty (30) of receipt of payment from DHCF. To the extent that DHCF the Centers for Medicare & Medicaid Services ("CMS") reduces any payments to Plan under Plan Health Products, Plan may notify Provider in writing of such reduction and both parties agree to negotiate in good-faith a revised fee schedule. If the parties are unable to agree upon a revised fee schedule within

sixty (60) days of Plan's notice of reduction to Provider, Plan reserves the right to terminate this Agreement pursuant to Section 7(a) below.

6. **TERM OF AGREEMENT:** This Agreement shall remain in effect for one (1) year from the date of the last signature executing this Agreement, and is automatically renewable for a second 1-year term. The parties may agree in writing to extend this Agreement for an additional one (1) year term, but in no event, shall the term of this Agreement exceed a total of three (3) years.

7. **TERMINATION**

a. **Termination without Cause** -Either party may terminate this Agreement without cause upon ninety (90) days prior written notice to the other party. Provider's participation in one (1) or more Plan Health Product(s) may be terminated without cause. The termination of Provider's participation in an individual Plan Health Product, as set forth in this Section, shall not terminate Provider's participation in other Plan Health Products and shall not automatically terminate this Agreement as it relates to any other Plan Health Product offered by Plan.

b. **Termination of Agreement for Cause** - Plan may terminate this Agreement for a material breach of its terms or provisions or for a material breach of the terms and provisions of any attachment, provided that Plan shall provide at least thirty (30) days written notice to Provider specifying the nature and the extent of the breach, except that such termination will not take effect if Provider cures such material breach no later than fifteen (15) days after receiving Plan's notice of material breach. Provider may terminate this Agreement for a material breach of its terms or provisions, provided that Provider shall provide at least sixty (60) days written notice to Plan specifying the nature and the extent of the breach, except that such termination will not take effect if Plan cures such material breach no later than thirty (30) days after receiving Provider's notice of material breach. In the event Provider's participation in one (1) or more Plan Health Product(s) is terminated for material cause, as provided in this section, then Provider's participation in all Plan Health Products and this Agreement shall be terminated in their entirety.

c. **Immediate Termination** - This Agreement may be terminated immediately by Plan in the event of: (1) the termination or non-renewal of Plan's Medicare Advantage contract with CMS; (2) the termination or non-renewal of Plan's Medicaid agreement with DHCF, subject to Section 7(d) below; (3) the suspension or revocation of any license or certification required by Providers to provide [TYPE OF ANCILLARY SERVICE] in the District of Columbia; (4) the imposition of sanctions or disciplinary action against Provider by a State or Federal licensing agency; (5) the cancellation, termination or reduction below the minimum amounts of Provider's professional and/or general liability insurance coverage; (6) a violation of Sections 3(b) or 3(i) of this Agreement; (7) a material breach of Section 11(a) of this Agreement; or (8) a reasonable determination by Plan, based on reasonable evidence, that the health and well-being of Members is jeopardized as a result of continuation of this Agreement.

d. **Payment upon Termination** - Within one hundred and eighty (180) days following termination of this Agreement, an accounting shall be made of monies due and owing both parties and payment shall be forthcoming to settle such balance within thirty (30) days following such accounting.

e. **Continuation of Care Upon Termination** - Unless Provider is terminated as provided in Sections 7(b) or 7(c), Provider shall to continue to be responsible for providing [TYPE OF ANCILLARY SERVICE] to Members under active treatment as of the effective date of termination, until the earlier of: (1) completion of the active treatment plan, or (2) Plan's orderly transition of Member's care to another [TYPE OF ANCILLARY PROVIDER]. Members may request that ongoing care continue by Provider for up to ninety (90) days even if Plan can arrange for an orderly transfer of Member's care. In such case, Provider shall continue to provide [TYPE OF ANCILLARY SERVICE] for a period up to ninety (90) calendar days, after which Plan will orderly transition the Member's care to another [TYPE OF ANCILLARY PROVIDER], unless the Provider has completed the then active treatment plan. If this contract is terminated by Plan under Section 7(c) of this Agreement, the Member does not have the right to request ninety (90) days of care; however all other provisions of this section shall apply. The continuing care obligations set forth in this Section 7(e) shall also apply upon termination of Provider's participation in one or more Plan Health Product(s), as provided in Sections 7(a) and 7(b). Payment for any continued [TYPE OF ANCILLARY SERVICE] as described in this Section shall be at the rates set forth under Attachment C.

8. RECORDS, DATA COLLECTION, CITATIONS, AND RIGHT TO INSPECT RECORDS

a. The duties imposed on Provider by this Section 8 shall not terminate upon termination of this Agreement, regardless of the cause giving rise to such termination. The cost of preparation and submission of the data required by this Section 8 shall be borne solely by the Provider.

b. **Records** - Provider shall maintain adequate records relating to [TYPE OF ANCILLARY SERVICE] provided to each Member in such form and containing such information as required by Plan, or by applicable District and Federal law (and in accordance with usual and customary practices in the United States), including medical histories, medical records, records of Emergency Services received by the Member, financial and programmatic information, and such other information as Plan may require. Provider shall maintain all such records for the greater of ten (10) years or the length of time required under applicable Federal and District law, which obligation shall not terminate upon termination of this Agreement.

c. **Confidentiality of Member Records** - Provider shall implement and maintain procedures for maintaining and safeguarding the confidentiality of Member medical records and treatment in accordance with all District and Federal laws.

d. **Access and Right to Inspect** - Subject to applicable District and federal law, Provider shall provide access at all reasonable times upon request by Plan, DHCF, the District of Columbia Department of Health ("DOH"), the United States Department of Health and Human Services ("HHS"), CMS, the Office of Inspector General ("OIG"), or other State or Federal regulatory agencies or departments, and/or their duly authorized representatives responsible for the administration of HMOs, to inspect facilities, equipment, books, documents, papers and records relating to the performance of this Agreement, including, but not limited to, Member patient records, financial records pertaining to the cost of operations, and income received for [TYPE OF ANCILLARY SERVICE] rendered to Members under this Agreement, for the purpose of making audit, examination, excerpts, copies and transcriptions. Whenever appropriate, Plan shall make best efforts to assure that all inspections or audits shall be conducted in a manner as will not unduly interfere with the performance of Provider's activities.

9. APPLICABLE LAW; DISPUTE RESOLUTION

a. **Applicable Law** - This Agreement and the rights and obligations of the parties hereunder shall be construed, interpreted, and enforced in accordance with, and governed by, the laws of the District of Columbia and the United States of America, as amended and the regulations promulgated thereunder. Any provisions required to be in this Agreement by District or Federal law or regulation shall bind Plan and Provider whether or not expressly provided in this Agreement.

b. **Dispute Resolution**- If any dispute, controversy or claim arises out of, or is related to, this Agreement (except for disputes arising under Sections 7(a) through 7(e) of this Agreement), or with respect to any of the documents executed in conjunction herewith, the parties shall first make their best efforts to resolve such dispute, controversy or claim informally, no later than thirty (30) days after either party notifies the other party in writing of the dispute. If the dispute cannot be timely resolved informally, the dispute, controversy or claim shall be settled by arbitration in accordance with the Rules and Procedures of JAMS/Endispute in Washington D.C., by a panel of three qualified arbitrators. Plan and Provider shall each choose an arbitrator and the two arbitrators so chosen shall choose the third. If either Plan or Provider fails to choose an arbitrator within thirty (30) days after notice of commencement of arbitration or if the two arbitrators fail to choose a third arbitrator within thirty (30) days after their appointment, JAMS/Endispute Washington D.C. shall, upon the request of any party to the dispute or difference, appoint the arbitrator or arbitrators to constitute or complete the panel as the case may be. rbitration proceedings hereunder may be initiated by either Plan or Provider making a written request to JAMS/Endispute, together with any appropriate filing fee, at the office of JAMS/Endispute Washington D.C. All arbitration proceedings or litigation (to the extent the remedy requested is not, by law, available through arbitration [e.g., injunctive relief]) relating to any claims or disputes arising under or relating to this Agreement shall be brought in the county in which the principal executive office of the party not initiating such action or proceeding (i.e. the defendant or responding party) is located. The parties irrevocably submit and consent to the exercise of subject matter jurisdiction and personal jurisdiction over each of the parties by the federal and/or state courts in such jurisdiction (the "Selected Jurisdiction"). The parties hereby irrevocably

waive any and all objections that any party may now or hereafter have to the exercise of personal and subject matter jurisdiction in the Selected Jurisdiction and to the laying of venue of any such proceeding or action brought in the Selected Jurisdiction. Any order or determination of the arbitral tribunal shall be final and binding upon the parties to the arbitration and may be entered in any court having jurisdiction.

10. NOTICE

a. **Notice** - Any notice required to be given hereunder shall be in writing sent by certified mail, return receipt requested via a nationally recognized overnight courier service, or by hand delivery to Provider at the address set forth herein, and to Plan at the address listed below or at such other addresses as either Plan or Provider may hereafter designate to the other:

To Plan:
Chika Duru
General Counsel
Trusted Health Plan (District of Columbia), Inc.
1100 New Jersey Avenue, S.E., Suite 840
Washington, D.C. 20003

With a copy To:
Kenny R. Greene
Vice President Provider Relations
Trusted Health Plan (District of Columbia), Inc.
1100 New Jersey Avenue, S.E., Suite 840
Washington, D.C. 20003

To Provider:

b. Any notice sent by registered or certified mail, return receipt requested, shall be deemed given on the date of delivery shown on the receipt card, or if no delivery date is shown, the postmark date. Any notice sent by a nationally recognized overnight courier service shall be deemed delivered the date of delivery by the service, with proof of delivery.

11. MISCELLANEOUS

a. **Confidential and Proprietary Information** – Provider shall agree to maintain confidential (the "Confidential Information"): (i) this Agreement (ii) eligibility lists and any other information containing the names, addresses and telephone numbers of Members which have been compiled by Plan; (iii) Plan's administrative service manuals and all forms related thereto; (iv) Plan Health Product contracts and the information contained therein; (v) the financial arrangements between Plan and any Plan contracting Provider; and (vi) any other information compiled or created by Plan which is proprietary to Plan or due to its nature or the circumstances surrounding its disclosure, would be considered confidential or proprietary by a reasonable person. Confidential Information also includes PHI. Provider shall not disclose or use the

Confidential Information for their own benefit or gain (or for the benefit or gain of any third party) either during the term of this Agreement or after the date of termination of this Agreement. Provider may use the Confidential Information to the extent necessary to perform their duties under this Agreement or upon express prior written permission of Plan. Upon the effective date of termination of this Agreement, Provider shall promptly return to Plan or destroy the Confidential Information in their possession, except where Provider is required by Federal or State law, or under this Agreement, to retain such information for a period of time. In the event of a breach or a threatened breach of this Section 11(a) by Provider, Plan shall have the right of specific performance and injunctive relief in addition to any and all other remedies and rights at law or in equity, and such rights and remedies shall be cumulative.

b. **Assignment** - This Agreement shall not be assigned by Provider without the prior written consent of Plan. Any such subcontractor approved by Plan under this subsection shall be subject to every provision of this Agreement. Plan may assign this Agreement and its rights, interests and benefits hereunder to any entity which has at least majority control of Plan or to any entity of which Plan has at least majority control. If required, any assignment or delegation of this Agreement shall be void unless prior written approval is obtained from the appropriate District or Federal agencies.

c. **Invalidity of Sections** - If any provision of this Agreement shall be held by a court of competent jurisdiction to be contrary to law, that provision will be enforced to the maximum extent permissible, and the remaining provisions of this Agreement will remain in full force and effect, unless to do so would result in either party not receiving the benefit of its bargain.

d. **Attorneys' Fees** - If any action at law or suit in equity is brought to enforce or interpret the provisions of this Agreement or to collect any monies due hereunder, the prevailing party shall be entitled to reasonable attorneys' fees and reasonable costs, together with interest thereon at the highest rate provided by law, in addition to any and all other relief to which it may otherwise be entitled.

e. **Amendment** - Plan may amend this Agreement immediately upon written notice to Provider in the event such amendment is required in order to maintain compliance with applicable District or Federal laws or regulations, or in order to maintain compliance with any requirements arising from a contractual relationship between Plan and DHCF or its designee, and Plan and CMS or its designee, related to Plan's Health Products. Other amendments to the Agreement shall be effective only upon mutual, written agreement of the parties.

f. **Force Majeure** - In the event that the performance by either party hereto of any of its obligations or undertakings hereunder shall be interrupted or delayed by any occurrence and not occasioned by the conduct of either party hereto, whether such occurrence be an act of God or the common enemy or the result of war, riot, civil

commotion, sovereign conduct, or shortage of material, then it shall be excused from such performance for such period of time as it is reasonably necessary after such occurrence to remedy the effects thereof.

g. **Entire Agreement** - This Agreement constitutes the entire understanding and agreement between the parties regarding the subject matter hereof, and supersedes all prior agreements, oral or written, regarding the subject matter hereof.

IN WITNESS WHEREOF, the parties hereto have executed this Agreement.

TRUSTED HEALTH PLANS, INC.	[PROVIDER]
_____	_____
Chika Duru General Counsel	Print Name:_____
	Title:_____
Date:_____	Date:_____

SCHEDULE OF ATTACHMENTS

A Provider Duties and Standards

B Plan Health Products Cover Sheet

C Medicaid Plan Health Product Compensation Schedule

D Medicare Advantage Health Product Compensation Schedule

ATTACHMENT A

PROVIDER DUTIES AND STANDARDS

A. PROVIDER DUTIES

1. **Provider Qualifications** - Providers ensures that they are duly licensed, certified or otherwise qualified in the District of Columbia to provide [TYPE OF ANCILLARY SERVICES].

2. **Ancillary Services** - Provider agrees to provide [TYPE OF ANCILLARY SERVICES] to Plan Members upon receipt of a Referral from a Primary Care Physician and where applicable, authorization pursuant to Section 3 of this Attachment A, and upon verification of a Member's eligibility by contacting Plan. Provider agrees that when applicable, they must also receive authorization from Plan's utilization management department prior to the provision of any additional [TYPE OF ANCILLARY SERVICES] not included in, or that are requested after to receipt of an initial authorization. Provider agrees to provide [TYPE OF ANCILLARY SERVICES] for Members only for the specified types of services for which Provider is qualified to provide as described in this Attachment A.

3. **Referral Services** - Provider shall provide [TYPE OF ANCILLARY SERVICES] upon receipt of a Referral from a Primary Care Physician and when applicable, authorization from Plan's utilization management department. This authorization will include the initial service/s and the duration of services. In coordinating with Primary Care Physicians, Provider shall submit referral reports and/or furnish copies of medical records to the Primary Care Physician from whom Referrals were made in order to maintain an integrated medical record for assigned Members. In the event the Provider fails to submit referral reports in a timely manner, Provider may be subject to monetary sanctions. Provider shall ensure that under no circumstances may they refer any Member to another health care provider for Covered Services without an authorized Referral from the Member's Primary Care Physician or from Plan's utilization management department. If Provider refers a Member to another Provider in a manner contrary to the Utilization Management or Quality Management Programs, the cost of such services shall be the financial responsibility of Provider. Plan, at its option, may reduce future payments to Provider due to failure to follow Plan's policies and procedures, as set forth in the Provider Manual.

4. **Insurance** - Provider shall maintain throughout the term of this Agreement, professional liability insurance and general liability insurance in the minimum amounts of one million dollars ($1,000,000) per occurrence and three million dollars ($3,000,000) combined single limits coverage for Provider, and Provider's agents and employees. In the event Provider procures a "claims made" policy as distinguished from an occurrence policy,

Provider shall procure and maintain prior to termination of such insurance, continuing "tail" coverage. Provider shall immediately notify Plan of any material changes in insurance coverage and shall provide a certificate of such insurance coverage to Plan upon Plan's request.

5. Standards - Provider shall provide [TYPE OF ANCILLARY SERVICE] in accordance with generally accepted standards of practice for [TYPE OF ANCILLARY SERVICE], as established by any and all applicable Federal standards, the applicable licensing entity of the District of Columbia, and the standards established by the Plan Quality Management Program.

Provider hereby represents and warrants to Plan that: (i) all medical personnel, nurses and other ancillary and paramedical personnel employed by, associated with and/or under contract with Provider are properly licensed or certified to practice in the District of Columbia; (ii) if applicable, Provider shall comply with the credentialing standards of Plan as set forth in the Provider Manual; (iii) if applicable, Provider shall maintain Federal and State registration to prescribe and dispense controlled substances; and (iv) Provider shall comply with applicable District and Federal laws and regulations related to the ancillary services under this Agreement.

Provider shall provide Plan with copies of the subcontracts entered into between Provider and sub-contracted Providers who are providing [TYPE OF ANCILLARY SERVICE] under this Agreement.

Provider shall immediately notify Plan in writing of any adverse action, proceeding, or decision, or of any sanctions imposed by a state or federal regulatory or licensing agency, court or other governmental entity, or of any other situation with respect to Provider, which could materially affect Provider's ability to carry out its duties and obligations under this Agreement. Provider shall also comply with any corrective action plan established by Plan related to the provision, arrangement or failure of Provider to provide [TYPE OF ANCILLARY SERVICE] at the level commensurate with other [TYPE OF ANCILLARY PROVIDER] Providers who are providing such ancillary services in the same local health care community.

Provider shall comply with any additional standards required by Plan that are unique to the ancillary services being provided through Provider on behalf of Plan. Such additional standards may be attached to and incorporated into this Attachment A.

6. NCQA - Provider shall implement all activities necessary to assist Plan to obtain external accreditation by the National Committee for Quality Assurance or any other similar organization selected by Plan, including, but not limited to, cooperating in the auditing of Members' medical records.

7. **Privacy and Security** – Provider will comply with 42 C.F.R Part 2, the HIPAA Privacy and Security Rules, and the D.C. Mental Health Information Act (D.C. Code § 6-2001 *et seq.*).

ATTACHMENT B

PLAN HEALTH PRODUCTS COVER SHEET

Upon execution of this cover sheet, Provider shall to agree to participate in the Plan Health Products as defined under Section 1 of this Agreement, and shall be bound by and comply with the terms and conditions of the Plan Health Products, as set out in the Provider Manual.

Provider further agrees and shall ensure that as a condition of participation as a [TYPE OF ANCILLARY SERVICES PROVIDER] under the Plan's Health Products, Provider shall provide [TYPE OF ANCILLARY SERVICES] to any and all Plan Members eligible under Plan's Health Products.

AGREED TO: _____

Signature

_____

Printed Name of Provider Representative

_____

Title of Provider Representative

DATE: _____

ATTACHMENT C

MEDICAID PLAN HEALTH PRODUCT COMPENSATION SCHEDULE

Below is the compensation schedule for [TYPE OF ANCILLARY SERVICE] provided to Plan Members under this Agreement. Provider agrees to accept compensation as payment in full.

Service - [TYPE OF ANCILLARY SERVICE]

Rate - 100% of District of Columbia Medicaid

Prompt Payment. Payment to Provider by Plan within seven (7) days of Plan's receipt of claims shall be paid at 98%, a 2% reduction of (a) the amount charged or (b) 100 % of the current Medicaid fee-for-service program for the same service.

ATTACHMENT D

MEDICARE ADVANTAGE HEALTH PRODUCT COMPENSATION SCHEDULE

Below is the compensation schedule for [TYPE OF ANCILLARY SERVICE] provided to Plan Members under this Agreement. Provider agrees to accept compensation as payment in full.

Service - [TYPE OF ANCILLARY SERVICE]

Rate -100% of the then current Medicare fee schedule.

Prompt Payment. Payment to Provider by Plan within seven (7) days of Plan's receipt of claims shall be paid at 98%, a 2% reduction of (a) the amount charged or (b) 100 % of the current Medicare fee-for-service program for the same service.

SAMPLE

TRUSTED HEALTH PLAN (DISTRICT OF COLUMBIA), INC.

FACILITY SERVICES AGREEMENT

With

[FACITLIY NAME]

TRUSTED HEALTH PLAN (DISTRICT OF COLUMBIA), INC.
FACILITY SERVICES AGREEMENT

This FACILITY SERVICES AGREEMENT ("Agreement") is made and entered into effective as of _____, [DATE] (the "Effective Date"), by and between Trusted Health Plan (District of Columbia), Inc. ("Trusted"), a District of Columbia corporation licensed as a Health Maintenance Organization ("HMO"), and [FACILITY] ("Facility"), [DESCRIPTION OF FACILITY].

RECITALS

WHEREAS, Trusted is an HMO licensed and operating in accordance with the laws of the District of Columbia.

WHEREAS, Trusted arranges for the provision of health care services to its Members (as later defined), in Trusted's health products, which may include commercial health plans (e.g. individual subscriber agreements, group contracts with employers or unions, or conversion contracts for individuals), Medicaid health plans, Medicare health plans, point of service plans and preferred provider organization plans.

WHEREAS, Facility is a duly licensed Facility under the laws of the [STATE OR TERRITORY] and is willing to provide Covered Services (as later defined) for Trusted's Members.

WHEREAS, Trusted desires for Facility to provide Covered Services for its Members, subject to the terms and conditions set forth below.

NOW, THEREFORE, for and in consideration of the mutual promises, covenants, and conditions contained herein, and other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, the parties agree as follows:

1 DEFINITIONS

a. **COPAYMENTS** - are charges under the Trusted Health Product which may be charged to the Member at the time a Covered Service is provided.

b. **COVERED SERVICES** - are the health care services covered under the Trusted Health Product.

c. **EMERGENCY SERVICES** - are those health care services that are rendered by a Participating Facility , Nonparticipating Facility, or or Physicians after the sudden onset of a medical condition that manifests itself by symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by a prudent layperson who possesses an average knowledge of health and medicine to result in (i) serious jeopardy to the mental or physical health of the individual, and in the case of a pregnant woman, the health of the woman or her unborn child; (ii) danger of serious impairment of the individual's bodily functions; or (iii) serious dysfunction of any of the individual's bodily organs or parts.

d. **EMERGENCY MEDICAL SCREENING** - is the service performed by Facility to determine the presence or absence of an emergency medical condition upon presentation to the emergency room.

e. **MEDICALLY NECESSARY SERVICES** - are Covered Services that: (i) are necessary and appropriate for the symptoms, diagnosis or treatment of a Member's condition; (ii) provide for the diagnosis, direct care, and treatment of a medical condition; and (iii) are not primarily for the convenience of the Member, the Member's attending or consulting physician, or another health care provider. Determinations regarding medical necessity shall be made, after review, by Trusted's Medical Director or his or her designee.

f. **MEMBER** - is any person who meets the eligibility requirements for membership in any Trusted Health Product, who is enrolled in and with Trusted, and for whom the applicable premiums have been paid and received by Trusted.

g. **PARTICIPATING FACILITY**- is licensed acute care facility, including Facility, that have entered into contracts with Trusted for the provision of Covered Services.

h. **PARTICIPATING PHYSICIANS** - are Physicians who have entered into contracts with Trusted for the provision of Covered Services.

i. **PHYSICIANS** - are any duly licensed doctors of medicine or osteopathy.

j. **PRIMARY CARE PHYSICIAN ("PCP")** - is a duly licensed internist, general practitioner, family practitioner, or pediatrician who is a Participating Physician and has agreed to supervise, coordinate, and be responsible for the management of care regarding Covered Services that are provided to Members who have selected or been assigned to the PCP as their primary provider of health care. A PCP who also meets the definition of a Specialist Physician (as defined under Section 1(o) below) may apply to be designated as both a PCP and a Specialist Physician by Trusted.

k. **PROVIDER** - is a duly licensed or certified health care professional or health care facility.

l. **PROVIDER MANUAL** – Trusted's manual that includes the rules, policies, and procedures applicable to Covered Services provided under this Agreement, including, but not limited to, medical management, utilization review, quality assurance, case management, disease management, quality improvement, provider and member grievance procedures, appeals processes, reimbursement policies, preauthorization and referral requirement, and credentialing and re-credentialing standards and policies.

m. **QUALITY MANAGEMENT PROGRAM** - is the program established by Trusted that will establish, maintain, and perform quality management reviews of Covered Services provided to Members.

n. **REFERRAL** - is an authorization form used by a PCP or a process used by Trusted's Utilization Management Program to refer a Member to a Specialist Physician.

o. **SPECIALIST PHYSICIAN** - is a Participating Physician under contract with Trusted, who is Board Certified or Board Eligible in a particular medical specialty or is approved by an exceptions process by Trusted's medical director.

p. **TRUSTED HEALTH PRODUCT** – includes the Medicare Advantage health plan, the District of Columbia's Healthy Families ("DCHFP") and Health Care Alliance Programs, and any other commercial health plans (e.g. individual subscriber agreements, group contracts with employers or unions, or conversion contracts for individuals), point of service plans, and preferred provider organization plans operated by Trusted.

q. **URGENT CARE** - is Covered Services required to prevent deterioration of a Member's health that results from an unforeseen illness or injury.

r. **UTILIZATION MANAGEMENT PROGRAM** - is a Trusted program outlining procedures for the efficient use of resources for the provision of Covered Services. The program shall include the review of elective admissions, Referrals and facility admissions on a concurrent and prospective basis and Emergency Services on a prospective and retrospective basis. The program shall also include the use of care management teams comprised of utilization management nurse coordinators, nurse case management coordinators, medical outreach representatives and social workers, working in coordination with PCPs to provide multi-disciplinary and comprehensive coordinated care to Members.

2 RELATIONSHIP OF PARTIES

a. **INDEPENDENT CONTRACTOR** - The relationship between Trusted and Facility is an independent contractor relationship. Neither Facility nor any employees or agents of Facility are employees or agents of Trusted; and neither Trusted nor any employee or agent of Trusted is an employee or agent of Facility. As such, all medical decisions regarding Covered Services are rendered solely by Providers and not by Trusted. None of the provisions of this Agreement shall be construed to create a relationship of agency, representation, joint venture, ownership, control, or employment between the parties.

b. **DUTY TO DEFEND AND INDEMNIFY** - Facility shall be solely responsible for and agrees to defend, indemnify, and hold Trusted free and harmless from any claim, judgment, or liability arising from the performance of Facility duties and obligations under this Agreement. Trusted shall indemnify and hold Facility harmless from any claim, judgment, or liability arising from Trusted's performance of its obligations under this Agreement. The terms of this Section 2(b) shall survive termination of this Agreement.

c. **MEDICAL DECISION-MAKING** - It is not the intention of Trusted to use the pre-authorization and approval provisions set forth herein as a device by which it may practice medicine. Rather, the authorization and approval procedures are used to make benefit and coverage determinations so that the Member and Providers know, before a course of treatment is initiated, that such course of treatment is covered in full, in part or not at all. If a course of treatment is not covered, *e.g.*, not approved, such determination

is not intended to suggest that the course of treatment is medically inappropriate. Trusted will notify the attending Participating Physician (Specialist Physician) and, if applicable, the PCP, of a denial of coverage; however, Participating Physicians and/or Facility may choose to provide such course of treatment, so long as prior written notice is given to the Member that the course of treatment is not covered by Trusted, as set forth in Section 3(r).

3 DUTIES OF FACILITY

a. **FACILITY SERVICES** - After compliance with the admission procedures set forth below in Section 3(e), Facility agrees to provide, on a twenty-four (24) hour a day, seven (7) days a week basis, Covered Services to Members.

b. **FACILITY-BASED PHYSICIAN SERVICES** - Facility shall make best efforts to encourage that its entire of Facility-based Physicians become Physicians under contract with Trusted and in accordance with Trusted's policies and procedures; Trusted may impose monetary penalties on Facility for failure to meet such requirement. Except for Emergency Services, Facility shall not utilize a non-Participating Physician for Facility-based physician services, including, but not limited to, emergency medicine, anesthesiology, radiology and pathology services, without the express written approval of Trusted's medical director or his/her designee. In the event a Member needs Facility-based physician services and a Participating Physician is not available, Facility shall contact Trusted's Utilization Management Program to obtain authorization for such services by a non-Participating Physician

c. **STANDARDS** - Facility shall provide Covered Services and arrange Facility-based physician services in accordance with generally accepted standards of medical practice and the standards established by the Trusted Quality Management Program. Facility shall ensure that its staff, including its Facility-based physicians, maintain a competent level of experience and training. Facility shall also comply with any corrective action plan established by Trusted related to the provision or failure to provide Covered Services and Facility-based physician services. Facility agrees to maintain and demonstrate to Trusted upon request, throughout the term of this Agreement, compliance with the following:

   i. Licensure as appropriate under the laws of the state in which it is located.

   ii. The quality-related standards of Trusted, by providing, upon request, information concerning Facility's malpractice and general liability insurance, medical staff, and clinical privileges. Facility shall make best efforts to immediately notify Trusted in writing of any adverse decision of a regulatory body or other governmental entity, or the JCAHO or a successor organization, with respect to Facility or of any other situation which would materially affect Facility's ability to carry out its duties and obligations under this Agreement. Facility shall cooperate with any quality performance audit, including but not limited to credentialing of Facility-based physicians, which may be held by Trusted annually to validate Facility's compliance with JCAHO standards and Trusted's policies and procedures.

d. **NCQA** - Facility shall implement all activities reasonably necessary to assist Trusted to obtain external accreditation by the National Committee for Quality Assurance ("NCQA") or any other accreditation organization recognized by HMOs and selected by Trusted including, but not limited to, cooperating in the auditing of Members' medical records.

e. **ADMISSION/DISCHARGE PROCEDURES**

i. Non-emergency Procedures - Except in case of an emergency, Facility agrees to admit Members to Facility only upon: (i) initiation of such admission by a PCP or Specialist Physician who has medical staff membership and admitting privileges at Facility; and (ii) obtaining verbal or written authorization from Trusted's Utilization Management department prior to admission, including certification of the Covered Services and authorization of the number of inpatient days under the Utilization Management Program. In the event authorization, in either verbal or written form, is not received from Trusted prior to an admission, Trusted reserves the right to deny Facility claims for which an authorization was required but Facility failed to obtain an authorization from Trusted. During any inpatient stay at Facility, Facility agrees that it will provide requested documentation for concurrent reviews by Trusted.

ii. Facility will admit Members in accordance with its normal and customary admissions policy and criteria and subject to bed and staff availability, and Facility shall only admit those Members for whom it reasonably believes in its sole discretion that it can properly serve. Trusted shall not retroactively deny payment for Covered Services rendered to Members whom Facility has confirmed as eligible using Trusted's designated verification mechanism and have received prior authorization. At the time of admission, Facility will provide the Member with a written statement or admission agreement describing the services provided by Facility and the related charges, including payment responsibilities of the Member that are consistent with restrictions under Federal and State law. Nothing in this Agreement shall preclude Facility from lawfully refusing to provide services to a Member, as long as the basis for the refusal is the same as that applied to Facility's other residents and patients.

iii. Trusted shall be responsible for payment pursuant to the terms and conditions of this Agreement for authorized Covered Services rendered to a Member who is admitted in accordance with the above-described procedures for the duration of the Facility stay, even if termination of the Member's enrollment is effective during the Facility stay.

iv. Verification of Membership - Trusted will provide Facility with the ability to verify eligibility of the Members who have been referred to it, including issuing each Member an identification card. Except for Emergency Services, Facility shall request and examine the Trusted identification of the person seeking admission as a Member. If Trusted does not provide verification services on a 24-hours a day/7-day per week basis, Facility shall be entitled to rely on the

information printed on the Member's identification card as conclusive evidence of such Member's eligibility. In the event that the person representing himself or herself as a Member does not have Trusted identification, Facility shall contact Trusted by telephone for verification before denying such person admission as a Member. Facility agrees that in an Emergency, it will follow the foregoing procedures as soon as practicable.

v. Acceptance of Pre-Admission Testing – Trusted, at its option, may elect to arrange for pre-admission diagnostic testing for any elective admissions to Facility. Facility shall accept the results of diagnostic tests performed in accordance with Trusted's arrangements provided that: (i) diagnostic test results are provided to Facility at the time of Member's admission; (ii) test results are reported in a format mutually acceptable to Trusted and Facility; (iii) for diagnostic laboratory tests performed, test results shall be acceptable only if the Facility that performed the tests is certified under the federal Clinical Laboratory Improvement Act, as amended; and (iv) the diagnostic tests to be utilized shall be performed within the time frames established by the rules and regulations of Facility's medical staff, which rules shall not unduly impede use of pre-admission tests. Facility shall not require duplicate tests or procedures be performed or charged to Trusted after the Member is admitted, unless ordered by a Specialist or PCP.

vi. Discharge - Facility may transfer or discharge a Member only as permitted by Federal or State law. Trusted shall be responsible for payment during the period a Member resides in Facility after Facility has concluded that the Member should be discharged, but Federal or State laws do not allow discharge, except that during such period, Trusted will not reimburse Facility at an acute inpatient level. During this period, Trusted shall be responsible for locating a new placement for such Member, if necessary.

f. **HEALTH CARE ACQUIRED CONDITIONS** - Trusted will not reimburse Facility for procedures relating to the following Health Care Acquired Conditions ("HCAC"), identified in the Affordable Care Act of 2010, Public Law 111-148, when any of the following conditions are not present upon admission in any inpatient setting, but subsequently acquired in that setting:

i. Foreign object retained after surgery;

ii. Air embolism;

iii. Blood incompatibility;

iv. Catheter associated urinary tract infection;

v. Pressure ulcers (decubitus ulcers);

vi. Vascular catheter associated infection;

vii. Mediastinitis After Coronary Artery Bypass Graft ("CABG");

viii. Facility-acquired injuries (fractures, dislocations, intracranial injury, crushing injury, burn or other unspecified effects of external causes);

ix. Manifestations of poor glycemic control;

x. Surgical site infection following certain orthopedic procedures;

xi. Surgical site infection following bariatric surgery for obesity; and

xii. Deep vein thrombosis and pulmonary embolism following certain orthopedic procedures except for pediatric (individuals under the age of 21 years) and obstetric populations.

g. **NEVER EVENTS** - Trusted will not reimburse Facility for any of the following Never Event in any inpatient or outpatient setting:

i. Surgery performed on the wrong body part;

ii. Surgery performed on the wrong patient; and

iii. Wrong surgical procedure performed on a patient.

h. **INSURANCE** - Facility shall maintain, by purchase of a policy or through self-insurance, throughout the term of this Agreement, general liability insurance in the minimum amounts of $1,000,000.00 million for each occurrence and $2,000,000.00 million in the aggregate. In the event Facility procures a "claims made" policy as distinguished from an occurrence policy, Facility shall procure and maintain prior to termination of such insurance, continuing "tail" coverage. Facility shall make best efforts to immediately notify Trusted of any material changes in insurance coverage or self-insurance arrangements and shall provide a certificate of insurance coverage to Trusted upon Trusted's request. Trusted agrees to maintain professional liability insurance with comparable limits to the coverage of Facility.

i. **COLLECTION OF CHARGES FROM MEMBERS** - Facility hereby agrees that in no event, including, but not limited to nonpayment by Trusted, insolvency of Trusted, or breach of this Agreement, shall Facility bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against Members (including subscribers) or persons other than Trusted for Covered Services provided pursuant to this Agreement. This provision shall not prohibit the collection of any applicable copayments or deductibles from Members billed in accordance with the terms of the applicable subscriber agreement or the health plan documents offered in a Trusted Health Product or for non-covered services in accordance with Section 3(r) below. Facility further agrees that (i) this provision shall survive the termination of this Agreement regardless of the cause giving rise to such termination and shall be construed to be for the benefit of Trusted's Members (including subscribers) and that (ii) this provision supersedes any oral or written agreement to the contrary now existing or

hereafter entered into between Facility and the Member (including subscribers) or persons acting on Member's behalf, insofar as such contrary agreement relates to liability for payment for, or continuation of Covered Services, pursuant to this Section 3(i) and Section 8(e) of this Agreement.

j. **ADMINISTRATIVE GUIDELINES** - Facility agrees to perform its duties under this Agreement in a manner consistent with the reasonable administrative guidelines provided by Trusted in its Provider Manual, which has been provided to Facility. Modifications of Trusted's Provider are not, and shall not be deemed to be amendments to this Agreement. In the event of conflict between Trusted's Provider Manual and this Agreement, the terms of this Agreement shall prevail. Trusted shall provide Facility with thirty (30) days advance notice of any material changes to its Provider Manual, unless such change is required by law or regulation to take place sooner.

k. **QUALITY MANAGEMENT AND UTILIZATION MANAGEMENT PROGRAMS** – Subject to Facility's right to appeal any adverse decision, Facility agrees to use its best efforts to participate in the Utilization Management and Quality Management Programs adopted by Trusted. These programs shall include, among other things, pre-admission certification and concurrent and retrospective review. Facility agrees to cooperate with and participate in telephonic utilization management conducted by Trusted. Facility shall comply with all final determinations rendered by the Utilization Management and Quality Management Programs subject to Facility's right to appeal any such final determination. Final determinations may include monetary or other sanctions against Facility as provided for in Trusted's Provider Manual. Approval by Trusted's Utilization Management department of a particular admission or other Covered Service for a Member does not automatically include approval and verification by Trusted of that Member's eligibility. Facility must separately request verification of a Member's eligibility from Trusted. Facility shall cooperate and comply with all reasonable aspects of Trusted's fraud, waste, and abuse efforts and its grievance system, as well as the reporting of clinical encounter data and other Trusted policies and procedures. Facility agrees that Trusted may amend such programs, policies and procedures from time to time with fifteen (15) days prior written notice.

   i. **REPORTABLE EVENTS** – Facility will report certain events in accordance with Trusted's **Sentinel Event Policy**, which will be distributed to Facility and is incorporated in the Provider manual. Any changes in the reporting requirements will be communicated through distribution of a revised Sentinel Event Policy. At a minimum, designated events must be reported as soon as possible after event identification and/or patient stabilization.

   ii. **REPORTABLE HEALTH CONDITIONS AMONG MEMBERS** – Facility shall report specific conditions and diseases in accordance with DC Code 7-131, 132 (2006) and Title 22 of the DC Code of Municipal Regulations. Trusted shall ensure that a copy of these reports are forwarded to the District of Columbia Department of Health Medical Assistance Administration (MAA) if Trusted is permitted to share this data.

   iii. **MEMBERS WITH EVIDENCE OF DEVELOPMENTAL DELAY** -

If applicable, Facility must report to Trusted, infants, toddlers and school-age children experiencing developmental delay. Facility shall send to Trusted information on DC Healthy Families and Health Care Alliance Program Members who are infants, toddlers, and school-age children, whose developmental assessment components of their EPSDT periodic or interperiodic exams reveal evidence of developmental delay.

iv. **SEXUALLY TRANSMITTED AND OTHER COMMUNICABLE DISEASES** – Facility shall report to Trusted information and or data on members with sexually transmitted and other communicable diseases, including HIV.

v. **TUBERCULOSIS** – Facility shall report within twenty-four (24) hours to Trusted, information on members suspected of being infected with tuberculosis.

vi. **LEAD SCREENING AND REPORTING** - In accordance with the District's Childhood Lead Poisoning Screening and Reporting Legislative Review Emergency Act of 2002, DC Code 7-871.03 (2006), Facility shall report results of all blood lead screening tests to MAA, the DC Department of Health, Childhood Lead Poisoning Prevention Program, and to Trusted within seventy-two (72) hours after identification.

vii. **DISTRICT OF COLUMBIA REGISTRIES AND PROGRAMS** – Facility and Trusted shall comply with reporting requirements of the District of Columbia registries and programs, including, but not limited to, the Cancer Control Registry and EPSDT Registry.

l. **BUSINESS TRANSACTION DISCLOSURES** - Facility must adhere to the following disclosure requirements:

i. Within thirty-five (35) days upon request of DHCF or the Secretary of HHS, Facility must disclose the business transaction information identified in 42 C.F.R. § 455.105, including:

1. The ownership of any independent contractor with whom Facility has had business transactions totaling more than twenty-five thousand dollars ($25,000.00) during the twelve (12) month period ending on the date of the request.

2. Any significant business transactions between the Facility and any wholly owned supplier during the five (5) year period ending on the date of the request.

3. Any significant business transaction between the Facility and any independent contractor during the five (5) year period ending on the date of the request.

ii. At any time upon request by Trusted or DHCF, Facility must disclose:

1. The identity of any person who has ownership or a controlling interest in Facility who has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or the Title XX services program since the inception of those programs; and

2. The identity of any person who is an agent or managing employee of Facility who has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or the Title XX services program since the inception of those programs.

m. **MARKETING** - Facility shall adhere to the below marketing conditions:

i. Any marketing information distributed by Facility directed at Trusted's Members shall be limited to general information about Trusted and notification that Facility participates in Trusted's network. Any such materials must be submitted to Trusted for review and approval prior to distribution to Members (Trusted will ultimately submit such materials to DHCF for review and approval).

ii. Facility will not utilize written information that is false or misleading in any material respect, including information regarding the Facility's network, the availability of services, the Facility's qualifications, hours, and location of services.

iii. Facility shall not host marketing events within the Facility's facility.

iv. Facility shall not offer to Members gifts of more than a de minimus value or other insurance products designed to induce persons to enroll in Trusted.

v. Facility shall not enter into compensation agreements with marketing personnel that utilize any type of payment structure in which compensation is tied to the number (or classes) of persons who enroll in Trusted.

n. **GRIEVANCE AND COMPLAINT PROCESS** - Facility agrees to participate in and cooperate with Trusted's Member grievance and complaint procedures, as set forth in Trusted's Provider Manual, and immediately notify Trusted of any Member complaints against Facility. Facility agrees to comply with all final determinations rendered in accordance with Trusted's Member grievance and complaint procedures.

o. **UTILIZATION OF SERVICES** - Facility understands that nothing in this Agreement shall require Members to utilize Facility or guarantee any minimum volume of Covered Services.

p. **DISCLOSURE OF INFORMATION** - Trusted may use Facility's name, address and telephone number in Trusted materials, including Trusted's provider directory. Facility may provide written notice that Facility is a Participating Facility. In the event Facility

wants to use Trusted's name in any other context or for any other purpose other than general administrative purposes as specified by Trusted, Facility shall obtain the prior written consent of Trusted, which consent shall not be unreasonably withheld. In the event Trusted wants to use Facility's name in any other context or for any other purpose, Trusted shall obtain the prior written consent of Facility, which consent shall not be unreasonably withheld.

q. **NONDISCRIMINATION** – Subject to bed availability, acuity, staffing, and adherence to skilled nursing facility criteria, Facility agrees that it will provide Covered Services without regard to race, color, gender, creed, religion, age, national origin, ancestry, marital status, sexual orientation, political affiliation, personal appearance, physical or mental disability, family responsibilities, income, Medicaid or Medicare status, political affiliation, religion, place of residence, marital status, health status, lawful occupation, source of payment, handicap, membership in Trusted, or frequency of utilization of Covered Services. Facility's hours of operation for Medicaid, DCHFP, Alliance, and Medicare Advantage participants will be the same as operating hours for other lines of business.

r. **BILLING FOR NON-COVERED SERVICES** - If any services provided by Facility are not Covered Services, Facility may bill Members at a rate not in excess of the rate which it bills the general public after first notifying the Member in writing in advance of rendering the service that the service is not covered and obtaining the Member's written consent to be billed. Facility agrees to provide Trusted with such documentation upon request. Facility shall, in no event, charge Trusted or the Member for any Covered Services which are not Medically Necessary. Prior to billing Members for non-Covered Services, Facility agrees to verify with Trusted that the claim is the Member's responsibility.

s. **TRUSTED HEALTH PRODUCTS** - Trusted has identified in the Attachments to this Agreement those Trusted Health Products in which Facility shall participate as a result of this Agreement. Facility shall acknowledge its participation in each Trusted Health Product and agree to be bound by the terms and conditions of such Trusted Health Product upon execution of this Agreement and upon execution of the cover sheet of each Trusted Health Product attachment. Trusted may modify the list of Trusted Health Products in which Facility is participating upon at least sixty (60) days prior written notice to Facility. Facility shall agree to participate in additional Trusted Health Products by executing the relevant cover sheet for the Trusted Health Product and returning it to Trusted within thirty (30) days after the date of notice from Trusted. Facility may object to participating in those additional Trusted Health Products by sending written notice to Trusted within thirty (30) days after the date of notice from Trusted.

t. **PROHIBITED INTERFERENCE WITH ENROLLMENT RELATIONSHIPS OF MEMBERS** - Notwithstanding any provision or understanding to the contrary, Facility acknowledges that Trusted has the sole proprietary interest in enrolling Members in the Trusted Health Product. Facility agrees and warrants that under no circumstances will Facility or any Facility employee or Facility-based physician solicit, influence, persuade, or advise any Member of Trusted to dis-enroll or to join: (i) another health maintenance

organization, including a health maintenance organization in which Facility has an ownership interest; (ii) another managed care plan; (iii) a case management arrangement; or (iv) any other similar arrangement, including any other arrangement in which Facility has an ownership interest (collectively referred to as "Alternative Care Plan"). To ensure compliance with this Section 3(t), Trusted may, in its sole discretion: (i) conduct a thorough investigation, in Trusted's reasonable judgment; (ii) find evidence of referral(s) by Facility to Alternative Care Plans; and (iii) provide Facility an opportunity to respond to Trusted's findings. A breach of this Section 3(t) constitutes a material breach of this Agreement and is grounds for immediate termination of this Agreement.

u. **COMMUNICATIONS WITH MEMBERS** - Facility agrees to make best efforts to communicate in an effective manner with all Members. Notwithstanding the foregoing, nothing in this Agreement shall limit the rights of Facility to: (i) communicate with Members regarding medical treatment options; (ii) recommend a course of treatment to a Member, even if the course of treatment is not covered, or approved, by Trusted; (iii) file an appeal or complaint pursuant to the procedures of Trusted; (iv) supply accurate, relevant factual information to a Member in connection with an appeal or complaint filed by such Member; or (v) object to policies, procedures, or decisions made by Trusted. The obligations set forth in this Section 3(u) shall survive termination of this Agreement. This provision is not intended to preclude Facility from discussing with Members any medical information relevant to a Member's health, including, but not limited to, discussing medical treatment options with Members or providing information related to a Member's medical condition.

v. **NOTICE OF OPERATIONAL CHANGES** - Facility shall provide Trusted with at least thirty (30) days prior written notice of any material changes in Facility's location, address, range of services, telephone numbers and other relevant information relating to Facility's operations. Facility shall also be responsible for providing notice of such changes to Members on or before the effective date of such changes.

w. **AMERICANS WITH DISABILITIES ACT REQUIREMENTS** – Facility shall be in compliance with the requirements of the Americans with Disabilities Act, (ADA) 42 U.S.C. Section 12101 et seq., and Section 504 of the Rehabilitation Act of 1973, 29 U.S.C. Section 794.

x. **ADVANCE DIRECTIVES** - Facility shall comply with the following advanced directives:

   i. Not discriminate against a Medicare or Medicaid Member on the basis of whether the Member has executed an advance directive;

   ii. Comply with District of Columbia law (whether statutory or recognized by the courts of competent jurisdiction) on advance directives; and

   iii. Cooperate with Trusted's educational efforts regarding advance directives.

4 **RELATIONSHIPS WITH EXCLUDED PARTIES** – Pursuant to 42 CFR §438.610, Facility

hereby represents and warrants that:

a. Facility is certified to participate in the Medicaid and Medicare programs;

b. Facility participates in the Medicaid and Medicare programs;

c. Neither Facility nor any employee, agent, or subcontractor of Facility, is excluded under Title XIX of the Social Security Act from participation in Medicaid, Medicare, or any other government program and will advise agents and subcontractors of this provision and its requirements;

d. Facility will immediately report to Trusted if Facility or any employee, agent, or subcontractor of Facility becomes excluded or debarred from participating in Medicaid, Medicare, or any other government program; and

e. Facility will review or cause to be reviewed the HHS OIG, the GSA Excluded Parties List, and the DC Excluded Parities List upon employment or contracting with any individual or entity and annually thereafter and shall immediately terminate from employment or contract any individual or entity that has been excluded.

5 DUTIES OF TRUSTED

a. **ADMINISTRATION** - Trusted shall provide all administrative services under this Agreement, including quality management, utilization management, budgeting, administration of claims from Providers other than Facility, coordination of benefits, funds management and compliance with all Federal and State regulatory requirements. Trusted shall provide Facility with Trusted's administrative policies and procedures applicable to various Trusted Health Products. Trusted also shall provide notice to Facility of any significant changes in Trusted's policies and procedures. Trusted shall also provide notice to Facility of any significant changes within 30 days written notice

b. **BENEFIT INFORMATION** - Trusted shall apprise Facility and all Members concerning the type, scope, and duration of benefits and services to which Members are entitled under the Trusted Health Products. Under all circumstances, Trusted shall retain final authority regarding coverage or benefit determinations for its Members.

c. **ASSISTANCE TO FACILITY** - Trusted agrees to assist Facility in the development and initial implementation of procedures necessary to carry out the terms of this Agreement.

d. **PAYMENT OF CLAIMS** - Facility agrees to submit claims to Trusted in a form and manner acceptable to Trusted, as specified from time to time, and will be in a HIPAA compliant format, or as otherwise required by law. Facility will submit any and all claims to Trusted within one-hundred eighty (180) days of the date of discharge, for inpatient Covered Services, and within one-hundred eighty (180) days after the date Covered Services are rendered, for outpatient Covered Services. Trusted reserves the right to deny claims that are not submitted within such one-hundred eighty (180) day period, except where Facility bills a third party payor as primary. For inpatient

admissions, Facility must make available the discharge summary or additional medical information if required by Trusted's Utilization Management Program in order to approve claims. Facility agrees to use best efforts to refrain from duplicate billing any claims submitted to Trusted, unless expressly approved by Trusted in order to process coordination of benefit claims. Trusted shall provide payment to Facility within thirty (30) days of Trusted's receipt of an uncontested claim from Facility, or other specified timeframes as may be required by the District of Columbia Insurance Administration or if additional information is needed. Facility must submit a request for appeal of an adverse claims determination made by Trusted within ninety (90)days after the date of Trusted's written notice. Trusted may deny appeals that are not submitted within ninety (90) days of the date of Trusted's written notice. For claims pended by Trusted for medical or administrative review, Trusted will provide payment for approved Covered Services within thirty (30) working days of receipt of the requested medical information or medical record from Facility.

6 COMPENSATION

a. **PAYMENTS** - Trusted shall provide compensation to Facility as set forth in the appropriate Trusted Health Product attachments to this Agreement, which shall be full compensation for Facility's responsibilities described herein, except for applicable co-payments including deductibles or coinsurance, as provided under Section 3(i). Facility's failure to follow the policies and procedures of Trusted as set forth in this Agreement and the Provider Manual may result in a denial of payment. Facility shall submit claims in accordance with industry standards. Trusted reserves the right to conduct audits related to payments when reasonably necessary. Such audits will include, but not be limited to, medical records, emergency room notes and non-allowable charges. To the extent DHCF or the Centers for Medicare and Medicaid Services ("CMS") reduces payment to Trusted under any Trusted Health Product, Trusted may notify Facility in writing of such reduction and both parties agree to negotiate in good-faith a revised fee schedule. If the parties are unable to agree upon a revised fee schedule within sixty (60) days of Trusted's notice of reduction to Facility, Trusted reserves the right to terminate this Agreement under Section 8 below.

b. **COLLECTION OF CHARGES FROM THIRD PARTIES** - Facility accepts payment from Trusted, together with authorized co-payments, as provided herein, as full payment for Covered Services, and shall not pursue or collect charges for such services from Members or other third parties, except where authorized under Sections 3(i) and 3(r) of this Agreement. However, Facility agrees to cooperate and use best efforts in the effective implementation of any coordination of benefits procedures and other procedures for handling third party claims, as set forth in Trusted's Provider Manual, including collecting information from Members regarding other health insurance coverage. In the event Facility receives payment for Covered Services from third parties, it shall promptly make appropriate adjustments due Trusted. Facility shall be responsible for and implement a system for notifying Trusted of any claims by Members involving coordination of benefits. In any case where a Member admitted to Facility has primary coverage from any third party payor, and Facility has reason to know of a primary payor other than Trusted, Facility shall bill the third party payor and notify Trusted of the existence of any primary payor source at the time that Facility submits a

claim to Trusted.

c. **REFUNDS** - Facility shall make best efforts to immediately refund to Members any and all sums collected by Facility from Members which should not have been collected under the terms of this Agreement. Such refunds shall take the form of payments by check from Facility to Members. Facility shall provide Trusted notice of all refunds issued to Members no more than two (2) weeks after such issuance. Notice for the purposes of this Section 6(c) shall include, without limitation, the Members' names, refund amounts per Member, and the date paid.

7 **TERM OF AGREEMENT** - This Agreement shall remain in effect for One (1) year ("Initial Term") from the Effective Date and is automatically renewable for one-year terms ("Renewal Term"), except that either party terminates this Agreement during the Initial Term or any Renewal Term with written notice no later than ninety (90) days before the end of the then term. In no event, shall the term of this Agreement exceed a total of three (3) years.

8 **TERMINATION**

a. **TERMINATION WITHOUT CAUSE** - Trusted or Facility may terminate this Agreement without cause upon no less than ninety (90) days prior written notice to the other.

b. **TERMINATION OF AGREEMENT WITH MATERIAL CAUSE** - Trusted or Facility may terminate this Agreement for a material breach of its terms or provisions upon at least thirty (30) days written notice to the other party specifying the nature and the extent of the breach, except that either party will have the ability to cure the breach within such thirty (30)=day period. If such breach is cured within that thirty (30)-day notice period, the termination will be rescinded.

c. **IMMEDIATE TERMINATION** - This Agreement may be terminated immediately by Trusted in the event of: (i) the suspension or revocation of Facility's license; (ii) the imposition of sanctions or disciplinary action against Facility or against Facility officers and directors in their capacities with Facility by a state or federal licensing agency; (iii) revocation of any license, certification or accreditation required by Facility to perform its obligations under this Agreement; (iv) the violation of Sections 3(i), 3(q), 3(r), 3(t) or 4 of this Agreement; (v) the cancellation, termination or reduction of Facility's malpractice or general liability insurance coverage; or (vi) a determination by Trusted, based on reasonable evidence, that the health and well-being of Members is jeopardized as a result of continuation of this Agreement.

d. This Agreement shall terminate immediately in the event of the revocation by the District of Columbia or the United States government of any certification or license required by Trusted to perform its obligations under this Agreement; however, the loss or revocation of Trusted's certification from a state or federal agency in connection with a Medicaid or Medicare Health Plan offered by Trusted shall not automatically terminate this Agreement as it relates to any other Trusted Health Product offered by Trusted.

e. **REPAYMENT UPON TERMINATION** - Within one hundred and eighty (180) days following termination of this Agreement, an accounting shall be made of monies due and owing either party, and payment shall be forthcoming to settle such balance within thirty (30) days following such accounting.

f. **CONTINUING CARE RESPONSIBILITIES**

i. **Continuation of Care Upon Termination** - Facility shall continue to be responsible for providing Covered Services to Members who are inpatients at Facility as of the effective date of termination, until the earlier of: (i) Member's appropriate discharge from Facility, or (ii) Trusted's orderly transition of the Member's care to another Participating Facility. Payment for any continued Facility Services as described in this Section 8(f)(i) shall be at the rates set forth in the appropriate Attachment to this Agreement.

ii. **Continuation of Care Upon Cessation of Operations or Insolvency of Trusted** - If this Agreement terminates as the result of insolvency or the cessation of operations of Trusted, Facility shall continue to provide Covered Services to Members through the last day of the month for which Trusted received a capitation payment from the District of Columbia Department of Health Care Finance ("DHCF"), as well as to Members confined at Facility on the date of insolvency or other cessation of operations, until medically appropriate discharge from Facility.

iii. Facility agrees that the provisions of Section 8(f) and Facility's obligations herein shall survive the termination of this Agreement without regard to the cause for termination of the Agreement and shall be construed to be for the benefit of the Members.

9 RECORDS, DATA COLLECTION, AND RIGHT TO INSPECT RECORDS

a. **RECORDS** - Facility shall maintain and provide such records and information as are necessary for the proper administration of the Trusted Health Product and consistent with State and Federal law. At a minimum, Facility shall provide one copy of the emergency room, operating room, admission and discharge reports, and shall provide copies of records required for performance of quality management and utilization management/claims processing at no cost to Trusted. Trusted will provide Facility with at least ten (10) business day notice of record request. Facility shall permit utilization management personnel from Trusted to bring a portable copier on site for purposes of copying any additional records or information required by Trusted. Facility agrees that Trusted shall have no liability, separate or otherwise, to any copier service utilized by Facility to prepare copies for Trusted. The duties imposed by this Section 9 shall not terminate upon termination of this Agreement.

b. **ACCESS AND RIGHT TO INSPECT** - Trusted or its designee shall have the right to audit records maintained by Facility regarding claims submitted by Facility and

payments received by Facility from Trusted or its designee. Facility agrees to provide reasonable access to Facility facilities and records for inspections and audits by Trusted, DHCF, the D.C. Department of Health ("DOH"), the U.S. Department of Health and Human Services ("HHS"), CMS, the Office of the Inspector General ("OIG"), and their respective designees, and to cooperate with all audits and inspections to the same extent that audits and inspections may be required under law or under Trusted's contract with DHCF . In the event right of access is requested under this section, Facility shall, upon request, provide and make available staff to assist in the audit or inspection effort, and provide adequate space on the premises to reasonably accommodate the state or federal personnel conducting the audit or inspection effort. All inspections or audits shall be conducted in a manner as to not unduly interfere with the performance of Facility's activities.

c. **RECORDS** - Facility shall maintain adequate records relating to Covered Services provided to Members in such form and containing such information as mutually agreed to by Trusted and Facility, or by applicable state and federal law (and in accordance with usual and customary practices in the United States), including medical histories, records, and reports from providers of specialty physician services such as Facility-based physician services, discharge summaries, records of Emergency Services received by Members, and such other information as Trusted may require. Facility shall maintain all medical records relating to Members for the greater of seven (7) years or the length of time facilities are required to maintain patient records under applicable state law, which obligation shall not terminate upon termination of this Agreement. Facility shall agree to reimburse Trusted for any fine, penalty, costs or liabilities that Trusted incurs as a result of the failure of Facility to maintain records in accordance with this Section 9(c).

d. **CONFIDENTIALITY OF MEMBER RECORDS** - Facility shall implement and maintain procedures for maintaining and safeguarding the confidentiality of Member medical records and treatment in accordance with all State and Federal laws.

e. **HIPAA** - To comply with the Health Insurance Portability and Accountability Act of 1996 (Public Law 104-191, August 1996), both parties must comply with the following: All individually identifiable information relating to Medicare, Medicaid and DC Alliance enrollees must be kept confidential pursuant to 42 U.S.C. Section 1396a (a)(7), 42 CFR Part 2 and other regulations promulgated there under. Such information may be used by the Facility only for a purpose directly connected with performance of Facility's obligations under this program and this Agreement. The provisions of this section will survive the termination of Trusted's participation and/or Facility participation in the Medicare program or the Medicaid managed care program and will remain in effect as long as Facility maintains any individually identifiable information relating to Medicare, Medicaid and/or DC Alliance beneficiaries. Facility must ensure compliance with the Health Insurance Portability and Accountability Act of 1996 (Public Law 104191, August 21, 1996) and all applicable regulations promulgated there under. Such regulations include, but are not limited to, the medical privacy rule, 45 C.F.R. Parts 160 and 164, and the electronic transactions and code set standards rule, 45 C.F.R. Parts 160 and 162. Facility shall maintain written procedures for compliance with all applicable privacy, confidentiality, and information security requirements. Facility shall train its physicians, employees, and agents on the requirements for compliance with all

applicable privacy, confidentiality, and information security requirements.

10 APPLICABLE LAW; DISPUTE RESOLUTION

a. **APPLICABLE LAW** - This Agreement and the rights and obligations of the parties hereunder shall be construed, interpreted, and enforced in accordance with, and governed by, the laws of the District of Columbia and the United States of America. Any provisions required to be in this Agreement by state or federal law or regulation shall bind Trusted and Facility whether or not expressly provided in this Agreement. Notwithstanding the foregoing, this Agreement shall be automatically amended by Trusted, upon written notice to Facility, to comply with any applicable federal, state or local law or regulation, or any order or directive of any governmental agency.

b. **DISPUTE RESOLUTION** - If any dispute, controversy or claim arises out of, or is related to this Agreement, the parties shall first make their best efforts to resolve such dispute, controversy or claim informally. If it cannot be resolved informally, the parties agree to resolve the dispute through arbitration in accordance with the rules and procedures of JAMS/Endispute in Washington, D.C. for domestic disputes. Trusted and Facility shall each choose an arbitrator and the two arbitrators so chosen shall choose the third. If either Trusted or Facility fails to choose an arbitrator within 30 days after notice of commencement of arbitration or if the two arbitrators fail to choose a third arbitrator within 30 days after their appointment, JAMS/Endispute Washington D.C. shall, upon the request of any party to the dispute or difference, appoint the arbitrator or arbitrators to constitute or complete the panel as the case may be. Arbitration proceedings hereunder may be initiated by either Trusted or Facility making a written request to JAMS/Endispute, together with any appropriate filing fee, at the office of JAMS/Endispute Washington D.C. All arbitration proceedings or litigation (to the extent the remedy requested is not, by law, available through arbitration [e.g., injunctive relief]) relating to any claims or disputes arising under or relating to this Agreement shall be brought in the county in which the principal executive office of the party not initiating such action or proceeding (i.e. the defendant or responding party) is located. The parties irrevocably submit and consent to the exercise of subject matter jurisdiction and personal jurisdiction over each of the parties by the federal and/or state courts in such jurisdiction (the "Selected Jurisdiction"). The parties hereby irrevocably waive any and all objections that any party may now or hereafter have to the exercise of personal and subject matter jurisdiction in the Selected Jurisdiction and to the laying of venue of any such proceeding or action brought in the Selected Jurisdiction. Any order or determination of the arbitral tribunal shall be final and binding upon the parties to the arbitration and may be entered in any court having jurisdiction.

11 NOTICE

a. **NOTICE** - Any notice required to be given hereunder shall be in writing sent by facsimile transmission, or registered or certified mail, return receipt requested, or via Federal Express or other recognized overnight delivery service or by hand delivery, to either Trusted or Facility at the addresses listed below or at such other addresses as either Trusted or Facility may hereafter designate to the other:

To Trusted: Chika Duru
General Counsel
Trusted Health Plan (District of Columbia), Inc.
1100 New Jersey Ave, S.E.
Ste. 840
Washington, D.C. 20003
Fax No.: 202-821-1098

With a copy to: Kenny Greene,
Vice President Provider Relations
Trusted Health Plan (District of Columbia), Inc.
1100 New Jersey Ave, S.E.
Ste. 840
Washington, D.C. 20003
Fax No.: 202-821-1098

To Facility: [CONTACT & ADDRESS]

b. Any notice sent by registered or certified mail, return receipt requested, shall be deemed given on the date of delivery shown on the receipt card, or if no delivery date is shown, the postmark date. If any notice is transmitted by facsimile transmission or similar means, the notice shall be deemed served or delivered upon telephone confirmation of receipt of the transmission, provided a copy is also delivered via delivery or mail. Any notice sent by Federal Express or other nationally recognized overnight delivery service shall be deemed delivered the day following delivery to Federal Express or a nationally recognized overnight delivery service, with proof of delivery.

12 MISCELLANEOUS

a. **CONFIDENTIAL AND PROPRIETARY INFORMATION** - Facility agrees to maintain confidential (the "Confidential Information"): (i) this Agreement; (ii) eligibility lists and any other information containing the names, addresses and telephone numbers of Members, including Members' Protected Health Information ("PHI"); (iii) Trusted's administrative service manuals and all forms related thereto; (iv) Trusted Health Product contracts and the information contained therein; (v) the financial arrangements between Trusted and any Trusted contracting Provider; (vi) Trusted's operational procedures and work processes; and (vi) any other information that due to its nature or the circumstances surrounding the disclosure of the information, would be considered confidential or proprietary by a reasonable person.. Facility shall not disclose or use the Confidential Information for its own benefit or gain either during the term of this Agreement or after the date of termination of this Agreement. Facility may use the Confidential Information to the extent necessary to perform its duties under this Agreement or upon express prior written permission of Trusted. Upon the effective date of termination of this Agreement, Facility shall promptly return to Trusted the Confidential Information in its possession. In the event of a breach or threatened breach of this Section 12(a) by Facility, Trusted shall have the right of specific performance and injunctive relief in addition to any and all other remedies and rights at law or in equity,

and such rights and remedies shall be cumulative. Trusted agrees to maintain same confidentiality standards regarding this agreement.

b. **ASSIGNMENT** - This Agreement shall not be assigned by Facility without the prior written consent of Trusted. Trusted may assign this Agreement and its rights, interests and benefits hereunder to any entity which has at least majority control of Trusted or any entity of which Trusted has at least majority control. Trusted will notify the Facility no less than sixty (60) days before any assignment hereunder. If required, any assignment or delegation of this Agreement shall be void unless prior written approval is obtained from the appropriate state or federal agencies.

c. **INVALIDITY OF SECTIONS** - If any provision of this Agreement shall be held by a court of competent jurisdiction to be contrary to law, that provision will be enforced to the maximum extent permissible, and the remaining provisions of this Agreement will remain in full force and effect, unless to do so would result in either party not receiving the benefit of its bargain.

d. **ATTORNEY'S FEES** - If any action at law or suit in equity is brought to enforce or interpret the provisions of this Agreement or to collect any monies due hereunder, the prevailing party shall be entitled to reasonable attorneys' fees and reasonable costs, together with interest thereon at the highest rate provided by law, in addition to any and all other relief to which it may otherwise be entitled.

e. **AMENDMENT** - Trusted may amend this Agreement immediately upon written notice to Facility in the event such amendment is required to maintain compliance with applicable state or federal laws. Other amendments to the Agreement shall be effective only upon mutual, written agreement of the parties.

f. **INCORPORATION OF ATTACHMENTS AND EXHIBITS** - This Agreement along with its Attachments constitutes the entire agreement between the parties regarding the subject matter herein. In addition, all Attachments to this Agreement are considered part of this Agreement and are hereby incorporated herein. Whenever there is variance between a term in the Agreement and a term in any Attachment to the Agreement, the term in the Attachment shall control, but only with respect to the particular Trusted Health Product referenced in the Attachment. No oral statements or prior written material not specifically incorporated herein shall be of any force and effect, and no modifications to the Agreement or any Attachments shall be recognized unless incorporated herein by amendment.

g. **FORCE MAJEURE** - Neither Facility nor Trusted shall be deemed to have breached this Agreement or be held liable for any failure or delay in the performance of all or any portion of its obligations under this Agreement if prevented from doing so by a cause or causes beyond its control. Without limiting the generality of the foregoing, such causes include acts of God or the public enemy, fires, floods, storms, earthquakes, riots, strikes, boycotts, lock-outs, wars, and war-operations, restraints of government, power or communication line failure or other circumstances beyond such party's reasonable control, or by reason of the judgment, ruling or order of any court or agency of competent jurisdiction subsequent to the execution of this Agreement.

h. **ENTIRE AGREEMENT**- This Agreement, including any exhibits and attachments hereto, constitutes the final and entire Agreement of the Parties, and supersedes all prior arrangements, understandings, and agreements, oral or written, among the Parties.

IN WITNESS WHEREOF, the parties hereto have executed this Agreement.

TRUSTED HEALTH PLAN

By:_____
Chika Duru
General Counsel

Date:_____

[FACILTIY NAME]

By:_____

Date:_____

SCHEDULE OF ATTACHMENTS

A. TRUSTED MEDICAID/HEALTHY FAMILIES PROGRAM PLAN COVER SHEET

B. COMPENSATION SCHEDULE FOR MEDICAID/HEALTHY FAMILIES PROGRAM

C. TRUSTED ALLIANCE COVER SHEET

D. COMPENSATION SCHEDULE FOR ALLIANCE

E. MEDICARE ADVANTAGE COVER SHEET

F. MEDICARE ADVANTAGE COMPENSATION SCHEDULE

ATTACHMENT A

TRUSTED MEDICAID PLAN

COVER SHEET

Upon execution of this cover sheet, Facility agrees to participate in the Trusted Medicaid/DC Healthy Families plan as set forth in this Attachment A, and shall be bound by and comply with the terms and conditions of the Trusted Medicaid/DC Healthy Families Plan.

AGREED TO:

_____

SIGNATURE

PRINT NAME: _____

TITLE: _____

PRINTED NAME OF FACILITY:

Date: _____

ATTACHMENT B

COMPENSATION SCHEDULE

FOR MEDICAID/HEALTHY FAMILIES PROGRAM MEMBERS

A. Payment for Medicaid Members

ATTACHMENT C

DC ALLIANCE NETWORK

COVER SHEET

Upon execution of this cover sheet, Facility agrees to participate in the Trusted's Health Care Alliance plan as set forth in this Attachment C, and shall be bound by and comply with the terms and conditions of the Trusted Health Care Alliance plan.

AGREED TO:

_____

SIGNATURE

PRINT NAME: _____

TITLE: _____

PRINTED NAME OF FACILITY:

Date: _____

ATTACHMENT D

COMPENSATION SCHEDULE

FOR ALLIANCE MEMBERS

A. Payment for Alliance Members

ATTACHMENT E

MEDICARE ADVANTAGE

COVER SHEET

Upon execution of this cover sheet, Facility agrees to participate in the Trusted Medicare Advantage plan as set forth in this Attachment E, and shall be bound by and comply with the terms and conditions of the Trusted Medicare Advantage plan.

AGREED TO:

_____

SIGNATURE

PRINT NAME: _____

TITLE: _____

PRINTED NAME OF FACILITY:

Date: _____

ATTACHMENT F

COMPENSATION SCHEDULE

MEDICARE ADVANTAGE

A. Payment for Medicare Advantage Members

SAMPLE

TRUSTED HEALTH PLAN, (DISTRICT OF COLUMBIA), INC.

PLAN/ PCP AGREEMENT

This Plan/PCP Agreement (this "**Agreement**") is made and entered into this _____ day of _____, 2015 between Trusted Health Plan (District of Columbia), Inc. ("**Plan**"), a Washington, DC corporation licensed as a health maintenance organization, whose business address is 1100 New Jersey Avenue, S.E., Suite 840, Washington, D.C., 20003, and [PCP NAME] ("**PCP**"), whose business address is [BUSINESS ADDRESS].

In consideration of their mutual covenants and promises contained in this Agreement, the parties agree as follows:

ARTICLE I: DEFINITIONS

For purposes of this Agreement and its exhibits, the following words and phrases shall have the following meanings:

i. "**Alliance**" means the District of Columbia Alliance program.

ii. "**Allied Health Professional**" means a qualified and licensed nurse practitioner, physician assistant, or nurse midwife who is employed by Provider, and has been accepted by Plan to provide certain Covered Services to Members hereunder.

iii. "**Clean Claim**" means a claim that has no defect, impropriety, lack of any required substantiating documentation or particular circumstance requiring special treatment that prevents timely payment.

iv. "**Covered Services**" means those properly authorized services that are covered by a Program and that Plan has committed to provide to Members under a Program/Plan Agreement.

v. "**Covering Physician**" means a contracted licensed physician of medicine or osteopathy who agrees to provide services to another contracted licensed physician's patients when that other physician is not available.

vi. "**DHCF Agreement**" means the Medicaid contract between the District of Columbia Department of Health Care Finance and Plan.

vii. "**DCHFP**" means the D.C. Healthy Family Program.

viii. "**Effective Date**" means the date the last party to this Agreement executes the Agreement.

ix. "**Emergency**" shall have the meaning defined for that term in a Program, and shall include the sudden onset of a medical condition that manifests itself by signs and symptoms of sufficient severity, including severe pain, such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: (a)

serious jeopardy to the health of the individual or, in the case of a pregnant woman, the health of the woman or her unborn child; (b) serious impairment to bodily functions; or (c) serious dysfunction of any bodily organ or part. Payment shall not be denied hereunder for services provided to a Member up to the point of stabilization of an Emergency because of the final diagnosis or because prior authorization was not given before such services were provided.

x. "**External Quality Review**" means a validation of performance/quality improvement measures and activities; compliance with local standards for access to care, structure and operations; and validation of consumer or provider surveys of quality of care.

xi. "**Government Program Fraud Control Unit**" means the D.C. Department of Health Care Finance Program Integrity Division and/or its authorized agent/s; the United States Department of Health and Human Services, the Office of Inspector General; the Centers for Medicare and Medicaid Services ("CMS"); the Federal Bureau of Investigation ("FBI"); the D.C. Medicaid Fraud Control Unit; or any other D.C., state, or federal agency with proper jurisdiction, charged with identifying, investigating, or prosecuting suspected fraud, waste, or abuse.

xii. **"Health Check"** means the well-child screen/visit required under EPSDT.

xiii. "**Member**" means any individual determined eligible for a Program who has enrolled or been enrolled with Plan for the provision of Covered Services.

xiv. "**Participating Hospital**" means a facility with an established contract with the Plan to provide Covered Services to Members.

xv. "**Provider Manual**" means a manual made available to PCP by Plan, which includes Plan's procedures and forms, requirements for record keeping and treating members, referral procedures, prior authorization requirements, appeal procedures, and information relating to benefits, co-payments, coordination of benefits, and other operational policies and procedures. Plan may make this manual (and any updates to this manual) available on line on its web site.

xvi. "**Primary Care Provider**" means a qualified and licensed participating physician, Allied Health Professional, or multi-specialty primary care practice who is engaged in the areas of Family Practice, Internal Medicine, Pediatrics or such other area as may be determined by Plan, has been accepted by Plan to provide Covered Services, and is selected by a Member to provide Primary Care Services.

xvii. "**Primary Care Services**" means those Covered Services customarily provided by a Primary Care Provider. Statements regarding the Covered Services under this Agreement are included herein at Exhibits A and B.

xviii. "**Program**" means any health coverage program offered through an employer, association or other entity, including government programs, where the municipality enters into a contract with Plan for the provision of Covered Services and any non-group health coverage program offered by Plan. The Programs applicable to this Agreement are listed under Exhibit E. Exhibit E may be amended by written notice from Plan to Provider of the addition of a new Program unless Provider elects in writing not to participate in such Program, and when necessary and applicable, shall be amended automatically to delete a specific Program(s) effective on the date the DHCF Agreement terminates

the relevant program.

xix. "**Referral Provider**" means a health care professional or provider who or which provides a Covered Service pursuant to authorization from a Primary Care Provider or Plan.

xx. "**Referral Service**" means a Covered Service which is prior authorized by a Primary Care Provider or Plan.

xxi. "**Regulatory Agencies**" means the Centers for Medicare and Medicaid Services, ("CMS"), the District of Columbia Department of Insurance, Securities, and Banking ("DISB") that has regulatory authority over Plan; the District of Columbia Department of Health Care Finance ("**DHCF**"), which oversees contractual compliance for the Medicaid Program; and any other governmental entities with regulatory authority over the Plan or any of its contractors or activities.

ARTICLE II: DUTIES AND OBLIGATIONS OF PCP

1. **Services**. PCP agrees to be responsible for supervising, coordinating, and providing all Primary Care Services to each assigned Member, to provide or refer Members to other providers or healthcare professionals who have been accepted by Plan to provide services to Members (whether or not such other providers or healthcare professionals are employed by PCP) for Covered Services as medically necessary and appropriate, and to verify the eligibility of Members at the time Covered Services are provided. PCP will not deny Covered Services to Members.

2. **Participation Status and Compliance**. PCP warrants that it and each Allied Health Professional, is a participant in good standing in the Medicare and Medicaid Programs, will maintain this goo standing during the term of this agreement, and has not been convicted of a felony or suspended from participating in Medicare and/or Medicaid. PCP agrees to comply with all policies of any Program covered under this Agreement. If for any reason, PCP receives notice of any sanction or proposed sanction from a Program (including, but not limited to, Medicare or Medicaid) relating to itself or any Allied Health Professional, PCP agrees to notify Plan within ten (10) business days, and PCP agrees to discontinue providing Covered Services under this Agreement or discontinue any Allied Health Professional's provision of Covered Services provided hereunder.

3. **Rules and Regulations**. PCP agrees to comply with all federal, district and local laws, rules and regulations, medical laws, and CMS instructions applicable to the provision of Covered Services and with all state laws requiring health care professionals to comply with reporting requirements for communicable diseases and other health indicators. PCP agrees to comply with all applicable rules, regulations, policies and procedures as set forth in the Provider Manual, and all requirements under any contracts between Plan and any Program that are applicable to Plan's subcontractors, including, but not limited to, cooperating with and complying with Plan's fraud, waste, and abuse efforts; quality improvement programs activities, grievance procedures; appeal procedures; and utilization review activities. All health professionals and laboratories providing services under this Agreement pursuant to an employment or other arrangement with PCP shall be licensed and/or certified as required by law and shall also be required to be in compliance with the requirements of this Agreement.

4. PCP and all other PCPs (where PCP is a group practice or is otherwise executing this Agreement on behalf of individual providers) providing services under this Agreement shall maintain at all times: (a) a valid District of Columbia license to practice allopathic or osteopathic medicine and surgery or, if appropriate with respect to the services to be rendered, a valid license for another health profession; (b) adequate liability and malpractice insurance coverage of a type and with limits satisfactory to Plan; (c) a current Drug Enforcement Agency registration and District of Columbia Controlled Substance License; (d) admitting privileges to at least one licensed, accredited acute care hospital within Plan's service area, unless the PCP is a physician of the type of clinical specialty which does not customarily have admitting privileges or this requirement is otherwise waived in writing by Plan; (e) unless the PCP is a general practitioner, board certification or board qualification in his or her practice specialty; and (f) the authority to participate in Medicare, Medicaid and any other government program with which Plan participates and that are applicable to this Agreement. PCP shall notify Plan in writing within two (2) days of the loss, termination, cancellation, restriction, sanction or other final disciplinary action with respect to any of the foregoing. PCP shall furnish evidence of the foregoing upon request of Plan at any time during the term of this Agreement. PCP agrees to participate in Plan's credentialing and re-credentialing processes and programs for quality improvement, utilization review and peer review. PCP acknowledges and agrees that Plan retains the right to establish additional requirements to comply with Plan's obligations under the DHCF Agreement and as Plan otherwise reasonably determines to be necessary, and agrees to carry out any obligations required of PCPs under the terms of the DHCF Agreement, pertinent parts of which are available from Plan.

5. **Allied Health Professional Obligations**. All Allied Health Professionals providing services under this Agreement shall be treated as PCPs for the purposes of this Agreement (including the assignment of Members and participation in Plan's credentialing and re-credentialing processes and programs for quality improvement, utilization review and peer review), except that where applicable, an Allied Health Professional's authority to provide services under this Agreement shall be directly tied to his/her supervising physician as described below. In addition, all Allied Health Professionals providing services under this Agreement shall maintain at all times: (a) a valid District of Columbia license to practice within the scope of their profession; (b) adequate liability and malpractice insurance coverage of a type and with limits satisfactory to Plan; (c) a current Drug Enforcement Agency registration; and (d) the authority to participate in Medicare, Medicaid and any other Programs with which Plan participates and that are applicable to this Agreement. PCP shall notify Plan in writing within two (2) days of the loss, termination, cancellation, restriction, sanction or other final disciplinary action with respect to any of the foregoing. PCP shall furnish evidence of the foregoing upon request of Plan at any time during the term of this Agreement. PCP shall ensure that all services provided by Allied Health Professionals hereunder are within the scope of license held by, and the authority delegated to, such practitioners. No Allied Health Professional is authorized to provide services hereunder, and Plan shall have no obligation to pay for services provided by an Allied Health Professional, unless he/she is supervised (in accordance with all applicable laws, regulations and Program requirements) by the relevant PCP. All services provided by Allied Health Professionals hereunder shall be billed by PCP or its designee under PCP's federal tax identification number (also known as an employer identification number or EIN).

6. **Independent Contractors.** The relationship between Plan and PCP is an independent contractor relationship. Neither PCP nor any employees or agents of PCP are employees, or agents of Plan and neither Plan, nor any employee or agent of Plan is an employee, or agent of PCP. As such, all medical decisions regarding Primary Care Services are rendered solely by PCP and not by Plan.

None of the provisions of this Agreement shall be construed to create a relationship of agency, representation, joint venture, ownership, control, or employment between the parties.

7. PCP agrees to provide on a twenty-four (24) hours a day, seven (7) days a week basis, Primary Care Services to Members who are assigned or have designated PCP as their primary provider of care. PCP shall meet or exceed Plan's access standards as set out in the Provider Manual. PCP shall be responsible for determining whether Members are eligible for Primary Care Services on the basis of the most current eligibility list issued for the month in which services are being furnished. PCP agrees that the average waiting time in PCP's office for an appointment scheduled by a Member shall be no greater than thirty (30) minutes.

8. PCP shall make arrangements for coverage by a covering physician whenever PCP is unavailable. PCP may not utilize a non-participating Physician as a covering physician without the express written approval of Plan's medical director. PCP shall be responsible for compensation payments to the covering physician and any non-participating physicians. PCP shall also cooperate with any afterhours triage program established by Plan.

9. In the event a Member assigned to PCP misses a scheduled appointment, PCP shall contact the Member to schedule a new appointment and to inquire as to the reason for his or her failure to appear. Further, PCP shall document such missed appointments. In the event PCP is unable to contact the Member or in the event a Member repeatedly misses scheduled appointments, PCP shall notify Plan's utilization management department and member services departments.

10. PCP shall arrange for Members, Referral Services to Specialists, Participating Hospitals, and ancillary service provider according to the procedures established by Plan as set forth in the Provider Manual. Evidence of referrals made by PCP must be submitted to Plan's utilization management department via immediate facsimile transmission, via U.S. mail, or other pre-approved methodology within three (3) days of the date of arrangement of Referral Services. In coordinating care with physicians, PCP shall request copies of medical records of physicians to whom referrals are made in order to maintain an integrated medical record for assigned Members. In the event a Member needs specialty services and a contracting Specialist is unavailable, PCP shall contact Plan's utilization management department to obtain authorization for the referral of the Member to a non-participating Specialist. Referrals made to non-participating Specialist without authorization from Plan's utilization management department shall be the financial responsibility of PCP. Further, PCP will evaluate the outcome of the Referral Services and coordinate the Member's further medical needs. Notwithstanding the foregoing, PCP shall not arrange for referrals for mental health and/or substance abuse services, but shall provide notice to Plan in the manner determined by Plan of the need for a referral of a Member for such services, which referral shall be arranged by Plan.

11. Approval by Plan of a particular course of treatment for a Member or for Referral Services, does not automatically include approval and verification by Plan of that Member's eligibility; PCP must confirm each Member's eligibility before performing Covered Services.

12. Management of inpatient hospital referrals - PCP shall manage the referral of Members to participating hospitals for inpatient care. To the extent practicable, PCP shall be the attending physician for its Members receiving inpatient care. If PCP is not the attending physician, PCP shall establish contact with the attending participating physician and monitor the care provided to

PCP's Member. PCP shall be responsible for providing updates to Plan's utilization management and case management departments regarding the inpatient care received by its Members, for purposes of continuity of care and for authorization for further inpatient treatment.

13. PCP shall provide Primary Care Services and arrange Referral Services in accordance with generally accepted standards of medical practice and the standards established by the Plan's quality management Program. PCP shall maintain a competent level of experience through continuing education programs in his or her particular discipline and shall participate in any continuing education program established or recommended by Plan that is appropriate to his/her practice. PCP shall also comply with any corrective action plan established by Plan related to the provision, arrangement or failure to provide or arrange for Primary Care Services and Referral Services by PCP. Final approval of this Agreement by Plan is not effective until PCP has met the credentialing requirements of Plan.

14. PCP agrees to maintain and demonstrate to Plan upon request, throughout the term of this Agreement, compliance with the following:

    a. Licensure as appropriate under the laws of the District of Columbia.

    b. Where applicable, Board certification or Board eligibility in his/her specialty, unless otherwise approved by Plan's medical director.

    c. Written assurances that all nurses and other ancillary and paramedical personnel employed by, associated with and/or under contract with PCP are properly licensed or certified to practice in the District of Columbia.

    d. Medical staff membership and applicable clinical privileges with at least one participating hospital, unless exempted in writing from such requirements by Plan.

15. Within two (2) days, PCP shall notify Plan in writing of any adverse action, proceeding, or decision, or of any sanctions imposed by a state or federal regulatory or licensing agency, court or other governmental entity, or of any other situation with respect to PCP, which could materially affect PCP's ability to carry out his or her duties and obligations under this Agreement, and provide a copy of any notification and/or other documents relating thereto. Within two (2) days, PCP shall also notify Plan in the event that any certifying authority tasks any action adversely affecting the PCP's board certification.

16. PCP shall implement all activities necessary (including, but not limited to, cooperating in the review and auditing of Members' medical records) to assist Plan in obtaining external accreditation by the National Committee for Quality Assurance ("NCQA") or any other similar organization selected by Plan. Such reviews and audits may include on-site visits; PCP staff and Member interviews; claim and encounter data reviews, reviews of PCP continuous quality improvement plans, credentialing and re-credentialing activities, corrective actions and follow-up plans, Member satisfaction surveys, PCP satisfaction surveys, PCP and PCP staff qualifications.

17. PCP shall maintain throughout the term of this Agreement, professional liability insurance and general liability insurance in the minimum amounts of one million dollars ($1,000,000) per occurrence and three million dollars ($3,000,000) combined single limits coverage for PCP, its

agents and employees. In the event PCP procures a "claims made" policy as distinguished from an occurrence policy, PCP shall procure and maintain, prior to termination of such insurance, continuing "tail" coverage. PCP shall immediately notify Plan of any material changes in insurance coverage and shall provide a certificate of such insurance coverage to Plan upon Plan's request.

18. PCP hereby agrees that in no event, including, but not limited to nonpayment by Plan, insolvency of Plan, or breach of this Agreement, shall PCP bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against Members or persons other than Plan for services provided pursuant to this Agreement. PCP further agrees that (1) this provision shall survive the termination of this Agreement, irrespective of the cause giving rise to such termination and shall be construed to be for the benefit of Plan's Members; and that (2) this provision supersedes any oral or written agreement to the contrary now existing or hereafter entered into between PCP and the Member or persons acting on Member's behalf.

19. PCP agrees to participate in the utilization management and quality management programs adopted by Plan. These programs shall include, among other things, preadmission certification and concurrent and retrospective review. PCP shall coordinate, through the care management teams, the care of Members with acute or chronic medical conditions or Members who are pregnant, including providing appropriate follow-up after any Participating Hospital discharge of a Member. PCP shall provide on-site access to Plan representatives upon reasonable notice and shall furnish pertinent sections of a Member's medical records as may be required to implement such programs. PCP shall comply with all final determinations rendered by the utilization management and quality management programs.

20. PCP shall cooperate with Plan in resolving any Member grievances or complaints related to the provision of Primary Care Services, and shall provide Plan with notice of any Member complaints involving PCP. PCP agrees to participate in and cooperate with Plan's Member grievance and complaint procedures.

21. PCP agrees to accommodate and accept Plan Members, unless his or her practice is closed to all patients covered by all payors. PCP will notify Plan at least ninety (90) days prior to closing his/her practice to all patients covered by all payors.

22. PCP agrees to assist any Member in completing the required forms to enroll newborns born to the Member under Medicaid. PCP shall advise the Member to enroll the newborn in Plan to maintain coverage.

23. PCP shall cooperate with any external review organization contracted by the Department or Plan to perform quality studies.

24. Within the limits of PCPs policies of professional and general liability insurance and to the extent not otherwise inconsistent with the laws and regulations of the jurisdiction in which PCP practices, PCP shall be solely responsible for the medical professional services the PCP performs and agrees to defend, indemnify and hold the D.C. Government, Plan, and all Members free and harmless from any loss, damage, expense, claim, judgment or liability of any kind arising from the provision of Covered Services to Members. Further, PCP shall not seek to recover from any Members or the D.C. government, any debt or portion of any debt of Plan in the event of Plan insolvency.

25. Plan may, in its sole discretion, place limits on the number of Members PCP may accept into PCP's practice, or may close PCP's practice to new Members in the event there are documented issues regarding the quality of Primary Care Services and/or administrative services provided to Plan Members by PCP or Covering Physicians.

26. Plan may use PCP's name, address and telephone number in Plan materials, including Plan's provider directory. PCP may provide Members and non-Members who are his/her patients written notice that PCP is a participating Primary Care Physician with Plan, and may post a notice in his/her offices and acknowledge to his/her patients that PCP participates in Plan. In the event PCP wants to use Plan 's name in any other context or for any other purpose other than general administrative purposes as specified by Plan, PCP shall obtain the prior written consent of Plan, which consent shall not be unreasonably withheld.

27. PCP shall comply with all applicable federal and District laws relating to non-discrimination and equal employment opportunity, and assure physical and program accessibility of all services to persons with physical and sensory disabilities pursuant to Section 504 of the Federal Rehabilitation Act of 1973, as amended (29 USC 794), all requirements imposed by the applicable regulations (45 CFR Part 84), and all guidelines and interpretations issued pursuant thereto. PCP shall also comply with the provisions of the Age Discrimination and Employment Act of 1967 and the Age Discrimination Act of 1975. In connection with performance under the Agreement, PCP agrees not to discriminate against any employee or applicant for employment because of age, race, religion, color, handicap, sex, physical condition, income, Medicaid status, place of residence, developmental disability, marital status, personal appearance, sexual orientation, family responsibility, matriculation, political affiliation, or national origin. PCP shall comply with the provisions of Executive Order 11246 "Equal Employment Opportunity," as amended by Executive Order 11375, and supplemented by the United States Department of Labor regulations (41 CFR Sec 60). PCP shall further comply with the Nondiscrimination Clause, including the Equal Opportunity clauses set forth in that clause, contained in Article 22 (as amended) of the D.C. Standard Contract Provisions (December 1984), incorporated in Attachment J.14R of District of Columbia Solicitation No. 7010-AA-NS-2-CR, issued October 21, 1996.

28. PCP may not impose any limitations on the acceptance of Members for care or treatment that it does not impose on other patients of the PCP. PCP may not require the transfer, discharge, or removal of any Member because of the Member's need for, or utilization of, services that are medically necessary, as that term is defined in the Provider Manual.

29. PCP may request in writing to Plan that a Member be transferred to another participating PCP. PCP shall not seek to have a Member transferred because of the amount of Covered Services required by the Member or because of the health status of the Member. PCP acknowledges that Members have a contractual right with Plan to request a transfer to another participating PCP. Plan's medical director, at his or her sole discretion, shall decide upon the appropriateness of PCP's or Member's transfer request. All decisions regarding such transfers shall be made and become effective as soon as administratively feasible, but in any event, decisions shall be made within sixty (60) days from the date of the request.

30. If any services provided by PCP are not Covered Services, PCP may bill Members at a rate not in excess of the rate which he/she bills the general public after first notifying the Member in writing in

advance of rendering the service that the service is not covered and obtaining the Member's written consent to be billed. PCP agrees to provide Plan with such documentation upon request. PCP shall, in no event, charge Plan or the Member for any Covered Services that are not medically necessary. Prior to billing Members for non-Covered Services, PCP agrees to verify with Plan that the claim is the Member's responsibility.

31. PCP agrees to assure that physician on-call services are available to Members twenty-four (24) hours per day, seven (7) days per week, three hundred sixty-five (365) days per year. PCP agrees to have each PCP providing Covered Services under this Agreement be available to see patients a minimum of twenty (20) hours per practice location per week and will immediately notify Plan in writing if PCP is unable to accept newly enrolled Members, unless this requirement is waived in writing by Plan with the concurrence of any affected government program.

32. PCP shall look only to Plan for compensation for services rendered to a Member when the applicable DHCF Agreement covers such services. PCP agrees not to bill, charge, collect a deposit from, seek compensation from, seek remuneration from, surcharge or have any recourse against any Member or person acting on behalf of a Member (other than Plan), except to the extent that co-payments are specified in the DHCF Agreement. PCP agrees not to collect payment from Members for non-Covered Services unless a Member is given prior notice of such Member's personal financial liability for such non-Covered Services. PCP agrees not to maintain any action at law or in equity against a Member to collect sums that are owed by Plan to PCP under the terms of this Agreement, even in the event Plan fails to pay, becomes insolvent or otherwise breaches the terms and conditions of this Agreement. This section shall survive termination of this Agreement, regardless of the cause of termination and shall be construed to be for the benefit of the Members. This section is not intended to apply to services provided after this Agreement has been terminated, except as otherwise provided in this Agreement, or to non-Covered Services.

33. In the event of insolvency or other cessation of operations by Plan, PCP agrees to provide Covered Services through the last day of the month for which the Plan has received capitation payment for Covered Services from the Member's Program and to provide Covered Services to any Member hospitalized on the date of such insolvency or other cessation of operations until such Member is discharged.

34. PCP agrees to designate in writing to Plan, a person at each of PCP's primary care sites to be responsible for assuring clinical patient records are maintained, completed, and preserved.

35. PCP agrees to submit all claims for payment for Covered Services provided hereunder to Plan electronically (i.e., rather than in a hard copy paper format).

36. PCP agrees that claims it submits to Plan for Covered Services will include such information as Plan requires to determine that the services were rendered in compliance with Plan's authorization procedures. PCP agrees to accept, as full compensation for Covered Services provided to Members, the compensation to be paid to PCP by Plan pursuant to and under the methodology described in Exhibits A & B. PCP agrees that at all times, such compensation agreement or arrangement shall comply with all requirements applicable to physician incentive plans under 42 CFR 417.479 (d)-(g), as amended from time to time.

37. PCP will confirm in writing to Plan that any and all Health Check provider employed by or under

contract with PCP, including PCP, have completed the web-based Health Check training within thirty (30) days of the Effective Date of this Agreement and at least every two (2) years thereafter for the Term of this Agreement. Compliance with this provision shall be a requirement for re-credentialing under this Agreement.

ARTICLE III: DUTIES AND OBLIGATIONS OF PLAN

38. Plan agrees to pay PCP pursuant to and under the payment methodology described in exhibits A & B to this Agreement for providing to Members the Covered Services under the Members' Program, except that if DHCF or CMS reduces any payments to Plan under any Program, Plan may notify PCP in writing of such reduction and both parties agree to negotiate in good-faith a revised fee schedule. If the parties are unable to agree upon a revised fee schedule within sixty (60) days of Plan's notice of reduction to PCP, Plan reserves the right to terminate this Agreement under Article V below. PCP agrees to submit claims to Plan in a computer readable form in 837P format within one hundred eighty (180) days after the Physician Services are rendered. Such bills shall include all diagnostic and/or procedure codes applicable to services performed for each Member's encounters. Plan may deny claims that are not submitted within one hundred eighty (180) days of the date of service. A Clean Claim that has no defect, impropriety, lack of any required substantiating documentation or particular circumstance requiring special treatment that prevents timely payment. Plan shall provide payment to PCP within thirty (30) days of Plan's receipt of an uncontested Clean Claim from PCP, or other specified timeframes as may be required by the District of Columbia. Payments of clean and complete claims made after thirty (30) days of receipt shall be considered late and subject to interest in accordance with the mandated prompt pay laws. PCP must submit a request for appeal of an adverse claims determination made by Plan within ninety (90) days after the date of Plan's written notice. Plan may deny appeals that are not submitted within ninety (90) days of the date of Plan's written notice.

39. To the extent necessary, payments to PCP may be retroactively denied or adjusted during the one hundred eighty (180) period after the date the claim was originally paid, provided that Plan, as the case may be, may retroactively deny or adjust reimbursement for services subject to coordination of benefits with another payor, the District of Columbia Medical Assistance Program, or the Medicare program during the eighteen (18) month period after the date the claim was originally paid. PCP shall recognize Plan's immediate right to recovery for retroactively denied or adjusted claims and shall repay contested paid claims within twenty (20) days of notice from Plan. The time limits under this Section 39 shall apply if Plan retroactively adjusts or denies a claim because (i) the information submitted to the Plan, upon which the claim was approved was fraudulent; (ii) the information submitted to the Plan was improperly coded; or (iii) the claim submitted to the Plan was a duplicate claim.

40. Plan shall perform all administrative, accounting and other functions that are necessary and appropriate for the administration of this Agreement.

41. PCP and all Allied Health Professionals must, as a condition of participation hereunder, comply with Plan's Provider Manual. Plan shall post any changes to the Provider Manual on its website at least fifteen (15) days prior to the effective date of any such change, after which PCP's compliance will be required. In the event PCP objects to the change, the parties shall attempt in good faith to resolve disputes concerning any proposed change. In the absence of such resolution, PCP may elect to terminate participation in the provision of Covered Services under the applicable Program

by giving advance written notice to Plan within ten (10) days after written notice that the proposed change has gone into effect. PCP's election to terminate participation shall be effective no more than sixty (60) days after the effective date of the change as determined by Plan. PCP shall be bound by such change through the effective date of termination. If such written notice of termination is not timely given, PCP agrees to be bound to comply with the change.

42. Plan may perform any of its obligations under this Article directly or pursuant to a delegation to Plan's designee, subject to any necessary approvals from Regulatory Agencies.

ARTICLE IV: MEDICAL RECORDS

43. PCP shall prepare and maintain appropriate, detailed medical records relating to the provision of services to Members consistent with the requirements in the Provider Manual and applicable law and to make such records available to Plan, Regulatory Agencies and their respective agents involved in assessing the quality of care or investigating Member grievances or complaints.

44. PCP agrees that until the expiration of ten (10) years after the furnishing of services pursuant to this Agreement, PCP shall make available to Plan, DHCF, the District of Columbia Department of Health ("DOH"), HHS, CMS, the OIG, and their respective designees, any medical records; required data; reports of services, complaints, grievances, quality or utilization issues; and any books, documents and other records of Specialist as necessary to certify the nature and extent of services provided and the cost thereof. PCP agrees that in the event of termination of this Agreement for any reason, PCP will provide copies of the medical records of any Member to the Primary Care Provider selected by the Member, within ten (10) business days following a written request from the Member or the Plan. PCP agrees to allow any Government Program Fraud Control Unit access to PCP's place of business as required by the DHCF Agreement.

45. Notwithstanding any other provision of this Agreement, the parties agree that the medical records of all Members shall be treated as confidential consistent with all federal and district laws regarding the privacy and confidentiality of medical records.

ARTICLE V: TERM AND TERMINATION

46. The term of this Agreement begins on the Effective Date, and shall remain in effect for an initial period ending December 31 of the calendar year in which it becomes effective, unless terminated earlier under the provisions of this Agreement. Each December 31, this Agreement shall automatically be renewed for an additional calendar year unless either party provides the other party with written notice of its desire not to renew at least sixty (60) days prior to the expiration of the then current term. Each party acknowledges and accepts the right of the other party to decide in its sole discretion not to renew this Agreement.

47. Either party may terminate this Agreement following thirty (30) days prior written notice to the other party of a material breach of this Agreement, provided that if such material breach is cured within fifteen (15) days of the notice of material breach, then such notice of termination shall be of no force and effect. It shall be considered a material breach by a party: (a) if the party substantially fails to perform its duties under this Agreement in accordance with the terms and conditions set forth herein and the Provider Manual (including a failure by PCP to comply with Paragraph 20 hereof); (b) if the party's failure to perform its duties under this Agreement causes the other party to

suffer material financial damages; (c) if the party commits an illegal or fraudulent act; or (d) if there is a filing by the party or its creditors of any petition of bankruptcy or insolvency with the bankruptcy court pursuant to any federal or state law which may be in effect from time to time, which petition is not discharged or dismissed within thirty (30) days after such filing. In addition, Plan may terminate this Agreement immediately upon written notice to PCP if Plan reasonably determines that PCP poses a threat to the health or safety of any Member or to the license, certification, or reputation of Plan.

48. Plan's approval of PCP or an Allied Health Professional shall be revoked, and such individual shall no longer be authorized to provide services hereunder, (i) if such individual acts, or fails to act, in a manner which may result in imminent danger to the health of Member; (ii) upon the loss of such individual's license to practice his/her profession in the District of Columbia; or (iii) upon notice to Plan that such individual has been suspended, expelled, excluded or terminated from participation under Medicare, Medicaid or any other government program. No payment will be made hereunder for services provided by any individual that has been so excluded or whose license has been revoked. In addition, Plan may terminate PCP or any Allied Health Professional immediately upon written notice to PCP, if Plan determines such PCP or Allied Health Professional poses a threat to the health or safety of any Member or to the license, certification or reputation of Plan.

49. This Agreement shall automatically terminate with respect to any specific Program upon termination of the applicable Program as a part of the DHCF Agreement. Plan shall provide PCP at least thirty (30) days written notice of such termination.

50. Either party may terminate this Agreement without cause following sixty (60) days prior written notice to the other party.

51. Notwithstanding any other provision of this Agreement, Plan, in its discretion, may suspend PCP's ability to accept newly enrolled Members for the provision of Primary Care Services due to a pending investigation of any allegations of fraud, abuse, or other serious improper action by PCP, or due to the inability of PCP to provide Members reasonable access to Primary Care Services. Plan shall conduct any investigation as expeditiously as reasonably possible, and limit the length of any suspension by either removing the suspension or giving notice of termination.

52. In the event of termination of this Agreement, Members in an ongoing course of treatment with PCP shall be permitted to continue such treatment with Plan's authorization as follows:

    a. For a period of ninety (90) days from the date the Member is notified of the termination.

    b. If the Member is in the second or third trimester of pregnancy, treatment shall continue through post-partum care.

    c. If it is determined that the Member is terminally ill as defined in Section 5653 of the Public Health Code, treatment will continue for the remainder of the Member's life care directly related to the treatment of terminal illness.

53. Plan will reimburse PCP for such services at the prevailing Plan rates according to the Plan fee schedule, attached hereto as Exhibit A, Exhibit B, and Exhibit C. Notwithstanding the foregoing, if this Agreement is terminated, Plan shall be free to reassign Members immediately.

ARTICLE VI: RESOLUTION OF DISPUTES

54. In the event of a dispute concerning the construction, interpretation, performance under, or breach of, this Agreement, which the parties in good faith are unable to resolve within thirty (30) days after written notice of a dispute has been given by the party raising the dispute, the party raising the dispute may file notice of arbitration request with JAMS/Endispute in Washington, D.C., no later than three (3) years after the dispute originally arose. The arbitration will be held in accordance with the rules and procedures of JAMS/Endispute in Washington, D.C. Plan and PCP shall each choose an arbitrator and the two arbitrators so chosen shall choose the third. If either Plan or PCP fails to choose an arbitrator within 30 days after notice of commencement of arbitration or if the two arbitrators fail to choose a third arbitrator within 30 days after their appointment, JAMS/Endispute Washington D.C. shall, upon the request of either Plan or PCP, appoint the arbitrator or arbitrators to constitute or complete the panel as the case may be. Arbitration proceedings hereunder may be initiated by either Plan or PCP making a written request to JAMS/Endispute, together with any appropriate filing fee, at the office of JAMS/Endispute Washington D.C. All arbitration proceedings or litigation (to the extent the remedy requested is not, by law, available through arbitration [e.g., injunctive relief]) relating to any claims or disputes arising under or relating to this Agreement shall be brought in the county in which the principal executive office of the party not initiating such action or proceeding (i.e. the defendant or responding party) is located. The parties irrevocably submit and consent to the exercise of subject matter jurisdiction and personal jurisdiction over each of the parties by the federal and/or state courts in such jurisdiction (the "Selected Jurisdiction"). The parties hereby irrevocably waive any and all objections that any party may now or hereafter have to the exercise of personal and subject matter jurisdiction in the Selected Jurisdiction and to the laying of venue of any such proceeding or action brought in the Selected Jurisdiction. Any order or determination of the arbitral tribunal shall be final and binding upon the parties to the arbitration and may be entered in any court having jurisdiction. Each party will bear its own costs of arbitration, including counsel and support in connection with the arbitration, irrespective of the final arbitration award or judgment.

ARTICLE VII: CONFIDENTIAL RECORDS, PROPRIETARY INFORMATION

55. PCP shall not disclose or release any of the data or information obtained by virtue of this Agreement to any other person, firm, or corporation without the written consent of Plan or where required to carry out obligations under this Agreement, and where applicable, the written consent of the Member(s).

56. Each party agrees to keep confidential, all individually identifiable information relating to Members pursuant to 42 U.S.C. Section 1396a(a)(7), 42 CFR Part 2 and other regulations promulgated thereunder. Such information may be used by the PCP only for a purpose directly connected with performance of PCP's obligations under this Agreement. The provisions of this section will survive the termination of Plan's participation and/or PCP participation in the Medicaid managed care program and will remain in effect as long as the PCP maintains any individually identifiable information relating to Members. PCP must ensure compliance with the Health Insurance Portability and Accountability Act of 1996 (Public Law 104191, August 21, 1996) and all applicable regulations promulgated thereunder. Such regulations include but are not limited to, the medical privacy rule 45 C.F.R. Parts 160 and 164) and the electronic transactions and code set standards rule, 45 C.F.R. Parts 160 and 162. PCP must also comply with the D.C. Mental Health

Information Act, D.C. Code § 6-2001 *et seq.* PCP shall maintain written procedures for compliance with all applicable privacy, confidentiality, and information security requirements. PCP shall train its physicians, employees, and agents on the requirements for compliance with all applicable privacy, confidentiality, and information security requirements.

57. Each party recognizes and agrees that the other party's name, assumed names, logos, financial and other identifying information, its business methods, forms, marketing methods and plans, and the names, addresses and identifying information of the Members (including those who are not assigned to PCP), business contacts, and any other information concerning the business, property and affairs of the other party, including, without limitation, all memoranda, notes, records, lists or other documents made available by one party to the other party during the term of this Agreement concerning the Members or anything covered under this Agreement, are confidential and constitute valuable property and proprietary information that are the exclusive property of the other party (hereinafter, "Proprietary Information"). Neither party shall copy, use, or disseminate any of the other party's Proprietary Information in any manner for its direct or indirect economic gain or advantage, except as expressly permitted in this Agreement for the purpose of the party's compliance with the terms hereof. Each party expressly agrees that the other party shall, in addition to any other right or remedy that may be available, be entitled to injunctive and other equitable relief to prevent a breach of these provisions of this Agreement and to secure its enforcement, in addition to any other rights and remedies provided by law or in equity. Each party further agrees that this Paragraph 39 shall not be subject to arbitration under Paragraph 36. Upon the expiration or termination of this Agreement, or at any time upon the demand of the other party, a party shall promptly return to the other party all Proprietary Information which the other party made available to the party, and the party shall destroy or continue to hold in confidence any notes or other information which the party, or a person or entity acting on its behalf, derived from the Proprietary Information.

ARTICLE VIII: INSURANCE

58. PCP agrees to maintain or to be at all times covered under policies of insurance with insurance companies approved by Plan or a program of self-insurance acceptable to Plan for the following types of coverage:

    a. General liability coverage insuring against any and all insurable claims that may arise directly or indirectly in connection with the acts or omissions of PCP or PCP's employees or agents. Such coverages shall be in amounts meeting any requirements set forth in the DHCF Agreement, which are applicable to Plan's subcontractors.

    b. Professional liability insurance which provides a minimum coverage of $1,000,000 per claim and $3,000,000 in the aggregate for PCP, its agents, and employees. In the event PCP procures a "claims made" policy as distinguished from an occurrence policy, PCP shall procure and maintain prior to termination of such insurance, continuing "tail" coverage.

    c. Unemployment compensation insurance and worker's compensation insurance in accordance with the requirements of all applicable federal and district laws and regulations, in the event PCP has any employees.

    d. PCP shall furnish Plan with evidence of all insurance coverage and riders required herein

before the effective date of this Agreement and thereafter at Plan's request. PCP shall notify Plan in writing within two (2) days of the cancellation of a policy of insurance maintained by PCP. PCP shall give Plan written notice of any changes to an insurance policy at least thirty (30) days before the effective date of any changes initiated by PCP and within two (2) business days after PCP receives notice of changes initiated by the insurer. In the event that coverage is of a "claims made" variety, PCP shall continue to arrange to maintain policies of insurance in effect to cover claims which occur during the term of this Agreement.

e. Failure on the part of PCP to maintain any coverage required in this Agreement shall be grounds for termination by Plan.

f. If any insurance policy required to be maintained hereunder is purchased on a "claims made" basis, such insurance policy shall include a provision stating that, in the event such insurance policy is terminated, PCP shall have the right to purchase a three (3) year extended reporting or discovery period insurance policy ("Extended Policy").

ARTICLE IX: RELATIONSHIP BETWEEN PLAN AND PCP

59. Plan and PCP shall at all times maintain an effective liaison and close cooperation with each other, to the end of providing required benefits to each Member at the most reasonable cost consistent with high standards of Covered Services, including cooperation of both parties in Plan's quality improvement activities.

60. Plan and PCP shall at all times freely and fully exchange information regarding all matters necessary to carry out their obligations under this Agreement.

61. Plan shall have the right to monitor the compliance of PCP, including all Allied Health Professionals, with all rules, regulations and procedures that may come into effect regarding care and treatment of Members.

62. Plan shall have the right to utilize Plan's peer review program for review of the nature and extent of the Covered Services provided by PCP to Members. PCP agrees to cooperate in such peer review and in such grievance procedures as Plan shall establish for the purpose of achieving amicable resolution of disputes or claims of Members.

63. Plan reserves the right to assign and reassign Members to and from PCP and to add physicians to serve Members as it may, in its sole discretion, deem to be in the Members' or Plan's best interests, during the term of this Agreement or upon its expiration or termination for any reason. All such transfers will become effective on the first day of the month following the date of Plan's notice of the change to PCP unless Plan notifies PCP of a different effective date, subject only to any requirements under the DHCF Agreement. Plan shall have the right to immediately transfer Members to another PCP (whether or not such Primary Care PCP is employed by PCP) if Plan has reason to believe in its discretion, that Members' health or safety is in jeopardy.

64. Under the DHCF agreement, Plan must provide the DHCF with detailed utilization reports which set forth information regarding utilization of Covered Services by Medicaid Members. In addition, Plan must collect data to provide to DHCF regarding compliance with the Early and Periodic

Screening, Diagnosis and Treatment ("EPSDT") requirements for Members under the age of twenty-one (21). Plan must provide information regarding its Members and regarding public health issues affecting its Members to DHCF upon request. PCP must cooperate with Plan in meeting these reporting requirements by providing Plan with information, upon request or as provided hereunder, which will include, without limitation, the following (to the extent applicable to PCP's areas of practice):

a. Known deaths of Members within 72 hours.

b. Members treated by PCP who are diagnosed with HIV/AIDS.

c. Members with developmental delays.

d. Members diagnosed as tuberculosis cases or tuberculosis-infected.

e. Members with vaccine-preventable diseases and other communicable diseases.

f. Female Members and Members up to the age of 5 who have or are at risk for nutritional deficiencies or have nutrition-related medical conditions.

g. Members under the age of 21 who have an elevated blood lead level (greater than 10 ug/dl), which information is to be reported to Plan within 48 hours after identification.

65. PCP shall cooperate with Plan in meeting the Early and Periodic Screening, Diagnosis and Treatment ("EPSDT") requirements for Members under the age of twenty-one (21), including, without limitation:

a. Notifying Members of the availability of transportation services.

b. Providing follow-up on missed appointments.

c. Contacting Members to schedule screenings and appointments.

d. Making follow-up telephone calls.

66. PCP shall comply with the EPSDT periodicity schedule to be provided to PCP by Plan.

67. PCP shall schedule appointments for health assessments, first physical examinations, general physical examinations, and health screenings in connection with EPSDT requirements, within thirty (30) days or sooner, if medically necessary, of the date of the request. For Members who are newly assigned to a PCP and who are eligible for EPSDT services, PCP shall offer initial health screenings within forty-five (45) days of request, or sooner if required to comply with the periodicity schedule, and shall complete such screenings within three (3) months of the Member's initial enrollment date with Plan. EPSDT screens, laboratory tests and immunizations provided by PCP shall be furnished within thirty (30) days of the due date established in the periodicity schedule for children under 2 years of age, and within sixty (60) days of the due date established in the periodicity schedule for children over 2 years of age.

68. PCP shall ensure that PCP meets the EPSDT participation ratio, as defined by the CMS State Medicaid Manual, for Members under the age of 21 assigned to each PCP, according to the following schedule: 80% participation.

69. PCP shall schedule appointments for initial assessments for pregnant Members or persons desiring family planning services to take place within ten (10) days of the request. PCP shall understand that a Member may choose instead to receive family planning services from a qualified family planning PCP/practitioner without a Referral from PCP.

70. To comply with the external quality review requirements, Plan is responsible to DHCF or its designee for compliance with all activities of the external quality review (EQR) process. To the extent that PCP is responsible for data, information or other requirements of the EQR, PCP shall:

    a. Submit requested pre-site survey documents and/or information in accordance with published timelines.

    b. Submit documents and/or information required during the on-site reviews within specified timelines.

    c. Submit requested member medical records/information for annual clinical studies within specified timelines.

    d. Adhere to HIPAA guidelines when securing and/or submitting consumer-related information.

    e. Maintain quality improvement programs and plans that focus on meeting and/or exceeding the performance standards with guidelines and timely access to care, services and satisfaction standards required by DHCF or its designee.

    f. Submit corrective action plans (CAPs) within pre-established timelines.

    g. Make available PCP's patient clinical records and/or information requested by Plan or its designee.

    h. Collect and report the data required by an EQR organization in support of Plan's obligation under 1902(a)(30)(C) and 1932(c)(2) of the Social Security Act 42 U.S.C.1396a(a)(30)(C) and 42 U.S.C.-1396u-2(c)(2).

71. Plan will make available to PCP, the results of each annual external independent Quality Review conducted by the DHCF or its designee.

72. Section 1932(b)(3) of the Social Security Act requires that a "Medicaid managed care organization shall not prohibit or otherwise restrict a covered health care professional from advising such an individual (Member) who is a patient of the professional about the health status of the individual or medical care or treatment for the individual's conditions or disease, regardless of whether benefits for such care or treatment are provided under the contract, if the professional is acting within the lawful scope of practice." In accordance with subsection (b) as required by 1903(m)(2)(A)(xi) of the Social Security Act, 42 U.S.C. 1396b(m)(2)(A)(xi), Plan does not interfere with such

communications between covered health care professionals and Members who are a patient of the professional.

73. PCP shall comply with the requirements of 1932(b)(6) of the Social Security Act, 42 U.S.C. 1396u 2(b)(6), that an enrolled individual or the individual's family or caregiver may not be held liable or be subject to collection efforts for:

    a. Debts or other obligations of the Plan or any PCP in the event of Plan's insolvency;

    b. The cost of Covered Services in the event that the Plan fails to receive payment from the District of Columbia;

    c. The cost of Covered Services if PCP fails to receive payment from the Plan; or

74. PCP is prohibited from imposing any cost-sharing or similar charge on a Member for Covered Services provided to a Member.

75. PCP is prohibited referring any amounts due to a collection agency or other party for collection if payment is being sought from Member for Covered Services.

76. PCP may direct a Member to an emergency or urgent care facility under this Agreement. If PCP makes such a referral, PCP shall document referral and notify Plan within two (2) business days of such referral. The notification received by Plan shall constitute authorization to pay for the emergency of urgent care services provided as required under the DHCF Agreement.

77. PCP shall cooperate in determining where third party liability exists, and if notified by Plan or a Member that a third party has primary liability for Covered Services provided to a Member, PCP shall bill the third party first. This provision includes, but is not limited to, cases involving coordination of benefits, workers compensation, liability coverage's and Medicare and Medicaid benefits.

78. If this Agreement terminates for any reason, within fifteen (15) days of the notice of termination or thirty (30) days before the effective date of termination, whichever is sooner, Provider will notify its Members in writing of such termination. The notice will include:

    a. the effective date of termination;

    b. instructions to the Member(s) to contact the Plan regarding securing a new Provider;

    c. a brief description of the Provider's process for transferring the Member's Protected Health Information ("PHI"); and if applicable

    d. future contact information for the Provider.

79. Provider shall adhere to the below marketing conditions:

    a. Any marketing information distributed by Provider directed at Plan's Members shall be limited to general information about Plan and notification that Provider participates in

Plan's network. Any such materials must be submitted to Plan for review and approval prior to distribution to Members (Plan will ultimately submit such materials to DHCF for review and approval).

b. Provider will not utilize written information that is false or misleading in any material respect, including information regarding the Provider's network, the availability of services, the Provider's qualifications, hours, and location of services.

c. Provider shall not host marketing events within the Provider's office.

d. Provider shall not offer to Members gifts of more than a de minimus value or other insurance products designed to induce persons to enroll in Plan.

e. Provider shall not enter into compensation agreements with marketing personnel that utilize any type of payment structure in which compensation is tied to the number (or classes) of persons who enroll in Plan.

ARTICLE X: MISCELLANEOUS

80. This Agreement, together with any exhibits hereto, constitutes the entire agreement between the parties with respect to PCP's provision of services to Members and supersedes any and all prior agreements between the parties, whether written or oral, or representations made by the parties with respect to PCP's provision of services to Members.

81. This Agreement may not be assigned by any party without the prior written consent of the other party. Any assigned subcontractor or third party approved by Plan under this section shall be subject to every provision of this Agreement.

82. Each party shall without limit, indemnify, hold harmless and, at the non-indemnifying party's election, defend the non-indemnifying party, its officers, agents, employees, and representatives with respect to any and all claims, damages, judgments, actions, and causes of action, arising out of the acts or omissions of the indemnifying party's officers, agents, employees, and representatives, related to the services provided pursuant to this Agreement, including all costs, expenses and attorney's fees incurred in the defense of any and all claims and/or litigation.

83. PCP must adhere to the following disclosure requirements:

a. Within 35 days upon request of DHCF or the Secretary of HHS, PCP must submit the business transaction information identified in 42 C.F.R. § 455.105, including:

i. The ownership of any independent contractor with whom the provider has had business transactions totaling more than twenty-five thousand dollars ($25,000) during the twelve (12) month period ending on the date of request.

ii. Any significant business transaction between the provider and any wholly owned supplier during the five (5) year period ending on the date of the request.

iii. Any significant business transaction between the provider and any independent contractor during the five (5) year period ending on the date of the request.

b. At any time upon request by Plan or DHCF, PCP must disclose:

i. The identity of any person who has ownership or control interest in the provider who has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid or the Title XX services program since the inception of those programs; and

ii. The identity of any person who is an agent or managing employee of the provider who has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or the Title XX services program since the inception of these programs.

84. Plan will not reimburse PCP for procedures relating to the following Health Care Acquired Conditions ("HCAC"), identified in the Affordable Care Act of 2010, Public Law 111-148, when any of the following conditions are not present upon admission in any inpatient setting, but subsequently acquired in that setting:

a. Foreign object retained after surgery;

b. Air embolism;

c. Blood incompatibility;

d. Catheter associated urinary tract infection;

e. Pressure ulcers (decubitus ulcers);

f. Vascular catheter associated infection;

g. Mediastinitis After Coronary Artery Bypass Graft ("CABG")

h. Hospital acquired injuries (fractures, dislocations, intracranial injury, crushing injury, burn or other unspecified effects of external causes);

i. Manifestations of poor glycemic control;

j. Surgical site infection following certain orthopedic procedures;

k. Surgical site infection following bariatric surgery for obesity; and

l. Deep vein thrombosis and pulmonary embolism following certain orthopedic procedures except for pediatric (individuals under the age of 21 years) and obstetric populations.

85. If applicable, Plan will not reimburse PCP for any of the following Never Events in any inpatient or outpatient setting:

a. Surgery performed on the wrong body party;

b. Surgery performed on the wrong patient; and

c. Wrong surgical procedure performed on a patient.

86. Any and all notices or other communications provided for or required by this Agreement shall be directed to the party to be so notified, in writing, by hand delivery; registered or certified mail, postage pre-paid return receipt requested; by a recognized overnight delivery service; or by electronic mail, and addressed to the applicable party at its respective electronic or business addresses shown below. For purposes of clarification, and without limiting the generality of the foregoing, notice sent via electronic mail shall constitute written notice for all purposes hereunder. Each party shall notify the other party promptly and in writing of any change in its respective business and/or email address.

To Plan:	Chika Duru General Counsel Trusted Health Plan (District of Columbia), Inc. 1100 New Jersey Avenue, SE, Suite 840 Washington, DC 20003
With a copy To:	Kenny R. Greene Vice President Provider Relations Trusted Health Plans, Inc. 1100 New Jersey Avenue, SE, Suite 840 Washington, DC 20003
To PCP:	[PROVIDER]
With a copy To:	[PROVIDER]

87. PCP consents to the use of PCP's name, address, and specialty in any marketing, advertising or media materials distributed by Plan.

88. Any section or paragraph title or caption contained in this Agreement is for convenience only, and in no way defines limits or describes the scope or intent of this Agreement or any of its provisions.

89. This Agreement, including, without limitation, any of its exhibits or attachments may be revoked, altered, amended, or modified at any time by written agreement executed by the parties hereto.

90. This Agreement, including without limitation, any of its exhibits or attachments may be amended by Plan by providing to PCP no less than thirty (30) days prior written notice of the effective date of the amendment. If PCP provides written acceptance of the amendment, PCP shall be bound by the amendment as of the effective date set forth in the notice of the amendment from Plan. If PCP does not provide written acceptance of the amendment or objects in writing to the amendment, PCP and Plan shall attempt in good faith to resolve the matter to their mutual satisfaction for a period not to exceed thirty (30) days following Plan's written notice of the amendment or Plan's receipt of PCP's written objection to the amendment. In the absence of such resolution, and notwithstanding anything in this Agreement to the contrary, either PCP or Plan may terminate this Agreement or

participation of PCP in the provision of Covered Services under the applicable Program, upon written notice to the other within five (5) days after the expiration of the thirty (30) day period described above. The effective date of such termination shall be on the expiration of the five (5) day notice period described above. In the event of such termination, PCP shall be bound by the amendment from its effective date through the effective date of termination.

91. No waiver of any provisions of this Agreement shall be valid unless in writing and signed by the party against whom such waiver is sought. One or more waivers of any covenant or condition of this Agreement by any of the parties hereto shall not be construed as a waiver of any subsequent breach of other covenants or conditions.

92. This Agreement is made pursuant to, and shall be governed by the laws and decisions of the District of Columbia, regardless of its choice of law provisions. This Agreement is subject to all rules and regulations promulgated from time to time by any relevant regulatory agency, and this Agreement shall be deemed to be amended to conform therewith at all times. When an amendment is required by federal or district law or regulation or by a regulatory agency, Plan shall provide thirty (30) days advance written notice of the amendment to PCP. PCP shall be deemed to have accepted the amendment unless PCP objects to Plan in writing within thirty (30) days of receipt of the notice of amendment. Either party may terminate this Agreement upon ten (10) days written notice if the parties are unable to reach agreement on the amendment within thirty (30) days of Plan's receipt of PCP's objection.

93. The invalidity or unenforceability of any particular provision of this Agreement shall not affect any other provision hereof. This Agreement shall be construed in all respects as if such invalid or unenforceable provisions were omitted.

94. When the context of this Agreement requires, the gender of all words shall include the masculine, feminine, and neuter, and the number of all words shall include the singular and plural.

95. The parties have not and do not intend to create any rights through this Agreement in any third parties, including Members.

96. Neither party shall be liable nor deemed to be in default for any delay or failure in performance under this Agreement or other interruption of service resulting, directly or indirectly, from acts of God, civil or military authority, acts of public enemy, war, accidents, fires, explosions, earthquakes, floods, failure of transportation, strikes or other work interruptions by either party's employees, or any similar or dissimilar cause beyond the reasonable control of either party; provided, however, in the event the provision of Covered Services is substantially interrupted, Plan shall have the right to terminate this Agreement upon ten (10) days prior written notice to PCP.

97. This Agreement and any amendments hereto may be executed in any number of counterparts, each of which shall be treated as an original, but all of which, collectively, shall constitute a single instrument.

98. Plan does not prohibit PCP from discussing treatment options with Members or from advocating on behalf of a Member in any grievance or utilization review process, or individual authorization process to obtain health care services.

99. Plan and PCP hereby acknowledge and agree that they intend for this Agreement (and all services furnished hereunder) to comply with all applicable federal and district laws, rules and regulations, including, without limitation, the Stark Law (Section 1877 of the Social Security Act). In furtherance of the foregoing, if during the term of this Agreement, Plan's or PCP's counsel reasonably determines that any changes are required with respect to this Agreement, including, without limitation, any changes in the amount of the compensation being provided hereunder, as a result of (a) the enactment of new laws, rules or regulations, or (b) any changes in the interpretation of existing laws, rules or regulations, either as a result of any court or agency decision, or any pronouncement, ruling or other interpretation by any governmental or regulatory agency or body, or otherwise, because of the reasonable likelihood that, in light of such enactment or changed interpretation, proceeding under this Agreement in its current form potentially might:

    a. Cause either of the parties to violate any applicable law, rules or regulations;

    b. Preclude Plan from presenting or causing to be presented to any payor any bills for services furnished by Plan or PCP;

    c. Cause any referrals or potential referrals between the parties to be in violation of any self-referral laws, including, without limitation, the Stark Law, then the parties shall negotiate in good faith changes to this Agreement as shall be reasonably required to address such issue(s).

100. To the extent that PCP is a group practice or is otherwise executing this Agreement on behalf of individual providers, including without limitation, individual Allied Health Professionals, PCP represents and warrants to Plan that it has the authority to bind and hereby binds each such provider to the terms and conditions set forth herein.

-Go to next page-

IN WITNESS WHEREOF, the parties hereto have caused this Agreement to be executed effective as of the Effective Date.

PCP (*i.e.*, AUTHORIZED REPRESENTATIVE WITH RESPECT TO THE TAX ID NUMBER LISTED BELOW):

Signature: _____

Print Name:

Title:

Address:

City/State/Zip:

Email Address:

Tax I.D. #:

Dated:

PLAN:
Trusted Health Plans, Inc.
1100 New Jersey Avenue, SE, Suite 840
Washington, DC, 20003
www.Trustedhp.com
45-2375150

_____
Signature: Chika Duru
Its: General Counsel
Dated:

EXHIBIT A

COMPENSATION SCHEDULE
FOR DC HEALTHY FAMILY PROGRAM MEDICAID

COVERED SERVICES AND PAYMENT ARRANGEMENT

1. Covered Services. The Covered Services shall consists of all services that are covered by the DCHFP, subject to the terms of this Agreement, all rules, regulations, policies and procedures of the DCHFP, and Plan's authorization for referral services.

2. Payment Arrangement. Payment to PCP for providing the Covered Services described above shall be equal to the lesser of (a) the amount charged by PCP; or (b) 85% of the current Medicaid fee-for-service program for the same service.

3. Prompt Payment. Payment to PCP by Plan within seven (7) days of Plan's receipt of claim shall be paid at 98% of the lesser of (a) the amount charged by PCP; or (b) 85% of the current Medicaid fee-for-service program for the same service.

PCP accepts the prompt pay method - Yes _____, No _____
Initial Initial

EXHIBIT B

COMPENSATION SCHEDULE
FOR ENROLLED ELIGIBLE DC ALLIANCE MEMBER

COVERED SERVICES AND PAYMENT ARRANGEMENT

1. Covered Services. The Covered Services shall consists of all services that are covered Alliance, subject to the terms of this Agreement, all rules, regulations, policies and procedures of Alliance, and Plan's authorization for referral services.

2. Payment Arrangement. Payment to PCP for providing the Covered Services described above shall be equal to the lesser of (a) the amount charged by PCP; or (b) 85% of the current Medicaid fee-for-service program for the same service.

3. Prompt Payment. Payment to PCP by Plan within seven (7) days of Plan's receipt of claim shall be paid at 98% of the lesser of (a) the amount charged by PCP; or (b) 85% of the current Medicaid fee-for-service program for the same service.

   PCP accepts the prompt pay method - Yes _____, No _____
   Initial Initial

EXHIBIT C

COMPENSATION SCHEDULE
FOR ENROLLED ELIGIBLE MEDICARE ADVANTAGE MEMBERS

1. Covered Services. The Covered Services shall consist of all services that are covered by the Medicare Advantage program, subject to the terms of this Agreement, and all rules, regulations, policies and procedures of the Medicare program, and THP's authorization for referral services.

2. THP will pay Hospital for Covered Services at 100% of the then current Medicare fee schedule.

EXHIBIT D

DC HEALTHY FAMILY PROGRAM MEDICAID/ALLIANCE PROGRAM NETWORK

Upon execution of this page, PCP agrees to participate in Plan's network to provide health care services to Plan's membership, and shall be bound by and comply with the terms and conditions of the Medicare Advantage program and the DHCF (D.C. Healthy Family Medicaid/Alliance Program) Agreement.

PCP further agrees that as a condition of participation as a PCP under Plan's Medicare Advantage program and the DC Healthy Family Medicaid/Alliance Programs, PCP shall make available Covered Services to enrolled eligible Medicare Advantage and DC Healthy Family Medicaid/Alliance Program members.

AGREED TO:

_____
(Printed Name of Group PCP)

By:_____
Signature

_____
(Printed Name of PCP Representative)

_____
(Title of PCP Representative)

DATE:_____

EXHIBITE

COVERRED PROGRAMS

1. Medicare Advantage
2. D.C. Healthy Family Program Medicaid
3. D.C. Alliance Program

SAMPLE

TRUSTED HEALTH PLAN (DISTRICT OF COLUMBIA), INC.

PLAN/ SPECIALIST AGREEMENT

This Plan/Provider Agreement (this "**Agreement**") is made and entered into this _____ day of _____, 2015, between Trusted Health Plan (District of Columbia), Inc. ("**Plan**"), a Washington, D.C. corporation licensed as a Health Maintenance Organization ("HMO"), whose business address is 1100 New Jersey Avenue, S.E., Suite 840, Washington, D.C., 20003, and [PROVIDER NAME] ("**Provider**"), whose business address is [BUSINESS ADDRESS].

In consideration of their mutual covenants and promises contained in this Agreement, the parties agree as follows:

ARTICLE I: DEFINITIONS

For purposes of this Agreement and its exhibits, the following words and phrases shall have the following meanings:

i. "**Alliance**" means the District of Columbia Alliance program.

ii. "**Clean Claim**" means a claim that has no defect, impropriety, lack of any required substantiating documentation or particular circumstance requiring special treatment that prevents timely payment.

iii. "**Covered Services**" means those properly authorized services that are covered by a Program and that Plan has committed to provide to Members under a Program/Plan Agreement.

iv. "**Covering Physician**" means a contracted licensed physician of medicine or osteopathy who agrees to provide services to another contracted licensed physician's patients when that other physician is not available.

v. "**DCHFP**" means the District of Columbia Healthy Family Program.

vi. "**Effective Date**" means the date this Agreement is executed by Plan.

vii. "**Emergency**" shall have the meaning defined for that term in a Program, and shall include the sudden onset of a medical condition that manifests itself by acute symptoms of sufficient severity (including severe pain), such that the absence of immediate medical attention could reasonably be expected to result in: (a) placing the health of the individual (or regarding a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, (b) serious impairment to bodily functions, or (c) serious dysfunction of any bodily organ or part. Payment shall not be denied hereunder for services provided to a Member up to the point of stabilization of an Emergency because of the final diagnosis or because prior authorization was not given before such services were provided.

viii. "**External Quality Review**" means a validation of performance/quality improvement measures and activities; compliance with local standards for access to care, structure and operations; and

validation of consumer or provider surveys of quality of care.

ix. "**Government Program Fraud Control Unit**" means the D.C. Department of Health Care Finance Program Integrity Division and/or its authorized agent/s; the United States Department of Health and Human Services ("HHS"), Office of Inspector General ("OIG"); the Centers for Medicare and Medicaid Services ("CMS"); the Federal Bureau of Investigation ("FBI"); the D.C. Medicaid Fraud Control Unit ("MFCU"); or any other D.C., state, or federal agency with proper jurisdiction, charged with identifying, investigating, or prosecuting suspected fraud, waste, or abuse.

x. "**Government Program**" means a Program funded in whole or in part by federal, district or local government funds other than any program such government unit provides to its employees or retirees, and including, but not limited to, programs such as Medicare, Mediaid, DCHFP, and Alliance.

xi. "**Member**" means any individual determined eligible for a Program who has enrolled or been enrolled with Plan for the provision of Covered Services.

xii. **"Never Event"** means reportable adverse events that are serious, largely preventable, and of concern to both the public and health care providers for the purpose of public accountability.

xiii. "**Participating Hospital**" means a facility with an established contract with the Plan to provide Covered Services to members.

xiv. "**Participating Provider**" means a qualified and licensed physician or allied health professional who has been accepted by Plan to provide certain Covered Services to Members hereunder.

xv. "**Provider Manual**" means a manual made available to Provider by Plan, which includes Plan's procedures and forms, requirements for record keeping and treating members, referral procedures, prior authorization requirements, appeal procedures, and information relating to benefits, co-payments, coordination of benefits, and other operational policies and procedures. Plan may make this manual (and any updates to this manual) available on line on its web site.

xvi. "**Primary Care Provider ("PCP")**" means a qualified and licensed physician, allied health professional, and multi-specialty primary care practitioner engaged in the areas of Family Practice, Internal Medicine, Pediatrics or such other area as may be determined by Plan, and is selected by a Member to provide Primary Care Services.

xvii. "**Primary Care Services**" means those Covered Services customarily provided by a Primary Care Provider.

xviii. "**Program**" means any health coverage program offered through an employer, association or other entity, including Government Programs, which enters into a contract with Plan for the provision of Covered Services and any non-group health coverage program offered by Plan.

xix. "**Program/Plan Agreement**" means any agreement between a Program and Plan pursuant to which Plan agrees to arrange for the provision of Covered Services to Members. A list of the Program/Plan Agreements covered by this Agreement is set forth on Exhibit E.

xx. "**Referral Provider**" means a health care professional or provider who or which provides a Covered Service pursuant to authorization from a Primary Care Provider or Plan.

xxi. "**Referral Service**" means a Covered Service which is prior authorized by a Primary Care Provider or Plan.

xxii. "**Regulatory Agencies**" means the Centers for Medicare and Medicaid Services ("CMS"), the District of Columbia Department of Insurance, Securities, and Banking ("DISB"), which has regulatory authority over Plan, and the District of Columbia Department of Health Care Finance ("DHCF"), which oversees contractual compliance for the Medicaid Program and any other governmental entities with regulatory authority over the Plan or any of its contractors or activities.

xxiii. "**Specialist**" means where applicable and appropriate, Provider, and any individual Specialist contracted with Plan pursuant to this Agreement with Provider, who is board certified or board eligible or approved as a Specialist physician by Plan, in a particular medical specialty, from whom a Member may receive Referral Services in the Specialist physician's particular medical specialty, upon referral from his or her Primary Care Provider.

xxiv. "**Specialist Physician Services**" means those Covered Services that fall within the specialty that Specialist is qualified to perform as a physician.

ARTICLE II: DUTIES AND OBLIGATIONS OF PROVIDER

1. Specialist agrees to provide Specialty Physician Services to Plan Members who are referred for diagnosis or treatment for Emergency Services or Referral Services that have been pre-approved by Primary Care Provider or Plan's utilization management program. Specialist will not deny Specialty Physician Services to eligible Members. Specialist agrees to provide Specialty Physician Services to Plan Members on a twenty-four (24) hours a day, seven (7) days a week basis or make arrangements with a Covering Physician who is also a Specialist, when Specialist is otherwise absent or unavailable to provide such services. For Specialty Physician Services that are not Emergency Services or urgent care, Specialist shall schedule appointment with Members within thirty (30) days or sooner, if medically necessary, of receipt of a referral from the Member's Primary Care Provider or from Plan's utilization management department. For any Member admitted by Specialist to a Participating Hospital, Specialist agrees to coordinate information and services with the Member's Primary Care Provider and with Plan's utilization management programs. Specialist agrees to perform Specialty Physician Services for Members only for the specified types of services for which he or she is qualified to perform, if he or she has been credentialed by Plan's physician credentialing committee in the specialty or received advanced written permission of Plan's medical director. For services rendered by a Covering Physician, Specialist shall be solely responsible to make arrangements with the Covering Physician to accept as full payment, the fee payable to Specialist in accordance with all conditions set forth in this Agreement regarding billing or treatment of Members. Any fee billed by a Covering Physician in excess of Plan's fee schedule shall be the sole responsibility of Specialist. Specialist shall cooperate with any after-hours triage program established by Plan.

2. Specialist shall perform Specialty Physician Services upon receipt of a referral. In coordinating with Primary Care Provider, Specialist shall submit referral reports and/or furnish copies of

medical records to the Primary Care Provider from whom referrals were made in order to maintain an integrated medical record for assigned Members. Plan shall monitor Specialist to ensure he or she submits referral reports to the Primary Care Provider in a timely manner. In the event that Specialist fails to submit referral reports in a timely manner, Specialist shall be subject to monetary sanctions.

3. Except for Emergency Services, Specialist agrees not to refer Members to other physicians, including other Specialist physicians, without prior authorization of Member's Primary Care Provider or Plan's utilization management program. Whenever Specialist must refer a Member for Emergency Services or has approval from the Primary Care Provider or Plan's utilization management program, he or she agrees to refer the Member to providers/practitioners under contract with Plan, where possible. If Specialist refers a Member to a provider/practitioner in a manner contrary to the Plan's utilization management or quality management programs, the cost of such services shall be the financial responsibility of Specialist. Plan, at its option, may reduce future payments to Specialist due to Specialist's failure to follow Plan's policies and procedures.

4. Specialist shall provide Specialty Physician Services in accordance with generally accepted standards of medical practice and the standards established by the Plan's quality management program. Specialist shall maintain a competent level of experience through continuing education programs in his or her particular discipline and shall participate in any continuing education program established or recommended by Plan that is appropriate to his or her practice.

5. Specialist warrants that (i) he or she is board-certified or board-eligible to perform services in the specialty discipline designated in his or her application to Plan's credentialing committee or its delegate, and has had the requisite education from an accredited physician residency program in his or her discipline; or (ii) he or she has the requisite experience to qualify to perform Specialty Physician Services and has received written permission from Plan's medical director to perform Specialty Physician Services. Any Specialist that fails to meet Plan's credentialing requirements will not be permitted to provide Covered Services under this Agreement.

6. Specialist shall also comply with any corrective action plan established by Plan related to the provision, arrangement, or failure to provide Specialty Physician Services at the level commensurate with other practices in his or her specialty.

7. Specialist agrees to maintain and demonstrate to Plain upon request, throughout the term of this Agreement, compliance with the following:

    a. Licensure as appropriate under the laws of the District of Columbia;

    b. Board certification or board eligibility in each and every one of Specialist's specialties or proof that each and every Specialist is seeking board certification within one (1) year of execution of this Agreement, unless exempted by Plan's medical director;

    c. Written assurances that all nurses and other ancillary and paramedical personnel employed by, associated with and/or under contract with Specialist, are properly licensed or certified to practice in the District of Columbia; and

    d. The credentialing standards of Plan as set forth in the Provider Manual, by providing, upon

request, information concerning Specialist's education, training, residency, malpractice liability insurance, pending malpractice claims, and, if applicable, hospital staff status, hospital clinical privileges, and hospital staff reappointment dates. Specialist shall immediately notify Plan in writing of any adverse action, proceeding or decision, or any sanctions imposed by a state or federal regulatory or licensing agency, court, or other governmental entity, or of any other situation regarding Specialist that could materially affect Specialist's ability to carry out his/her or its duties and obligations under this Agreement, and provide a copy of any notification and/or documents relating thereto. Specialist shall also immediately notify Plan in the event that any certifying authority takes any action adversely affecting Specialist's board certification.

8. Specialist shall implement all activities necessary (including, but not limited to, cooperating in the review and auditing of Members' medical records) to assist Plan in obtaining external accreditation by the National Committee for Quality Assurance ("NCQA") or any other similar organization selected by Plan. Such reviews and audits may include on-site visits; Specialist staff and Member interviews; claim and encounter data reviews, reviews of Specialist continuous quality improvement plans, credentialing and re-credentialing activities, corrective actions and follow-up plans, Member satisfaction surveys, Specialist satisfaction surveys, Specialist and Specialist staff qualifications.

9. Specialist hereby represents and warrants that:

    a. All Specialists are certified to participate in the Medicaid program; and

    b. Neither Specialist nor any employee or agent of Specialist is excluded from participating in Medicaid, under Title XIX of the Social Security Act.

10. Specialist hereby agrees that in no event, including, but not limited to nonpayment by Plan, insolvency by Plan, or breach of this Agreement, shall Specialist bill, charge, collect a deposit from, seek compensation, remuneration, or reimbursement from, or have any recourse against Members or persons other than Plan for Covered Services provided pursuant to this Agreement. Specialist further agrees that (i) this provision shall survive the termination of this Agreement irrespective of the cause giving rise to such termination and shall be construed to be for the benefit of Plan's Members, and that (ii) this provision supersedes any oral or written agreement to the contrary now existing or hereafter entered into between Specialist and the Member or persons acting on Member's behalf.

11. Specialist agrees to perform his or her duties under this Agreement in a manner consistent with the reasonable administrative guidelines provided by Plan in its Provider Manual. In the event of conflict between such manual and this Agreement, the terms of this Agreement shall prevail.

12. Specialist agrees cooperate with Plan's reasonable fraud, waste, and abuse efforts, as well as participate in the utilization management and quality management programs adopted by Plan. These programs shall include, among other things, preadmission certification and concurrent and retrospective review, and the use of care management teams. In cases where a Member requires a hospital admission for a non-Emergency Service, Specialist agrees to obtain prior authorization for such admission in accordance with Plan's utilization management program. Specialist agrees that in order for Plan to provide coverage for any extension of a length of stay for a hospital admission,

Specialist must obtain prior authorization from Plan's utilization management program.

13. Specialist shall provide on-site access to Plan representatives upon reasonable notice and shall furnish pertinent sections of Member's medical records as may be required to administer relevant Programs. Specialist shall comply with all final determinations rendered by the utilization management and quality management programs. Final determinations may include monetary or other sanctions against Specialist, as provided for in Plan's policies, procedures, rules, and regulations; including, but not limited to, the sanction provisions in Plan's Provider Manual.

14. Specialist shall provide Plan with encounter data by type of Specialty Physician Service(s) in a computer readable form in 837P format in accordance with any additional D.C. reporting requirements. The encounter data shall be the property of Plan. In the event Specialist fails to provide encounter data to Plan as provided in this section, Plan may in its sole discretion, require re-education procedures, or may impose monetary sanctions after the established deadline that Specialist fails to submit such data. In the event of continued or repeated violations of this section, Plan, in its sole discretion, may impose a range of additional sanctions, including not allowing new referrals to Specialist, limiting Specialist's participation in any or all Plan incentive payment programs, or termination of this Agreement. The cost of preparing and submitting such encounter data to Plan shall be borne solely by Specialist.

15. Specialist shall cooperate with Plain in resolving any Member grievances or complaints related to the provision of Specialty Care Services, and shall provide Plan with notice of any Member complaints involving Specialist. Specialist agrees to participate in and cooperate with Plan's Member grievance and complaint procedures, as set forth in the Provider Manual, and to comply with all final determinations rendered in accordance with those procedures.

16. Plan may use Specialist's name, address, and telephone number in Plan materials, including Plan's provider directory. In the event Specialist wants to use Plan's name in any context or for any purpose, other than general administrative purposes as specified by Plan, Specialist shall obtain written consent from Plan, which consent shall not be unreasonably withheld. Specialist may post a notice in its offices and acknowledge to his or her patients that Specialist participates in Plan.

17. Specialist represents and assure that they shall not discriminate against any Plan Members on the basis of race, color, creed, national origin, ancestry, sex, age, disability, sexual orientation, personal appearance, family responsibilities, income, Medicaid status, political affiliation, religion, place of residence, marital status, health status, lawful occupation, source of payment, handicap, membership in Plan, or frequency of utilization of Covered Services. Specialist shall comply with all applicable federal and District laws relating to non-discrimination and equal employment opportunity, and assure physical and program accessibility of all services to persons with physical and sensory disabilities pursuant to Section 504 of the Federal Rehabilitation Act of 1973, as amended (29 U.S.C. § 794), all requirements imposed by the applicable regulations (45 C.F.R. Part 84), and all guidelines and interpretations issued pursuant thereto, and the provisions of the Age Discrimination and Employment Act of 1967 and the Age Discrimination Act of 1975. In connection with performance under the Agreement, Specialist agrees not to discriminate against

any employee or applicant for employment because of age, race, religion, color, handicap, sex, physical condition, income, Medicaid status, place of residence, developmental disability, marital status, personal appearance, sexual orientation, family responsibility, matriculation, political affiliation, or national origin. Specialist shall comply with the provisions of Executive Order 11246 "Equal Employment Opportunity" as amended by Executive Order 11375 and supplemented by the United States Department of Labor regulations (41 C.F.R. § 60). Provider and Specialist shall further comply with the Nondiscrimination Clause, including the Equal Opportunity clauses set forth in the that clause, contained in Article 22 (as amended) of the D.C. Standard Contract Provisions (December 1984), incorporated in Attachment J.14R of District of Columbia Solicitation No. 7010-AA-NS-2-CR, issued October 21, 1996.

18. Specialist may not impose any limitations on the acceptance of Members for care or treatment that it does not impose on other patients of Specialist. Specialist may not require the transfer, discharge, or removal of any Member because of the Member's need for, or utilization of, medically necessary services.

19. If any services provided by Specialist are not Covered Services, Specialist may bill Members at a rate not in excess of the rate which he/she bills the general public after first notifying the Member in writing in advance of rendering the service that the service is not covered and obtaining the Member's written consent to be billed. Specialist agrees to provide Plan with such documentation upon request. Specialist shall, in no event, charge or attempt to recover from Plan or the Member for any Covered Services which are not Medically Necessary. Prior to billing Members for non-Covered Services, Specialist agrees to verify with Plan that the claim is the Member's responsibility.

20. Specialists who are also Primary Care Providers shall not refer Members to him or herself in a capacity as a Specialist unless Specialist has secured the prior approval of Plan's medical director or his or her designee or in accordance with the method set forth in Plans' Provider Manual.

21. Specialist agrees that in connection with all actions taken on behalf of Members and in all communications with Members in connection with this Agreement, Specialist shall avoid actions and communications that could or shall undermine the confidence of the Member, a potential Member, employers, unions, governmental or licensing or certifying entities, or the general public, in Plan or in the quality of care Plan provides. Notwithstanding the foregoing, nothing in this Agreement shall limit the rights of Specialist to: (i) communicate with Members regarding medical treatment options; (ii) recommend a course of treatment to a Member, even if the course of treatment is not covered, or approved by Plan; (iii) file an appeal or complaint on a Member's behalf, pursuant to the procedures of Plan; (iv) supply accurate, relevant factual information to a Member in connection with an appeal or complaint filed by such Member; or (v) object to policies, procedures, or decisions made by Plan. If a recommended course of treatment is not covered, e.g., not approved by Plan, Specialist must notify the Member if Specialist intends to charge the Member for such non-Covered Services.

22. Specialist shall provide Plan with at least thirty (30) days prior written notice of any changes in Specialist's name, office locations, addresses, hours of operation, telephone numbers and other relevant information relating to Specialist's operations. Specialist agrees to provide written notice

of such changes(s) to all Plan Members on existing practice appointment schedules at the time of such change(s).

23. If this Agreement terminates for any reason, within fifteen (15) days of the notice of termination or thirty (30) days before the effective date of termination, whichever is sooner, Provider will notify its Members in writing of such termination. The notice will include:

    a. the effective date of termination;

    b. instructions to the Member(s) to contact the Plan regarding securing a new Provider;

    c. a brief description of the Provider's process for transferring the Member's Protected Health Information ("PHI"); and if applicable

    d. future contact information for the Provider.

24. Provider shall adhere to the below marketing conditions:

    a. Any marketing information distributed by Provider directed at Plan's Members shall be limited to general information about Plan and notification that Provider participates in Plan's network. Any such materials must be submitted to Plan for review and approval prior to distribution to Members (Plan will ultimately submit such materials to DHCF for review and approval).

    b. Provider will not utilize written information that is false or misleading in any material respect, including information regarding the Provider's network, the availability of services, the Provider's qualifications, hours, and location of services.

    c. Provider shall not host marketing events within the Provider's office.

    d. Provider shall not offer to Members gifts of more than a de minimus value or other insurance products designed to induce persons to enroll in Plan.

    e. Provider shall not enter into compensation agreements with marketing personnel that utilize any type of payment structure in which compensation is tied to the number (or classes) of persons who enroll in Plan.

ARTICLE III: DUTIES AND OBLIGATIONS OF PLAN

25. Plan shall provide all administrative services under this Agreement, including quality management, utilization management, budgeting, administration of Specialist claims, coordination of benefits, funds management, and compliance with all Federal and State HMO regulatory requirements.

26. Plan shall provide Specialist with a Provider Manual setting forth the policies and procedures that Plan has adopted in administering its Programs. Plan shall also provide written notice to Specialist of changes to its Provider Manual at least thirty (30) days prior to the effective date of such changes.

27. Plan shall apprise all Members concerning the type, scope, and duration of benefits and services to which Members are entitled under the Plan. Plan shall retain final authority regarding benefits determinations for its Members.

28. Plan agrees to assist Specialist in the development and initial implementation of procedures necessary to carry out the terms of this Agreement.

29. Plan shall not terminate Specialist on the basis of gender, race, age, religion, national origin, or any protected category under the Americans with Disabilities Act.

30. Plan reserves the right immediately transfer any of its Members to another Specialist if Plan reasonably determines that Specialist is jeopardizing a Member's health or safety.

ARTCILE IV: COMPENSATION

31. Plan shall provide compensation to Specialist as set forth in the relevant compensation Exhibits A , B, and C to this Agreement, which shall be full compensation for Specialist's services under this Agreement.

32. Specialist agrees to accept payment from Plan, together with authorized copayments, as provided herein as full payment for Covered Services, and shall not pursue or collect charges for such services from third parties. However, Specialist agrees to cooperate and use best efforts in the effective implementation of any coordination of benefits procedures and other procedures for handling third party claims, as set forth in the Provider Manual, including collecting information from Members regarding other health coverage.

33. Specialty Physician Services are to be provided to Members by Specialist on a fee-for-service basis, and Specialist agrees to submit claims to Plan within one hundred eighty (180) days after the Specialty Physician Services are rendered, on CMS 1500 forms or in electronic form compliant with 837P format. Such bills shall include all diagnostic and/or procedure codes applicable to services performed for each Member's encounters. Plan may deny claims that are not submitted within one hundred eighty (180) days of the date of service. Plan shall provide payment to Specialist within thirty (30) days of Plan's receipt of a Clean Claim from Specialist, or other specified time frame as may be required by DHCF or DISB. Specialist must submit a request for appeal of an adverse claims determination made by Plan within ninety (90) days after the date of Plan's written notice. Plan may deny appeals that are not submitted within ninety (90) days of the date of Plan's written notice of an adverse claims determination.

34. To the extent necessary, payments to Specialist may be retroactively denied or adjusted during the one hundred eighty (180) period after the date the claim was originally paid, provided that Plan, as the case may be, may retroactively deny or adjust reimbursement for services subject to coordination of benefits with another payor, the District of Columbia Medical Assistance Program or the Medicare program during the eighteen (18) month period after the date the claim was originally paid. Specialist shall recognize Plan's immediate right to recovery for retroactively denied or adjusted claims and shall repay contested paid claims within twenty (20) days of notice from Plan. The time limits under this Section 34 shall apply if Plan retroactively adjusts or denies a claim because (i) the information submitted to the Plan, upon which the claim was approved was fraudulent; (ii) the information submitted to the Plan was improperly coded; or (iii) the claim submitted to the Plan was a duplicate claim.

ARTICLE V: MEDICAL RECORDS

35. Specialist shall prepare and maintain appropriate and detailed medical records relating to the provision of services to Members as required by Plan and applicable law, and to make such records available to Plan, Regulatory Agencies and their respective agents involved in assessing the quality of care or investigating Member grievances or complaints.

36. Specialist agrees that until the expiration of ten (10) years after the furnishing of services pursuant to this Agreement, Specialist shall make available to Plan, DHCF, the District of Columbia Department of Health ("DOH"), HHS, CMS, the OIG, and their respective designees, any medical records; required data; reports of services, complaints, grievances, quality or utilization issues; and any books, documents and other records of Specialist as necessary to certify the nature and extent of services provided and the cost thereof. Specialist agrees that in the event of termination of this Agreement for any reason, Specialist will provide copies of the medical records of any Member to the Primary Care Provider selected by the Member, within ten (10) business days following a written request from the Member or the Plan. Specialist agrees to allow any Government Program Fraud Control Unit access to Specialist's place of business as required by the contract between the Government Program and Plan.

37. Notwithstanding any other provision of this Agreement, the parties agree that the medical records of all Members shall be treated as confidential consistent with all federal and district laws regarding the privacy and confidentiality of medical records.

ARTICLE VI: TERM AND TERMINATION

38. The term of this Agreement begins on the Effective Date and shall remain in effect for an initial period ending December 31 of the calendar year in which it becomes effective, unless terminated earlier under the provisions of this Agreement. Each December 31, this Agreement shall automatically be renewed for an additional calendar year unless either party provides the other party with written notice of its desire to terminate the Agreement at least sixty (60) days before the expiration of the then current term. Each party acknowledges and accepts the right of the other party to decide, in its sole discretion, to terminate the Agreement.

39. Either party may terminate this Agreement following thirty (30) days prior written notice to the other party of a material breach of this Agreement, provided that if such material breach is cured within fifteen (15) days of the written notice of material breach, then such notice of termination shall be of no force and effect. It shall be considered a material breach by a party: (i) if a party substantially fails to perform its duties under this Agreement in accordance with the terms and conditions set forth herein, (ii) if the party's failure to perform its duties under this Agreement causes the other party to suffer material financial damages, (iii) if the party commits an illegal or fraudulent act, or (iv) if there is a filing by the party or its creditors of any petition of bankruptcy or insolvency with the bankruptcy court pursuant to any federal or state law which may be in effect from time to time, which petition is not discharged or dismissed within thirty (30) days after such filing. In addition, Plan may terminate this Agreement immediately upon written notice to Specialist if Plan reasonably determines that Specialist poses a threat to the health or safety of any Member or to the license, certification, or reputation of Plan.

40. Plan's approval of a Specialist shall be revoked and Specialist shall no longer be authorized to provide services hereunder: (i) if such individual acts or fails to act in a manner that may result in imminent danger to the health of a Member, (ii) upon the loss of such individual's license to practice his/her profession in the District of Columbia, or (iii) upon notice to Plan that such individual has been suspended, expelled, excluded or terminated from participation under Medicare, Medicaid, or any other Government Program. No payment will be made hereunder for services provided by any individual that has been so excluded or whose license has been revoked. In addition, Plan may require Provider to terminate any Specialist immediately upon written notice to Provider if Plan determines that such Specialist poses a threat to the health or safety of any Member or to the license, certification, or reputation of Plan. Where Plan reasonably determines that a Specialist has acted or failed to act in a manner that may jeopardize a Member's safety or health, Provider shall cooperate with Plan to transfer the relevant Member(s) to a different Specialist.

41. This Agreement shall automatically terminate with respect to any specific Program, upon termination of the relevant Program/Plan agreement.

42. This Agreement shall automatically terminate in its entirety: (i) if Specialist acts or fails to act in a matter that may result in imminent danger to the health of a member, (ii) upon loss by Specialist of the legal right to render health care services in the District of Columbia, or (iii) upon notice to Plan that Specialist has been suspended, expelled, excluded, or terminated from participation under Medicare, Medicaid, or any other Governemnt Program. No payment will be made hereunder for services provided by Specialist if Specialist has been so excluded or has lost the legal right to render health care services in the District of Columbia.

43. Either party may terminate this Agreement without cause following sixty (60) days prior written notice to the other party.

44. Notwithstanding any other provision of this Agreement, Plan, in its discretion, may suspend Specialist's ability to accept newly enrolled Members for the provision of services due to illness or

disability of Specialist, pending investigation of any allegations of fraud, abuse, or other serious improper action by Specialist, or due to the inability of Specialist to provider Members reasonable access to services, as described in the Provider Manual. Plan shall conduct any investigation as expeditiously as reasonably possible, and limit the length of any suspension by either removing the suspension or giving notice of termination.

45. In the event of termination of this Agreement, Members in an ongoing course of treatment with Specialist shall be permitted to continue such treatment with Plan's authorization as follows:

    a. For a period of ninety (90) days from the date the Member is notified of the termination.

    b. If the Member is in the second or third trimester of pregnancy, treatment shall continue through post-partum care.

    c. If it is determined that the Member is terminally ill as defined under Section 5653 of the Public Health Code, treatment will continue for the remainder of the Member's life care directly related to the treatment of the terminal illness.

46. Specialist shall continue to be responsible for providing Specialty Physician Services to Members under active treatment as of the effective date of termination, until the earlier of: (a) completion of active treatment, or (b) Plan's orderly transition of the Member's care to another Participating Provider or Specialist. Member may request that ongoing care continue by Specialist for up to ninety (90) days even if Plan can arrange for an orderly transfer of Member's care. In such case, Specialist shall continue to provide Specialty Physician Services for a period of up to ninety (90) calendar days. If Specialist is providing obstetrical care, Specialist shall be responsible for providing obstetrical care through the postpartum period for Members in their second or third trimester of pregnancy at the time the contract terminates. Payment for any continued Specialty Physician Services as described in this section shall be at the rates set forth under Exhibits A, B, and C.

47. If this Agreement terminates because of insolvency or the cessation of operations of Plan, Specialist shall continue to provide Specialist Physician Services to Members through the period for which premiums have been paid to Plan under the Program/Plan agreement, and for Members confined in an inpatient facility on the date of insolvency or other cessation of operations, until medically necessary appropriate discharge from the inpatient facility.

48. Within five (5) days of notice of termination, Specialist shall provide Plan with a list of all patients undergoing treatment by Specialist. Plan shall notify Members of termination of this Agreement upon receipt of the listing from Specialist. Should Specialist discover it has not submitted a complete list to Plan, Specialist shall immediately supply Plan with the additional information. Minimum information supplied to Plan shall include Member name, date of birth, Member I.D number, parent or guardian name (if applicable), most current address, telephone number, date of next schedule visit, diagnosis, current therapy and any other information reasonably required by Plan. This provision also applies if a Specialist leaves the Provider; however, in such a case, Plan

and Specialist shall work together to ensure continuity of care within practice of Specialist if clinically appropriate and consistent with desires of the Member.

ARTICLE VII: RESOLUTION OF DISPUTES

49. In the event of a dispute concerning the construction, interpretation, performance under, or breach of this Agreement, which the parties, in good faith are unable to resolve within thirty (30) days after written notice of a dispute has been given by the party raising the dispute, the dispute shall be submitted to arbitration by either party filing a notice of arbitration with JAMS/Endispute in Washington, D.C. no later than three (3) years after the dispute originally arose. The arbitration will be held in accordance with the rules and procedures of JAMS/Endispute in Washington, D.C. Plan and Specialist shall each choose an arbitrator and the two arbitrators so chosen shall choose the third. If either Plan or Specialist fails to choose an arbitrator within thirty (30) days after notice of commencement of arbitration or if the two arbitrators fail to choose a third arbitrator within thirty (30) days after their appointment, JAMS/Endispute Washington D.C. shall, upon the request of either Plan or Specialist, appoint the arbitrator or arbitrators to constitute or complete the panel as the case may be. Arbitration proceedings hereunder may be initiated by either Plan or Specialist making a written request to JAMS/Endispute, together with any appropriate filing fee, a the office of JAMS/Endispute Washington D.C. All arbitration proceedings or litigation (to the extent the remedy requested is not, by law, available through arbitration [e.g., injunctive relief] relating to any claims or disputes arising under or relating to this agreement shall be brought in the county in which the principal executive office of the party not initiating such action or proceeding (i.e. the defendant or responding party) is located. The parties irrevocably submit and consent to the exercise of subject matter jurisdiction and personal jurisdiction over each of the parties by the federal and/or state courts in such jurisdiction (the "Selected Jurisdiction"). The parties hereby irrevocably waive any and all objections that any party may now or hereafter have to the exercise of personal and subject matter jurisdiction in the Selected Jurisdiction and to the laying of venue of any such proceeding or action brought in the Selected Jurisdiction. Any order or determination of the arbitral tribunal shall be final and binding upon the parties to the arbitration and may be entered in any court having jurisdiction. Each party will bear its own costs of arbitration, including counsel and support in connection with the arbitration, irrespective of the final arbitration award or judgment.

ARTICLE VIII: CONFIDENTIAL RECORDS, PROPRIETARY INFORMATION

50. Specialist shall not disclose or release any of the data or information obtained by virtue of this Agreement to any other person, firm, or corporation without the written consent of the Plan or

where required to carry out obligations under this Agreement, and where applicable, the written consent of the Member(s).

51. Each party recognizes and agrees that the other party's name; assumed names; logos; financial and other identifying information; its business methods; forms; marketing methods and plans; the names, addresses and identifying information of the Members; Member lists; business contacts; and any other information concerning the business, property, and affairs of the other party; including, without limitation, all memoranda, notes, records, lists or other documents made available by the disclosing party to the receiving party during the term of this Agreement concerning the Members or anything covered under this Agreement, are confidential and constitute valuable property and proprietary information that is the exclusive property of the disclosing party (hereinafter, "Proprietary Information"). Neither party shall copy, use, or disseminate any of the disclosing party's Proprietary information in any manner for its direct or indirect economic gain or advantage, or that of any other person or entity whatsoever, except as expressly permitted in this Agreement for the purpose of the receiving party's compliance with the terms hereof. Each party expressly agrees that the other party shall, in addition to any other right or remedy that may be available, be entitled to injunctive and other equitable relief to prevent a breach of these provision of this Agreement and to secure its enforcement, in addition to any other rights and remedies provided by law or in equity. Each party further agrees that this Article VIII shall not be subject to arbitration under Article VII. Upon expiration or termination of this Agreement, or at any time upon the demand of the disclosing party, the receiving party shall promptly return to the disclosing party all Proprietary Information which the disclosing party made available to receiving party, and the receiving party shall destroy or continue to hold in confidence any notes or other information the receiving party, or a person or entity acting on its behalf, derived from the Proprietary Information.

ARTICLE IX: INSURANCE

52. Specialist agrees to maintain or to be at all times covered under policies of insurance with insurance companies approved by Plan or a program of self-insurance acceptable to Plan for the following types of coverage:

    a. Specialist shall maintain throughout the term of this Agreement, professional liability insurance and general liability insurance in the minimum amounts of one million dollars ($1,000,000.00) per occurence and three million dollars ($3,000,000.00) combined single limits coverage for Specialist, its agents, and employees. In the event Specialist procures a "claims made" policy as distinguished from an occurrence policy, Specialist shall procure and maintain prior to termination of such insurance, continuing "tail" coverage. Specialist shall immediately notify Plan of any material changes to insurance coverage and shall provide a certificate of insurance of such coverage to Plan upon Plan's request.

b. Unemployment compensation insurance and worker's compensation insurance in accordance with the requirements of all applicable federal and District of Columbia laws and regulations.

c. Specialist shall furnish plan with evidence of all insurance coverage and riders required herein before the Effective Date of this Agreement and thereafter at Plan's request. Specialist shall notify Plan in writing within two (2) days of the cancellation of a policy of insurance maintained by Specialist. Specialist shall give Plan written notice of any material changes to an insurance policy at least thirty (30) days before the effective date of any such change initiated by Specialist and within two (2) business days after Specialist receives notice of material changes initiated by the insurer. To the extent available, all insurance policies shall contain riders requiring the carrier to notify Plan of cancellation or material changes. In the event that coverage is of a "claims made" variety, Specialist shall continue to arrange to maintain policies of insurance in effect to cover claims which occur during the term of the Agreement.

d. Failure on the part of Specialist to maintain any coverage required hereunder shall be grounds for immediate termination of this Agreement.

e. If any insurance policy required to be maintained hereunder is purchased on a "claims made" basis, such insurance policy shall include a provision stating that in the event such insurance policy is terminated, Specialist shall have the right to purchase a three (3) year extended reporting or discovery period insurance policy ("Extended Policy").

ARTICLE X: RELATIONSHIP BETWEEN PLAN AND SPECIALIST

53. Plan and Specialist shall at all times maintain an effective liaison and close cooperation with each other, to the end of providing required benefits to each Member at the most reasonable cost consistent with high standards of Covered Services, including cooperation of both parties in Plan's quality improvement activities.

54. In the event DHCF fails to provide or delays payment to Plan for the provision of Covered Services to Members, Plan shall suspend payment to Specialist until such time as Plan receives payment from DHCF. Plan shall compensate Specialist in a timely manner once payment is received from DHCF. To the extent that DHCF or CMS reduces payments provided to Plan under the Medicaid or Medicare Advantage programs in any manner, Plan may notify Specialist in writing of such reduction and both parties agree to negotiate in good-faith a revised fee schedule. If the parties are unable to agree upon a revised fee schedule within sixty (60) days of Plan's notice of reduction to Specialist, Plan reserves the right to terminate this Agreement under Article VI above.

55. Plan and Specialist shall at all times feely and fully exchange information regarding all matters necessary to carry out their obligations under this Agreement.

56. Plan shall have the right to monitor the compliance of Specialist, with all rules, regulations, and procedures that may come into effect regarding the care and treatment of Members.

57. Plan shall have the right to utilize Plan's peer review program for review of the nature and extent of Covered Services provided by Specialist to Members. Specialist agrees to cooperate in such peer review and in such grievance procedures as Plan shall establish for the purpose of achieving amicable resolution of disputes or claims of Members.

58. Under the Plans' Healthy Families and Alliance programs with DHCF, Plan must provide DHCF with detailed utilization reports that set forth information regarding utilization of Covered Services by Members. In addition, Plan must collect data to provide to DHCF regarding compliance with the Early and Periodic Screening, Diagnosis and Treatment ("EPSDT") requirements for Members under the age of twenty-one (21). Specialist shall provide Plan with information regarding utilization by Members of EPSDT and non-EPSDT services provided by Specialist on an ongoing basis no later than thirty (30) calendar days after the date service(s) are performed. Specialist shall provide such information to Plan electronically. Plan must provide information regarding its Members and regarding public health issues affecting its Members to DHCF upon request. Specialist must cooperate with Plan in meeting these reporting requirements by providing Plan with information upon request or as provided hereunder, which will include, without limitation, the following (to the extent applicable to Specialist's area of practice):

    a. Within seventy two (72) hours, known deaths of Members;

    b. Members treated by Specialist who are diagnosed with HIV/AIDS;

    c. Members with developmental delays;

    d. Members diagnosed as tuberculosis cases or tuberculosis-infected;

    e. Members with vaccine-preventable diseases and other communicable diseases;

    f. Female Members and Members up to the age of five (5) who have or are at risk for nutritional deficiencies or have nutrition-related medical conditions; and

    g. Members under the age of twenty one (21) who have an elevated blood lead level (greater than 10 ug/dl), which information is to be reported to Plan within forty eight (48) hours after identification.

59. Specialist shall cooperate with Plan in meeting the EPSDT requirements for Members under the age of twenty-one (21), including, without limitation:

    a. Notifying Members of the availability of transportation services;

    b. Providing follow-up on missed appointments;

    c. Contacting Members to schedule screenings and appointments;

d. Making follow-up telephone calls; and

e. Specialist shall comply with the EPSDT periodicity schedule to be provided to Specialist by Plan.

60. Specialist shall schedule appointments for health assessments, first physical examinations, general physical examinations, and health screenings in connection with EPSDT requirements, within thirty (30) days or sooner, if medically necessary, of the date of the request. For Members who are newly assigned to a Specialist and who are eligible for EPSDT services, Specialist shall offer initial health screenings within forty-five (45) days of request, or sooner if required to comply with the periodicity schedule, and shall complete such screenings within three (3) months of the Member's initial enrollment date with Plan. EPSDT screens, laboratory tests, and immunizations provided by Specialist shall be furnished within thirty (30) days of the due date established in the periodicity schedule for children under two (2) years of age, and within sixty (60) days of the due date established in the periodicity schedule for children over two (2) years of age.

61. Specialist Group shall ensure that all Specialists meet the EPSDT participation ratio, as defined by the CMS State Medicaid Manual, for Members under the age of twenty-one (21) assigned to each Specialist, according to the following schedule: 80% participation.

62. Plan is responsible to DHCF or its designee for compliance with all activities of the External Quality Review ("EQR") process. To the extent Specialist is responsible for data, information , or other requirements of the EQR, Specialist shall:

a. Submit requested pre-site survey documents and/or information in accordance with published timelines;

b. Submit documents and/or information required during the on-site reviews within specified timelines;

c. Submit requested Member medical records/information for annual clinical studies within specified timeliness;

d. Comply with 42 C.F.R. Part 2, the HIPAA Privacy and Security Rules and the D.C. Mental Health Information Act (D.C. Code § 6-2001 *et seq.*);

e. Maintain quality improvement programs and plans that focus on meting and/or exceeding the performance standards with guidelines and timely access to care services and satisfaction standards, required by DHCF or its designee;

f. Submit Corrective Action Plans ("CAP") within pre-established timelines;

g. Make available Specialist's patient clinical records and/or information requested by Plan or designee;

h. Collect and report the data required by an EQR organization in support of Plan's obligation under 1902(a)(30)(C) and 1932(c)(2) of the Social Security Act, 42 U.S.C. 1396a(a)(30)(C) and 42 U.S.C. 139u-2(c)(2).

63. Plan will make available to Specialist, the results of each annual external independent quality review conducted by DHCF or its designee

64. Section 1932(b)(3) of the Social Security Act requires that a "Medicaid managed care organization shall not prohibit or otherwise restrict a covered health care professional from advising such an individual (Member) who is a patient of the professional about the health status o the individual or medical care or treatment for the individual's conditions or disease, regardless of whether benefits for such are or treatment are provided under the contract, if the professional is acting within the lawful scope of practice." In accordance with subsection (b) as required by 1903(m)(2)(A)(xi) of the Social Security Act, Plan does not interfere with such communications between covered health care professional and Members who are a patient of the professional.

65. Specialist shall comply with the requirements of 1932(b)(6) of the Social Security Act, which provides that an enrolled individual or the individual's family or caregiver may not be held liable or be subject to collection efforts for:

    a. Debts or other obligations of the Plan or any Specialist participating in the Provider's network in the event of insolvency;

    b. The cost of items and services covered under the contract in the event that the Plan fails to receive payment from the District of Columbia; and

    c. The cost of items and services covered under the contract if Specialist fails to receive payment from Plan.

66. Specialist is prohibited from imposing any cost-sharing or similar charge on a Member for Covered Services provided to a Member. Specialist is prohibited from referring any amounts due to a collection agency or other party for collection if payment is being sought from Member for Covered Services.

67. Specialist shall cooperate in determining where third party liability exists, and if notified by Plan or a Member that a third party has primary liability for Covered Services provided to a Member, Specialist shall bill the third party first for Covered Services. This provision includes, but is not limited to, cases involving coordination of benefits, workers compensation, and Medicare and Medicaid benefits.

68. Specialist shall provide to Plan all information necessary for any Member appeal within a time frame established by DHCF or the Office of Administrative Hearings ("OAH"), upon notification by Plan, DHCF, or OAH, that such information is required.

69. Specialist may direct a Member to an emergency facility under this Agreement. If Specialist makes such a referral, Specialist shall document referral and notify Plan within two (2) business

days of such referral. The notification received by Plan shall constitute authorization to pay for the emergency or urgent care services provided as required under the Program/Plan agreement.

ARTICLE X: MISCELLANEOUS

70. This Agreement, together with any exhibits hereto, constitutes the entire agreement between the parties with respect to Specialist's provision of services to Members and supersedes any and all prior agreements between the parties, whether written or oral, or representations made by the parties with respect to Specialist's provision of services to Members.

71. This Agreement may not be assigned by any party without the prior written consent of the other party. Any assigned subcontractor approved by Plan under this section shall be subject to every provision of this Agreement.

72. Any and all notices or other communications provided for or required by this Agreement shall be directed to the party to be so notified, in writing, by registered or certified mail, return receipt requested, or by electronic mail, and addressed to the applicable party at its respective business or electronic addresses shown on the first page of this Agreement, or such other address of which the other party has received written notice; provided, however, that any notice posted on Plan's website shall constitute notice for all purposes hereunder. For purposes of clarification, and without limiting the generality of the foregoing, notice sent via electronic mail shall constitute written notice for all purposes hereunder. Each party shall notify the other party promptly and in writing of any change in its respective business and/or email address.

73. Specialist consents to the use of its name, address, and specialty in any marketing, advertising, or media materials distributed by Plan.

74. Specialist must adhere to the following disclosure requirements:

    a. Within thirty-five (35) days upon request of DHCF or the Secretary of HHS, Specialist must disclose the business transaction information identified under 42 C.F.R. § 455.106, including:

        i. The ownership of any independent contractor with whom Specialist has had business transactions totaling more than $25,000.00 during the twelve (12) month period ending on the date of the request;

        ii. Any significant business transactions between the Specialist and any wholly owned supplier during the five (5) year period ending on the date of the request; and

        iii. Any significant business transaction between the Specialist and any independent contractor during the five (5) year period ending on the date of the request.

    b. At any time upon request by Plan or DHCF, Specialist must disclose:

i. The name of any person who has ownership or a controlling interest in Specialist who has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or the Title XX services program, since the inception of those programs; and

ii. The name of any person who is an agent or managing employee of Specialist who has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or the Title XX services program since its inception of those programs.

75. Plan will not reimburse Specialist for procedures relating to the following Health Care Acquired Conditions ("HCAC"), identified in the Affordable Care Act of 2010, Public Law 111-148, when any of the following conditions are not present upon admission in any inpatient setting, but subsequently acquired in that setting:

a. Foreign object retained after surgery;

b. Air embolism;

c. Blood incompatibility;

d. Catheter associated urinary tract infection;

e. Pressure ulcers (decubitus ulcers);

f. Vascular catheter associated infection;

g. Mediastinitis After Coronary Artery Bypass Graft ("CABG")

h. Hospital acquired injuries (fractures, dislocations, intracranial injury, crushing injury, burn or other unspecified effects of external causes);

i. Manifestations of poor glycemic control;

j. Surgical site infection following certain orthopedic procedures;

k. Surgical site infection following bariatric surgery for obesity; and

l. Deep vein thrombosis and pulmonary embolism following certain orthopedic procedures except for pediatric (individuals under the age of 21 years) and obstetric populations.

76. Plan will not reimburse Specialist for any of the following Never Events in any inpatient or outpatient setting:

a. Surgery performed on the wrong body party;

b. Surgery performed on the wrong patient; and

c. Wrong surgical procedure performed on a patient.

77. Any section or paragraph title or caption contained in this Agreement is for convenience only, and in no way defines limits or describes the scope or intent of this Agreement or any of its provisions.

78. This Agreement, including, without limitation, any of its exhibits or attachments, may be revoked, altered, amended, or modified at any time by written agreement executed by the parties hereto.

79. This Agreement, including, without limitation, any of its exhibits or attachments, may be amended by Plan by providing Specialist no less than thirty (30) days prior written notice of the effective date of the amendment. If Specialist provides written acceptance of the amendment, Specialist shall be bound by the amendment as of the effective date set forth in the notice of the amendment from Plan. If Specialist does not provide written acceptance or timely objects in writing to the amendment, Specialist and Plan shall attempt in good faith to resolve the matter to their mutual satisfaction for a period not to exceed fifteen (15) days following Plan's written notice of the amendment or Plan's receipt of Specialist's written objection to the amendment. In the absence of such resolution, and notwithstanding anything in this Agreement to the contrary, either Specialist or Plan may terminate this Agreement or the participation of an individual Specialist in the provision of Covered Services under the applicable Program/Plan agreement, upon written notice to the other party within five (5) days after the expiration of the fifteen (15) day period described above. The effective date of such termination shall be on the expiration of the five (5) day notice period described above. In the event of such termination, Specialist shall be bound by the amendment from its effective date through the effective date of termination.

80. Each party shall without limit indemnify, hold harmless, and at the non-indemnifying party's election, defend the non-indemnifying party, its officers, agents, employees, and representatives with respect to any and all claims, damages, judgments, actions, and causes of action, arising out of the acts or omissions of the indemnifying party's officers, agents, employees, and representatives, related to the services provided pursuant to this Agreement, including all costs, expenses and attorney's fees incurred in the defense of any and all claims and/or litigation.

81. Any notice hereunder shall be in writing an shall be deemed given when sent by certified United States mail, postage prepaid, by recognized overnight delivery service, or by hand deliver to Plan and Specialist at the addresses set forth below:

To Plan:	Kenny Greene Vice President of Provider Services Trusted Health Plan 1100 New Jersey Avenue, S.E. Suite 840 Washington, D.C. 20003
With a copy to:	Chika Duru General Counsel Trusted Health Plan 1100 New Jersey Avenue, S.E. Suite 840

To Specialist:

82. No waiver of any provisions of this Agreement shall be valid unless in writing and signed by the party against whom such waiver is sought. One or more waivers of any covenant or condition of this Agreement by any of the parties hereto shall not be construed as a waiver of any subsequent breach or of other covenants or conditions.

83. This Agreement is made pursuant to, and shall be governed by the laws and decisions of the District of Columbia, regardless of its choice of law provisions. This Agreement is subject to all rules and regulation promulgated from time to time by any regulatory agency, and this Agreement shall be deemed to be amended to conform therewith at all times. When amendment is required by federal or district law or regulation or by a regulatory agency, Plan shall provide thirty (30) days advance written notice of the amendment to Specialist. Specialist shall be deemed to have accepted the amendment unless Specialist objects to Plan in writing within thirty (30) days of receipt of the notice of amendment. Either party may terminate this Agreement upon ten (10) days written notice if the parties are unable to reach an agreement on the amendment within thirty (30) days of Plan's receipt of Specialist's objection.

84. The invalidity or unenforceability of any particular provision of this Agreement shall not affect any other provision hereof. This Agreement shall be construed in all respects as if such invalid or unenforceable provision(s) were omitted.

85. When the context of this Agreement requires, the gender of all words shall include the masculine, feminine, and neutral, and number of all words shall include the singular and plural.

86. The parties have not and do not intend to create any rights through this Agreement in any third parties, including Members.

87. Neither party shall be liable nor deemed to be in default for any delay or failure in performance under this Agreement or other interruption of service resulting, directly or indirectly, from acts of God, civil or military authority, acts of a public enemy, war, accidents, fires, explosions, earthquakes, floods, failure of transportation, strikes or other work interruptions by either party's employees, or any similar or dissimilar cause beyond the reasonable control of either party; provided, hoever, in the event the provision of Covered Services is substantially interrupted, Plan reserves the right to terminate this Agreement upon ten (10) days prior written notice to Specialist.

88. This Agreement and any amendments hereto may be executed in any number of counterparts, each of which shall be treated as an original, but all of which, collectively, shall constitute a single instrument.

89. To the extent that Specialist is a group practice or is otherwise executing this Agreement on behalf of individual providers, Specialist warrants that it has the authority to bind and hereby binds each individual Specialist to the terms and conditions set forth herein.

IN WITNESS WHEREOF, the parties hereto have caused this Agreement to be executed effective as of the Effective Date.

SPECIALIST (*i.e.*, AUTHORIZED REPRESENTATIVE WITH RESPECT TO THE TAX ID NUMBER LISTED BELOW):

Signature: _____

Print Name:

Title:

Address:

City/State/Zip:

Email Address:

Tax I.D. #:

Dated:

Plan hereby accepts Specialist under this Agreement effective as of the Effective Date.

PLAN:
Trusted Health Plan (District of Columbia), Inc.
1100 New Jersey Avenue, S.E., Suite 840
Washington, D.C. 20003
www.Trustedhp.com
45-2375150

_____
Signature: Chika Duru
Title: General Counsel
Date:

EXHIBIT A

COMPENSATION SCHEDULE
FOR DC HEALTHY FAMILY PROGRAM MEDICAID

COVERED SERVICES AND PAYMENT ARRANGEMENT

1. Covered Services. The Covered Services shall consists of all services that are covered by the DCHFP Medicaid program, subject to the terms of this Agreement, all rules, regulations, policies and procedures of the DCHFP Medicaid Program, and Plan's authorization for referral services.

2. Payment Arrangement. Payment to Specialist for providing the Covered Services referenced herein shall be equal to the lesser of (a) the amount charged by Specialist; or (b) 80% of the current Medicaid fee-for-service program for the same service.

3. Prompt Payment. Payment to Specialist by Plan within seven (7) days of Plan's receipt of claim shall be paid at 98% of the lesser of (a) the amount charged by Specialist; or (b) 80% of the current Medicaid fee-for-service program for the same service.

Specialist accepts the Prompt Payment method - Yes _____ No _____
Initial Initial

EXHIBIT B

COMPENSATION SCHEDULE
FOR ENROLLED ELIGIBLE DC ALLIANCE MEMBER

COVERED SERVICES AND PAYMENT ARRANGEMENT

1. Covered Services. The Covered Services shall consists of all services that are covered by the DC Alliance program, subject to the terms of this Agreement, all rules, regulations, policies and procedures of the DC Alliance Program, and Plan's authorization for referral services.

2. Payment Arrangement. Payment to Specialist for providing the Covered Services referenced herein shall be equal to the lesser of (a) the amount charged by Specialist; or (b) 80% of the current Medicaid fee-for-service program for the same service.

3. Prompt Payment. Payment to Specialist by Plan within seven (7) days of Plan's receipt of claim shall be paid at 98% of the lesser of (a) the amount charged by Specialist; or (b) 80% of the current Medicaid fee-for-service program for the same service.

   Specialist accepts the Prompt Payment method - Yes _____ No _____
   Initial Initial

EXHIBIT C

COMPENSATION SCHEDULE
FOR ENROLLED ELIGIBLE MEDICARE ADVANTAGE MEMBERS

1. Covered Services. The Covered Services shall consist of all services that are covered by the Medicare Advantage program, subject to the terms of this Agreement, and all rules, regulations, policies and procedures of the Medicare program, and THP's authorization for referral services.

2. THP will pay Specialist for Covered Services at 100% of the then current Medicare fee schedule.

EXHIBIT D

MEDICARE ADVANTAGE, DC HEALTHY FAMILY PROGRAM MEDICAID/ALLIANCE PROGRAM NETWORK

Upon execution of this page, Specialist agrees to participate in Plan's network to provide Specialty Physician Services to Plan's Members, and shall be bound by and comply with the terms and conditions of the programs set out under Exhibit E below.

Specialist further agrees that as a condition of participation as a Specialist under the Medicare Advantage and DC Healthy Family Medicaid/Alliance Programs, Specialist shall make available Covered Services to enrolled eligible Medicare and DC Healthy Family Medicaid/Alliance Program members.

AGREED TO:

_____
(Printed Name of Specialist)

By:_____
Signature

_____
(Printed Name of Specialist Representative)

_____
(Title of Specialist Representative)

DATE:_____

EXHIBIT E

COVERED PROGRAMS

1. Medicare Advantage
2. D.C. Healthy Family Program Medicaid
3. D.C. Alliance Program

SAMPLE

TRUSTED HEALTH PLAN (DISTRICT OF COLUMBIA), INC.
PLAN/REFERRAL HOSPITAL PARTICIPATION AGREEMENT

This Plan/Referral Hospital Participation Agreement (this "Agreement") is made and entered into as of the Effective Date (as defined on the signature page of this Agreement), between [HOSPITAL NAME], including any Hospital Entity (collectively, "Hospital"), and Trusted Health Plan (District of Columbia), Inc. ("THP"), a Washington, DC corporation licensed as a Health Maintenance organization ("HMO"), and which has contracted with the District of Columbia Department of Health Care Finance ("DHCF"), to provide certain services under the THP-DHCF Managed Care Organization ("MCO") Contract ("MCO Contract"). Each Hospital Entity providing Covered Services hereunder on behalf of Hospital shall be bound to the terms and conditions of this Agreement to the same extent as Hospital and all duties and obligations of Hospital hereunder shall be the duties and obligations of each Hospital Entity.

In consideration of the mutual obligations and promises set forth herein, the parties agree as follows:

1. DEFINITIONS

a. "Clean Claim" means a claim that has no defect, impropriety, lack of any required substantiating documentation or particular circumstance requiring special treatment that prevents timely payment.

b. "Covered Services" means health care services a Member is entitled to receive under THP's Medicaid program, DC Alliance program, and Medicare program.

c. "Dispute Resolution" means the process set out under paragraph 22(i) below

d. "External Quality Review" means a validation of performance/quality improvement measures and activities; compliance with local standards for access to care, structure and operations; and validation of consumer or provider surveys for quality of care.

e. "Hospital Entity" any Hospital subsidiary entity, business line, or division of Hospital.

f. "Member" means any individual currently eligible to participate in and enrolled in THP's Medicaid program, DC Alliance program, and Medicare program.

g. "Participating Hospital" means a hospital that is an in-network hospital provider for THP.

h. "Provider Manual" means the rules, policies, and procedures applicable to Covered Services provided under this Agreement regarding medical management, utilization review, quality assurance, case management, disease management, quality improvement, provider and member grievance procedures, the appeals process, and the use of THP Participating Hospitals, including reimbursement policies, preauthorization and referral requirements, and credentialing and re-credentialing standards and policies.

SAMPLE

i. "Quality Management Program" means THP's program to establish, maintain, and perform quality management reviews of Covered Services provided to Members.

j. "Referral" means the document issued or process used by a Primary Care Physician ("PCP") directing the Member to another health care provider for specialty services, ancillary services, or other Covered Services.

k. "Second Level Appeal" means a provider appeal of an adverse claims determination issued by THP in response to the provider's first appeal.

l. "Sentinel Event Policy" THP's policy, as described in the Provider Manual, regarding an unexpected occurrence involving death or serious physical or psychological injury or risk thereof.

m. "Serious Reportable Events" means an incident involving death or serious harm to a Member resulting from a lapse or error in a healthcare facility.

n. "Utilization Management Program" means THP's program outlining procedures for the efficient use of resources for the provision of Covered Services. The program shall include the review of elective admissions, Referrals and hospital admissions on a concurrent and prospective basis and emergency services on a prospective and retrospective basis. The program shall also include the use of care management teams comprised of utilization management nurse coordinators, nurse case management coordinators, medical outreach representatives and social workers, working in coordination with PCPs to provide multi-disciplinary and comprehensive coordinated care to Members.

2. Hospital agrees to provide the health care services, supplies and/or products described in Exhibit A (attached hereto) of this Agreement ("**Covered Services**") to THP Members. Covered Services will be subject to any restrictions or limitations set forth in the Provider Manual or hospital manuals, bulletins, directives, and other written information received by THP from DHCF. THP will give Hospital notice of any changes to such restrictions or limitations, as well as of any changes in Covered Services, operational policies and procedures, and/or appeal procedures with respect to the policies and administrative decisions that Hospital is required to follow.

3. Hospital warrants that it is a participant in good standing in the Medicaid and Medicare Advantage programs, and it will maintain this good standing during the term of this Agreement. Hospital warrants that it has not been convicted of a felony or suspended from participating in Medicare, Medicaid or any other third-party payor program. Hospital further warrants that it does not now and will not, during the term of this Agreement, employ or contract, directly or indirectly, with any individual or entity that has been excluded from participation in Medicare, Medicaid, or any other third-party payor program. If for any reason Hospital receives notice from Medicare, Medicaid, or any other third-party payor program of any sanction or proposed sanction against Hospital or any individual or entity providing services hereunder, Hospital agrees to notify THP no later than ten (10) days after Hospital receives notice of the sanction or proposed sanction.

4. Neither Hospital, THP, nor any employee, agent, or subcontractor of Hospital or THP, is excluded under Title XIX of the Social Security Act, from participation in Medicaid, Medicare or any other government program and will advise agents and subcontractors of this provision and its requirements.

SAMPLE

a. Each party will immediately report to the other party if any of its employees or agents is excluded or debarred as outlined herein.

b. Each party will review or cause to be reviewed the HHS OIG, the GSA Excluded Parties List, and the DC Excluded Parties List, upon employment or contracting with an individual or entity and annually thereafter, and shall immediately terminate from employment or contract an individual or entity that has been excluded.

c. This Agreement is subject to all the rules and regulations promulgated from time to time by the regulatory agencies that oversee the District of Columbia MCO Program (*e.g.*, DHCF) and any other governmental entity with regulatory authority over THP, including, but not limited to, the Department Of Insurance, Securities, and Banking for the District of Columbia ("DISB"), and this Agreement shall be deemed to be amended to conform therewith at all times. When amendment is required by federal or state law or regulation or by a regulatory agency, or when amendment is required to permit THP to do business with another payor program, THP shall provide sixty (60) days advance written notice of the amendment to Hospital. Hospital shall be deemed to have accepted the amendment unless Hospital objects to THP in writing within thirty (30) days of receipt of the notice of amendment. Either party may terminate this Agreement upon ten (10) days written notice if the parties are unable to reach agreement on the amendment within thirty (30) days of THP's receipt of Hospital's objection.

5. THP will pay Hospital for Covered Services provided to Members as set forth in Exhibit A of this Agreement. Claims submitted by Hospital to THP for Covered Services must include such information as THP requires to determine that the services were rendered and in compliance with THP's authorization procedures. Hospital agrees (i) that all encounter information and claims for payment for Covered Services provided hereunder shall be submitted to THP electronically (*i.e.*, rather than in a hard copy paper format); and (ii) that THP shall have the right to terminate this Agreement upon Hospital's failure to do so. Hospital also agrees to allow THP to review and copy all records pertaining to Covered Services provided by Hospital to Members. THP will maintain a current eligibility system for identifying Members and will give Hospital access to the system and provide for reconciliation of errors. THP will provide initial information to Hospital and notice of changes in Covered Services and all operational policies and procedures with which Hospital must comply. The internal appeal procedures for policies or procedures affecting hospitals will be set forth in the THP Provider Manual.

6. Hospital shall only look to THP for payment for services rendered to a Member. Hospital agrees that in no event, including, but not limited to, nonpayment by THP, insolvency of THP or breach of this Agreement, shall Hospital bill, charge, collect a deposit from, seek compensation, remuneration, or reimbursement from, or have any recourse or maintain any action at law or in equity against DHCF, the District of Columbia, an Member or persons (other than THP) acting on the Member's behalf, for Covered Services. This provision shall not prohibit collection of any applicable copayments or deductibles from Members billed in accordance with the terms of the applicable subscriber agreement or the health plan documents offered by THP. Hospital further agrees that (i) this provision shall survive the termination of this Agreement regardless of the cause giving rise to such termination and shall be construed to be for the benefit of THP's Members and that (ii) this provision supersedes any oral or written agreement to the contrary now existing or hereafter entered into between Hospital and the Member or persons acting on the Member's behalf, insofar as such contrary agreement relates to

liability for payment for, or continuation of Covered Services. No changes shall be made in this provision without the prior written approval of DHCF.

a. Hospital shall comply with the requirements of Section 1932(b)(6) of the Social Security Act, 42 U.S.C. 1396u-2 (b)(6), that a Member or the Member's family or caregiver may not be held liable or be subject to collection efforts for:

i. Debts or other obligations of THP or any hospital participating in the THP's hospital network in the event of insolvency.

ii. The cost of Covered Services under this Agreement in the event that THP fails to receive payment from the District of Columbia.

iii. The cost of Covered Services under this Agreement if Hospital fails to receive payment from the THP.

b. Hospital is prohibited from imposing any cost-sharing or similar charge on a Member for Covered Services provided to such Member.

c. Hospital is prohibited from referring any amounts due to a collection agency or other party for collection if payment is being sought from Member for Covered Services.

7. Hospital shall cooperate with and comply with all reasonable aspects of THP's fraud, waste, and abuse efforts; quality assurance; quality improvement; and utilization review programs and grievance system, and participate in and cooperate with the decisions, rules, and regulations established by THP's utilization review program, including, but not limited to, precertification of elective admissions and procedures, referral processes, and reporting of clinical encounter data and other THP policies and procedures. Hospital agrees that THP may amend such program, policies and procedures from time to time with fifteen (15) days prior written notice.

8. Hospital shall not discriminate against Members on any grounds prohibited by law, including, without limitation, on the basis of membership in THP, source of payment, physical or mental handicap, sex, age, race, color, creed, religion, national origin, ancestry, marital status, sexual preferences, health status, or disability, in providing health care services under this Agreement. Hospital shall accept all Members and not segregate them in any way or treat them in a location or manner different from other persons enrolled in THP. Hospital shall comply with the provisions of the Americans with Disabilities Act of 1990 (42 USC 12101 et seq. and 47 USC 225) and not discriminate against any employee or applicant for privileges of employment, or any matter directly or indirectly related to employment, because of race, color, religion, national origin, ancestry, age, sex, height, weight, marital status, physical or mental handicap, or disability. Hospital shall comply with all applicable federal and District laws relating to non-discrimination and equal employment opportunity, and assure physical and program accessibility of all services to persons with physical and sensory disabilities, pursuant to Section 504 of the Federal Rehabilitation Act of 1973, as amended, 29 U.S.C. §794, all requirements imposed by the applicable regulations (45 CFR Part 84), and all guidelines and interpretations issued pursuant thereto. Hospital will comply with the provisions of the Age Discrimination and Employment Act of 1967 and the Age Discrimination Act of 1975. In connection with performance under the Agreement, Hospital agrees not to discriminate against any employee or applicant for employment because of age, race, religion, color, handicap, sex, physical condition, income, Medicaid

SAMPLE

or Medicare status, place of residence, developmental disability, marital status, personal appearance, sexual orientation, family responsibility, matriculation, political affiliation, or national origin. Hospital shall comply with the provisions of Executive Order 11246 "Equal Employment Opportunity" as amended by Executive Order 11375 and supplemented by the United States Department of Labor regulations (41 CFR Sec 60).

9. Hospital's hours of operation for Medicare and Medicaid (DC Healthy Family Program (DCHFP), and Alliance participants) will be the same as operating hours for other lines of business. Hospital may not impose any limitations on the acceptance of Members for care or treatment that are available within the hospital that it does not impose on other patients of Hospital.

10. Hospital and each Hospital Entity shall meet THP's credentialing and re-credentialing requirements as they may be amended from time to time, including any requirements regarding licensure, certification, liability, worker's compensation, and malpractice insurance coverages, and provide to THP or its representatives information and documentation to demonstrate compliance with such requirements.

11. Hospital and each Hospital Entity shall secure and maintain all licenses, permits, certificates, and registrations required by district, federal or local laws, rules and regulations to perform its duties hereunder.

12. No individual or entity shall be permitted to provide services hereunder, (i) if such individual or entity acts, or fails to act, in a manner which may result in imminent danger to the health of a Member; (ii) upon the loss of such individual's or entity's license to practice his/her/its profession in the District of Columbia; or (iii) upon notice to THP that such individual or entity has been suspended, expelled, excluded or terminated from participation under Medicare, Medicaid or any other government program No payment will be made hereunder for services provided by any individual or entity that has been so excluded or whose license has been revoked. In addition, THP may require Hospital or any Hospital Entity to terminate the provision of services hereunder by any individual or entity immediately upon written notice to Hospital if THP determines such individual or entity poses a threat to the health or safety of any Member or to the license, certification or reputation of THP. Alternatively, THP may immediately transfer out of Hospital, any Member, if THP reasonably determines that any Member's health or safety is in jeopardy at the Hospital.

13. After compliance with the admission procedures set forth below , Hospital agrees to provide, on a twenty-four (24) hour a day, seven (7) days a week basis, Covered Services to Members:

    a. Hospital shall ensure that its Hospital-based physicians comply with the terms and conditions of this Agreement, including participation in THP's Utilization Management Program and Quality Management Program.

    b. Hospital shall provide Covered Services and arrange Hospital-based physician services in accordance with generally accepted standards of medical practice and the standards established by the THP Quality Management Program. Hospital shall ensure that its staff, including its Hospital-based physicians, maintain a competent level of experience and training. Hospital shall also comply with any and all reasonable corrective action plans established by THP related to the provision or failure to provide Covered Services and Hospital-based physician services. Refusal to accept corrective action plan may result in THP initiating termination options available under Section 42 herein. Hospital agrees to maintain and demonstrate to THP, upon request, throughout the term of this Agreement,

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compliance with the following:

i. Licensure as appropriate under the laws of the District of Columbia.

ii. Accreditation by the Joint Commission on Accreditation of Healthcare Organizations or its successor hospital accrediting organization, unless exempted from this requirement by THP or the District of Columbia.

iii. Written assurances that all Hospital-based physicians and nurses and other ancillary and paramedical personnel employed by, associated with, and/or under contract with Hospital are properly credentialed and licensed or certified to practice in the District of Columbia.

iv. The quality-related standards of THP, by providing, upon request, information concerning Hospital's malpractice and general liability insurance, medical staff, and clinical privileges. Hospital shall immediately notify THP in writing of any adverse decision of a regulatory body or other governmental entity, or Joint Commission or a successor organization, with respect to Hospita,l or of any other situation that would materially affect Hospital's ability to carry out its duties and obligations under this Agreement

c. Hospital shall implement all activities reasonably necessary to assist THP to obtain and maintain external accreditation by the National Committee for Quality Assurance ("NCQA") or any other accreditation organization recognized by Health Maintenance Organizations ("HMO") and selected by THP, including, but not limited to, cooperating in the auditing of Members' medical records. Such reviews and audits may include on-site visits, Hospital staff and Member interviews, medical record reviews, claim and encounter data reviews, reviews of Hospital continuous quality improvement policies and procedures, credentialing and re-credentialing activities, corrective actions and follow-up plans, Member satisfaction surveys, Hospital satisfaction surveys, and review of Hospital staff and Hospital provider qualifications.

d. Hospital agrees that it will seek prior authorization from THP for any and every inpatient admission other than for an emergency by contacting THP and giving notice of such admission for purposes of utilization review and quality assurance. Such contact and notification will be conducted by facsimile prior to or on the date of any such admission and will include the applicable admitting ICD-9, ICD-10, or any other revision of the ICD coding standard then in use, and the bed type. Contact and notification for emergency admissions will also be conducted by facsimile and will include the applicable admitting ICD code and bed type. Notification of non-emergency admissions will be provided within one (1) business day for an admission occurring outside of normal business hours or on state or federal holidays. Notification for emergency admissions will be made at the time when such emergency admissions occur during normal business hours and such notice requirement is consistent with applicable law. If such emergency admission occurs at any other time, Hospital will notify THP within one (1) business day after the admission. THP may authorize non-emergency admissions telephonically and will follow the same up with a written authorization sent by first class mail or via other approved methodologies to Hospital within forty-eight (48) hours of the verbal authorization. In the event authorization, in either verbal or written form, is not received from THP prior to a

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non-emergency admission, THP may not pay Hospital for such admission but may consider extenuating circumstances. In the event prior authorization for a non-emergent inpatient admission was not obtained, hospital shall submit medical record information as needed to make an authorization determination.

e. Hospital shall comply with the following admission procedures for emergencies. THP shall pay Hospital, pursuant to the terms of this Agreement and as mandated by the Emergency Medical Treatment and Active Labor Act ("EMTALA"), for an Emergency Medical Screening ("EMS") needed by a Member. Hospital shall not be required to obtain preauthorization from THP for an EMS. After the EMS and after any existing emergency medical condition has been stabilized, in order for the Hospital to receive reimbursement for an admission associated with this episode, hospital must obtain from THP an authorization number for treatment or to confirm that the authorization request has been denied. Hospital agrees that THP shall have access to timely information and documentation as needed in order to enable THP to review emergency admissions and to determine the number of inpatient days authorized under the Utilization Management Program. All information requested by THP's Utilization Management staff shall be made available to THP within twenty-four (24) hours, or as soon as reasonably available, of any such request.

f. Except for Emergency Services, Hospital shall request and examine the THP identification of the person seeking admission as an Member. In the event that the person representing himself or herself as an Member does not have THP identification, Hospital shall contact THP by telephone for verification before denying such person admission as an Member. Hospital agrees that in an Emergency, it will follow the foregoing procedures as soon as practicable.

g. Upon admission, every THP Member will be assigned to a licensed, and appropriately credentialed Hospital physician who attends to and will be responsible for the care of the Member until discharge. An attending physician will sign any orders and/or other appropriate admission documents within twenty-four (24) hours of the admission of any member. The attending physician shall maintain responsibility for the Member's care within Hospital unless the attending becomes unavailable through illness, absence from the District of Columbia metropolitan area, or termination from the Hospital staff.

h. Discharge Planning - Every THP member shall have a discharge plan consistent with industry standards and The Joint Commission guidelines completed by the Hospital and reviewed and signed by the attending physician prior to the discharge. A copy of the discharge plan shall be sent to THP. Facility may transfer or discharge a Member only as permitted by Federal or State law. THP shall be responsible for payment during the period a Member resides in Hospital after Hospital has concluded that the Member should be discharged, but Federal or State laws do not allow discharge, except that during such period, THP will not reimburse Hospital at an acute inpatient level. During this period, THP shall be responsible for locating a new placement for such Member, if necessary.

i. If Hospital fails to comply with the requirements outlined in Section 13, THP may deny payment for such services without recourse against the Member.

j. THP will not reimburse Hospital for procedures relating to the following Health Care Acquired Conditions ("HCAC"), identified in the Affordable Care Act of 2010, Public Law

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111-148, when any of the following conditions are not present upon admission in any inpatient setting, but subsequently acquired in that setting:

i. Foreign object retained after surgery;

ii. Air embolism;

iii. Blood incompatibility;

iv. Catheter associated urinary tract infection;

v. Pressure ulcers (decubitus ulcers);

vi. Vascular catheter associated infection;

vii. Mediastinitis After Coronary Artery Bypass Graft ("CABG");

viii. Hospital acquired injuries (fractures, dislocations, intracranial injury, crushing injury, burn or other unspecified effects of external causes);

ix. Manifestations of poor glycemic control;

x. Surgical site infection following certain orthopedic procedures;

xi. Surgical site infection following bariatric surgery for obesity; and

xii. Deep vein thrombosis and pulmonary embolism following certain orthopedic procedures except for pediatric (individuals under the age of 21 years) and obstetric populations.

k. THP will not reimburse Hospital for any of the following Never Event in any inpatient or outpatient setting:

i. Surgery performed on the wrong body part;

ii. Surgery performed on the wrong patient; and

iii. Wrong surgical procedure performed on a patient.

l. Throughout the term of this Agreement, Hospital will maintain for itself, its agents, and its employed providers, professional liability and general liability insurance of at least $1 million per occurrence or claim and $3 million in the annual aggregate. This insurance requirement may be met through self-insurance set at an actuarially determined amount established by an independent actuary. Hospital shall also require that any health care professionals which may be employed by or under contract with Hospital to render Covered Services to Members procure and maintain malpractice insurance in the amount of at least $1 million per occurrence or claim and $3 million in the annual aggregate, unless they are covered under the Hospital's insurance policies. Prior to the Effective Date and thereafter, upon reasonable request of THP, and upon any material adverse change in

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insurance coverage, Hospital shall submit evidence of this coverage to THP, including a Certificate of Insurance. In the event any such professional liability policy for Hospita. or for individual providers employed by Hospital is a claims made policy, Hospital will make provisions for "tail" coverage effective upon the termination of the primary policy, or obtain replacement coverage which insures for prior acts, insuring for losses arising from occurrences during the term of this Agreement, which tail policy or prior acts coverage shall have the same policy limits as the primary policy and shall extend the claims reporting period for the longest period for which coverage is available. Hospital shall provide THP with written notice of any cancellation or material adverse change to any such policy. Failure by Hospital to provide THP with proof of adequate insurance coverage within thirty (30) business days of Hospital's receipt of THP's written notice requesting the same will be regarded as a material breach of this Agreement and may be cause for immediate termination.

m. Hospital agrees to perform its duties under this Agreement in a manner consistent with the reasonable administrative guidelines provided by THP in its Provider Manual, a copy of which shall be provided to Hospital upon execution of this Agreement. Modifications of THP's Provider Manual are not, and shall not be deemed to be, amendments to this Agreement. In the event of conflict between THP's Provider Manual and this Agreement, the terms of this Agreement shall prevail. THP shall provide Hospital with thirty (30) days advance notice of any changes to its Provider Manual, unless such change is required by law or regulation to take place sooner.

n. Hospital agrees to reasonably cooperate in the Utilization Management and Quality Management Programs adopted by THP and communicated to Hospital. These programs shall include, among other things, processes to validate accuracy and appropriateness of coding information submitted, quality of care reviews, quality improvement projects, investigation of Member grievances, pre-admission certification and concurrent and retrospective review. Hospital agrees to reasonably cooperate with quality reviews as soon as reasonably practical after request by THP and once the purpose and scope are clearly defined. Hospital shall make available a designated on-site location for the use of THP employees, use of a telephone for such employees, and pertinent sections of an Member's medical records as may be required to implement such programs. Approval by THP's Utilization Management department of a particular admission or other Hospital service for a Member does not automatically include approval and verification by THP of that Member's eligibility. Hospital must separately request verification of a Member's eligibility from THP. All information requested by Utilization Management staff shall be made available to THP as soon as reasonably possible but not to exceed fifteen (15) business days.

o. Hospital shall report certain events in accordance with THP's Sentinel Event Policy, which will be distributed to Hospital and is incorporated in the Provider Manual. Any changes in the reporting requirements will be communicated through distribution of a revised Sentinel Event Policy. At a minimum, designated events must be reported as soon as possible after event identification and/or patient stabilization.

p. Hospital shall report to THP and applicable local and federal government entities all occurrences defined as Serious Reportable Events ("Never" Events) as outlined by the National Quality Forum. Hospital shall not bill or expect reimbursement for these events.

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q. Hospital shall report specific conditions and diseases in accordance with DC Code 7-131, 132 (2006) and Title 22 of the DC Code of Municipal Regulations. THP shall ensure that a copy of these reports are forwarded to DHCF, if THP is permitted to share this data.

i. Hospital shall report to THP, infants, toddlers, and school-age children experiencing a developmental delay. Hospital shall send to THP, information on DC Medicaid and Alliance members who are infants, toddlers, and school-age children, whose developmental assessment components of their Early and Periodic Screening, Diagnostic, and Treatment ("EPSDT") periodic or inter-periodic exams reveal evidence of developmental delay.

ii. Hospital shall submit data to THP regarding the occurrence of a vaccine-preventable illness for any and all members of THP.

iii. Hospital shall report to THP, information and/or data on members with sexually transmitted and other communicable diseases, including HIV.

iv. Hospital shall report to THP within twenty-four (24) hours, information on members suspected as being infected with tuberculosis.

v. In accordance with the District's Childhood Lead Poisoning Screening and Reporting Legislative Review Emergency Act of 2002, DC Code 7-871.03 (2006), Hospital shall report laboratory results of all blood lead screening tests to DHCF, the DC Department of Health, Childhood Lead Poisoning Prevention Program, and to THP, within seventy-two (72) hours after identification.

vi. Hospital and THP shall comply with reporting requirements of the District of Columbia registries and programs, including, but not limited to, the Cancer Control Registry and EPSDT Registry.

r. Hospital shall cooperate with THP in resolving any Member complaints and grievances related to the provision of Covered Services. Hospital agrees to participate in and cooperate with THP's Member grievance and complaint procedure, as set forth in THP's Provider Manual and to make best efforts to comply with all reasonable final determinations rendered in accordance with that procedure. Hospital agrees to provide information necessary to investigate, and where reasonably practicable, resolve a grievance or complaint within three (3) calendar days of the request.

s. Hospital understands that nothing in this Agreement shall require Members to utilize Hospital or guarantee any minimum volume of Covered Services.

14. THP may use Hospital's name, address and telephone number in THP materials, including THP's hospital directory. Hospital may provide written notice that Hospital is a Participating Hospital. In the event Hospital wants to use THP's name in any other context or for any other purpose other than general administrative purposes as specified by THP, Hospital shall obtain the prior written consent of THP, which consent shall not be unreasonably withheld. In the event THP wants to use Hospital's name in any other context or for any other purpose, THP shall obtain the prior written consent of Hospital, which consent shall not be unreasonably withheld.

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15. If any services provided by Hospital are not Covered Services, Hospital may bill Members at a rate no in excess of the rate which it bills the general public after first obtaining the Member's written consent to receive non-Covered Services and to be billed. Such consent may be a part of the standard documentation found in the facility's conditions of admission or such initial documentation as is customarily utilized by Hospital and completed by the patient. Hospital agrees to provide THP with such documentation upon request. Hospital shall, in no event, charge THP for any Covered Services, which are not medically necessary. Prior to billing Members for non-Covered Services, Hospital agrees to verify with THP that the claim is the Member's responsibility.

16. Notwithstanding any provision or understanding to the contrary, Hospital agrees and warrants that under no circumstances will Hospital or any Hospital employee or Hospital-based physician solicit, influence, persuade, or advise any Member of THP to dis-enroll or to join: (i) another HMO, including an HMO in which Hospital has an ownership interest; (ii) another managed care plan; (iii) a case management arrangement; or (iv) any other similar arrangement, including any other arrangement in which Hospital has an ownership interest (collectively referred to as "Alternative Care Plan"). If THP determines that hospital has violated this clause it shall constitute grounds to initiate actions in accordance with Section 42 herein.

17. Hospital agrees that in connection with all actions taken on behalf of Members, and in all communications with Members in connection with this Agreement, Hospital shall avoid actions and communications that could or shall undermine the confidence of the Member, a potential Member, employers, unions or the public in THP or in the quality of care THP provides. Notwithstanding the foregoing, nothing in this Agreement shall limit the rights of Hospital to: (i) communicate with patients, including Members, regarding medical treatment options; (ii) recommend a course of treatment to a Member, even if the course of treatment is not covered, or approved, by THP; (iii) file an appeal or complaint pursuant to the procedures of THP; (iv) supply accurate, relevant and factual information to a Member in connection with an appeal or complaint filed by such Member; or (v) object to policies, procedures, or decisions made by THP.

18. Hospital shall make best efforts to provide THP with at least thirty (30) days prior written notice of any material changes in Hospital's location, address, range of services, telephone numbers, and other relevant information relating to Hospital's operations. Hospital shall also be responsible for providing notice of such changes to Members on or before the effective date of such changes, as applicable.

19. Duties of THP - THP shall provide all administrative services under this Agreement, including quality management, utilization management, budgeting, administration of claims from hospitals other than Hospital, coordination of benefits, funds management, and compliance with all federal and D.C. regulatory requirements. THP shall provide Hospital with THP's administrative policies and procedures. THP also shall provide thirty days (30) written notice to Hospital of any significant changes in THP's policies and procedures.

    a. THP shall apprise Hospital and all Members concerning the type, scope, and duration of benefits and services to which Members are entitled under THP. Under all circumstances, THP shall retain final authority regarding coverage or benefit determinations for its Members.

    b. THP agrees to assist Hospital in the development and initial implementation of procedures necessary to carry out the terms of this Agreement.

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c. THP shall provide compensation to Hospital as set forth in the appropriate exhibit to this Agreement at the full and complete contracted amount, which shall be full compensation for Hospital's responsibilities described herein, except for applicable co-payments, including deductibles and co-insurance and as provided in Section 6. Any claims not paid at the full and complete contract amount shall be immediately subject to Dispute Resolution. Hospital's failure to follow the policies and procedures of THP as set forth in this Agreement and the Provider Manual may result in a denial of payment. Hospital shall submit claims in accordance with industry standards.

20. Hospital agrees to submit claims to THP on a completed CMS form UB-92 for facility services (or its successor form), or in such other format as mutually agreed to by the parties, within one-hundred eighty (180) days of the date of discharge for inpatient Hospital Covered Services and within one-hundred eighty (180) days after the date Covered Services are rendered for outpatient Hospital services. THP reserves the right to deny claims that are not submitted within such one-hundred eighty (180) day period, except where Hospital bills a third party payor as primary and extenuating circumstances exist. Hospital agrees to refrain from duplicate billing any claims submitted to THP, unless expressly approved by THP in order to process coordination of benefit claims. THP shall provide payment to Hospital within thirty (30) days of THP's receipt of an uncontested Clean Claim from Hospital, or other specified timeframes as may be required by the District of Columbia.

21. Hospital must submit a request for appeal of an adverse claims determination made by THP within ninety (90) days after the date of receipt of THP's written notice. THP may deny appeals that are not submitted within that timeframe. THP will respond to all timely appeals within fifteen (15) days to provide a written decision to the appeal, including the specific basis for the decision. If Hospital disagrees with this determination, Hospital may submit a Second Level Appeal within thirty (30) days of receipt of the initial appeal response. THP shall provide a written decision within thirty (30) days from receipt of Hospital's Second Level Appeal. If the appeal involves a clinical determination, the review shall be conducted by individuals with appropriate qualifications in the applicable specialty. A Second Level Appeal on a clinical determination shall not be conducted by the same individual involved in the initial appeal. If the appeal is not resolved following THP's response to the Second Level Appeal, the matter shall be subject to Dispute Resolution.

22. The following shall govern Hospital's submission of and THP's payment of claims:

a. Receipt of claim - For purposes of this clause, claims shall be recorded to have been received no later than twenty four (24) hours or one (1) working day, after actual receipt by THP and will be date stamped accordingly.

b. Payments of clean and complete claims made after thirty (30) days of receipt shall be considered late and subject to interest in accordance with the relevant prompt pay laws.

c. Subject to the D.C. Prompt Pay Law, D.C. Code § 31-3132, THP may request additional reasonable and necessary documentation when a claim is pended for administrative or medical review. THP shall adjudicate such claims in accordance with the DC Prompt Pay Law. Any portion of a claim that is not in question shall be paid in accordance with DC Prompt Payment Law provisions.

d. Hospital may submit interim claims if a Member's stay is greater than thirty (30) days.

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Claims will be settled according to all appropriate contract and reimbursement terms within thirty (30) days of submission of a final, clean discharge claim from the Hospital.

e. Hospital accepts payment from THP, together with authorized co-payments, as provided Herein, as full payment for Covered Services, and shall not pursue or collect charges for such services from Members or other third parties, except where authorized in this Agreement. However, Hospital agrees to cooperate and use best efforts in the effective implementation of any coordination of benefits procedures and other procedures for handling third party claims, as set forth in THP's Provider Manual, including collecting information from Members regarding other health insurance coverage. In the event Hospital receives payment for Covered Services from third parties, it shall promptly make appropriate adjustments due THP. Hospital shall be responsible for and implement a system for notifying THP of any claims by Members involving coordination of benefits. In any case where a Member admitted to Hospital has primary coverage from any third party payor and Hospital has reason to know of a primary payor other than THP, Hospital shall bill the third party payor and notify THP of the existence of any primary payor source at the time that Hospital submits a claim to THP.

f. When THP is notified of retroactive dis-enrollments of Members or when THP obtains information from a previous member eligibility report from DHCF that contradicts THP's prior reliance on a Member's eligibility for Covered Services, THP may retroactively deny Covered Services furnished to Members within ninety (90) days of receipt of notice or evidence contradicting a Member's prior eligibility, and shall send immediate written notice of such denial to Hospital with information identifying the proper coverage. Hospital shall recognize THP's immediate right to recovery for retroactively dis-enrolled Members and shall repay contested paid claims within thirty (30) days of notice from THP.

g. Hospital shall immediately refund to Members any and all sums collected by Hospital from Members, which should not have been collected under the terms of this Agreement. Such refunds shall take the form of payments by check from Hospital to Members. Upon request, Hospital shall provide THP notice of all refunds issued to Members no more than one week after such request from THP. Notice for the purposes of this section shall include, without limitation, the Members' names, refund amounts for each Member and the date paid.

h. THP and Hospital hereto understand that THP's ability to pay the rates in the attached schedules is conditioned upon the payments received from the District of Columbia Government. To the extent that DHCF or the Centers for Medicare and Medicaid Services ("CMS") reduces payments provided to THP under the Medicaid or Medicare Advantage programs in any manner, Plan may notify Hospital in writing of such reduction and both parties agree to negotiate in good-faith a revised fee schedule. If the parties are unable to agree upon a revised fee schedule within sixty (60) days of Plan's notice of reduction to Hospital, Plan reserves the right to terminate this Agreement under Section 40 below.

i. The parties shall work cooperatively and in good faith to attempt to resolve payment issues on an informal basis. However, either party may notify the other party in writing of a specific dispute, outlining the information and issues involved in such dispute and the part receiving such notification must respond in writing within thirty (30) days of the first

notification. If the issue is not resolved successfully in this timeframe, then parties shall attempt to resolve the dispute within an additional 60 (sixty) days of informal negotiations. If the parties do not resolve the dispute within the additional 60 (sixty) days, the parties agree to resolve the dispute through arbitration in accordance with the rules and procedures of JAMS/Endispute in Washington, D.C. for domestic disputes. THP and Hospital shall each choose an arbitrator and the two arbitrators so chosen shall choose the third. If either THP or Hospital fails to choose an arbitrator within 30 days after notice of commencement of arbitration or if the two arbitrators fail to choose a third arbitrator within 30 days after their appointment, JAMS/Endispute Washington D.C. shall, upon the request of any party to the dispute or difference, appoint the arbitrator or arbitrators to constitute or complete the panel as the case may be. Arbitration proceedings hereunder may be initiated by either THP or Hospital making a written request to JAMS/Endispute, together with any appropriate filing fee, at the office of JAMS/Endispute Washington D.C. All arbitration proceedings or litigation (to the extent the remedy requested is not, by law, available through arbitration [e.g., injunctive relief]) relating to any claims or disputes arising under or relating to this Agreement shall be brought in the county in which the principal executive office of the party not initiating such action or proceeding (i.e. the defendant or responding party) is located. The parties irrevocably submit and consent to the exercise of subject matter jurisdiction and personal jurisdiction over each of the parties by the federal and/or state courts in such jurisdiction (the "Selected Jurisdiction"). The parties hereby irrevocably waive any and all objections that any party may now or hereafter have to the exercise of personal and subject matter jurisdiction in the Selected Jurisdiction and to the laying of venue of any such proceeding or action brought in the Selected Jurisdiction. Any order or determination of the arbitral tribunal shall be final and binding upon the parties to the arbitration and may be entered in any court having jurisdiction.

j. If the parties determine that THP has underpaid Hospital, THP shall pay the underpaid amount to Hospital within sixty (60) days of said determination. If the parties determine that THP has overpaid Hospital, Hospital shall reimburse THP for the overpayment within sixty (60) days of said determination.

k. Neither party shall be permitted to request an adjustment to reimbursement made to Hospital more than one hundred eighty (180) days from the date of payment.

l. THP or its designee shall have the right to audit records maintained by Hospital regarding claims submitted by Hospital and payments received by Hospital from THP or its designee. Hospital agrees to provide reasonable access to Hospital facilities and records for inspections and audits by THP, DHCF, the D.C. Department of Health ("DOH"), the U.S. Department of Health and Human Services ("HHS"), CMS, the Office of the Inspector General ("OIG"), and their respective designees, and to cooperate with all audits and inspections to the same extent that audits and inspections may be required under law or under THP's contract with DHCF.

m. THP will notify Hospital in writing of any request for Hospital bill audits within 365 days of the paid date. Such audits may include individual cases selected for review or sample cases of a particular category selected for review in conjunction with THP's obligations to CMS to assure the integrity of Medicaid and Medicare program spending. The reason or

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focus for such review must be outlined, and Hospital will respond in a timely manner and use reasonable efforts to arrange for such audit to be completed within thirty (30) days of request, provided that the claim has been paid in full in accordance with the Agreement. Such audits shall be conducted on site at Hospital and shall be scheduled on a basis that is appropriate and reasonable for the volume and extent of records requested. A bill audit conference or exit interview shall occur prior to finalizing audit results, at which time the preliminary findings and conclusions shall be provided to Hospital. All final audit results shall be net of overcharges, undercharges, unbilled charges and disallowed charges and Hospital shall have an opportunity to address any documentation issues. If the parties are in agreement on the audit findings a summary of the findings will be signed off by the parties to close the audit. Any monies due from one party to the other shall be paid within sixty (60) days of the execution of the audit summary of findings. If the parties cannot agree on the final audit findings, either party may institute Dispute Resolution proceedings pursuant to Section 22(i) above.

23. To comply with the Health Insurance Portability and Accountability Act of 1996 (Public Law 104-191, August 1996), both parties must comply with the following:

    i. All individually identifiable information relating to Medicare, Medicaid and DC Alliance enrollees must be kept confidential pursuant to 42 U.S.C. Section 1396a (a)(7), 42 CFR Part 2 and other regulations promulgated there under. Such information may be used by the hospital only for a purpose directly connected with performance of Hospital's obligations under this program and this Agreement. The provisions of this section will survive the termination of THP's participation and/or Hospital participation in the Medicare program or the Medicaid managed care program and will remain in effect as long as Hospital maintains any individually identifiable information relating to Medicare, Medicaid and/or DC Alliance beneficiaries. Hospital must ensure compliance with the Health Insurance Portability and Accountability Act of 1996 (Public Law 104191, August 21, 1996) and all applicable regulations promulgated there under. Such regulations include, but are not limited to, the medical privacy rule, 45 C.F.R. Parts 160 and 164, and the electronic transactions and code set standards rule, 45 C.F.R. Parts 160 and 162. Hospital shall maintain written procedures for compliance with all applicable privacy, confidentiality, and information security requirements. Hospital shall train its physicians, employees, and agents on the requirements for compliance with all applicable privacy, confidentiality, and information security requirements.

24. Hospital shall comply with the following advanced directives:

    i. Not discriminate against a Medicare or Medicaid Member on the basis of whether the Member has executed an advance directive.

    ii. Comply with District of Columbia law (whether statutory or recognized by the courts of competent jurisdiction) on advance directives.

    iii. Cooperate with THP's educational efforts regarding advance directives.

25. Hospital agrees to assist any Medicaid Member in completing the required forms to enroll newborns

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born to the Medicaid Member under Medicaid.

26. Hospital shall cooperate with any external review organization contracted by DHCF or THP to perform quality studies.

27. In addition, THP must provide information regarding its Members and regarding public health issues affecting its Members to DHCF upon request. Hospital must cooperate with THP in meeting these reporting requirements by providing THP with information, upon request or as provided hereunder, which will include, without limitation, the following (to the extent applicable to Hospital's areas of practice):

    i. Known deaths of Members within 72 hours.

    ii. Members treated by Hospital who are diagnosed with HIV/AIDS.

    iii. Members with developmental delays.

    iv. Members diagnosed as tuberculosis cases or tuberculosis-infected.

    v. Members with vaccine-preventable diseases and other communicable diseases.

    vi. Female Members and Members up to the age of 5 who have or are at risk for nutritional deficiencies or have nutrition-related medical conditions.

    vii. Members under the age of 21 who have an elevated blood lead level (greater than 10 ug/dl), which information is to be reported to THP within 48 hours after identification.

28. Hospital shall ensure that Hospital schedules appointments for initial assessments for pregnant Members or persons desiring family planning services to take place within ten (10) days of the request. Hospital understands that a Member may choose instead to receive family planning services from a qualified family planning hospital without a Referral from Hospital. Hospital shall ensure that urgent care services are provided within twenty four (24) hours of receipt of a valid request.

    a. THP is responsible to DHCF or its designee for compliance with all activities of the External Quality Review (EQR) process. To the extent that Hospital is responsible for data, information or other requirements of the EQR, Hospital shall:

        i. Submit requested pre-site survey documents and/or information in accordance with published timelines.

        ii. Submit documents and/or information required during the on-site reviews within specified timelines.

        iii. Submit requested Member medical records/information for annual clinical studies within specified timelines.

        iv. Adhere to HIPAA guidelines when securing and/or submitting consumer-related information.

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v. Maintain quality improvement programs and plans that focus on meeting and exceeding the performance standards, services and satisfaction standards, required by the District of Columbia or their designee.

vi. Ensure that it meets or exceeds THP's access standards as set out in the Provider Manual.

vii. Submit corrective action plans (CAPs) within pre-established timelines.

viii. Make available Hospital's patient clinical records and/or information requested by THP.

29. Hospital shall collect and report the data required by an EQR organization in support of THP's obligation under sections 1902(a)(30)(C) and 1932(c)(2) of the Social Security Act, 42 U.S.C. U.S.C.1396a(a)(30)(C) and 42 U.S.C.-139u-2(c)(2).

30. THP will make available to Hospital, the results of each annual external independent quality review conducted by the DHCF or its designee.

31. Section 1932(b)(3) of the Social Security Act requires that a "Medicaid managed care organization shall not prohibit or otherwise restrict a covered health care professional from advising such an individual (Member) who is a patient of the professional about the health status of the individual or medical care or treatment for the individual's conditions or disease, regardless of whether benefits for such care or treatment are provided under the contract, if the professional is acting within the lawful scope of practice." As required by 1903(m)(2)(A)(xi) of the Social Security Act, 42 U.S.C. 1396b(m)(2)(A)(xi), THP will not interfere with such communications between covered health care professionals and Members who are a patient of the professional.

32. Hospital shall not be prohibited from advising an individual about the individual's health status or medical care or treatment for the individual's condition or disease, regardless of whether items and services for such care or treatment are covered under the Contract, if the professional is acting within their lawful scope of practice. In addition, the Hospital may not refuse an assignment or seek to discharge from care, a Member, or otherwise discriminate against a Member on the basis of age, sex, race, gender, physical or mental handicap/developmental disability, national origin, or type of illness or condition, except when that condition can better be treated by another hospital type.

33. If Hospital receives a Referral for, or identifies a request for experimental treatment, Hospital must submit the request to THP within twenty (24) hours of identifying or receiving the request, even if Hospital chooses not to recommend the requested experimental treatment.

34. THP is responsible for actively conducting valid reviews of Members' medical records as a regular, consistent component of THP's Quality Management Program. Hospital will cooperate with such reviews by ensuring that Members' medical records are maintained in a manner that allows THP to be in compliance with this provision. Medical record reviews will be conducted on a population sample of sufficient size so as to yield valid and reliable statistical information. All medical record reviews and evaluation will be conducted pursuant to HIPPA regulations and accepted industry standards for quality assurance and quality improvement related to:

SAMPLE

a. The diagnosis and treatment of injury, illness and disease.

b. Disease prevention, health promotion and health education activities.

c. The appropriate documentation of care in clinical records.

35. Hospital is responsible for submitting Members' medical records for review pursuant to a request from THP, DHCF or their designee.

36. Members are entitled to hearings before the District of Columbia Office of Administrative Hearings ("OAH"). As a part of that process, THP is required to provide all information necessary for a Member appeal. Hospital shall provide to the Member all information necessary for the Member's appeal within a time frame established by the District of Columbia Office of Managed Care and/or OAH, upon notification by THP, DHCF, the Office of Managed Care and/or OAH, that such information is required.

37. Hospital shall comply with CMS guidelines for observation care. CMS defines observation status as a "well defined set of specific, clinically appropriate services, which include ongoing short-term treatment, assessment, and reassessment, before a decision can be made regarding whether patients will require further treatment as hospital inpatients or whether they can be discharged from the hospital."

a. Observation time must be documented in the medical record. THP will utilize its standard criteria to determine whether a case qualifies for observation status upon receipt of notification of the admission decision from the Hospital. Time begins with the patient's admission to an observation bed. THP will only cover observation up to 23 (twenty-three) hours.

b. When both emergency department charges, and observation charges appear on the claim, the payment shall be based on the observation revenue code and be paid at the observation rate for up to 23 (twenty-three) hours.

38. Until the expiration of ten (10) years (or longer, to the extent required by applicable law) after the furnishing of services pursuant to this Agreement, Hospital shall maintain medical records, required data, reports of services, reports on complaints and grievances, records of quality or utilization issues and any books, documents and records, electronic or paper, for the purpose of assessing quality of care, conducting medical care evaluations and audits, and determining on a concurrent basis, the medical necessity, appropriateness, nature and extent of care provided to Members, and to permit representatives of THP, DHCF, or the Department of Inspector General to inspect the premises and equipment used by Hospital and to review and copy records pertaining to the provision of Covered Services under this Agreement to Members. Such records shall be maintained in compliance with applicable district laws and administrative rules and federal laws and regulations related to privacy and confidentiality of medical records. Such records shall be maintained in a detailed and comprehensive manner, which conforms to good professional medical practice, permits effective professional medical review and medical audit processes and facilitates an adequate system for follow-up treatment, and shall be signed and dated.

39. THP and Hospital agree that they are independent contractors and that this Agreement is not intended to

create the relationship of employer and employee, or principal and agent.

40. Either party may terminate this Agreement with or without cause upon ninety (90) days written notice to the other party. THP may terminate this Agreement immediately when it reasonably determines that continuation of the contract may negatively affect patient care. This Agreement may be terminated automatically by THP without the requirement of advance notice when: (a) THP's contract with DHCF terminates; (b) Hospital fails to maintain all licenses, permits, certificates, and registrations required by district, federal or local laws, rules and regulations to perform its duties hereunder or fails to remain in compliance with all of THP's credentialing requirements; (c) Hospital fails to maintain the insurance coverage required under this Agreement; or (d) Hospital is suspended or terminated from participation in the Medicare, Medicaid, any other federal health program, or the DC Alliance programs. In the event of insolvency or other cessation of operations by THP, Hospital agrees to provide Covered Services through the last day of the month for which THP has received capitation payment for Covered Services from DHCF whether or not Hospital receives any payments for such month, and to provide Covered Services to any Member hospitalized on the date of such insolvency or other cessation of operations until such Member is discharged.

41. Hospital agrees not to subcontract or delegate its duties or assign any of its rights or obligations under this Agreement except to a Hospital Entity or as otherwise expressly permitted by this Agreement. Any subcontract, delegation or assignment in violation of the foregoing will be void, unless approved in writing by THP. THP may subcontract or delegate its duties without prior approval of Hospital. At its option, Hospital may contract with a management company to perform certain management and administrative functions on behalf of Hospital under the direction and control of Hospital. However, Hospital shall at all times be responsible for compliance with the terms of this Agreement.

42. THP does not prohibit Hospital or any individual providing services hereunder on behalf of Hospital from discussing treatment options with Members that may not reflect THP's position or may not be covered by THP, or from advocating on behalf of a Member in any grievance, utilization review, or individual authorization process to obtain health care services.

43. This Agreement shall remain in effect for an initial period of twelve (12) months, unless sooner terminated pursuant to the terms of this Agreement. Thereafter, this Agreement shall automatically be renewed for successive twelve (12) month terms unless either party provides the other party with written notice of its intent not to renew at least ninety (90) days prior to the expiration of the then current term.

44. Hospital must adhere to the following disclosure requirements:

    a. Within thirty-five (35) days upon request of DHCF or the Secretary of HHS, Hospital must disclose the business transaction information identified in 42 C.F.R. § 455.105, including:

        i. The ownership of any independent contractor with whom Hospital has had business transactions totaling more than twenty-five thousand dollars ($25,000.00) during the twelve (12) month period ending on the date of the request.

        ii. Any significant business transactions between the Hospital and any wholly owned supplier during the five (5) year period ending on the date of the request.

SAMPLE

iii. Any significant business transaction between the Hospital and any independent contractor during the five (5) year period ending on the date of the request.

b. At any time upon request by THP or DHCF, Hospital must disclose:

i. The identity of any person who has ownership or a controlling interest in Hospital who has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or the Title XX services program since the inception of those programs; and

ii. The identity of any person who is an agent or managing employee of Hospital who has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or the Title XX services program since the inception of those programs.

45. Hospital shall adhere to the below marketing conditions:

a. Any marketing information distributed by Hospital directed at THP's Members shall be limited to general information about THP and notification that Hospital participates in Plan's network. Any such materials must be submitted to THP for review and approval prior to distribution to Members (THP will ultimately submit such materials to DHCF for review and approval).

b. Hospital will not utilize written information that is false or misleading in any material respect, including information regarding the Hospital's network, the availability of services, the Hospital's qualifications, hours, and location of services.

c. Hospital shall not host marketing events within the Hospital's facility.

d. Hospital shall not offer to Members gifts of more than a de minimus value or other insurance products designed to induce persons to enroll in THP.

e. Hospital shall not enter into compensation agreements with marketing personnel that utilize any type of payment structure in which compensation is tied to the number (or classes) of persons who enroll in THP.

46. Each party shall, without limit, indemnify, hold harmless, and at the non-indemnifying party's election, defend the non-indemnifying party, its officers, agents, employees, and representatives, with respect to any and all claims, damages, judgments, actions, and causes of action, arising out of the acts or omissions of the indemnifying party's officers, agents, employees, and representatives, related to the services provided pursuant to this Agreement, including all costs, expenses and attorney's fees incurred in the defense of any and all claims and/or litigation.

47. Any and all notices or other communications provided for or required by this Agreement shall be directed to the party to be so notified, in writing, by registered or certified mail, return receipt requested, or by electronic mail, and addressed to the applicable party at its respective business or electronic addresses shown on the first page of this Agreement, or such other address of which the other party has

received written notice; provided, however, that any notice posted on THP's website shall constitute notice for all purposes hereunder. For purposes of clarification, and without limiting the generality of the foregoing, notice sent via electronic mail shall constitute written notice for all purposes hereunder. Each party shall notify the other party promptly and in writing of any change in its respective business and/or email address. Any notice hereunder shall be in writing and shall be deemed given when sent by certified United States mail, postage prepaid, by recognized overnight delivery service, or by hand delivery to THP and Hospital at the addresses set forth below:

To THP: Chika Duru
General Counsel
Trusted Health Plans, Inc.
1100 New Jersey Avenue, SE, Suite 840
Washington, DC 20003

To Hospital:

_____

_____

_____

_____

48. Any amendment to this Agreement shall be in writing and signed by both parties to this Agreement, except as provided in this paragraph. This Agreement, including, without limitation, any of its exhibits, may be amended by THP by providing to Hospital no less than thirty (30) days prior written notice of the effective date of the amendment. Hospital shall have up to thirty (30) days immediately thereafter during which to notify THP in writing of any objection to the amendment. If Hospital fails to timely object to the amendment, Hospital shall be bound by the amendment as of the effective date set forth in the notice of the amendment from THP. If Hospital timely objects in writing to the amendment, Hospital and THP shall attempt in good faith to resolve the matter to their mutual satisfaction for a period not to exceed fifteen (15) days following THP's receipt of Hospital's written objection to the amendment. In the absence of such resolution, and notwithstanding anything in this Agreement to the contrary, either Hospital or THP may terminate this Agreement upon written notice to the other within five (5) days after the expiration of the fifteen (15) day period described above. The effective date of such termination shall be on the expiration of the five (5) day notice period described above. In the event of such termination, Hospital shall be bound by the amendment from its effective date through the effective date of termination.

49. No waiver of any provision of this Agreement shall be valid unless in writing and signed by the party against whom such waiver is sought. One or more waivers of any covenant or condition of this Agreement by any of the parties hereto shall not be construed as a waiver of any subsequent breach or of other covenants or conditions.

50. To the extent Hospital is executing this Agreement on behalf of any subsidiary entity, business line or division of Hospital (each a "**Hospital Entity**") each such Hospital Entity is listed on Exhibit C hereof With respect to each such Hospital Entity, Hospital represents and warrants to THP that it has the authority to bind and hereby binds each such Hospital Entity to the terms and conditions set forth herein.

SAMPLE

In furtherance of the foregoing, Hospital shall cause an authorized representative of each such current and future Hospital Entity to acknowledge such Hospital Entity's duties and obligations hereunder by executing the form attached hereto as Exhibit D. Copies of such exhibits for each Hospital Entity shall be provided to THP upon request.

51. Notwithstanding anything to the contrary herein, Hospital shall be fully responsible for the acts and omissions of each Hospital Entity as if they were the acts and omissions of Hospital. In furtherance of the foregoing, Hospital represents and warrants that each Hospital Entity is either a legitimate business line or division of Hospital or a separate legal entity duly formed and in good standing under the laws of the District of Columbia and is owned or controlled by Hospital. Hospital further represents and warrants to THP that all information provided by or on behalf of each Hospital Entity, including, without limitation, all information provided on Exhibits B and C are true, accurate and complete.

52. This Agreement constitutes the entire understanding and agreement between the parties regarding the subject matter hereof, and supersedes all prior agreements, oral or written, regarding the subject matter hereof.

-go to next page

SAMPLE

IN WITNESS WHEREOF, the parties hereto have caused this Agreement to be executed to be effective as of date THP executes this Agreement (the "**Effective Date**").

TRUSTED HEALTH PLANS, INC. 1100 New Jersey Avenue, SE, Suite 840 Washington, D.C. 20003	**HOSPITAL**
By:_____ Chika Duru General Counsel	By_____:_____
Date:_____	Date_____:_____

SAMPLE

EXHIBIT A

COVERED SERVICES AND PAYMENT ARRANGEMENT FOR MEDICAID SERVICES

1 Covered Services. The Covered Services shall consist of all services that are covered by the DC Alliance and / or Medicaid programs, subject to the terms of this Agreement, and all rules, regulations, policies and procedures of the Medicaid Program, and THP's authorization for referral services.

(FEE SCHEDULE)

SAMPLE

EXHIBIT B

COVERED SERVICES AND PAYMENT ARRANGEMENT FOR MEDICARE SERVICES

1. Covered Services. The Covered Services shall consist of all services that are covered by the Medicare Advantage program, subject to the terms of this Agreement, and all rules, regulations, policies and procedures of the Medicare program, and THP's authorization for referral services.

2. THP will pay Hospital for Covered Services at 100% of the then current Medicare fee schedule.

SAMPLE

EXHIBIT C

HOSPITAL ENTITIES

Entity/Division Name: _____

Tax ID (indicate if same as Hospitals): _____

Street Address: _____

City, State, Zip: _____

E-Mail: _____

Phone: _____

Entity/Division Name: _____

Tax ID (indicate if same as Hospitals): _____

Street Address: _____

City, State, Zip: _____

E-Mail: _____

Phone: _____

Entity/Division Name: _____

Tax ID (indicate if same as Hospitals): _____

Street Address: _____

City, State, Zip: _____

E-Mail: _____

Phone: _____

-make additional copies if necessary

SAMPLE

EXHIBIT D

ACKNOWLEDGEMENT AND AGREEMENT

The undersigned acknowledges and agrees that (i) he/she is an authorized representative of the entity, business line or division listed below, (the "**Hospital Entity**"); (ii) he/she has been provided with a copy of the Plan/Referral Hospital Participation Agreement ("**Agreement**") between THP and Hospital; (iii) the Hospital Entity provides or will be providing services pursuant to such Agreement on behalf of Hospital; (iv) the Hospital Entity agrees to be bound by the terms and conditions of the Agreement with respect to its provision of services thereunder; and (v) neither the Hospital Entity nor any individual or entity employed by or under contract with the Hospital Entity is or has ever been excluded from Medicare, Medicaid or any other third party payor program, and the Hospital Entity will promptly notify THP and Hospital of any change in its or any such individual's or entity's participation status with any such program. The Hospital Entity is responsible for notifying THP of any changes to the information contained in this acknowledgement. Amendments to this exhibit may be submitted to THP's Credentialing Department by sending a written notice to the attention of the Credentialing Department 1100 New Jersey Avenue, SE, Suite 840, Washington, DC 20003.

Entity/Division Name:

Tax ID (indicate if same as Hospitals):

Signature:

Print Name: _____

Date:

-make additional copies if necessary



PROVIDER MANUAL

TRUSTED HEALTH PLAN
1100 New Jersey Avenue SE
Suite 840
Washington, DC 20003

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Welcome to TRUSTED Health Plan

Dear Provider:

Welcome to TRUSTED Health Plan. As a valued participating provider, you are one of the most essential elements of our fully integrated Medicaid Health Network. We are committed to ensuring that all of our members receive optimum quality health care. We value our partnership and the relationship you have with your patients and members.

This Provider Manual is intended to complement your onsite orientation and has been prepared as a reference manual for administrative procedures and clinical issues. It provides a quick and easy resource with contact phone numbers, detailed processes and site lists for various services such as access to information about verifying member eligibility, obtaining authorization for services, reimbursement and checking claim status.

The Provider Manual also gives you general information about the various departments throughout TRUSTED Health Plan, the services that they provide, and your role and responsibilities as a participating provider.

We have made it convenient for you to access the Provider Manual at our website at www.TRUSTEDhp.com. We encourage you to visit our website often, as it is modified frequently and contains the most updated plan related information available.

We are committed to ensuring that we provide you with the most up to date information so that you can then deliver the highest level of care to our members. We welcome your feedback and if at any time, you have a question or concern about the information outlined in this manual or about TRUSTED Health Plans medical care programs; you can reach the TRUSTED Health Plans Provider Services Department by calling (202) 821-1145 or (202) 821-1100 Option #3 between the hours of 8:00 a.m. and 5:00 p.m. Monday through Friday.

Please do not hesitate to contact us to discuss your issues and suggestions. Thank you for joining the TRUSTED Health Plan network.

Quick References

Quick Reference Contact Information

TRUSTED Health Plan
1100 New Jersey Ave., SE • Suite. 840 • Washington, DC 20003

Provider Services	(202) 821-1145 (202) 905-0178 (EFax)
Member Services	(202) 821-1100 (855) 326-4831 (toll free)
Utilization Review/Prior Authorizations	(202) 821-1132 (202) 905-0157 (EFax)
Appeals	(202) 821-1100 (202) 905-0156 (EFax)
Case Management/Disease Management/Discharge Planning	(202) 821-1132 (202) 905-0157 (EFax)
Member Eligibility Line **District of Columbia Eligibility Verification System (IVR)**	(202) 906-8319 – DC (202) 821-1100 (855) 326-4831 (toll free)
TTY Line	711
Language Line Services	(866) 874-3972
Beacon Health Options **(Behavioral Health)**	(888) 204-5581
MTM- Member Transportation Services	(855) 824-5693
Centene / Nurse Response Line	(855) 872-1852
DentaQuest	(855) 418-1620
EyeQuest	(855) 418-1620
Meridian Pharmacy Benefit Manager **Providers Only** **Member Services**	(855) 323-4588 (888) 274-2031 (877) 647-4026 (855) 323-4586 fax
Lab Corp	(800) 859-0391

How do I submit a claim?

You can mail claims to:

TRUSTED Health Plans
DC Healthy Families Program (Medicaid)
P.O. Box 830786
Birmingham, AL 35283-0786

TRUSTED Health Plans
Alliance Program
P.O. Box 830210
Birmingham, AL 35283-0210

Electronic claims can be submitted to Emdeon TRUSTED Payor ID: **L0230**

Do I need a referral?

All Specialty Care providers require a referral from the TRUSTED Member's PCP. This can be done through the TRUSTED Provider Portal.

How do I request a Prior Authorization?

Prior Authorization (PA) requests can be faxed to: 202-905-0157. Requests for services will be reviewed by experienced Nurses utilizing InterQual criteria and/or other relevant clinical practice guidelines.

- Urgent PA decisions will be made within 1 calendar day and oral notification will be made within the same day of the decision.
- Priority decisions will be made within 3 calendar days and oral notification will be made within the same day of the decision.
- Non-Urgent PA decisions will be made within 14 calendar days, and oral notification will be made within 48 hours of the decision.

Prior Authorization (PA) requests for Behavioral Health Services are handled by Beacon Health Options. (888) 204-5581.

Prior Authorization (PA) requests for certain non-emergent imaging services are handled by National Imaging Associates (NIA). www.RadMd.com or 1-888-899-7804. **Please note: Services rendered in an Emergency Room, Observation Room, Surgery Center or Hospital Inpatient setting are not managed by NIA.**

Medicaid –Only Covered Services

BENEFIT	DC HEALTHY FAMILIES PROGRAM	WHO CAN GET THIS BENEFIT
Primary Care Services	• Preventive, acute, and chronic health care services.	All Members
Adult Wellness Services	• Health care services provided by specially trained doctors or advanced practice nurses. • Referrals are required • Does not include cosmetic services and surgeries except for surgery required to correct a condition resulting from surgery or disease, created by an accidental injury or a congenital deformity, or is a condition that impairs normal body function.	All Members
Laboratory & Radiology Services	• Lab tests and X-rays	All Members
Hospital Services	• Outpatient Services (preventive, diagnostic, therapeutic, rehabilitative, or palliative Services) • Inpatient Services (hospital stay)	Any Member with a Referral from their PCP or who has an emergency
Pharmacy Services (prescription drugs)	• Prescription drugs included on the TRUSTED drug formulary. You can find the drug formulary at: www.TRUSTEDhp.com or by calling Member Services. • Only includes medications from network pharmacies. • Includes the following non-prescription (over-the-counter) medicines:	All Members other than dually eligible(Medicaid/Medicare) Members whose prescriptions are covered under Medicare Part D
Emergency Services	• A Screening exam of your health condition and stabilization if you have an Emergency Medical Condition, regardless if the Provider is in or out of the TRUSTED network. • Treatment for emergency conditions	All Members

BENEFIT	DC HEALTHY FAMILIES PROGRAM	WHO CAN GET THIS BENEFIT
Family Planning	• Pregnancy Testing: Counseling for the woman • Routine and Emergency Contraception • Voluntary sterilizations for Members over 21 years of age (requires signature of an approved sterilization form by the Member 30 days prior to the procedure) • Screening, Counseling and Immunizations (including for HPV) • Screening and preventive treatment for all sexually transmitted diseases • Does not include sterilization procedures for Members under age 21	All Members as appropriate
Podiatry	• Special care for foot problems • Regular foot care when medically needed.	All Members
Rehabilitation Services	• Rehabilitation Services, including physical, speech and occupational therapy	All Members
Prosthetic devices	• Replacement, corrective, or supportive devices prescribed by a licensed provider	All Members
Vision Care	• Eye exams at least once every year and as needed; and eye glasses (corrective lenses) as needed	Members under age 21
	• One pair of eyeglasses every two years except when the Member has lost his or her eyeglasses or when the prescription has changed by more than 0.5 diopter	Members age 21 and older
Home Health Services	In-home health care Services, including: • Nursing and home health aide care • Home health aide Services provided by a home health agency • Physical therapy, occupational therapy, speech pathology and audiology Services	All Members

BENEFIT	DC HEALTHY FAMILIES PROGRAM	WHO CAN GET THIS BENEFIT
Personal care Services	• Services provided to a Member by an individual qualified to provide such Services who is not a member of the individual's family, usually in the home, and authorized by a physician as a part of the Member's treatment plan.	Not available to Members in a hospital or nursing home
Nursing Home Care	• Full-time skilled nursing care in a nursing home up to 30 consecutive days	All Members
Hospice Care	• Support Services for people who are dying	All Members
Transportation Services	• Transportation to and from medical Appointments	All Members
Wellness Services	• Immunizations • Routine Screening for Sexually Transmitted Diseases • HIV/AIDS Screening, testing and counseling • Breast cancer Screening (women only) **40 and under Prior Authorization Required** • Cervical cancer Screening (women only) • Osteoporosis Screening (post-menopausal women) • HPV Screening (women only) • Prostate cancer Screening (men only) • Abdominal aortic aneurysm Screening (men only) • Screening for obesity • Diabetes Screening • Screening for high blood pressure and cholesterol (lipid disorders) • Screening for depression • Colorectal cancer Screening (Members 50 years and older) **50 and under Prior Authorization Required** • Smoking cessation counseling • Diet and exercise counseling • Mental Health counseling • Alcohol and drug Screening	Members over age 21 as appropriate

BENEFIT	DC HEALTHY FAMILIES PROGRAM	WHO CAN GET THIS BENEFIT
Child Wellness Services	Whatever is needed to take care of sick children and to keep healthy children well, including Screening and assessments such as: • Health and development history and Screenings • Physical and mental health development and Screenings • Comprehensive health exam • Immunizations • Lab tests including of blood lead levels • Health education • Dental Screening Services • Vision Screening Services • Hearing Screening Services • Alcohol and drug Screening and counseling • Mental health Services	Members under age 21
Dental Benefits	• General dentistry (including regular and emergency treatment) and orthodontic care for special problems • Check-Ups twice a year with a dentist are covered for children ages 3 through 20. • A child's PCP can perform dental Screenings for a child up to age 3 • Does not include routine orthodontic care	Members under age 21 (Members 21 years and older can receive dental services from Medicaid. Call MCO Dental Help Line at 1-866-758-6807)
Hearing Benefits	Diagnosis and Treatment of conditions related to hearing, including hearing aids and hearing aid batteries	All Members
Alcohol & Drug Abuse Treatment	• Inpatient detoxification • Other alcohol/drug abuse services are provided by the Addiction, Prevention and Recovery Administration (APRA) • Help with getting care from APRA	All Members
	• Inpatient and outpatient substance abuse treatment • Other alcohol/drug abuse Services are provided by the Addiction, Prevention and Recovery Administration (APRA) • Help with getting care from APRA	Members under age 21
Dialysis	• Hemodialysis • Peritoneal Dialysis	All Members

BENEFIT	DC HEALTHY FAMILIES PROGRAM	WHO CAN GET THIS BENEFIT
Durable Medical Equipment (DME) & Disposable Medical Supplies (DMS)	• Durable Medical Equipment (DME) • Disposable medical supplies (DMS)	All Members

Medicaid Member - Services We Do Not Pay For

Services We Do Not Pay For

Exclusions are benefits and/or services that are not paid for by TRUSTED or DC Medicaid. They include the following:

- Cosmetic surgery
- Experimental or investigational services, surgeries, treatments, and medications
- Services that are part of a clinical trial protocol
- Abortion, or the voluntary termination of a pregnancy, not required under Federal law
- Infertility treatment
- Sterilizations for persons under the age of 21
- Services that are not medically necessary
- Services furnished in schools

After clinical review based on scientific evidence, new technology is evaluated by TRUSTED for inclusion as a covered benefit. Technology assessment decisions are published in the form of medical policies and are posted to our website for your **review** and use. In addition, members may request a copy of a medical policy by contacting our Member Services at (202) 821-1100. All existing medical policies are reviewed at least annually and updated accordingly.

Alliance Only Covered Benefits

BENEFIT	ALLIANCE PROGRAM	WHO CAN GET THIS BENEFIT
Primary Care Services	• Preventive, acute, and chronic health care Services generally provided by your PCP	All Members
Specialist Services	• Health care Services provided by specially trained doctors or advanced practice nurses. • Referrals are required • Does not include cosmetic Services and surgeries except for surgery required to correct a condition resulting from surgery or disease, created by an accidental injury or a congenital deformity, or is a condition that impairs the normal function of your body	All Members
Laboratory & X-ray Services	• Lab tests and X-rays	All Members
Hospital Services	• Outpatient Services (preventive, diagnostic, therapeutic, rehabilitative, or palliative Services) • Inpatient Services (hospital stay) that do not meet the criteria for an admission as the result of an emergency	Any Member with a Referral from their PCP
Pharmacy Services (prescription drugs)	• Prescription drugs included on the Alliance drug formulary. You can find the drug formulary at www.TRUSTEDhp.com or by calling Member Services. • Only includes medications from Alliance network pharmacies	All Members
Family Planning	• Pregnancy Testing: Counseling for the woman • Routine and Emergency Contraception • Voluntary sterilizations for Members over 21 years of age (requires signature of an approved sterilization form by the Member 30 days prior to the procedure) • Screening, Counseling and Immunizations (including for HPV) • Screening and preventive treatment for all sexually transmitted diseases • Does not include sterilization procedures for Members under age 21	All Members as appropriate

BENEFIT	ALLIANCE PROGRAM	WHO CAN GET THIS BENEFIT
Podiatry	• Special care for foot problems • Regular foot care when medically needed.	All Members
Rehabilitation Services	• Rehabilitation Services, including physical, speech and occupational therapy	All Members
Prosthetic devices	• Replacement, corrective, or supportive devices prescribed by a licensed provider	All Members
Home Health Services	In-home health care Services, including: • Nursing and home health aide care • Home health aide Services provided by a home health agency • Physical therapy, occupational therapy, speech pathology and audiology Services	All Members
Nursing Home Care	• Full-time skilled nursing care in a nursing home up to 30 consecutive days	All Members
Hospice Care	• Support Services for people who are dying	All Members
Adult Wellness Services	• Immunizations • Routine Screening for Sexually Transmitted Diseases • HIV/AIDS Screening, testing and counseling • Breast cancer Screening (women only) • Cervical cancer Screening (women only) • Osteoporosis Screening (post-menopausal women) • HPV Screening (women only) • Prostate cancer Screening (men only) • Abdominal aortic aneurysm Screening (men only) • Screening for obesity • Diabetes Screening • Screening for high blood pressure and cholesterol (lipid disorders) • Screening for depression • Colorectal cancer Screening (Members 50 years and older) • Smoking cessation counseling • Diet and exercise counseling • Mental Health counseling • Alcohol and drug Screening	Members over age 21 as appropriate

BENEFIT	ALLIANCE PROGRAM	WHO CAN GET THIS BENEFIT
Dental Benefits	• General dentistry (including regular and emergency treatment) and orthodontic care for special problems • Check-Ups twice a year with a dentist are covered for children ages 3 through 20. • Does not include routine orthodontic care • Includes X-rays, extractions and fillings	All Members
Hearing Benefits	• Diagnosis and Treatment of conditions related to hearing, including hearing aids and hearing aid batteries	Members under age 21
Alcohol & Drug Abuse Treatment	• Inpatient detoxification • Other alcohol/drug abuse services are provided by the Addiction, Prevention and Recovery Administration (APRA) • Help obtaining care from APRA	All Members
Durable Medical Equipment (DME) & Disposable Medical Supplies (DMS)	• Durable Medical Equipment (DME) • Disposable medical supplies (DMS)	All Members

Alliance Member - Services We Do Not Pay For

Services We Do Not Pay For

Exclusions are benefits and/or services that are not paid for by TRUSTED or DC Alliance. They include the following:

- Acupuncture
- Emergency Services
- Alcohol and other drug abuse services
- Chiropractic services
- Cosmetic surgery
- Deliveries (if you are pregnant, contact the Economic Security Administration (ESA) at 202-727-5355 to determine eligibility for Medicaid. Deliveries are covered by Medicaid)
- Experimental or investigational services, surgeries, treatments, and medications
- Hearing services for members over 21
- Services that are part of a clinical trial protocol
- Abortion, or the voluntary termination of a pregnancy, not required under Federal law
- Infertility treatment
- Open heart surgery
- Organ transplantation
- Private duty nursing
- Sclerotherapy services and items

- Services furnished in schools
- Screening and stabilization services for emergency medical conditions outside of the network including inside of the District. You will be responsible for the charges for the out of network services including emergency services
- Treatment for obesity
- Vision services for members over 21
- Any covered services when furnished by providers that are not members of the Network.
- Sterilizations for persons under the age of 21
- Services that are not medically necessary
- Non - emergency transportation services
- Out of Network /Non Par services

TRUSTED HEALTH PLANS' MISSION

TRUSTED Health Plan is committed to provide comprehensive, state of the art tools and management to enhance the health status of every member. TRUSTED Health Plan is devoted to reducing health disparities in our community and promoting healthy lifestyles. TRUSTED is also dedicated to the provision of the highest level of care for our members.

TRUSTED HEALTH PLAN WILL OFFER TO PROVIDERS:

- Fair actuarially sound financial arrangements.
- Prompt payment through electronic claims processing.
- Utilization Management with Early Intervention.
- Consistent communication between TRUSTED Health Plans medical team and providers.
- Qualified and responsive Provider Relations staff.
- Comprehensive clinical guidelines to direct our quality and health-management programs.
- Online accessibility to create and check referrals, member eligibility and claim status.
- Translation / Interpretation services for Non-English speaking members.
- An extensive network of health care facilities, specialists and primary care providers.

Credentialing

Participating Practitioner Process

COUNCIL FOR AFFORDABLE QUALITY HEALTHCARE (CAQH)

TRUSTED participates with the Council for Affordable Quality Healthcare's (CAQH). TRUSTED requires all practitioners seeking to participate to complete the Universal Credentialing Datasource (UCD) application, which may be downloaded from CAQH website. An application will be required for all practitioners' seeking participation within the TRUSTED Health Plan, Inc. (THP) provider network. CAHQ is a nonprofit alliance of health plans and organization that supports the industry collaboration on initiatives that streamlines healthcare administration. At no cost to the provider, CAQH allows the

practitioner to fill out one set of credentialing information for all participating health plans and healthcare organizations. This reduces the time, cost, and frustrations associated with completing multiple credentialing applications. Completing an application online with CAQH is as easy as registering at www.caqh.org. Once the practitioner completes the registration process, they will create a unique user name and password and are then ready to begin updating their information online. Information may be entered at any time and changes or updates are instantly available to the health plans and other healthcare organizations authorized by the practitioner.

CREDENTIALING PROCESS

The Credentialing process for providers and practitioners is outlined in the TRUSTED Health Plan, Inc. (TRUSTED) Credentialing Program, comprised of all credentialing policies and procedures. All practitioners participating with TRUSTED undergo a review of their qualifications, including education and training, licensure status, board certification, hospital privileges, and malpractice history. The credentialing process begins when the practitioner submits a completed, signed and dated Uniform Credentialing Datasource (UCD) application, along with a Standard Authorization, Attestation and Release Form. Copies of the practitioner's state licenses, DEA or CDS, malpractice face sheet, and curriculum vitae must accompany the completed application. Upon receipt of a clean and complete application package, the Credentialing department will begin the credentialing process. The Credentialing Committee is responsible for making decisions regarding practitioner credentialing. The Credentialing Committee is described in the Quality Management Program. The Credentialing Committee approves providers for participation in the network and reviews and approves policies related to credentialing and the overall peer review program. This Committee reports directly to the Quality Executive Committee (QEC). Applicants that meet TRUSTED's credentialing criteria will be recommended to the credentialing committee for inclusion in the provider network. The credentialing committee provides final approval for network participation decisions.

In addition, as part of provider performance monitoring procedures, the Credentialing Committee may review grievances (quality of care concerns) and adverse event data regarding individuals and facilities and may recommend to the Board of Directors that interventions be taken to ensure members' safety and satisfaction. When presented with information on potential risks to the safety of members in the treatment community, the Credentialing Committee may; based on the information provided recommend to sanction suspend and /or terminate a provider.

CREDENTIALING COMMITTEE

The Credentialing Committee, chaired by the Chief Medical Officer, is the physician-based committee that monitors and evaluates the mechanism for licensure of practitioners through the use of a peer review process. It is comprised of a minimum of 3 licensed providers required for credentialing file review and meets at least quarterly. The Credentialing Committee is responsible for making recommendations on credentialing and re-credentialing of the practitioner and provider networks. It also maintains the authority for recommending sanctions against individual practitioners and providers to the Board of

Directors. The Credentialing Committee approves providers for participation in the network and reviews and approves policies related to credentialing and the overall peer review program. This Committee reports directly to the Quality Executive Committee.

PRACTITIONER PARTICIPATION

In order to participate with TRUSTED provider network, a practitioner must:

- Be a qualified practitioner in their respective discipline-Primary Care Practitioners (PCP's) should be licensed and practicing Family/General Practitioner, Internist, Pediatrician, Obstetrician/ Gynecologist, Nurse Practitioner or Certified Nurse Midwife.
- Maintain active admitting privileges or demonstrate adequate admitting arrangements at one or more participating TRUSTED facilities.
- Be willing to collaborate with TRUSTED in coordination and optimizing the delivery and quality of care to TRUSTED members.
- Comply with Federal, State and TRUSTED's Fraud, Waste and Abuse regulations and requirements.
- Have an executed contractual agreement.
- Meet the credentialing requirements outlined below and are approved by the Credentialing Committee.

Initial Credentialing Requirements

TRUSTED requires all practitioners to complete the Uniform Credentialing Datasource (UCD) Application which may be downloaded from CAQH. The application will require the practitioner to provide:

- Current copy of DEA Certificate and/or CDS Certificate, if applicable.
- Copy of internship and residency certification (if not board certified).
- Current copy of malpractice insurance liability certificate, with minimum coverage amounts for specific discipline as required by TRUSTED.
- Current copy of unrestricted license to practice.
- A current curriculum vitae (CV) describing professional work history to include beginning and ending month, any year for each position held.
- Copy of Educational Committee for Foreign Medical Graduates Certificate (ECFMG), if applicable.
- Reasons for inability to perform the essential functions as a provider, with or without accommodation; lack of present substance abuse, including illegal drug use.
- History of loss of license and felony convictions.
- History of loss or limitation of privileges or disciplinary activities.
- Written explanation regarding any sanction activity, malpractice judgments/settlements, restrictions of privileges, gaps in work history greater than six months, etc.

- Professional peer references, concerning the individual's professional performance, judgment, and clinical or technical skills.

In addition, practitioners are required to demonstrate a degree of professional competence comparable to all practitioners in their specialty, as well as demonstrate the ability to meet the geographic, specialty and business needs of TRUSTED Health Plan. Practitioners must agree to participate in all quality management activities required by the Quality Management Department.

The Credentialing Committee approves providers for participation in the network and reviews and approves policies related to credentialing and the overall peer review program. This Committee reports directly to the Quality Executive Committee.

Credentialing Process

The credentialing process begins when the practitioner submits a completed, signed and dated Uniform Credentialing Datasource (UCD) application, along with a Standard Authorization, Attestation and Release Form The completed application must be accompanied by copies of the practitioner's state licenses (DEA or CDS, malpractice face sheet, and curriculum vitae. Upon receipt of a clean and complete application package, the Credentialing department will begin the credentialing process as defined below:

Incomplete Practitioner Application

The Credentialing Department will process and complete the credentialing application within 120 days from the date of receipt of the Provider Information (PI) form and applicable documentation. The Credentialing Department will notify the applicant by fax, letter, or telephone of any missing information. When an incomplete application is received, three (3) attempts will be made over a sixty - day (60) period to obtain the requested information. Failure to submit the information after the third attempt will be considered a voluntary withdrawal of the application and will result in the practitioner not being considered for the TRUSTED provider network.

Primary Source Verification

Upon receipt of a completed application, the Credentialing Department will obtain and primary source verify the following information:

- **Current Professional License:** Licensure is verified by the appropriate State Department of Regulations. A verification of the practitioner's license status is received and placed in the practitioner's credentialing file.
- **Current Malpractice Coverage:** Current and adequate professional liability insurance is verified via submission certificate of insurance that includes dates and amount of coverage. At a minimum, the

coverage amount should be $1,000,000 per incident and an aggregate $3,000,000.

- **Malpractice Claims History:** A request for professional liability claims history or at least the past five (5) years is included in the application. Affirmative responses require additional information/investigation. Additionally, for all applicants the National Practitioner Databank (NPDB) is queried for the verification of professional liability claims history.
- **Drug Enforcement Agency (DEA) Certificate:** The Credentialing Department will obtain a current copy of the DEA certificate and/or verify certificate via the DEA verification website. Any restrictions will require further investigation by TRUSTED. Practitioners that do not dispense medication in the course of practice are exempt from verification.
- **Education and Training:** When a board certification cannot be verified, education and training is verified through either the school attended, online education verification service, American Medical Association Provider Profile (AMA) or the American Board of Medical Specialties (ABMS).
- **Board Certification:** MD and DO board certification is verified by the American Board of Medical Specialties (ABMS) Compendium; Osteopaths AOA Directory of Osteopathic Physicians; Podiatrists-Directory of American Board of Podiatric Surgery or ABPOPPM; Chiropractors-not applicable. Please note that Board Certification is not a requirement for inclusion in the TRUSTED network.
- **Non-Board Certified Practitioners:** Completion of residency training is verified through the residency training school, or AMA Provider Profile. The Education Commission for Foreign Medical Graduates Certificate (ECFMG) serves as verification for non-board certified practitioners who are foreign educated.
- **Review of Work History:** TRUSTED will review the applicant's work history for the previous five (5) years. The history may be part of the application, or part of the curriculum vitae. A written explanation is required for gaps in work history in excess of six (6) months. Applicants work history must reflect month and year of employment to identify any gaps in history greater than six (6) months.

COMMUNICATION TO APPLICANT

Upon receipt of all the documentation and responses to verification request and queries, the Credentialing Department will review the file for any discrepancies between the applicants provided information and information received from other parties. Should a discrepancy between these sources be identified, the applicant shall be given a timeframe to respond to the third party information. Upon the earlier date of the receipt of the applicant's response or the deadline for the receipt of the response, the file shall be forwarded to the Chief Medical Officer (CMO) and the Credentialing Committee for review.

PROVIDER CREDENTIALING RIGHTS

Providers and applicants have the following rights:

- To be notified of their rights to review information submitted to support the credentialing

application

- Providers and applicants have the right to review information obtained from outside sources, such as malpractice insurance carriers or state licensing boards, to support their credentialing application. TRUSTED is not required to make available information obtained from references, recommendations or peer-review protected information.

- To correct erroneous information
  - If information is obtained during the credentialing process that varies substantially from the information submitted by the provider, TRUSTED contacts the provider via letter with notification of the discrepancy. The applicant is notified by the credentialing specialist in writing within 30 calendar days of receipt of the discrepant information. The notification includes a description of the discrepancy, the source of the information as appropriate and the provider's right to correct erroneous information submitted by another party. TRUSTED is not required to reveal the source of information that was not obtained to meet verification requirements or if federal or state law prohibits disclosure. Applicants are instructed to respond to the credentialing specialist, in writing, within 30 calendar days and that failure to respond is considered a withdrawal of the application with resulting in non-participating status. TRUSTED documents receipt of corrected information in the provider's credentialing file.

- To be informed of the status of the credentialing/re credentialing application upon request.
  - Providers and applicants are notified of their right to receive status information from a statement on the provider application stating: "I understand that I have the right to be informed of the status of my credentialing or recredentialing application upon request to the credentialing specialist. Requests may be made in writing or by telephone. The TRUSTED staff responds to these requests in writing, no more than 10 business days after the request is received. The response to providers does not include disclosure of information prohibited by law, references, recommendations or other information that is peer-review protected.

CREDENTIALING DEFINITIONS

- **Appeal:** A formal request by a practitioner for reconsideration of a decision with the goal of finding a mutually acceptable solution.
- **Attestation:** A signed statement indicating that the practitioner personally confirmed validity, correctness and completeness of his or her credentialing application at the time of application to TRUSTED Health Plan.
- **Board Certified:** A practitioner who has satisfied the requirements and/or standards of a nationally recognized specialty board and has received certification as a specialist from the specialty board.
- **Chief Medical Officer:** A physician employed by TRUSTED, appropriately licensed and credentialed.

- **Credentials:** Documented evidence of registration, licensure, education, training, experience, or other qualifications.
- **Credentialing:** The process of obtaining, verifying, and evaluating the qualifications of licensed practitioners prior to providing health care services to members of TRUSTED Health Plan, Inc.
- **Criteria:** Systematically developed, objective and quantifiable statements used to assess the appropriateness of specific decisions, services and outcomes against which performance can be assessed.
- **Delegation:** A formal process by which TRUSTED Health Plan, Inc. gives another entity the authority to perform certain credentialing functions on its behalf. Although TRUSTED may delegate the authority to perform the credentialing functions, it will not delegate the responsibility for ensuring that the function is performed appropriately.
- **National Practitioner Data Bank (NPDB):** A federally mandated agency that is the repository of information about settled malpractice suits and adverse actions, sanctions or restrictions against the practice privileges of a physician.
- **Peer Review:** Evaluation of one physician's credentials and practice by another physician.
- **Practitioner:** A professional who provides health care services; e.g., a physician (MD, DO), dentist (DDS), podiatrist (DPM), nurse practitioner (NP), and/or chiropractor (DC), and/or other licensed practitioner (non-physician, mid-level practitioner)
- **Privileging:** A process whereby an individual is formally granted permission to perform specific duties and job functions as defined in clinical privileges or job descriptions based on the individual's qualifications, experience, education, training and credentials.
- **Primary Source Verification:** The process of verifying credentialing information from the entity that originally conferred or issued the credential.
- **Provider:** An institution or organization that provides health care services to TRUSTED members; e.g. a hospital, skilled nursing facility, or home health care agency.
- **Provisional Credentialing:** An authorization process that will permit a new practitioner to participate in the network before collection or verification of all required credentials.
- **Re-credentialing:** The process of obtaining, updating and re-verifying, the qualifications of current licensed practitioners to provide health care services to TRUSTED Health Plan, Inc. members.

SITE VISIT/MEDICAL RECORD REVIEW

TRUSTED Health Plan's Provider Relations Department conducts provider site visits and practice Assessments for locations serving enrolled members. Targeted locations are selected per the guidelines outlined in TRUSTED's Credentialing Policy and Procedure, or conducted as a result of complaints. TRUSTED's office site performance standards address the following domains:

- Physical accessibility to the building, exam rooms, and other patient access areas including accommodations for individuals with disabilities.
- Physical appearance to provide a safe clean environment for patients, visitors and staff.
- Adequacy of waiting room space to accommodate the average number of patients seen per Licensed Independent Practitioner (LIP) per hour.
- Adequacy of exam room space including provisions for privacy during examinations or procedures.
- Adequacy of medical/treatment record-keeping.
- Availability of appointments if applicable.

The Assessment is documented on a Site Assessment and Medical Record Keeping Assessment and Tool Form which captures the following:

- Provider/Facility issues or concerns
- Resolution
- Follow up criteria if needed

If indicated during the Credentialing process, or if one provider or provider site receives three (3) or more complaints within a six month period, or if any one complaint is received regarding the physical accessibility, physical appearance or adequacy of waiting- and examining-room space, an office site evaluation is conducted.

- The quality coordinator notifies the director of the quality department that the provider/provider site exceeded the complaint threshold of three (3).
- The director notifies the medical director and director of network and provider relations that a site visit with the provider will be scheduled.
- Within 60 calendar days of determining that the complaint threshold was exceeded, a site visit is conducted.
- A provider relations representative, with the assistance of a nurse from the UM or quality department, conducts the assessment at a mutually agreed-upon date and time, at the provider's office.
- The tool in Attachment A is used for the assessment.
- The site visit tool results are scored and any deficiencies are reported to the provider at the time of the site visit.
- Any provider that fails to meet the scoring threshold for any mandatory component

(indicated with a scoring threshold of 10 points) and / or fails to meet the 85% minimum scoring threshold will be placed on a 30 day Corrective Action Plan (CAP).

- Provider Relations Rep will conduct a follow up visit every 6 months or until non-complaint factors have been corrected.

Re-credentialing Process

Re-credentialing is performed every three (3) years, as required by NCQA and TRUSTED Health Plan, Inc. Practitioners will be contacted approximately three months prior to the expiration of their current credentialing file and asked to update their information for the next re-credentialing review. TRUSTED re-verifies only the information that is subject to change over time. Static elements such as education are not re- verified during the re-credentialing process. The intent of the re-credentialing process is to identify any changes in the practitioner's process. The intent of the re-credentialing process is to identify any changes in the practitioner's licensure, certification, clinical privileges, health status, sanctions status, clinical competence or any other area that may affect the practitioner's ability to render quality healthcare services to TRUSTED members.

In addition, the re-credentialing process incorporates an assessment of the practitioner's prior performance with TRUSTED, including but not limited to, medical record review, member complaints, member satisfaction, and information from quality and medical management activities. To ensure quality of care between re-credentialing cycles, TRUSTED performs ongoing quality monitoring for any adverse events, sanctions, or member complaints. TRUSTED will verify Medicare/Medicaid and applicable state information regarding practitioners who have received sanctions or limitations on licensure within 30 days of its release. If a practitioner is identified on a sanction report, or there is evidence of poor quality, the practitioner's ability to provide services will be reviewed and assessed by the CMO and Credentialing Committee.

Our Standards and Evaluation Forms are available in Appendices C and D respectively. The application, all verification and site review results are forwarded to the Credentialing Committee for a decision. The Credentialing Committee consists of participating network practitioners. All practitioners are sent written notification of initial credentialing and re-credentialing decisions.

Provider Responsibilities

RESPONSIBILITIES BY TYPE OF PROVIDER

All Providers

Practitioners and providers shall facilitate advance directives for individuals as defined in 42 C.F.R 489.100. An advance directive is a written instruction, such as a living will or durable power of attorney for health care recognized under District of Columbia law (whether statutory or as recognized by the

courts of the District) relating to the provision of health care when the individual is incapacitated. Practitioners and providers can receive information about procedures for advance directives from Caring Connections, 1-800-658-889, **www.caringinfo.org**.

PRIMARY CARE PRACTITIONER (PCP) RESPONSIBILITIES

A PCP serves medical needs of their panel of TRUSTED members. PCP's administer primary care and guarantee that the services provided to members are necessary and appropriate. A PCP should strive to provide optimum levels of care while keeping unnecessary services to a minimum.

A Primary Care Practitioner is responsible to TRUSTED and its members for diagnostic services, care planning and treatment plan development. The PCP shall work with TRUSTED to monitor treatment planning and provision of treatment.

All new TRUSTED members with a newly assigned PCP who has not previously cared for the member shall perform a comprehensive initial examination and screenings for mental health and alcohol and drug abuse problems using a validated screening tool approved by TRUSTED prior to referrals for any additional tests or examinations needed in order to complete a comprehensive assessment of the member's health condition. TRUSTED shall forward to the PCP any information about member's health history or health conditions received upon enrollment from DHCF, the Enrollment Broker, members, or other sources, in a manner that protects the member's confidentiality within thirty (30) days of receipt so that it can be considered in the member's initial evaluation.

During the initial examination and assessment of a child, the PCP shall perform EPSDT screening and any additional assessment, using the approved tool(s) needed to determine whether a child meets the definition of as the member's personal practitioner and is responsible for coordinating and managing the Child with special health care needs and shall report this determination to the TRUSTED Care Management Department within 72 hours (3 business days).

In addition, the PCP is responsible for:

- Generating electronic referrals for specialty and other medically necessary services.
- Managing and coordinating the medical care of a member with a participating specialist(s) and/or behavioral health provider.
- Early identification of members with special health care needs and notification to TRUSTED about any such member as soon as possible.
- Collaboration with TRUSTED about members enrolled in Disease Management, Behavioral Health Management or Care Coordination program.
- Use of a valid and standardized developmental screening tool, approved by TRUSTED, to screen for developmental delays during well-child visits, episodic visits or as a stand-alone service.
- Referral of a child, identified as having a developmental delay, to the appropriate specialist for a

comprehensive developmental evaluation.

- Early identification of children with special health care needs and notification to TRUSTED about such member within 72 hours. Documentation of all care rendered in a complete and accurate manner including maintaining a current medical record for TRUSTED members that meets TRUSTED's medical record documentation standards. These standards are available in Appendix D.
- Providing follow-up services for members who have been seen in the Emergency Department.
- Promptly and accurately reporting all encounters to TRUSTED Health Plan.
- Working with the TRUSTED multi-disciplinary teams, which include Disease Managers, Case Managers, Social Workers, Care Coordinators, and health educators to facilitate the member's care.
- Releasing medical record information upon written consent of the member.
- Providing preventive healthcare to members according to preventive health care guidelines.
- Advising TRUSTED's Outreach Department (202) 821-1100 when a member does not keep an appointment and/or when a member cannot be reached after an outreach effort.

OB/GYN PRACTITIONER AS A PCP

Participating Obstetricians are responsible for medical services during the course of the member's pregnancy and for coordinating testing and referral services. Obstetricians may provide routine primary care and treatment to pregnant members under their care. Examples of routine primary care include but are not limited to:

- Treatment of minor colds, sore throat and asthma.
- Treatment of minor physical injuries.
- Preventive health screenings and maintenance.
- Routine gynecological care.

SPECIALISTS RESPONSIBILITIES

A TRUSTED specialist is responsible for:

- Providing specialty care as indicated on the referral form.
- Reporting clinical findings to the referring PCP.
- Ordering the appropriate diagnostic tests (radiology, laboratory) related to the treatment of the patient as requested by the referring practitioner utilizing a referral form.
- Documenting all care rendered in a complete and accurate manner including maintaining a current medical record for TRUSTED members that meets TRUSTED's medical record documentation standards (*see Appendix D*).
- Refrain from referring members to other specialists without the intervention of the referring PCP
- Assisting patients who come for services with getting a necessary referral

- Checking the Provider Portal for the member's continued eligibility and a referral

CARE PLANS

TRUSTED works with practitioners, members and outside agencies to develop Care Plans for members with health care needs. TRUSTED Care Plans specifies mutually agreed upon goals, medically necessary services, and mental health, alcohol and drug abuse services. If the member consents to share this information with the PCP and/or treatment team, any support Services necessary to carry out or maintain the Treatment Plan, and, for children with more complex needs, planned Care Coordination activities.

Care Plans shall take into account the cultural values and any special communication needs of the family and/or the child. TRUSTED requires that care planning is based upon a comprehensive assessment of each member's condition and needs. Each member's care is appropriately planned with active involvement and informed consent of the member and his or her family or caregiver as clinically appropriate and legally permissible as determined by the member's practitioner and standards of practice. TRUSTED utilizes EPSDT standards in the development of Care Plans for members under age twenty-one (21).

TRUSTED works with practitioners to coordinate care with other treatment services provided by District agencies such as DMH, APRA, and DCPS. The member is assisted in accessing any support needed to maintain the Care Plan. TRUSTED and the PCP must jointly ensure that members and their families (as clinically appropriate as determined by enrollee's provider) are fully informed of all covered and non-covered treatment options as well as the recommended options, their expected effects, and any risks or side effects of each option. In order to make treatment decisions and give informed consent, available treatment options shall include the option to refuse treatment and shall include all treatments that are medically available, regardless of whether TRUSTED provides coverage for those treatments.

Care Plans for an Enrollee with special health care needs are to be reviewed and updated at least every twelve (12) months or as determined by the member's PCP on the basis of the PCP's assessment of the member's health and developmental status and needs. The revised Care Plan will be incorporated into the member's medical record following each update.

TRUSTED's Case Management provides for effective methods for referring members to non-network Medicaid services specified in the Care Plan. When a Care Plan includes multiple services inside or outside of TRUSTED network, providers must ensure that there is effective communication and collaboration between Network Providers and other Medicaid Providers inside or outside of TRUSTED's network, Contractor's Care Coordinators, and non-Medicaid Providers.

PERFORMANCE DATA

Provider agrees that during the term of this Agreement, TRUSTED may collect and develop data, including, but not limited to, claims, cost, utilization, outcomes, quality, financial performance, and patient satisfaction data related to the health benefit plans offered or administered by TRUSTED, for quality improvement activity with the Provider and public reporting to consumers. Provider agrees to comply with all reasonable request s by TRUSTED in the collection of such data. Collectively, such data and reports shall be referred to as, "Performance Data." Any Performance Data regarding services of a specific provider for a specific Member shall be referred to as "Provider Specific Performance Data". TRUSTED shall be the owner of all Performance Data and Provider Specific Performance Data, and to the extent permitted by law (during the term and after the termination of this Agreement), such data may be shared with a current or prospective Member, payor Member, a current or prospective employer or payor of a group health benefit plan and their auditors or health care consultants, insofar as the information concerns covered services that are or would be considered allowable charges under a current or prospective Certificate of Coverage. Performance Data and Provider Specific Performance Data provided to Provider by TRUSTED shall be kept confidential by Provider and used only for the purposes of carrying out Provider's obligations under this Agreement. Upon termination of this Agreement, Provider shall return to TRUSTED any Performance Data that is not Provider Specific Performance Data. Upon written request of the Provider, TRUSTED shall make available to Provider, a description of how TRUSTED intends to use Provider Specific Performance Data, the methodology used in collecting and analyzing the data, and a copy of the Provider's data TRUSTED intends to disclose. To the extent that Provider can reasonably demonstrate, in writing, that any data that TRUSTED intends to disclose is inherently inaccurate, Provider shall notify TRUSTED of its specific concerns. In such a case, TRUSTED shall make a good-faith effort to resolve Provider's concerns; provided, however, that TRUSTED shall have the sole and final discretion, responsibility, and authority over the content, dissemination, and release of such data.

Member Access Standards

GENERAL ACCESS STANDARDS

Appointment scheduling and wait times for members should comply with the access standards defined below. The first set of access standards apply to all practitioners. The second set of access standards apply specifically to behavioral health practitioners. If a practitioner or provider becomes unable to meet these standards, he/she must immediately advise his/her Provider Relations Representative or the Provider Services Department at (202) 821-1145.

Access to Medical Care

Emergency care (life threatening) Urgent Care or Sick Care appointments with PCP	Immediately at the nearest facility Within 24 hours of request
Urgent Care with a Specialist	Within 48 hours of referral
Routine Appointments (including Health Check and IDEA appointments)	Within 30 days of request
Initial Appointments for pregnant women or persons needing family planning	Within 10 days of request
Routine Physical Examinations	Within 30 days of request
Waiting Time in Practitioner's office	Not to exceed 45 minutes
Use of free interpreter services either onsite by prior request or by telephone	As needed during all appointments

ACCESS TO BEHAVIORAL HEALTH CARE

After a careful analysis of its Behavioral Health Program, TRUSTED decided to contract with Beacon Health Options to manage the benefits and services provided to our members needing behavioral health evaluation and treatment. Please go to Beacon's web site, www.beaconhealthoptions.com for more information about the company and the services provided for TRUSTED members.

Behavioral Health Emergency care (Life threatening)	Immediately at the nearest facility
Behavioral Health Telephone Crisis Triage	Within 15 minutes over the telephone
Psychiatric Intervention or face-to-face Assessment	Within 90 minutes of completion of telephone assessment, when needed. Available on a 24 hour basis 7 days a week
Treatment for a non-life threatening emergency	Treated as emergency care
Urgent care with Outpatient Behavioral Health Program Director and Doctor	Within 48 hours of request
Routine Behavioral Health Appointments	Within 7 days of request
Waiting Time in Practitioner's office	Not to exceed 1 hour

Use of free interpreter services either onsite by prior request or by telephone	As needed during all appointments

TRUSTED Health Plan does not perform behavioral health triage or screenings. Should a member call a Behavioral Health Practitioner, the Behavioral Health practitioner shall perform telephone triage and interventions in the time frames shown above, as appropriate. Emergency care does not require preauthorization.

A Beacon Health Options behavioral health clinician will work with the Department of Behavioral Health (DBH) in the coordination of substance abuse services. Please call Beacon at 1-888-204-5581, and ask to speak with a behavioral health clinician.

ACCESS TO AFTER-HOURS CARE/ON-CALL REQUIREMENTS

If a PCP is unavailable for any reason, arrangements must be made for coverage with a back-up practitioner who is also a participating PCP with TRUSTED Health Plan. **A recorded message directing all members to the emergency room is not acceptable.** TRUSTED requires that all network practitioners have coverage for after-hours care and have the appropriate member instructions on the practitioner telephone service after hours. All practitioners' telephone services must provide the following after hour's instructions:

Emergency care	Call 911 and/or go to the nearest facility immediately
Urgent non-medical emergency where care is needed before business hours	Provide a telephone number for the covering practitioner
Urgent non-medical emergency where care is not needed until business hours	Advise member to call during business hours

ACCESS TO OUT OF NETWORK SERVICES

If the network is unable to provide necessary medical services covered under the contract to a member, TRUSTED will cover these services for the member. TRUSTED will continue to cover these services until the member has access to a provider in-network. TRUSTED will coordinate services for out of network providers with respect to payment and will ensure that the cost for services provided to the member is not greater than it would be if the services were furnished within the network to the extent possible.

Approval of out of network services must be obtained in advance of the services. The exception to this is in situations in which obtaining the authorization would create a delay in care resulting in jeopardizing the medical outcome of the member. In such emergent or urgent situations, the plan should be notified as soon as possible.

ACCESS SURVEY/ MAXIMUM PANEL NOTIFICATION

TRUSTED will conduct a regular survey using secret shoppers to verify that practitioners are in compliance with the access standards. All survey results, including any recommendations for improvement, are communicated to the practitioner in writing at the conclusion of the review. A Corrective Action Plan (CAP) will be developed and implemented for any practitioners who fails to fully meet the access standards. Follow-up surveys and visits will be conducted in three to six months to monitor the practitioner's progress towards compliance with the standard panel closing requirements.

When members choose a practitioner as their PCP, they are assigned to the practitioner's panel of members. The panel remains open unless the following occurs:

- The PCP is under sanction.
- The PCP has voluntarily closed his/her panel.
- The panel is closed by TRUSTED due to member access issues.

A PCP must provide written notice to TRUSTED at least 30 days in advance of reaching 2,000 enrollees across all Medicaid health plans. A PCP must provide written notice to TRUSTED at least 90-days in advance if the PCP should decide to close their panel. TRUSTED PCP's are contractually obligated to be available and accessible to their panel members 24 hours a day, 7 days a week.

CULTURAL AND LINGUISTICALLY COMPETENT SERVICES PROGRAM

TRUSTED Health Plan is committed to reducing barriers to health care delivery. As a major provider of health care, TRUSTED recognizes the emerging challenges and opportunities associated with the rapidly changing population we serve. The District of Columbia is comprised of various cultures, sub-cultures, and ethnicities. The Medicaid and Alliance population includes people with varied cultural values and backgrounds.

TRUSTED requires that enrollees with limited or no English proficiency be assessed for the need for, and offered, translation services. The translation services may be provided by either telephonic or face-to-face interpretation. TRUSTED Health Plan strongly recommends that all interpreters be appropriately trained in medical terminology to assure accurate translation of information. TRUSTED provides free access to Interpretation services via, Language Line Services to facilitate practitioner-member-practitioner communication. Callers may access Interpretation services by calling member services at: 202-821-1100. If a member needs an interpreter to attend their appointment with them TRUSTED member services must be notified two (2) days or 48 hours prior to the appointment.

Family members, especially minor children, shall not be used as interpreters in assessments, therapy or other medical situations in which impartiality and confidentiality are necessary, unless specifically requested by the member. Should the member express a preference to rely on a family member or friend, the member must be advised that there is a free interpreter available. If the member refuses professional oral interpretation services, the practitioner shall document the offer of professional interpretation services and the member's declination in the member's medical record. If an onsite interpreter is needed, please contact Member Services at 202-821-1100.

TRUSTED Health Plan recognizes that cultural competence is not limited to the provision of medical information in an enrollee's preferred language. The health care practitioner's ability to accept, value, serve, communicate and interact with individuals who are racially, ethnically, linguistically, or culturally different from that of the practitioner. TRUSTED, in collaboration with the practitioner, will provide assistance with cultural and language barriers by implementing strategies supportive of cultural competency through the organization including health education and case management.

THE AMERICANS WITH DISABILITIES ACT OF 1990 & REHABILITATION ACT OF 1973

Section 504 of the Rehabilitation Act of 1973 ("Rehab Act") and Title III of the Americans with Disabilities Act of 1990 (ADA) prohibit discrimination against individuals with disabilities and require TRUSTED network of practitioners and providers to make their services and facilities accessible to such individuals. TRUSTED expects all practitioners and providers in its network to comply with the requirements of these statutes. The requirements of the ADA and the Rehab Act regarding accessibility are lengthy and complex. TRUSTED policy on access summarizes the main requirements and sets forth TRUSTED minimum expectations of its practitioners and providers. The policy is provided in Appendix A. This policy is not legal advice and does not purport to cover every statutory requirement. Practitioners and providers should consult with their own legal counsel about their obligations under these statutes.

REPORTING DISCRIMINATION COMPLAINTS

TRUSTED practitioners and providers must promptly address all complaints of discrimination or lack of access by individuals with disabilities. Complaints must be reported to TRUSTED as soon as reasonably possible after the complaint is received. In no case should the report be made more than seven (7) business days after receipt. Please report complaints:

IN WRITING TO:

TRUSTED HEALTH PLAN, INC.
ATTENTION: GRIEVANCE COORDINATOR
1100 New Jersey Ave., SE • Ste. 840
Washington, DC 20003

(202) 821-1100 or (855) 326-4831
www.TRUSTEDhp.com

TRUSTED Health Plan Committees

PHYSICIAN ADVISORY COMMITTEE

The Physician Advisory Committee (PAC) provides a forum for the high-volume TRUSTED Health Plan primary care practitioners to participate with TRUSTED leadership on issues related to the clinical and operational facets of TRUSTED Health Plan. The Committee provides TRUSTED with a mechanism to involve practitioners in the development of policies and procedures affecting patient care, clinical practice trends, and evidence-based guidelines and HEDIS performance. Committee members provide support and participate on other TRUSTED Quality committees.

Responsibilities:

1. Enhance TRUSTED ability to provide quality health care and services.
2. Provide strategies to improve member retention and member satisfaction.
3. Participate as advisors in member complaint resolution.
4. Participate in a forum to discuss and resolve practitioner and provider satisfaction issues.
5. Provide input in the development of educational and training sessions for TRUSTED practitioners, providers and members.
6. Participate as advisors in the discussions about the development of policies and procedures that affect clinical care, service and HEDIS performance.

MEMBER ADVISORY COMMITTEE

The Member Advisory Committee (MAC) provides a forum for TRUSTED Health Plan members to participate with TRUSTED leadership on issues related to the administration of TRUSTED Health Plan. The Committee formalizes member advocacy and member input on health care services and administration.

Committee members discuss policies and procedures, complaints and operational issues and put forward

suggestions for improvement. Committee members are invited and encouraged to participate in health education sessions and community outreach initiatives and to provide feedback to TRUSTED leadership. The Committee provides TRUSTED with a mechanism to involve members in the review process, the development of new benefits and coverages, health programs, and recruitment activities.

TRUSTED ADVISORY COMMITTEE

TRUSTED has established an advisory committee to provide feedback and suggestions for improving the service TRUSTED provides its members. The Committee scope includes all aspects of TRUSTED member services. The Committee's purpose is to enhance collaboration between TRUSTED, District of Columbia agencies and community members in improving TRUSTED operational systems.

The Committee is composed of TRUSTED employees and includes but is not limited to: TRUSTED members; primary, specialty and behavioral health practitioners with expertise in IDEA, EPSDT, adolescent health, HIV/AIDS, substance abuse, obstetrics and gynecology, and pediatric dentistry; community representatives of advocacy groups and trade associations; District of Columbia (DC) agencies; and, TRUSTED administrative staff.

The committee is charged with:

- Providing feedback on member services and on member, practitioner and provider communications.
- Reviewing qualitative and quantitative data.
- Identifying opportunities to improve member services.
- Providing suggestions on actions to improve performance.

Any practitioner may volunteer to participate on the Committee by calling the Director of Quality at (202) 821-1100.

PHARMACY AND THERAPEUTICS (P&T) AND FORMULARY MANAGEMENT COMMITTEE

The Pharmacy & Therapeutics (P&T) Committee is a subcommittee of the Quality Management Committee. The Committee serves in a decision making capacity to TRUSTED Health Plan in matters pertaining to the use of pharmaceuticals to promote high quality, cost-effective pharmaceutical therapy to TRUSTED members. The committee develops and approves policies regarding evaluation, selection and therapeutic use of pharmaceuticals for members. The Committee provides TRUSTED with a mechanism to involve pharmacists and appropriate practitioners in the development and periodic updates of its pharmaceutical management procedures.

The Pharmacy & Therapeutics Committee is further responsible for the analysis and evaluation of new developments in technology and new applications of existing technology, procedures, pharmaceuticals

and devices for medical and behavioral health care. The Committee provides TRUSTED with a mechanism to involve practitioners and pharmacists in the evaluation of published scientific evidence regarding the clinical use, safety, efficacy and outcomes of medical technology to ensure that TRUSTED members have equitable access to safe and effective care.

PHARMACY AND PATIENT SAFETY PRECAUTIONS

TRUSTED maintains a comprehensive pharmaceutical patient safety program. In partnership with its pharmacy benefits manager, TRUSTED requires that pharmaceutical safety information be provided to all members at the point of pharmaceutical dispensing. TRUSTED will notify practitioners when point of dispensing screening identifies specific interactions that may place a member at risk.

TRUSTED and its PBM monitor for Class I and II recalls by the Federal Drug Administration (FDA). Practitioners will be notified of these recalls as expeditiously as patient safety warrants. Class I notifications are expedited. Class II notification will occur within 30 days of FDA notification. Whenever possible, TRUSTED notification will include a listing of specific members receiving the recalled medication.

Practitioners are expected to assure the security of their prescription pads, DEA numbers and CDS numbers. It is unlawful to use an unauthorized DEA number or CDS number and/or to pass forged prescriptions. Practitioners should immediately report any instances of the improper or the unauthorized use of prescriptions pads involving TRUSTED members. Reports may be made by contacting TRUSTED at:

PHARMACY

Medicaid Members can fill all prescriptions written by participating practitioners at the designated pharmacies. There is no co-payment for prescriptions. Specific over-the-counter drugs are covered for Medicaid members with a written prescription when purchased at a participating pharmacy. Alliance Members can fill all prescriptions at one of the Department of health Pharmacy Network Pharmacy locations.

If your patient requires a medication not on the formulary, practitioners may request an exception. Download the form from the TRUSTED web site **(www.TRUSTEDhp.com)** or call the Utilization Management Department at **(202) 821-1132 or (855) 326-4831** to request that a non-formulary exception override form be faxed to you. Complete the form and return it with a copy of the prescription (This is required. Avoid delays by including the prescription with your request.)

Note: A script for a 3-day supply of the medicine may be filled while the review is completed for prescriptions written at discharge from a Hospital or Emergency Room.

Meridian Pharmacy Benefit Manager manages TRUSTED's pharmacy network and prescription processing. There is no co- payment for prescriptions. Prescriptions must be written by participating practitioners. Specific over-the- counter drugs are covered for Medicaid members with a written prescription when purchased at a participating pharmacy.

If a patient requires a medication not on the formulary, providers may request a non-formulary exception by faxing a request to EFax (202) 654-5729 or mailing it to: Pharmacy Director; TRUSTED Health Plan, 1100 New Jersey Avenue, SE. Suite 840, Washington DC 20003.

The prescriber may call the Pharmacy Director at 202-821-1127.

The request will be reviewed to determine if it meets the criteria for approval. Note: **A three- day supply of the medication may be dispensed while the review process is being completed for prescriptions written upon discharge from a Hospital or Emergency Room.**

Continuous Quality Improvement (CQI)

TRUSTED is a National Committee on Quality Assurance (NCQA) accredited managed care organization. The Continuous Quality Improvement Program (CQI) is a coordinated, multi-disciplinary approach designed to objectively and systematically monitor and evaluate the quality, appropriateness and outcome of medical care and services and the processes by which they are delivered to the THP enrollees. The program continuously pursues opportunities for improvement within the organization and incorporates problem resolution.

The primary purpose of the CQI is to promote excellence in medical care through continuous objective assessment of important aspects of care/service and the resolution and improvement of identified problems. It is the goal and purpose of the CQI to achieve, using available resources, optimal outcomes with continuous, incremental improvements which are consistently representative of a high standard of practice in the community, minimize risk to the participant and organization and promote cost-effective appropriate services.

The program also includes an annual work plan which defines the program's goals; the specific activities that the committees and staff members will undertake to meet these goals, and establishes the time frame for reporting. The work plan also provides a structure for measuring progress toward achieving the defined goals.

Goals

THP strives to continuously improve the care and service provided by our care delivery systems. The CQI establishes the standards that encompass all quality improvement activities within THP. THP's goals are:

Goal 1: Meet CQI requirements established by District of Columbia-DHCF.

Goal 2: Improve the care and service received by plan members.

Goal 3: Provide Health Education/Outreach Programs to ***THP*** enrollees, providers, and communities.

Goal 4: By providing excellent care and service to our constituencies, to increase enrollment in THP through reputation with providers, enrollees and potential enrollees as an HMO with dedicated to quality health care.

The TRUSTED CQI Program monitors and evaluates significant aspects of the clinical care, member services and administrative services provided to members. The program integrates cross-functional activities using interdisciplinary teams whenever possible establishes performance measures and targets, identifies variation and root causes and initiates improvements to processes. Cross-functional activities are integrated to assure continuity. Monitoring of measures is conducted and results are reported on organization-wide and individual practitioner level whenever possible.

Important aspects of care and service in monitoring and improvement activities include:

- Primary network
- Access to network (including ADA standards)
- Appointment availability
- Appeals & denials
- Appropriateness and efficiency of ancillary services
- Compliance and regulatory issues
- Continuity of care
- Focused studies
- High volume and/or high risk diagnoses and/or problem prone processes
- Internal customer needs and expectations
- Medical records documentation
- Member satisfaction
- Member concerns
- Number of practitioners by geographic location
- Over utilization, miss-utilization and under utilization

- Oversight of delegated activities
- Vendor monitoring
- Preventive care
- Quality and risk occurrences
- Quality control monitoring
- Sentinel events
- Patient safety
- Fraud, waste and abuse

TRUSTED uses a model for improvement based on W. Edwards Deming's PDSA cycle. The PDSA cycle tests a change by developing a plan to test the change (Plan), carrying out the test (Do), observing and learning from the consequences (Study), and determining what modifications should be made to the test (Act). The model contains three fundamental questions that form the basis of improvement:

- What are we trying to accomplish?
- How will we know that a change is an improvement?
- What changes can we make that will result in improvement?

Once the three questions have been answered, a test of change is run. The cycle then repeats. Focus on the three questions and the PDSA cycle allows the application of the model to be as simple or sophisticated as necessary.

Well-defined quantitative performance measures drive clinical and service improvement activities. Whether initiated as a key element of the organizational planning process or by an individual department, every quality improvement project begins with measurable performance indicators.

Performance targets are identified for comparison with current TRUSTED performance. Interventions are designed by teams with direct clinical and operational accountability to achieve target outcomes and systematic performance improvement. In general, the Quality Management Program targets improvement in processes and outcomes that affect high risk, high volume, and under-served populations.

Leaders establish performance measures and collect data on key processes and outcomes related to patient care and organizational functions. The approach is planned, systematic and organization wide. The activities are collaborative and interdisciplinary. TRUSTED uses health status data of its members to fulfill its responsibility for meeting members' health needs, and develops and implements initiatives as needed to assist members and practitioners in managing chronic conditions.

TRUSTED is committed to a philosophy of continuous quality improvement. Excellence in clinical care and service is our mission with these important themes. Member needs determine our care delivery

system (member-centered care). The key relationship for our member is with his or her physician(s) in the care delivery system. The member-physician relationship, responsibility, and accountability is enhanced by effective information and multi-disciplinary problem solving that is data driven; fear-free learning that is important for continuous improvement ("information for improvement, not for judgment") and the goal to find better ways to meet or exceed our member's need or expectations. Physician leadership in all aspects of quality activities is vital to success. Teams function effectively with precise information, leadership development, and technical process facilitation.

The overall evaluation of the effectiveness of TRUSTED CQI Program is conducted annually. The primary objective of the formal evaluation and assessment is to assure that the Program is effective in meeting its established goals and objectives as defined in the CQI Work Plan.

The formal evaluation process of the CQI Program includes assessment of TRUSTED quality structure and processes. Goals, initiatives, structure or responsibilities are revised as needed to assure an effective program. Quality initiatives are continuously assessed throughout the year. Quality issues are tracked and improvement efforts are documented. Improvement opportunities are identified through the formal evaluation process and other assessment processes.

QUALITY OF CARE REVIEW

TRUSTED reviews member complaints and risk management referrals for deviations from the accepted standards of practice. When a potential quality of care issue is identified, a licensed health care practitioner reviews the case. Any practitioner involved in such a review will be notified and offered the opportunity to respond to the issue(s) raised in the investigation.

In the event that health care service rendered to TRUSTED members is outside the recognized standards of practice or the TRUSTED CQI standards, the Practitioner may be subject to sanctioning. If formal sanctioning proceedings result in negative outcomes, then TRUSTED will provide the appropriate notification to all designated authorities in accordance with the specifications of such law(s).

Such actions may include: closure of practitioner member panels, suspension of privileges, withholding of payments, deduction from future payments, and termination of agreement with TRUSTED. Information on the sanction process will be provided upon request.

The TRUSTED CQI description, including information on progress toward quality goals, is available to all practitioners, providers, members and TRUSTED employees upon request. To obtain a copy of the complete CQI Program description, Work Plan or annual evaluation, or to provide input on TRUSTED CQI Program, call **(202) 821-1100** to reach the Quality Department or visit the additional provider resources section on our website at www.TRUSTEDhp.com.

COMPLIANCE REQUIREMENTS

TRUSTED providers are required to comply with all TRUSTED policies and with legal or regulatory standards set by relevant outside entities. Although not an exclusive list, the primary areas of compliance with policies and regulations for TRUSTED providers are:

- Medical Records Documentation Standard - See Appendix D for details
- ADA and Office Site Standards - See Appendix A, Appendix B, & Appendix C for details
- HIPAA
- DHCF Contractual Obligations
- Waste, Fraud & Abuse

As a practitioner or provider, new and unique complexities create risks to you and your practice daily. TRUSTED is concerned about the ethics and legality of the health care provided to its members and seeks partnerships with providers to comply with uniform and safe standards.

The TRUSTED Compliance program, a DHCF mandate, is responsible for detecting and reporting suspected Fraud, Waste, and Abuse and ensuring adherence to legal, regulatory, and contractual obligations. The supervision of this program has been delegated to the Compliance Officer and the Compliance Committee. The Compliance Committee is composed of management staff- level representatives from all administrative departments.

The Compliance Committee also oversees Risk Management, reviews all reported incidents and is supervising the implementation and management of the Health Insurance and Portability and Accountability Act of 1996 (HIPAA).

Medicaid Fraud is a major priority of the Department of Justice and the Inspector General of the Department of Health and Human Services. It is estimated that 2-5% of claims submitted annually can be identified as potential fraud. The most common abuses are up coding, unbundling, billing for non-performed services, and organized crime. TRUSTED employees receive training in detecting and reporting suspected fraud, waste and abuse cases, and are aware of the common illegal practices of vendors, employees, and members. Providers should be aware that as subcontractors of TRUSTED Health Plan, they are recipients of Federal funds. Therefore, fraudulent billing, as well as providing assistance to members in receiving improper benefits, are both considered Medicaid fraud and subject to prosecution by Federal authorities.

TRUSTED encourages the reporting of instances of Fraud, Waste, and Abuse, by its members, practitioners and providers, employees and other vendors. Reports and complaints can be made directly and anonymously to the Compliance Hotline at (855) 228-1700 or via email at ReportFraud@TRUSTEDhp.com, 24 hours a day 7 days a week. Individuals making reports are not required to leave their name. TRUSTED Health Plan does not discriminate or take any adverse action

against members, practitioners and providers, employees, or others who make good faith reports of Fraud, Waste and/or Abuse.

Practitioners and providers pursuant to the Deficit Reduction Act of 2005 should be aware of the provisions of the Federal False Claims Act and the District of Columbia Procurement Reform Act. The Federal False Claims Act (the "Act") allows for triple damages and a penalty of $5,500 to $11,000 per claim for anyone who "knowingly" submits or causes the submission of a false or fraudulent claim in the United States. The government does not need to prove specific intent to defraud to find liability; rather, liability can be proven by evidence of deliberate ignorance of the falsity of the claim or if the individual acts in "reckless disregard" of the falsity of the information. A "claim" under the Act for health care purposes generally means each claim form submitted for payment but can also result from a false certification of a government-required document (e.g., false time and effort reports).

A "false claim" under the Act can result from a number of non-compliant actions; examples of false claims include billing for services not performed, up-coding (billing at a higher level when the applicable level of service was either not performed or the documentation does not support the level of service billed), knowing misuse of provider identification numbers, routine waiver of co-payments and deductibles, billing more than once for the same service, billing for services that are known to be non-covered services, or false time and effort reports. The Act has also been used to enforce the Federal Anti-Kickback Statute and the Stark law (federal prohibition on physician self-referrals).

The Act contains very detailed provisions for the filing of and prosecution of false claims actions. Under the Act, a private person, known as a "relator," can bring a lawsuit on behalf of the United States when this private person has information that a false claim has been filed for payment to the United States. The relator does not have to be personally harmed by the submission of the false claim to bring such a lawsuit.

When the complaint is filed, it is shared only with the government (i.e., not the defendant) and it must be filed under seal (in secrecy). After the complaint is filed under seal, the government has 60 days to decide whether or not it wants to take over the lawsuit (i.e. "intervene"). Typically, the government requests many extensions to this 60-day time period. Once the government makes the decision to intervene, the complaint is finally served on the defendant. If the government decides not to intervene, the relator is still entitled to pursue the case on his/her own behalf. If the government intervenes in the lawsuit, a settlement or trial verdict in favor of the relator is obtained, and if the relator was not involved in the wrongdoing, the relator can receive between 15 and 25 percent of the settlement or proceeds of the lawsuit. If the government does not intervene and the relator obtains a settlement or trial verdict, the relator will receive between 25 and 30 percent of the proceeds. In general, a lawsuit under the Act must be filed within 6 years of the date of the violation; in some instances it can be brought later than 6 years, but in no case more than 10 years after the violation occurred.

Relators are protected under the Act from any type of retaliation (including being discharged, demoted,

suspended, threatened, harassed or discriminated against) by his or her employer as a result of providing any assistance or information relating to a lawsuit under the Act.

The Procurement Reform Amendment Act (Reform Act) is very similar to the Federal False Claims Act. The Reform Act provides for treble damages, but the penalties are $5,000 and $10,000 for each false claim. The Reform Act does require that the individual have knowledge that the claim was false. The Act also provides for reduced penalties if the person committing the violation, reports the matter within 30 days of learning of the violation, cooperates in the investigation, and no formal action has been instituted.

As in the federal statute, individuals may bring a private civil action for violations of the Reform Act. The qui tam plaintiff, as such individuals are called, must serve the Office of the Attorney General of the District of Columbia on the same day that the civil action is filed. The Office of the Attorney General has 180 days in which to determine whether it will proceed with the action or decline to proceed. The action is held in abeyance until this decision is made. If the Attorney General decides to proceed, he or she will have complete control over the action, including any decision to settle.

As in the Federal False Claims act employees who disclose, assist in the investigation, initiation, testify, or provide assistance in the filing of a qui tam action may not be discharged, demoted, suspended, threatened, harassed, denied promotion, or in any other manner discriminated against in the terms and conditions of their employment.

MEDICAL RECORD KEEPING GUIDELINES

TRUSTED is committed to partnering with our contracted practitioners and providers in providing our members with the highest possible quality of care. Consistent, current and complete documentation is an essential component of quality patient care. The medical record must "tell the story" of the patient as determined by the physician in the circumstances in which he or she saw the patient. The record is not just a personal memory aid for the individual physician who creates it, it must allow other health care practitioners and providers to read quickly and understand the patient's past and current health concerns. Efficient medical record keeping facilitates current and future medical treatment of individuals by recording which treatments have and which have not been effective and the degree to which they have been effective as well as preventing harmful interactions attributable to different medical treatments.

In recognition of the key role that medical records play in providing clinical care, and to promote best-practice medical record keeping, we have adopted the components identified by the National Committee for Quality Assurance (NCQA) as our standard for medical record keeping. These guidelines have been incorporated into our ongoing quality oversight of contracted practitioners and providers and are available in *Appendix D of this manual.*

Practitioners should have a member's medical record available and accessible at all times for patient care.

MEDICAL RECORDS HIPAA ISSUES

TRUSTED is committed to strict adherence with the privacy and security provisions of the Health Insurance Portability and Accountability Act (HIPAA) and expects that its practitioners and providers are familiar with their responsibilities under HIPAA and take all necessary actions to fully comply. Any member record containing clinical, social, financial, or any other data on a member should be treated as strictly confidential and be protected from loss, tampering, alteration, destruction, and unauthorized or inadvertent disclosure. Medical records of network practitioners are to be maintained in a manner that is current, detailed, organized and permits for effective and confidential patient care and quality review. Practitioner offices are to have an organized medical record filing system that facilitates access and availability of records at all times. To maintain these standards, practitioners should ensure that the following standards for avail-ability, confidentiality and organization of medical records are met:

1. A designated staff-person qualified by training or experience, which has oversight of and access to the medical records storage system (paper or electronic system).
2. The office has a policy that includes the manner, in which the medical record is organized, the content of the medical record and the manner in which it is filed.
3. If the practitioner has several offices, there is a system to obtain records from one office to another if a patient is seen at several office locations.
4. Records for patients who have not been seen by the practitioner for a period of time may be stored off site and are easily accessible if the patient should return.
5. The office implements and maintains procedures for maintaining and safeguarding the confidentiality of member medical records and treatment in accordance with applicable federal and state law.

RELEASE OF MEDICAL RECORDS

A member has the right to review a copy of his/her medical records. A written authorization from the member or responsible party is required for the release of medical records, and such request shall be at no cost to the member. The authorization should include the following:

- Name of the institution or practitioner that is to release information
- Name of the institution or practitioner that is to receive the information
- Member's full name
- Member's address
- Member's date of birth
- Description of type of information to be released (including dates of services)
- Date consent is signed
- A statement with respect to the member's rights regarding to the release of psychotherapy notes if applicable

- A statement advising the member that they can revoke their authorization at any time

Copies of medical records should be released promptly upon written request and reasonable notice from the member or their representative. After the authorized release of medical record copies, the written authorization should be retained in the member's original medical records.

AMBULATORY MEDICAL RECORD REVIEW

Ambulatory medical record documentation review is conducted for primary care practitioners (PCPs) and specialists, as needed. Reviews will be conducted to determine compliance with established standards and performance goals.

Satisfactory completion of the review requires PCPs and non-behavioral health specialists to have met at least 4 of the 6 critical elements for each record reviewed. Practitioners not meeting TRUSTED medical records performance goals will be informed of areas needing improvement be required to submit a corrective action plan and be re-audited within 90 days.

At the time of the review, verbal feedback will be provided to the practitioner/office staff concerning the results of the review. Practitioners who fail to meet the required 4 of the 6 elements will be expected to document and implement a corrective action plan. A follow-up visit and ambulatory chart review will be conducted no sooner than three (3) and no more than six (6) months after the initial review to monitor progress towards compliance.

If the practitioner's medical records fail to meet the required standards at that time, a third and final review will be conducted within three (3) months.

Failure to meet the required standard after three reviews based on the guidelines will result in disciplinary action to include but not limited to sanctioning and/or censure.

UNDERSTAND YOUR BILLING PRACTICES

Practitioners should be diligent in supervising and training billing personnel. It is the responsibility of the practitioner to ensure compliance with billing guidelines and regulations. Upcoding, unbundling, billing for phantom patients and billing for services that have not been performed could be found to be fraudulent practices and may be forwarded to the appropriate legal entity for review. Underutilization of services might constitute fraud in a capitated network. Each member should be seen by his or her health care practitioner at least once a year, if only for preventative screenings.

REPORT SUSPECTED WASTE, FRAUD AND ABUSE

Issues involving TRUSTED members can be reported to the anonymous and confidential Compliance Hotline at 855-228-1700. Issues can also be reported via email to ReportFraud@TRUSTEDhp.com. TRUSTED shall ensure that no individual who reports plan violations or suspected fraud and abuse is subject to retaliation.

REPORT SUSPECTED CHILD ABUSE OR NEGLECT

Suspected abuse and/or evidence of abuse or neglect must be reported to the Child and Family Services Agency (CFSA) and/or the Metropolitan Police department. The Child Abuse and Neglect Reporting Hotline for District referrals is (202) 671- SAFE or (202) 671-7233. CFSA takes reports of child abuse and neglect 24 hours a day, seven days a week. Appropriate referrals for other social agencies should also be initiated. TRUSTED network hospitals are required to also report child abuse to TRUSTED Compliance and Risk Management Department.

IMPLEMENT HIPAA PRACTITIONER PROVISIONS

TRUSTED is a HIPAA compliant company. It is essential that practitioners understand the impact of this act on his/her practice. See Appendix E for additional information about TRUSTED Privacy Practices. All practitioners and providers must report potential HIPAA violations to TRUSTED Compliance Department at (855) 228-1700.

RISK MANAGEMENT

Risk Management is the process of identification, analysis, intervention, and monitoring of all departments within TRUSTED Health Plan, Inc. and their actual or potential ability to cause loss within the financial, reputation, patient care and/or any other sphere of operation.

Incidents are evaluated for their level of risk of loss and interventions developed to prevent or control further occurrences. Monitoring of processes and interventions with regard to the ability to control and/or decrease losses, keeping in mind company policy and strategic goals, will determine the overall success of the Risk Management Program.

The Risk Management Program is committed to ensuring safe and professional care for all members and to ensure the safety of TRUSTED employees and health care practitioners. The Risk Management Program will identify and evaluate risks, and take appropriate action(s), including the development of corrective action plans, to prevent and reduce loss exposure.

Patient Safety is an integral part of the overall Quality and Risk Management Program. All quality initiatives are designed with consideration given to improving safety and reducing risk for our members by assuring a safe patient-care environment in the facilities of our network providers and practitioners. Recognizing that effective medical care error reduction requires an integrated and coordinated approach,

we encourage our providers and practitioners to utilize a systematic program to minimize physical injury, accidents and undue psychological stress during instances of inpatient and outpatient treatment. TRUSTED organization-wide safety program includes all activities contributing to the maintenance and improvement of patient safety.

TRUSTED leadership assumes a role in establishing a culture of safety that helps to minimize hazards and patient harm by focusing on processes of care and incident reporting. The leaders of the organization are responsible for fostering an environment through their personal example emphasizing patient safety as an organizational priority, providing education to staff regarding the commitment to the reporting of medical care errors, supporting proactive endeavors to reduce medical care errors and integrating patient safety priorities into the design of all relevant organizational processes, functions and services.

TRUSTED monitors Joint Commission on Accreditation of Healthcare Organizations (JCAHO) accreditation status and whether the JCAHO National Patient Safety Goals are met at the time of accreditation. Almost 50 percent of Joint Commission standards are *directly* related to safety, addressing such issues as medication use, infection control, surgery and anesthesia, transfusions, restraint and seclusion, staffing and staff competence, fire safety, medical equipment, emergency management, and security. Additional patient safety standards went into effect for hospitals in 2001, and similar standards went into effect for behavioral health care and long-term care organizations in 2003, and for ambulatory care and home care organizations in 2004. These standards address a number of significant patient safety issues, including the implementation of patient safety programs; the response to adverse events when they occur; the prevention of accidental harm through the prospective analysis and redesign of vulnerable patient systems (e.g. the ordering, preparation and dispensing of medications), and the organization's responsibility to tell a patient about the outcomes of the care provided to the patient—whether good or bad.

TRUSTED strongly encourages that practitioners in all care settings implement processes to meet JCAHO's National Patient Safety Goals. The purpose of the Joint Commission's National Patient Safety Goals is to promote specific improvements in patient safety. The goals highlight problematic areas in health care and describe evidence and expert-based consensus to solutions to these problems. Recognizing that a service delivery system design is intrinsic to the safe, high quality health care, the goals generally focus on system wide solutions, wherever possible. The following table lists a few of JCAHO's Patient Safety Goals that can be implemented in any care setting:

JCAHO Patient Safety Goal	Suggested Action to Improve Safety
Improve the accuracy of patient identification	Use at least two patient identifiers when providing care, treatment or services

Improve the effectiveness of communication among caregivers	Implement a standardized approach to "hand off" communications, including an opportunity to ask and respond to questions.
Reduce the risk of health care-associated infections	Comply with current Centers for Disease Control and Prevention (CDC) hand hygiene guidelines
Encourage patients' active involvement in their own care as a patient safety strategy	Define and communicate the means for patients and their families to report concerns about safety and encourage them to do so

REPORTING UNUSUAL AND/OR CRITICAL INCIDENTS

TRUSTED monitors the quality and appropriateness of care provided to its members by hospitals, clinics, physicians, home health care agencies, and other providers of health care services. The intent of this review is to identify those unexpected occurrences involving death or serious physical or psychological injury, or the risk thereof, or which otherwise adversely affects the quality of care and service, operations, assets, or the reputation of TRUSTED. The phrase "or the risk thereof" includes any process variation for which an occurrence (as in "near miss') or recurrence would carry a significant chance of a serious adverse outcome. TRUSTED's goal is to:

1. Have a positive impact on improving patient care, treatment, and services and prevent sentinel events.
2. Focus the attention of the organization on understanding the causes that underlie the event, and on changing systems and processes to reduce the probability of such an event in the future.
3. Increase general knowledge about sentinel events, their causes, and strategies for prevention.

Practitioners are expected to report unusual occurrences, including near misses, to TRUSTED in real time. TRUSTED recognizes that the safety of the involved member is the primary goal of the treating practitioner; therefore allowance is made for the stabilization of the member prior to reporting. All sentinel and critical events (*see Appendix F for a full copy of TRUSTED Sentinel Event policy*) must be reported to TRUSTED within 24 hours of occurrence. Reports may be made directly to TRUSTED Risk Manager by calling (202) 821-1100.

TRUSTED will not take punitive action or retaliate against any person for reporting an unusual occurrence. Involved practitioners will be offered the opportunity to present the factors leading to the unusual occurrence and respond to any questions arising from the review of the unusual occurrence.

PHARMACY AND PATIENT SAFETY PRECAUTIONS

TRUSTED maintains a comprehensive pharmaceutical patient safety program. In partnership with its pharmacy benefits manager, TRUSTED requires that pharmaceutical safety information be provided to all members at the point of pharmaceutical dispensing. TRUSTED will notify practitioners when point of dispensing screening identifies specific interactions that may place a member at risk.

TRUSTED and its PBM monitor for Class I and II recalls by the Federal Drug Administration (FDA). Practitioners will be notified of these recalls as expeditiously as patient safety warrants. Class I notifications are expedited. Class II notification will occur within 30 days of FDA notification. Whenever possible, TRUSTED notification will include a listing of specific members receiving the recalled medication.

Practitioners are expected to assure the security of their prescription pads, DEA numbers and CDS numbers. It is unlawful to use an unauthorized DEA number or CDS number and/or to pass forged prescriptions. Practitioners should immediately report any instances of the improper or the unauthorized use of prescriptions pads involving TRUSTED members. Reports may be made by contacting TRUSTED at:

Compliance Hotline at: (855) 228-1700 or, ReportFraud@TRUSTEDhp.com

HEALTH EFFECTIVENESS DATA INFORMATION SET (HEDIS)

In an effort to assess the quality of care and service provided by the Medicaid managed plans, the District of Columbia Office of Managed Care adopted the HEDIS set of effectiveness of care measures as a tool used to assess this quality. HEDIS is a set of measures used to assess the effectiveness of health plans in providing services to promote wellness and enhance the receipt of preventive care. These measures study the proportion of the health plan population who receives the services for which they are eligible. Eligibility for any specific measure is determined by the Committee on Performance Measures (CPM) within the National Committee for Quality Assurance (NCQA).

The HEDIS process consists of following members for a set of care processes that are determined by the CPM. The CPM also sets forth criteria to determine how these processes must be completed in order to constitute compliance that meets the intended quality measure. At the end of the calendar year unless otherwise specified by the measure, members eligible for the various measures are randomized into a sample of 411 members and are reviewed to determine if they had the particular service under study. TRUSTED can determine if the member received the service using either administrative claims data and/or chart review for certain measures determined eligible for chart review.

Administrative claims review is the preferred mechanism for determining compliance. However if practitioners do not submit claims routinely, the TRUSTED must supplement the administrative compliance with compliance found during the review of charts. Therefore to enhance the efficiency of collecting HEDIS data, which is mandated by the District of Columbia Office of Managed Care,

TRUSTED request that all practitioners submit encounter data with the appropriate CPT code to indicate the service rendered during the office visit.

Category II CPT Codes are codes developed to denote services rendered that have no composite CPT code. For example the Controlling Blood Pressure measure (CBP), the systolic blood pressure must be below 140 and the diastolic blood pressure must be below 90 for compliance. Before the advent of category II CPT Codes, this measure required review of the medical record. However the category CPT II codes has a code (3076F) to indicate that the systolic BP is less than 140 and the diastolic code is less than 90 (3079F). Clinicians using these codes on the encounters submitted to the health plan can request a chart review for the measures. Practitioners desiring additional information regarding HEDIS measures or processes may contact the Clinical Quality Improvement department at (202) 821-1100.

PERFORMANCE DATA

Provider agrees that during the term of this Agreement, TRUSTED may collect and develop data, including, but not limited to, claims, cost, utilization, outcomes, quality, financial performance, and patient satisfaction data related to the health benefit plans offered or administered by TRUSTED, for quality improvement activity with the Provider and public reporting to consumers. Provider agrees to comply with all reasonable request s by TRUSTED in the collection of such data. Collectively, such data and reports shall be referred to as, "Performance Data." Any Performance Data regarding services of a specific provider for a specific Member shall be referred to as "Provider Specific Performance Data". TRUSTED shall be the owner of all Performance Data and Provider Specific Performance Data, and to the extent permitted by law (during the term and after the termination of this Agreement), such data may be shared with a current or prospective Member, payor Member, a current or prospective employer or payor of a group health benefit plan and their auditors or health care consultants, insofar as the information concerns covered services that are or would be considered allowable charges under a current or prospective Certificate of Coverage. Performance Data and Provider Specific Performance Data provided to Provider by TRUSTED shall be kept confidential by Provider and used only for the purposes of carrying out Provider's obligations under this Agreement. Upon termination of this Agreement, Provider shall return to TRUSTED any Performance Data that is not Provider Specific Performance Data. Upon written request of the Provider, TRUSTED shall make available to Provider, a description of how TRUSTED intends to use Provider Specific Performance Data, the methodology used in collecting and analyzing the data, and a copy of the Provider's data TRUSTED intends to disclose. To the extent that Provider can reasonably demonstrate, in writing, that any data that TRUSTED intends to disclose is inherently inaccurate, Provider shall notify TRUSTED of its specific concerns. In such a case, TRUSTED shall make a good-faith effort to resolve Provider's concerns; provided, however, that TRUSTED shall have the sole and final discretion, responsibility, and authority over the content, dissemination, and release of such data.

UTILIZATION MANAGEMENT

The purpose of the Utilization Management (UM) Program is to ensure appropriate allocation of resources by providing quality care/service in the most cost effective manner to TRUSTED' s enrollees.

The goal of the Utilization Management (UM) Program is to assure:

- Care provided is the right care, for the right patient, at the right time.
- Care is provided in the most appropriate setting.
- Care is provided is by the most appropriate provider.

To accomplish this goal, the processes must be sound and the application of the processes must be consistent. The health plan:

- Uses Case Management and continuums of care principles.
- Uses guidelines for care.
- Tracks medical utilization data.
- Follows guidelines as established by all applicable regulatory and accrediting bodies including NCQA and CMS.
- Evaluates annually the effectiveness of the health care management programs.
- TRUSTED Health Plan reports outcomes and customer satisfaction using the standard measures of Medicare, Healthcare Effectiveness Data and Information Set (HEDIS) and Consumer Assessment of Health care Providers (CAHPS) and Systems.

REFERRALS

The Primary Care Physician (PCP) **must be the (ordering)** physician that generates the referral for the member to see the Specialist **(rendering)** provider. A specialist **cannot** generate a referral for a member. Referrals must be created through the TRUSTED Health Plan Provider Portal.

Referrals are valid for 90 days. The member must have the first appointment with the specialist within the first 30 days or the referral is considered void.

If you do not have access to the provider portal please contact TRUSTED Health Plan at 202-821-1145.

Internal referrals for facilities / groups comprised of both Specialists and PCP's may be waived. (Please contact your provider relations representative for additional information).

AUTHORIZATION FOR SERVICE

Prior authorization (PA) may be required for some services, products or procedures to verify documentation of medical necessity. The ordering provider is responsible for obtaining PA; however, any provider can request PA when necessary. Prior authorization is issued to the ordering and the rendering providers. It is the responsibility of the provider to clearly document that the beneficiary has met the clinical coverage criteria for the service, product or procedure.

Prior Authorizations may be obtained by contacting the Utilization Management Department (UM) at (202) 821-1132. Prior Authorization (PA) requests can be faxed to: 202-905-0157. Requests for services will be reviewed by experienced Nurses utilizing InterQual criteria and/or other relevant clinical practice guidelines.

An Urgent PA is a request for service to be rendered within 24 hours and where the standard or priority review timeframe may seriously jeopardize the life or health of the member. Decisions will be rendered within1 calendar days, and oral notification will be made the same day of the decision.

A Priority PA is a request for service to be rendered within 3 calendar days where the standard review timeframe may seriously jeopardize the life or health of the member. A priority prior authorization request decision will be made within 3 calendar days and oral notification will be made with 48 hours of the decision.

Non-Urgent (Routine) PA is a request for service that is being rendered 14 or more calendar days from the date of the request. **A non-urgent/routine decisions will be made within 14 calendar days, and oral notification will be made** within 48 hours of the decision.

In the event of an adverse decision, the Provider may discuss the case with the Medical Director, and the member has the right to appeal as outlined in their member handbook.

Prior Authorization (PA) requests for Behavioral Health Services are handled by Beacon Health Options.

Prior Authorization for non-emergent imaging services are handled by National Imaging Associates (NIA). www.RadMd.com or 1-888-899-7804. **Please note: Services rendered in an Emergency Room, Observation Room, Surgery Center or Hospital Inpatient setting are not managed by NIA.**

PRIOR AUTHORIZATION / PRE-CERTIFICATION

Requesting Prior authorization

The purpose of a prior authorization is to evaluate and manage use of resource-intensive services and to ensure that the member receives services at the most medically appropriate location or level of care.

The objective of the prior authorization process is to:

- Ensure that anticipated services or treatments follow sound medical practice.
- Determine whether or not the services to be rendered can be performed safely and effectively in a less intensive setting.
- Ensure that after the PCP evaluation, the appropriate practitioner and/or facility have been selected to provide the anticipated service.

TRUSTED will accept prior authorization requests from 8:00 a.m. to 5:30 p.m., Monday - Friday.

The following is a list of services requiring prior authorization review for medical necessity and place of service.

- Elective/Non-Emergent Air Ambulance Transportation
- Inpatient Services
- All Inpatient Hospital Admissions (including medical, surgical and rehabilitation)
- Obstetrical Admissions/Newborn Deliveries (exceeding 48 hours after vaginal delivery and 96 hours after caesarean section)
- Inpatient Medical Detoxification
- Elective Transfers (for inpatient and/or outpatient services between acute care facilities)
- Long-Term Care (initial placement if still enrolled with the plan)
- All Out-of-Network Services (except emergency services)
- Home-Based Services
- Home Health Care (after 12 visits for therapies and 6 visits for skilled nurse visits).
- Extended Home Health Services (when covered)
- Home Infusions and Injections ($250 and over) provided in an outpatient setting, (not required for outpatient hospital setting)
- Enteral Feedings (including related DME)
- Therapy and Related Services
- Speech Therapy, Occupational Therapy and Physical Therapy (after 12 visits for each modality)
- Cardiac Rehabilitation
- Transplants (including transplant evaluations)
- All DME Rentals
- DME Purchases (for billed charges $500 and over, including prosthetics and orthotics)
- Diapers/Pull-Ups (age 3 and above): For quantities over 200 per month (for either or both)
- For brand-specific diapers
- Hyperbaric Oxygen
- Implants

- Injectable Medications not listed on the Medicaid Fee Schedule are not covered by TRUSTED Health Plan
  - Medications: 17-P and all infusion/injectable medications listed on the District of Columbia Medicaid Professional Services Fee Schedule with billed amounts of $250 or greater
- Surgical Services that may be considered cosmetic, including:
  - Blepharoplasty
  - Mastectomy for Gynecomastia
  - Mastoplexy
  - Maxillofacial
  - Panniculectomy
  - Penile Prosthesis
  - Plastic Surgery/Cosmetic Dermatology

  - Reduction Mammoplasty
  - Septoplasty
- Cochlear Implantation
- Gastric Bypass/Vertical Band Gastroplasty
- Hysterectomy
- Pain Management – external infusion pumps, spinal cord neurostimulators, implantable infusion pumps, radio frequency ablation and nerve blocks
- Radiology Outpatient Services (Requested thru NIA)
  - CT Scan
  - MRI
  - MRA
  - MRS
  - PET scan
  - SPECT scan
  - Nuclear Cardiac Imaging
- All miscellaneous/unlisted or not otherwise specified codes
- All services that may be considered experimental and/or investigational

Services that Do Not Require Prior Authorization

The following services do not require prior authorization from TRUSTED:

- Emergency Services
- Women's Health Specialist (to provide women's routine and preventive health care services)
- OB/GYN services for one annual visit and the medically necessary follow up care for a condition detected at that visit (the recipient must use a Plan Provider for these services)
- Diagnosis and treatment of sexually transmitted diseases and other communicable diseases such as tuberculosis and human immunodeficiency rendered by county health departments
- Podiatry, and some dermatology services (the member must see a plan provider for these services)
- Immunizations by county health departments and participating PCPs
- Imaging procedures related to emergency room services, observation care and inpatient care

Services that Require Notification

- Maternity Obstetrical Services (after the first visit) and Outpatient Care (includes 30-hour observations). Prenatal care providers are expected to complete the D.C. Collaborative Perinatal Risk Screening Tool to assess risk for each expectant mother. The completed screening tool must be submitted to TRUSTED Health Plan as part of the authorization for obstetric services.
- Normal Newborn Deliveries

FACILITY ADMISSIONS

Prior authorization is mandatory for all elective inpatient facility admissions for all TRUSTED members. The admitting physician must initiate the process by calling the Utilization Management Department at 202-821-1132 **at least 5 days prior to an elective admission** and within 24 hours of an emergent/urgent admission.

OUTPATIENT SERVICES

TRUSTED must be notified before service is rendered to determine if medical necessity criteria is met. Payment is contingent upon the member's eligibility at the time the service is rendered.
Prior authorization will be valid for ninety- (90) days. The first service should take place within thirty- (30) days. Home health, podiatry, physical therapy (PT), occupational therapy (OT), & speech therapy (ST) require an evaluation and treatment plan for authorization of additional visits. Treatment plans may be required for other services at the discretion of the Medical Director.

PRIOR AUTHORIZATION POLICY

All services requested will be verified for benefit coverage. Member eligibility and practitioner status in the network will be verified prior to evaluation for authorization.

Requests for prior authorization for selected specialty services, elective inpatient services and restricted procedures/services will be evaluated for medical necessity by nurse reviewers with the appropriate clinical background. **CERTAIN PROCEDURES MAY REQUIRE MEDICAL DIRECTOR REVIEW AND DETERMINATION, WHERE QUALITY, APPROPRIATENESS, AND EFFECTIVENESS POSE SPECIAL CONCERNS.**

The Medical Management staff has the authority to approve prior authorization requests that meet medical necessity screening criteria. All requests not meeting the medical necessity screening criteria will be referred to the Medical Director. The Medical Director has sole responsibility for rendering medical necessity denials.

Requests for prior authorization will be evaluated utilizing the standard clinical decision support criteria. Criteria updates and revisions are obtained and incorporated, as available.

Requests for prior authorization will be accepted from the attending practitioner or designee according to the following guidelines:

- The Medical Management Department will accept prior authorization requests during the hours of 8:00 a.m. to 5:30 p.m., Monday – Friday at (202) 821-1132 or toll free at (855) 326-4831.

  * After Hours, Utilization Management issues, and notification of Emergency Admission can be communicated via EFax at (202) 905-0157 or by contacting the afterhours Nurse line at (855) 878-

1852.

- The Medical Management Department must be notified no later than 24 hours after an emergency admission for authorization for continued acute hospital stay.
- Requests for prior authorization of procedures normally done on an outpatient basis will not be approved for inpatient stay unless medical necessity for the inpatient stay is clearly documented and approved by the Medical Director.
- Pre-admission diagnostic work-ups, including laboratory, radiology and/or supporting specialty consultations will be performed on an outpatient basis, unless underlying or critical conditions exist that preclude outpatient studies.
- The UM staff will refer chronic disease cases or those with a potential for high risk or special needs to the Case management department.
- Practitioners or their designees requesting prior, concurrent and/or retrospective authorizations must report pertinent medical and member information. This includes:
  - Diagnosis and appropriate ICD-9/10 codes
  - Supporting clinical history and physical findings (brief summary)
  - Anticipated surgical or diagnostic procedures and appropriate CPT codes
  - Attending Practitioner
  - Anticipated consultants
  - Anticipated length-of-stay
  - The name of the facility
  - Scheduled date of admission
  - Need for an assistant surgeon
- Coordination of benefits data (may include spouse, group insurance, workman's compensation coverage, accident insurance coverage, and other third party liability)
- All authorization requests will be evaluated for:
  - Member eligibility
  - Covered benefits
  - Use of participating practitioners
  - Medical necessity and appropriateness of care
- **Authorization requests must be complete and legible. Incomplete or illegible authorizations will result in delay of review.**

PRIOR AUTHORIZATION DISCLAIMER

The following statement is made to the Practitioner who has requested approval for services/care at the time the authorization is approved:

"Based upon the information you have provided, we are approving your prior authorization request for medically necessary services. The amount of actual benefit coverage, if any, is subject to all plan benefit provisions including member eligibility and any contractual limitations in effect when the services are provided."

APPLICATION OF MEDICAL NECESSITY CRITERIA

"Medically Necessary" or "Medical Necessity" is defined as services or supplies that are needed for diagnosis or treatment of the member's medical condition according to accepted standards of medical practice. The need for the item or service must be clearly documented in the member's medical record.

Members ages 21 and older

A service is medically necessary if a physician or other treating health provider, exercising prudent clinical judgment, would provide or order the service for the purpose of evaluating, diagnosing or treating illness, injury, disease, physical or mental health conditions, or their symptoms. A service is medically necessary if provision of the service is:

- In accordance with generally accepted standards of medical practice;
- Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury, disease, or physical or mental health condition; and
- Not primarily for the convenience of the individual or treating physician, or other treating healthcare providers, and more cost effective than an alternative service or sequence of services, and at least as likely to produce equivalent therapeutic or diagnostic results with respect to the diagnosis or treatment of that individual's illness, injury, disease or physical or mental health condition.

Members through age 20

A service is medically necessary if it promotes normal growth and development and prevents, diagnoses, detects, treats, ameliorates the effects of a physical, mental, behavioral, genetic, or congenital condition, injury, or disability. A service is medically necessary if it meets the following provision;

- A recommended EPSDT screening service;
- A health care, diagnostic service, treatment, or other measure described in Section 1905(a) of the Social Security Act, 42 U.S.C. § 1396d(a), to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, whether or not such services are covered under the District of Columbia State Medicaid plan.
- A health care intervention
  - That assist in achieving, maintaining, or restoring health and functional capabilities without discrimination to the nature of a congenital/developmental abnormality.
  - Is appropriate for the age and developmental status of the child.

- Is reasonably expected to produce the intended results for children and to have expected benefits that outweigh potential harmful effects.
- An immunization recommended by the Advisory Committee on Immunization Practices (ACIP)

For those services furnished in a hospital on an inpatient basis, medical necessity means that appropriate medical care cannot be effectively furnished more economically or appropriately on an outpatient basis or an inpatient facility of a different type. The fact that a provider has prescribed, recommended or approved medical or allied goods or services does not, in itself, make such care, goods or services medically necessary or a covered service/benefit.

TRUSTED Health Plan uses InterQual (UM) criteria as guidelines for determinations related to medical necessity. Criteria are applied for all authorization requests that require a medical necessity determination. Reviews are performed on a prospective, concurrent or retrospective basis. The Medical Management staff determines if the diagnostic and therapeutic services are clinically indicated at the proposed level of care. Once the eligibility and benefit availability are established standard criteria are utilized to determine medical necessity. Should the review result in an adverse determination, the member and/or their designated representative, the practitioner and/or the designated representative has the right to request a copy of the review criteria used to make the determination. Copies of the criteria are available on request by calling the UM Department at: (202) 821-1132. Additionally, they may request to speak directly with the reviewing medical practitioner making the adverse determination by calling: (202) 821-1107.

To initiate an appeal or request to speak with the medical practitioner making the determination call (202) 821-1107.

Medically necessary means services, equipment, or pharmaceutical supplies that are required or are:

- To prevent the onset of an illness, condition, or disability or sustain the member's physical, mental, behavioral, or developmental health
- To assist the individual to achieve, maintain, or regain maximum functional capacity in performing daily activities, taking into account both the functional capacity of the individual and those functional capacities appropriate for individuals of the same age
- Reasonably expected to provide an accessible and effective course of treatment or site of service that is equally effective in comparison to other available, appropriate, and suitable alternatives, and is no more intrusive or restrictive than necessary
- Sufficient in amount, duration and scope to reasonably achieve their purpose as defined in federal law and the coverage shall be no more restrictive than that used in the District's Medicaid program as indicated in District statutes and regulations, District Plan, and other District policy and procedures and of a quality that meets standards of medical practice and/or health care generally accepted at the

time services are rendered.

The Utilization Management (UM) Department will indicate which specific criteria were used to approve or deny the service. Questions or concerns will be directed to the Medical Director.

TRUSTED members and practitioners are advised that (UM) decision making is based only on the appropriateness of care and service and the existence of coverage. TRUSTED does not reward practitioners or other individuals for issuing denials of coverage or service care. Financial incentives for the UM decision makers do not encourage decisions that result in underutilization.

NON-COVERED SERVICES

The following services are not covered:

- Services and procedures provided at non-network facilities or by non-participating Practitioners except for Family Planning Services
- All services and procedures related to the treatment of the Temporo-mandibular Joint (TMJ)
- Chiropractic Services
- Cosmetic Surgery
- Experimental/investigation services, surgeries, treatments and medications
- Non-network nutrition counseling
- Organ Transplants (covered by DC Medicaid members only)
- Sclerotherapy
- Therapeutic Abortion, unless medically necessary according to Federal guidelines
- Treatment and procedures related to obesity
- Treatment for infertility
- Fertility medications
- Immunizations for overseas travel
- For the Alliance member, newborn delivery coverage for both the mother and baby.

ADVERSE DETERMINATIONS

If the review results in an adverse determination, the member, his/her designated representative, the practitioner, or his/her designated representative has the right to request a copy of the documentation and or review criteria used to make the determination. The explanation of the appeal process must be provided including the time frames. The member has the right to appeal in person in front of the health

plan's personnel. The member must also be notified of which benefits will continue pending resolution of the appeal of issuance of a District Fair Healing Decision. The member must be notified that the assistance of an Ombudsman is available and be informed how to contact the Ombudsman. The member must also be advised of the expedited appeal process, including the circumstances in which that may occur. The member must be notified that he or she has the right to a hearing from the Office of Administrative Hearing (District Fair Hearing) at any point in the process. Additionally, a member may request to speak directly with the reviewing medical practitioner making the adverse determination.

APPEALS

TRUSTED Health Plan offers two types of Appeals: Expedited Appeal and Standard Appeal (see *Appendix G for types of appeals*). A member, member's representative, attending physician/practitioner or facility, may request appeals. The appeal may be initiated by a verbal or written request; however, TRUSTED prefers that verbal requests be followed by a written request for proper documentation. Submit written appeals to:

TRUSTED HEALTH PLAN, INC.
Attn: Appeals Coordinator
1100 New Jersey Ave., SE • Ste.840
Washington, DC 20003
Fax: (202) 905-0156

MEDICAL EMERGENCY CARE

Members are not required to contact their PCP in an emergency. In a true emergency, members may go directly to the emergency room. PCPs should not refer members to an emergency room during regular office hours for non-emergent conditions that can reasonably be managed in practitioner's office.

MEDICAL REFERRALS

It is the PCP's responsibility to coordinate all aspects of the member's medical care, including referrals to participating specialists and facilities. The PCP must use the TRUSTED Health Plan Provider Portal to refer to specialty providers.

REFFERRAL GUIDELINES

The Referral Process is outlined below:

- Referrals are required for evaluation and follow-up with specialists, diagnostic testing, and other

ancillary services.

- Practitioners may not refer to a non-participating practitioner or facility without prior authorization from TRUSTED.
- Referral requests for non-participating practitioners are reviewed on a case-by-case basis the Utilization Management Department.
- Availability of service or specialty within the network and member's history with a practitioner is considered when reviewing referrals to nonparticipating practitioners.
- The first service should occur within thirty- (30) days from the date of referral. Referrals expire after ninety- (90) days.
- Practitioners should indicate the number of visits on a referral, up to three (3) or it will be valid for only one visit.
- Referrals must be generated before the service, procedure, and/or evaluation occurs.

The PCP is charged with coordinating the care of members assigned to their panel.

If the network is unable to provide necessary medical services, covered under the contract, to a particular member, TRUSTED will adequately and timely cover these services out of network for the member for as long as the MCO is unable to provide them. TRUSTED will coordinate services for out of network providers with respect to payment and will ensure that the cost for services provided to the member is not greater than it would be if the services were furnished within the network to the extent possible. Approval of out of network services must be obtained in advance of the services unless a delay in care based on the need to obtain such authorization would jeopardize the medical outcome for the member. In such emergent or urgent situations, the plan should be notified as soon as possible.

Participating practitioners may not bill TRUSTED or the member for any covered services that have been denied by TRUSTED because the service was not medically necessary.

PRE-NATAL/GYN SERVICES

Participating specialists who have been credentialed as an OB/GYN are responsible for providing obstetric and gynecological care to members. Members who are pregnant may select both a PCP and Gynecologist from the current list of participating practitioners. Members may choose a practitioner who provides well woman care as their Gynecologist or Advanced Practice Registered Nurse who specializes in OB/GYN as their PCP. **Female members may obtain Family Planning Services from any Woman's Health Specialist in or out of the Network.**

Routine and gynecological services means the full scope of medically necessary services provided by the obstetrician or gynecologist or advance practice registered nurse in the care of, or related to, the female

reproductive system and breasts and in performing annual screening and immunizations for disorders and diseases in accordance with nationally recognized medical practice.

OB REGISTRATION FORM

Practitioners providing obstetrical care for all members enrolled in Medicaid and Alliance are required to notify TRUSTED Health Plan of a pregnancy. Practitioners may notify TRUSTED via submission of the OB notification form by mail or fax to the address listed below. ***OB Registration forms are used as notification of pregnant moms. However, payment is contingent upon receiving pre-authorization and the receipt of your claims.*** When calling to report a pregnancy, the following information should be provided:

- Member's name
- Medicaid/ID,
- DOB
- Patients' phone
- Obstetrician/Midwife Name
- LMP
- EDC
- Gravidi /Para
- Date Prenatal care initiated
- Planned C-Section indication
- Previous pregnancy outcomes
- Current pregnancy complications
- Considered high risk pregnancy (if yes, why)
- Current weight
- Pre-pregnancy weight and DOS
- Number week's gestation at time of first visit, delivery hospital and any high risk issues that could lead to an adverse pregnancy outcome.
  This information is used to assign a pregnancy care manager who works collaboratively with the obstetrical practitioner and office to coordinate care for the member. The office will be apprised of the care manager and receive contact information so that a joint effort can be made to meet the members' needs. For practitioners choosing to send the notification form, it can be downloaded from the website at **www.TRUSTEDhp.com.** The completed OB Registration Form can be faxed or mailed to:

TRUSTED HEALTH PLAN, INC.
Attn: Utilization Management Department
1100 New Jersey Ave., SE • Ste.840
Washington, DC 20003
Fax: (202) 905-0157

AN OB/GYN PRACTITIONER AS A PCP

Participating Obstetricians are responsible for following the Academy of Obstetrics and Gynecology

Guidelines for the provision of obstetrical care during pregnancy. Specific information regarding the guidelines can be obtained by contacting the Clinical Quality Improvement Department (202) 821-1100. Obstetricians may provide routine primary care services and treatment to members during pregnancy. Examples of routine primary care include but are not limited to:

- Treatment of minor colds, sore throat, asthma.
- Treatment of minor physical injuries.
- Preventive health screenings and maintenance.

OB/GYNs are responsible for coordinating services with participating hospitals and specialists for pregnancy related care. The OB/GYN is responsible for notifying the TRUSTED Case Manager at (202) 821-1132 for assistance with support services needed to help the pregnant member during pregnancy. Any high-risk pregnancies due to physical, social or behavioral conditions must be reported to TRUSTED at the time of the first visit or at the time when the high-risk situation develops during the pregnancy. All high- risk conditions should be reported to the high-risk obstetrical case manager. The case manager can be contacted via phone (202) 821-1132. The high-risk case manager partners with the OB practitioner to provide reinforcement education for the high-risk condition and coordinate services needed. For high-risk situations that require consultation and/or management of a perinatologist, practitioners should contact the high-risk case manager at the number above. She/he will help the member to contact the perinatologist for consultation and/or transition management.

If an OB/GYN practitioner feels that a member's medical condition is outside his or her scope of clinical competence, please refer the member to an appropriate participating specialist for evaluation and treatment of the condition.

TREATMENT FOR ROUTINE GYNECOLOGICAL CARE

Participating PCPs are responsible for the initial evaluation and treatment of gynecological conditions that require examination to include a pelvic examination. Any sexually transmitted disease (STD) must be reported to the Department of Health Communicable Disease Division. PCPs may refer cases that are unresponsive to treatment to Participating OB/GYNs.

Members are allowed one (1) annual well woman exam a year, (unless medically necessary to be performed more frequently). The examination allows for the following:

- Detailed gynecological history including sexual practices.
- Routine gynecological exam, including pelvic exam.
- Pap smear.
- Clinical Breast exam and Mammography for all women ages 40 or older unless the clinical history indicates that earlier screening is advisable. Prior authorization is required on all women under 40 years of age.

- Counseling regarding STD prevention, pregnancy prevention if pregnancy is not desired and routine health maintenance recommendations.

CLINICAL PRACTICE GUIDELINES

TRUSTED Health Plan is committed to partnering with our network practitioners and providers to provide quality medical care and customer service. Therefore, TRUSTED has developed and adopted preventive health and clinical practice guidelines relative to conditions prevalent within the membership. These guidelines represent the core level of care recommended for the various conditions. All members having conditions for which clinical practice guidelines exist should receive care consistent with the guideline recommendations.

TRUSTED Health Plan reviews and updates clinical practice guidelines every two years. The guidelines meet the following criteria:

- Evidence based, as the guidelines are adopted from recognized professional organizations or involve clinical practitioners from the appropriate specialties when guidelines are developed that are not from recognized professional sources.
- Relevant to the members of TRUSTED Health Plan.
- Adopted in consultation with network health care professionals who treat populations with illnesses or diseases covered in the guidelines.

All guidelines were reviewed and approved by the Quality Management Committee. Guidelines adopted by TRUSTED Health Plan may be viewed on the Provider Website at www.TRUSTED.com. The website contains treatment protocols, and algorithms taken from the full-length guidelines. The complete guidelines are available upon request for review and use by the practitioner network. To obtain the guidelines in hard copy, contact the Sr. Director for Quality Improvement Activities at (202) 821-1100

Practitioners are responsible for reviewing and following the Clinical Practice Guidelines. A listing of the guidelines adopted by the health plan is provided below:

Condition	Evidence-Based Guideline
Pediatric Asthma	*Global Initiative for Asthma (GINA)* http://www.ginasthma.org/Guidelines/guidelines-resource.html
Diabetes	*American Diabetes Association: Clinical Practice Recommendations 2015* http://professional.diabetes.org/ResourcesForProfessionals.aspx?cid=84160
ADHD	*American Academy of Pediatrics (AAP)* http://pediatrics.aappublications.org/content/early/2011/10/14/peds.2011-2654

Depression in people with Diabetes	*American Diabetes Association: Clinical Practice Recommendations 2015* **http://professional.diabetes.org/ResourcesForProfessionals.aspx?cid=84160** *American Psychiatric Association Practice Guidelines* **http://psychiatryonline.org/guidelines**
Sickle-Cell Disease	*National Heart, Lung, and Blood Institute* **http://www.nhlbi.nih.gov/health-pro/guidelines/sickle-cell-disease-guidelines**

Preventative Measure	Evidence-Based Guideline
Perinatal Care	*American College of Obstetricians and Gynecologists (ACOG) Clinical Guidelines* **http://www.acog.org/About-ACOG/ACOG-Departments/Deliveries-Before-39-Weeks/ACOG-Clinical-Guidelines** *American Academy of Pediatrics (AAP) Guidelines for Perinatal Care* **http://www2.aap.org/sections/perinatal/index.html**
Children up to 24 months	*DC HealthCheck Resources: DC Medicaid Healthcheck Periodicity Schedules* **http://dchealthcheck.net/resources/healthcheck/periodicity.html** *American Academy of Pediatrics Recommendations for Preventive Pediatric Care* **http://pediatrics.aappublications.org/content/suppl/2007/12/03/120.6.1376.DC1/Preventive_Health_Care_Chart.pdf**
Children ages 0-20	*DC HealthCheck Resources: DC Medicaid Healthcheck Periodicity Schedules* **http://dchealthcheck.net/resources/healthcheck/periodicity.html** *American Academy of Pediatrics Recommendations for Preventive Pediatric Care* **http://pediatrics.aappublications.org/content/suppl/2007/12/03/120.6.1376.DC1/Preventive_Health_Care_Chart.pdf**
A1C Testing for Diabetes and Pre-Diabetes in Adults 20+	*American Diabetes Association: Clinical Practice Recommendations 2015* **http://professional.diabetes.org/ResourcesForProfessionals.aspx?cid=84160**
Cervical Cancer Screening for Women ages 21-64	*US Preventive Services Task Force Recommendations for Primary Care Practice* **http://www.uspreventiveservicestaskforce.org/Page/Topic/recommendation-summary/cervical-cancer-screening**
Adult Vaccinations 21-64	*Centers for Disease Control- Advisory Committee on Immunization Practices* **http://www.cdc.gov/vaccines/acip/recs/**
Colonoscopy for Adults ages 50+	*US Preventive Services Task Force Recommendations for Primary Care Practice*

	http://www.uspreventiveservicestaskforce.org/Page/Topic/recommendation-summary/colorectal-cancer-screening

Summary information for select clinical guidelines is available on the website. This material is for informational purposes only. These guidelines are neither comprehensive nor are they intended to serve as a substitute for individualized clinical judgment and decision-making in the care of the members. All clinical care for TRUSTED Health Plan members and related decisions are the sole responsibility of the practitioner. This information does not dictate control of the practitioner's clinical decision regarding appropriate care of members. TRUSTED does not commit to provide coverage for all recommendations that may appear. Please refer to the member handbook or the Medical Management Department for clarification of benefit design. These guidelines may be used for objective comparison of clinical practices among net-work providers and to assist in assessing appropriateness of care to our members.

CASE MANAGEMENT

The Case Management Program provides coordination of care for patients with complex, chronic, or critical health care needs. EPSDT services are also a focus of the Case Management program. The program assists families, patients, and doctors in planning care and services. This is part of a team plan, which looks at individual health care needs. Case Managers assist members and their families by analyzing all options/choices available to them within the health care delivery system. Case Managers contact these members to work cooperatively and effectively with patients for whom some form of behavioral change and motivational interviewing might result in better health outcomes. The intended outcome is to empower members to better manage their chronic conditions and improve their use of clinical, caregiver/family and community resources to improve their health outcome. The role of the Case Manager is intended to support the care prescribed for the member by the attending physician. Their health problems can cut them off from family, co-workers and friends. A cycle of isolation, depression, and a deterioration of their health frequently sends them into a downward trend. In a combined effort of the Case Manager, and in collaboration with the member's PCPs, members are supported in ways that make the most difference to their health. All home services must be ordered by a physician and prior authorized before services are rendered.

DISEASE MANAGEMENT

TRUSTED offers Disease Management Programs designed to assist in the coordination of care for members with chronic medical conditions and mental health issues. TRUSTED programs entail coordination of practitioner-delivered care, treatment guidelines, patient counseling and empowerment, patient self-management, and education.

The goals of the Disease Management Programs are to:

- Improve the health outcomes for the individual.

- Reduce the complications associated with these particular illnesses.
- Preserve the best quality of life for the member.

Disease Management programs are designed to include and involve TRUSTED practitioners. Practitioners participate in the initial development of the programs and with any succeeding revisions. Practitioners are advised of all members who have been identified for any Disease Management Programs and reminded about any member who is not current with recommended preventive measures.

TRUSTED offers free programs to help manage a member's medical and mental health issues. The Disease Management referral form is available on the website: www.TRUSTEDhp.com.

Common health issues managed by our Disease and Case Management Programs are:

- Pediatric Asthma
- Children and Adults with Diabetes
- Adult with Hypertension
- Adults with Cardiovascular Condition
- Persons with HIV or AIDS
- High Risk Pregnancy
- Infants, toddlers, school-age children and adolescents with evidence of development and mental disability and delay (Children with Special Needs)
- Obesity in children and adults
- Adults with mental illness and substance abuse
- Children and adults with cancers
- Complex Conditions

To refer a member for Case / Disease Management call **(202) 821-1132 or** fax (202) 905-0157

BEHAVIORAL HEALTH & SUBSTANCE ABUSE CARE

Beacon Health Options provides case management services for members affected by:

- Adults with mental illness and substance abuse related conditions.
- Behavioral (Mental) Health Disorders.

Beacon's case managers are co-located at TRUSTED to ensure seamless communication and collaboration with their colleagues in the Plan's Medical Management department.

Our case managers are licensed health care professionals who are responsible for developing and maintaining specific disease or case management program. The Disease Management Team assists members to learn more about their illness and master self-management skills necessary to control their chronic illness and decrease the risk of complications. Each program is designed to support the practitioner's plan of care.

Behavioral Health providers will receive a separate provider manual from Beacon Health Options describing all aspects of the TRUSTED Behavioral Health program. To contact Beacon, call (855) 481-7041.

ANCILLARY SERVICES

Dental

DentaQuest administers dental services. To contact DentaQuest, call 1-855-418-1620.

Home Health /Home Infusion

TRUSTED Health Plan administers all Home Health and Home Infusion benefits. To access assistance for Home Health and Home Infusion, practitioners and members should contact (202) 821-1132

Laboratory

LabCorp provides outpatient laboratory services to TRUSTED members. Participating Practitioners should contact LabCorp at (800) 859-0391 to schedule specimen pick-ups, order supplies, discuss test results or get information. To establish a LabCorp provider account call (800) 859-039.

Routine specimens are processed upon receipt at LabCorp. Written reports are sent to practitioners within twenty-four (24) hours after the specimen receipt. Reporting time may vary due to the nature of the request and the amount of time required performing the test.

STAT laboratory tests are completed within four hours of their receipt at the nearest STAT laboratory. STAT results are provided by telephone as soon as they become available.

Practitioners must use a LabCorp requisition form to request services from the LabCorp locations. If LabCorp cannot provide a service for any reason, members should not be referred to freestanding laboratory centers without prior authorization.

Pharmacy

Meridian Pharmacy Benefit Manager manages TRUSTED pharmacy network and prescription processing. There is no co- payment for prescriptions. Prescriptions must be written by participating practitioners. Specific over-the- counter drugs are covered for Medicaid members with a written

prescription when obtained at a participating pharmacy. You can view the most current formulary at www.TRUSTEDhp.com. The prescriber may call the Pharmacy Director, at: (202) 821-1127.

If a patient requires a medication not on the formulary, providers may request a non-formulary exception by faxing a request to EFax (202) 654-5729, completing the exception request form at www.TRUSTEDhp.com or by mailing it to:

Pharmacy Director:
TRUSTED Health Plan
1100 New Jersey Avenue, SE. Suite 840
Washington DC 20003

The request will be reviewed to determine if it meets the criteria for approval. **Note: A three- day (3) supply of the medication may be dispensed while the review process is being completed.**

Radiology

Outpatient radiology services are provided at contracted facilities. Members should not be referred to non-participating hospitals or freestanding diagnostic radiology centers. TRUSTED Health Plan (THP) has entered into an agreement with National Imaging Associates, Inc. (NIA), an affiliate of Magellan Health Services. This program includes management of non-emergent, advanced, outpatient imaging services to include prior authorization.

Prior authorization through NIA will be required for the following outpatient imaging procedures:

- CT/CTA
- MRI/MRA
- PET Scan
- CCTA
- Nuclear Cardiology/Nuclear Stress/MPI
- Stress Echocardiography
- Echocardiography

The ordering physician is responsible for obtaining authorization prior to rendering the above-listed services. To obtain authorization, the provider should go to the NIA web-site www.RadMD.com or through the NIA dedicated toll-free phone number, 1-888-899-7804. Providers rendering the services listed above should verify that the necessary authorization has been obtained by visiting www.RadMD.com, or by calling NIA at 1-888-899-7804. Failure to do so may result in nonpayment of your claim. ***Emergency room, observation and inpatient imaging procedures do not require authorization.***

Vision

Vision services are administered by EyeQuest. A member's PCP or Optometrist can refer members to a TRUSTED participating Ophthalmologist for medical conditions of the eye. To contact EyeQuest call

1-855-418-1620.

HEALTH CHECK/EPSDT/ SALAZAR ORDER / CONSENT DECREE

The Federal Government established the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program in 1967, which was renamed Health Check in the District of Columbia in 2002. The purpose of the program is to provide low-income children under the age of 21 with comprehensive preventive screening, diagnostic and treatment services.

In accordance with the Salazar Consent Decree all DC Medicaid Managed Care primary care practitioners are responsible for providing Medicaid Health Check services to patients from birth to 21. Practitioners must document the refusal of services in the member's record. Practitioners in the following specialties qualify as Health Check practitioners and are responsible for providing Health Check services:

- Pediatrics
- General Practice (including Osteopathy)
- Internal Medicine
- Obstetrics /Gynecology (if the practitioner is contracted as a primary care practitioner)
- Nurse Practitioners (practicing in the clinical areas listed above)
- Family Practice Medicine

The components of the Health Check Exam include:

- Comprehensive unclothed physical examination
- Developmental screening
- Immunizations
- Laboratory screening tests
- Behavioral health screening

All patients under 21 are expected to be current with the age-appropriate preventive health supervision visits/screening. The most current District of Columbia Health Check Periodicity Schedule can be found on the District of Columbia EPSDT website. Practitioners are obligated to follow the age-appropriate screening schedule a minimum guide-line, but may expand screenings (inter-periodic screens), as necessary. Additional information is available at the Bright Futures website: http://www.brightfutures.org/. Primary Care Practitioners are required to use a valid and standardized developmental screening tool during well child visits as well as episodic visits to assess developmental delays. Any practitioner who suspects that a child has a developmental delay must contact a TRUSTED Care Coordinator for assistance in coordinating during well child visits as well as specific visits and

stand-alone services.

SCREENING TIMEFRAMES

PCPs are contractually obligated to provide Health Check/EPSDT screenings within 60 days of the due date. The due date is one year from the date of the previous year's Health Check/EPSDT examination except for children under the age of two years wherein the screening must be performed within 30 days of its due date. Members newly assigned to a PCP and in need of Health Check/EPSDT services must be offered an appointment for screening within 45 days of the request. The PCP must complete the screening within three months (90 days) of the member's initial enrollment date with TRUSTED. The enrollment date can be found on the PCP panel report. Contractually, TRUSTED is obligated to make Health Check/EPSDT appointments available to current members within 60 days of the due date.

If the child misses a regular periodic screening, that child must be screened off the regular periodicity schedule in order to bring the child up-to-date.

INTER-PERIODIC AND PARTIAL SCREENS

Inter-periodic screens occur more frequently than scheduled screens due to medical necessity (e.g., when a child has tested positively for a condition and the physician determines that there is a medical need to re- screen for that condition.) Partial screens are incomplete screens that occur when the practitioner (e.g., specialty Practitioners) is able to perform only part of the screens required at a particular time. For example, if hearing and vision is done at one visit, this is a partial screen because the child needs to return to get the remaining components of the Health Check exam, namely the comprehensive unclothed physical, age appropriate laboratory testing, developmental screening and age-appropriate immunizations. It is important to note that partial screenings are not considered compliant with the Health Check requirement. Therefore, if a partial screening is performed, the practitioner office needs to remember to have the child return to have the remaining components of the Health Check as soon as possible.

CONDUCTING THE MEDICAL WELL-CHILD SCREENING VISIT

To meet Federal Health Check screening requirements, a Health Check exam/visit must include the following five components:

- Administration of a standardized developmental screening tool to identify potential developmental and or behavioral issues.
- A comprehensive health history and unclothed physical examination;
- Immunizations
- Appropriate laboratory tests
- Health education and anticipatory guidance

Annually, TRUSTED must demonstrate compliance with the Health Check screening process. The time-frame for this compliance review is October 1, of the current year to September 30 of the next year. The compliance to be achieved is 80% of the eligible population's receipt of the Health Check comprehensive screening. Preferably, TRUSTED relies on the submission of encounter data to ascertain the compliance of Health Check examinations. However, if not enough encounter data is submitted to reach 80%, TRUSTED Health Plan staff performs reviews of office practice medical records for TRUSTED members to look for additional visits that have not been submitted. Any additional Health Check visits found during chart review are added toward the compliance needed to achieve no less than 80%. TRUSTED realizes that chart review is intrusive to practitioner office operations. Therefore to avoid the need for chart review, encounters should be submitted to the TRUSTED Health Plan Claims Department no less than monthly. TRUSTED will audit member medical records to confirm that the approved screening tool(s) are used as part of the encounter associated with the claim submitted for reimbursement.

INFORMING MEMBERS ABOUT HEALTHCHECK

To help practitioners meet Health Check compliance, TRUSTED Health Plan employs multiple strategies, including written and audio-visual materials, and face-to-face encounters, to inform and educate all HealthCheck eligible members. The TRUSTED HealthCheck representative can assure that you have information in your offices about HealthCheck to give to members.

TRUSTED HealthCheck materials are available in English and Spanish and will be produced in other languages as needed. TRUSTED offers specialized assistance with obtaining information on HealthCheck, including TTY services for hearing impaired individuals and Language Line Services for individuals needing translation services. Information regarding use of the language line is available at (202) 821-1100.

PRACTITIONER AND MEMBER COMPLIANCE WITH HEALTHCHECK/ EPSDT SERVICES

Practitioner

Health Check is a web- based EPSDT provider training developed by Georgetown University's National Center for Education in Maternal and Child Health in collaboration with DHCF and the MCO'S. The HealthCheck Provider Training module satisfies the EPSDT and IDEA provider Training Requirements. Successful completion and verification of completion of Health Check training is required for new HealthCheck providers within thirty (30) days of joining the TRUSTED Health Plan network and at least every two (2) years thereafter. Failure to complete the HealthCheck Trainings as outlined will result in discharge from the TRUSTED Health Plan provider network. Providers should complete the Health Check Training at www.dchealthcheck.net.

CODING AND SUBMITTING ENCOUNTERS FOR HEALTHCHECK SERVICES

All practitioners are asked to submit an encounter for every member for whom a HealthCheck /EPSDT service is rendered. The encounter can be submitted on the CMS 1450 billing form, which is used as both

a billing form for fee-for-service claims and as an encounter form for reporting non-billable services.

When coding for HealthCheck services, it is important that the practitioner or billing person use the correct procedure coding. The Current Procedural Terminology (CPT) coding book is the recommended source for appropriate coding. Since CPT codes can be revised from time to time, practitioners are encouraged to use the most current edition of the CPT. Below are the most common CPT codes related to HealthCheck services.

Preventive Medicine Codes That Are Valid HealthCheck Codes

EVALUATION AND MANAGEMENT CODES

99381 ..... (new patient; initial comprehensive examination) less than one year of age

99382 ..... (new patient; initial comprehensive examination) 1-4 years of age

99383 ..... (new patient; initial comprehensive examination) 5-11 years of age

99384 ..... (new patient; initial comprehensive examination) 12-17 years of age

99385 ..... (new patient; initial comprehensive examination) 18-39 years of age

99391 ..... (established patient, periodic comprehensive exam) less than one year of age

99392 ..... (established patient, periodic comprehensive exam) 1-4 years of age

99393 ..... (established patient, periodic comprehensive exam) 5-11 years of age

99394 ..... (established patient, periodic comprehensive exam) 12-17 years of age

99395 ..... (established patient, periodic comprehensive exam) 18-39 years of age

99431 ..... (Newborn care, history and examination)

99432 ..... (Normal newborn care)

COMBINATION CPT AND DIAGNOSTIC V CODES THAT ARE VALID FOR HEALTHCHECK)

99201-99205

99211-99215 ....in conjunction with V20=V20.2 and/or V70.0 and/or V70.3-V70.9.

86580 .....In conjunction with V20=V20.2 and/or V70.0 and/or V70.3-V70.9.

The following diagnostic V codes with CPT codes 99201-99205 or 99211-99215

V03	V05	V20	V72	V82
V04	V06	V70	V74	

Vision Screening Coding

99173 In conjunction with V72.0

Hearing Screening Coding

V5008	92552	92555	
92551	92553	92555	in conjunction with V72.1

Immunizations

90647 ..... (HIB) in conjunction with V03.81

90655 ..... (Influenza, split virus, preservative free for 3 years old and older)

90657 ..... (Influenza, split virus, 6-35 months of age)

90658 ..... (Influenza, split virus 3 years old and older) in conjunction with V04.8

90669 ..... (Pneumococcal conjugate vaccine, less than 5 years of age) in conjunction with V03.82

90700 ..... In conjunction with V06.1

90702 ..... In conjunction with V06.5

90707 ..... In conjunction with V06.4

90713 ..... In conjunction with V04.0

90716 ..... In conjunction with V05.4

90718 ..... In conjunction with V06.5

90723 ..... In conjunction with V06.8

90732 ..... In conjunction with V03.82

90744 ..... In conjunction with V05.3

90748 ..... In conjunction with V06.8

86580 ..... In conjunction with V74.1

36415 ..... In conjunction with V82.5

All practitioners are required to submit a record of the immunizations given to the Department of Health/Division of Immunizations, Vaccines for Children (VFC) program. The program houses a registry that is a repository for all immunizations given to a child. This database can be of value to practitioners as they can view the registry to see which immunizations a child has been given prior to the current visit. This is extremely helpful for new patients for whom there is no vaccine history available.

TRUSTED sends members notices reminding them of their need for HealthCheck services approximately 90 days prior to the actual HealthCheck due date (one year after the previous year's examination except for children under two years of age for whom services are due more frequently). TRUSTED EPSDT staff also attempt to contact the member to remind them to make an appointment to have the HealthCheck examination. The staff will also assist in making the appointment for the member if the member is agreeable to accept the help. Beginning in April 2008, the department will begin sending a listing of members due for HealthCheck services to the practice sites 90 days before the due date. Practices are asked to monitor the list and record the date that the member presents for the appointment.

At the end of the 90-day period, the office staff is asked to fax the list back to the EPSDT staff at (202) 905-0175. The staff will use the list to contact noncompliant members immediately to rein-force the need for HealthCheck services and to help obtain the appointment. The goal of this intervention is to have the member have the HealthCheck appointment as soon after the compliance date as possible. Practitioner staff can contact the Prevention and Wellness staff for any help they may require to have the member receive HealthCheck services. Additionally, if the member has HealthCheck services and the screening requires a more comprehensive follow-up, the office staff can contact the Prevention and Wellness staff who will communicate the request to the appropriate TRUSTED Health Plan department as needed and will work with the parent and child to obtain the necessary additional services. When appropriate, these children will be referred to the Care Management Program for assistance with obtaining comprehensive evaluations, intervention treatment planning, and monitoring.

HEALTHCHECK TRACKING SYSTEM

TRUSTED maintains a comprehensive system for documenting and monitoring the provision of HealthCheck services. The CMS 1450 billing form is used as both a billing form for fee-for-service claims and as an encounter form for reporting non-billable services.

A patient-specific software tracking system includes actual CPT-4 codes for each procedure performed. The listing of CPT-4 codes is vital in the reporting of specific procedures being completed and is particularly important when tracking immunizations. The tracker also imports data from the Department of Health/Division of Immunizations Vaccines for Children (VFC) program to provide additional information on vaccines provided to HealthCheck eligible members that TRUSTED may not otherwise be aware. The tracker also maintains non-clinical information such as; membership, the status of notification letters, and outcomes from follow-up calls and home visits. In addition to information available on the tracking system, this software also indicates when a member is eligible for an immunization or well-child exam according to the periodicity schedule.

Outreach via telephone calls and home visits will follow as needed. Outreach will also be initiated upon practitioner request.

CHILDREN WITH SPECIAL HEALTH CARE NEEDS

The Individuals with Disabilities Education Act (IDEA), a Federal law, passed in 1975 and reauthorized

in 1990, mandates that all children receive a free, appropriate public education regardless of the level or severity of their disability.

IDEA provides funds to enable states to provide a public education to students with disabilities. Under IDEA, students with disabilities are able to receive public education because the law provides for individualized education programs (IEP) that meet the unique needs in the least restrictive environment for each child in the IDEA program. The law also provides guidelines for determining what related services are necessary and outlines a "due process" procedure to make sure these needs are adequately met.

Children ages 3-21 assessed to need special education services because of a disabling condition are eligible for the program. Comprehensive evaluations are performed by a multidisciplinary professional team and shared with the parent, PCP, teachers and other interested parties involved with the learning of the child. TRUSTED is involved as a participant in the coordination of wrap-around services needed to support the child's educational process. TRUSTED Health Plan notifies the Primary Care Practitioner whenever a child receiving IDEA services is identified. However, because school health personnel do not necessarily know TRUSTED as the child's insurance carrier, TRUSTED often is placed in a position of not being aware of these children or their needs. Therefore, TRUSTED also relies upon the practitioner to inform the health plan of children they know are receiving special education services. The Care Coordinator can then work with the practitioner to obtain any services that are needed to support the educational process and are included in the benefit coverage.

IDEA, Part B, specifically details eligibility criteria and services under the IDEA program that support an appropriate, free public education for children who meet eligibility criteria. Practitioners are advised to call TRUSTED Care Coordinator for assistance as needed in obtaining support services for children receiving IDEA educational services.

IDEA, Part C, specifically details services for children from birth to three years who either have or are "at risk" for a developmental, educational, or behavioral or physical care delay. These children are likely not receiving special education services. The District of Columbia Infant and Toddlers program monitors the progress of children who are eligible for this program simultaneously with the health plan. Practitioners are asked to report any child they perceive may be eligible for services under this program. The Care Coordinator works with practitioners to obtain evaluative services for any child who has a screening procedure that indicates the potential need for services under this program. Practitioners can call (202) 821-1100 to contact the Care Coordinator.

IDENTIFICATION OF CHILDREN WITH SPECIAL HEALTH CARE NEEDS

Primary Care Practitioners are required to use a valid and standardized developmental screening tool to screen for developmental delays during well child visits or episodic care visits (standalone visits are

episodic visits). If a child is identified as having a delay that is significantly different than an expected variation; however, within the norm of age-appropriate development, the PCP is required to refer the child for a comprehensive developmental evaluation. PCPs may refer the child independently of the Care Coordinator but must make the Coordinator aware of the referral within 72 hours. If the PCP would like assistance in referring the child for further evaluation, contact the Care Coordinator at the telephone number above or complete a Care Management/Disease Management referral form to fax to 202-905-0157.

Examples of children who may require a referral include, but are not limited to, those listed below:

- Diagnosed hyperactivity, attention deficit disorders, autism, severe attachment disorders, and other pervasive developmental disorders, or other behavioral disorders. Please contact Beacon Health Options at 1-855-481-7041 for assistance with referrals or consultation.
- Delay or abnormality in achieving emotional milestones, such as attachment, parent-child interaction, pleasurable interest in adults and peers, ability to communicate emotional needs, or ability-ty to tolerate frustration.
- Persistent failure to initiate or respond to most social interactions.
- Fearfulness or other distress that does not respond to comforting by caregivers.
- Indiscriminate sociability, for example, excessive familiarity with relative strangers; or self-injurious or other aggressive behavior.
- Substantiated physical abuse, sexual abuse, or other environmental situations that raise significant concern regarding the children's emotional being.

Special Member Support Services

HEALTH PROMOTION AND HEALTH EDUCATION

Wellness Services encompass a range of activities that begin and continue throughout a member's enrollment. All aspects of TRUSTED's health education programs and other health promotion activities focus on efforts to reinforce healthy behaviors and lifestyles.

Health Education Program Philosophy and Approach
TRUSTED is committed to providing quality health education programs and health promotion activities as a part of a continuum of member services.

TRUSTED Health Education Programs include the following components:

- The importance and availability of testing for HIV/AIDS and the services available for its treatment.
- The importance and availability of early intervention for infants, toddlers and school-age children, including children who either have been diagnosed as having, or who are suspected of having, a

developmental disability or delay.

- Weight control and nutritional counseling.
- Guidelines on nutrition for pregnant women and children, the importance of prenatal and post-partum care and the how to obtain benefits from the WIC program.
- Sexuality education for teenagers: prevention of pregnancy, protection from STDs, and issues of sexual orientation and gender identification.

These activities focus on wellness and begin during the enrollment and new Member orientation process. Health education programs share the dual goals of increasing Members' knowledge, while at the same time fostering their desire to attain and maintain healthy behaviors and skills that enhance their quality of life. TRUSTED firmly believes that promoting self-confidence in managing one's medical condition is crucial. Educating members how to do this is an adjunct to helping members be able to manage their health conditions. In addition to evaluating each class, the Health Education staff will be incorporating an evaluation of the member's ability to sustain the behaviors learned in the classes. Practitioners are encouraged to refer members to classes and to recommend various class topics they feel will be beneficial for their patients. The Health Education Coordinator will send a summary of your patient's participation activity and the goals accomplished at the end of the class.

Practitioners may fax a health education referral for your member to 202-905-0157

SERVICES FOR NON-ENGLISH SPEAKING MEMBERS

One of the tools that TRUSTED makes available to providers is Language Line translation service to allow providers to communicate with members who are not proficient in English. Language Line provides translators by telephone. To access the Language Line call 202-821-1100.

SERVICES FOR HEARING IMPAIRED MEMBERS

TTY/TTD Relay Service (telephonic assistance) is available for members by calling 711.
A representative will answer the TTY/TTD phone and will relay requested information. All information will be documented.

Sign language assistance is also available. Please schedule an appointment by calling the member service department at (202) 821-1100. The TTY/TTD phone number above may also be used to schedule sign language interpreters.

TRANSPORTATION

Transportation is available for all members for non-emergency scheduled medical appointments to and

from participating practitioners' offices during normal business hours. If non-emergency medical transportation services are required on Sundays or Holidays, members or practitioners may contact the twenty-four hour (24) Nurse Response Line. Members must present their TRUSTED Health Plan Membership Card to schedule transportation members or practitioners may contact the member services line at (202) 821-1100 or (855) 326-4831, Monday- Friday 8:00-5:30.

Member Eligibility, Benefits & Rights

To check eligibility, you may call the District's Eligibility Verification System at (202) 906-8319, or contact TRUSTED Health Plan Members Services at (202) 821-1100. You may also check eligibility on the TRUSTED Health Plan Provider Portal. For Access to the THP provider Portal, contact our Provider Services Department at (202) 821-1145 or (202) 821-1100 option #3.

Practitioners must verify each member's eligibility prior to providing medical services.

MEMBER ID CARDS

Member ID card - Medicaid and Alliance

TRUSTED Cards are issued to DC Medicaid (TANF), DC Healthy Family Program (DCHF) and DC Healthcare Alliance members. The card includes the following information:

PCP SELECTION

TRUSTED will ensure that members are assigned to a participating Primary Care Practitioner (PCP) of choice. Upon enrollment into TRUSTED Health Plan, members select their PCP (through the Enrollment Broker or through Customer Service). In the event that a member chooses to delay their PCP choice and no selection is made, one of two mandatory selection processes will occur:

1. If a member was previously enrolled with TRUSTED and their PCP is still participating, the member is reassigned to their previous PCP of record.

2. The Enrollment Department assigns the member to a PCP who is located in the same zip code as the member's residence. This is done to ensure that the member is assigned within 30 minutes travel time of their home via public transportation.

CHANGING OF PCP

At any time, the member has the right to change the assigned or selected PCP. If a member elects to change their PCP, and the request is made prior to the 15th of the month, the change will occur within 24 hours. However, if the change is requested after the 15th of the month, the change becomes effective on

the 1st of the following month.

- PCP is no longer participating.
- There is a language barrier between the member and the practitioner.
- There is an enrollment error made by TRUSTED.

Should any of these factors arise, TRUSTED will change the PCP selection effective immediately.

MEMBER SERVICES

The Member Services department can be reached at (202) 821-1100 or toll free 1-855-326-4831. Member Services is open Monday through Friday, 8:00 am-5:30 pm.
The Customer Services department is staffed to assist practitioners and members with any of the following:

- Choosing or changing a member's PCP.
- Educating members on how to access their benefits.
- Updating a member's demographic information.
- Issuing new and replacement identification cards.
- Providing phone numbers and addresses to participating practitioners.
- Documenting and following up on concerns or complaints with services and medical treatment.
- Arranging medical appointments.
- Verifying eligibility.
- Assisting with re-certification.
- Assisting and/or facilitating the grievance process.
- Educating members on proper emergency department usage.
- Verifying claim status.

MEMBER'S RIGHTS AND RESPONSIBILITIES

Member Rights:

TRUSTED Health Plan Members have the right to:

- Be treated with respect and dignity.
- Know that when you talk with your doctors and other providers its private.
- Have an illness or treatment explained to you in a language you can understand.
- Participate in decisions about your care.
- Refuse treatment or care.
- Be able to see your medical records and to request that they be fixed if they are wrong.

- Choose an eligible PCP from within TRUSTED's network and to change your PCP.
- Make a Complaint ("Grievance") about the care provided to you and receive an answer.
- Request an Appeal or a Fair Hearing if you believe TRUSTED was wrong in denying, reducing or stopping a service or item.
- Obtain medical care without unnecessary delay
- Receive information on advance directives and choose not to have or continue any life-sustaining treatment.
- Receive a copy of TRUSTED Member Handbook.
- Continue treatment you are currently receiving until you have a new treatment plan.
- Receive interpretation and translation services free of charge if you need them.
- Refuse oral interpretation services.
- Get an explanation of prior authorization procedures.
- Obtain summaries of customer satisfaction surveys.
- Receive TRUSTED's "Dispense As Written" policy for prescription drugs.
- Receive family planning services and supplies from the provider of your choice.
- Be free from any form of restraint or seclusion used as coercion, discipline, convenience or retaliation, as specified in other federal regulations on the use of restrains and seclusion.
- Receive information about benefits available under the District plan, but not covered by TRUSTED.
- To a candid discussion of appropriate or medically necessary treatment options for your conditions regardless of cost and benefit coverage.
- Have direct access to a women's health specialist within the network for the covered care necessary to provide women's routine and preventive healthcare services. Also, female enrollees have a right to designate as their PCP a participating provider or an advanced practicing registered nurse who specializes in obstetrics (OB) and gynecology (GYN).
- Ask for a chaperone to be present when you receive health care.
- Receive information about TRUSTED Health Plan's financial condition and any special ways we pay our doctors.
- Receive information about TRUSTED Health Plan, our services, our providers and other health care workers, our facilities, and your rights and responsibilities as a member.
- Receive a second opinion from a qualified health care provider within the network, or arrange for the enrollee to obtain one outside the network, at no cost to you.
- Be informed about how and where to access any benefits available under the district of Columbia plan but not covered under the contract, including any cost sharing, and how transportation is provided upon enrollment, annually an at least 30 days prior to any change.
- Not be held liable for the TRUSTED Health Plan's debts in the event of the TRUSTED Health Plan's insolvency.
- Use any hospital or other setting for emergency care.

- Be treated no differently by providers or by TRUSTED Health Plan for exercising your rights listed here.

Responsibilities of a TRUSTED Health Plan Member:

- Treating those providing your care with respect and dignity.
- Following the rules of the D.C. Medicaid Managed Care Program and TRUSTED Health Plan.
- Following plans and instructions you receive from your doctors and other providers.
- Going to Appointments you schedule or that TRUSTED schedules for you.
- Telling your doctor at least 24 hours before the Appointment if you have to cancel.
- Asking for more explanation if you do not understand your doctor's instructions.
- To make recommendations regarding TRUSTED Health Plan's Member Rights and Responsibilities policy.
- Going to the Emergency Room only if you have a medical emergency.
- Telling TRUSTED and your PCP about medical and personal problems that may affect your health, to help them to provide you care.
- Reporting to Economic Security Administration (ESA) and TRUSTED if you or a family member have other health insurance.
- Trying to understand your health problems and participate in developing treatment goals to help TRUSTED and PCP provide your care.
- Helping your doctor get medical records from providers who have treated you in the past.
- Telling TRUSTED if you were injured as the result of an accident or at work.

ADVANCE DIRECTIVES

The Advance Directive is a written instruction recognized under District law, relating to providing health care when an individual is incapacitated. If a member is an adult (18 years of age or older), he/she has the right under Federal law to decide what medical care that he/she wants done, if in the future the member is unable to make his/her wishes known about medical treatment. The member has the right to choose a person to act on his or her behalf to make health care decisions for them, if the members cannot make the decision for themselves.

Advance Directives shall be written in one of two ways:

- Living Will - A written document that tells what medical treatment the member does or does not want if the member is unable to make his/her wishes known.

- Durable Power of Attorney for Health Care - A written document that says the member has chosen someone to make their decisions for them if they are unable to do so and names the individual in the

document.

TRUSTED requires that its contracted hospitals, skilled nursing facilities, nursing facilities, home health agencies, providers of home health care and/or personal care services, hospices and religious non-medical health care institutions maintain written policies and procedures concerning advance directives with respect to all adults receiving medical care or patient care. The information regarding advanced directives must be furnished by providers/organizations as required by Federal regulations:

- Hospital - At the time of the individual's admission as an inpatient.
- Skilled nursing facility - At the time of the individual's admission as a resident.
- Home health agency - In advance of the individual coming under the care of the agency. The home health agency may furnish information about advance directives to a patient at the time of the first home visit, as long as the information is furnished before care is provided.
- Personal care services - In advance of the individual coming under the care of the personal care services provider. The personal care provider may furnish advance directives information to a patient at the time of the first home visit, as long as the information is furnished before care is provided.
- Hospice program - At the time of initial receipt of hospice care by the individual from the program.

The providers/organizations:

- Are not required to provide care that conflicts with an advance directive.
- Are not required to implement an advance directive if, as a matter of conscience, the provider cannot implement an advance directive and District law allows any health care provider or any agent of such provider to conscientiously object.
- Prepaid or eligible organizations (as specified in sections 1833(a) (1) (A) and 1876(b) of the Act) must meet the requirements specified in § 417.436 of this chapter.

If an adult individual is incapacitated at the time of admission or at the start of care and is unable to receive information (due to the incapacitating conditions or a mental disorder) or to say whether or not he/she has executed an advance directive, then the provider may give advance directive information to the individual's family or surrogate. The provider is not relieved of its obligation to provide this information to the individual once he or she is no longer incapacitated or unable to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time.
Members can call TRUSTED Member Services department to get more information on how to make an Advanced Directive. Useful information about Advanced Directives is available from Caring Connections at 1-800-658-8898 or their website, www.caringinfo.org

BILLING AND CLAIMS

CLAIMS SUBMISSION

All claims for services rendered must be submitted within 180 days from the date of service or discharge date for inpatient admissions. All claims submitted by practitioners must be billed on CMS-1450 forms. All claims must have the following pertinent information:

- Member/Patients name and Medicaid identification number
- Member's date of birth and address
- Diagnosis code(s)
- CPT-4 and /or Revenue Codes
- Date(s) of service
- Place of service codes
- Charges (per line and total)
- Practitioner's federal tax identification number
- Practitioner's name
- Practitioner's TIN number and group number as applicable
- National Provider Identifier (NPI)
- Vendor name and billing address
- Name and address of facility where services were rendered
- Signature

HOW DO I SUBMIT A CLAIM?

TRUSTED Health Plan will accept both paper and electronically submitted claims. TRUSTED accepts claims electronically through Emdeon, **payor ID: L0230**. Paper claims must be mailed to the following addresses:

MEDICAID:
TRUSTED Health Plans, Inc.
DC Healthy Families
P.O. Box 830786
Birmingham, AL 35283-0786

ALLIANCE:
TRUSTED Health Plans, Inc.
Alliance Program
P.O. Box 830210
Birmingham, AL 35283-0210

All clean claims submitted in a timely manner will be paid within 30 days in accordance with the provisions of the DC Prompt Payment Act of 2002.

FEE-FOR-SERVICE CLAIMS

Fee-for-Service claims for services rendered to TRUSTED members must be submitted within (180) days of the Date of Service (DOS) or as specified on the practitioner's contracts.

PRIMARY CARE AND DEPRESSION MANAGEMENT

TRUSTED Health Plan, Inc. (TRUSTED) requires that Primary Care Practitioners submit a claim or encounter when diagnosing and treating a TRUSTED member for depression. Capitated practitioners are required to submit an encounter and will not be reimbursed above the capitation fee. Non-capitated practitioners will be reimbursed when an appropriately coded claim is submitted.

The ICD-9-CM codes that may be used and are covered for primary care depression management services are: 296.0-296.9, 298.0, 300.4, 309.1, 309.28, and 311. The depression diagnosis does not have to be the primary diagnosis.

Primary care practitioners may submit these diagnoses codes with the standard medical evaluation and management CPT codes, or with the 90862-medication management code.

PROMPT PAYMENT ACT OF 2002

TRUSTED Health Plan shall pay all clean claims within 30 days after the receipt in accordance with the District of Columbia Prompt Payment Act of 2002. A clean claim is a claim that has no material defect or impropriety, include any lack of reasonably required substantiating documentation, which substantially prevents timely payment being made on the claim. There shall be a reputable presumption that TRUSTED has received a claim within 5 business days from the date the Practitioner or person entitled to reimbursement placed the claims in the United States mail. This presumption is 24 hours for electronic submission, if not returned by the electronic claims clearinghouse.

All claims without the necessary information required to ensure timely processing will be returned within with a letter of explanation attached indicating the reason for return.

In the event that clean claims are not paid within 30 days of receipt, and TRUSTED Health Plan does not notify the Practitioner within the said 30 days of any information missing that is required to pay the claims. TRUSTED Health Plan will implement measures to calculate and pay interest penalties in accordance with the provision of the prompt payment Act of 2002 as follows:

- One and a half percent from the 31st day through the 60th day.
- Two percent from the 61st day through the 120th day.
- Two and one half percent after the 120th day.

CLAIMS INQUIRIES

If a practitioner has not received payment for a claim within 45 days or has concerns regarding any claim issue, claim status can be checked by doing one of the following:

- Call the Claims resolution department at (202) 821-1100 option #4 or (855) 326-4831 (toll free), select option #4 to speak directly with a Claims Resolution representative.
- Call our Provider Services Department at (202) 821-1145 or (202) 821-1100 and ask to speak to their assigned Provider Relations Representative, or call the Representative directly.
- Log in to the TRUSTED Health plan provider portal.

When calling to check the status of a claim, the following information must be provided:

- Member name and identification number
- Date of service(s)
- Practitioner Name & Identification
- Billed amount(s)
- Approximate date of claim submission

CLAIMS DENIAL

When a claim is denied, Remittance Advice (RA) with reason for the denial will be sent to the practitioner. The appropriate denial code(s) detailing the denial reason(s) can include but are not limited to the following:

- The services were not covered
- The member is not eligible for that DOS
- Claim was not filed within the time limit (DOS to receipt date)

All denied claims can be resubmitted for reconsideration through the appeals process.

BALANCE BILLING MEMBERS

All Providers shall comply with the requirements of sections 1932(b) (6) of the Social Security Act, 42 U.S.C. 1396u 2(b) 96) that an enrolled individual or the individual's family or care giver may not be held liable or be subject to collection efforts for debts or obligation of TRUSTED Health Plan or any provider participating in our network even if in cases of insolvency.

All payments from TRUSTED Health Plan to its providers must be accepted as payment in full for services provided. Members may not be balance billed under any circumstances.

Section 1128B (d) (1) of the Social Security Act states that whoever knowingly and willfully charges for any service provided to a patient under a State plan approved under Title XIX or under a managed care organization contract under 1903(m) of the Act, money or other consideration at a rate in excess of the

rates established by the State or contract shall be guilty of a felony and upon conviction shall be fined no more than $25,000 or imprisoned for no more than five years, or both.

All Providers are encouraged to use the appeal process to resolve any outstanding claims payment issues.

CLAIMS PAYMENT REVIEW

It is TRUSTED's policy to review all claims for irregularities utilizing its claims audit system. If the system uncovers coding irregularities such as unbundling, utilization of obsolete CPT codes, etc., the specific claims line will be denied using the appropriate denial code. All claims denied for these reasons may be appealed and submitted in writing with additional documentation for reconsideration.

THIRD PARTY LIABILITY/SUBROGATION

In the event of an accidental injury (personal or automobile) where a third party payor is deemed to have liability and makes payment for services that have been considered and paid under the TRUSTED contract, TRUSTED will be entitled to recover any funds up to the amount of the third party payor. Forward all inquiries to the Compliance Officer at:

TRUSTED HEALTH PLANS, INC.
1100 New Jersey Ave., SE • Ste. 840
Washington, DC 20003
(202) 821-1100

SURGICAL REIMBURSEMENT POLICIES

Preoperative Test Requirements

It is the surgeon's responsibility to provide information to the member on the hospital's requirements for preoperative physical examinations, laboratory and radiology tests. Lab specimens may be drawn by the surgeon or PCP and sent to the appropriate participating lab for work-up.

Multiple Procedures

Multiple surgical or invasive procedures are paid at a reduced rate. The secondary procedure is paid at 50% of the allowable charge. Subsequent procedures will be paid at 25% of the allowable charge or per provision of individual practitioner's contract.

Incidental Surgery

Incidental procedures are not reimbursed as separate charges when they are performed in conjunction with other surgical procedures. The following are a few examples of incidental procedures:

- Procedures to create surgical entry
- Exploratory Laparotomy
- Incidental Appendectomy

Assistant Surgeons

Assistant surgeons should be limited to minor procedures and will be reimbursed at 20% of the TRUSTED maximum fee for the procedure performed. The use of an assistant surgeon does not require preauthorization when the surgeon participates with TRUSTED Health Plan. Use of a non-participating assistant surgeon is not permitted unless prior authorization is given by the Medical Management Department.

Global Surgical Reimbursement

Pre and postoperative visits are considered to be part of the surgical fee. Payment for visits, which do not fall within the Medicare surgical global guidelines, will be denied.

National Provider Identifier

The NPI is a unique 10-digit numeric identifier assigned to:

- Healthcare providers: physicians, dentists and pharmacists.
- Organizational health care providers: hospitals, pharmacies, group medical practices laboratories, ambulatory care facilities and nursing homes; and
- Other covered entities under HIPAA, i.e. managed care organizations

TRUSTED Health Plan is required by the DC Department of Health Care Finance (DHCF) to provide a National Provider Identifier (NPI) for all of TRUSTED contracted providers. Under the Federal HIPAA legislation, as of May 23, 2008, all health plans must use the NPI number to process claim transactions.

How to Apply for Your New NPI:

The Centers for Medicare & Medicaid Services (CMS) National Plan and Provider Enumeration System (NPPES) assigns these unique identifiers. There are several ways to apply:

- Practitioners can apply electronically at **https://nppes.cms.hhs.gov/NPPES/Welcome.do** and click on the highlighted *National Provider Identifier (NPI)* text
- A paper application can be faxed. It is available at **https://nppes.cms.hhs.gov**
- Practitioners can call the CMS NPPES at 1-800-465-3203 or TTY 1-800-692-2326

Complaints, Appeals and Grievances

MEMBER COMPLAINTS AND GRIEVANCES

TRUSTED maintains a defined process for members to resolve disputes regarding any aspect of service pro-vision or administration. Members, practitioners acting on behalf of a member, or a member's authorized representative, may contact TRUSTED telephonically, in writing, or in person to voice a complaint regarding any aspect of service provision or administration of the benefit plan, including complaints regarding TRUSTED provider network and/or quality of care concerns.

There is no time limit on filing a complaint if no Notice of Action (denial) was issued. If a Notice of Action was issued, the request to file a complaint or grievance must be received within ninety- (90) days of such notice.

The member may elect to authorize a representative to act on the member's behalf in the complaint/grievance process. This representative may be:

1. The parent, guardian, or other legal representative of a minor child.
2. A person designated through written authorization of the member, including the member's health care practitioner.
3. The executor of the member's estate.
4. An attorney.
5. A non-legal advocate.

TRUSTED will in no way penalize any member, or any individual acting on behalf of the member, who files a complaint or grievance, or requests a fair hearing.

Practitioners must report any complaint they receive to TRUSTED as soon as reasonably possible after the complaint is received. In no case should the report be made more than seven (7) business days after receipt. Please report complaints to:

TRUSTED HEALTH PLANS, INC.
1100 New Jersey Ave., SE • Ste. 840
Washington, DC 20003
(202) 821-1100

Compliance Hotline at (202) 821-1060

If the complaint includes a potential quality of care issue, the practitioner may also report the issue directly to the Senior Director of Quality and Risk Management (202) 821-1100.

If a member desires assistance in filing a complaint or grievance, the member may contact Member Services at (202) 821-1100. Member Services is available to assist members in filing complaints or grievances. TRUSTED will ensure that the members and his/her representative are notified of the resolution. Complaints are resolved as expeditiously as the member's clinical condition requires (if there

is a medical service component of the complaint). In no case will resolution take longer than thirty (30) days from receipt of the complaint unless the member has agreed to an extension of the resolution due date.

PRACTITIONER COMPLAINTS

TRUSTED will work with practitioners and providers to resolve any dissatisfaction with TRUSTED operations and services. If you have an issue you wish to bring to TRUSTED attention, please call (202) 821-1100 and speak to a TRUSTED representative. Issues may also be directed to your Provider Relations Representative.

APPEALS OF UTILIZATION REVIEW NON-CERTIFICATION OF SERVICES

The Appeals process is a mechanism through which a member, member's representative, attending physician/practitioner or facility can request a review of a TRUSTED Health Plan utilization review non-certification decision. Such a request may be made after a Non-certification Letter is sent or at the time the decision is verbally given over the telephone or in person. TRUSTED Health Plan will consider all requests for appeals, but requires that the request for an appeal be made within ninety (90) days of the decision. The Appeals process is effective for review of non-certification due to failure to demonstrate medical necessity for admission, continued lengths of stay, services, procedures, and diagnostic tests.

APPEAL PROCESS

When TRUSTED has made a determination to deny, reduce, terminate or delay approval of a service, a member, member's representative, attending physician/practitioner or facility, may request an appeal of that determination. Providers must have the TRUSTED members' written consent in order to file an appeal of his/her behalf. A standard appeal will be investigated and an appeal determination will be issued within fifteen (15) days of the receipt of the appeal request. During this appeal review all aspects of the initial adverse determination will be reviewed. If the initial adverse determination was based on the medical necessity of the requested service, a health care practitioner who has appropriate training and experience in the field of medicine involved will review the appeal. This will not be the same practitioner who made the initial adverse determination.

TRUSTED will expedite an appeal review if taking the time for a standard appeal review could seriously jeopardize the enrollee's life or health or ability to attain, maintain or regain maximum function. Expedited appeals are resolved within 72 hours or three (3) days of receipt. The appeal may be initiated by a verbal or written request; however, TRUSTED prefers that verbal requests be followed by a written request for proper documentation.

TRUSTED HEALTH PLANS, INC.
1100 New Jersey Ave., SE • Ste. 840
Washington, DC 20003
Attn: Appeals Coordinator or fax the request to 202-905-1056

Verbal requests for appeal may be made by calling the Customer Service Department at 202-821-1100.

TRUSTED enrollees have the right to ask the District of Columbia to review an appeal request at any point in the appeal process. The enrollee may contact the District of Columbia in writing or telephonically using the information below:

DISTRICT OF COLUMBIA OFFICE OF ADMINISTRATIVE HEARINGS CLERK OF THE COURT
441 4th Street, NW, - Ste. 450 - North
Washington, DC 20001
(202) 442-9094

The enrollee may also be entitled to obtain legal services from the following non-exclusive list of free legal service providers including:

- **Columbus Community Legal Services**, 3600 John McCormack Road, NE, Washington, DC (202)319-6788
- **Neighborhood Legal Services**, 680 Rhode Island Avenue, NE, Washington, DC 20002 (202) 832-6577
- **Legal Aid Society**, 1331 H Street, NW, Suite 350, Washington, DC 20005 (202) 628-1161

The enrollee may also contact the Ombudsman Program for assistance and advice in receiving health care from TRUSTED Health Plan. The Ombudsman Program does not make decisions in complaints, grievances, appeals or Fair Hearings. The office of Health Care Ombudsman & Bill of Rights is located at:

441 4th Street, NW, 900 South
Washington, DC 20001
(202) 724-7491 (Office)
(202) 442-6724 (Fax)
(877) 685-6391 (Toll Free)
TTY: 711
Email: **healthcareombudsman@dc.gov**

If the enrollee wishes assistance with any part of the appeal, such as requesting an appeal from TRUSTED, understanding the appeal process, submitting information to support the appeal, obtaining

copies of documents used to make an appeal determination or requesting an appeal through the Office of Administrative Hearings, TRUSTED will assist the enrollee. The enrollee may request this assistance by contacting TRUSTED Customer Service Department.

CLAIMS APPEALS

- If a claim or a portion of a claim is denied for any reason or underpaid, it can be resubmitted as an appeal to the Appeals Department.
- Practitioners have ninety (90) days from the date of the denial to appeal.

Time for processing an appeal is thirty (30) days from the receipt date. If medical records are required, the claim will be closed pending receipt and review of those records.

- All claim appeals must be submitted in writing, along with supporting documentation.
- A telephone inquiry regarding a claim payment or denial does not constitute an appeal. All appeals must be mailed to:

TRUSTED HEALTH PLANS, INC.
1100 New Jersey Ave., SE • Ste. 840
Washington, DC 20003
Attn: Appeals Coordinator

List of Appendices

A. Section 504 of the Rehabilitation Act ("Rehab Act") and Title III of the Americans with Disabilities Act (ADA) Specific Requirements
B. Medical Practitioner Office Site Evaluation Standards
C. Medical Practitioner Office Site Evaluation Form
D. Medical Record Documentation Standards
E. Notice of Privacy Practices
F. Sentinel Events Policy and Procedure
G. Member Appeals Process

APPENDIX A:

Section 504 of the Rehabilitation Act ("Rehab Act") of 1973 and Title III of the Americans with Disabilities Act (ADA) Specific Requirements of 1990

Section 504 of the Rehabilitation Act ("Rehab Act") and Title III of the Americans with Disabilities Act (ADA) prohibit discrimination against individuals with disabilities and require TRUSTED network of providers to make their services and facilities accessible to such individuals. TRUSTED expects all providers in its network to comply with the requirements of these statutes. The requirements of the ADA and the Rehab Act regarding accessibility are lengthy and complex. TRUSTED policy on access summarizes the main requirements and sets forth TRUSTED minimum expectations of its providers. Providers should consult with their own legal counsel about their obligations under these statutes.

NON-DISCRIMINATION

The ADA and Rehab Act prohibit discrimination by public accommodations and recipients of federal assistance, respectively, against individuals with disabilities. TRUSTED providers fall into both of these categories. Accordingly, they may not, on the basis of an individual's disability or an individual's association with someone with a disability, (1) deny that individual goods, services, facilities, privileges, advantages, or accommodations; (2) provide that individual goods, services, facilities, privileges, advantages, or accommodations that are not equal to that afforded to other individuals; (3) provide that individual goods, services, facilities, privileges, advantages, or accommodations that are different than or separate from that afforded to other individuals; or (4) provide goods, services, facilities, privileges, advantages, or accommodations in a segregated setting.

In addition, TRUSTED providers must not use eligibility criteria that would screen out or tend to screen out individuals with disabilities from fully and equally enjoying any of their goods, services, facilities, privileges, advantages or accommodations.

MODIFICATIONS IN POLICIES, PRACTICES AND PROCEDURES

TRUSTED providers have an affirmative obligation to make reasonable modifications in policies, practices, or procedures, when the modifications are necessary to afford goods, services, facilities, privileges, advantages or accommodations to individuals with disabilities, unless they can demonstrate that making the modification would fundamentally alter the nature of the goods, services, facilities, privileges, advantages or accommodations or pose an undue burden. In other words, unless providing the modification would change the fundamental nature of a provider's service, or pose an undue burden, the

modification must be made. The undue burden analysis takes into account the resources of the provider, which means that small doctors' offices, for example, will be more likely to be able to demonstrate an undue burden than a hospital. The nature of the reasonable modification will vary depending on the circumstances of each case. However, TRUSTED providers should always consider a request for a modification carefully. It is never appropriate to reject a request without giving meaningful consideration to the request or possible alternatives' if the request cannot be accommodated. Requests for a reasonable modification and responses to such requests should be documented. The following are some examples of reasonable modifications in policies, practices and procedures:

- **Example 1:** A medical facility has a policy of not allowing animals into any part of the building. This facility is required to modify this policy to allow a person with a disability to bring a service animal into the building, unless doing so would result in a fundamental alteration or jeopardize the safe operation of the medical facility. If there are facts showing that the presence or use of a service animal would pose a significant health risk in certain designated areas of a hospital, for example, may serve as a basis for excluding service animals in those areas. The provider has no obligation to care for or supervise a service animal. In addition, if the service being provided by the service animal is not apparent, a provider may ask what the animal performs for the person with a disability.
- **Example 2:** A health clinic has an evacuation plan for use during a fire or other emergency under which elevators will be shut off. The clinic must modify this evacuation procedure to provide alternative means for mobility-impaired patients to be evacuated from the building.
- **Example 3:** A doctor's office is located in a building that has an entrance that cannot be made accessible to a patient who uses a wheelchair. Normally, the doctor does not see patients off-site. The doc-tor may have to modify this policy to see this patient at an alternate location that is accessible.

AUXILIARY AIDS AND SERVICES

The ADA and Rehab Act require providers to provide auxiliary aids and services to individuals with disabilities that are necessary to ensure their equal access to the goods, services, facilities, privileges, or accommodations that they offer, unless an undue burden or a fundamental alteration would result. Providers may not charge extra for these auxiliary aids and services.

Auxiliary aids and services can take many forms, depending on the needs of the individual with a disability. A good way to approach the situation is to have a dialogue with the individual with a disability about what auxiliary aid or service he or she needs. Although the decision of what auxiliary aid or service to offer is ultimately the provider's, a dialogue between the patient and provider is usually very productive and resolves most issues.

One of the greatest challenges that providers face is how to provide "effective communication" with patients who are vision or hearing impaired. The ADA and Rehab Act both require that providers provide auxiliary aids and services to their vision or hearing impaired patients to ensure that there is "effective communication." Depending on the length, importance and complexity of the communication at issue, a provider may have to provide a deaf patient with a qualified sign language interpreter, at no charge. In

other cases, written materials or the exchange of written notes may suffice.

- **Example 1:** An oncologist meets with a deaf patient for an hour to discuss treatment options for her leukemia. A qualified sign language interpreter must be present to provide "effective communication."

- **Example 2:** A deaf patient goes to his doctor for a bi-weekly check-up, during which the nurse records the patient's blood pressure and weight. Exchanging notes and using gestures are likely to provide an effective means of communication at this type of check-up.

If the circumstances require a qualified interpreter, a provider may not rely on the family members or friends of the individual with a disability to provide interpretation services.
To provide effective communication with vision impaired patients, a provider may have to provide a reader, brailed materials, or large print materials, depending on the circumstances.

- **Example:** A blind patient cannot read and fill out the patient intake forms that must be completed for new patients. The provider should have someone read the form to the patient and help the patient complete the form.

Providers should also be aware that they may also have to provide a means for effective communication to family members and friends with vision or hearing impairments to the extent that those persons play an important role in the care of the patient, even if the patient does not have a vision or hearing impairment.

- **Example:** A patient receiving chemotherapy in the hospital is very sick and her mother, who is deaf, is at the hospital virtually all the time to assist in her care and communicate with hospital staff about her daughter's needs. The hospital must provide effective communication with the mother.

1. DIRECT THREAT

A provider may exclude an individual from participating in or benefiting from its goods, services, facilities, privileges, advantages and accommodations if the individual poses a direct threat to others that cannot be mitigated with reasonable modifications of policies, practices, or procedures, or by providing auxiliary aids or services. This determination must be based on an individualized assessment of the facts, not generalizations or stereotypes about the effects of a particular disability. Exclusions based on a "direct threat" determination should be carefully documented.

2. ACCESSIBLE FACILITIES

TRUSTED providers must have physical facilities that are accessible to individuals with disabilities. The level of accessibility that is required depends on when the facility was constructed. Facilities constructed for first occupancy after January 26, 1993, must meet the highest level of accessibility set forth in the ADA regulations at 28 C.F.R. part 36, Appendix A (the "ADA Standards"). Facilities constructed for first occupancy prior to January 26, 1993 (Pre-1993 Facilities) are not required to meet the ADA Standards but must still remove structural barriers to the extent the removal is "readily achievable" (i.e.,

can be carried out without much difficulty and expense). In addition, any alterations to a Pre-1993 facility made after January 26, 1992, must comply with the ADA Standards to the maximum extent feasible. TRUSTED recommends that its providers conduct a self-evaluation of their facilities to determine if they are in compliance with these requirements. More information concerning the ADA Standards can be found at **www.ada.gov**.

TRUSTED will conduct periodic reviews of its providers to ensure compliance with this and other policies. With regard to physical accessibility, TRUSTED will focus primarily on the following aspects of each facility in its reviews:

a. **Accessible parking.** If parking is provided at a provider's facility, there must be accessible parking spaces located as close to the accessible entrance as possible marked with the international symbol of accessibility (ISA). For a lot with up to 100 spaces, one in every 25 spaces must be accessible. (A provider with more than 100 spaces should consult the ADA Standards for the required number). An accessible parking space for a car must be located on level ground and at least 8' wide; with an adjacent access aisle that is at least 5' wide. There must be one van accessible space for every eight accessible spaces (with a minimum of one in all parking lots). Van accessible spaces must have 8' wide access aisles.

b. **Accessible Entrance.** There must be at least one accessible public entrance for every two at the facility. An accessible entrance must meet the following minimum requirements:

   1. Have no abrupt change in level greater than 1:12" (e.g., no steps). Thresholds must be beveled with a maximum 1:2 slope and no higher than 3 inches";
   2. Provide 32" of clear width when the door is open at 90 degrees; and
   3. Have door hardware that can be used with a closed fist or flail hand (e.g., lever hardware).

   Note: If the facility has public entrances that are not accessible, there must be signage at those entrances indicating the location of the accessible entrance(s).

c. **Accessible Route.** Individuals with mobility impairments who use wheelchairs or scooters must have accessible routes that they can use to access provider facilities.

   There must be an accessible route from the accessible parking, public sidewalk, passenger loading zone, and public transportation stop to the building entrance.

   There must be an accessible route connecting (a) the accessible entrance, (b) accessible rest- rooms, and (c) and all locations within the facility where goods and services are provided to the public (e.g. reception area, exam rooms, treatment rooms, hospital rooms).

   As a general matter, an accessible route is a clear unobstructed path that is at least 36" wide with (1) a maximum primary slope of 5%; (2) a maximum cross slope of 2%; (3) a firm, stable, and slip resistant surface; (4) no abrupt change in level more than 3 inches" (e.g. steps), although thresholds can be up to 6 inches" high if they are beveled with a 1:2 slope. An accessible route can narrow to 32" clear width at doorways. An accessible route can also include curb ramps and ramps, for which there are specific standards, set forth in the ADA Standards. One of the basic requirements for ramps

is that the slope cannot exceed 8.33%.

d. **Accessible restrooms.** Every facility must have at least one accessible ladies and men's restroom that is on an accessible route. As a general rule, an accessible restroom must have the following features:

1. A door that provides a 32" clear width when open at 90 degrees;
2. A door that can be open with less than 5 lbs. of force;
3. Entrance door hardware that can be used with a closed fist or flail hand;
4. Have maneuvering space on both sides of the door that is level (i.e., maximum 2% cross slope in both directions) and at least 24" of clear space next to the latch side of the door;
5. A 5' x 5' stall ("Accessible Stall") with an out-swinging door with the following features:
   i. A toilet that has a centerline at 18" from the adjacent sidewall with a seat that is no higher than 17" to 19" from the floor to the top of the seat;
   ii. A hook in the Accessible Stall that is no higher than 48" from the floor;
   iii. A horizontal grab bar behind the toilet that is at least 36" long and mounted between 33"-36" above the floor; and
   iv. A horizontal grab bar along one side of the toilet (the side closest to the toilet) that is at least 40 inches long and mounted between 33"-36" above the floor.
6. At least one sink that has (1) a bottom edge located at between 29" and 34" above the floor; (2) insulated pipes; (3) hardware that can be operated with a closed fist or flail hand; and (4) a 30" x 48" clear floor space to allow someone to approach the sink from the front.
7. Soap and towel dispensers that are no higher than 48" from the floor.
8. Either a full-length mirror, or a mirror mounted no more than 40" above the floor.

e. **Restroom signage.**

1. If there are restrooms that do not have an Accessible Stall, there must be signage at those restrooms indicating the location of the restrooms that have an Accessible Stall.
2. Signs designating restrooms must be mounted on the wall next to the latch side of the door, 60" from the floor to the centerline of the sign with raised lettering and Braille.

Providers should be aware that this is not a complete list of requirements under the ADA Standards and is only intended to provide guidance to providers about what accessibility features will be the focus of TRUSTED reviews. TRUSTED also recognizes that some Pre-1993 Facilities may not be able to meet all of these requirements due to technical or structural issues or expense (for small providers) and will take those factors into consideration.

EVALUATION STANDARDS

Appendix B. Medical Practitioner Office Site

I. Physical Accessibility and Appearance

A. Physical Accessibility and Appearance — General Facility

1. **The office should be handicapped/wheelchair accessible.** The office should provide a ramp to access the front door and should have at least one restroom that has a widened doorway to accommodate a wheelchair and safety bars and hand-rails near the toilet.
2. **The office should have visible exit signs.** Exits in the office should be clearly marked to assist patients in evacuating the office in an emergency. While the office environment is familiar to the staff that is there on a daily basis, it can be very confusing to patients who may be new to the office or visit the office on an infrequent basis. Evacuation maps should be posted at regular intervals.
3. **The office should have an adequate sprinkler system or accessible fire extinguishers available in case of a fire.** Ideally, a building should be equipped with an automated sprinkler sys-tem that would be triggered and activated in the event of a fire. Offices with sprinkler systems should have hand-held fire extinguishers available in the office. A small fire may be extinguish- able by use of the hand held fire extinguisher, thus preventing the sprinkler system from being activated, which can result in water damage to office equipment and medical. If the building does not have a sprinkler system it is essential that the office have at least one fire extinguisher in the office. All staff should be familiar with the location and use of the fire extinguisher. A fire extinguisher in the hall is not considered accessible.
4. **Fire extinguishers in the office should be maintained according to the manufacturer's specifications, and documentation of this maintenance should be current.** Fire extinguishers require periodic inspection and may require recharging/replacement after use or long periods of non-use. Manufacturer's specifications for inspection and maintenance should be followed. Documentation ensures that the required maintenance has occurred.

5. **The office should have the TRUSTED Health Plan Member Rights and Responsibilities statement available to patients and practitioners in the office.** TRUSTED Health Plan is committed to maintaining a mutually respectful relationship with its members. The Member Rights and Responsibilities statement sets a structure for cooperation among members, practitioners and TRUSTED Health Plan. The statement should be available to members and practitioners in the office setting to ensure that those who receive care and those who provide care are aware of the associated member rights and responsibilities.

B. Physical Accessibility and Appearance — Waiting Room

1. **The office waiting area should accommodate patients and provide adequate seating.** The waiting area should include a sufficient number of chairs for patients and others waiting during office hours.
2. **The office waiting area should have adequate lighting for reading.** Lighting should include focused lights and/or lamps adjacent to chairs so patients and others waiting can be comfortable while reading.
3. **The office waiting area should be well ventilated.** The waiting area should be comfortably ventilated for patients. Smoking should be prohibited at all times in the office.
4. **The office waiting area should be clean in appearance.** The waiting area should be clean with floors, seating areas, and tables clear of clutter, toys or trash. The area should be vacuumed and cleaned on a regular schedule. Trash cans should be available and emptied routinely.
5. **The office should have educational information easily available to patients.** Appropriate written educational material concerning health issues should be available to patients. Information should be relevant to the patient's needs and should be written at an easily understood reading level.

C. Physical Accessibility and Appearance — Examination Room

1. **The office's exam rooms should be clean in appearance.** Examination areas should be clean, with floors; examination tables, chairs and other furniture clear of clutter and trash. Areas should be vacuumed and cleaned on a regular schedule. Trash cans should be available and emptied routinely.
2. **Patient privacy should be maintained during exams and consultations with practitioners or staff.** Patient privacy should be priority during all encounters with the practitioner and staff. Examinations should be privately conducted. Medical consultations should be conducted in a confidential manner. Discussions about billing or other business issues should be conducted privately between staff and patients.
3. **Female chaperone should be available, offered and present during female examinations.** During female examinations, especially OB/GYN examinations, a female should have the right to have a female chaperone present.

4. **Drape sheets and gowns should be available for patients.** If it is necessary for the patient to disrobe, adequate drape sheets and gowns should be available and offered to the patient to ensure his/her modesty during the physical examinations.
5. **Sinks and soap should be available in the examination room.** Clean running water and soap should be available in the examination rooms and office to ensure that basic hand washing techniques can be observed.
6. **A needle control and bio-hazardous waste disposal system should be in place.** Federal regulations (OSHA Exposure Control Plan) require practitioners to have a system in place to handle sharps and bio-hazardous waste disposal. The system should include needle boxes for sharps disposal and red bags for the disposal of bio-hazardous waste.
7. **The office should have gloves available in the exam/procedure rooms or in the patient care areas.** In order to allow all staff to observe universal infection control precautions, gloves should be easily available in all examination areas. There should be a written Blood Bourne Pathogen and Other Potentially Infectious Materials Standard. This plan describes the actions taken for exposures and needle sticks according to CDC protocols.
8. **Red bags should be available and visible in each examination room for the disposal of bio-hazardous waste.** Red bio-hazardous waste disposal bags should be in each examination room and clearly marked as waste.

II. Risk Management

A. Risk Management — Emergency Care

1. **The office should have basic emergency equipment available.** Basic emergency equipment should consist of a Bag-valve-mask resuscitation bag or a mask/pocket mask and airways. Offices that see adult patients should have adult airways, and if pediatric patients are seen, pediatric sized airways should also be available. OB/GYN practitioners should also have a pre-natal pack available.
2. **The office should have a procedure in place to document routine checks of emergency equipment.** Emergency equipment should be regularly inspected and checked for continued functionality. These routine checks should be documented in a consistent manner to ensure that the office is prepared for any emergency occurrence.
3. **The office should have at least one CPR-certified healthcare staff member present in the office when patients are scheduled.** At least one office staff member, in addition to the practitioner, should maintain current CPR certification to ensure an adequate response to emergency situations that may occur in the office.
4. **The following emergency medications should be available in Crash Cart/Emergency boxes, as required:**
    - **A & B - Nitroglycerin SL or spray and Procardia should be available if the office**

administers stress tests. Offices that conduct stress testing must have appropriate medications available for patients in an emergency. Possession of an AED (Automatic External Defibrillator) is strongly encouraged.

- **C & D - Appropriate emergency resuscitation equipment and medications should be available at offices that administer injections to patients.** Medications should be available in the dosages appropriate for the ages and types of patients seen at that office. Staff should be trained to respond quickly and appropriately to emergencies and in a coordinated fashion... Allergic responses are unpredictable and require immediate attention.

B. Risk Management — Plans, Licensure and Certification

1. **The office should have a written OSHA Exposure Control Plan in place.** Federal regulations require practitioner offices to have the OSHA Exposure Control Plan in place. This plan should address blood, body fluids, chemicals, and gases, depending on the office capacity. This plan is required to be updated annually. Offices failing to meet these Federal regulations may be liable for significant fines. If a citation was issued, a corrective action should be in place or the citation closed.
2. **The office should have a written Hazard Communication Plan.** The Employee Right to know document that includes any chemicals, reagents, or other solutions the employee may con-tact while at work must be in place. A MSDS (Material Safety Data Sheet) is required to be physically present in the office for each substance at all times.
3. **The office should have an emergency preparedness plan in place.** The office should have a plan to handle the evacuation of patients and visitors in an emergency. While office staff may be very familiar with the layout of the office, patients and visitors may become confused and become trapped if there is smoke or a loss of power in the building. Staff should discuss emergency evacuations ahead of time, so each staff person will know his/her role.
4. **The office should store all controlled drugs and substances in locked areas at all times.** By law, controlled substances are required to be secured in locked areas at all times and inventory control records to be maintained. Many offices have sample medications that are actually controlled substances in open cabinets/closets. Staff should familiarize themselves with the controlled substances packaging labels on medications and stock controlled sample medications in locked areas.
5. **The office should post current licensure, certifications or registrations to practice in a prominent place in the office.** Necessary licensure and other certification and registration documents should be available to both patients and reviewers for inspection.
6. **The office should have written policies and procedures that cover the requirements of the Health Insurance Portability and Accountability Act of 1996.** The HIPAA Security Rule requires that covered entities have in place reasonable and appropriate administrative, technical, and physical safeguards to protect the privacy of protected health information.
7. **The HIPAA "Notice of Privacy Practice" should be posted in areas that are visible to patients.** If a practitioner maintains an office or other physical site where he/she provides health care directly to individuals, the practitioner must post the HIPAA "Notice of Privacy Practice" notice in the facility in a clear and prominent location where individuals are likely to see it, as well

as make the notice available to those who ask for a copy.

8. **All members should receive written notice of their Health Insurance Portability and Accountability Act of 1996 (HIPAA) rights and responsibilities.** The HIPAA Privacy Rule requires a covered health care practitioner with direct treatment relationships with individuals to give the notice to every individual no later than the date of first service delivery to the individual and to make a good faith effort to obtain the individual's written acknowledgment of receipt of the notice. All members should receive notice and the practitioner's office should make a good faith effort to have a statement of receipt signed by the member. The signed statement of receipt should be maintained in the member's medical record. This should be updated annually.
9. **All employees should be trained regarding the Fraud and Abuse regulations as they relate to the medical practice and billing.**
10. **All employees shall be trained regarding HIPAA privacy and security regulations**
11. **Annual training of staff should be conducted and documented on:**
    a. Exposure Control Plan
    b. Hazard Communication Plan
    c. Fire Safety
    d. Human Resource issues- i.e. discrimination, harassment, FMLA
    e. Clinical competencies

C. Risk Management — Ancillary Services

1. **CLIA Certification**
    a. **If the office requires CLIA certification, certification should be current.** CLIA certification for laboratory services must be current and available for inspection, by law.
    b. **If the office does not require CLIA certification, a waiver should be present.** When offices are exempt from CLIA certification due to the nature of testing performed, a waiver is issued by CLIA and must be available for inspection.
2. **The office should have policies and procedures in place to test laboratory equipment calibration and validation.** Laboratory equipment requires periodic calibration and validation to ensure consistent accuracy of results. Equipment should be monitored and testing performed on a scheduled basis. Maintaining documentation of this is a requirement for continued CLIA certification.
3. **The office should have policies and procedures in place to ensure ancillary equipment (e.g. audiometers, scales, and mercury blood pressure cuffs) receives calibration and test validation.** Medical office equipment requires periodic maintenance and calibration to ensure accuracy of results obtained. The office should have policies to ensure equipment is monitored and a sys-tem is in place to ensure testing and validation occurs on a scheduled basis.
4. **If present, the office should ensure that X-ray equipment is inspected and licensed annually.** X-

ray equipment requires periodic inspection, preventive maintenance and annual licensure in many states. Offices should ensure that all equipment in use is maintained and licensed according to local law. Technicians should wear personal radiation monitors.

5. **If X-ray equipment is in use, the office should provide radiation protective devices, including shields, warning signs and alerts to pregnant women.** Radiation protective devices should be available in the office to shield patients receiving x-rays. Warning signs should be prominently posted in several locations.
6. **The medical refrigeration system should maintain a temperature of 35 - 46 degrees Celsius.** A consistent refrigeration temperature important to the efficacy of medications and the composition of testing samples. Non-medical items should not be stored in the refrigerator.

III. Availability of appointments

1. **The office should have a 24-hour answering service or an answering machine available to instruct patients on how to obtain care after hours.** Patients may need to contact the practitioner after hours during urgent and emergency situations. The office should have a system in place to provide access to care after regular office hours.
2. **The office should provide coverage 24 hours per day, 7 days per week.** Practitioners should arrange to be accessible to patients 24 hours per day, 7 days per week. Groups of practitioners may arrange to share calls or other coverage arrangements. Patients should have access to a designated in network practitioner at all times.
3. **The office hours and after hours phone numbers should be easily accessible for patients.** Office hours and after hours phone numbers may be posted on the outer door, or available on the practitioner's business card, or listed in the practitioner's patient handbook. Patients should be educated on when the office is open and how to access care after hours.
4. **The office should ensure that TRUSTED Health Plan's Customer Services toll- free number is available to TRUSTED members.** Office staff should ensure that TRUSTED members can reach the Member Services toll free number.
5. **The office should have a procedure in place to remind members of their appointments.** Offices can call prior to appointments or mail out reminder cards to ensure that members will keep scheduled appointments.
6. **The office should have a no-show policy, including follow-up with members who have missed their appointments.** The office has a responsibility for and should demonstrate concern for completion of the ongoing treatment plan. A record of broken or missed appointments should be maintained in the patient's record with documentation of follow-up efforts. Documentation in the office appointment log is not adequate.

IV. EPSDT Availability

1. **All practitioners who perform EPSDT procedures must have the appropriate equipment and it must be maintained in working condition.** TRUSTED on-site review will include a review and visual inspection of the necessary EPSDT equipment.

V. Medical Record keeping and Filing

1. **The Office should have a policy that covers the content of the medical record and the manner in which it is filed.** Organization of the medical record keeping system ensures that individual records can be located in a timely manner and are available for all patient care needs. A standard organizational format within each medical record allows the practitioner maximum efficiency when reviewing each record.

2. **The office should maintain medical records in an area away from public access.** The office should protect the confidentiality and integrity of medical records by storing them away from main traffic areas in the office. Medical records should not be stored in patient exam areas. Records should be stored in a private part of the office where patients and visitors do not routinely have access. Only authorized office staff should have access to the medical records.
3. **An experienced staff person should be designated to have oversight of and access to the medical records filing system.** It is important that a staff person who is trained and experience in medical record keeping and filing be in charge of the system.
4. **The office should maintain an organized medical record keeping system to ensure new information is filed in the correct record in a timely manner.** New information should be added as soon as possible to ensure a complete medical record at every patient appointment.
5. **Medical Records should be dictated and transcribed.** Medical records must be easy to read. Handwritten notes and records may be miss-read or misinterpreted in the future.
6. **The office should require a written authorization from the patient or responsible party for the release of medical records.** Office staff should provide for the confidentiality of the patient's record by requiring a written release before copying any part of the medical record.

   Only copies of medical records should be released. TRUSTED requires that its members be given a copy of their medical records upon request.
7. **The office should have a confidentiality policy for medical records.** The office should develop a confidentiality policy concerning medical records so that all staff understands how records are to be handled. Many offices now require that staff sign a confidentiality agreement outlining the medical records policy, to ensure that medical records handling is conducted to protect patient privacy.
8. **Medical Record Review Format** - Medical records should be maintained in an organized manner consistent with TRUSTED Medical Record Documentation Standards. The record should include a place for the following types of information (based on a review of sample record or blinded

TRUSTED member):

a. **Medication allergies and adverse reaction notification.** Notice of any allergies and/or adverse reactions should be prominently displayed.

b. **Past medical history should be included.** Past medical history should be easily identified and readable.

c. **Notation concerning use of cigarettes, alcohol and/or substances should be included in children age 12 and above and adults.** File notation regarding counseling on the use of cigarettes, alcohol and substances should be in each file.

d. **The ordering practitioner initials consultation, laboratory and imaging reports.** All consultation, laboratory and imaging reports should be in the file and should be initialed by the ordering practitioner to indicate that they have been reviewed.

e. **An immunization record (child) or appropriate history (adult) is in the medical record.** On-going immunization or history should be maintained.

f. **Each page contains the patient's name.**

g. **Personal data, including address, employer, home and work telephone numbers and marital status is included.**

h. **Entries in the medical record require the author's signature, initials or other identification.**

i. **Entries are dated.**

j. **The record is legible to the reviewer.**

VI. Evaluating the On-Site Review

TRUSTED Health Plan conducts on-site office visits to primary care practitioners; obstetricians/gynecologists, specialists and behavioral health care practitioners meet our office site standards.

The TRUSTED Provider Relations Representative will conduct this review and will provide the results of the review. Your office will be scored based on TRUSTED standards and thresholds for office-site criteria and medical record keeping. 75% is the acceptable minimum score.

Appendix C. Medical Practitioner Office Site

PROVIDER OFFICE SITE EVALUTATION FORM

TRUSTED Health Plan
THP

Site Assessment and Medical Record Keeping Assessment and Tool

Practitioner Name (s):	Check One: ☐ Group ☐ Private Practice
Practice Name:	Check One: ☐ PCP ☐ OB/GYN ☐ Specialist
Office Address:	Specialty:
	Provider Relations Representative:
Facility Contact Person:	Date:

TRUSTED Provider Office Site Visit Tool	Points	Points Earned
A. Physical Accessibility:	**10**	
Threshold:	**8**	
1. Is there accessibility for people with disabilities? (First floor access, ramps or elevator access) If not, does staff have an alternative plan of action? Access throughout the office including bathrooms)?	2	

2. Is accessible parking clearly marked? (Sign/painted symbol on pavement.) Only applies to off-street parking: N/A if parking is street-side only.	2	
3. All doorways and stairways that provide access are free from obstructions at all times and allow easy access by wheelchair or stretcher?	2	
4. Are exits clearly marked and is there emergency lighting in instances of power failure?	2	
5. Are the building and office suite clearly identifiable (clearly marked office sign)?	2	
B. Physical Appearance:	**10**	
Threshold:	**8**	
1. Is the office clean and well kept (Neat appearance, no trash on floor, furniture in good repair? No significant spills/stains on floors/ furnishings.)?	2	
2. Is treatment area clean and well kept (Neat appearance, no trash on floor, furniture in good repair? No significant spills on floors, counters or furnishings.)?	2	
3. Does office have smoke detector(s)	2	
4. Easy access to a clean, supplied bathroom (Soap, toilet paper, hand towels and nd washing instructions)?	2	
5. Fire extinguishers clearly present and fully charged and recently inspected (even if office has sprinkler system)?	2	
C. Adequacy of Waiting and Examining Room Space:	**12**	
Threshold:	**10**	
1. Is there adequate seating in the waiting are (based on number of physicians/ practitioners)?	2	
2. Does the staff provide extra seating when the waiting room is full?	1	
3. Is there a minimum of 2 exam rooms per scheduled provider (2 consultation rooms for Behavioral Health (BH) Providers)?	2	
4. Is there privacy of exam/ consultation rooms (Doors or curtain closures: rooms cannot be visualized from waiting room)?	2	
5. Are exam/ consultation rooms reasonably sound proof (Conversations cannot be heard from waiting room or other exam rooms)?	2	
6. Are an otoscope, ophthalmoscope, blood pressure cuff and scale readily accessible (N/A for BH Providers)?	1	
7. For OB/GYNs or any physicians/practitioner providing OB Care: Does the office have the following readily accessible: (If not OB/GYN, Check N/A)	1	
7a. A fetal scope (Delee and /or Dopler) and a measuring tape for fundal height measurement?	1	
7b. Supplies for dipstick urine analysis (glucose, protein)?	1	
Adequacy of Medical Records:	**16**	

Threshold:	**10**	
1. Does the office maintain an organized medical record keeping system?	1	
2. Are records stored in a manner that ensures confidentiality- are they kept in an area not accessible by patients?	1	
3. Are all items secured in the chart?	1	
4. Does the office maintain a filing system to ensure new information is filed in individual records in a timely manner?	1	
A. Does each page of the medical record include patient identification?	1	
B. Does the office use a standard organizational format for medical records?	1	
C. Does the office use any standard medical record forms (if yes, describe type)?	1	
5. Does the office use an electronic medical record (this is for tracking only; not scored)?	0	
A.*Is written authorization obtained for the release of medical records?	1	
B.*Is there a confidentiality policy for medical records?	1	
6. Are medical records readily available? (Within 15 minutes of request) Ask them if they are.	1	
7. Medical recordkeeping practices:		
7a. Is there a place to document allergies?	1	
7b. Is there a place to document current medication list?	1	
7c. Is there a place to document current chronic problems list?	1	
7d. Is there an immunization record on pediatric charts? N/A for BH Providers	1	
7e. Is there a growth chart on pediatric charts? N/A for BH Providers	1	
7f. Is there a place to document presence/absence and discussion of a patient self-determination/advance directive? (if not appropriate, check N/A)	1	
E. Appointment Availability: Is the physician/practitioner available:	**11**	
Threshold:	**8**	
1. Are patients routinely seen within 45 minutes of check in (ask office manager)?	2	
2. Is the physician/practitioner available: At least 4 days or 20 hours per week?	2	
3. 24 hour call coverage for emergencies (by themselves or by covering provider)?	2	
4. Are urgent care appointments available within 24 hours?	1	
5. Are routine/problem care appointments available within 10 days of appointment request?	1	
6. Are phone lines adequate to handle volume of total patient population?	2	
7. Physical/wellness exams for children within 30 days of request?	1	
F. Documentation Evaluation: Does the office have the following:	**15**	
Threshold:	**10**	
1. No-show follow-up procedure/policy? (If not written, can the staff verbally explain the process?	1	
2. Is there a procedure to remind patients of their appointments?	1	

3. Is there a chaperon policy? (If provider does not have written chaperone policy, office must provide statement on letterhead indicating chaperone will be in exam room.)	1	
4. Is the Patient Bill of Rights posted?	1	
5. Is medical license/occupational license displayed?	1	
6. Is there a written policy for hand washing, gloved procedures, and disposal of shape, etc.? May not be applicable for BH Providers in private practice setting.	2	
7. Is there a written OSHA Exposure Control Plan which includes Universal Precautions & Blood Born Pathogen exposure procedures for staff?	1	
8. If provider employs NP's, Pas or other mid-level providers that will assess health care needs of members, do they have written policies that describe duties and supervision of such providers?	1	
9. Does the office require CLIA certification?	2	
9.A. if Yes, verify the following: Level: Cert.# ; Exp. Date:	2	
9. B. if no, is there a waiver? Cert.#	2	
G. HIPPA Requirements/ Regulations:	**7**	
Threshold:	**5**	
1. Is there a written P & P addressing permitted uses/disclosures and required disclosures of patient PHI/IIHI	2	
2. Does Provider have authorization forms available to designate Personal epresentative(s) to which PHI/IIHI may be released and / or disclosed?	2	
3. Are there physical safeguards in place to protect the privacy of patient PHI/IIHI?	2	
4. Is there a designated Compliance & Privacy person? Name:	1	
H. Office Evaluation:	**12**	
Threshold:	**10**	
1. Is there an approved process for biohazards disposal?	2	
2. Are pharmaceutical supplies and medication stored in a locked area that is not readily accessible to patients?	2	
3. Is there a plan/ procedures for narcotic inventory, control and disposal?	2	
4. Are vaccines and other biologicals refrigerated, as appropriate?	2	
4A.Is there a working thermometer in the refrigerator?	2	
5. Observe 2-3 office staff interactions: Are they professional and helpful?	1	
6. Is emergency equipment available (an oral airway and ambu bag)? If not, note how staff accommodates emergency situations.	1	
I. EPSDT AVAILABILITY CHECK LIST	**7**	
Threshold:	**5**	
EPSDT Equipment List		
1. What equipment is used to check Vital Signs - Thermometer - Stethoscope - Blood Pressure Cuff (age/weight appropriate)?	1	
2. What Visual Hearing equipment is used in your office? Wall Mounted eye chart ge appropriate) - Occluder - Occlusive eye patch- Audiometer- Tympanometer	1	

3. Identify the lab test performed in the office: Hemocue- Microcuvertes- Specimen collection tubes- Specimen collection cups- Syringes- Needles - Alcohol Swabs- Uri- Sticks- Disposable gloves	1	
4. What equipment is used to perform the growth Assessment? Recumbent Board- Wall mounted height Chart- Tape Measure- Adult weight scale- Table model beam scale	1	
5. Are the Following items used to perform the physical examination? Ophthalmoscope- otoscope- Tuning Fork- Disposable gown (age/size appropriate)- Tongue depressors- Disposable Gloves	1	
6. Are the following items used to administer immunizations? Syringes- Needles- Alcohol Swabs-Band- Aids Disposable gloves	1	
7. Which screening tool is used to perform the Developmental Assessment? Denver DST- Developmental Profile II- Project Memphis DST- Minneapolis Preschool Screening Instrument	1	
To complete the form, answer every question, then total the number of points and record here		
*These critical elements must be met, in addition to receiving an average score of 85% to achieve an acceptable rating on the Site Assessment and Medical Records Keeping Assessment and Tool		

Provider/ Facility issues / concerns

_____

_____

Resolution:

_____

_____

_____

Follow up needed:

_____

_____

_____

THP Representative Signature: _____

Title: _____ **Date:** _____

Appendix D. Medical Record Documentation

STANDARDS

It is the responsibility of TRUSTED Health Plan to ensure that consistent, current and complete documentation is in the medical record, as it is an essential component of quality patient care. TRUSTED has adopted the following best practice standards for medical record documentation. Critical elements that must be included in the documentation for TRUSTED Health Plan members are starred.

1. Each page in the record contains the patient's name or ID number.
2. Personal biographical data include the address, employer, home and work telephone numbers and marital status.
3. All entries in the medical record contain the author's identification. Author identification may be a handwritten signature, unique electronic identifier or initials.
4. All entries are dated.
5. The record is legible to someone other than the writer.
6. Significant illnesses and medical conditions are indicated on the problem list.
7. Medication allergies and adverse reactions are prominently noted in the record. If the patient has no known allergies or history of adverse reactions, this is appropriately noted in the record.
8. Past medical history (for patients seen three or more times) is easily identified and includes serious accidents, operations and illnesses. For children and adolescents (18 years and younger), past medical history relates to prenatal care, birth, operations and childhood illnesses.
9. For patients 12 years old and older, there is appropriate notation concerning the use of cigarettes, alcohol and substances (for patients seen three or more times, query substance abuse history).
10. The history and physical examination identifies appropriate subjective and objective information

pertinent to the patient's presenting complaints.

11. Laboratory and other studies are ordered, as appropriate.
12. Working diagnoses are consistent with findings.
13. Treatment plans are consistent with diagnoses.
14. Encounter forms or notes have a notation, regarding follow-up care, calls or visits, when indicated. The specific time of return is noted in weeks, months or as needed.
15. Unresolved problems from previous office visits are addressed in subsequent visits.
16. There is review for under- or over-utilization of consultants.
17. If a consultation is requested, there is a note from the consultant in the record.
18. Consultation, laboratory, and imaging reports filed in the chart are initialed by the practitioner who ordered them, to signify review. (Review and signature by professionals other than the ordering practitioner do meet this requirement.) If the reports are presented electronically or by some other method, there is also representation of review by the ordering practitioner. Consultation and abnormal laboratory and imaging study results have an explicit notation in the record of follow-up plans.
19. There is no evidence that the patient is placed at inappropriate risk by a diagnostic or therapeutic procedure.
20. An immunization record (for children) is up to date or an appropriate history has been made in the medical record (for adults).
21. There is evidence that preventive screening and services are offered in accordance with the organization's practice guidelines.

Appendix E. Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION

PLEASE REVIEW IT CAREFULLY.

Q. Why are you giving this notice to me?

TRUSTED Health Plan knows that information about you and your health is personal, and we are required by the federal Health Insurance Portability and Accessibility Act (HIPAA) to tell you what your responsibilities are and what rights you have under the law.

Q. What is TRUSTED Health Plan required to do under HIPAA?

TRUSTED Health Plan is required by HIPAA to:

- Make sure that your protected health information is kept private;
- Give you this notice to tell you about our legal duties and privacy practices with respect to your PHI; and
- Follow the terms of this notice.

Q. What is Protected Health Information (PHI)?

Protected Health information (PHI) is defined as any oral, written or electronic information that:

- Identifies you or can be used to identify you.
- Either comes from you or has been created or received by a health care provider, a health plan, or a healthcare clearinghouse.
- Has to do with your physical and/or mental health or condition, providing health care to you, or paying for providing health care to you.

In this notice, "protected health information" will be written as PHI.

Q. How can you use or share my PHI?

There are laws that allow or require us to use or disclose your PHI for many reasons. This Notice tells you how we may use and disclose your PHI. While not every use or disclosure is listed, the ways we may use or share your PHI falls within one of the descriptions below.

For Treatment. We may use and share your PHI for treatment. For example, we may use or share your PHI to enroll you in a disease management program, or to share it with your case manager.

For Payment to Caregivers. We may use and share your PHI in order to pay for health care you receive.

For example, a bill that we may receive from your doctor may have information on it that identifies you, the nature of your illness, the treatment or tests given to you and the supplies that might have been used.

For Health Care Operations. We may use and share your PHI to run our business. We protect your PHI by limiting access to it within our Plan. Only our employees directly involved in our business activities that require access to your PHI are authorized to see or discuss your PHI. For example, we may use your PHI to review and improve the quality of health care services you receive.

For another covered entity's needs. We may share your PHI with another covered entity, such as a doctor or health plan, for their treatment or payment use. For example, we may share your PHI with a health plan to help them pay for your care. We may also share your PHI with them so that they can do certain business tasks if you have or have had a relationship with them.

To remind you of appointments and health-related benefits or services. We may use your PHI to send you appointment reminders. We may use PHI to tell you about other health care treatment, services, or benefits.

To comply with the law. We will share your PHI when we are required by law to do so. We will share PHI when we are required to in a court or other legal proceeding. For example, we will disclose PHI if a law says that we must report PHI about people who have been abused.

To report public health activities. We will share PHI with government officials in charge of collecting certain PHI. For example, we may share PHI about births, deaths, and some diseases.

For health oversight activities. We may share PHI if a government agency conducting activities approved or required by law, such as audits, investigations, licensure or disciplinary actions. Oversight agencies include government agencies that look after the health care system, benefit programs, including Medicaid. Alliance, SCHIP, or Healthy Kids, and government regulation programs.

For purposes of disposition of your remains. We may share your PHI with coroners, medical examiners, and funeral directors. If permitted by law, we may also share PHI with organizations that help find organs, eyes, and tissue to be donated or transplanted.

To avoid harm. In order to avoid a serious threat to the health or safety of a person or the public, we may provide PHI to law enforcement or others who may be able to stop or lessen the harm.

For certain government functions. We may share PHI for national security reasons. For example, we may share PHI to protect the President of the United States.

For workers' compensation. We may share PHI to obey workers' compensation laws.

Lawsuits and disputes. If you are involved in a lawsuit or a dispute, we may share PHI about you in response to a court or administrative order, or other lawful process.

For Research. We may share your PHI with researchers when an institutional review board or privacy board has followed the HIPAA information requirements.

Other Uses and Sharing of Your Health Information. We will ask for your written permission, called as an authorization, before we make any use or disclosure of your PHI not described in this notice. If you give us your written permission, you may still decide later that you no longer want us to use or disclose your PHI in that way. If you change your mind, you may tell us in writing. We will then stop using your PHI in that way.

Q. Will you give my PHI to my family, friends, or others?

We may share PHI about you with a friend or family member who is involved in your care or who helps pay for your care when you are present. For example, if one of our case managers visits you in the hospital and your mother is with you, we may discuss your PHI with you in front of her. We will not discuss your PHI with others if you tell us not to. There may be times when you are not present or are unable to make healthcare decisions. If this should happen, we may share your PHI if we think it is best for you. For example, we may share PHI with someone who is with you when you are unconscious so that you can receive care.

Q. What are my rights under federal law with respect to my PHI?

The law gives you the following rights regarding your PHI. To exercise these rights, please call Member Services at (202) 821-1100 Toll Free (855) 326-4831.

1. **You can see or get copies of some of your PHI.** Sometimes your right to see or get copies of your PHI may be limited. You must ask us in writing. We may charge a fee for copying and mailing the PHI.
2. **You may ask us to limit our uses and disclosures for purposes of treatment, payment or healthcare operations.** We are not required to agree to the request. You may also ask us to limit disclosures to someone who is involved in your care or payment for your care, like a family member or friend.
3. **You may ask us to send your PHI to another address if it is necessary to protect you from danger. You may ask us to communicate with you in a certain way if it is necessary to protect you from danger.** For example, you may ask us to send PHI to you at work instead of at home. You may ask us to send your PHI by e-mail rather than regular mail. You must tell us in writing what you want. You must tell us that you could be in danger if we do not agree to your request.
4. **You can get a list of certain disclosures we have made of your PHI.** The list will only include disclosures made after April 14, 2003. The list will not include certain types of disclosures. We will give you one list free during any 12-month period. You will need to pay for any additional lists during that time.
5. **You may ask us to correct your PHI if you think there is a mistake.** You must ask us in writing

and tell us why you want us to correct the information.

6. **You may get a paper copy of this notice at any time.** To obtain a paper copy of this notice, please call Member Services at (202) 821-1100 Toll Free (855) 326-4831.

Q. May I complain about your privacy practices?

YOU WILL NOT BE PUNISHED FOR FILING A COMPLAINT.

If you think we violated your privacy rights you may file a complaint. You may send your written complaint to:

TRUSTED Health Plans, Inc.
1100 New Jersey Ave., SE
Ste. 840
Washington, DC 20003

You may send a written complaint to the Secretary of the Department of Health and Human Services ("DHHS") at:

Office for Civil Rights
200 Independence Avenue, SW
Washington, DC 20201
You may also call DHHS at 877-696-6775.

Q. How will I know if my rights change?

We may change this notice and our privacy policies at any time. Then the new notice will apply to your entire PHI. We will make the new notice available to you at all times. The new notice will contain the new effective date.

If you have any questions about this notice, please contact Member Services at (202) 821-1100 Toll Free (855) 326-4831.

Appendix F. Sentinel Events Policy and Procedure

SCOPE **MEDICAL MANAGEMENT- TRUSTED HEALTH PLAN AND ALLIANCE**

TITLE **MONITORING AND REPORTING OF SENTINEL EVENTS**

POLICY

TRUSTED Health Plan, Inc. (TRUSTED) will monitor the quality and appropriateness of care provided to its members by hospitals, clinics, physicians, home health care agencies, and other providers of health care services that we authorize. The intent of this policy is to identify those unexpected occurrences involving death or serious physical or psychological injury, or the risk thereof, or which otherwise adversely affects the quality of care and service, operations, assets, or reputation of TRUSTED. The phrase "or the risk thereof "includes any process variation for which an occurrence (as in "near miss") or recurrence would carry a significant chance of a serious adverse outcome.

The goal of this policy is to:

- Have a positive impact on improving patient care, treatment, and services and prevent sentinel events.
- Focus the attention of the organization on understanding the causes that underlie the event, and on changing systems and processes to reduce the probability of such an event in the future.
- Increase general knowledge about sentinel events, their causes, and strategies for prevention.

Definitions

1. **Sentinel Event:** Real-time identification of an unexpected occurrence involving death or serious physical or psychological injury, or the risk thereof, or which otherwise adversely affects the quality of care and service, operations, assets, or reputation of TRUSTED. Such events are called sentinel because they signal the need for immediate investigation and response. For the purpose of this policy. TRUSTED limits identification of sentinel events to occurrences in the course of a member accessing health care services. The terms "sentinel event" and "medical error" are not synonymous; not all sentinel events occur because of an error and not all errors result in sentinel events.

2. **Critical Event:** Retrospective identification of an unexpected occurrence that, upon investigation, is found to have caused serious harm or injury to a TRUSTED member. Critical events differ from sentinel events only in the time frame in which they are identified.

3. **Never Event:** Reportable adverse events that "are serious, largely preventable, and of concern to both the public and healthcare providers for the purpose of public accountability."

PROCEDURE

1. A TRUSTED employee identifies, or is notified of, an event which meets criteria as a potential sentinel event.
2. The following is a listing of the indicators monitored at TRUSTED Health Plan as potential sentinel events. This list should not be considered an all-inclusive list.
   a. The event has resulted in an unanticipated death or major permanent loss of function, not related to the natural course of the patient's illness or underlying condition
   b. Suicide of any patient receiving care, treatment and services in a staffed around-the-clock care setting or within 72 hours of discharge
   c. Unanticipated death of a full term infant
   d. Abduction of any patient receiving care, treatment, and services
   e. Discharge of an infant to the wrong family
   f. Rape - *Rape* as a reviewable sentinel event is defined as unconsented sexual contact involving a patient and another patient, staff member, or other perpetrator while being treated or on the premises of the organization, including oral, vaginal, or anal penetration or fondling of the patient's sex organ(s) by another individual's hand, sex organ, or object. One or more of the following must be present to determine reviewability:
      - Any staff-witnessed sexual contact as described above
      - Sufficient clinical evidence obtained by the organization to support allegations of unconsented sexual contact.
      - Admission by the perpetrator that sexual contact, as described above, occurred on the premises
   g. Hemolytic transfusion reaction involving administration of blood or blood products having major blood group incompatibilities
   h. Surgery on the wrong patient or wrong body part
   i. Unintended retention of a foreign object in a patient after surgery or other procedure
   j. Severe neonatal hyperbilirubinemia (bilirubin >30 milligrams/deciliter)
   k. Prolonged fluoroscopy with cumulative dose >1500 rads to a single field or any delivery of radiotherapy to the wrong body region or >25% above the planned radiotherapy dose
3. The Sr. Director, Quality and Risk Management is notified of the event via incident report, telephone, E-mail, or personal visit as soon as reasonably possible after identification.
4. The Sr. Director, Quality and Risk Management will collaborate with the Chief Medical Officer and investigate as appropriate. Certain incidents may require review of medical records to assist in the

investigation.

5. The Quality Management Department leads the investigation; analysis and reporting of all identified sentinel events.
6. All sentinel events require root cause analysis. Root cause analysis is a process for identifying the basic or causal factors that underlie variation in performance, including the occurrence or possible occurrence of a sentinel event. A root cause analysis focuses primarily on systems and processes, not on individual performance. It progresses from special causes in clinical processes to common causes in organizational processes and systems and identifies potential improvements in processes or systems that would tend to decrease the likelihood of such events in the future or determines, after analysis that no such improvement opportunities exist. At the discretion of the Sr. Director, Quality and Risk Management and the Chief Medical Officer, other incidents may be subject to root cause analysis. A multidisciplinary team led by the Chief Medical Officer will perform all root cause analyses.
8. When appropriate, systems issues are identified and corrective action plans developed to prevent recurrence of the event. The corrective action plan will identify the strategies that the organization intends to implement in order to reduce the risk of similar events occurring in the future. The plan will address responsibility for implementation, oversight, time lines, and strategies for measuring the effectiveness of the actions.
9. All confirmed sentinel events will be reported to the DHCF and the HCSNA in compliance with section C.13.2.1 & C.13.2.2 of the TRUSTED Health Plan, Inc. Core Contract. Reporting will be completing using the prescribed District of Columbia *Unusual Incident Report* (Attachment 2).
10. When appropriate, other agencies (such a practitioner licensing boards) will be notified of con-firmed sentinel events.
11. When appropriate, information from sentinel event investigations will be provided to the Credentialing Committee to support the re-credentialing process.

General Guidelines

1. Prenatal visit is recommended for parents who are at high risk, for first-time parents, and for those who request a conference. The prenatal visit should include anticipatory guidance, pertinent medical history, and a discussion of benefits of breastfeeding and planned method of feeding per AAP statement "The Prenatal Visit" (1996).
2. Every infant should have a newborn evaluation after birth. Breastfeeding should be encouraged, and instruction offered as recommended in the AAP statement "Breastfeeding and the Use of Human Milk" (1997).
3. For newborns discharged in less than 48 hours after delivery refer to AAP statement "Hospital Stay for Healthy Term Newborn" (1995).
4. Developmental, psychosocial, and chronic disease issues for children and adolescents may require frequent counseling and treatment visits separate from preventive care visits.

5. If a child comes under care for the first time at any point on the schedule, or if any items are not accomplished at the suggested age, the schedule should be brought up to date at the earliest possible time.
6. If the patient is uncooperative, re-screen within 6 months.
7. All newborns should be screened per the AAP Task Force on Newborn and Infant Hearing Loss: Detection and Intervention (1999).
8. By history and appropriate physical examinations: If suspicious, by specific objective developmental testing. Parenting skills should be fostered at every visit.
9. At each visit, a complete physical examination is essential, with infant totally unclothed, older child undressed and suit-ably draped.
10. These may be modified, depending upon entry point into schedule and individual need.
11. Metabolic screening (e.g., thyroid, hemoglobinopathies, PKU, galactosemia) should be done according to state law.
12. Every visit should be an opportunity to update and complete a child's immunizations as per AAP (American Academy of Pediatrics) guidelines.
13. See AAP Pediatric Nutrition Handbook (1998) for a discussion of universal and selective screening options. Consider earlier screening for high-risk infants (premature infants and low birth weight infants). See also "Recommendations to Prevent and Control Iron Deficiency in the United States". MMWR. 1998; 47.
14. All menstruating adolescents should be screened annually.
15. Conduct dipstick urinalysis for leukocytes annually for sexually active male and female adolescents.
16. For children at risk of lead exposure refer to the District of Columbia "Childhood Lead Poisoning Screening and Reporting Emergency Act of 2002". After 26 months, blood lead level testing is required twice up to age 6, if not done previously. If family history cannot be ascertained and other risk factors are present, a lead blood level should be drawn.
17. TB testing per recommendations of the Committee on Infectious Diseases, published in the current edition of "Red Book; Report of the Committee on Infectious Diseases". Testing should be done upon recognition of high-risk factors.
18. Cholesterol screening for high-risk patients per AAP statement "Cholesterol in Childhood" (1998). If family history cannot be ascertained and other risk factors are present, screening should be at the discretion of the physician.
19. All sexually active patients should be screened for sexually transmitted diseases (STDs). Refer to STD practice guide-lines.
20. All sexually active females should have a pelvic examination. A pelvic examination and routine Pap smear should be offered as part of preventive health maintenance between the ages of 18 and 21 years.

21. Age-appropriate discussion and counseling should be an integral part of each visit for care per the AAP Guidelines for Health Supervision III (1998).
22. From birth to age 12, refer to the AAP injury prevention program (TIPP^{T}t as described in A Guide to Safety Counseling in Office Practice (1994).
23. Violence prevention and management for all patients per AAP Statement "The Role of the Pediatrician in Youth Violence Prevention in Clinical Practice and the Community Level" (1999).
24. Parents and caregivers should be advised to place healthy infants on their backs when putting them to sleep. Side positioning is a reasonable alternative but carries a slightly higher risk of SIDS. Consult the AAP statement "Changing Concepts of Sudden Infant Death Syndrome: Implications for Infant Sleeping Environment and Sleep Position" (2000).
25. Age-appropriate nutrition counseling should be an integral part of each visit per the AAP Handbook of Nutrition (1998).
26. Between 12 months and 24 months, one documented dental evaluation must be performed. Referrals to the dentist must begin at 3 years of age.

Appendix G. MEMBER APPEALS PROCESS

Definitions:

1. **Administrative Denial-** A decision by TRUSTED Health Plan staff that a requested service will not be approved due to one or more of the following reasons:

a. The service requested is not a Covered Benefit as described in the Member's Handbook.

b. The member is not eligible for service at the time of the request or the date the service is rendered

c. The member has exhausted the benefits provided by the benefit plan.

d. The member and/or practitioner/provider failed to follow the rules of the plan as outlined in the Member Handbook and/or the Provider Manual.

e. The Practitioner fails or refuses to supply sufficient information to the plan to conduct a review of the service requested.

f. The service is conducted out of network when Network providers or practitioners are avail-able to render the service.

2. **Medical Necessity Denial-** A decision by a Medical Director, a Physician Advisor, or other appropriately licensed practitioner that the services requested do not meet accepted standards of care, or the service or location of service is not appropriate for the condition being treated. A medical necessity denial may also be referred to as an Adverse Determination.

3. **Reconsideration**-A request from a practitioner that a medical necessity denial decision be reconsidered based on the submission of additional information and/or physician-to-physician discussion. Reconsideration is not considered an appeal and is not a prerequisite for filing an appeal. The request for reconsideration must be received within 2 business days following verbal notification to the practitioner of the denial or services based on medical necessity.

LEVELS OF APPEALS

Immediate Reconsideration

When a denial is issued, the requesting or designee is notified that TRUSTED Health Plan's Medical or Behavioral Health Director or designee is available to discuss the denial decision with the requesting practitioner.

1. If the discussion results in an approval, the review nurse will documents the decision in MHC, including the date and time of the decision, the date and time of verbal notification to the requesting practitioner and the name and title to whom the verbal notification was given.

2. If this discussion does not result in an approval, there is a dispute about whether the member has an urgent or

emergent medical condition or there is a delay in the furnishing of an emergent or urgent service, a physician not involved in the original decision shall perform a review and reconsideration of the matter and a decision shall be issued within one (1) hour[2].

3. Immediate reconsideration will be provided when:

a. A member submits an expedited appeal request and taking the time for a standard resolution could seriously jeopardize the member's life or health.

b. A practitioner submits an expedited appeal request or supports a member's request and indicates that taking the time for a standard resolution could seriously jeopardize the member's life, health, or functioning; or,

c. A member submits an expedited appeal request while accessing services for urgent or emergent care.

Expedited Appeal

1. The member, the practitioner on behalf of the member, or the member's authorized representative may request an expedited appeal if:

a. The member and his/her practitioner feel that waiting for a standard appeal could seriously jeopardize the member's life or health, or ability to attain, maintain, or regain maximum function, OR in the opinion of a practitioner with knowledge of the member's medical condition, would subject the member to severe pain that cannot be adequately managed without the care or treatment that is the subject of the request.

b. A request for urgent care has been denied;

c. A person with HIV/AIDS is dissatisfied with TRUSTED decision;

d. A request for acute services, or for services that may be authorized as alternative to acute inpatient services, has been denied;

e. A request for a surgical procedure, including circumcision, has been denied

2. Expedited request may be received verbally or in writing.

3. A verbal request for expedited appeal does not need to be followed up in writing.

4. The date the request is made, either verbally or in writing, is considered to be the date the appeal was received by TRUSTED.

5. TRUSTED will acknowledge the receipt of the expedited request immediately, and will communicate its determination as to the granting of expedited status, within twenty-four (24) hours of receiving an expedited appeal.

6. TRUSTED will ensure that no punitive action is taken against a practitioner who requests an expedited resolution or supports a member's appeal.

7. The member or his/her authorized representative will be advised of the time limit for the member to present evidence and allegations of fact or law, in person and in writing, prior to a final determination.

8. Expedited Appeals must be completed as expeditiously as the member's health condition requires, not to exceed seventy-two (72) hours following receipt of the request;

a. TRUSTED may extend the seventy-two (72) hour time period by up to five (5) calendar days if the Member requests an extension, or if TRUSTED justifies a need for additional time and explains how the extension is in the member's interest.

b. An Extension Letter providing the rationale for the extension and the right to file a grievance will be sent to the member.

TRUSTED will ensure that an appeal is automatically transferred to the timeframe for standard resolution should the request for expedited resolution be denied. TRUSTED will give the member or his/her authorized representative prompt verbal notice (within 24 hours) that the request for an expedited appeal has been denied. TRUSTED will also provide written notice of the denial within two (2) calendar days of the decision. TRUSTED may determine that it is appropriate to transfer the expedited Appeal to the timeframe standard resolution in accordance with 42 C.F.R. § 438.408(b) (2). The member has the right to file a complaint with TRUSTED regarding the decision not to expedite the appeal, but the decision is not subject to appeal.

Standard Appeal

The member, practitioner (with the written authorization of the member), or the member's authorized representative may request a reconsideration of the adverse determination.

1. These requests may be received verbally or in writing

2. A written signed follow-up is required within ten (10) days following a verbal request.

3. The date the request is made is considered the date the appeal was received by TRUSTED

4. TRUSTED will acknowledge, in writing, the receipt of the appeal within two (2) days of receipt of the request.

A standard Appeal will be completed within fifteen (15) days. TRUSTED may extend this by an additional five (5) calendar days if the Member requests an extension, or if TRUSTED justifies a need for additional time and why the extension is in the Member's' interest. An Extension Letter providing the rationale for the extension and the right to file a grievance will be sent to the member.

External Appeals

All members have the right to request a Fair Hearing from the District of Columbia at any point during the appeal process. TRUSTED Health Plan's General Counsel will forward all documents regarding the Plan's actions and the member's dispute to the Medical Assistance Administration within five business days of notification that a fair-hearing request has been filed. The disputed item or service will continue to be provided at the level and in the amount, scope and duration that the item or service was provided prior to TRUSTED adverse determination. TRUSTED will assist the member with filing a request for Fair Hearing and send a copy of the request to the member's home address.

Appeal Resolution

If TRUSTED reversed or modifies an authorized decision through the appeal process or is notified of the District's Fair Hearing decision to reverse a decision, the service shall be authorized or provided no later

than two (2) business days after reversal or notification of the reversal from the District. In the case of an expedited appeal, services must begin within 24 hours of the reversal.

Pre-Service Appeals

Pre-Service appeals are requests to change an adverse determination for care or service that the organization must approve, in whole or in part, in advance of the member obtaining care or services.

1. TRUSTED Health Plan's Appeals Department receives a request for reconsideration of an adverse determination from a member, a practitioner on the member's behalf, or the member's authorized representative. Any area within TRUSTED Health Plan, including, but not limited to, may receive appeals: Members Services, Utilization Management, Claims, or Provider Services.

2. Upon receipt of a written appeal, the appeal is time and date stamped and forwarded immediately to the Appeals unit within the Medical Management Department.

3. The staff member receiving a verbal appeal will inform the member of the need to follow the request with a written, signed appeal. The staff member will offer the assistance of TRUSTED Health Plan Member Services to write the appeal.

4. The staff member will forward the verbal request for appeal to the Appeals Coordinator. The Appeals Coordinator will send a written acknowledgement letter to the member, along with instructions for completing the written signed appeal.

5. The Appeals Coordinator logs the appeal request into the appeals database and documents the substance of the pre-service appeal and any actions taken. The Appeals Coordinator prepares an acknowledgement response for the member and /or practitioner, and mails or faxes the acknowledgment within 2 calendar days of receipt of the request. The acknowledgment letter includes the estimate date that a decision regarding the appeal will bc madc. If the appeal request is for an expedited appeal, the Appeals Coordinator will verbally acknowledge the receipt of the appeal and follow with the written acknowledgement within 24 hours.

6. The Appeals Coordinator compiles all the information relevant to the appeal, including any additional information received from the member or his/her authorized representative.

a. If the appeal concerns a medical necessity determination, the Appeals Coordinator forwards the file via overnight mail, to the appropriate contracted peer review organization.

b. The peer review organization reviews all the information relevant to the appeal and makes recommendation regarding the appeal. The peer review organization returns the review recommendation to TRUSTED, both verbally and in writing.

7. Decisions are rendered, and notification issues to the member within the mandated time frames: 72 hours for expedited appeals, 15 calendar days for standard appeals, unless an extension has been requested by the member or TRUSTED, with justification that the extension is in the best interest of the member.

8. The appeals coordinator will ensure prompt oral notice to the enrollee of any denial and will follow-up within two (2) calendar days with a written notice.

9. The Appeals includes the following:

a. The specific reasons for the appeal decision, in easily understandable language,

b. A reference to the benefit provisions, guidelines, protocol, or other similar criterion on which the appeal decision was based;

c. Notification that the member is entitled to receive, upon request, reasonable access to and copies of all documents relevant to the appeal. Relevant documents include documents or records relied upon in making the appeal decision and documents and records submitted in the course of making the appeal decision;

d. A list of titles and qualification, including the specialty of the individual conducting the medical necessity review, and of individuals participating in the appeal review. **NOTE:** Participant names do not need to be included in the written notification to members, but must be provided to members upon request;

e. A description of the next level of appeal, along with any written procedures for initiating the second level appeal.

f. Specific notification to the member of the right for a District Fair Hearing, the process for initiating a Fair Hearing and the contact information for the District Fair Hearing office.

g. If TRUSTED completely overturns the denial, the appeal notice will state the decision and the date of the decision.

10. The Appeal Coordinator logs the pre-service appeal information into the Appeals database, including the date of the decision, date(s) of notification, the parties notified, the decision rendered and all actions taken.

Post -Service Appeals

Post Service appeals are requests to change and the member for care or services that has already received adverse determination.

1. TRUSTED Health Plan receives a request for reconsideration of an adverse determination from a member; a practitioner acting on the member's behalf, or the member has received the member's authorized representative after the care or service. Any area within TRUSTED Health Plan, including, but not limited to, may receive this appeal: Member Services, Utilization Management, Claims, or Provider Services.

2. Upon receipt of a written appeal, the appeal is time and date stamped and forwarded immediately to the Appeals unit within the Medical Management department.

3. The staff person receiving a verbal appeal will inform the member of the need to follow the request with a written, signed appeal. The staff member will offer the assistance of TRUSTED Health Plan Member Service to write the appeal.

4. The staff member will forward the verbal request for appeal to the Appeals Coordinator. The Appeals Coordinator will send a written acknowledgement letter to the member, along the instructions for completing the written, signed appeal.

5. The Appeals Coordinator logs the appeals request into the appeals database including full documentation of the post-service and actions taken. The Appeals Coordinator prepares an acknowledgment response for the member and /or practitioner, and mails the acknowledgment within 2 calendar days of receipt of the request. The acknowledgment letter includes the estimated date that a decision regarding the appeal will be made.

6. The Appeals Coordinator compiles all the information relevant to the appeal, including any aspects of clinical care involved and additional information received from the member or his/her authorized representative.

a. If the appeal concerns a medical necessity determination, the Appeals Coordinator forwards the file via overnight mail, to the appropriate contracted peer review organization.

b. The peer review organization reviews all the information relevant to the appeal and makes a recommendation to TRUSTED regarding the appeal decision. The peer review organization returns the results of the peer review to TRUSTED both verbally and in writing.

7. Decisions are rendered, and notification issued to the member, within 15 days, unless an extension has been requested by the member or TRUSTED, with justification that the extension is in the best interest of the member.

8. The appeals coordinator will ensure prompt oral notice to the enrollee of any denial and will follow-up within two calendar days with a written notice.

9. The Appeals coordinator prepares and issues the written appeal decision. The appeal decision letter includes the following:

a. The specific reasons for the appeal decision, in easily understandable language,

b. A reference to the benefit provision, guideline, protocol, or other similar criterion on which the appeal decision was based;

c. Notification that the member, upon request, can obtain a copy of the actual benefit provision, guideline, protocol, or other similar criterion on which the appeal decision was based;

d. A list of titles and qualifications, including the specialty of the individual conducting the medical necessity review, and of individuals participating in the appeal review. **NOTE:** Participant names do not need to be included in the written notification to members, but must be provided to members upon request;

f. Specific notification to the member of the right for a District Fair Hearing, the process for initiating a Fair Hearing and the contact information for the District Fair Hearing office.

g. If TRUSTED completely overturns the denial, the appeal notice will state the decision and the date of decision.

10. The Appeal Coordinator logs the information on the post service appeal into the Appeals database, including the date of the decision, date(s) of notification, the parties notified, the parties notified, the

decision rendered and all actions taken.

Effectuation of Appeals Decisions

If TRUSTED reverses or modifies a decision through the appeals process or is notified of the District's Fair Hearing decision to reverse a decision, the service shall be authorized or provided as promptly and as expeditiously as the member's health conditions requires, but not later that two (2) working days after reversal or notification of reversal from the District. In the case of an expedited appeal, services must begin within 24 hours of the reversal.

(1) TRUSTED HEALTH PLAN
100 NEW JERSEY AVE SE, SUITE 840
WASHINGTON DC 20003

(5) TRUSTED Health Plan THP

(2) 90 FG 1 B 1 1 A 10081 10081 **5 DGT

(3)
IMA PHYSICIAN
(4) C/O IMA PHYSICIAN GROUP
123 MAIN ST
APT. 10
PINEHURST NC 28374-0042

(6A) Vendor Name IMA PHYSICIAN GROUP (6Aa)
(7A) Vendor Address 123 MAIN ST. (7Aa)
APT. 10
PINEHURST NC 28374-0042
(8A) Vendor Number 01234 (8Aa)

(12) Questions? Call Customer Service at (202) 821-1180
M-F 8 am - 5:30 pm ET. Or reach us online at:
www.trustedhp.com.

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Explanation of Payment (13)

(14) Provider Name	(15) Provider Number	(16) Group Number
IMA PHYSICIAN (14a)	15a DD1234567	16a A12345
(17) Patient Name	**(18) Member ID Number**	**(19) Patient Number**
JOE PATIENT (17a)	18a 12345678901	19a B12345

(20) Claim Number 20a 0101100600101

(21) Date	(22) SVC Code	(23) Charged	(24) Allowed	(25) Not Cov	(26) Discount	(27) Other Ins	(28) Deduct	(29) Co-Ins	(30) Copay	(31) Ins Paid	(32) Note
99/99/99	D1234	-999,999.99	-999,999.99	-999,999.99	-999,999.99	-999,999.99	-999,999.99	-999,999.99	-999,999.99	-999,999.99	XXXX
01/01/06	XXXXOXXXXO XXXXOXXXXO XXXXOXXXXO (22a)	30.00	25.00	0.00	0.00	0.00	0.00	0.00	25.00		003
21a		23a	24a	25a	26a	27a	28a	29a	30a	31a	32a
01/01/06	X9999	75.00	75.00	0.00	0.00	0.00	0.00	0.00	75.00		003
01/01/06	N1212	1,000.00	900.00	900.00	0.00	0.00	0.00	0.00	0.00		
Total (33)		(33b) 1,205.00	1,070.00	900.00	0.00	0.00	0.00	20.00	150.00	(33j)	

Patient Responsibility: (34) (34a) 600.00 (33c) (33d) (33e) (33f) (33g) (33h) (33i)

003 PRIOR TO EFFECTIVE DATE OR AFTER TERMINATION DATE

(35) (35a)

(52)

Provider Name	Provider Number	Group Number
IMA PHYSICIAN	DD1234567	A12345
Patient Name	**Member ID Number**	**Patient Number**
JOE PATIENT	12345678901	B12345

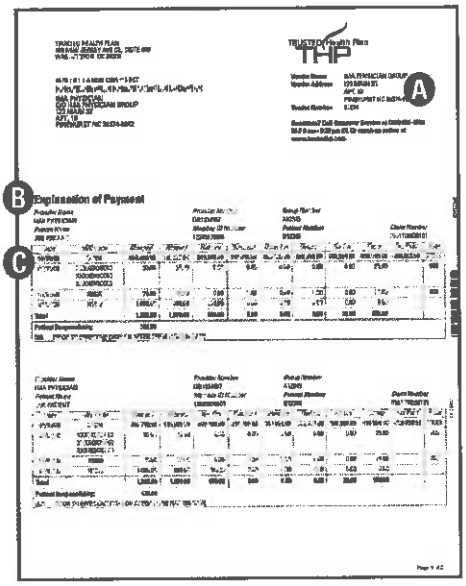
Claim Number 0101100600101

Date	SVC Code	Charged	Allowed	Not Cov	Discount	Other Ins	Deduct	Co-Ins	Copay	Ins Paid	Note
99/99/99	D1234	-999,999.99	-999,999.99	-999,999.99	-999,999.99	-999,999.99	-999,999.99	-999,999.99	-999,999.99	-999,999.99	XXXX
01/01/06	XXXXOXXXXO XXXXOXXXXO XXXXOXXXXO	30.00	25.00	0.00	0.00	0.00	0.00	0.00	25.00		003
01/01/06	X9999	75.00	75.00	0.00	0.00	0.00	0.00	0.00	75.00		003
01/01/06	N1212	1,000.00	900.00	900.00	0.00	0.00	0.00	0.00	0.00		
Total		1,205.00	1,070.00	900.00	0.00	0.00	0.00	20.00	150.00		

Patient Responsibility: 430.00

003 PRIOR TO EFFECTIVE DATE OR AFTER TERMINATION DATE

How to Read Your Statement



A. This is your contact information, which includes your name, address, and vendor number.

B. This is a summary of all claims, which includes the provider's name, the patient name, the patient number, and the claim number.

C. This is the explanation of payment. It shows how this claim was processed, which services were paid by us, and which services are your patient's responsibility.

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Contact Us

Phone
(202) 821-1100

Fax
(202) 821-1099

E-mail
provider@trustedhp.com

Online
www.trustedhp.com

Mail
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Washington, DC 20003

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TRUSTED HEALTH PLAN	Effective Date: 12/01/2013	Policy #: CGA-2015-0002
Department: Medical Management	Reviewed Date: 04/06/2015	Expiration Date:
Policies and Procedures: Complaints and Grievances	Revised Date: 08/06/2015	Page(s): 8

POLICY TITLE: Complaints and Grievances

PURPOSE: THP recognizes that an effective complaint and grievance protocol is essential to the quality improvement process. Therefore, THP has a multi-level mechanism in place in which it processes inquiries, complaints and grievances. This policy is designed to comply with the requirement of accrediting bodies and other regulatory agencies.

The purpose is to ensure that the right of all participating members and providers to seek recourse when dissatisfied with THP, or its services is respected.

SCOPE: This policy applies to all departments within THP. The outlined responsibilities are the assignment of the designated Complaints and Grievances Coordinator.

DEFINITIONS:

I. Complaint: An expression of dissatisfaction about any matter related to the provision of health care delivery other than an Action.

2. Action:
    i. The denial or limited authorization of a requested service, including the type or level of service;
    ii The reduction, suspension, or termination of a previously authorized service,
    iii. The denial, in whole or in part of payment for a service;
    iv. The failure to provide services in a timely manner as defined by the District: or
    v. The failure of THP to act within the timeframes for resolution and notification of complaints and grievances.
3. Grievance: A written expression of dissatisfaction about any matter other than an Action. The term is also used to refer to the overall system that includes grievances and appeals at THP and access to the Fair Hearing Process.

4. Ombudsman: Entity that engages in impartial and independent investigation of individual complaints, advocates on behalf of consumers, and issues recommendations. This function is operated by DHCF.
5. Timeframes: A telephonic response will be provided within the timeframes indicated below:
    - Medical emergency related issues will be resolved within twenty-four (24) business hours.
    - Quality of service and care issues will be resolved within fourteen (14) business days.
    - Administrative issues will be resolved within thirty (30) business days. THP may extend the thirty (30) day timeframe by up to fourteen (14) days if the member or the member's representative requests an extension or if THP shows to the satisfaction of DHCF that there is a need for additional information and how the delay is in the member's interest. The member will be given written notice of the reason for the delay.
    - Inquiries will be processed immediately.

PROCEDURE:

Complaints and Grievance Tracking system

THP maintains a record-keeping and tracking system to document all Complaints and Grievances and will make available to DHCF and supporting documentation upon request. The system will capture:

1. Whether the matter is a complaint or a grievance;
2. The subject/ category of each complaint or grievance;
3. The member's PCP and the provider involved in the complaint or grievance (if different from PCP);

4. How the matter was resolved; and
5. What, if any, corrective action was taken by THP.

Function:

1. When a complaint is administrative in nature, THP staff documents the complaint on the complaint intake form or electronically in MHC and routes the complaint to the Complaints and Grievances Coordinator who will:
    a. Document all pertinent information pertaining to the call/correspondence on the complaint log;
    b. Investigate the concerns;
    c. Coordinate with other departments within THP if necessary to reach a solution;
    d. Document the nature of the issue, the intervention, and the resolution in the complaint database;
    e. The following individuals will be notified, telephonically (in writing upon request) of the actions taken and resolution and right to appeal:
        - Member.
        - Physician or Hospital.
        - Department Head.
        - The Department of Health Care Finance.

2. THP will notify enrollees and potential enrollees that oral interpretation is available for any language and written information is available in prevalent languages and how to access those services during the complaint process.

3. When a call is medical in nature, such as issues regarding injury, medical misadventure, neglect or abuse, the call is classified as a "Risk Management Event" and forwarded to the Clinical Quality Manager who will:

    a. Report the issue to the Senior Director of Quality Management within twenty-four (24) hours of receipt for investigation;

b. Document all pertinent information related to the call on the Complaint Intake Form;
c. Follow-up with the Senior Director of Quality Management for closure.

4. When an issue is related to a medical emergency or regarding the authorization of medical services, the Complaints and Grievance Coordinator will:

a. Coordinate with the Utilization Management Department/Chief Medical Officer for investigation and resolution.
b. Inform the Chief Medical Officer when an urgent determination of medical appropriateness has been requested.
c. Document the nature of the problem and the resolution in the database.
d. Follow-up with the Chief Medical Officer for closure.

5. If an issue has not been resolved in a timely manner to the satisfaction of the enrollee or provider, the complainant may present a grievance to an ad hoc First Level Grievance Review Committee. This Committee will be comprised of no less than three employees of THP. Members of this Committee will be chosen at the discretion of the Chief Medical Officer depending on the nature of the grievance.

6. A grievance may be filed in writing or orally with THP. All grievances will be acknowledged upon receipt, both orally and in writing, utilizing the Grievance Acknowledgement Letter. Any of the following may invoke the grievance procedure under this section by filing with THP within ninety (90) days of determination notice:

a. The enrolled individual affected by the determination (or in the case of an enrolled adolescent);
b. The primary care provider (and specialist, if any) of the enrolled individual affected by the determination;
c. If the enrollee is a minor child, a parent, guardian, or authorized representative;

d. Any enrollee may have an authorized representative request a grievance on his/her behalf;

e. An authorized representative may include, but is not limited to an attorney or non-legal advocate; and

f. With the permission of the enrolled individual affected by the determination, the agency, program or provider that referred the enrolled individual for the item or service at issue;

A. First Level of Review:

- The enrollee, his/her designee, or the provider has the right to appear before the Committee or present the grievance in writing.
- The Committee will review and investigate the grievance.
- The Committee will provide a written decision within thirty (30) days of receipt of the grievance.
- The response will outline in clear terms the reasons for the committee's decision and the rights of the member or provider to appeal the decision if necessary.
- The decision of the First Level Grievance Review Committee is binding unless the member or provider appeals (in writing) within thirty (30) days of receipt of the first decision.
- The appeal of the First Level Grievance Review Committee shall be to an ad hoc Second Level Grievance Review Committee. This committee will be established by THP's QEC. Upon enrollee's request, peer representation will be made available.

B. Second Level of Review:

- The enrollee, his/her designee, or provider has the right to appear before the Committee or present the appeal in writing.
- The Committee will review and investigate the appeal.
- The Committee will hold an informal hearing to consider each appeal.

- When arranging the hearing, the member or designee will be notified in writing of the hearing procedures and their rights at the hearing.

- The hearing will be held within thirty (30) days of the request to appeal.
- If the complainant has requested a hearing and does not appear (without prior notification) the First Level Grievance Review decision will be binding.
- The Second Level Grievance Review Committee will issue a formal written decision within ten (10) days of the hearing, which details the reasons for the decision.

  •The decision at this level will be binding unless the member or designee chooses to appeal to the President of THP. The President is the last level of appeal within THP and his/her decision is binding.

7. In cases where the member and/or the provider believes that THP did not provide medically necessary and/or covered health services:

   •The complaint will be submitted to the THP Chief Medical Officer for review within twenty-four (24) hours of the initial contact by the member or provider.
   •The Chief Medical Officer will inform all parties involved of his/her decision in writing.
   •If the member does not agree with the decision, he/she may appeal to the First Level Grievance Review Committee (outlined above).

8. At each stage in the process, the member or provider must be as specific as possible.
9. THP will not penalize any member or Provider that acts on behalf of the member, for filing a grievance or an appeal or that requests a Fair Hearing.

Reporting:

1. The Complaints, Grievance & Appeals Manager will report monthly to the Senior Director of Utilization Management who will analyze the data to ensure compliance with established resolution timeframes.

2. The complaints will be analyzed monthly to ensure that the following bench marks have been met:

Medical Emergencies	100%
Services Issues	90%
Administrative Issues	90%

3. The analysis of the complaints shall be presented to the THP Quality Executive Committee (QEC) for discussion and further recommendations quarterly.

4. The Satisfaction Survey data gathered in the complaint tracking database will be utilized during the analysis of annual member survey data to ensure that accurate scores are acquired for the complaint handling section of the survey.

5. The complaint process will be reviewed annually by the Quality Executive Committee to ensure continuous improvement.

6. Results and recommendations of the evaluation will be communicated to the respective directors, managers and staff.

7. Complaint and Grievance Reports will be submitted to the Department of Healthcare Finance on a monthly basis.

TRUSTED HEALTH PLAN	Effective Date: 12/01/2013	Policy #: CGA-2015-0002
Department: Medical Management	Reviewed Date: 04/06/2015	Expiration Date:
Policies and Procedures: Complaints and Grievances	Revised Date: 08/06/2015	Page(s): 8

APPROVED BY:

Director of Utilization Management — Date: 8/6/2015

Chief Medical Officer — Date: 08/06/2015

TRUSTED HEALTH PLAN	Effective Date: 12/01/2013	Policy #: CGA-2015-0001
Department- Medical Management	Reviewed Date: 07/02/2014	Expiration Date:
Policies and Procedures	Revised Date: 8/6/2015	Pages: 11

POLICY TITLE: APPEALS

PURPOSE: Trusted maintains a process for enrollees to appeal any delayed, modified, or denied request for health care service, if the enrollee believes that health care services have been improperly denied, modified, or delayed. An appeal is a request to change a previous decision made by the organization, including the outcome of a complaint.

Trusted maintains a process for enrollees to request an independent medical review ("IMR") of disputed health care services if the enrollee believes that health care services have been improperly denied, modified, or delayed.

SCOPE: This policy document is applicable to all staff, as well as delegated entities. This policy applies to complaints, as well as benefit and medical necessity appeals for pre-service, post-service, concurrent, expedited and external appeals.

DEFINITIONS:

1. Appeals are defined as a request for review of an action. An action is defined as:
    a. The denial or limited authorization of a requested service, including the type or level of service.
    b. The reduction, suspension, or termination of a previously authorized service.
    c. The denial, in whole or in part, of payment for a service.
    d. The failure to provide services in a timely manner, as defined by the District of Columbia.
    e. The denial, for a resident of a rural area with only one contractor, of a Medicaid enrollee's request to exercise his or her right to obtain services out of network.

2 Eligibility for expedited appeals: Requests for expedited appeals are evaluated for the following. If the case meets any of these criteria, the case is handled in an expedited manner, per the procedures and timelines delineated in this procedure.
    a. A delay that could seriously jeopardize the life or health of the member or the member's ability to regain maximum function, based on a prudent layperson's judgment;

b. In the opinion of a practitioner with knowledge of the member's medical condition, would subject the member to severe pain that cannot be adequately managed without the care or treatment that is the subject of the request.
c. All requests concerning admissions, continued stay or other health care services for a member who had received emergency services but has not been discharged from a facility.

If a case is deemed to meet the expedited appeal criteria above, Trusted does not require an enrollee to file their request in writing. If Trusted denies an enrollee's request for an expedited appeal, the appeal is processed according to the standard appeal timeframe. The enrollee is notified, in writing, within two business days of the decision not to expedite the appeal. An attempt is also made to notify the appellant telephonically. No punitive action is taken against an enrollee for filing or supporting an expedited appeal.

For concurrent review cases, Trusted allows the appellant continued coverage under their medical benefit pending the outcome of their appeal. This policy applies to cases where Trusted has approved an ongoing course of treatment and subsequently decides to deny, reduce or terminate the approved course of treatment.

PROCEDURE:

1 Appeals are accepted up to 90 calendar days after the notification of the denial. Appeals may be received from a member, practitioner on the member's behalf, legal representatives of a deceased enrollee's estate, or the member's authorized representative. Providers must have the enrollee's written consent to file an appeal on their behalf.
   1.1 Trusted will continue enrollee benefits pending resolution in the enrollee or provider files the appeal timely. The request for a continuation of benefits must be made within 10 days of the NOA.
   1.2 Trusted will continue the enrollee's benefits pending resolution if the services were ordered by an authorized provider.
   1.3 If an appeal request is received after 90 days after the initial notification of denial, the appeals coordinator documents this fact and informs the appellant that Trusted cannot process the appeal, as the request exceeded the allowed timeframe. The notification is both telephonic and in writing.

1.4 If the request is made outside of business hours, the appeals request is received by the on-call nurse response line. The on-call nurse evaluates the urgency of the expedited request.

1.4.1 The request qualifies for an expedited process if either of the following circumstances is met:

- Could seriously jeopardize the life or health of the member or the member's ability to regain maximum function, based on a prudent layperson's judgment; or
- In the opinion of a practitioner with knowledge of the member's medical condition, would subject the member to severe pain that cannot be adequately managed without the care or treatment that is the subject of the request.
- All requests concerning admissions, continued stay or other health care services for a member who had received emergency services but has not been discharged from a facility.

1.4.2 If the request meets any of these criteria, the case is treated as expeditiously as the medical condition requires, and is resolved within 72 hours of the request. The procedural steps for the appeal outlined below are all completed within this time frame.

1.4.3 If the request fails to meet the qualifications for an expedited process the case proceeds within the standard timeframes.

1.4.4 The after-hours, on-call nurse informs the appeals coordinator (or Director of the Quality Management Department) of receipt of the appeal request after-hours, and the determination about whether the case shall be handed within the expedited timeframes or under the standard appeal timeframes.

2 The appeals coordinator documents the substance of the appeal in the Care Connect system. The appeals coordinator acknowledges receipt of the appeal request within two business days of receipt by sending a written acknowledgement letter to the appellant, which includes the enrollee's rights during the appeal process. Trusted uses the date that an appeal was received orally to establish the earliest possible filing date. Enrollee rights are listed below.

2.1 Enrollees have the right to participate in Trusted's appeal process, as well as present and review information and documents relevant to their case, either in person or via telephone.

2.2 With the exception of an expedited appeal, oral appeals must be followed by a written, signed request for appeal by the enrollee or his authorized representative within ten business days.

2.3 If the appeal request is verbal and the appellant has difficulty or cannot document the appeal in writing, the appeals coordinator assists the member in documenting the appeal by completing an appeal request form. If a language barrier is evident, the appeals coordinator arranges for translation services to assist in documentation of the appeal.

2.4 If the appellant has difficulty expressing the appeal to the appeal coordinator either verbally or in writing, cultural or linguistic issues may be involved.

For linguistic issues the translation vendor is immediately contacted via telephone and a three-way conversation takes place to elicit the information needed to document the appeal. The appeal coordinator assesses for any cultural sensitivities regarding the member's appeal.

2.4.1 If cultural barriers are identified, the appeals coordinator identifies a culturally appropriate staff member or other resource (e.g., female for a female appellant, male for a male appellant, someone of the same cultural background as the appellant, someone familiar with the cultural preferences of the appellant, etc.), who discusses the case with the member and documents the appeal in writing. The appellant's cultural preferences are included in this documentation.

2.4.2 The member's cultural and linguistic preferences are documented in the appeal case file for all staff involved to review and follow going forward.

2.4.3 If language barriers are present and the language the member is able to read can be identified, future member correspondence regarding the appeal is translated into the member's preferred language.

3 If the appeal is received by an employee other than the appeals coordinator, upon receipt of a written appeal, the appeal is time- and date-stamped and forwarded immediately to the appeals unit within the Quality Management Department, and the appeals coordinator, for processing.

4 The Appeals Coordinator logs the appeal request into the appeals database, prepares an acknowledgement response letter for the member and/or practitioner, and faxes and mails the acknowledgment within 2 calendar days of receipt of the request.

4.1 The acknowledgment letter includes the estimated date that a decision regarding the appeal will be made.

4.2 The member is provided the opportunity to submit written comments, documents records and other information relevant to the appeal.

4.3 The member may be represented in the appeals process by anyone they choose, including an attorney. Members are informed of this right in the appeal acknowledgement letter.

4.4 Members are allowed reasonable access to and copies of all documents relevant to the appeal, free of charge, upon request.

4.4.1 After a request is received by the appellant or representative for access to the documents relevant to the appeal, the appeal coordinator notified the chief privacy officer of the request for case files

4.4.2 The appeals coordinator gathers all documents relevant to the appeal which were requested and forwards them to the chief privacy officer for review.

4.4.3 The chief privacy officer reviews the documents to ensure that the materials to be forwarded are consistent with HIPAA requirements. S/he consults the medical director as needed. The documents are prepared for the member's review.

4.4.4 The appeals coordinator arranges for the member to either review the documents on-site, or to forward the documents to the appellant via certified, return receipt mail.

4.4.5 If the member chooses an on-site review, a clinician is available to the member during the document review to answer any questions the member may have. The meeting is located in a private location within the Trusted's office space.

4.5 If the appeal request is for an expedited appeal, the Appeals Coordinator verbally acknowledges the receipt of the appeal and follows with the written acknowledgement within 24 hours.

5 The Appeals Coordinator compiles all the information relevant to the appeal, including any aspects of clinical care involved, as well as any additional information received from the member or his/her authorized representative and forwards the case to the Clinical Quality Manager for review.

6 A full investigation of the substance of the appeal ensues, including any aspects of clinical care involved.

6.1 If the information meets benefit or medical necessity criteria, the Clinical Quality Manager may overturn the prior decision and approve the request.

6.2 If the information fails to meet benefit or medical necessity criteria, the Clinical Quality Manager forwards the case to the medical director, or designee, for further investigation and research.

7 The file is forwarded to a medical director (or designee) who determines the correct practitioner to review the appeal.

7.1 Benefit determinations may be made by a Trusted staff member not involved in the initial denial. A qualified consultant with experience and familiar with Trusted benefits may be asked to review the case and provide their opinion. The Trusted medical director (or physician designee) will make the final benefits appeal decision.

7.2 If the case is a medical necessity decision, it is assigned and reviewed by a board certified, licensed physician (or other appropriate licensed practitioner, such as an oral surgeon for oral surgery cases, chiropractor for chiropractic cases, physical therapist for physical therapy cases, psychologist for psychological testing cases, etc.):

- With appropriate expertise to evaluate the case
- Who practices in a same or similar specialty that typically treats the medical condition, performs the procedure or provides the treatment (for medical necessity appeals only)
- Who was not a prior decision-maker in the case, and
- Who is not the subordinate of any person who made a prior determination in the case.

7.3 If Trusted's CMO was originally involved in the initial denial and must recuse him or herself, the file is forwarded to a physician reviewer via overnight mail or secured fax or email to the appropriate contracted peer review organization for review and decision.

8 The reviewing practitioner evaluates the request, conducts additional research as necessary (such as requesting additional information, contacting the treating practitioners), consults Trusted UM decision criteria and benefit materials, evaluates network capacity, etc., then renders a decision on the appeal.

8.1 The decision, as well as the documentation supporting the decision, is communicated to the appeals coordinator.

8.2 If the case was sent to an outside agency for decision, the case materials are returned or destroyed.

8.3 In all cases, the deciding practitioner documents and communicates the rationale for the decision, including relevant case facts and the associated medical necessity criteria used to make the decision.

9 The Appeals Coordinator ensures prompt notice to the enrollee and the enrollee's treating practitioner of the decision.

9.1 The appeals coordinator communicates the appeal decision via telephone within 24 hours.

10 Written notification is transmitted within 3 working days of the decision, and within the timeframes in the table below. Written notification is provided to the member/guardian/member representative/legal representatives of a deceased enrollee's estate, and the treating practitioner and/or facility (as appropriate).

11 The Appeals Coordinator prepares and issues the written appeal decision. The appeal decision letter includes the following:

a. The specific reasons for the appeal decision, in easily understandable language;
b. A reference to the benefit provision, guideline, protocol, or other similar criterion on which the appeal decision was based
c. Notification that the member, upon request, can obtain a copy of the actual benefit provision, guideline, protocol, or other similar criterion on which the appeal decision was based
d. Notification that the member is entitled to receive, upon request, free of charge, reasonable access to and copies of all documents relevant to the appeal. Relevant documents include documents or records relied upon in making the appeal decision and documents and records submitted in the course of making the appeal decision.
e. Notification to the member about further appeal rights
f. Notification to the member about the right to request to continue to receive benefits while the District Fair Hearing is pending.
g. A list of titles and qualifications, including the specialty of the individual conducting the medical necessity review, and of individuals participating in the appeal review. **NOTE:** Appeal participant names do not need to be included in the written notification to members, but must be provided to members upon request

h. Specific notification to the member of the right for a District Fair Hearing, the process for initiating a Fair Hearing and the contact information for the District Fair Hearing office
i. If Trusted completely overturns the denial, the appeal notice will state the decision and the date of decision, and may not include the items listed above

12 The Appeal Coordinator logs the information into the appeal database, including the date of the decision, date(s) of notification, the parties notified, and the decision rendered.

13 **Independent Review Organization Review**

In the event a denial is upheld in the appeal process, the appellant is offered the option of review by an independent review organization (IRO). Instructions on how to initiate a case review by the IRO are included in the denial and appeal decision letters.

13.1 If the member chooses to initiate a IRO review of the case, all case information is copied and forwarded to the IRO. Any further assistance is provided upon request.

13.2 Members are notified annually and with each appeal request of the availability of the right to independent review. Members with eligible internal appeals receive specific notification via mail detailing independent review rights and processes, including contact information for the IRO.

14 **Appeal Timeframes**

Timeframes for urgent (expedited) and non-urgent appeals are contained in the table below.

Appeal Type	Days from Receipt of Request to Decision and Written Notification
Non-urgent, pre-service and post-service	30 calendar
Expedited/urgent pre-service and concurrent*	72 hours

* Urgent appeals are resolved as expeditiously as the medical condition requires, and no later than the timeframes specified.

Appeal timeframes noted may be extended by up to five calendar days upon enrollee request or where Trusted demonstrates to the Department of Health the need for additional information and that the extension is in the enrollee's best interest. Where Trusted decides the decision timeframe should be extended, a grievance and appeals team member sends a letter to the enrollee informing them of the delay in decision and the reason for such delay. Trusted must notify the member of his/her right to file a grievance if he/she disagrees with a decision to extend the timeframe for the authorization decision. Trusted will issue and carry out its determination as expeditiously as the enrollee's health condition requires and no later than the date on which the extension expires.

For service authorization decisions not reached within the periods specified, a decision will be made on the date on which the extended period expires.

15 Continued Coverage for Concurrent Cases

For concurrent care UM cases, Trusted allows the appellant continued coverage under their medical benefit, pending the outcome of their appeal. This policy applies to cases where Trusted has approved an ongoing course of treatment and subsequently decides to deny, reduce or terminate the course of treatment. If the enrollee requests an extention of benefts, Trusted will continue or reinstate the enrollee's benefits pending resolution or until the enrollee withdraws the appeal.

15.1 In rare circumstances a concurrent review case may be reviewed as part of ongoing UM processes and the reviewing physician determines that the previously approved length of treatment or the number of services case should be changed.

15.2 In these cases Trusted will continue to cover and pay for the previously approved services.

15.3 At the end of the term of the approved services the case will be evaluated for additional services, per the procedures above.

16 Continuation of coverage

Trusted will continue to provide benefits to the enrollee while the appeal and the state fair hearing are pending.

1. Trusted will continue the enrollee's benefits pending resolution if the enrollee requests an extension of benefits. The request for the continuation of benefits must be made within ten (10) days of the NOA.
2. Trusted will continue the enrollee's benefits pending resolution if the appeal involves the termination, suspension, or reduction of a previously authorized course of treatment.
3. Trusted will continue the enrollee's benefits pending resolution if the services were ordered by an authorized provider.
4. Trusted will continue the enrollee's benefits pending resolution if the period covered by the original authorization has not expired.
5. Trusted will continue or reinstate the enrollee's benefits while the appeal is pending until the enrollee withdraws the appeal.
6. If Trusted continues or reinstates the enrollee's benefits while the appeal is pending, the following applies:
    a. The benefits must be continued until a State Fair Hearing Officer issues a hearing decision adverse to the enrollee.
    b. The benefits must be continued until the time period or service limit of a previously authorized service has been met.
    c. The benefits need not be continued past 10 days after Trusted mails notice of an adverse resolution unless the enrollee has requested continuation of benefits pending a state fair hearing decision.
7. Trusted will not recover payment for continuation of benefits during a pending appeal or District Fair Hearing.

17 **Effectuation of Appeals Decisions**

If Trusted reverses or modifies a decision through the appeals process or is notified of the District's Fair Hearing decision to reverse a decision, the service shall be authorized, provided, and paid for as promptly and as expeditiously as the member's health condition requires, but no later than two (2) working days after reversal or notification of reversal from the District. In the case of an expedited appeal, services must begin within 24 hours of the reversal.

TRUSTED Health Plan
THP

TRUSTED HEALTH PLAN	Effective Date: 12/01/2013	Policy #: CGA-2015-0001
Department- Medical Management	Reviewed Date: 07/02/2014	Expiration Date:
Policies and Procedures	Revised Date: 8/6/2015	Pages: 11

17.1 Notification from the appeals process or DC Fair Hearing office is forwarded to the UM department.

17.2 A clinician in the UM department processes the service approval/s electronically.

17.3 The clinician notifies the member/guardian/authorized representative and treating practitioner or facility of the approval via telephone and in writing. If a delegate which is responsible for approval/claims payment is involved (such as the PBM), the Trusted appeals coordinator or clinician notifies the responsible party at Trusted or at the delegate that service/payment has been authorized for the payment.

17.4 The service for the member ensues (if a prior authorization or concurrent review decision).

17.5 If a retrospective decision, the claim is paid electronically. If the service is a prior authorization or concurrent review decision, the claim is paid when received.

APPROVED BY:

Director of Utilization Management — Date: 8/6/2015

Chief Medical Officer — Date: 08/06/2015

TRUSTED Health Plan
THP

TRUSTED HEALTH PLAN	Effective Date: 07/01/2013	Policy #: ES-2013-0001
Department: Member Services	Reviewed Date:	Expiration Date:
Policies and Procedure: Enrollee Services	Revised Date: 10/22/2015	Page: 14

POLICY TITLE: ENROLLEE SERVICES

PURPOSE: Trusted understands that an effective, well run Enrollee Service Department is based on responsive and knowledgeable staff. Trusted's staff are trained in Trusted's policies, procedures, and the overall managed care program as well as customer service.

SCOPE: Enrollee Service Representatives (ESRs) serve as Enrollee advocates who provide guidance, assistance and education to members, potential members, caregivers, and providers. Trusted' s Enrollee Services Department assists members with their health care needs, answer questions, and effectively resolve issues raised by members. Trusted's Enrollee Service Representatives (ESR) assist enrollees identifying special health care needs.

DEFINITIONS: N/A

PROCEDURE:

1. **Confidentiality of Member Information –**

Enrollee Services Reps are trained on all of Trusted's confidentiality policies and they are aware of the need to keep all member information strictly confidential.

- To ensure that Trusted is protecting its member's health information:
  - Enrollees' identity is verified by the ESR at the beginning of each call by requesting and verifying the Enrollee Medicaid number, Social Security number (SSN), name, date of birth, address, and phone number.

- Unique enrollee ID numbers are used to identify members. The social security number will not be used on ID cards.
- If Trusted becomes aware of discrepancies with a member's demographic information, we will report these discrepancies to the District.
- As part of the enrollment package, the enrollee is given a written explanation of the enrollee's rights with respect to protected health information (PHI).
- On an annual basis, the Enrollee Services Manager will ensure that all Enrollee Services Representatives receive continued training and information on the importance of member confidentiality.
- All Enrollee Services Reps will sign confidentiality statements on an annual basis.

2. General Call Center Overview -

- All calls to the Enrollee Services line are distributed and monitored by an Automated Call Distribution (ACD) system, which automatically distributes calls to available staff, places callers in wait queues as needed, monitors wait time, and performs other tasks to ensure efficient call-handling operations.
- The system also provides real-time online information and historical reports on call center performance.
- The Enrollee Services Department will assist members and providers with benefit and eligibility questions, claims, reissuing of ID cards, PCP changes, demographic updates, complaints and grievances and appeals.
- The Enrollee Services Department ensures that all non-clinical services are provided in a culturally competent manner, including those with limited English proficiency or reading skills, and those with diverse cultural and ethnic backgrounds.

- As needed, translator/interpreter services are available for non-English speaking and Enrollees who are hearing impaired. These services will be available through our multilingual staff, the use of Language Line services, and using TTY/TDD telephone services. Hearing impaired enrollees are able to communicate with Enrollee Services via the TTY/TDD number. In addition Interpreter services are provided in Spanish, Portuguese, Vietnamese, French, Korean, Amharic, Tigrinya, Mandarin, Arabic and Cantonese (others as needed) through our contract with La Clinica Del Pueblo.

- When receiving a call, our ESR's will listen to the caller's reason for calling. The ESR will make a determination if the caller is calling regarding an inquiry or a complaint. An inquiry is a request for information or a general question. It is not an expression of dissatisfaction. A complaint is an oral expression of dissatisfaction in which case the complaint process may need to be initiated.
- Enrollee Services Reps log all calls in our information system. Each subsequent follow up activity will be added to the member's record in the system (e.g., follow-up calls, distribution of materials via the mail, email, personal visit, etc.). All requests for assistance are answered with 24 hours or 1 business day. If a non-member contacts our Enrollee Services line (i.e. Providers), our staff records the name, contact information, and any relevant identification numbers in our system based on the call type.
- The Team Lead will ensure all calls are returned with 24 hours by pulling a report of calls presented to the ACD call system that do not reach a live representative.
- The Enrollee Services Department operates Monday through Friday between the hours of 8:00am to 5:30pm. Trusted employs multilingual staff that are available during business hours to provide assistance to enrollees. The telephone number is

(202) 821-1100 or Toll Free (855) 326-4831. For hearing impaired, the TTY number is 711.

- Trusted offers a 24/7 Nurse Advice Line (NurseWise). NurseWise offers access to qualified clinicians at all times. They also offer after- hours Enrollee assistance for queries related to benefits and authorizations
- NurseWise sends a daily summary of afterhours calls to the Medical Management Department. Upon review, calls needing follow up will be assigned to the appropriate ESR or Medical Management staff member to return within the next business day. Follow up calls are logged as described within this policy.
- Trusted will report any systemic issues that prohibit callers' ability to reach our Enrollee Services Lines. We will report these occurrences to our DHCF Contracting Officer immediately and provide a written incident report within 24 hours.

3. Call Center Inquiries/Functions -

A. Eligibility Verification:

- Enrollees and providers contact Enrollee Services daily to verify eligibility. Eligibility verification includes providing:
  - Enrollee's effective date with Trusted
  - Enrollee's termination date with Trusted

- When an ESR receives a call regarding Enrollee eligibility, the ESR will check our system to verify the Enrollee's enrollment status.

- If the Enrollee is determined to be active with Trusted, the ESR can proceed in providing benefits information.

- If the Enrollee is not active in the trusted system, the ESR will not proceed with providing benefits information.

- If the Enrollee states he/she is eligible thus noting a discrepancy, the ESR will verify eligibility using the system operated by DCHF. If the Enrollee is eligible the ESR will have the system updated to reflect the effective date and provide the Enrollee with benefit information.

B. **PCP Change Requests or Termination:**

- Trusted's enrollees will have access to the Enrollee Services hotline to make requests for PCP changes or initial selection. Additionally, all Trusted personnel will be equipped to address these requests at each encounter.
- When a member calls to change their PCP, the Enrollee Services Rep makes a notation in our system which will specify the reason why the member is transferring to another provider (i.e. accessibility, member relocation, etc.).
- The Enrollee Services Representative will make the change in our system and inform the member of the effective date of the transfer.
- The Enrollee Services Representative will also advise the member that if they are currently under any type of treatment they will need to obtain new referrals from the new PCP.
- If a potential/actual quality of care/service issue is suspected/identified based on the reason for the transfer, the Enrollee Services Representative shall inform the Enrollee Services Manager.
- A new Enrollee ID card will be issued within 10 business days.

- Enrollee Services will report the number of requests to change PCP's, along with the reason for such requests to DCHF on a quarterly basis in accordance with Section C.16.
- From time to time Trusted Health Plans Primary Care Physicians (PCP) will have closed panels for new members. Trusted will not open closed panels unless the new member is a current patient of that provider panel.
  - When a member calls Enrollee Services requesting a PCP change to a closed PCP panel, the Enrollee Services Rep will ask the member if they are a current patient of that provider.
  - If the member advises that they are a current patient of that panel the Enrollee Services Rep will open the closed panel and assign that member to that PCP. The ESR will need to seek assistance from management in order to open the panel to assign the member the PCP.
  - If the member responds that they are not a current patient of that provider, the Enrollee Services Rep will advise that the panel is closed to new patients and that they are unable to make the change to that PCP at this time. The member will have to select a PCP with an open panel.
  - If a PCP desires to leave the plan network and a member is currently receiving care from a Participating Provider, the Enrollee Services Department will notify the Member within 30 calendar days or less of the notice of termination.
  - If a PCP leaves the program, Trusted will generate a list of members on the Participating Provider's panel.
  - Trusted will then send a notice to all Members on the Participating Provider's panel offering them the option of choosing another PCP.
  - The provider directory will be updated to reflect the network change.

C. Warm Transfers:

- There are cases where Trusted's ESR's will not be able to answer questions asked by members or providers. In these cases, a warm transfer may be required.
- If the caller is a provider and Enrollee Services cannot meet their needs, a warm transfer will occur promptly.
- Warm transfers will be performed internally as well as to external entities.
- When a call is received by an Enrollee Services Representative, and the ESR has determined that he/she will need to perform a warm transfer, the process is as follows:
  - Once the ESR identifies the questions/concerns of the caller, what department and/or agency will be able to help, the caller will be informed that he/she will be on hold for a few minutes while the call is directed to the appropriate department.
  - Once the designated line is answered, a brief explanation will be provided to the representative or the department that they are receiving a call from the Enrollee Services Line and he/she will be provided the reason for the call.
  - An explanation will be provided that a warm transfer is occurring and the enrollee will be given the name of the person who will be assisting them further.
  - Warm transfers occur when an ESR keeps the caller on the line while they contact the appropriate entity, explain the situation and confirm that the caller and the entity are connected before hanging up.

D. Billing Issues:

- Members who receive a bill or statement requesting payment for services rendered from a participating or non-participating provider, are instructed to forward a copy of the bill or the statement to Trusted' s billing
Department.
- When an ESR receives a call from a member regarding a bill, the call is logged and the member is instructed to forward a copy of the bill along with the following information: their n a

m e, ID n u m b e r, and Medicaid ID number. This information s h o u l d be mailed to the attention of the Enrollee Services Manager at the 1100 New Jersey Avenue location.

- Once the Enrollee Services Manager receives the bill from the member, he/she is responsible for researching the member's situation.
- As a result of the Enrollee Services Manager's research, one of the following determinations are made:
  - No claim on file; the member is to follow up with the provider in question.
  - Received a routine accounting statement; the member is instructed to disregard.
  - The member was appropriately billed; monies s due are out of pocket expenses for the member.

E. Pharmacy Benefit Information:

- Members calling for Pharmacy Benefit Information can receive help via phone within one attempt.
- The following services can be handled by the ESR's using the Trusted website.
  - Initiation of the Drug Exception Process – If a member calls to start a request for a non-formulary medication, the Trusted ESR can fill out the form at the end of page http://www.trustedhp.com/medicaid-pharmacy-prescriptions.html - to begin the exceptions process
  - Find the location of an in-network pharmacy– If a member calls and would like to find an in-network pharmacy, the Trusted ESR utilizes the Pharmacy Locator at http://www.trustedhp.com/pharmacy-locator.php to access the pharmacies within the members preferred geographic area, and zip code.
  - Conduct a Proximity Search for a Provider – If a member calls to find a specific type of provider within a certain area, the Trusted ESR can access the locator at

http://www.trustedhp.com/provider-locator.php and assist the member in picking the in-network provider within their geographic area.

- Members calling for the following Pharmacy Benefit Information can receive help via phone by a warm transfer to the Meridian Pharmacy Benefit Manager. ESR's transfer requests for:
  - Potential Drug/Drug Interactions.
  - Drugs Common Side Effects.
  - Member/Pharmacy dispute of a prescription request or override due to invalid dosage.
  - Understanding of the generic-based formulary and questions members have about generic medications vs. brand name as delineated in the health plan's Drug Formulary.
- ESR's are aware of benefits and know that members have no financial responsibility for medications.

F. Benefits, Referrals and Authorizations:

- Members often call with questions on benefit information and how and when to obtain referrals and authorizations. Trusted ESR's are trained to handle questions related to benefits and Medical Management queries.
- The ESR will assist callers with a verification of an auth number or if an auth is pending.
- If the called is requesting the status of a pending auth or expected Time to complete, the ESR will complete a warm transfer to Medical Management
- If a request is made after hours through the Nurseline procedure described above, the ESR will return the call to complete the request within one business day.

4. Email/Web-Contact System Overview

- Though most enrollee contact is conducted via the Call Center, Trusted has a "Contact Us" link on the website available for member email communication.
- When members (or non-members) utilize this capability, the message is sent directly to the Enrollee Services Manager.
- The ESR Manager then assigns one ESR to review the request and respond.
- The ESR will respond to the email within one business day and notes will be placed into the system outlining actions taken and follow up activities.
- If an ESR has any questions, or the mailing would contain PHI, the ESR follows up by phone.

5. Call Monitoring –

- At Trusted, Enrollee Services Representatives are monitored on a regular basis to ensure that program information being provided to the Enrollees is delivered in an accurate and comprehensive manner.
- Trusted's Enrollee Services Manager monitors no less than four (4) calls per ESR each month and provides prompt, constructive feedback and coaching. He/she also utilizes the call monitoring process to facilitate continuous quality improvement and to develop and provide ongoing training.
- Trusted analysis data against each standards and/or goal, identifies deficiencies and takes action to improve deficiencies as needed. Each ESR must continually meet a monthly average score of 95%. In the event that this standard is not met, increased coaching and corrective action plans will be implemented.
- Enrollee Services has adopted telephone performance standards to ensure that Enrollees are receiving prompt service when they call and calls are answered within the industry standard of 20 seconds to a live representative with an abandonment rate of less than 5%.

6. Email Monitoring –

- At Trusted, ESR Email responses are monitored annually to ensure that program information being provided to Enrollees is delivered in an accurate, timely and comprehensive manner.
- Annually, the Enrollee Services Manager requests a report of Email (or Contact Us) queries from the Web Host.
- A random sample of ## inquiries are chosen from the sample
- Emails and responses are then evaluated for:
    - Quality of response
    - Timeliness of response (within one business day)
- Trusted analysis data against each standards and/or goal, identifies deficiencies and takes action to improve deficiencies as needed. Email response accuracy and timeliness must meet the 95% accuracy goal. In the event that this standard is not met, increased coaching and corrective action plans will be implemented.

7. New Enrollee Orientation –

Trusted will offer each new Enrollee, including non-English speaking Enrollees, an opportunity to participate in a culturally appropriate New Enrollee Orientation. The sessions will be conducted within 60 days of the Enrollee's date of enrollment and will be offered in group or individual sessions in accordance with the following procedure:

- On a monthly basis, Trusted will host New Enrollee Group sessions conducted in various languages to ensure that non-English speaking Enrollees have access to our staff.

- We will conduct group meetings at convenient locations throughout communities within the District of Columbia. We will work and partner with organizations who work with non-English speaking populations to host group sessions.
- We will also conduct group interviews at our Facility or at a location convenient for the Enrollee. If the group interviews are to be conducted at a site other than the Trusted facility we will obtain written approval to conduct the group interview at the other locations.
- Trusted will offer Enrollees the opportunity for individual meetings. The individual session will give the Enrollee an opportunity to speak with our staff which will be able to communicate with the Enrollee in their primary language, or will facilitate the meeting with an interpreter.
- All meetings will be monitored for attendance, duration, and content. If regular attendance consistently exceeds 25 Enrollees per meeting, we will schedule more to increase service availability.
- The New Enrollee Orientation sessions will cover, at a minimum
    - Explanation of DCHFP and Alliance services, including: EPSDT, primary and preventive healthcare, and specialty care services
    - Transportation services (including the scheduling process)
    - Family-centered care and treatment planning
    - How to access care and services (including mental health, alcohol, and drug abuse services)
    - The Office of the Ombudsman
    - Enrollee's rights
    - Third party payment sources
    - Emergency services
    - Language access services and scheduling for services
    - Primary Care Providers
    - Rights under IDEA
    - Enrollee Services Toll-Free Line

- Grievance and Appeal

8. Accountability –

- Call center statistics will be tracked via Trusted's performance dashboard and reported to the Quality Executive Committee quarterly.
- Data will be analyzed by Quality department personnel and where trends are noted corrective actions will be recommended.

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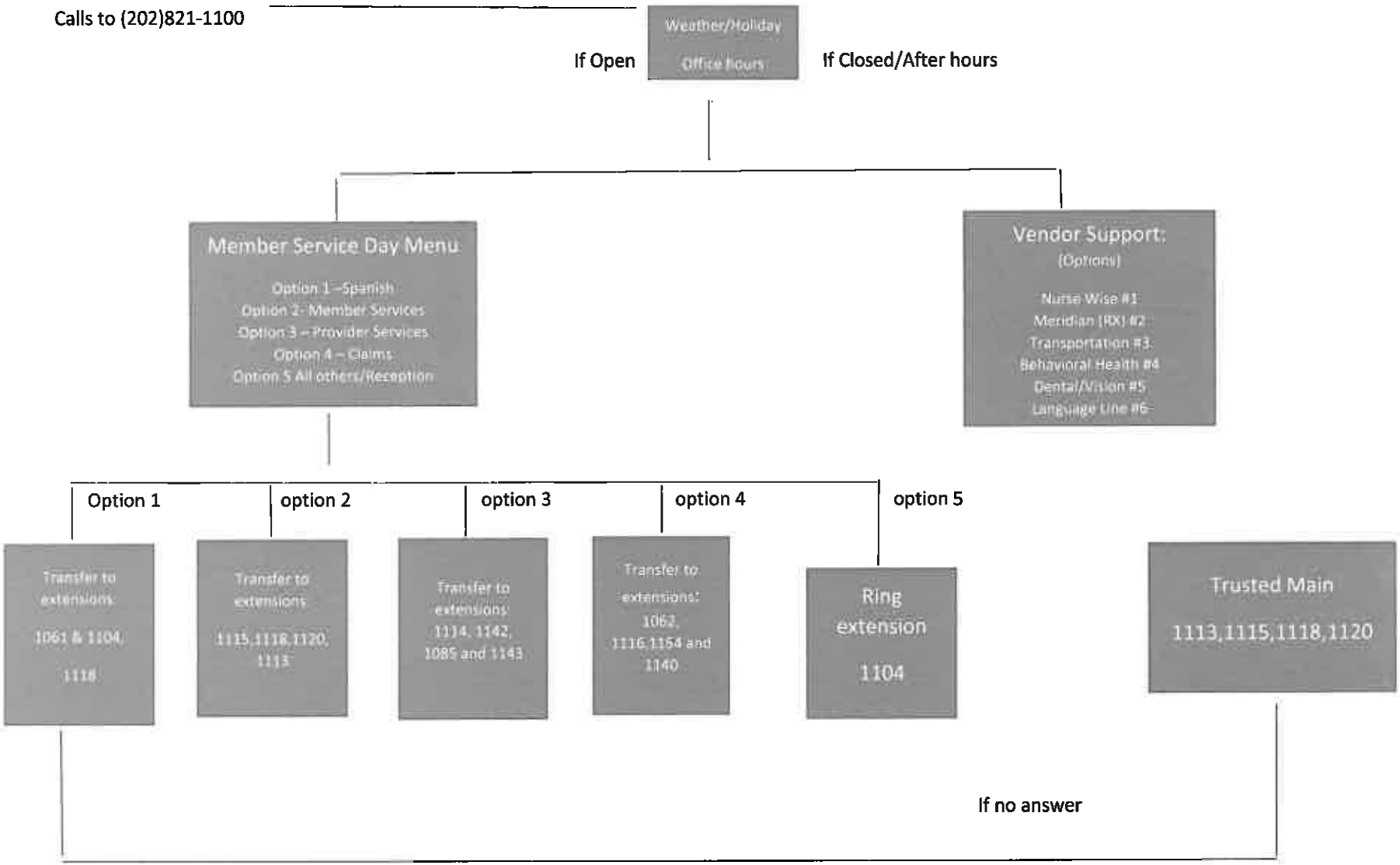
APPROVED BY:

Enrollment Services Manager — Date: 10/22/15

Director of Operations — Date: 10/22/15

Compliance Officer — Date: 10/22/15

ACD Call Flow Chart



TRUSTED HEALTH PLAN	Effective Date:	Policy #:
Department-	Reviewed Date:	Expiration Date:
Policies and Procedures	Revised Date:	Pages

POLICY TITLE: Advance Directives

PURPOSE: To inform Trusted Staff on Patient Rights and Contract Requirements surrounding Advance Directives

SCOPE: The policy is applicable to all Trusted enrollees, staff and providers.

DEFINITIONS:

Advance Directives (Living Will): A written instruction, such as a living will or durable power of attorney for health care, recognized under District of Columbia law, relating to the provision of health care when the individual is incapacitated.

POLICY AND PROCEDURE:
The following policies and procedures ensure that staff and Network Providers comply with the requirements regarding Advance Directives. These policies and procedures shall apply to all adult individuals receiving medical care by or through Trusted.

1.1 Advance Directives[1]

1) Trusted will provide written notification to Enrollees of their right:
    a) To make decisions concerning medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate, at the individual's option, advance directives
    b) To include a statement of any limitation regarding the implementation of Advance Directives as a matter of conscience

[1] http://www.ecfr.gov/cgi-bin/text-idx?SID=0bc84094caaf37e5c205415ae39b91ae&node=42:5.0.1.1.7.8.14.2&rgn=div8

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2) Trusted will document in a prominent part of the individual's current record whether or not the individual has executed an advance directive;
    a) If an adult individual is incapacitated at the time of admission or at the start of care and is unable to receive information, Trusted may give advance directive information to the individual's family or surrogate in the same manner that it issues other materials about policies and procedures to the family of the incapacitated individual or to a surrogate or other concerned persons in accordance with District of Columbia law. Trusted is not relieved of its obligation to provide this information to the individual once he or she is no longer incapacitated or unable to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time.
3) Trusted will not condition the provision of care or otherwise discriminate against an individual based on whether or not the individual has executed an advance directive;
4) Trusted will provide for education of staff concerning its policies and procedures on advance directives, situations in which Advance Directives may be of benefit to Enrollees, and their responsibility to educate Enrollees about this tool and assist them to make use of it.
5) Trusted will provide for education regarding issues concerning advance directives. The material will define what constitutes an advance directive, emphasizing that an advance directive is designed to enhance an incapacitated individual's control over medical treatment, and describe applicable District of Columbia law concerning advance directives.
6) Trusted's Member services and Outreach center staff will document all education efforts, and supply the legal Advance Directives form. (see Appendix A).

    a) Members should be encouraged to take the document to their PCP or seek assistance at The Neighborhood Legal Services Program (http://www.nlsp.org/)

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7) Trusted will inform enrollees that appeals concerning noncompliance with the Advance Directive requirements shall be filed with the Health Regulation Administration, Department of Health.

1.2 Notification of Updates to Laws regarding Advance Directives

Trusted will ensure compliance with requirements of State law regarding advance directives.
Trusted will notify adult enrollees of any changes in State law regarding advance directives as soon as possible, but no later than ninety days after the effective date of the change.

Appendix A


advance_directive_for m.pdf

Policy: Standard Operating Procedure Disenrollment Process
Policy created: July 14, 2013 (revised 4/9/2014)

Purpose:

Identify referrals that present the probability of Disability based on medical history or new onset diagnosis. The objective is to assist High Risk members with the enrollment and application process for Social Security Administration.

Procedure:

Disenrollment Coordinator participates in Medical Management Rounds to identify members with extended LOS(s) and high Risk admits. Referrals for Disenrollment are based on Medical condition, high pharmaceutical costs and repeat admissions. Referrals are submitted electronically and uploaded to Master file on Shared Drive by:

- Case Management(Rounds)
- Pharmacy
- Utilization Management
- EI(Early Intervention)
- Outreach Coordinators

Referral requirements:

- Name
- Address
- Phone number
- Member ID
- Diagnosis/reason for referral
- Requestor

Disenrollment Coordinator acknowledge receipt of referral

- referrals are updated on Shared drive by date and activity
- action and next action dates are included for timely follow up
- case(s) reviewed daily
- documentation required for adequate and timely follow up

High Risk assessment conducted to determine level of probability by:

- patient/guardian contact for profile of medical condition
- disability diagnosis codes and risk levels

If High Risk assessment does not meet Disability criteria:

- case is listed as low probability
- duration of medical condition reviewed
- patient participation required to continue with FFS
  (If medication cost criteria exist)

If High Risk assessment meets Disability criteria:

- Disability screening form/SSA application completed (on line via phone)
- Medical Examination Report faxed to Providers office
- If Physician request office visit to complete MER/ Rep to schedule appointment
- If no appointment required /Rep to secure completed MER from provider
- Submit completed MER to SSA

Disability Request form used to schedule SSA appointment

- Signed 3288 secured to represent member(on line)
- Signed 827 secured to obtain case information(on line)
- SSA Forms sent to DDU for access/authorization
- Member/guarantor notified of SSA appointment
- Medical Records requested to support SSA application

Disenrollment Coordinator to utilized authorization(s) to follow disenrollment process and obtain status of SSA medical review for final determination.

Once SSA determination/disenrollment notification received rep must:

- Notify of Disenrollment date
  - Enrollment Broker
  - Claims Department
  - Requestor
- Remove case from "Active" list, add to "Closed" file

PCP Selection

POLICY

Trusted will allow members the freedom of choice to make a PCP and PDP selection. In an effort to help a member best meet their healthcare needs, Trusted will provide assistance to members in selecting a PCP who meets unique medical, physiological, cultural or geographical needs. Information on the role of the PCP is included in our enrollment packages and enrollment materials.

In educating the Member on the program, we stress the importance and benefits of selecting a PCP. We express that the PCP is each Member's central point of contact for many services, including coordinating all covered care under Trusted, issuing authorizations and referrals to specialists, and authorizing all hospital services except covered emergency care.

Trusted will ensure that all new members select or are assigned to a PCP within ten days of enrollment. We will ensure all members receive information about where they can receive care during the time period between enrollment and PCP selection and assignment.

PROCEDURE:

- **Trusted** will ensure all members have selected or are assigned a PCP within ten days of his/her enrollment. Prior to the ten day deadline, Trusted will ensure all Members receive information about how and where they can receive care during the time period between enrollment and PCP selection/assignment.
- Medicaid Members will have the choice in selecting a PCP and to change providers as requested.
- Trusted will allow Female members to designate as their PCP a participating physician or advanced practice registered nurse who specializes in obstetrics and gynecology
- Trusted will allow a Member with a chronic, disabling, or life threatening condition the opportunity to choose an appropriate participating specialist as his or her PCP.
- For continuity of care Trusted allows a Member to remain with his or her existing PCP, if the PCP is a member of **Trusted**'s primary care network.
- Members who do not yet have a PCP assignment will be notified where they can receive services until one is selected

If a Member does not select a PCP within 10 days of enrollment, **Trusted** will automatically select one for the member using the process below:

- Assign members to a provider who has previously provided services to the member.
- Assign all children with a single family to the same PCP.
- Assign a child with a special health care need to a health professional with the training and experience to appropriately treat and manage the condition.
- In the absence of previous service by a PCP within the network, Trusted will designate a PCP who is geographically accessible to the member.
- Once **Trusted** assigns a PCP, we will notify the member within ten days of the assignment.

PCP Changes

Trusted members will have access to the Member Services hotline to make requests for PCP changes or initial selection. Additionally, all Trusted personnel will be equipped to address these requests at each encounter. Members will receive an updated identification card within ten days of the change.

POLICY:

Trusted members may request a Primary Care Physician (PCP) change and the change will be effective immediately.

PROCEDURE:

- When a member calls to change their PCP, the Member Services Rep makes a notation in our system which will specify the reason why the member is transferring to another provider (i.e. accessibility, member relocation, etc.)
- The Member Services Representative will make the change in our system and inform the member of the effective date of the transfer.
- The Member Services Representative will also advise the member that if they are currently under any type of treatment they will need to obtain new referrals from the new PCP.
- If a potential/actual quality of care/service issue is suspected/identified based on the reason for the transfer, the Member Services Representative shall inform the Member Services Supervisor.

- A new Member ID card will be issued within 10 business days.

- Member Services will report the number of requests to change PCP's, along with the reason for such requests to the governing body on a quarterly.

DRAFT

<Date>

Dear _____:

This letter is to inform you that as of _____ your Primary Care Physician (PCP) is

Doctor's Name:	
Group Name:	
Specialty:	
Address:	
Telephone Number:	
Hours of Operation:	

If you would like to choose another Primary Care Physician (PCP) other than _____, please call the Member Services Department at 202-821-1100 or toll free 1-855-326-4831.

A Member Services Representative will:

1. Take your PCP change over the phone or help you find another PCP in the Trusted Health Plan provider network.
2. Help make arrangements for transferring your Private Health Information (PHI) and medical records.

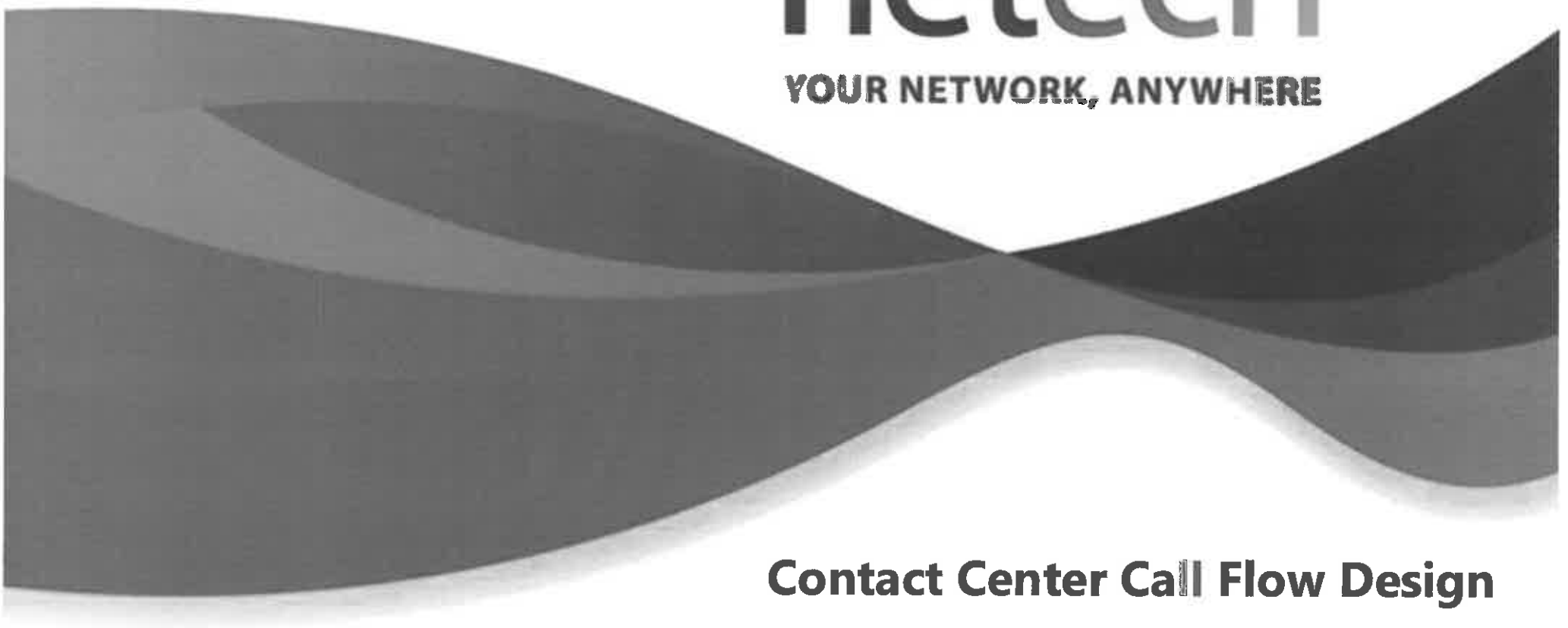
Enclosed is your new Member ID card with _____ as your PCP. If you would like to select another PCP or if you have any questions, please call the Member Services Department at 202-821-1100 or toll free 1-855-326-4831.

Thank you for your continued membership.

Sincerely,

Trusted Health Plan

Enclosure: Member ID Card



Contact Center Call Flow Design

Caidan Management Company - MRx

Last Updated: Thursday, October 22, 2015

DOCUMENT REVISION HISTORY

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YOUR NETWORK, ANYWHERE

Version	Date	Summary of Changes	Author
1.0	6/10/2015	Initial version of document	Justin Kendall
1.1	7/27/2015	• Changed references to MHP.PS.Contracts to CMC.MRx.NetworkMgmt • Added Weather, Unforeseen, and Technical Difficulty administrative checks per Clarence McMurray for a beginning to a DR plan in the future. • Added an agents logged in check to check to see if agents are logged into the queue, to catch the event of no agents being logged in when a caller is in the queue.	Justin Kendall
1.2	8/11/2015	• Corrected local numbers after additional discovery and added placeholders for temporary migration DIDs • Changed all references of Medicaid to Caid and Medicare to Mcare • Changed all references to MI Health Link to Meridian Complete – Michigan • Changed all references to IL MMAI to Meridian Complete - Illinois • Changed all references of Riverspring to Rspring due to character length limits • Updated the SAU sections of the main number call flows to forward to voicemail instead of ending the call. • Re-worked presentation of the queue logic to better illustrate the process	Justin Kendall
1.3	8/17/2015	• Corrected call type names on all pages • Changed all references of Bridgestone to Bridge due to character length limits • Removed Westlandford per Emily • Updated voicemail references on all call flows to have just 3 – Medicaid, Medicare, and Commercial • Added additional iteration of queue music to put the time to cell phone forward more in line with current system • Added detail to values for SAU checks instead of yes/no • Added prompt filenames	Justin Kendall
1.4	8/18/2015	• Corrected media file path names • Added the temporary migration numbers to be used for the two stages of cutover, along with mapped existing queue numbers for MS queues that will not be cut over by 10/19. • Reconciled names of all queues that go to Member Services – All are now verified correct.	Justin Kendall
1.5	8/20/2015	• Added additional logic to the capture of the called number on all call flows. All calls coming from 313 area code numbers will be hard-coded to match one of the toll-free numbers to reduce confusion for the agents. • Added information regarding MRx Care Coordination and MRx Credentialing teams	Justin Kendall

Continues on next page.

DOCUMENT REVISION HISTORY

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Version	Date	Summary of Changes	Author
1.6	8/25/2015	◦ Updated wrap up time for Medicare team ◦ Added team-based not ready code "Documentation" ◦ Removed forward of calls to cell phones after 2 minutes and added standard queue loop logic ◦ Removed the initial temporary migration numbers from the non-commercial call flows due to changes in migration plan. ◦ Changed all of the "New PA" options that played a Medicaid message to forward to MS if the caller stays on the line instead of ending the call. ◦ Added "Xfer to MS" message after the Medicaid portal message in all of the "New PA" options that forward to MS. • Added capture of calling number to a call variable for display to the agent at the top of the queue logic page.	Justin Kendall
1.7	8/27/2015	◦ Added Pharmacist and CC queue call flows ◦ Adjusted global not ready codes ◦ Changed queue logic to use Precision Queues instead of Skill Groups	Justin Kendall
1.8	9/8/2015	• Adjusted Open/Closed check on commercial-employee call flow • Added agents logged in check on commercial-employee call flow • Adjusted call type name of "CMC.MRx.Comm.Open.Weekend"on the commercial-employee call flow • Adjusted call type name of "CMC.MRx.VM.Comm" to "CMC.MRx.VM.Comm.Emp" on the commercial-employee call flow	Justin Kendall
1.9	9/8/2015	◦ Adjusted Open/Closed check on commercial-employee call flow and associated logic to go to menu structure. • Simplified the "Open" call types for the commercial-employee call flow, removing extraneous ones.	Justin Kendall
1.10	9/8/2015	• Broke out queue logic for Credentialing and Appeals	Justin Kendall
1.11	9/9/2015	• Added hours for appeals • Changed all references to "Credentialing" to "NetworkMgmt" • Updated NetworkMgmt queue logic • Updated NetworkMgmt business hours	Justin Kendall
1.12	9/10/2015	• Updated all call type names and queue names to accurately reflect line of business for each ◦ Removed Place in Queue message from queue logics per project management.	Justin Kendall
1.13	9/16/2015	◦ Updated all references of the "Choice" queue to reflect that it is a commercial queue and not a medicaid queue.	Justin Kendall

DOCUMENT REVISION HISTORY

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Version	Date	Summary of Changes	Author
1.14	10/5/2015	• Updated all call flows that have a PA Menu under the provider menu. These options were pointing to Member Services, however should have been pointing to MRx. • Updated PDP to conform to naming conventions	Justin Kendall
1.15	10/7/2015	• Fixed line of business designation for Riverspring. It had incorrectly been identified as a commercial queue rather than a medicare queue.	Justin Kendall

CONVENTIONS

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Start/End
Signals the beginning or the end of the call flow

Connector
Represents the flow from one icon to another

Decision
Internal check of the status of a variable within the system to determine routing. Call flow proceeds to various exit states according to status

SAU Controlled Check
Decision controlled by an admin utility to change path of calls during exceptions to normal business operation. "Default" value indicates the normal path.

Set Variable

Set Variable
Administrative global data used for audio decisions and routing decisions

CTI Data

CTI Data
Call-specific data to be used in routing and display to agents

Call Type

Call Type
Classification of call. Used for reporting of call statistics

Menu Name
Prompt#
1
2
*
#

Menu
Prompt with options for user input. Call proceeds to the right from selected option.

Prompt Name

Prompt
Message with no options

Queue Music | Duration

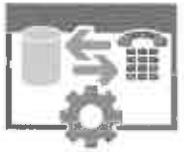
Queue Music
Audio played to caller while waiting for an agent

Off-Page Reference
Points to another point in the call flow, on a different page

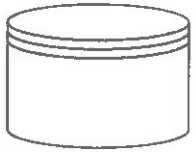
On-Page Reference
Points to another point in the call flow, on the same page



Agent
Represents call center agents



IVR
Represents an IVR application



Database Lookup
Represents data for call routing retrieved from external database

Transfer To
??????
(????????)

Transfer
Send call to specified phone number

Queue
??????
(????????)

Queue
Send call to queue logic for specified queue

Transfer To Script
??????

Transfer To Script
Send call to a specific point in another call flow script

	Item	Values	Exceptions
1	Business Hours	**MRx – 24x7x365** Pharmacists - 8am to 6pm Monday - Friday Care Coordination – 8am to 6pm Monday – Friday Appeals – 8am to 6pm Monday – Friday Network Management – 8am to 4:30pm Monday - Friday	
2	Holidays	Main MRx - No Holidays, Pharm/CC/Appeals/Network Management – Meridian Holidays	
3	Interdigit Timeout	5 seconds	
4	No Input Timeout	10 seconds	
5	Max Retries	1 Try + 2 Retries	
6	Max Retries Reached Action	Send caller to the main MRx queue for that call flow. For instance, in the MRx.IL.Medicaid call flow, the caller should be sent to the MRx.IL.Medicaid queue. For the MRx.MI.Medicaid call flow, the caller should be sent to the MRx.MI.Medicaid queue. So on and so forth for each of the MRx flows.	
7	Service Level Goal	98% in 30 seconds	

NOT READY CODES

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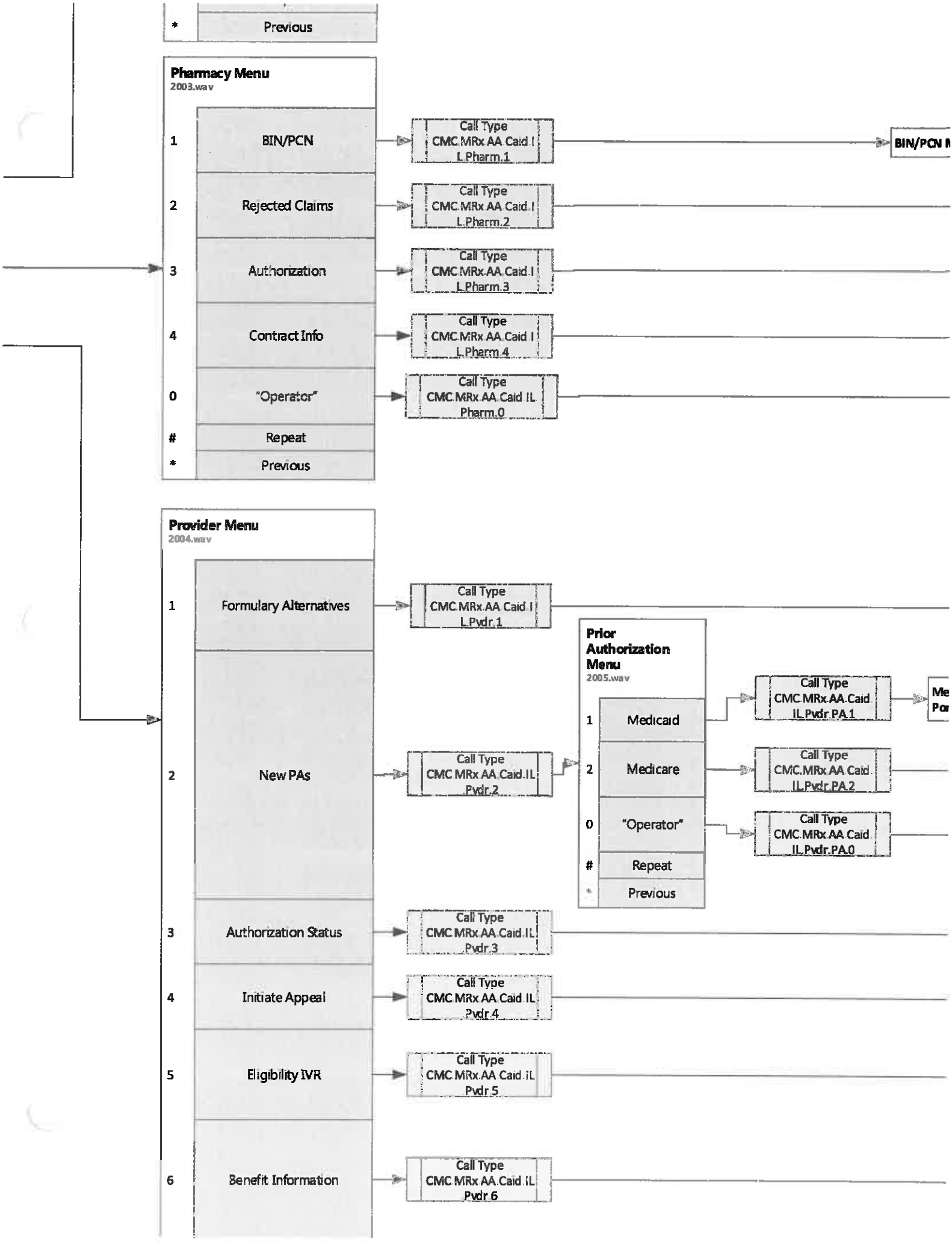
The following global Not Ready codes will exist for everyone:

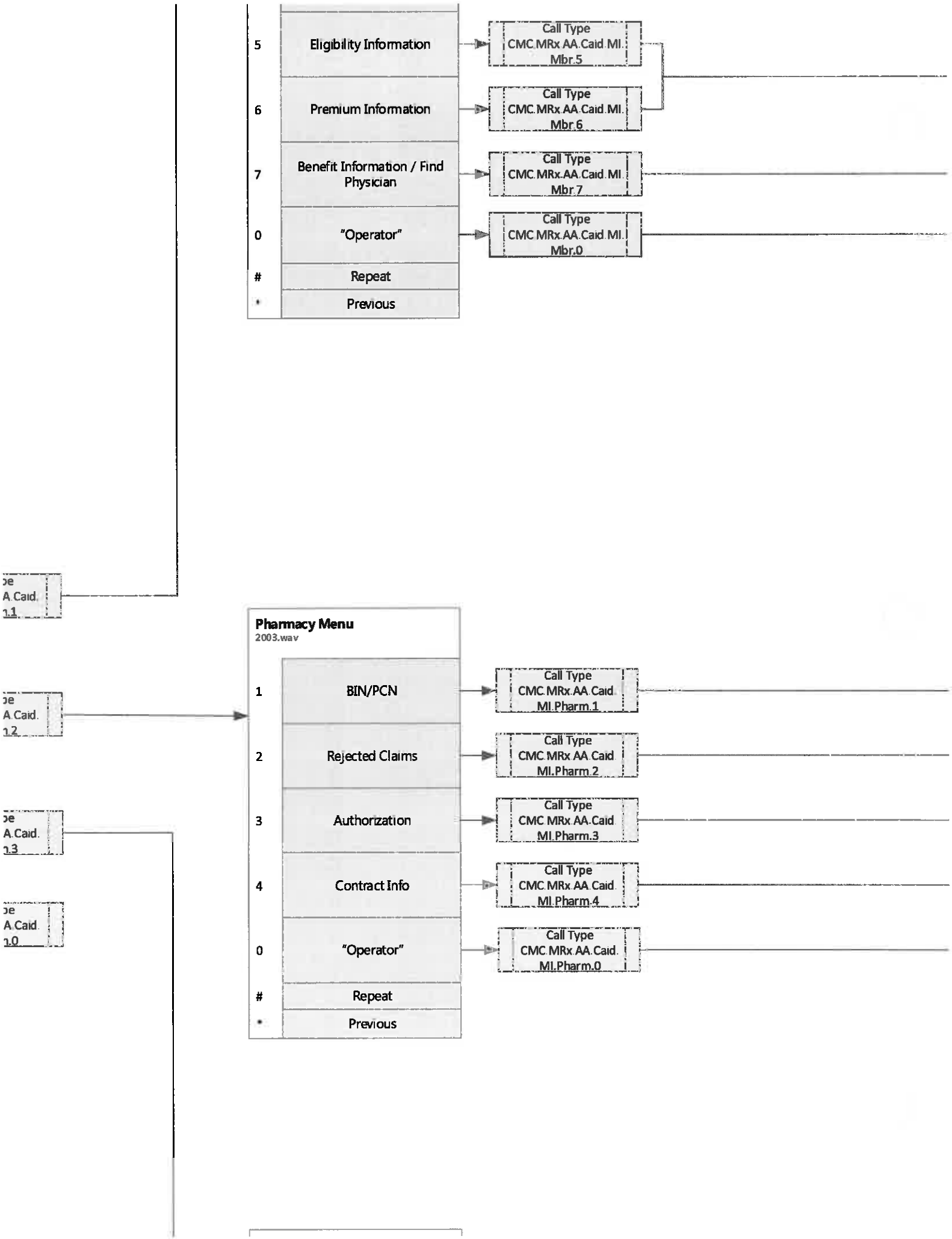
Reason Label	Reason Code
Break	1000
Lunch	1001
Meeting	1002
Consult	1003
Tech Support	1004
Training	1005
End of Shift	1006
Documentation	1007

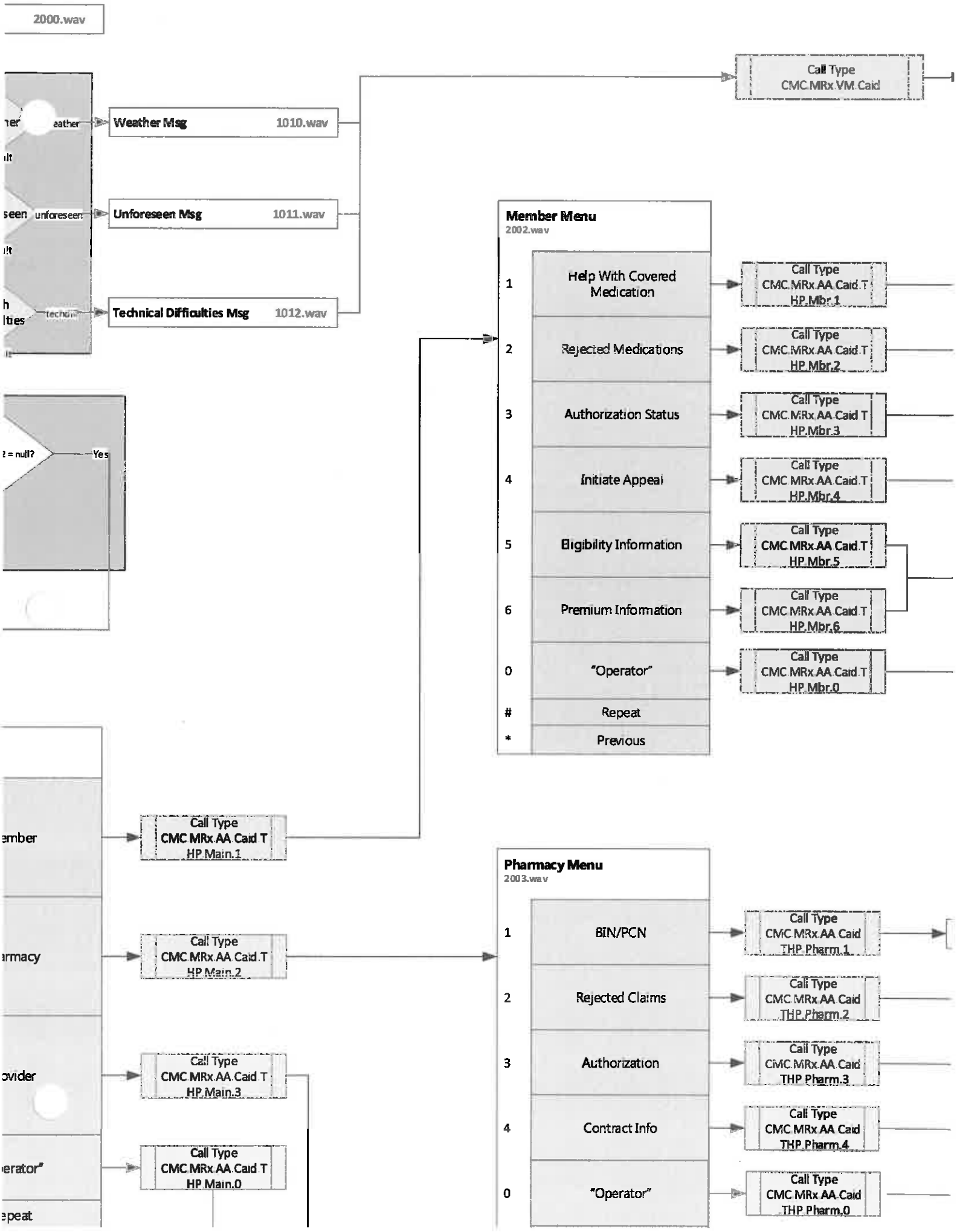
TEAM DETAILS

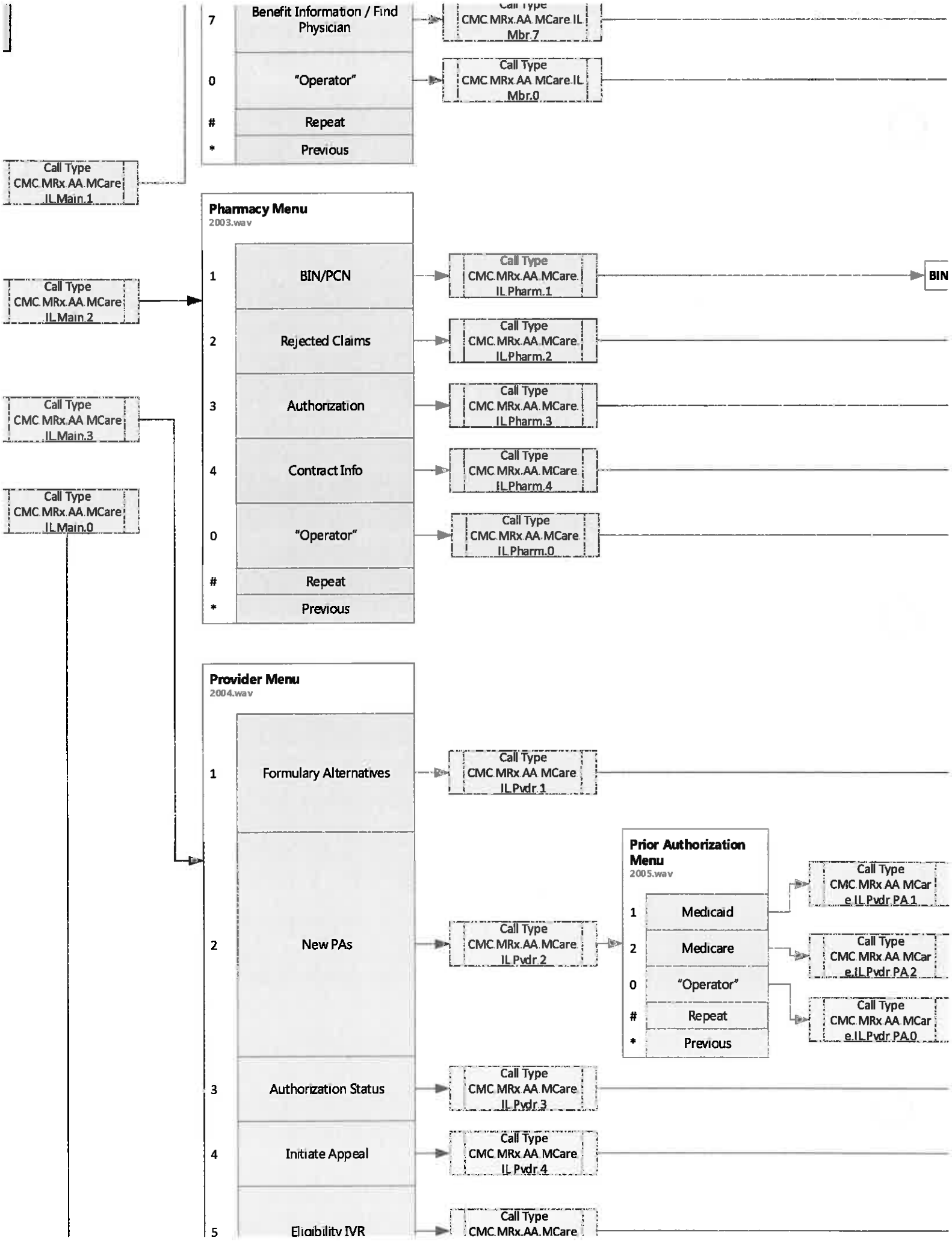
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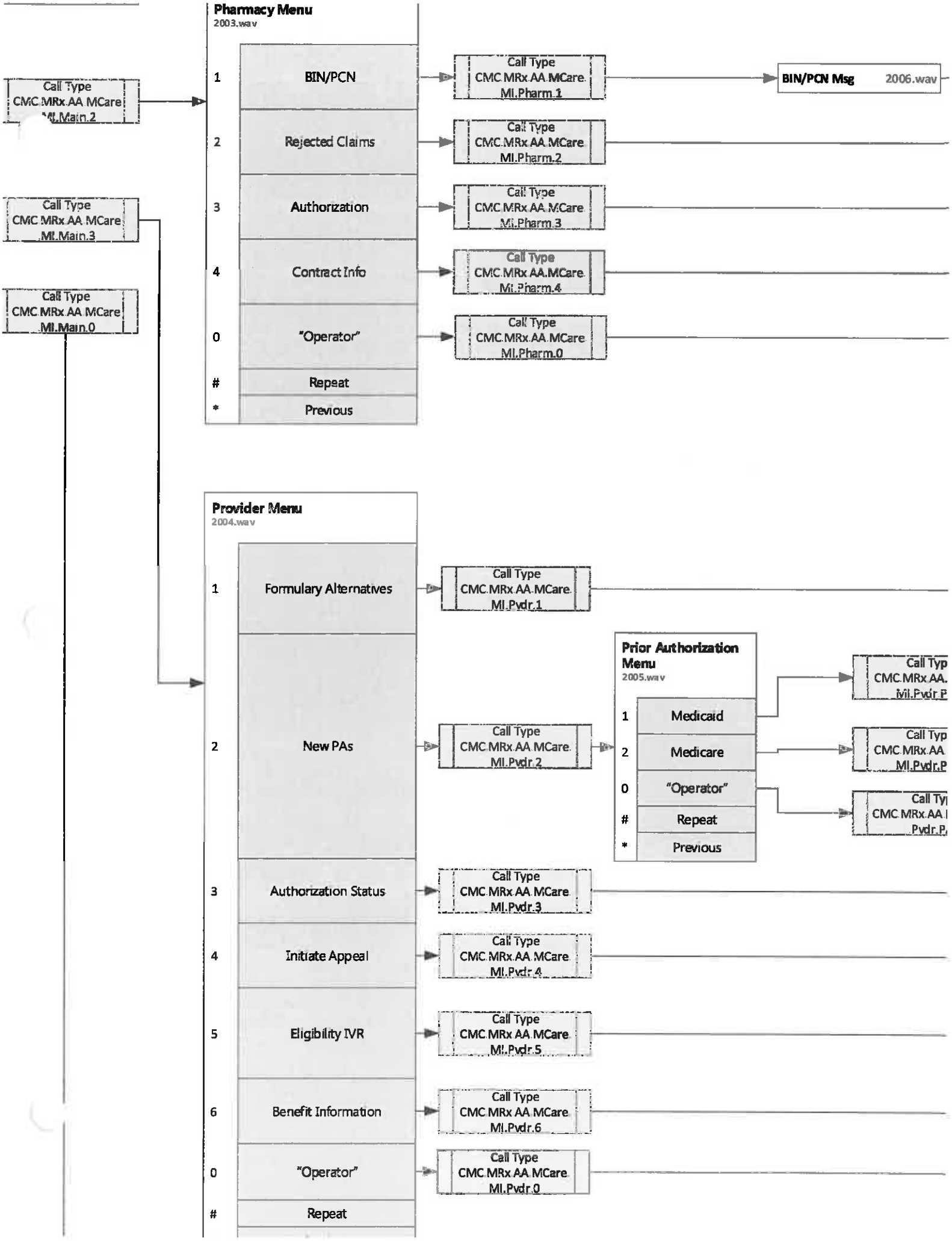
Team	Role	# of users	Wrap Up Settings
			Duration
CMC.MRx.Commercial	Agent		15
	Supervisor		15
CMC.MRx.Medicaid	Agent		15
	Supervisor		15
CMC.MRx.Medicare	Agent		15
	Supervisor		15
CMC.MRx.NetworkMgmt	Agent		0
	Supervisor		0
CMC.MRx.Pharmacists	Agent		0
	Supervisor		0
CMC.MRx.CC	Agent		0
	Supervisor		0

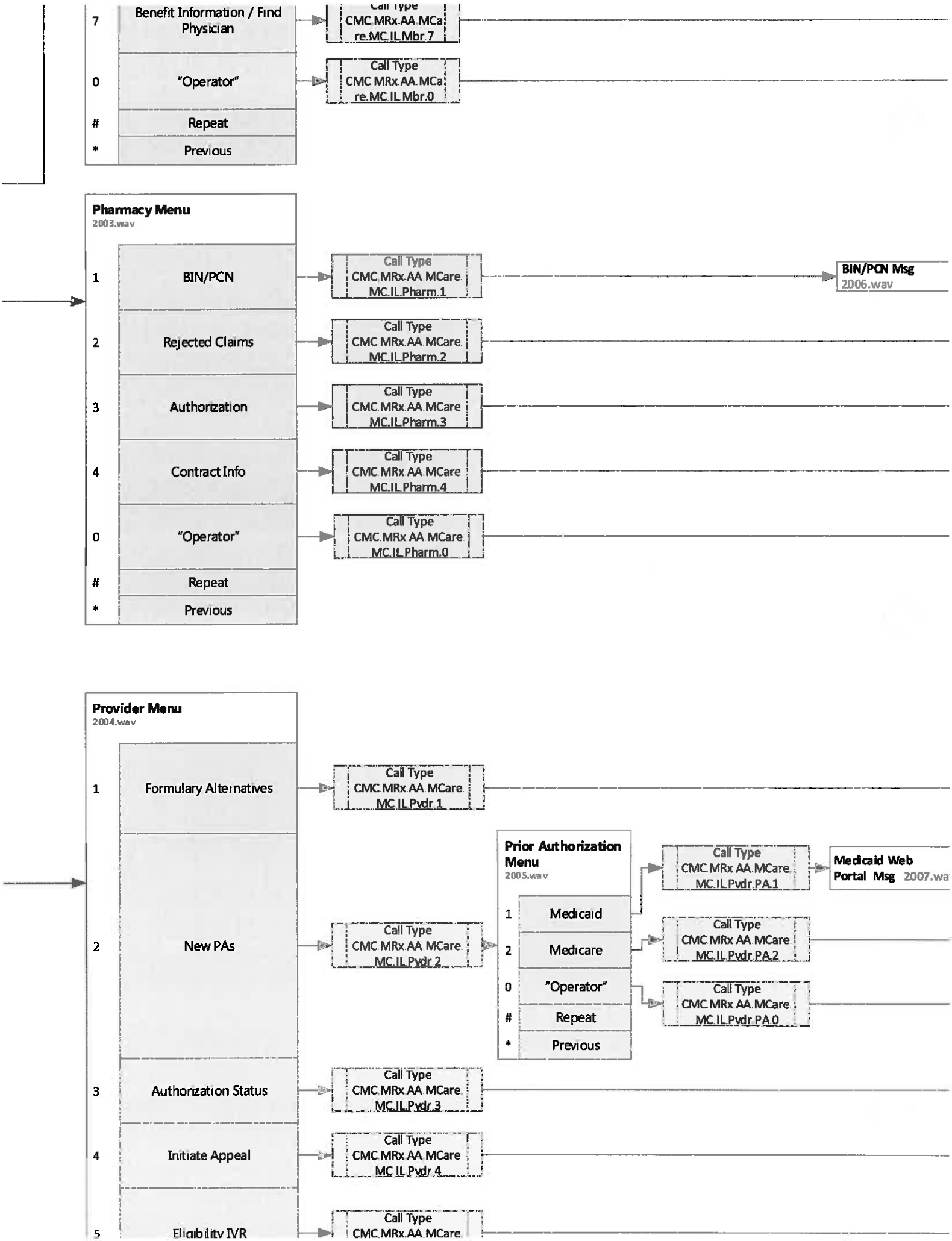

*
Previous
Pharmacy Menu
2003.wav
1
BIN/PCN
2
Rejected Claims
3
Authorization
4
Contract Info
0
"Operator"
#
Repeat
*
Previous
Call Type CMC.MRx.AA.Caid.IL.Pharm.1
Call Type CMC.MRx.AA.Caid.IL.Pharm.2
Call Type CMC.MRx.AA.Caid.IL.Pharm.3
Call Type CMC.MRx.AA.Caid.IL.Pharm.4
Call Type CMC.MRx.AA.Caid.IL.Pharm.0
BIN/PCN M
Provider Menu
2004.wav
1
Formulary Alternatives
2
New PAs
3
Authorization Status
4
Initiate Appeal
5
Eligibility IVR
6
Benefit Information
Call Type CMC.MRx.AA.Caid.IL.Pvdr.1
Call Type CMC.MRx.AA.Caid.IL.Pvdr.2
Call Type CMC.MRx.AA.Caid.IL.Pvdr.3
Call Type CMC.MRx.AA.Caid.IL.Pvdr.4
Call Type CMC.MRx.AA.Caid.IL.Pvdr.5
Call Type CMC.MRx.AA.Caid.IL.Pvdr.6
Prior Authorization Menu
2005.wav
1
Medicaid
2
Medicare
0
"Operator"
#
Repeat
*
Previous
Call Type CMC.MRx.AA.Caid.IL.Pvdr.PA.1
Call Type CMC.MRx.AA.Caid.IL.Pvdr.PA.2
Call Type CMC.MRx.AA.Caid.IL.Pvdr.PA.0
Me
Por

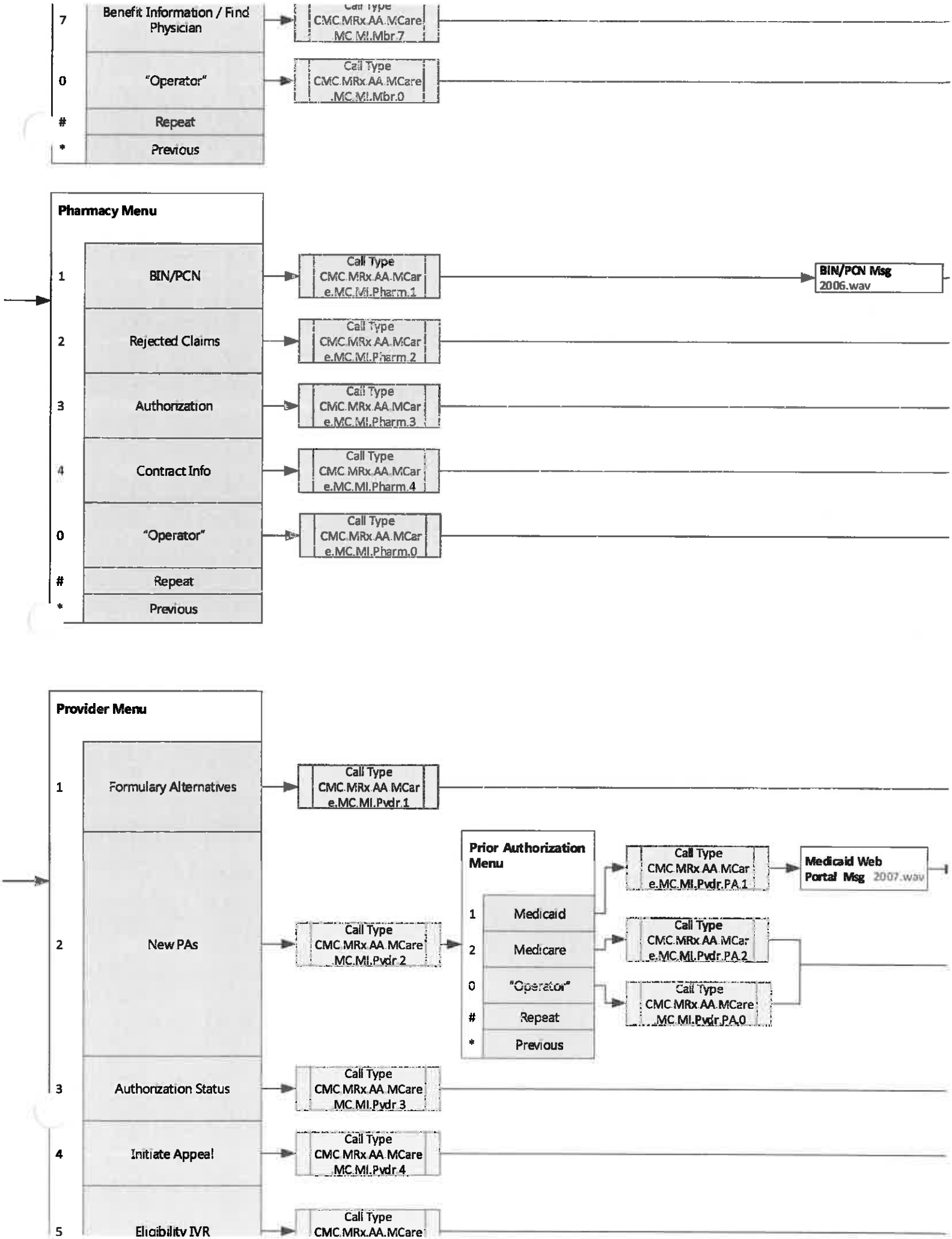

5
Eligibility Information
Call Type CMC.MRx.AA.Caid.MI.Mbr.5
6
Premium Information
Call Type CMC.MRx.AA.Caid.MI.Mbr.6
7
Benefit Information / Find Physician
Call Type CMC.MRx.AA.Caid.MI.Mbr.7
0
"Operator"
Call Type CMC.MRx.AA.Caid.MI.Mbr.0
#
Repeat
*
Previous
Pharmacy Menu
2003.wav
1
BIN/PCN
Call Type CMC.MRx.AA.Caid.MI.Pharm.1
2
Rejected Claims
Call Type CMC.MRx.AA.Caid.MI.Pharm.2
3
Authorization
Call Type CMC.MRx.AA.Caid.MI.Pharm.3
4
Contract Info
Call Type CMC.MRx.AA.Caid.MI.Pharm.4
0
"Operator"
Call Type CMC.MRx.AA.Caid.MI.Pharm.0
#
Repeat
*
Previous

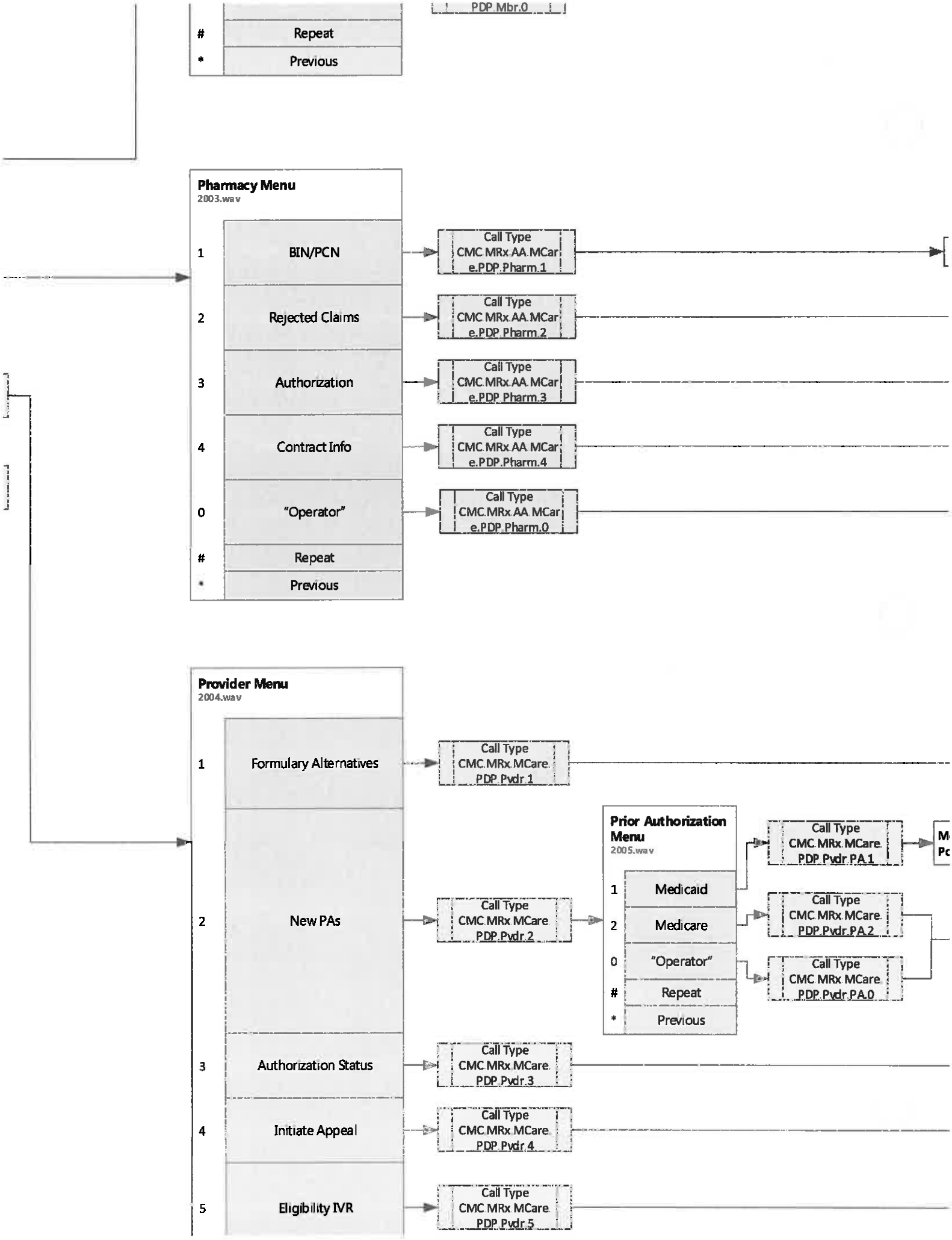

2000.wav
Call Type
CMC.MRx.VM.Caid
Weather Msg
1010.wav
Unforeseen Msg
1011.wav
Technical Difficulties Msg
1012.wav
Member Menu
2002.wav
1
Help With Covered Medication
2
Rejected Medications
3
Authorization Status
4
Initiate Appeal
5
Eligibility Information
6
Premium Information
0
"Operator"
#
Repeat
*
Previous
Call Type
CMC.MRx.AA.Caid.T
HP.Mbr.1
Call Type
CMC.MRx.AA.Caid.T
HP.Mbr.2
Call Type
CMC.MRx.AA.Caid.T
HP.Mbr.3
Call Type
CMC.MRx.AA.Caid.T
HP.Mbr.4
Call Type
CMC.MRx.AA.Caid.T
HP.Mbr.5
Call Type
CMC.MRx.AA.Caid.T
HP.Mbr.6
Call Type
CMC.MRx.AA.Caid.T
HP.Mbr.0
Call Type
CMC.MRx.AA.Caid.T
HP.Main.1
Call Type
CMC.MRx.AA.Caid.T
HP.Main.2
Call Type
CMC.MRx.AA.Caid.T
HP.Main.3
Call Type
CMC.MRx.AA.Caid.T
HP.Main.0
Pharmacy Menu
2003.wav
1
BIN/PCN
2
Rejected Claims
3
Authorization
4
Contract Info
0
"Operator"
Call Type
CMC.MRx.AA.Caid
THP.Pharm.1
Call Type
CMC.MRx.AA.Caid
THP.Pharm.2
Call Type
CMC.MRx.AA.Caid
THP.Pharm.3
Call Type
CMC.MRx.AA.Caid
THP.Pharm.4
Call Type
CMC.MRx.AA.Caid
THP.Pharm.0

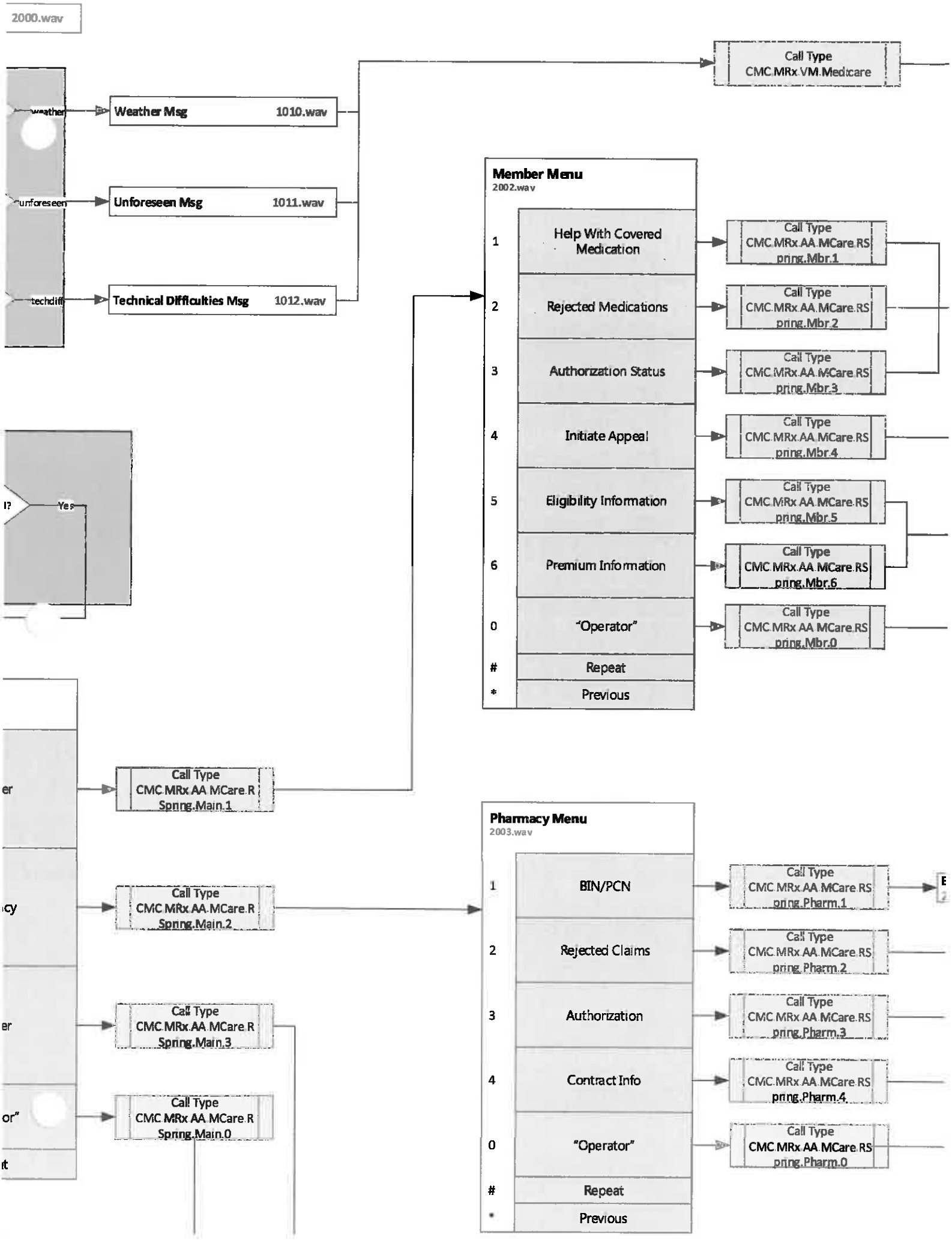

7
Benefit Information / Find Physician
Call Type CMC.MRx.AA.MCare.IL Mbr.7
0
"Operator"
Call Type CMC.MRx.AA.MCare.IL Mbr.0
#
Repeat
*
Previous
Call Type CMC.MRx.AA.MCare.IL.Main.1
Pharmacy Menu
2003.wav
Call Type CMC.MRx.AA.MCare.IL.Main.2
1
BIN/PCN
Call Type CMC.MRx.AA.MCare.IL.Pharm.1
BIN
2
Rejected Claims
Call Type CMC.MRx.AA.MCare.IL.Pharm.2
Call Type CMC.MRx.AA.MCare.IL.Main.3
3
Authorization
Call Type CMC.MRx.AA.MCare.IL.Pharm.3
4
Contract Info
Call Type CMC.MRx.AA.MCare.IL.Pharm.4
Call Type CMC.MRx.AA.MCare.IL.Main.0
0
"Operator"
Call Type CMC.MRx.AA.MCare.IL.Pharm.0
#
Repeat
*
Previous
Provider Menu
2004.wav
1
Formulary Alternatives
Call Type CMC.MRx.AA.MCare.IL.Pvdr.1
2
New PAs
Call Type CMC.MRx.AA.MCare.IL.Pvdr.2
Prior Authorization Menu
2005.wav
1
Medicaid
Call Type CMC.MRx.AA.MCare.IL.Pvdr.PA.1
2
Medicare
Call Type CMC.MRx.AA.MCare.IL.Pvdr.PA.2
0
"Operator"
Call Type CMC.MRx.AA.MCare.IL.Pvdr.PA.0
#
Repeat
*
Previous
3
Authorization Status
Call Type CMC.MRx.AA.MCare.IL.Pvdr.3
4
Initiate Appeal
Call Type CMC.MRx.AA.MCare.IL.Pvdr.4
5
Eligibility IVR
Call Type CMC.MRx.AA.MCare

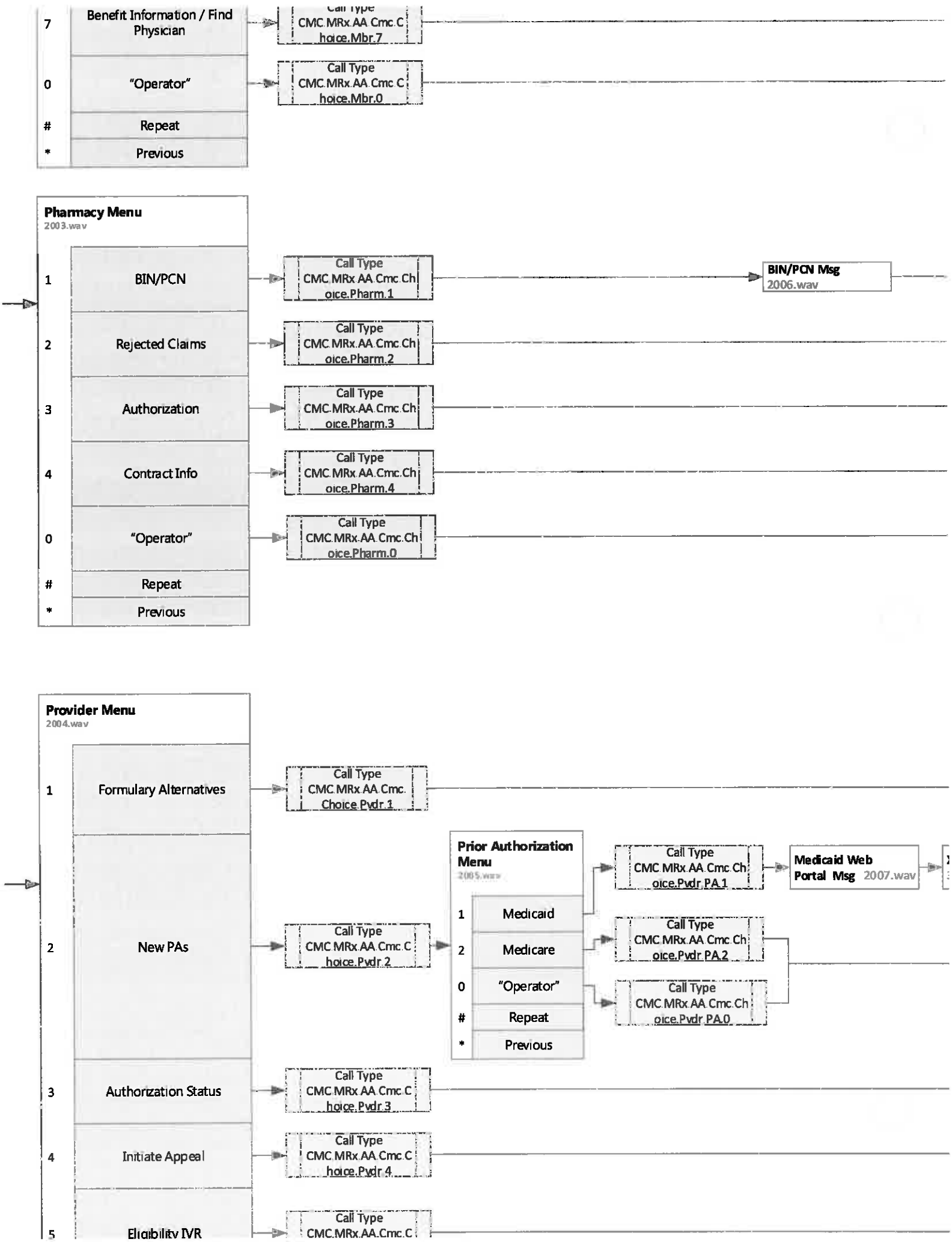

Call Type CMC.MRx.AA.MCare MI.Main.2
Call Type CMC.MRx.AA.MCare MI.Main.3
Call Type CMC.MRx.AA.MCare MI.Main.0
Pharmacy Menu
2003.wav
1 BIN/PCN
2 Rejected Claims
3 Authorization
4 Contract Info
0 "Operator"
Repeat
* Previous
Call Type CMC.MRx.AA.MCare MI.Pharm.1
Call Type CMC.MRx.AA.MCare MI.Pharm.2
Call Type CMC.MRx.AA.MCare MI.Pharm.3
Call Type CMC.MRx.AA.MCare MI.Pharm.4
Call Type CMC.MRx.AA.MCare MI.Pharm.0
BIN/PCN Msg 2006.wav
Provider Menu
2004.wav
1 Formulary Alternatives
2 New PAs
3 Authorization Status
4 Initiate Appeal
5 Eligibility IVR
6 Benefit Information
0 "Operator"
Repeat
Call Type CMC.MRx.AA.MCare MI.Pvdr.1
Call Type CMC.MRx.AA.MCare MI.Pvdr.2
Call Type CMC.MRx.AA.MCare MI.Pvdr.3
Call Type CMC.MRx.AA.MCare MI.Pvdr.4
Call Type CMC.MRx.AA.MCare MI.Pvdr.5
Call Type CMC.MRx.AA.MCare MI.Pvdr.6
Call Type CMC.MRx.AA.MCare MI.Pvdr.0
Prior Authorization Menu
2005.wav
1 Medicaid
2 Medicare
0 "Operator"
Repeat
* Previous
Call Typ CMC.MRx.AA. ivil.Pvdr.P
Call Typ CMC.MRx.AA MI.Pvdr.P
Call Ty CMC.MRx.AA Pvdr.P

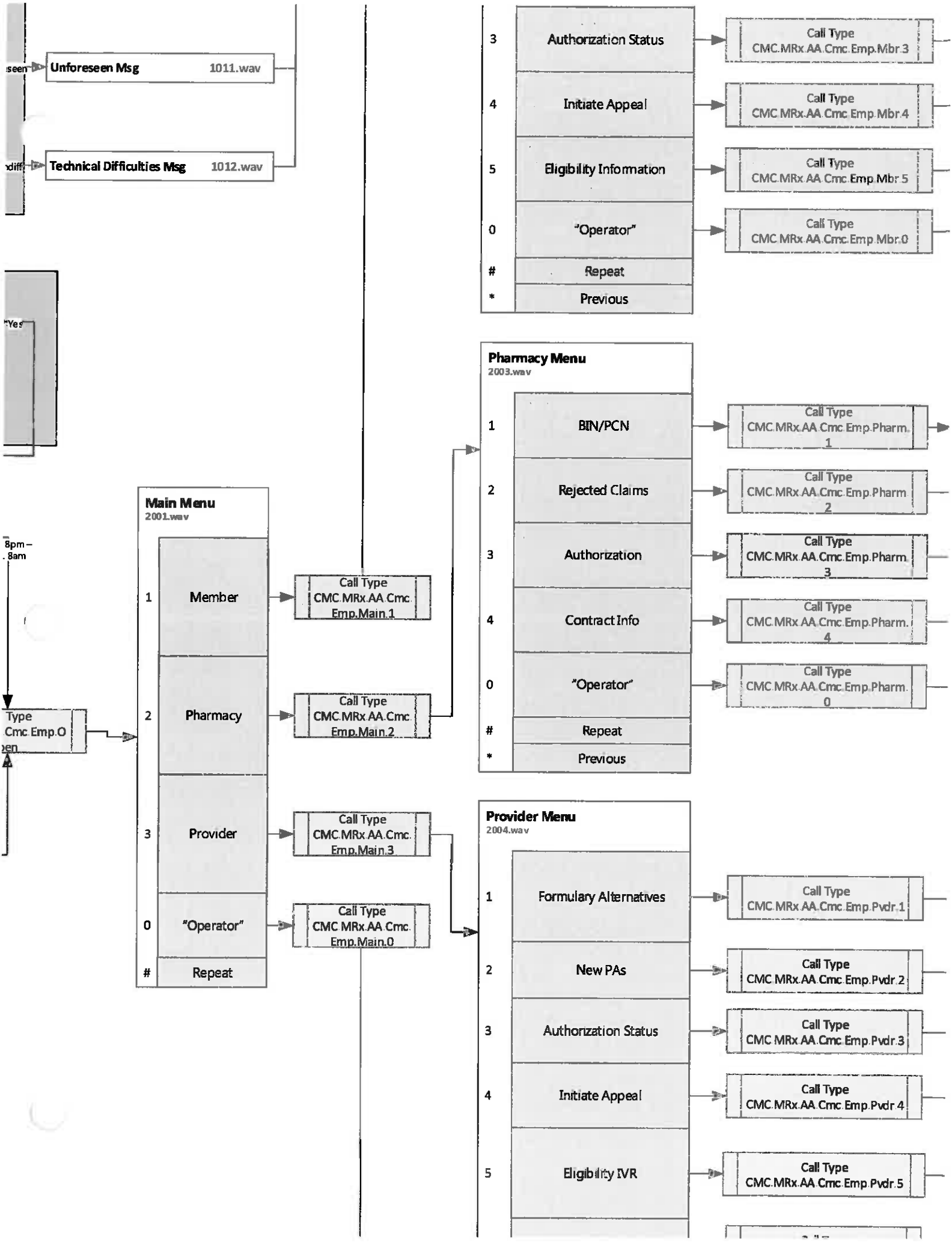

7
Benefit Information / Find Physician
Call Type CMC.MRx.AA.MCare.MC.IL.Mbr.7
0
"Operator"
Call Type CMC.MRx.AA.MCare.MC.IL.Mbr.0
#
Repeat
*
Previous
Pharmacy Menu
2003.wav
1
BIN/PCN
Call Type CMC.MRx.AA.MCare.MC.IL.Pharm.1
BIN/PCN Msg
2006.wav
2
Rejected Claims
Call Type CMC.MRx.AA.MCare.MC.IL.Pharm.2
3
Authorization
Call Type CMC.MRx.AA.MCare.MC.IL.Pharm.3
4
Contract Info
Call Type CMC.MRx.AA.MCare.MC.IL.Pharm.4
0
"Operator"
Call Type CMC.MRx.AA.MCare.MC.IL.Pharm.0
#
Repeat
*
Previous
Provider Menu
2004.wav
1
Formulary Alternatives
Call Type CMC.MRx.AA.MCare.MC.IL.Pvdr.1
2
New PAs
Call Type CMC.MRx.AA.MCare.MC.IL.Pvdr.2
Prior Authorization Menu
2005.wav
1
Medicaid
Call Type CMC.MRx.AA.MCare.MC.IL.Pvdr.PA.1
Medicaid Web Portal Msg 2007.wa
2
Medicare
Call Type CMC.MRx.AA.MCare.MC.IL.Pvdr.PA.2
0
"Operator"
Call Type CMC.MRx.AA.MCare.MC.IL.Pvdr.PA.0
#
Repeat
*
Previous
3
Authorization Status
Call Type CMC.MRx.AA.MCare.MC.IL.Pvdr.3
4
Initiate Appeal
Call Type CMC.MRx.AA.MCare.MC.IL.Pvdr.4
5
Eligibility IVR
Call Type CMC.MRx.AA.MCare

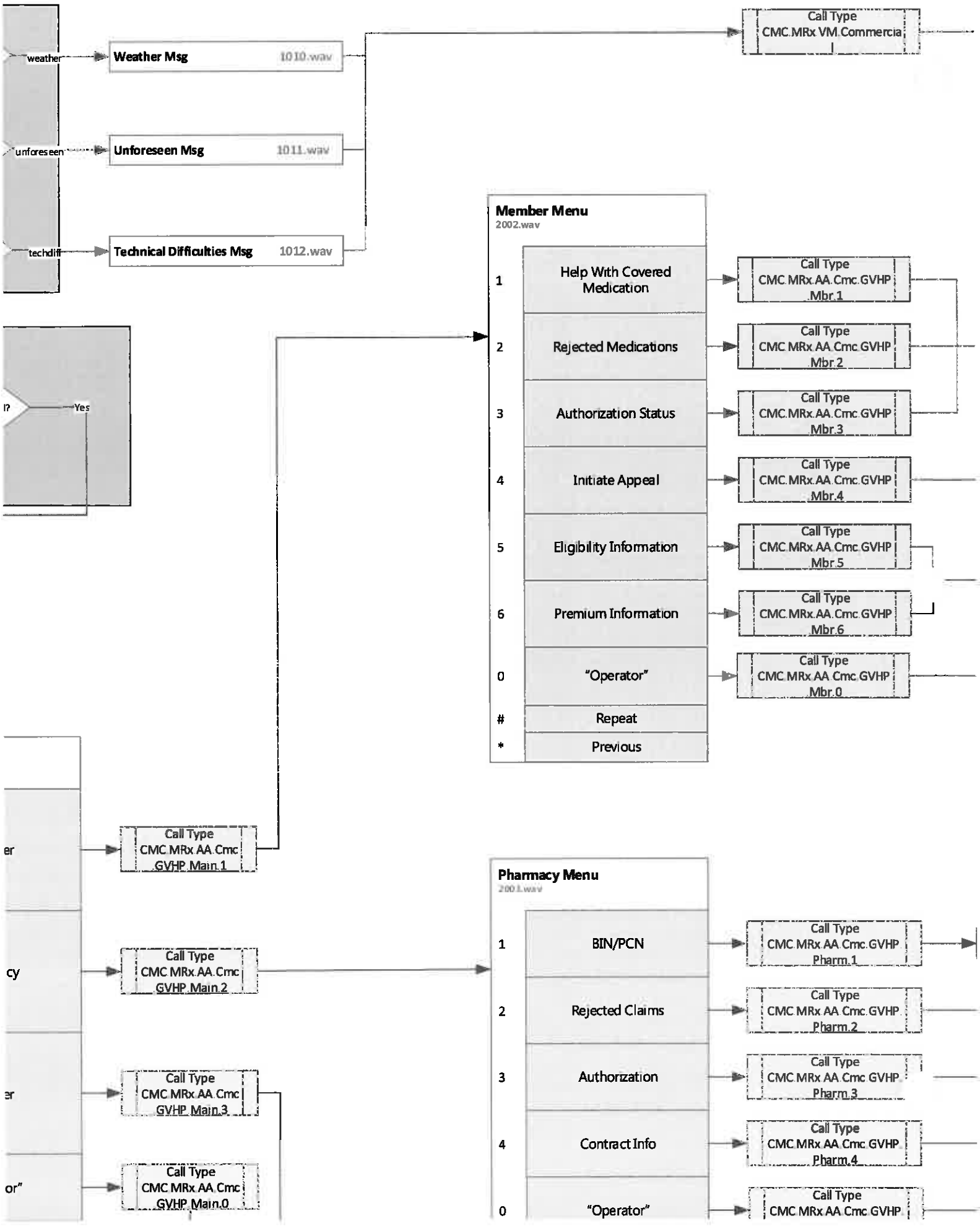

7
Benefit Information / Find Physician
Call Type CMC.MRx.AA.MCare.MC.MI.Mbr.7
0
"Operator"
Call Type CMC.MRx.AA.MCare.MC.MI.Mbr.0
#
Repeat
*
Previous
Pharmacy Menu
1
BIN/PCN
Call Type CMC.MRx.AA.MCare.MC.MI.Pharm.1
BIN/PCN Msg 2006.wav
2
Rejected Claims
Call Type CMC.MRx.AA.MCare.MC.MI.Pharm.2
3
Authorization
Call Type CMC.MRx.AA.MCare.MC.MI.Pharm.3
4
Contract Info
Call Type CMC.MRx.AA.MCare.MC.MI.Pharm.4
0
"Operator"
Call Type CMC.MRx.AA.MCare.MC.MI.Pharm.0
#
Repeat
*
Previous
Provider Menu
1
Formulary Alternatives
Call Type CMC.MRx.AA.MCare.MC.MI.Pvdr.1
2
New PAs
Call Type CMC.MRx.AA.MCare.MC.MI.Pvdr.2
Prior Authorization Menu
1
Medicaid
Call Type CMC.MRx.AA.MCare.MC.MI.Pvdr.PA.1
Medicaid Web Portal Msg 2007.wav
2
Medicare
Call Type CMC.MRx.AA.MCare.MC.MI.Pvdr.PA.2
0
"Operator"
Call Type CMC.MRx.AA.MCare.MC.MI.Pvdr.PA.0
#
Repeat
*
Previous
3
Authorization Status
Call Type CMC.MRx.AA.MCare.MC.MI.Pvdr.3
4
Initiate Appeal
Call Type CMC.MRx.AA.MCare.MC.MI.Pvdr.4
5
Eligibility IVR
Call Type CMC.MRx.AA.MCare

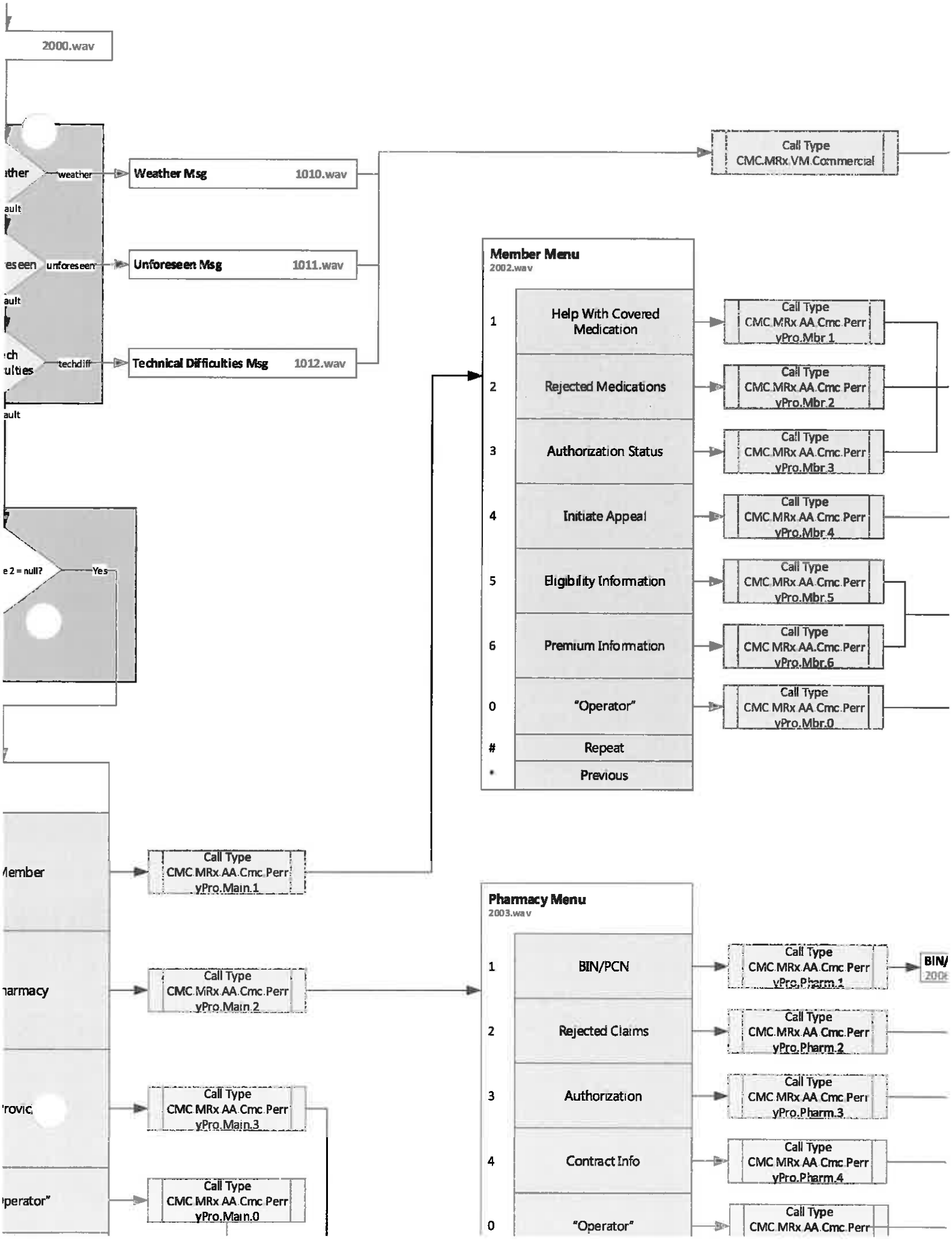

PDP.Mbr.0
Repeat
* Previous
Pharmacy Menu
2003.wav
1 BIN/PCN
Call Type CMC.MRx.AA.MCare.PDP.Pharm.1
2 Rejected Claims
Call Type CMC.MRx.AA.MCare.PDP.Pharm.2
3 Authorization
Call Type CMC.MRx.AA.MCare.PDP.Pharm.3
4 Contract Info
Call Type CMC.MRx.AA.MCare.PDP.Pharm.4
0 "Operator"
Call Type CMC.MRx.AA.MCare.PDP.Pharm.0
Repeat
* Previous
Provider Menu
2004.wav
1 Formulary Alternatives
Call Type CMC.MRx.MCare.PDP.Pvdr.1
2 New PAs
Call Type CMC.MRx.MCare.PDP.Pvdr.2
Prior Authorization Menu
2005.wav
1 Medicaid
Call Type CMC.MRx.MCare.PDP.Pvdr.PA.1
2 Medicare
Call Type CMC.MRx.MCare.PDP.Pvdr.PA.2
0 "Operator"
Call Type CMC.MRx.MCare.PDP.Pvdr.PA.0
Repeat
* Previous
3 Authorization Status
Call Type CMC.MRx.MCare.PDP.Pvdr.3
4 Initiate Appeal
Call Type CMC.MRx.MCare.PDP.Pvdr.4
5 Eligibility IVR
Call Type CMC.MRx.MCare.PDP.Pvdr.5

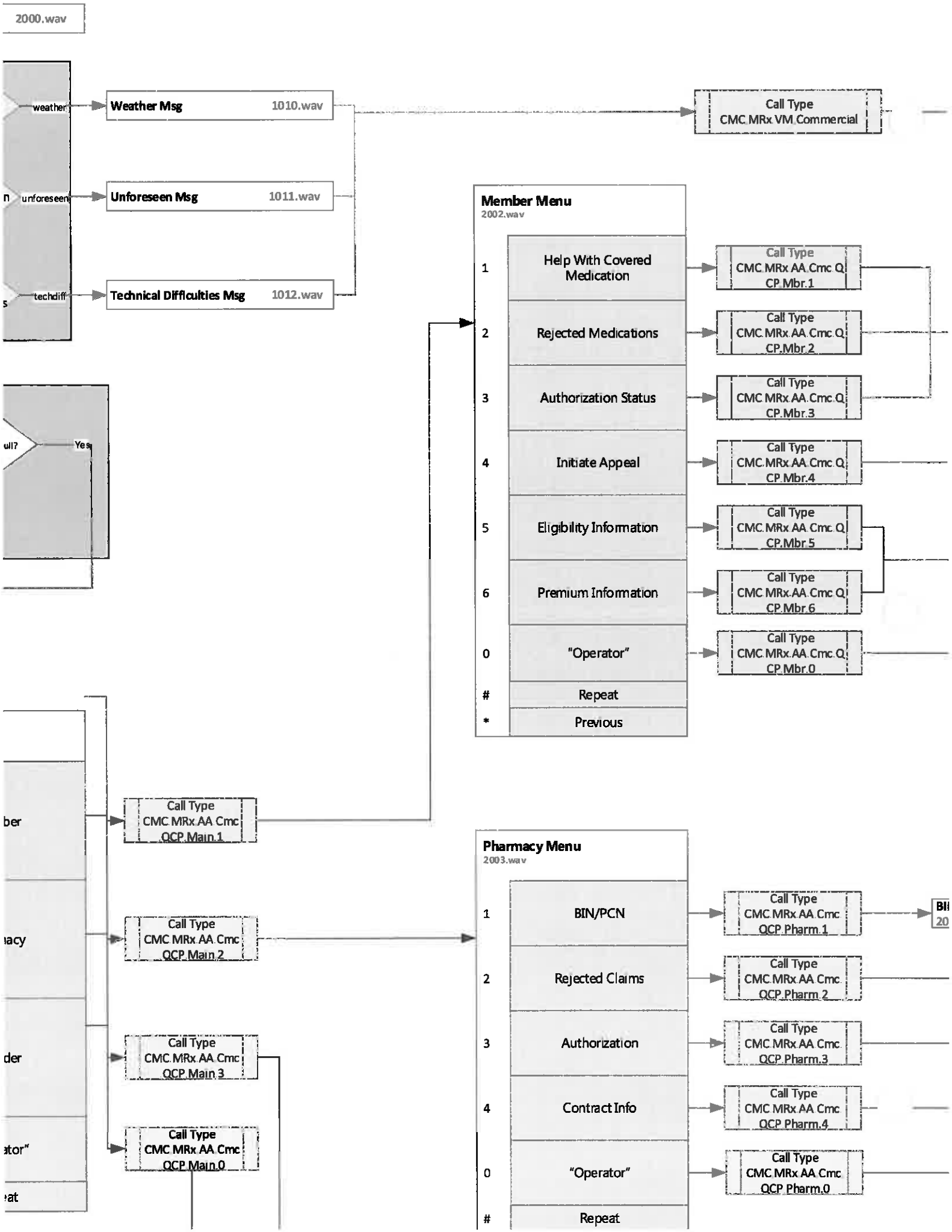

2000.wav
Call Type
CMC.MRx.VM.Medicare
Weather Msg 1010.wav
Unforeseen Msg 1011.wav
Technical Difficulties Msg 1012.wav
Member Menu
2002.wav
1 Help With Covered Medication
2 Rejected Medications
3 Authorization Status
4 Initiate Appeal
5 Eligibility Information
6 Premium Information
0 "Operator"
Repeat
* Previous
Call Type
CMC.MRx.AA.MCare.RS pring.Mbr.1
Call Type
CMC.MRx.AA.MCare.RS pring.Mbr.2
Call Type
CMC.MRx.AA.MCare.RS pring.Mbr.3
Call Type
CMC.MRx.AA.MCare.RS pring.Mbr.4
Call Type
CMC.MRx.AA.MCare.RS pring.Mbr.5
Call Type
CMC.MRx.AA.MCare.RS pring.Mbr.6
Call Type
CMC.MRx.AA.MCare.RS pring.Mbr.0
Yes
Call Type
CMC.MRx.AA.MCare.R Spring.Main.1
Call Type
CMC.MRx.AA.MCare.R Spring.Main.2
Call Type
CMC.MRx.AA.MCare.R Spring.Main.3
Call Type
CMC.MRx.AA.MCare.R Spring.Main.0
Pharmacy Menu
2003.wav
1 BIN/PCN
2 Rejected Claims
3 Authorization
4 Contract Info
0 "Operator"
Repeat
* Previous
Call Type
CMC.MRx.AA.MCare.RS pring.Pharm.1
Call Type
CMC.MRx.AA.MCare.RS pring.Pharm.2
Call Type
CMC.MRx.AA.MCare.RS pring.Pharm.3
Call Type
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Call Type
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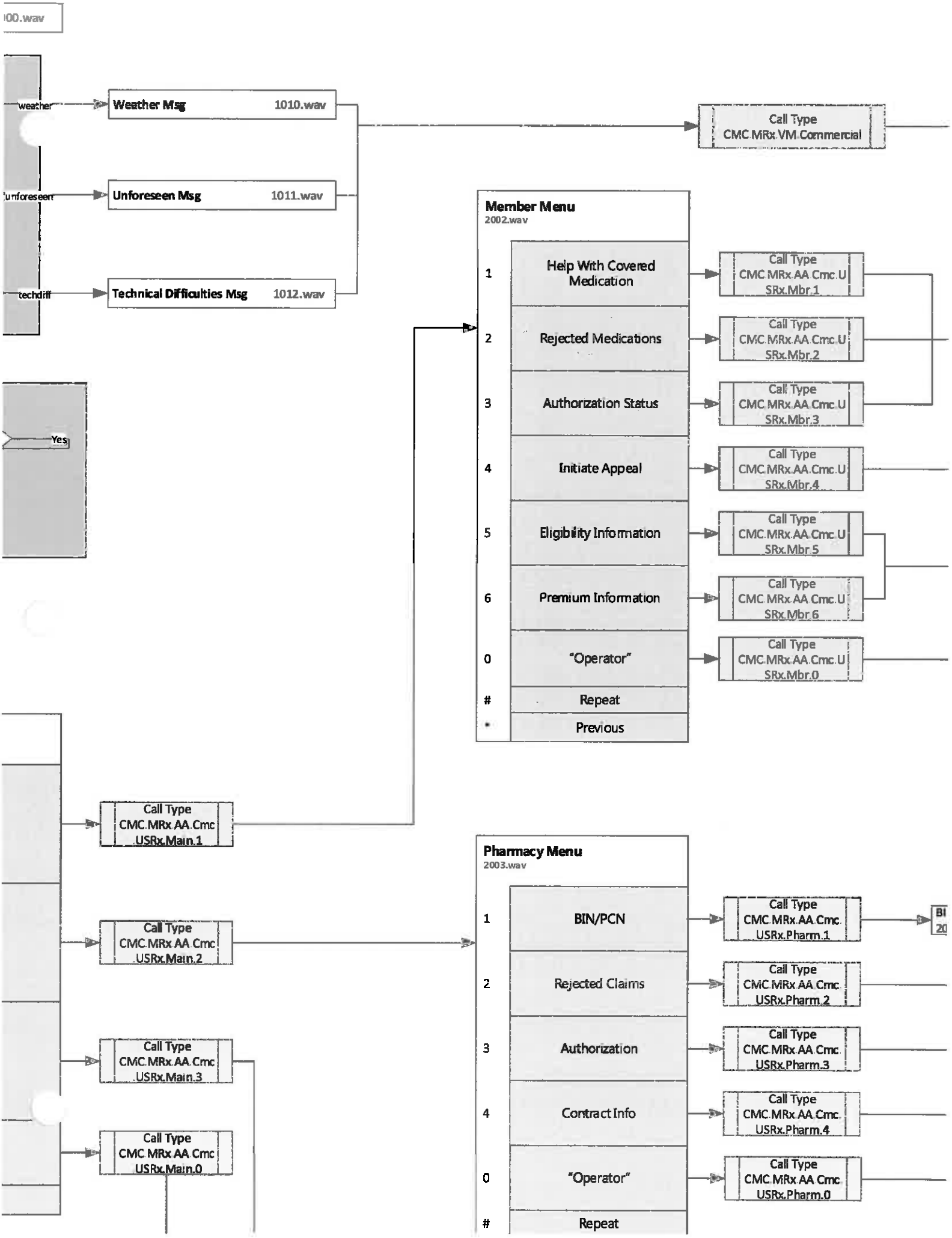

7
Benefit Information / Find Physician
Call Type CMC.MRx.AA.Cmc.Choice.Mbr.7
0
"Operator"
Call Type CMC.MRx.AA.Cmc.Choice.Mbr.0
#
Repeat
*
Previous
Pharmacy Menu
2003.wav
1
BIN/PCN
Call Type CMC.MRx.AA.Cmc.Choice.Pharm.1
BIN/PCN Msg
2006.wav
2
Rejected Claims
Call Type CMC.MRx.AA.Cmc.Choice.Pharm.2
3
Authorization
Call Type CMC.MRx.AA.Cmc.Choice.Pharm.3
4
Contract Info
Call Type CMC.MRx.AA.Cmc.Choice.Pharm.4
0
"Operator"
Call Type CMC.MRx.AA.Cmc.Choice.Pharm.0
#
Repeat
*
Previous
Provider Menu
2004.wav
1
Formulary Alternatives
Call Type CMC.MRx.AA.Cmc.Choice.Pvdr.1
2
New PAs
Call Type CMC.MRx.AA.Cmc.Choice.Pvdr.2
Prior Authorization Menu
2005.wav
1
Medicaid
Call Type CMC.MRx.AA.Cmc.Choice.Pvdr.PA.1
Medicaid Web Portal Msg 2007.wav
2
Medicare
Call Type CMC.MRx.AA.Cmc.Choice.Pvdr.PA.2
0
"Operator"
Call Type CMC.MRx.AA.Cmc.Choice.Pvdr.PA.0
#
Repeat
*
Previous
3
Authorization Status
Call Type CMC.MRx.AA.Cmc.Choice.Pvdr.3
4
Initiate Appeal
Call Type CMC.MRx.AA.Cmc.Choice.Pvdr.4
5
Eligibility IVR
Call Type CMC.MRx.AA.Cmc.C

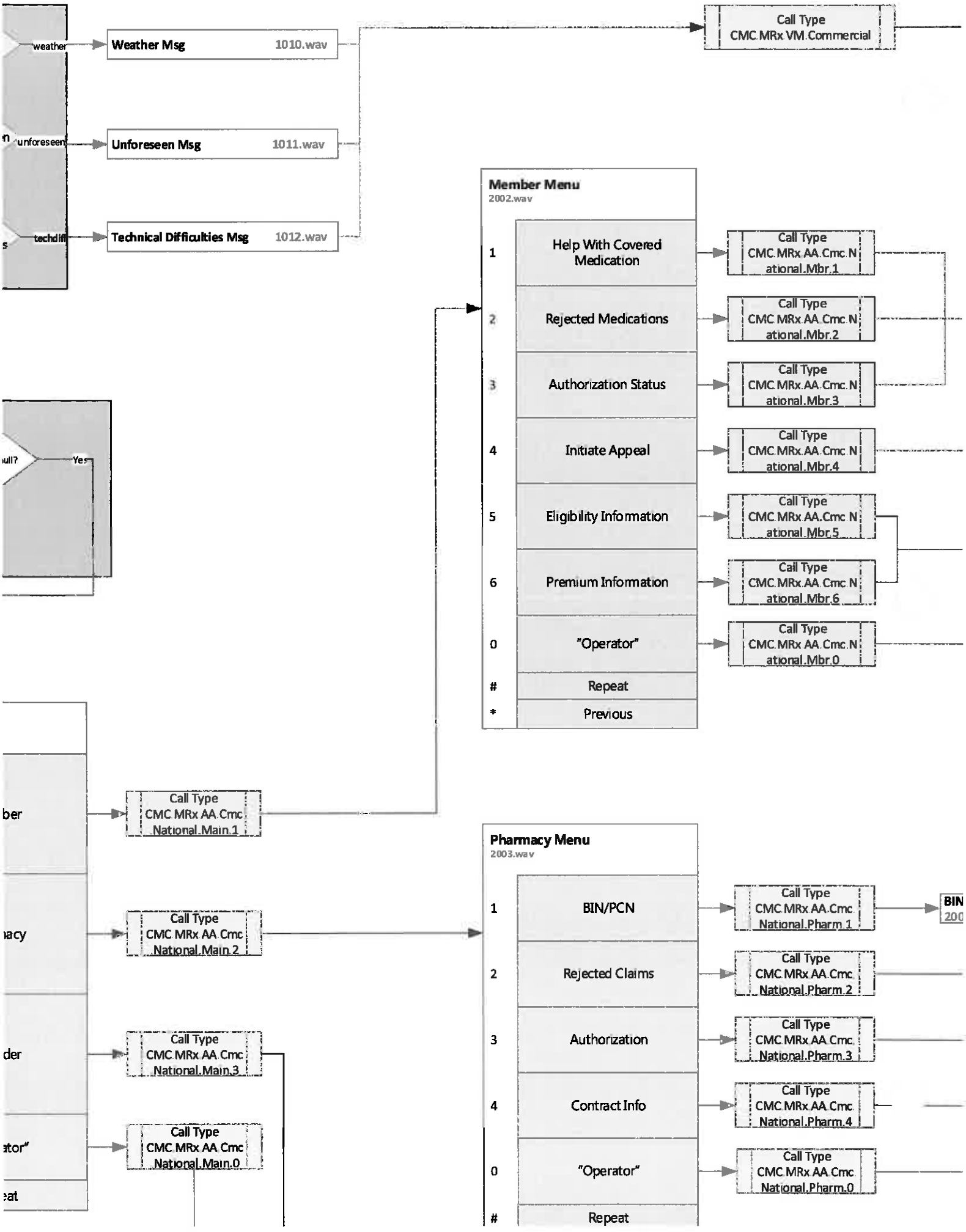

Unforeseen Msg 1011.wav
Technical Difficulties Msg 1012.wav
3 Authorization Status
Call Type CMC.MRx.AA.Cmc.Emp.Mbr.3
4 Initiate Appeal
Call Type CMC.MRx.AA.Cmc.Emp.Mbr.4
5 Eligibility Information
Call Type CMC.MRx.AA.Cmc.Emp.Mbr.5
0 "Operator"
Call Type CMC.MRx.AA.Cmc.Emp.Mbr.0
Repeat
* Previous
Pharmacy Menu
2003.wav
1 BIN/PCN
Call Type CMC.MRx.AA.Cmc.Emp.Pharm.1
2 Rejected Claims
Call Type CMC.MRx.AA.Cmc.Emp.Pharm.2
3 Authorization
Call Type CMC.MRx.AA.Cmc.Emp.Pharm.3
4 Contract Info
Call Type CMC.MRx.AA.Cmc.Emp.Pharm.4
0 "Operator"
Call Type CMC.MRx.AA.Cmc.Emp.Pharm.0
Repeat
* Previous
Main Menu
2001.wav
1 Member
Call Type CMC.MRx.AA.Cmc.Emp.Main.1
2 Pharmacy
Call Type CMC.MRx.AA.Cmc.Emp.Main.2
3 Provider
Call Type CMC.MRx.AA.Cmc.Emp.Main.3
0 "Operator"
Call Type CMC.MRx.AA.Cmc.Emp.Main.0
Repeat
Provider Menu
2004.wav
1 Formulary Alternatives
Call Type CMC.MRx.AA.Cmc.Emp.Pvdr.1
2 New PAs
Call Type CMC.MRx.AA.Cmc.Emp.Pvdr.2
3 Authorization Status
Call Type CMC.MRx.AA.Cmc.Emp.Pvdr.3
4 Initiate Appeal
Call Type CMC.MRx.AA.Cmc.Emp.Pvdr.4
5 Eligibility IVR
Call Type CMC.MRx.AA.Cmc.Emp.Pvdr.5

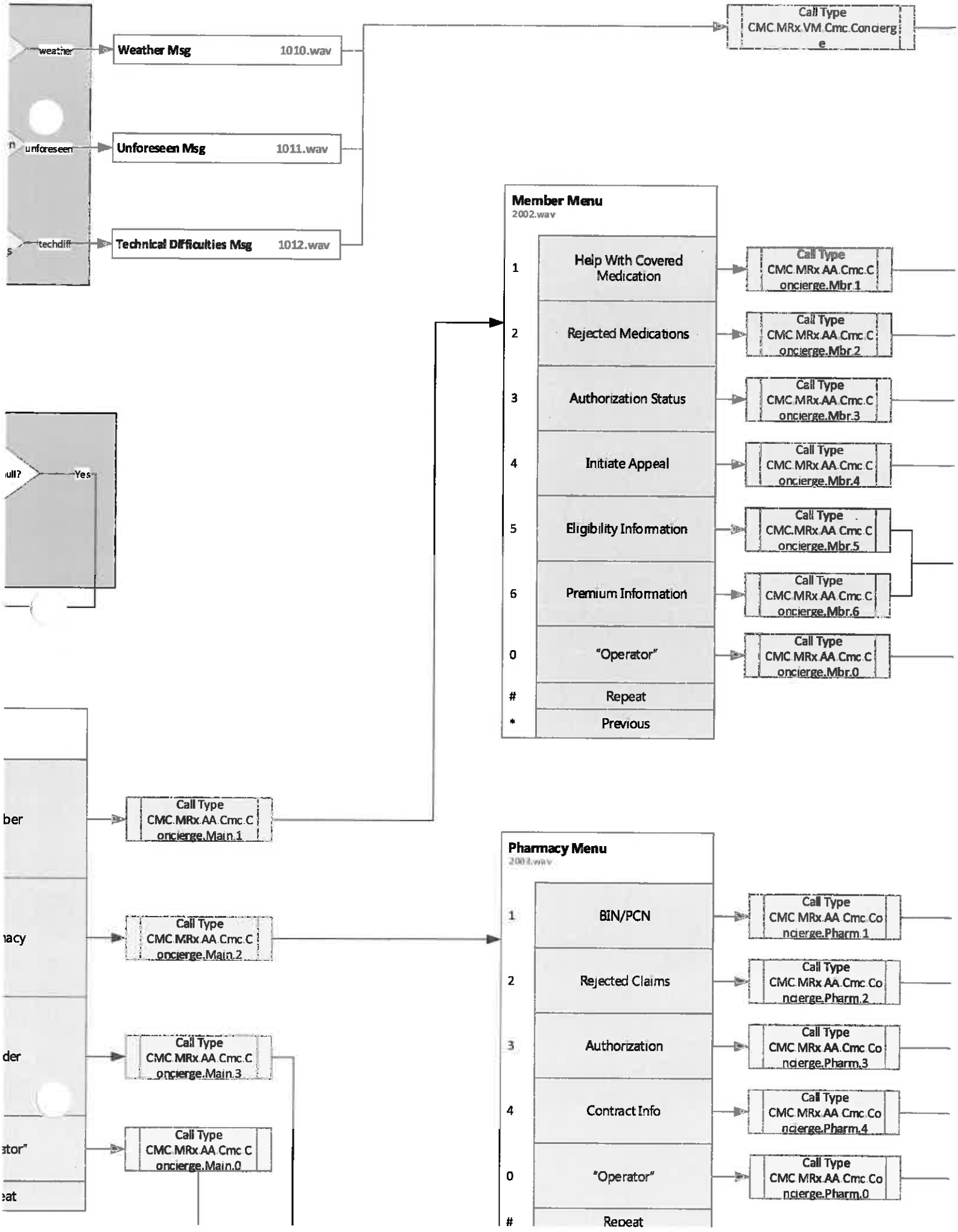

weather
Weather Msg 1010.wav
unforeseen
Unforeseen Msg 1011.wav
techdiff
Technical Difficulties Msg 1012.wav
Call Type CMC.MRx.VM.Commercia
Member Menu
2002.wav
1 Help With Covered Medication
2 Rejected Medications
3 Authorization Status
4 Initiate Appeal
5 Eligibility Information
6 Premium Information
0 "Operator"
Repeat
* Previous
Call Type CMC.MRx.AA.Cmc.GVHP.Mbr.1
Call Type CMC.MRx.AA.Cmc.GVHP.Mbr.2
Call Type CMC.MRx.AA.Cmc.GVHP.Mbr.3
Call Type CMC.MRx.AA.Cmc.GVHP.Mbr.4
Call Type CMC.MRx.AA.Cmc.GVHP.Mbr.5
Call Type CMC.MRx.AA.Cmc.GVHP.Mbr.6
Call Type CMC.MRx.AA.Cmc.GVHP.Mbr.0
Yes
Call Type CMC.MRx.AA.Cmc.GVHP.Main.1
Call Type CMC.MRx.AA.Cmc.GVHP.Main.2
Call Type CMC.MRx.AA.Cmc.GVHP.Main.3
Call Type CMC.MRx.AA.Cmc.GVHP.Main.0
Pharmacy Menu
2003.wav
1 BIN/PCN
2 Rejected Claims
3 Authorization
4 Contract Info
0 "Operator"
Call Type CMC.MRx.AA.Cmc.GVHP.Pharm.1
Call Type CMC.MRx.AA.Cmc.GVHP.Pharm.2
Call Type CMC.MRx.AA.Cmc.GVHP.Pharm.3
Call Type CMC.MRx.AA.Cmc.GVHP.Pharm.4
Call Type CMC.MRx.AA.Cmc.GVHP

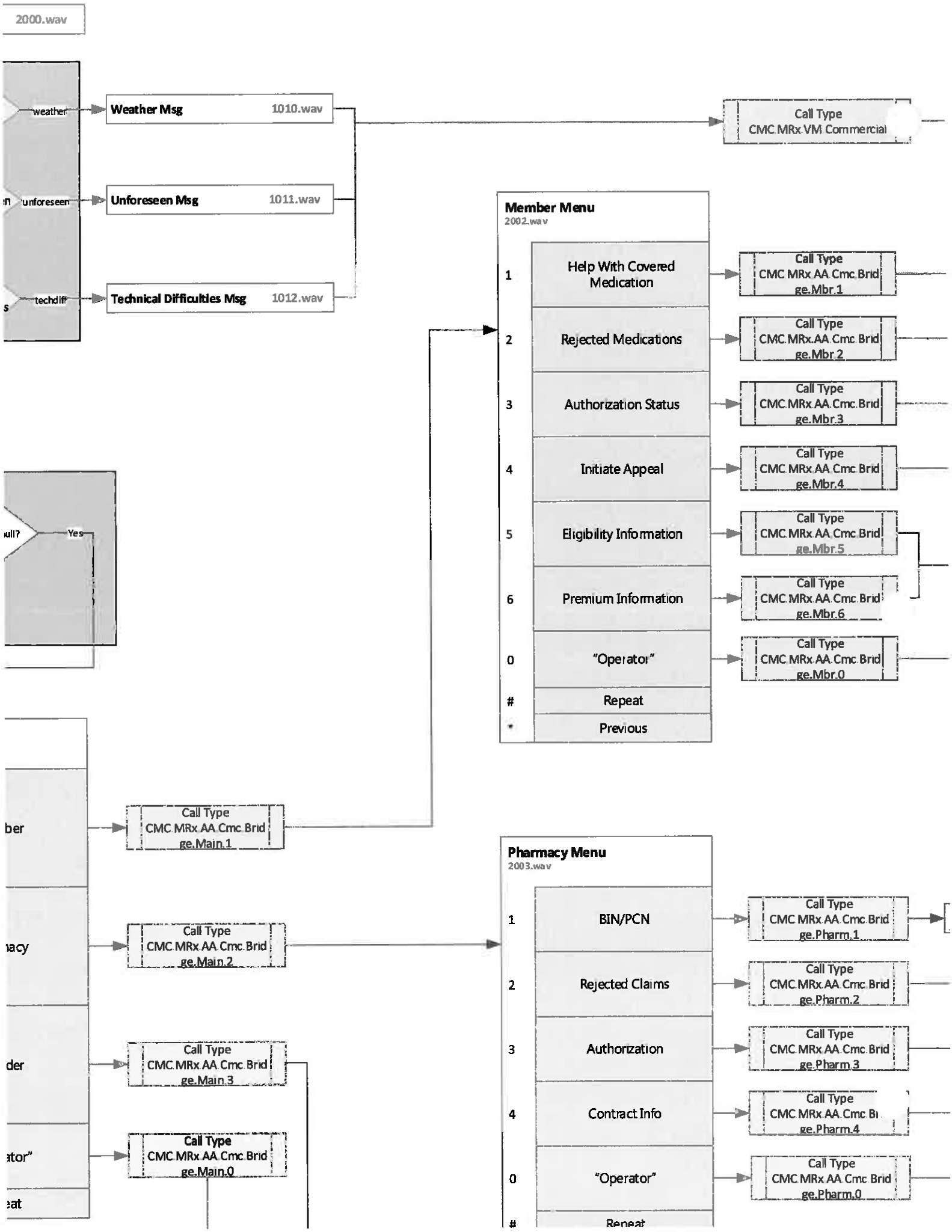

2000.wav
weather
Weather Msg 1010.wav
unforeseen
Unforeseen Msg 1011.wav
techdiff
Technical Difficulties Msg 1012.wav
Call Type CMC.MRx.VM.Commercial
Member Menu
2002.wav
1 Help With Covered Medication
2 Rejected Medications
3 Authorization Status
4 Initiate Appeal
5 Eligibility Information
6 Premium Information
0 "Operator"
Repeat
* Previous
Call Type CMC.MRx.AA.Cmc.Perr yPro.Mbr.1
Call Type CMC.MRx.AA.Cmc.Perr yPro.Mbr.2
Call Type CMC.MRx.AA.Cmc.Perr yPro.Mbr.3
Call Type CMC.MRx.AA.Cmc.Perr yPro.Mbr.4
Call Type CMC.MRx.AA.Cmc.Perr yPro.Mbr.5
Call Type CMC.MRx.AA.Cmc.Perr yPro.Mbr.6
Call Type CMC.MRx.AA.Cmc.Perr yPro.Mbr.0
Yes
Call Type CMC.MRx.AA.Cmc.Perr yPro.Main.1
Call Type CMC.MRx.AA.Cmc.Perr yPro.Main.2
Call Type CMC.MRx.AA.Cmc.Perr yPro.Main.3
Call Type CMC.MRx.AA.Cmc.Perr yPro.Main.0
Pharmacy Menu
2003.wav
1 BIN/PCN
2 Rejected Claims
3 Authorization
4 Contract Info
0 "Operator"
Call Type CMC.MRx.AA.Cmc.Perr yPro.Pharm.1
Call Type CMC.MRx.AA.Cmc.Perr yPro.Pharm.2
Call Type CMC.MRx.AA.Cmc.Perr yPro.Pharm.3
Call Type CMC.MRx.AA.Cmc.Perr yPro.Pharm.4
Call Type CMC.MRx.AA.Cmc.Perr

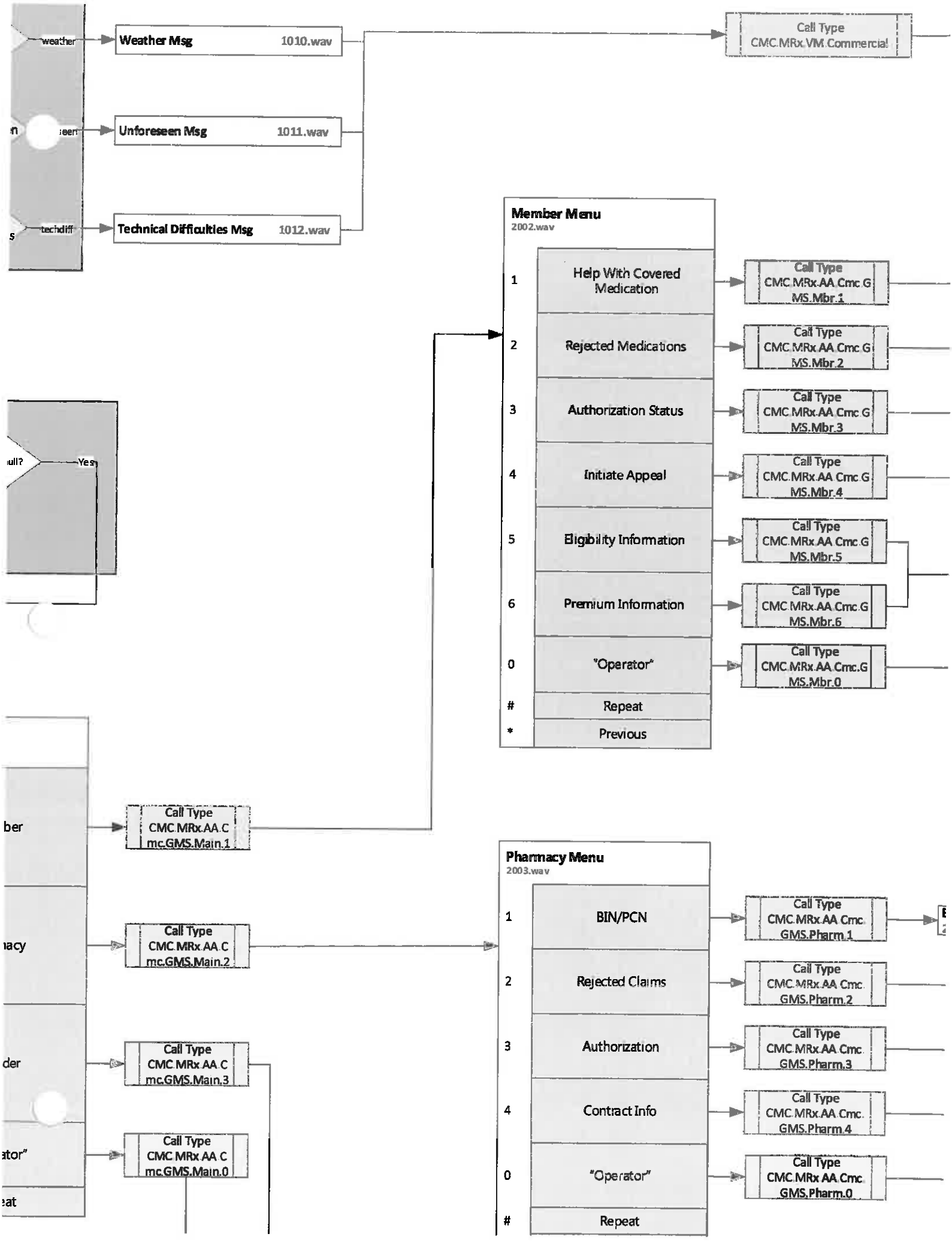

2000.wav
weather
Weather Msg 1010.wav
unforeseen
Unforeseen Msg 1011.wav
techdiff
Technical Difficulties Msg 1012.wav
Call Type CMC.MRx.VM.Commercial
Member Menu
2002.wav
1 Help With Covered Medication
2 Rejected Medications
3 Authorization Status
4 Initiate Appeal
5 Eligibility Information
6 Premium Information
0 "Operator"
Repeat
* Previous
Call Type CMC.MRx.AA.Cmc.QCP.Mbr.1
Call Type CMC.MRx.AA.Cmc.QCP.Mbr.2
Call Type CMC.MRx.AA.Cmc.QCP.Mbr.3
Call Type CMC.MRx.AA.Cmc.QCP.Mbr.4
Call Type CMC.MRx.AA.Cmc.QCP.Mbr.5
Call Type CMC.MRx.AA.Cmc.QCP.Mbr.6
Call Type CMC.MRx.AA.Cmc.QCP.Mbr.0
Call Type CMC.MRx.AA.Cmc.QCP.Main.1
Call Type CMC.MRx.AA.Cmc.QCP.Main.2
Call Type CMC.MRx.AA.Cmc.QCP.Main.3
Call Type CMC.MRx.AA.Cmc.QCP.Main.0
Pharmacy Menu
2003.wav
1 BIN/PCN
2 Rejected Claims
3 Authorization
4 Contract Info
0 "Operator"
Repeat
Call Type CMC.MRx.AA.Cmc.QCP.Pharm.1
Call Type CMC.MRx.AA.Cmc.QCP.Pharm.2
Call Type CMC.MRx.AA.Cmc.QCP.Pharm.3
Call Type CMC.MRx.AA.Cmc.QCP.Pharm.4
Call Type CMC.MRx.AA.Cmc.QCP.Pharm.0

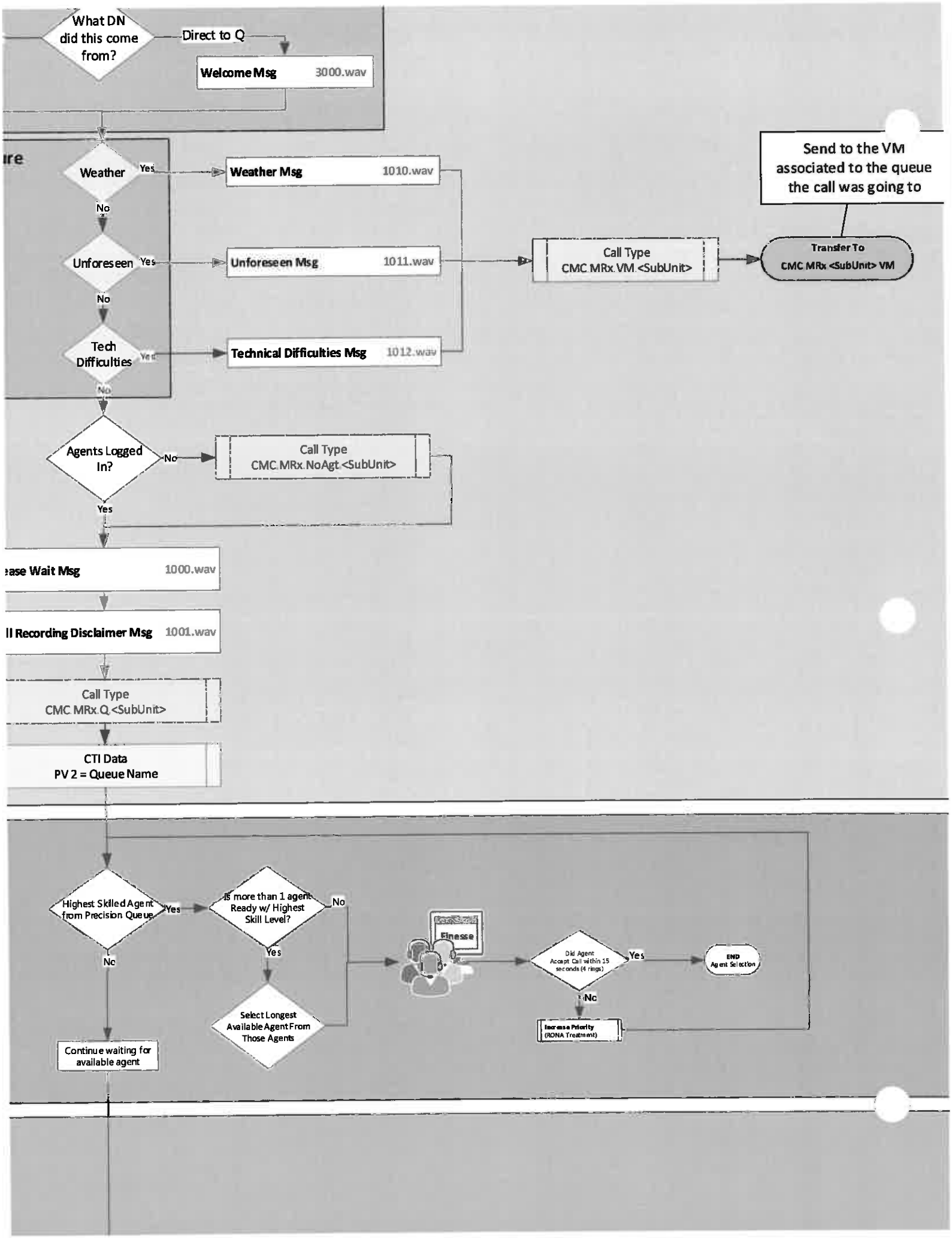

00.wav
weather
Weather Msg 1010.wav
unforeseen
Unforeseen Msg 1011.wav
techdiff
Technical Difficulties Msg 1012.wav
Call Type CMC.MRx.VM.Commercial
Yes
Member Menu
2002.wav
1 Help With Covered Medication
2 Rejected Medications
3 Authorization Status
4 Initiate Appeal
5 Eligibility Information
6 Premium Information
0 "Operator"
Repeat
* Previous
Call Type CMC.MRx.AA.Cmc.USRx.Mbr.1
Call Type CMC.MRx.AA.Cmc.USRx.Mbr.2
Call Type CMC.MRx.AA.Cmc.USRx.Mbr.3
Call Type CMC.MRx.AA.Cmc.USRx.Mbr.4
Call Type CMC.MRx.AA.Cmc.USRx.Mbr.5
Call Type CMC.MRx.AA.Cmc.USRx.Mbr.6
Call Type CMC.MRx.AA.Cmc.USRx.Mbr.0
Call Type CMC.MRx.AA.Cmc.USRx.Main.1
Call Type CMC.MRx.AA.Cmc.USRx.Main.2
Call Type CMC.MRx.AA.Cmc.USRx.Main.3
Call Type CMC.MRx.AA.Cmc.USRx.Main.0
Pharmacy Menu
2003.wav
1 BIN/PCN
2 Rejected Claims
3 Authorization
4 Contract Info
0 "Operator"
Repeat
Call Type CMC.MRx.AA.Cmc.USRx.Pharm.1
Call Type CMC.MRx.AA.Cmc.USRx.Pharm.2
Call Type CMC.MRx.AA.Cmc.USRx.Pharm.3
Call Type CMC.MRx.AA.Cmc.USRx.Pharm.4
Call Type CMC.MRx.AA.Cmc.USRx.Pharm.0

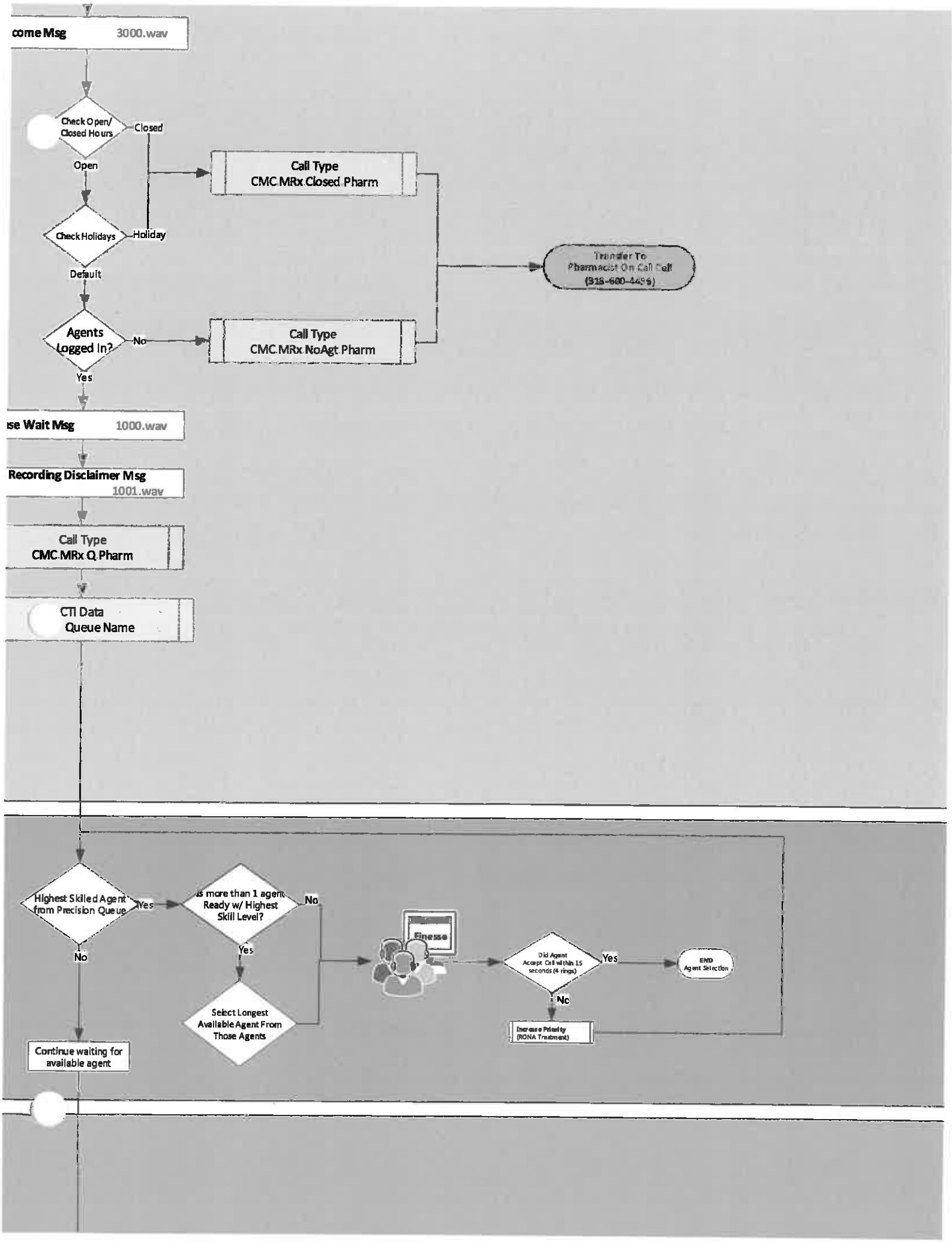

weather
Weather Msg 1010.wav
unforeseen
Unforeseen Msg 1011.wav
techdiff
Technical Difficulties Msg 1012.wav
Call Type CMC.MRx.VM.Commercial
Member Menu
2002.wav
1 Help With Covered Medication
2 Rejected Medications
3 Authorization Status
4 Initiate Appeal
5 Eligibility Information
6 Premium Information
0 "Operator"
Repeat
* Previous
Call Type CMC.MRx.AA.Cmc.National.Mbr.1
Call Type CMC.MRx.AA.Cmc.National.Mbr.2
Call Type CMC.MRx.AA.Cmc.National.Mbr.3
Call Type CMC.MRx.AA.Cmc.National.Mbr.4
Call Type CMC.MRx.AA.Cmc.National.Mbr.5
Call Type CMC.MRx.AA.Cmc.National.Mbr.6
Call Type CMC.MRx.AA.Cmc.National.Mbr.0
Yes
Call Type CMC.MRx.AA.Cmc.National.Main.1
Call Type CMC.MRx.AA.Cmc.National.Main.2
Call Type CMC.MRx.AA.Cmc.National.Main.3
Call Type CMC.MRx.AA.Cmc.National.Main.0
Pharmacy Menu
2003.wav
1 BIN/PCN
2 Rejected Claims
3 Authorization
4 Contract Info
0 "Operator"
Repeat
Call Type CMC.MRx.AA.Cmc.National.Pharm.1
Call Type CMC.MRx.AA.Cmc.National.Pharm.2
Call Type CMC.MRx.AA.Cmc.National.Pharm.3
Call Type CMC.MRx.AA.Cmc.National.Pharm.4
Call Type CMC.MRx.AA.Cmc.National.Pharm.0

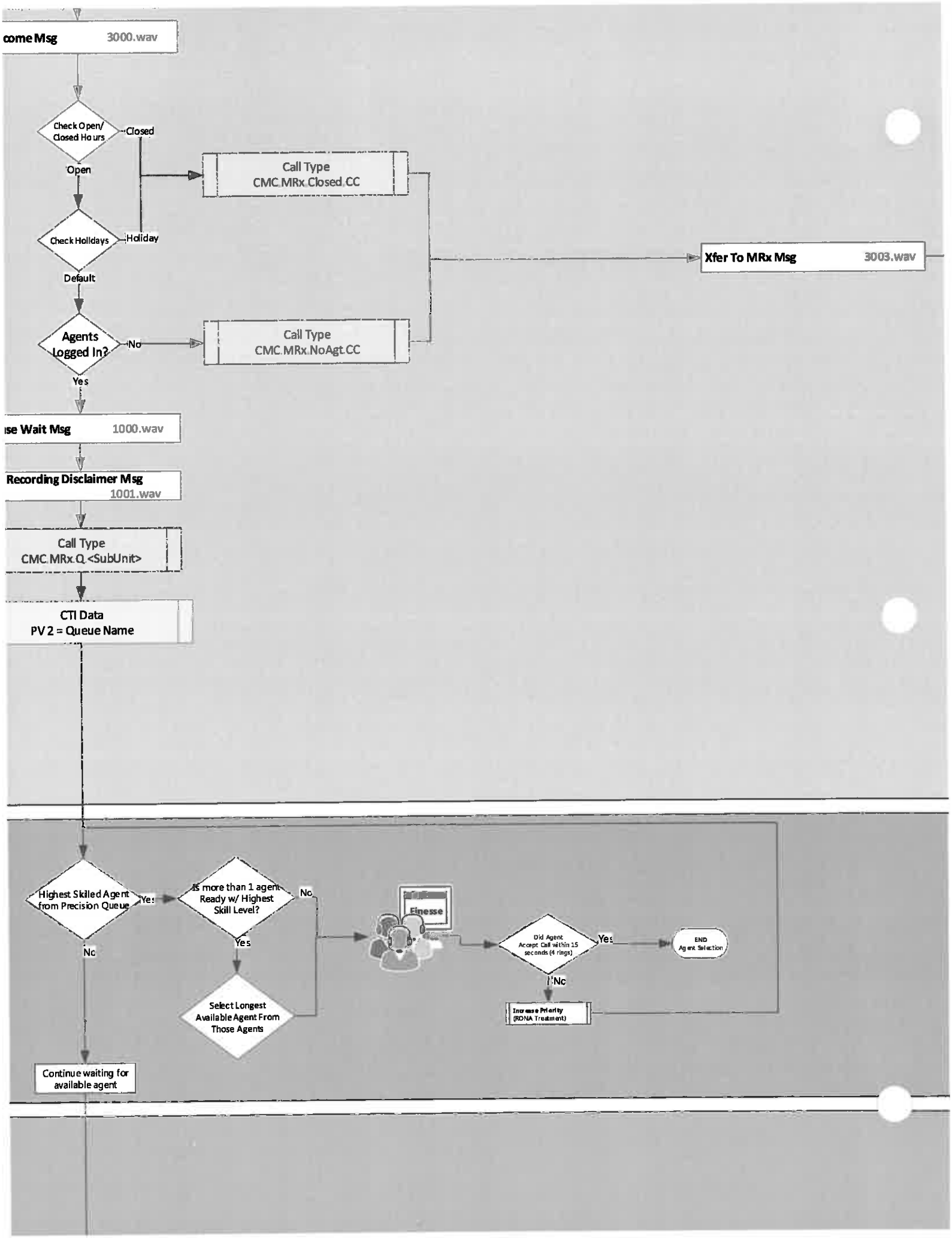

weather
Weather Msg 1010.wav
unforeseen
Unforeseen Msg 1011.wav
techdiff
Technical Difficulties Msg 1012.wav
Call Type CMC.MRx.VM.Cmc.Concierge
Member Menu
2002.wav
1 Help With Covered Medication
2 Rejected Medications
3 Authorization Status
4 Initiate Appeal
5 Eligibility Information
6 Premium Information
0 "Operator"
Repeat
* Previous
Call Type CMC.MRx.AA.Cmc.Concierge.Mbr.1
Call Type CMC.MRx.AA.Cmc.Concierge.Mbr.2
Call Type CMC.MRx.AA.Cmc.Concierge.Mbr.3
Call Type CMC.MRx.AA.Cmc.Concierge.Mbr.4
Call Type CMC.MRx.AA.Cmc.Concierge.Mbr.5
Call Type CMC.MRx.AA.Cmc.Concierge.Mbr.6
Call Type CMC.MRx.AA.Cmc.Concierge.Mbr.0
Yes
Call Type CMC.MRx.AA.Cmc.Concierge.Main.1
Call Type CMC.MRx.AA.Cmc.Concierge.Main.2
Call Type CMC.MRx.AA.Cmc.Concierge.Main.3
Call Type CMC.MRx.AA.Cmc.Concierge.Main.0
Pharmacy Menu
1 BIN/PCN
2 Rejected Claims
3 Authorization
4 Contract Info
0 "Operator"
Repeat
Call Type CMC.MRx.AA.Cmc.Concierge.Pharm.1
Call Type CMC.MRx.AA.Cmc.Concierge.Pharm.2
Call Type CMC.MRx.AA.Cmc.Concierge.Pharm.3
Call Type CMC.MRx.AA.Cmc.Concierge.Pharm.4
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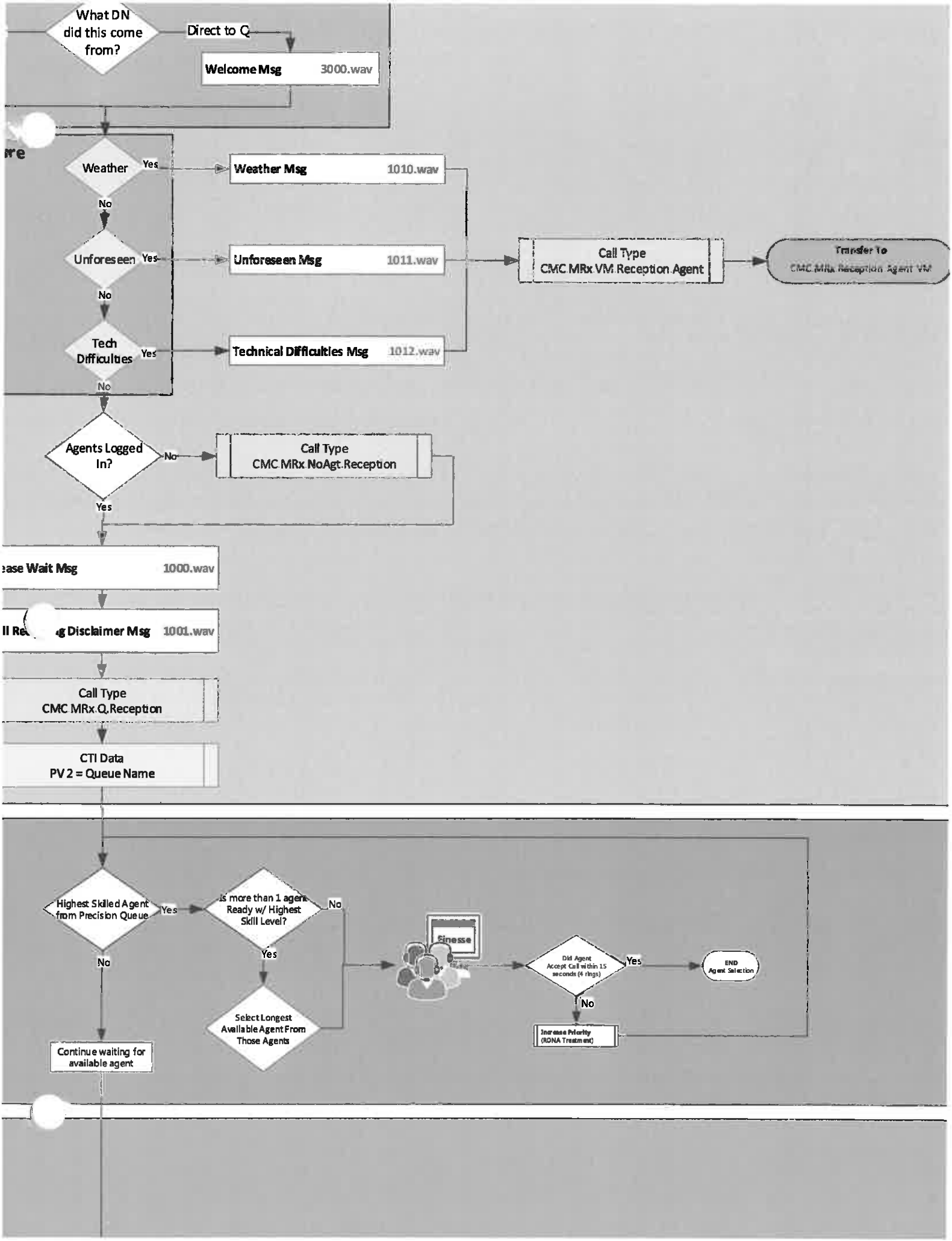

2000.wav
weather
Weather Msg
1010.wav
unforeseen
Unforeseen Msg
1011.wav
techdiff
Technical Difficulties Msg
1012.wav
Call Type
CMC.MRx.VM.Commercial
Member Menu
2002.wav
1
Help With Covered Medication
2
Rejected Medications
3
Authorization Status
4
Initiate Appeal
5
Eligibility Information
6
Premium Information
0
"Operator"
#
Repeat
*
Previous
Call Type
CMC.MRx.AA.Cmc.Bridge.Mbr.1
Call Type
CMC.MRx.AA.Cmc.Bridge.Mbr.2
Call Type
CMC.MRx.AA.Cmc.Bridge.Mbr.3
Call Type
CMC.MRx.AA.Cmc.Bridge.Mbr.4
Call Type
CMC.MRx.AA.Cmc.Bridge.Mbr.5
Call Type
CMC.MRx.AA.Cmc.Bridge.Mbr.6
Call Type
CMC.MRx.AA.Cmc.Bridge.Mbr.0
Yes
Call Type
CMC.MRx.AA.Cmc.Bridge.Main.1
Call Type
CMC.MRx.AA.Cmc.Bridge.Main.2
Call Type
CMC.MRx.AA.Cmc.Bridge.Main.3
Call Type
CMC.MRx.AA.Cmc.Bridge.Main.0
Pharmacy Menu
2003.wav
1
BIN/PCN
2
Rejected Claims
3
Authorization
4
Contract Info
0
"Operator"
#
Repeat
Call Type
CMC.MRx.AA.Cmc.Bridge.Pharm.1
Call Type
CMC.MRx.AA.Cmc.Bridge.Pharm.2
Call Type
CMC.MRx.AA.Cmc.Bridge.Pharm.3
Call Type
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Call Type
CMC.MRx.AA.Cmc.Bridge.Pharm.0

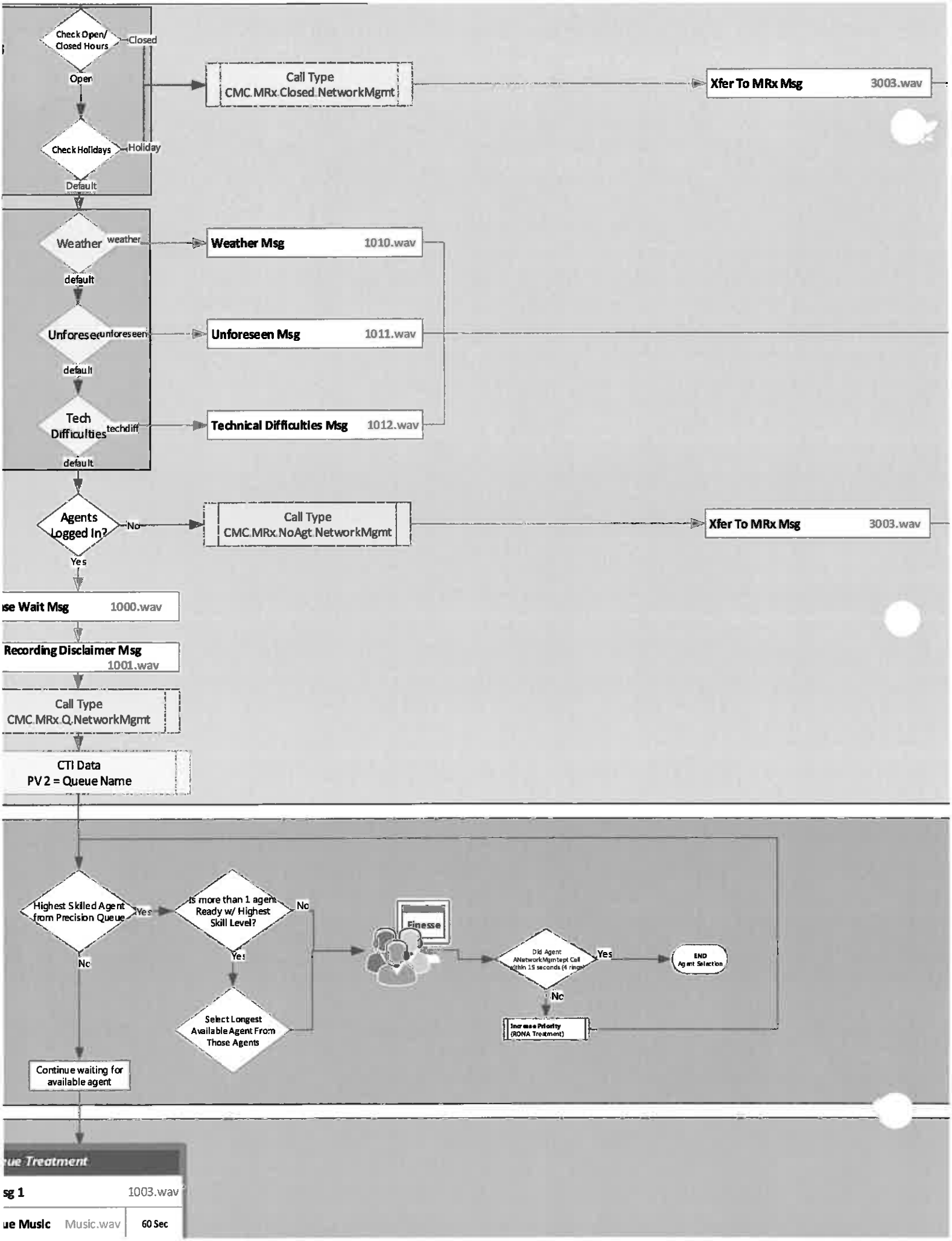

weather
Weather Msg 1010.wav
Unforeseen Msg 1011.wav
techdiff
Technical Difficulties Msg 1012.wav
Call Type CMC.MRx.VM.Commercial
Member Menu
2002.wav
1 Help With Covered Medication
2 Rejected Medications
3 Authorization Status
4 Initiate Appeal
5 Eligibility Information
6 Premium Information
0 "Operator"
Repeat
* Previous
Call Type CMC.MRx.AA.Cmc.GMS.Mbr.1
Call Type CMC.MRx.AA.Cmc.GMS.Mbr.2
Call Type CMC.MRx.AA.Cmc.GMS.Mbr.3
Call Type CMC.MRx.AA.Cmc.GMS.Mbr.4
Call Type CMC.MRx.AA.Cmc.GMS.Mbr.5
Call Type CMC.MRx.AA.Cmc.GMS.Mbr.6
Call Type CMC.MRx.AA.Cmc.GMS.Mbr.0
Yes
Call Type CMC.MRx.AA.Cmc.GMS.Main.1
Call Type CMC.MRx.AA.Cmc.GMS.Main.2
Call Type CMC.MRx.AA.Cmc.GMS.Main.3
Call Type CMC.MRx.AA.Cmc.GMS.Main.0
Pharmacy Menu
2003.wav
1 BIN/PCN
2 Rejected Claims
3 Authorization
4 Contract Info
0 "Operator"
Repeat
Call Type CMC.MRx.AA.Cmc.GMS.Pharm.1
Call Type CMC.MRx.AA.Cmc.GMS.Pharm.2
Call Type CMC.MRx.AA.Cmc.GMS.Pharm.3
Call Type CMC.MRx.AA.Cmc.GMS.Pharm.4
Call Type CMC.MRx.AA.Cmc.GMS.Pharm.0

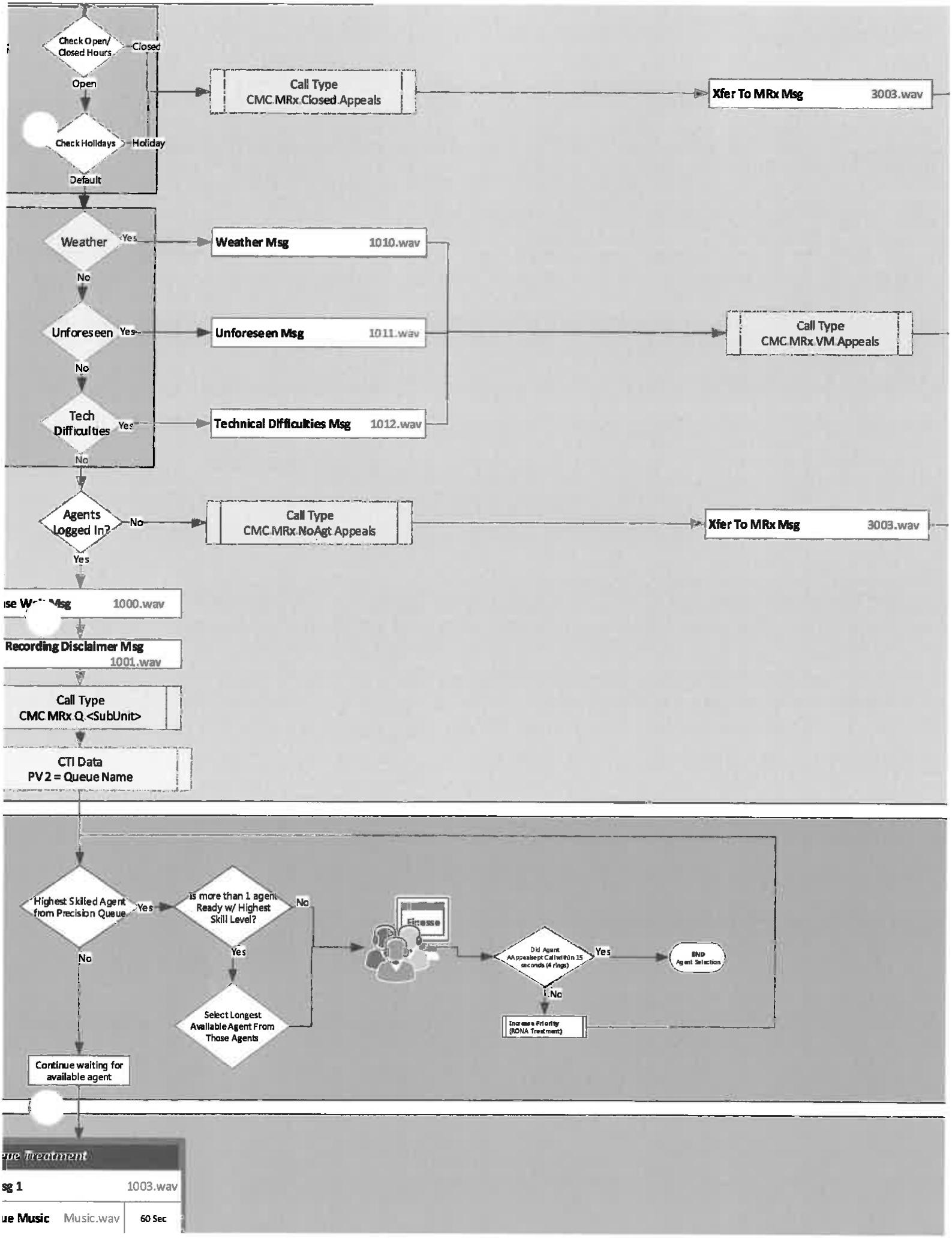

What DN did this come from?
Direct to Q
Welcome Msg 3000.wav
Weather
Yes
Weather Msg 1010.wav
No
Unforeseen
Yes
Unforeseen Msg 1011.wav
No
Tech Difficulties
Technical Difficulties Msg 1012.wav
No
Agents Logged In?
No
Call Type CMC.MRx.NoAgt <SubUnit>
Yes
Send to the VM associated to the queue the call was going to
Call Type CMC.MRx.VM.<SubUnit>
Transfer To CMC MRx <SubUnit> VM
1000.wav
1001.wav
Call Type CMC.MRx.Q.<SubUnit>
CTI Data PV 2 = Queue Name
Highest Skilled Agent from Precision Queue
Yes
No
Is more than 1 agent Ready w/ Highest Skill Level?
No
Yes
Select Longest Available Agent From Those Agents
Finesse
Did Agent Accept Call within 15 seconds (4 rings)
Yes
No
END Agent Selection
Increase Priority (RONA Treatment)
Continue waiting for available agent

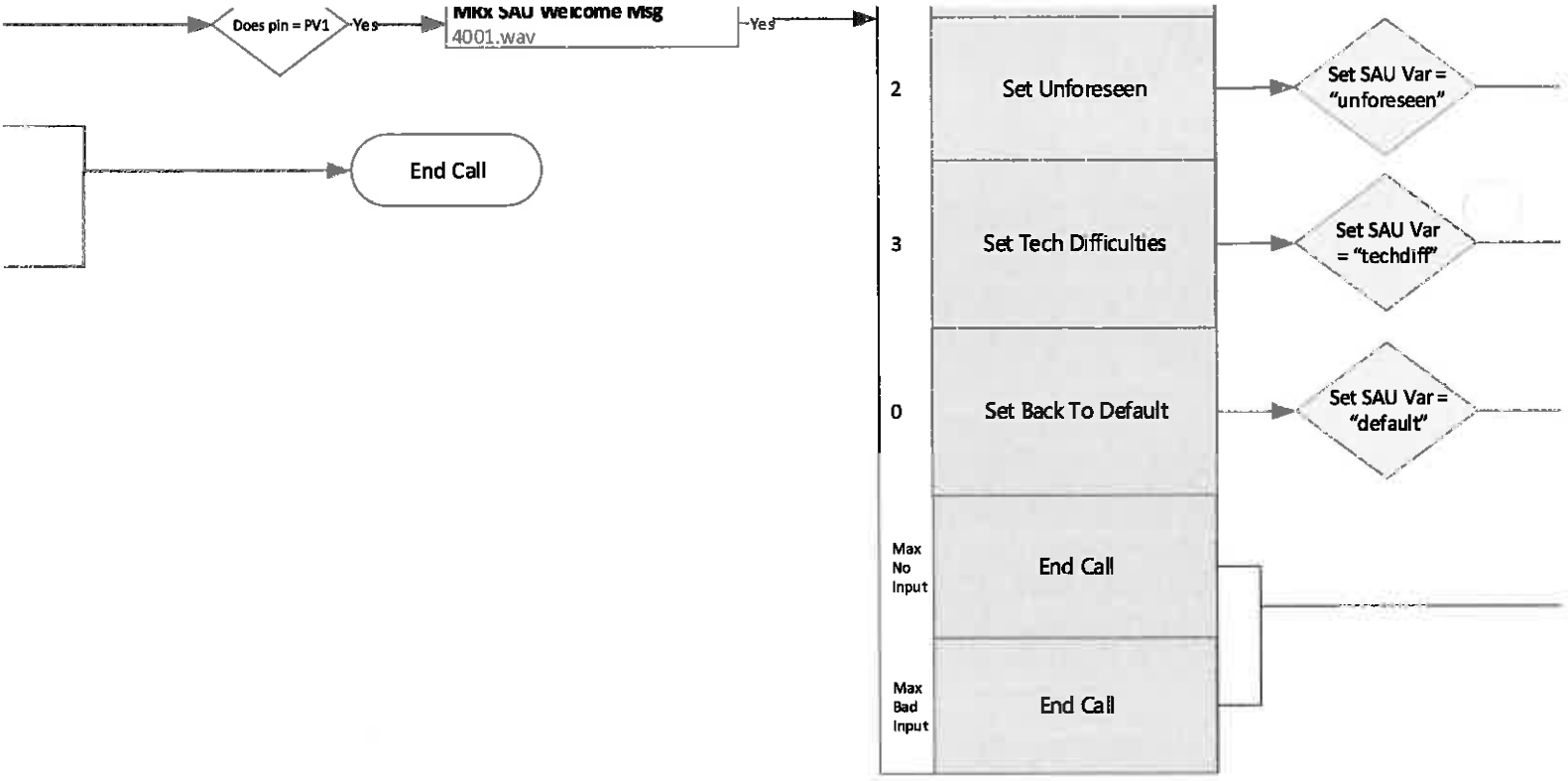

come Msg 3000.wav
Check Open/ Closed Hours
Closed
Open
Call Type CMC MRx Closed Pharm
Check Holidays
Holiday
Default
Transfer To Pharmacist On Call Cell (918-600-4456)
Agents Logged In?
No
Call Type CMC MRx NoAgt Pharm
Yes
se Wait Msg 1000.wav
Recording Disclaimer Msg 1001.wav
Call Type CMC MRx Q Pharm
CTI Data Queue Name
Highest Skilled Agent from Precision Queue
Yes
No
Is more than 1 agent Ready w/ Highest Skill Level?
No
Yes
Select Longest Available Agent From Those Agents
Finesse
Did Agent Accept Call within 15 seconds (4 rings)
Yes
END Agent Selection
No
Increase Priority (RONA Treatment)
Continue waiting for available agent


come Msg
3000.wav
Check Open/ Closed Hours
Closed
Open
Call Type CMC.MRx.Closed.CC
Check Holidays
Holiday
Default
Xfer To MRx Msg
3003.wav
Agents Logged In?
No
Call Type CMC.MRx.NoAgt.CC
Yes
se Wait Msg
1000.wav
Recording Disclaimer Msg
1001.wav
Call Type CMC.MRx.Q.<SubUnit>
CTI Data PV 2 = Queue Name
Highest Skilled Agent from Precision Queue
Yes
Is more than 1 agent Ready w/ Highest Skill Level?
No
Yes
Finesse
Did Agent Accept Call within 15 seconds (4 rings)
Yes
END Agent Selection
No
Increase Priority (RONA Treatment)
Select Longest Available Agent From Those Agents
No
Continue waiting for available agent


What DN did this come from?
Direct to Q
Welcome Msg 3000.wav
Weather
Yes
Weather Msg 1010.wav
No
Unforeseen
Yes
Unforeseen Msg 1011.wav
No
Tech Difficulties
Yes
Technical Difficulties Msg 1012.wav
No
Agents Logged In?
No
Call Type CMC MRx NoAgt Reception
Yes
Call Type CMC MRx VM Reception Agent
Transfer To
ease Wait Msg 1000.wav
g Disclaimer Msg 1001.wav
Call Type CMC MRx Q Reception
CTI Data PV 2 = Queue Name
Highest Skilled Agent from Precision Queue
Yes
No
Is more than 1 agent Ready w/ Highest Skill Level?
No
Yes
Select Longest Available Agent From Those Agents
Continue waiting for available agent
Finesse
Did Agent Accept Call within 15 seconds (4 rings)
Yes
No
END Agent Selection
Increase Priority (RONA Treatment)


Check Open/ Closed Hours
Closed
Open
Check Holidays
Holiday
Default
Call Type CMC.MRx.Closed.NetworkMgmt
Xfer To MRx Msg 3003.wav
Weather
weather
default
Weather Msg 1010.wav
Unforesee
unforeseen
default
Unforeseen Msg 1011.wav
Tech Difficulties
techdiff
default
Technical Difficulties Msg 1012.wav
Agents Logged In?
No
Yes
Call Type CMC.MRx.NoAgt.NetworkMgmt
Xfer To MRx Msg 3003.wav
se Wait Msg 1000.wav
Recording Disclaimer Msg 1001.wav
Call Type CMC.MRx.Q.NetworkMgmt
CTI Data PV 2 = Queue Name
Highest Skilled Agent from Precision Queue
Yes
No
Is more than 1 agent Ready w/ Highest Skill Level?
No
Yes
Select Longest Available Agent From Those Agents
Finesse
Did Agent ANetworkMgmtept Call within 15 seconds (4 rings)
Yes
No
END Agent Selection
Increase Priority (RONA Treatment)
Continue waiting for available agent
ue Treatment
sg 1 1003.wav
ue Music Music.wav
60 Sec


Check Open/ Closed Hours
Closed
Open
Check Holidays
Holiday
Default
Call Type CMC.MRx.Closed.Appeals
Xfer To MRx Msg 3003.wav
Weather
Yes
No
Weather Msg 1010.wav
Unforeseen
Yes
No
Unforeseen Msg 1011.wav
Tech Difficulties
Yes
No
Technical Difficulties Msg 1012.wav
Call Type CMC.MRx.VM.Appeals
Agents Logged In?
No
Yes
Call Type CMC.MRx.NoAgt.Appeals
Xfer To MRx Msg 3003.wav
1000.wav
Recording Disclaimer Msg 1001.wav
Call Type CMC.MRx.Q.<SubUnit>
CTI Data PV2 = Queue Name
Highest Skilled Agent from Precision Queue
Yes
No
Is more than 1 agent Ready w/ Highest Skill Level?
No
Yes
Select Longest Available Agent From Those Agents
Continue waiting for available agent
Finesse
Did Agent AAppealsept Call within 15 seconds (4 rings)
Yes
No
END Agent Selection
Increase Priority (RONA Treatment)
ue Treatment
sg 1
1003.wav
ue Music
Music.wav
60 Sec


Does pin = PV1
Yes
Mkx SAU Welcome Msg
4001.wav
Yes
End Call
2
Set Unforeseen
Set SAU Var = "unforeseen"
3
Set Tech Difficulties
Set SAU Var = "techdiff"
0
Set Back To Default
Set SAU Var = "default"
Max No Input
End Call
Max Bad Input
End Call

TRUSTED Health Plan
THP

Pharmacy Department

Lock In Process Workflow

1. Receive 3-3-3 Report from MeridianRX
2. Review the report
3. Look at each member's pharmacy profile and retrieve the claim information *date, prescriber's info, pharmacy info, quantity, day supply.
4. Record all the above information
5. Call the Primary Care Provider (PCP) to verify if there have been any referral or medical reason for the member to receive the prescriptions in question.
6. If no referral or medical reason verified by the PCP
   * Call each prescriber and inquire about the nature of the visit and reason for the prescription.
7. Notify the PCP of the findings and discuss the possible need to lock the member to a specific prescriber.
8. If need to place the member on lock in
   * notify DHCF of the intend and reason for the lock in
   * notify the member via letter of the lock in (designation of restricted beneficiary)

- The member has fourteen (14) days to dispute the lock in

9. If no dispute from the member

   * place a prescriber lock in the Merlin system (MeridianRx) for a period of six months.

10. After the six (6) months period, discuss with the PCP the need to extend the Lock in or release the lock in.

TRUSTED Health Plan
THP

If you need this information in English, please contact Member Services at (202) 821-1100 or (855) 326-4831, 24 hours a day, 7 days a week.
Si necesita esta información en español, por favor póngase en contacto con Servicio al Miembro las 24 horas del día a (202) 821-1100 o (855) 326-4831.
(855) [illegible] (202)821-1100 [illegible] 4831
Si vous avez besoin de cette information en français, s'il vous plaît communiquer avec les Services aux membres au (202) 821-1100 ou (855) 326-4831, 24 heures par jour.
如果你需要這裡在中國的信息，請聯繫會員服務： (202) 821-1100或(855) 326-4831，每天24小時。
Se você precisar de informações em Português, por favor contacte os Serviços para Associados no (202) 821-1100 ou (855) 326-4831, 24 horas por dia

PLEASE READ CAREFULLY

THIS LETTER IS ABOUT A RESTRICTED MEDICAID BENEFICIARY

Date

Trusted Health Plan
1100 New Jersey Avenue SE
Suite 840
Washington, DC 20003

Name
Address
Address
Washington, DC

Member ID:

Dear Member,

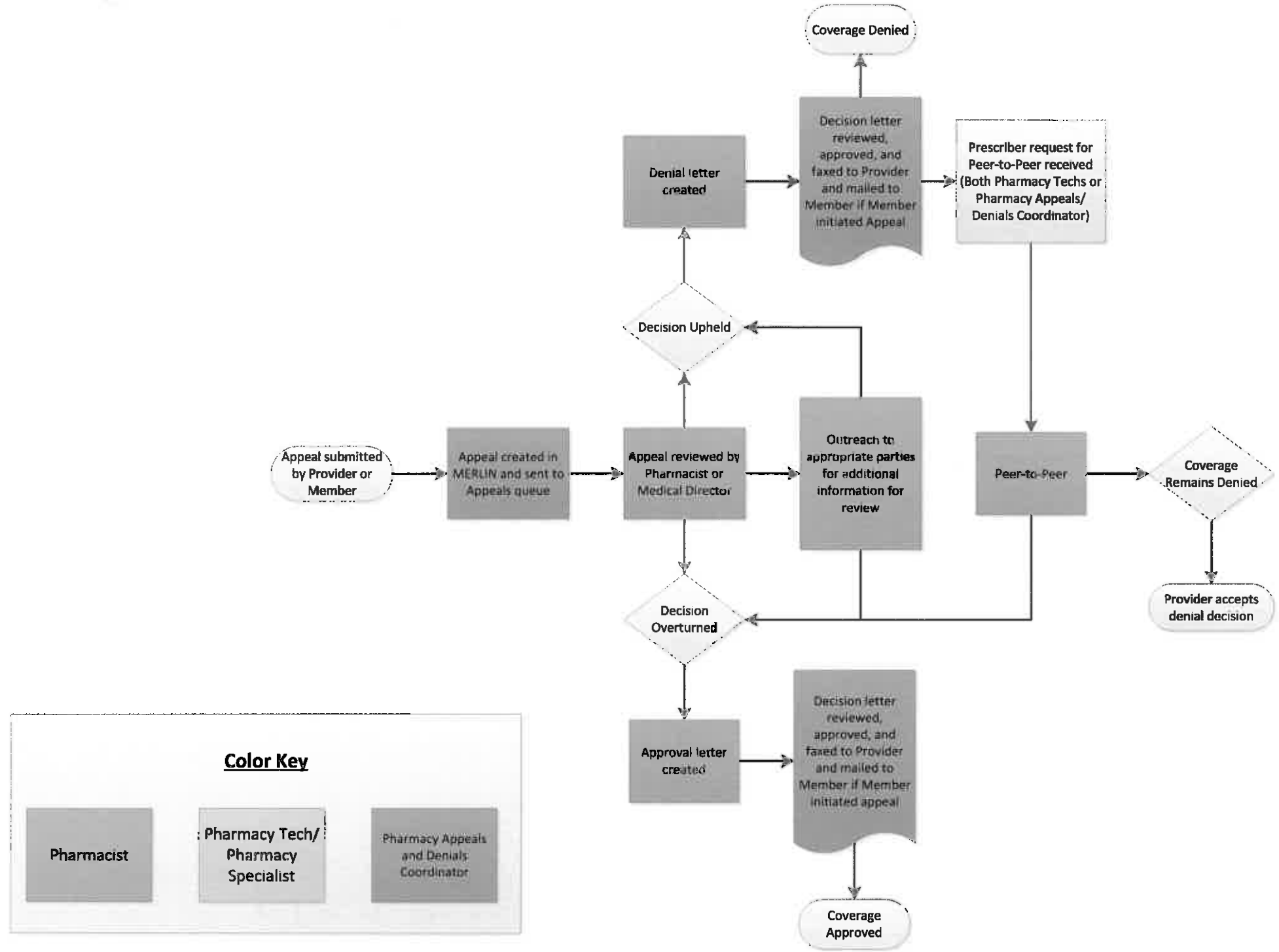
We have identified you as a restricted Medicaid Beneficiary.
The reason for this action is that you have received multiple controlled substances from multiple prescribers without clinical reason. You will only be able to receive prescriptions from your Primary Care Physician (PCP Name). This restriction will be in place for a period of six (6) months beginning fifteen (15) days from the date of this letter (XX/XX/2014).

If you disagree with this decision, you have the right to request a hearing with the Office of Administrative Hearings. You have fifteen (15) days from the date of this letter to file a request for a hearing. You can file by calling the Office of Administrative Hearings at (202) 442-9094.

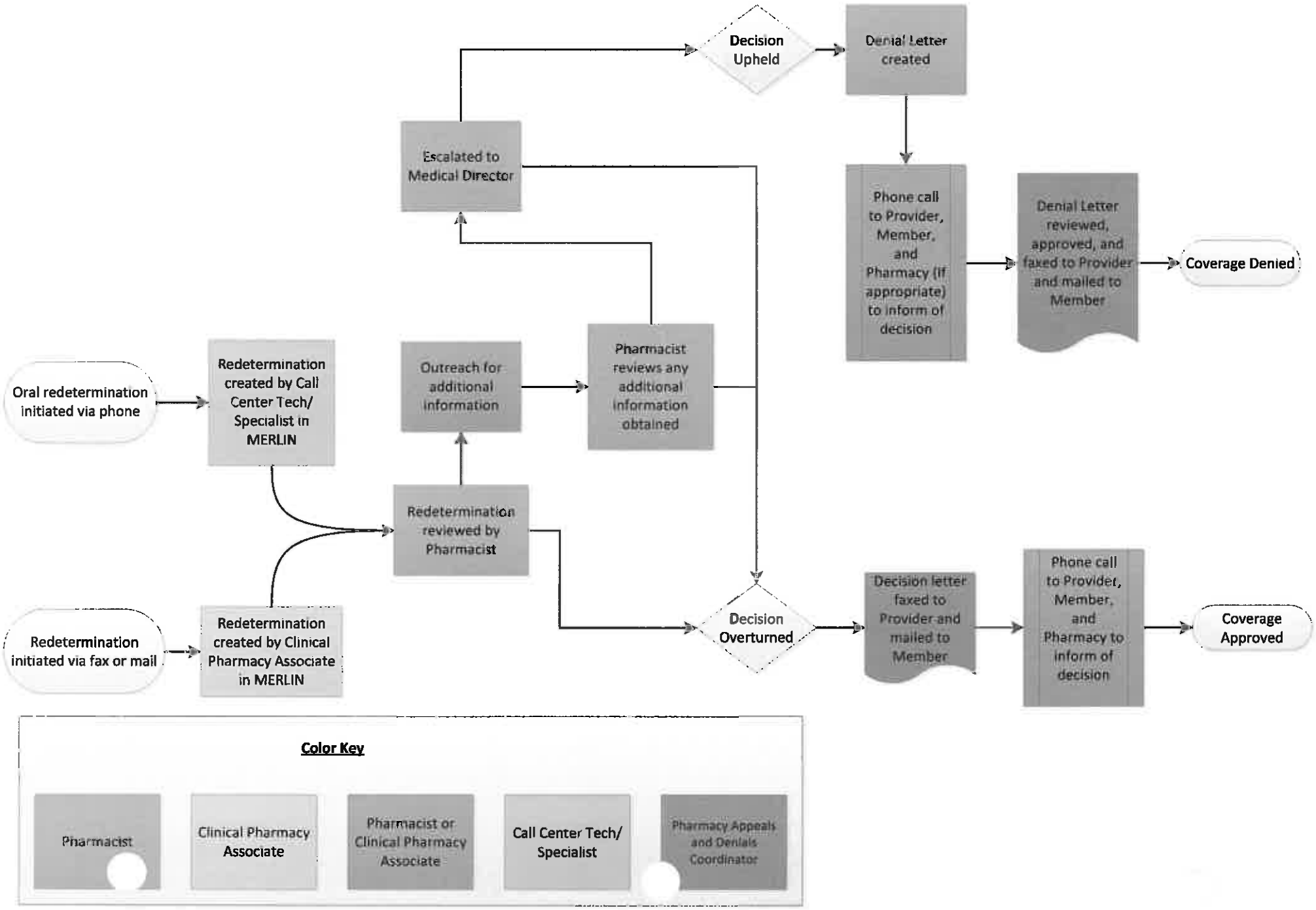
Thank you,

Jose I. Diaz-Luna, RPh
Pharmacy Manager
Trusted Health Plan
Tel: (202) 821-1127
Email: jdiaz-luna@trustedhp.com

MERLIN Appeal Flow - Medicaid



MERLIN Redetermination Flow - Medicare



Appendix L: CLAIMS REPORT- Place documents here

TRUSTED HEALTH PLAN	Effective Date: 07/02/2014	Policy #: UM-2015-0002
Department- Utilization Management	Reviewed Date:	Expiration Date:
Policies and Procedures	Revised Date: 11/18/2015	Pages: 3

POLICY TITLE: **ED and Post-Stabilization Care**

PURPOSE:

To define Trusted's policy on payment for emergency department (ED or ER) services received by members. The ED and Post-Stabilization Care policy is designed to outline policies and procedures with regards to retrospective review, authorization, and payment responsibilities for Emergency and Post-Stabilization care per contract requirements C.8.2.5.4.1.3- C.8.2.5.9.

SCOPE:

The policy is applicable to all Trusted enrollees, staff and providers.

DEFINITIONS:

1. **Post-stabilization Care Services:** Covered services that are (a) related to an emergency medical condition; (b) provided after a member is stabilized; and (c) provided either to maintain the stabilized condition, or under certain circumstances (see below), to improve or resolve the member's condition.

POLICY AND PROCEDURE:

1. Emergency Care Authorization and Payment

1. Trusted covers emergency services necessary to screen and stabilize members without prior authorization in cases where a prudent layperson, acting reasonably, would have believed that an emergency medical condition existed.
2. Trusted does not require prior authorization for emergency services. This applies to out-of-network as well as to in-network services, which an Enrollee seeks in an emergency.
3. Trusted will not refuse to cover emergency services based on the failure of the emergency room provider, hospital, or fiscal agent to notify the enrollee's primary care provider or Trusted of screening and treatment within 10 calendar days of presentation for emergency services.
4. Trusted covers emergency services if an authorized representative authorizes the provision of emergency services, including ambulance transport.

TRUSTED HEALTH PLAN	Effective Date: 07/02/2014	Policy #: UM-2015-0002
Department- Utilization Management	Reviewed Date:	Expiration Date:
Policies and Procedures	Revised Date: 11/18/2015	Pages: 3

5. Trusted enrollees will not be held liable for payment of ED services and subsequent screening and treatment needed to diagnose the specific condition and to stabilize the patient.
6. The attending emergency physician, treating the enrollee is responsible for determining when the enrollee is stable for transfer or discharge. This determination is upheld by Trusted.

2. Post-Stabilization Care Authorization

Trusted Health Plan is financially responsible for post-stabilization care services following the treatment of an emergency medical condition, which are obtained within, or outside, the health plan that:

1. Are pre-approved by a plan provider or other Trusted Health Plan representative;
2. Are not pre-approved by a plan provider or other Trusted Health Plan representative, but are administered to maintain the member's stabilized condition within one hour of a request to Trusted Health Plan for pre-approval of further post-stabilization care;
3. Are not pre-approved by a plan provider or other Trusted Health Plan representative, but administered to maintain, improve, or resolve the member's stabilized condition if:
    a. Trusted Health Plan does not respond to a request for pre-approval within one hour;
    b. Trusted Health Plan cannot be contacted; or
    c. Trusted Health Plan representative and the treating physician cannot reach an agreement concerning the enrollees care, and a plan physician is not available for consultation. (In this situation, Trusted Health Plan must give the treating physician the opportunity to consult with a plan physician).
    d. The treating physician may continue with care of the member until a plan physician is reached or one of the criteria in below are met.
4. Trusted Health Plan's financial responsibility for post-stabilization care services it has not pre-approved ends when:
        1. A plan physician with privileges at the treating hospital assumes responsibility for the member's care;
        2. A plan physician assumes responsibility for the member's care through transfer;
        3. A Trusted Health Plan representative and the treating physician reach an agreement concerning the member's care; or
        4. The member is discharged

TRUSTED HEALTH PLAN	Effective Date: 07/02/2014	Policy #: UM-2015-0002
Department- Utilization Management	Reviewed Date:	Expiration Date:
Policies and Procedures	Revised Date: 11/18/2015	Pages: 3

3. Court Ordered Treatment

In the event that a Court orders a level or form of treatment that Trusted does not consider Medically Necessary, Trusted shall develop and furnish the Court with an alternative treatment plan and, if the Court approves the plan, Trusted shall assist the Enrollee to secure the treatment set forth in the plan. If the Court rejects the alternative plan, Trusted shall furnish the Court-ordered services. Trusted shall comply with the setting of care specified by the Court (e.g., work, school, childcare, home, or other setting). (C.8.2.5.5)

1.4 Treatment During Transition

During the first sixty (60) days after an individual's enrollment (i.e., the Transition Period), a service is Medically Necessary if it relates to the treatment that the individual was receiving immediately prior to enrollment. (C.8.2.5.6)

APPROVED BY:

Judith Hunter — 11/18/2015

Sr. Director of Clinical Programs — Date

N Jackson MD — 11/18/2015

Chief Medical Officer — Date

TRUSTED Health Plan
THP

TRUSTED HEALTH PLAN	Effective Date: 7/01/2014	Policy #: CM-2014-0001
Department- Case Management	Reviewed Date:	Expiration Date:
Policies and Procedures: Complex Case Management Program Description	Revised Date: 6/30/2015	Pages 15

POLICY TITLE: Complex Case Management Program Description

PURPOSE: The purpose of this Complex Case Management program description is to establish and document processes to ensure that high-risk, and chronically ill individuals receive medically necessary care, and the care is coordinated and delivered effectively throughout the integrated care delivery system.

SCOPE: This policy involves Trusted staff in Medical Management, Case Management, Disease Management, Outreach, EPSDT, Pharmacy Management and all applicable delegates.

DEFINITIONS:

1. **Care Coordination:** Functions that supports information-sharing across providers, patients, types and levels of service, sites and timeframes.
2. **Case Manager:** A nurse or licensed clinician, experienced and skilled to accurately assess and evaluate the individual in terms of medical and psychosocial parameters. The Case Manager is responsible for working cooperatively with the practitioners, providers and facilities to identify, coordinate and evaluate services and care across the continuum for individuals and disease-based populations.
3. **Chronic Care Management:** Focuses on members with chronic conditions who have moderately significant symptom management issues and/or behavioral and psychosocial needs that require resources to help minimize disease progression and education or support to address care opportunities.
4. **Complex Case Management (CCM):** The coordination of care and services provided to members who have experienced a critical event or diagnosis that requires the extensive use of resources and who need help navigating the system to facilitate appropriate delivery of care and services.

TRUSTED HEALTH PLAN	Effective Date: 7/01/2014	Policy #: CM-2014-0001
Department- Case Management	Reviewed Date:	Expiration Date:
Policies and Procedures: Complex Case Management Program Description	Revised Date: 6/30/2015	Pages 15

Overview

Trusted Health Plan (THP) understands that Complex Case Management is the coordination of care and services provided to members who have experienced a critical event or diagnosis that require the extensive use of resources and who need help navigating the system to facilitate appropriate delivery of care and services.

This Complex Case Management Program Description outlines processes for implementing case management activities followed by Trusted Health Plan and its delegates, and includes:

1. Evidence used to develop the program.
2. Criteria for identifying members who are eligible for the program.
3. Services offered to individuals.
4. Defined program goals.
5. How case management services are integrated with services of others involved in member care.

The goals of THP's Complex Case Management Program are to:

- Assist members in achieving optimum health, functional capability, and quality of life through improved management of their disease or condition.
- Assist members in determining and accessing available benefits and resources.
- Work collaboratively with members, family and significant others, providers, and community organizations to develop goals and assist members in achieving those goals.
- Assist members by facilitating timely receipt of appropriate services in the most appropriate setting.
- Maximize benefits and resources through oversight and cost-effective utilization management.

Population Assessment

THP assesses the characteristics and needs of its entire member population and relevant subpopulations annually. THP utilizes its clinical management database (CareAnalyzer™) to run reports to identify enrollees at risk of illness or diagnosed with a condition that requires support. Analysis also includes claims data, historical data, etc. to identify treatment patterns and trends in disease, and data from other sources to identify characteristics of THP memberships, which may include:

- Age and Gender (number, rate and ranges) Distribution
- Racial, Ethnic and Language Preferences
- Top 10 Inpatient Diagnosis (including number and rate of occurrences)
- Top 10 Ambulatory Diagnosis (including number and rate of occurrences)
- Top 5 Emergency Room Diagnosis (including number and rate of occurrences)
- Top 5 Behavioral Health Diagnosis (including number and rate of occurrences)
- Needs of children and adolescents including physical, mental, emotional and other special needs for complex case management
- Prevalence and needs of members with comorbidities (members with two or more chronic diseases), physical disabilities and with serious and persistent mental illness.

Case Management, in collaboration with THP's Quality Department, utilizes the findings from the annual needs analysis to review the overall comprehensiveness of the case management program and make updates to the program as needed to include:

- The program description and processes followed to coordinate care for a member.
- Resources both internal (e.g. Outreach Center, staffing ratios, job training, etc.) and external (e.g. service agencies) used to meet the needs of its membership.

Coordination and Continuity of Care

THP's Complex Case Management Program is developed with the circumstances of the enrollee and family in mind. We understand that the health care system is complicated and requires hard work to assist each enrollee in navigating through its many complexities by communicating with the provider, exchanging data and providing education and

awareness. Identifying gaps in the treatment plan or noncompliance are key; incorporating opportunities to go to where the enrollee lives and socializes is vital to THP's success.

Access: In an effort to impact health outcomes, THP is committed to ensuring a provider network that is accessible to the enrollees served. There is a strong emphasis on ensuring the provider network is adequate and responsive to the enrollee and that each person has an active and engaged provider to coordinate care.

Quality: THP has implemented a robust quality program. Transparency of performance is provided to enrollees, providers, staff and the District of Columbia. THP is committed to decreasing the District of Columbia's gaps in disparity by ensuring access to board – certified providers, incorporation of evidenced – based medicine into treatment plans and the evaluation of performance by identifying indicators that will determine whether the program is working.

Complex Case Management Eligibility Criteria

Any member with serious and complex conditions that are persistent and substantially disabling or life threatening that requires treatments and services across a variety of domains of care (medical and social) is eligible for complex case management. Examples include, but are not limited to spinal injuries, trauma, multiple chronic diseases, and chronic illness that result in high utilization of services. Integration with Disease Management programs is leveraged to identify and refer members to Complex Case Management based on the severity and complexity of member's health problem(s), and the intensity of case management services necessary.

The criteria used for inclusion in Complex Case Management include, but is not limited to:

- Conditions associated with negative consequences for someone else: high-risk pregnancy, HIV/AIDS
- Members that have frequent ED visits (3< ED visits in 6 months)
- Members that are non-compliant with Diabetes Management
- Conditions that affect multiple organ systems: Metastatic cancer, degenerative disorders

- Conditions that are life threatening
- Members with very severe complicated co-morbidities
- Member who may have had at least two unplanned inpatient readmissions within the last 30 days
- Member who may have multiple providers of care that are not communicating and who are creating an on-going risk for an acute event.
- Member who may have indications of a dangerous lack of supportive resources or safety issues.

Evidence Based Program

THP's Complex Case Management Program design is based on the Case Management Society of America's (CMSA) Standards of Practice for Case Management (2010) that are the practice guidelines for the case management industry. Specifically, the CCM program uses a client-centric, holistic approach, encourages self-determination and self-care, integrates behavioral change principles, links with community resources and assists with navigating the health care system –within the framework of cultural competence and professional excellence. The program also promotes quality outcomes and has established periodic assessments to measure and track outcomes.

The roles of Complex Case Managers are consistent with those outlined in the guidelines: assessment, care planning, communication and coordination, education, empowering and advocacy. The program also follows the case management process detailed in the guidelines: member identification and selection, assessment and problem/opportunity identification, development of care plan, implementation of interventions, and evaluation of progress and termination of the case management process.

The Complex Case Management Program uses nationally recognized evidence-based clinical practice guidelines issued by leading health organizations, including, but not limited to, the National Clearinghouse (www.guideline.gov), National Heart, Lung and Blood Institute (NHLBI), American Diabetes Association (ADA), and American Heart Association (AHA) to guide case management assessment and management for members with chronic conditions, such as, Asthma, Coronary Artery Disease, Chronic Obstructive Pulmonary Disease, Diabetes, and Heart Failure.

Localized health issues are considered and integrated into CCM program planning and interventions based on information from Healthy People 2020.

Healthy People 2020 is the federal government's prevention agenda for building a healthier nation. It is a statement of national health objectives designed to identify the most significant preventable threats to health and to establish national goals to reduce these threats. Used as a baseline for comparison with the District of Columbia population, HealthyPeople 2020 allows us to gauge our health status, and highlights how the District compares to national statistics.

Identification of Members for Complex Case Management

THP's Complex Case Management program uses multiple sources in the identification of members to be included in case management such as:

1. Claim or encounter data
2. Hospital discharge data
3. Pharmacy data, if applicable
4. Data collected through the UM Management process
   - Prior authorization data
   - Concurrent review data
   - Hospital admission data
5. Data supplied by purchasers (enrollment broker data)
6. Data supplied by members or caregivers
7. Data supplied by practitioners

CareAnalyzer™ serves as a primary platform for data used for identification of members for CCM. On a monthly basis data is refreshed in CareAnalyzer™ and used to identify and conduct an initial risk stratification of all members eligible for the CM program. The algorithm, at a minimum, takes into consideration inpatient hospital claims, emergency room use, co-morbid conditions and pharmacy claims.

Access to Case Management

It is the goal of the Complex Case Management program to ensure that members who experience critical events or diagnosis will receive timely complex case management services. To that end, THP has developed several sources of referrals that can be initiated upon immediate identification, at the time of care. Multiple referral options minimize the time between member identification and active case management participation.

1. Nurse Line Referral

   THP Medical Management receives daily reports of all inbound calls to THP's nurse line. Nurse Line provides health information and triage response to members who call with inquiries or problems. Member information, reason for the call, as well as instructions provided during the triage or health education process are documented by Nurse Line staff, and may include CM referral requests and care recommendations based on inbound member calls.

2. Disease Management Referral

   Members that are participating in a Disease Management program may, based on their acuity, need more intense coordination and management of their health. At any time during the disease management process, the Disease Manager or Outreach staff may refer the member to a higher/ highest level of services within the Complex Case Management Program. The referral may be based on assessment findings or increased utilization of services.

3. Discharge Planner Referral/ UM Referral

   The THP UM nurses communicate complex case management program availability to the Hospital Discharge Planners and provide information about how to refer members with each daily hospital discharge communication log. As needed, assistance is provided to the Discharge planner by the THP's UM nurse to complete referrals.

   The UM staff through their prior authorization, concurrent review, retrospective review and/or appeals review process, may identify members that qualify for

complex case management service and have the ability to refer directly for immediate assessment and identification of needs while hospitalized (if applicable). Additionally, THP Medical Management may identify a case based on the daily census review of the member, diagnosis, length of stay, or during UM case rounds and refer to a CM to reach out immediately to implement the complex CM program.

4. Member/ Caregiver Referral

   Members and/or caregivers can self-refer either by calling the Case Management department directly, presenting at the Outreach Center or by completing the online case management referral form on the THP website and forwarding to THP (either via mail or fax). Information about Complex Case Management services and how to contact CM are communicated via new member orientation, educational sessions and written communications periodically (e.g. member flyers/ newsletters).

5. Practitioner Referral

   Practitioners that have identified a member that meets the complex case management criteria can refer a member for complex case management either telephonically or electronically by downloading the referral form and sending directly to the case management department. Case Management services and CM program contact information are communicated via provider training, THP website portal and written communications periodically (e.g. provider flyers/ newsletters).

Referral sources have the ability to submit a complex case management referral using the referral form to the CM Program using multiple routes:

- Electronically
  - Via E-mail or fax to Medical Management
  - THP Website
  - Internal task using the CM referral task queue via CareConnect™ *(THP UM and DM Staff only)*

- Mailing the completed referral form to:
  Trusted Health Plan
  1100 NJ Ave., SE
  Ste. 840
  Washington, DC 20003
  Attn: Complex Case Management

The THP Complex Case Management program is an "opt-out" program. All eligible members have the right to participate or decline participation. The case manager provides an explanation of the Complex Case Management program and services to the member during initial contact.

Complex Case Management service components include clinical condition monitoring, treatment plan and medication adherence, assessment of medical and behavioral health co-morbidities to include depression screening, health behaviors, psychosocial issues and stressors (including barriers to care), provision of information to a caregiver as needed, support for member to practitioner communication, integration with disease and/or behavioral management programs, and additional resources for member education within and outside of the health plan.

Because the Complex Case Management program provides benefits and quality-of-life improvements that ultimately impact overall member care, case management staff makes every attempt to enroll eligible members in the program. Strategies are utilized to contact the member or member's parents/ guardian/caregivers, including but not limited to, searching for updated member information by contacting the PCP/specialist office and sending written correspondence. Outreach attempts are tracked and documented to ensure that all options for program enrollment have been exhausted prior to reporting failure to contact the member.

If after three or more failed attempts to contact a member across a two-week period (using two or more mechanisms such as telephone, mail or home visit) are documented within the first 30 days after eligibility or enrollment, the case manager can close the case and attempt to re-enroll the member into complex case management at a later date.

Case Management Integration

THP's case management integration includes Care Coordination, Complex Case Management, Disease Management (DM) and Health promotion activities. This facilitates timely transitions in levels of care, follow-up and individualized care and services within the constructs of managed care. Case Management integration is designed to ensure that medically necessary care is coordinated and delivered effectively throughout the care delivery system.

The primary focus of the system is the coordination of care and services for high-risk, complex, and chronic members in order to facilitate efficacy in both quality and cost. However, a secondary and equally important focus is on member education and preventive measures to facilitate a long-term optimal quality of health. Therefore, a member may, based on his/her needs and achievement of goals identified within the treatment plan, move throughout the Case Management/ Disease Management continuum.

Ongoing assessments, housed within CareConnect™, are conducted by the Case Manager and are available for review for Disease Management programs. Additionally, the Case Manager evaluates utilization of resources and the predictive modeling within CareAnalyzer™ to determine whether a member should be moved from CCM to a lower level within Case Management or vice-versa. The same process is utilized for members enrolled in Disease Management who may be in need of higher level of intensity of care through Complex Case Management services.

Pharmacy Management Integration

The THP Pharmacist performs patient-centered medication reconciliation and, upon request, educates members, case managers and health care providers about the benefits and limitations of medication. To help ensure optimal health outcomes, pharmacy management monitors for and makes CM referrals for members with potential non-adherence issues and/or unusual patterns in drug utilization.

Case Management Systems

THP utilizes the CareConnect™ care management system to support clinical documentation and management, data capture, and reporting of members in Complex Case Management. The system incorporates assessment tools that are in alignment with adopted clinical practice guidelines. All prompts and scripts embedded within the system are also supported by evidence-based clinical guidelines.

All communications (telephonic and in person) with the member and the member's providers are documented in the system and include a recording of actions, interactions with anyone associated with member's case. The system will automatically log and store the user's (e.g. Case Manager) name/ ID, date and time of each entry and for each member interaction.

Based on the contact protocols for Complex Case Management, the Case Manager can schedule reminders for follow-up and monitoring prompts for next steps that are associated with milestones within the member's care plan.

Case Management Process

Stratification Based Interventions

Based on application of the criteria in the eligibility screening assessment, candidates are preliminarily stratified in low, medium, or high levels of care that correlate with the frequency of contact and intensity of interventions required to achieve favorable outcomes.

> *Low Intensity* - Generally, members identified as stable regarding any medical condition, and with primarily psychosocial needs are designated as Low Intensity and are assigned to Care Coordination level of care for ≤ a 30 day period.
>
> *Medium Intensity* - Members with moderate intensity medical conditions where the condition is mostly stable and the member has adequate caregiver support are identified as a Medium Intensity with a moderate frequency of contact for ≤ 60 days and assigned a Chronic Case Management level of care.

High Intensity - Members identified with acute and complex care management needs are assigned to a High Intensity level of care that includes completion of a comprehensive CCM assessment and a plan of care with a higher frequency of contact for ≥ 90 days with enrollment to the Complex Case Management program.

Stratification and assignment to Care Coordination, Chronic Care, or Complex Case Management may be revised at any time per CM review and interventions are subject to variation to meet the needs of the individual member.

Initial Assessment and Ongoing Monitoring

The complex case management process begins with a comprehensive initial assessment and evaluation conducted by the case manager assigned for the enrolled member within 30 calendar days of CCM program eligibility. The initial assessment includes:

1. Health status and condition-specific issues: screening for comorbidities and information on the event or diagnosis that led to the member's eligibility for CCM. Data are collected from discharge information, medical records and member's self-reported health status. Case managers screen for presence or absence of comorbidities to determine current health status.
2. Clinical History: disease onset, acute phases, inpatient stays, clinical treatment history, current and past medications including dosing and schedules.
3. Activities of daily living and functional status such as eating, bathing and mobility.
4. Behavioral health status, including cognitive functions: assessment of the member's ability to communicate and understand instructions, ability to process information about their illness, mental health conditions, and substance abuse disorders.
5. Psychosocial issues: assessment of beliefs and concerns about health conditions, perceived treatment barriers, financial issues and problems with access to care.
6. Life planning activities . Members are asked whether they have completed life planning activities such as wills, living wills, advanced directives or health care power of attorney. Life planning discussions may be excluded, as appropriate, for

pediatric CCM assessments. Life planning information is provided to all THP members in the Member Handbook.

7. Cultural and linguistic preferences or limitations: consideration of cultural beliefs and practices, language preferences, health literacy and communication needs.
8. Visual and hearing needs, preferences or limitations to identify any potential of visual or auditory barriers to effective communication or care.
9. Caregiver resources and involvement: Evaluation of caregiver and/or family involvement in the member's care plan and decision-making.
10. Available benefits. The case manager evaluates adequacy of health benefits to fulfill the member's plan of care or treatment plan.
11. Available community resources: evaluation of community-based resources that supplement those provided by the health plan, including, but not limited to resources such as:
    i. Community Mental Health Services
    ii. Disease Management programs
    iii. Wellness programs offered by local organizations such as YMCA or community centers.
    iv. Palliative care programs.

Case managers develop a customized case management plan and goals are prioritized and documented. The prioritized goals are documented in order of importance as indicated by the member's condition and case management team. The care management plan considers the members' and caregivers' goals, preferences, and desired level of involvement in the case management plan. The case management plan including the self-management plan is communicated to the member and caregiver.

Appropriate referrals to community or plan-based resources are provided, barriers to meeting or complying with the plan are identified, and a follow up schedule is developed. The documented follow-up schedule includes but is not limited to counseling, providing referrals for disease management, education and self-management have occurred, and communication about the member's current status and ongoing needs. Follow-up is

conducted to determine whether members act on referrals. Member adherence to the care plan, including adherence to self-management plans such as monitoring of weight, checking and documenting glucose levels, etc., is developed and then evaluated during each interaction with the member and caregiver. Reinforcement is provided verbally and/or with written materials, as available, to support self-management activities.

An assessment of the member's progress toward overcoming barriers to care and meeting treatment goals is conducted to determine whether changes to the care plan or goals are needed. On-going reassessments are conducted by telephonic interview between the care manager and the member at mutually agreed upon scheduled intervals of time. After interviewing the member, and /or reviewing information such as lab data, progress notes, diagnostic results, etc. in the medical record, a note regarding the member's progress is documented in the Complex Case Management care plan. The case manager documents the member's progress toward each goal, re-assesses progress and may change or add goals, if needed. The resolution date in the care plan is completed once goal(s) have been met and a summary note is completed.

The member is closed from case management services when (1) identified goals have been reached, (2) identified goals are deemed unobtainable due to member non-adherence, (3) member terminates, (4) member revokes consent for case management services, or (5) member expires.

Complex Case Management Program Satisfaction

At least annually, THP evaluates satisfaction with its Complex Case Management Programs by obtaining feedback from members through the use of satisfaction surveys or focus groups, and analysis of member complaints. Member feedback can include information about the overall program, program staff, the usefulness of the information provided through complex case management and the ability of the member to adhere to case management recommendations. Member feedback is specific to the complex case management programs being evaluated.

Complex Case Management Program Effectiveness

At least annually, three targeted quality improvement measures are selected as program goals and are used to measure the effectiveness of the Complex Case Management Program. The quality improvement measures for Trusted Health Plan are identified as:

1. Reducing Emergency Room visit rate

2. Reducing Unscheduled Readmission rate
3. Improving Complex Case Management Member Satisfaction rate

The health plan performs the following for each measure:

1. Identifies a relevant process or outcome
2. Uses valid methods that provide quantitative results
3. Sets a performance goal
4. Clearly identifies measure specifications
5. Collects data and analyzes results
6. Identifies opportunities for improvement, if applicable
7. Develops a plan for intervention and re-measurement

THP establishes quantifiable performance goals for each measure that indicate the desired levels of achievement for the health plan. Analysis of findings includes an annual comparison of results against established goals and an analysis of causes for any deficiencies, if appropriate.

Based on the measurements and analysis of Complex Case Management effectiveness, at least one intervention is implemented to improve performance and satisfaction results. A re-measurement, using methods consistent with initial measurements, is performed to determine the success of the effectiveness of interventions.

APPROVED BY:

Director of Utilization Management — **Date** 06/30/2015

Sr. Director of Clinical Programs — **Date** 06/30/2015

Chief Medical Officer — **Date** 06/30/2015

Audit Review Table

DC Trusted Health Plan, INC. (Org ID: 22297, SubID: 11506, Medicaid, Spec Area: None, Spec Proj:

This submission is unlocked.

Measure/Data Element	Report Measure	Benefit Offered	Rotated Measure
Effectiveness of Care: Prevention and Screening			
Adult BMI Assessment (aba)	Y		
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (wcc)	Y		
BMI Percentile			
Counseling for Nutrition			
Counseling for Physical Activity			
Childhood Immunization Status (cis)	Y		
DTaP			
IPV			
MMR			
HiB			
Hepatitis B			
VZV			
Pneumococcal Conjugate			
Hepatitis A			
Rotavirus			
Influenza			
Combination #2			
Combination #3			
Combination #4			
Combination #5			
Combination #6			
Combination #7			
Combination #8			
Combination #9			
Combination #10			
Immunizations for Adolescents (ima)	Y		
Meningococcal			
Tdap/Td			
Combination #1			
Human Papillomavirus Vaccine for Female Adolescents (hpv)	Y		
Lead Screening in Children (lsc)	Y		
Breast Cancer Screening (bcs)	Y		
Cervical Cancer Screening (ccs)	Y		
Non-Recommended Cervical Cancer Screening in Adolescent Females (ncs)	Y		
Chlamydia Screening in Women (chl)	Y		
16-20 Years			
21-24 Years			
Total			
Effectiveness of Care: Respiratory Conditions			
Appropriate Testing for Children with Pharyngitis (cwp)	Y	Y	
Appropriate Treatment for Children With URI (uri)	Y	Y	

Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (aab)	Y	Y	
Use of Spirometry Testing in the Assessment and Diagnosis of COPD (spr)	Y		
Pharmacotherapy Management of COPD Exacerbation (pce)	Y	Y	
Systemic Corticosteroid			
Bronchodilator			
Use of Appropriate Medications for People With Asthma (asm)	Y	Y	
5-11 Years			
12-18 Years			
19-50 Years			
51-64 Years			
Total			
Medication Management for People With Asthma (mma)	Y	Y	
5-11 Years - Medication Compliance 50%			
5-11 Years - Medication Compliance 75%			
12-18 Years - Medication Compliance 50%			
12-18 Years - Medication Compliance 75%			
19-50 Years - Medication Compliance 50%			
19-50 Years - Medication Compliance 75%			
51-64 Years - Medication Compliance 50%			
51-64 Years - Medication Compliance 75%			
Total - Medication Compliance 50%			
Total - Medication Compliance 75%			
Asthma Medication Ratio (amr)	Y	Y	
5-11 Years			
12-18 Years			
19-50 Years			
51-64 Years			
Total			
Effectiveness of Care - Cardiovascular			
Cholesterol Management for Patients With Cardiovascular Conditions (cmc)	Y		
LDL-C Screening Performed			
LDL-C Control (<100 mg/dL)			
Controlling High Blood Pressure (cbp)	N		N
Persistence of Beta-Blocker Treatment After a Heart Attack (pbh)	Y	Y	
Effectiveness of Care - Diabetes			
Comprehensive Diabetes Care (cdc)	Y		
Hemoglobin A1c (HbA1c) Testing			
HbA1c Poor Control (>9.0%)			
HbA1c Control (<8.0%)			
HbA1c Control (<7.0%)			
Eye Exam (Retinal) Performed			
LDL-C Screening Performed			
LDL-C Control (<100 mg/dL)			
Medical Attention for Nephropathy			

Blood Pressure Control (<140/80 mm Hg)			
Blood Pressure Control (<140/90 mm Hg)			
Effectiveness of Care: Musculoskeletal			
Disease Modifying Anti-Rheumatic Drug Therapy in Rheumatoid Arthritis (art)	Y	Y	
Use of Imaging Studies for Low Back Pain (lbp)	Y		
Effectiveness of Care: Behavioral Health			
Antidepressant Medication Management (amm)	Y	Y	
Effective Acute Phase Treatment			
Effective Continuation Phase Treatment			
Follow-Up Care for Children Prescribed ADHD Medication (add)	Y	Y	
Initiation Phase			
Continuation and Maintenance (C&M) Phase			
Follow-Up After Hospitalization for Mental Illness (fuh)	Y	Y	
30-Day Follow-Up			
7-Day Follow-Up			
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medication (ssd)	Y	Y	
Diabetes Monitoring for People With Diabetes and Schizophrenia (smd)	Y		
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia (smc)	Y		
Adherence to Antipsychotic Medications for Individuals With Schizophrenia (saa)	Y	Y	
Effectiveness of Care: Medication Management			
Annual Monitoring for Patients on Persistent Medications (mpm)	Y	Y	
ACE Inhibitors or ARBs			
Digoxin			
Diuretics			
Anticonvulsants			
Total			
Access/Availability of Care			
Adults' Access to Preventive/Ambulatory Health Services (aap)	Y		
20-44 Years			
45-64 Years			
65+ Years			
Total			
Children and Adolescents' Access to Primary Care Practitioners (cap)	Y		
12-24 Months			
25 Months - 6 Years			
7-11 Years			

12-19 Years			
Annual Dental Visit (adv)	Y	Y	
2-3 Years			
4-6 Years			
7-10 Years			
11-14 Years			
15-18 Years			
19-21 Years			
Total			
Initiation and Engagement of AOD Dependence Treatment (iet)	Y	Y	
Initiation of AOD Treatment: 13-17 Years			
Engagement of AOD Treatment: 13-17 Years			
Initiation of AOD Treatment: 18+ Years			
Engagement of AOD Treatment: 18+ Years			
Initiation of AOD Treatment: Total			
Engagement of AOD Treatment: Total			
Prenatal and Postpartum Care (ppc)	Y		N
Timeliness of Prenatal Care			
Postpartum Care			
Call Answer Timeliness (cat)	Y		
Utilization			
Frequency of Ongoing Prenatal Care (fpc)	Y		N
<21 Percent			
21-40 Percent			
41-60 Percent			
61-80 Percent			
81+ Percent			
Well-Child Visits in the First 15 Months of Life (w15)	Y		
0 Visits			
1 Visit			
2 Visits			
3 Visits			
4 Visits			
5 Visits			
6+ Visits			
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (w34)	Y		
Adolescent Well-Care Visits (awc)	Y		
Frequency of Selected Procedures (fsp)	Y		
Ambulatory Care: Total (amba)	Y		
Ambulatory Care: Dual Eligibles (ambb)	N		
Ambulatory Care: Disabled (ambc)	N		
Ambulatory Care: Other (ambd)	N		
Inpatient Utilization--General Hospital/Acute Care: Total (ipua)	Y		
Inpatient Utilization--General Hospital/Acute Care: Dual Eligibles (ipub)	N		
Inpatient Utilization--General Hospital/Acute Care: Disabled (ipuc)	N		
Inpatient Utilization--General Hospital/Acute Care: Other (ipud)	N		

Identification of Alcohol and Other Drug Services: Total (iada)	Y	Y	
Identification of Alcohol and Other Drug Services: Dual Eligibles (iadb)	N	N	
Identification of Alcohol and Other Drug Services: Disabled (iadc)	N	N	
Identification of Alcohol and Other Drug Services: Other (iadd)	N	N	
Mental Health Utilization: Total (mpta)	Y	Y	
Mental Health Utilization: Dual Eligibles (mptb)	N	N	
Mental Health Utilization: Disabled (mptc)	N	N	
Mental Health Utilization: Other (mptd)	N	N	
Antibiotic Utilization: Total (abxa)	Y	Y	
Antibiotic Utilization: Dual Eligibles (abxb)	N	N	
Antibiotic Utilization: Disabled (abxc)	N	N	
Antibiotic Utilization: Other (abxd)	N	N	
Relative Resource Use			
Relative Resource Use for People With Diabetes (rdi)	Y		
Relative Resource Use for People With Asthma (ras)	Y	Y	
Relative Resource Use for People With Cardiovascular Conditions (rca)	Y		
Relative Resource Use for People With Hypertension (rhy)	Y		
Relative Resource Use for People With COPD (rco)	Y		
Health Plan Descriptive Information			
Board Certification (bcr)	N		
Total Membership (tlm)	Y		
Enrollment by Product Line: Total (enpa)	Y		
Enrollment by Product Line: Dual Eligibles (enpb)	N		
Enrollment by Product Line: Disabled (enpc)	N		
Enrollment by Product Line: Other (enpd)	N		
Enrollment by State (ebs)	Y		
Race/Ethnicity Diversity of Membership (rdm)	Y		
Language Diversity of Membership (ldm)	Y		
Weeks of Pregnancy at Time of Enrollment (wop)	Y		N

None); Measurement Year - 2013		
Rate	**Reportable**	**Comment**
NA	R	
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35.53%	R	
3.95%	R	
35.48%	R	
3.87%	R	
75.58%	R	
34.88%	R	
80.75%	R	
13.95%	R	
18.60%	R	
20.93%	R	
24.42%	R	
22.09%	R	
NA	R	
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Audit Review Table

DC Trusted Health Plan, INC. (Org ID: 22297, SubID: 11506, Medicaid, Spec Area: None, Spec Proj:

The Auditor lock has been applied to this

Measure/Data Element	Report Measure	Benefit Offered	Rotated Measure
Effectiveness of Care: Prevention and Screening			
Adult BMI Assessment (abs)	Y		N
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (wcc)	Y		N
BMI Percentile			
Counseling for Nutrition			
Counseling for Physical Activity			
Childhood Immunization Status (cis)	Y		N
DTaP			
IPV			
MMR			
HiB			
Hepatitis B			
VZV			
Pneumococcal Conjugate			
Hepatitis A			
Rotavirus			
Influenza			
Combination #2			
Combination #3			
Combination #4			
Combination #5			
Combination #6			
Combination #7			
Combination #8			
Combination #9			
Combination #10			
Immunizations for Adolescents (ima)	Y		N
Meningococcal			
Tdap/Td			
Combination #1			
Human Papillomavirus Vaccine for Female Adolescents (hpv)	Y		
Lead Screening in Children (lsc)	Y		N
Breast Cancer Screening (bcs)	Y		
Cervical Cancer Screening (ccs)	Y		
Non-Recommended Cervical Cancer Screening in Adolescent Females (ncs)	Y		
Chlamydia Screening in Women (chl)	Y		
16-20 Years			
21-24 Years			
Total			
Effectiveness of Care: Respiratory Conditions			
Appropriate Testing for Children with Pharyngitis (cwp)	Y	Y	
Appropriate Treatment for Children With URI (uri)	Y	Y	

Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (aab)	Y	Y	
Use of Spirometry Testing in the Assessment and Diagnosis of COPD (spr)	Y		
Pharmacotherapy Management of COPD Exacerbation (pce)	Y	Y	
Systemic Corticosteroid			
Bronchodilator			
Use of Appropriate Medications for People With Asthma (asm)	Y	Y	
5-11 Years			
12-18 Years			
19-50 Years			
51-64 Years			
Total			
Medication Management for People With Asthma (mma)	Y	Y	
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Total - Medication Compliance 50%			
Total - Medication Compliance 75%			
Asthma Medication Ratio (amr)	Y	Y	
5-11 Years			
12-18 Years			
19-50 Years			
51-64 Years			
Total			
Effectiveness of Care: Cardiovascular Conditions			
Controlling High Blood Pressure (cbp)	Y		
Persistence of Beta-Blocker Treatment After a Heart Attack (pbh)	Y	Y	
Effectiveness of Care: Diabetes			
Comprehensive Diabetes Care (cdc)	Y		N
Hemoglobin A1c (HbA1c) Testing			
HbA1c Poor Control (>9.0%)			
HbA1c Control (<8.0%)			
HbA1c Control (<7.0%)			
Eye Exam (Retinal) Performed			
Medical Attention for Nephropathy			
Blood Pressure Control (<140/90 mm Hg)			
Effectiveness of Care: Musculoskeletal Conditions			
Disease Modifying Anti-Rheumatic Drug Therapy in Rheumatoid Arthritis (art)	Y	Y	
Use of Imaging Studies for Low Back Pain (lbp)	Y		

Effectiveness of Care: Behavioral Health			
Antidepressant Medication Management (amm)	Y	Y	
Effective Acute Phase Treatment			
Effective Continuation Phase Treatment			
Follow-Up Care for Children Prescribed ADHD Medication (add)	Y	Y	
Initiation Phase			
Continuation and Maintenance (C&M) Phase			
Follow-Up After Hospitalization for Mental Illness (fuh)	Y	Y	
30-Day Follow-Up			
7-Day Follow-Up			
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medication (ssd)	Y	Y	
Diabetes Monitoring for People With Diabetes and Schizophrenia (smd)	Y		
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia (smc)	Y		
Adherence to Antipsychotic Medications for Individuals With Schizophrenia (saa)	Y	Y	
Use of Multiple Concurrent Antipsychotics in Children and Adolescents (apc)	Y	Y	
1-5 Years			
6-11 Years			
12-17 Years			
Total			
Metabolic Monitoring for Children and Adolescents on Antipsychotics (apm)	Y	Y	
1-5 Years			
6-11 Years			
12-17 Years			
Total			
Effectiveness of Care: Medication Management			
Annual Monitoring for Patients on Persistent Medications (mpm)	Y	Y	
ACE Inhibitors or ARBs			
Digoxin			
Diuretics			
Total			
Access/Availability of Care			
Adults' Access to Preventive/Ambulatory Health Services (aap)	Y		
20-44 Years			
45-64 Years			
65+ Years			
Total			

Children and Adolescents' Access to Primary Care Practitioners (cap)	Y		
12-24 Months			
25 Months - 6 Years			
7-11 Years			
12-19 Years			
Annual Dental Visit (adv)	Y	Y	
2-3 Years			
4-6 Years			
7-10 Years			
11-14 Years			
15-18 Years			
19-21 Years			
Total			
Initiation and Engagement of AOD Dependence Treatment (iet)	Y	N	
Initiation of AOD Treatment: 13-17 Years			
Engagement of AOD Treatment: 13-17 Years			
Initiation of AOD Treatment: 18+ Years			
Engagement of AOD Treatment: 18+ Years			
Initiation of AOD Treatment: Total			
Engagement of AOD Treatment: Total			
Prenatal and Postpartum Care (ppc)	Y		
Timeliness of Prenatal Care			
Postpartum Care			
Call Answer Timeliness (cat)	Y		
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (app)	Y	Y	
1-5 Years			
6-11 Years			
12-17 Years			
Total			
Utilization			
Frequency of Ongoing Prenatal Care (fpc)	Y		
<21 Percent			
21-40 Percent			
41-60 Percent			
61-80 Percent			
81+ Percent			
Well-Child Visits in the First 15 Months of Life (w15)	Y		N
0 Visits			
1 Visit			
2 Visits			
3 Visits			
4 Visits			
5 Visits			
6+ Visits			
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (w34)	Y		N
Adolescent Well-Care Visits (awc)	Y		N
Frequency of Selected Procedures (fsp)	Y		
Ambulatory Care: Total (amba)	Y		

Ambulatory Care: Dual Eligibles (ambb)	N		
Ambulatory Care: Disabled (ambc)	N		
Ambulatory Care: Other (ambd)	N		
Inpatient Utilization--General Hospital/Acute Care: Total (ipua)	Y		
Inpatient Utilization--General Hospital/Acute Care: Dual Eligibles (ipub)	N		
Inpatient Utilization--General Hospital/Acute Care: Disabled (ipuc)	N		
Inpatient Utilization--General Hospital/Acute Care: Other (ipud)	N		
Identification of Alcohol and Other Drug Services: Total (iada)	Y	N	
Identification of Alcohol and Other Drug Services: Dual Eligibles (iadb)	N	N	
Identification of Alcohol and Other Drug Services: Disabled (iadc)	N	N	
Identification of Alcohol and Other Drug Services: Other (iadd)	N	N	
Mental Health Utilization: Total (mpta)	Y	Y	
Mental Health Utilization: Dual Eligibles (mptb)	N	N	
Mental Health Utilization: Disabled (mptc)	N	N	
Mental Health Utilization: Other (mptd)	N	N	
Antibiotic Utilization: Total (abxa)	Y	Y	
Antibiotic Utilization: Dual Eligibles (abxb)	N	N	
Antibiotic Utilization: Disabled (abxc)	N	N	
Antibiotic Utilization: Other (abxd)	N	N	
Relative Resource Use			
Relative Resource Use for People With Diabetes (rdl)	Y		
Relative Resource Use for People With Asthma (ras)	N	Y	
Relative Resource Use for People With Cardiovascular Conditions (rca)	N		
Relative Resource Use for People With Hypertension (rhy)	Y		
Relative Resource Use for People With COPD (rco)	Y		
Health Plan Descriptive Information			
Board Certification (bcr)	Y		
Total Membership (tlm)	Y		
Enrollment by Product Line: Total (enpa)	Y		
Enrollment by Product Line: Dual Eligibles (enpb)	N		
Enrollment by Product Line: Disabled (enpc)	N		
Enrollment by Product Line: Other (enpd)	N		
Enrollment by State (ebs)	Y		
Race/Ethnicity Diversity of Membership (rdm)	Y		
Language Diversity of Membership (ldm)	Y		
Weeks of Pregnancy at Time of Enrollment (wop)	Y		

None); Measurement Year - 2014		
submission.		
Rate	**Reportable**	**Comment**
NA	R	Denominator fewer than 30
21.30%	R	Reportable
14.58%	R	Reportable
13.19%	R	Reportable
17.44%	R	Reportable
20.64%	R	Reportable
55.77%	R	Reportable
22.60%	R	Reportable
19.41%	R	Reportable
56.02%	R	Reportable
17.20%	R	Reportable
56.76%	R	Reportable
14.99%	R	Reportable
25.55%	R	Reportable
14.99%	R	Reportable
14.00%	R	Reportable
14.00%	R	Reportable
11.55%	R	Reportable
10.81%	R	Reportable
11.55%	R	Reportable
10.81%	R	Reportable
9.09%	R	Reportable
9.09%	R	Reportable
24.55%	R	Reportable
20.91%	R	Reportable
18.18%	R	Reportable
6.90%	R	Reportable
59.21%	R	Reportable
NA	R	Denominator fewer than 30
28.54%	R	Reportable
1.43%	R	Reportable
64.97%	R	Reportable
69.37%	R	Reportable
68.09%	R	Reportable
NA	R	Denominator fewer than 30
99.52%	R	Reportable

62.82%	R	Reportable
NA	R	Denominator fewer than 30
7.69%	R	Reportable
23.08%	R	Reportable
NA	R	Denominator fewer than 30
NA	R	Denominator fewer than 30
NA	R	Denominator fewer than 30
NA	R	Denominator fewer than 30
NA	R	Denominator fewer than 30
NA	R	Denominator fewer than 30
NA	R	Denominator fewer than 30
NA	R	Denominator fewer than 30
NA	R	Denominator fewer than 30
NA	R	Denominator fewer than 30
NA	R	Denominator fewer than 30
NA	R	Denominator fewer than 30
NA	R	Denominator fewer than 30
NA	R	Denominator fewer than 30
NA	R	Denominator fewer than 30
NA	R	Denominator fewer than 30
NA	R	Denominator fewer than 30
NA	R	Denominator fewer than 30
NA	R	Denominator fewer than 30
NA	R	Denominator fewer than 30
6.50%	R	Reportable
NA	R	Denominator fewer than 30
77.34%	R	Reportable
91.91%	R	Reportable
6.83%	R	Reportable
4.85%	R	Reportable
38.49%	R	Reportable
76.98%	R	Reportable
10.61%	R	Reportable
NA	R	Denominator fewer than 30
91.74%	R	Reportable

49.09%	R	Reportable
31.82%	R	Reportable
NA	R	Denominator fewer than 30
NA	R	Denominator fewer than 30
40.48%	R	Reportable
26.79%	R	Reportable
64.58%	R	Reportable
NA	R	Denominator fewer than 30
NA	R	Denominator fewer than 30
NA	R	Denominator fewer than 30
NA	R	Denominator fewer than 30
NA	R	Denominator fewer than 30
NA	R	Denominator fewer than 30
NA	R	Denominator fewer than 30
NA	R	Denominator fewer than 30
NA	R	Denominator fewer than 30
NA	R	Denominator fewer than 30
NA	R	Denominator fewer than 30
80.83%	R	Reportable
NA	R	Denominator fewer than 30
76.24%	R	Reportable
78.83%	R	Reportable
57.04%	R	Reportable
68.06%	R	Reportable
56.76%	R	Reportable
60.52%	R	Reportable

86.00%	R	Reportable
81.43%	R	Reportable
NA	R	Denominator fewer than 30
NA	R	Denominator fewer than 30
55.15%	R	Reportable
68.86%	R	Reportable
68.77%	R	Reportable
62.20%	R	Reportable
48.35%	R	Reportable
32.94%	R	Reportable
59.10%	R	Reportable
NB	R	Required benefit not offered
NB	R	Required benefit not offered
NB	R	Required benefit not offered
NB	R	Required benefit not offered
NB	R	Required benefit not offered
NB	R	Required benefit not offered
62.57%	R	Reportable
33.25%	R	Reportable
76.46%	R	Reportable
NA	R	Denominator fewer than 30
NA	R	Denominator fewer than 30
NA	R	Denominator fewer than 30
NA	R	Denominator fewer than 30
15.45%	R	Reportable
10.47%	R	Reportable
18.59%	R	Reportable
27.23%	R	Reportable
28.27%	R	Reportable
6.27%	R	Reportable
6.27%	R	Reportable
8.12%	R	Reportable
9.23%	R	Reportable
17.34%	R	Reportable
18.08%	R	Reportable
34.69%	R	Reportable
70.83%	R	Reportable
45.83%	R	Reportable
	R	Reportable
	R	Reportable

	NR	Measure Unselected
	NR	Measure Unselected
	NR	Measure Unselected
	R	Reportable
	NR	Measure Unselected
	NR	Measure Unselected
	NR	Measure Unselected
	R	Required benefit not offered
	NR	Measure Unselected
	NR	Measure Unselected
	NR	Measure Unselected
	R	Reportable
	NR	Measure Unselected
	NR	Measure Unselected
	NR	Measure Unselected
	R	Reportable
	NR	Measure Unselected
	NR	Measure Unselected
	NR	Measure Unselected
	R	Reportable
	NR	Measure Unselected
	NR	Measure Unselected
	R	Reportable
	R	Reportable
	R	Reportable
	R	Reportable
	R	Reportable
	NR	Measure Unselected
	NR	Measure Unselected
	NR	Measure Unselected
	R	Reportable
	R	Reportable
	R	Reportable
	R	Reportable



Continuous Quality Improvement
Policies and Procedures

* * * * *

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1 Continuous Quality Improvement Program Overview

1.1 PURPOSE

The Continuous Quality Improvement Program (CQI) is a coordinated, multi-disciplinary approach designed to objectively and systematically monitor and evaluate the quality, appropriateness and outcome of medical care and services and the processes by which they are delivered to the THP enrollees. The program continuously pursues opportunities for improvement within the organization and incorporates problem resolution.

The primary purpose of the CQI is to promote excellence in medical care through continuous objective assessment of important aspects of care/service and the resolution and improvement of identified problems. It is the goal and purpose of the CQI to achieve, using available resources, optimal outcomes with continuous, incremental improvements which are consistently representative of a high standard of practice in the community, minimize risk to the participant and organization and promote cost-effective appropriate services.

The program also includes an annual work plan which defines the program's goals; the specific activities that the committees and staff members will undertake to meet these goals, and establishes the time frame for reporting. The work plan also provides a structure for measuring progress toward achieving the defined goals.

1.2 MISSION STATEMENT

The mission of THP Health Plan (THP) is to become the Health Maintenance Organization of choice by delivering quality care to our community; to ensure the provision of culturally sensitive and linguistically competent services through our providers, by treating our enrollees and/or customers with respect, consideration and dignity; by encouraging, developing and setting high performance standards for our employees and provider community; and by controlling costs.

Philosophy and Values
The participant is the central focus of our plans, which makes the delivery of continuous, high quality, and cost-effective services the primary objective of the plan. THP's commitment to the provision of quality medical care is guided by the following values:

- To foster an organizational culture that promotes excellence in health care delivery.
- To perform our responsibilities as providers of health care in a professional, efficient and safe manner.
- To continually offer and implement methods of improving our service delivery.
- To support our fellow staff members in an enthusiastic and equitable manner.
- To consider suggestions as challenges for improvement and innovation.

- To pursue professional growth and development through ongoing education.
- To set quality performance as a personal and professional goal.
- To promote continual commitment to customer satisfaction (both internal and external).
- To promote the dignity of our patients by giving them the opportunity to participate in decisions involving their health care.

Consistent with the commitment to promote excellence medical service delivery, THP has created and adopted this CQI Plan. This Plan serves as a guide in the coordination of quality improvement activities to aid in the assessment, evaluation, and identification of opportunities to improve and to implement corrective actions where improvement is needed.

1.3 GOALS AND OBJECTIVES

THP strives to continuously improve the care and service provided by our care delivery systems. The CQI establishes the standards that encompass all quality improvement activities within THP. THP's goals are:

Goal 1: Meet CQI requirements established by District of Columbia-DHCF.

Goal 2: Improve the care and service received by plan members.

Goal 3: Provide Health Education/Outreach Programs to ***THP*** enrollees, providers, and communities.

Goal 4: By providing excellent care and service to our constituencies, to increase enrollment in THP through reputation with providers, enrollees and potential enrollees as an HMO with dedicated to quality health care.

To ensure achievement of these goals, the following objectives have been established:

A. Promote and incorporate quality into organizational structure and processes.

1. Facilitate a partnership between members; practitioners, providers and health plan staff for the continuous improvement of quality care delivery.
2. Clearly define roles, responsibilities and accountability for the quality program.
3. Continuously improve communication and education in support of these efforts.
4. Consider and facilitate achievement of public health goals in the areas of health promotion and early detection and treatment.
5. Assist other departments in the integration of continuous quality improvement processes and facilitate projects as necessary.

B. Provide effective monitoring and evaluation of patient care and services to ensure that care provided by contracted practitioners/providers meets the requirements of safe, evidence-based practice.

1. Evaluate and disseminate clinical and preventive practice guidelines.
2. Monitor performance of practitioners and providers against evidence-based guidelines.
3. Develop and monitor performance standards for service activities (e.g. access and availability, credentialing/re-credentialing, peer review, telephone service, etc.).
4. Survey plan members and practitioners' satisfaction with the quality of care and services provided.
5. Conduct and report data annually to regulatory entities as requested.
6. Develop, define, and maintain data systems to support quality improvement activities and encourage data-driven decision-making.
7. Monitor utilization management programs for appropriate use of services.

C. Ensure prompt identification and analysis of opportunities for improvement with implementation of actions and follow-up.

1. Identify and monitor important aspects of care and services, quality indicators, problems, and concerns about services provided to members.
2. Implement and conduct a comprehensive Continuous Quality Improvement Program.
3. Provide feedback to health plan members and practitioners regarding the measurement and outcome of quality improvement (clinical and non-clinical) activities.
4. Support re-measurement of effectiveness and continued development and implementation of improvement interventions.

D. Coordinate quality improvement and risk management activities.

1. Aggregate and use data to develop quality improvement activities.
2. Provide a regular means by which risk management and patient safety are included in the development of quality improvement initiatives.
3. Identify, develop and monitor key aspects of patient safety

E. Maintain compliance with local, state and federal regulatory requirements and accreditation standards.

1. Monitor compliance with regulatory requirements for quality improvement and risk management opportunities and respond as needed.
2. Ensure that reporting systems provide appropriate information for meeting the requirements of external regulatory review and accrediting bodies.

1.4 SCOPE OF CONTINUOUS QUALITY IMPROVEMENT PROGRAM

THP has established a CQI program which includes quality management functions and quality improvement activities in compliance with 42 C.F.R. § 438.240, the D.C. HMO Act, D.C. Code § 31-3406, the Quality Improvement System for Managed Care (QISMC), and DHCF's CQI Plan. At a minimum, THP CQI program will:

- Include a Continuous Quality Improvement Plan (CQI Plan).
- Be consistent with the utilization control requirements of 42 C.F.R. Part 456 and ***THP's*** Utilization Review and Care Coordination requirements.
- Provide for review by appropriate health professionals and Providers of THP policies, procedures and processes for providing health services.
- Provide for systematic collection of data concerning performance and Enrollee outcomes.
- Maintain a health information system that collects analyzes and integrates the data necessary to implement the CQI program.
- Provide for interpretation of data concerning performance and Enrollee outcomes to Network Providers.
- Identify and evaluate methods for identifying enrollees with multiple or sufficiently severe chronic conditions that would benefit from participate in a chronic care improvement program.
- Provide mechanisms for monitoring enrollees that are participating in the chronic care improvement program.
- Provide a mechanism for making necessary changes to THP operations, policies and procedures.
- Annually measure and report to DHCF its performance under the CQI program.

As part of its larger CQI program, THP will develop, annually update, and submit to DHCF a written CQI Plan that includes, at a minimum, a description of THP's performance goals and objectives including measurable goals for:

- Improving performance as a result of information obtained through analysis of HEDIS performance measures, survey results including CAHPS surveys and chart reviews.
- Improving health outcomes for enrollees with chronic preventable health conditions.
- Reducing racial, socioeconomic and ethnic disparities in health care utilization and in health outcomes indicated by baseline data comparing health care utilization data for enrollees by enrollee subgroups, against prior year performance and where possible, against national benchmarks.
- Improving performance in response to information obtained through the EQRO report.

Continuous quality improvement activities are integrated with quality improvement reviews and address trends that warrant review. Furthermore, these activities address diagnoses, and treatments.

THP's Complex Case Management Quality Improvement Program is designed to address the potential healthcare-related issues faced by beneficiaries. There is a focus on the most vulnerable members, such as the disabled, high risk pregnancies, multiple complex chronic conditions, HIV AIDS, etc. A formal evaluation of the Quality Improvement Program is performed annually.

Specifically, program activities include the following:

- Measure performance against key monitors for quality improvement as identified by the CQI and activities identified in the Work Plan.
- Review of the quality and utilization of services.
- System interventions, including the establishment or alteration of practice guidelines.
- Improving performance.
- Systematic and periodic follow-up on the effect of the interventions.
- Implement an annual CQI that is relevant to the population and that can be expected to have a favorable effect on health outcomes and/or member satisfaction.
- Ensure compliance with applicable regulatory and contractual requirements including state and federal regulations as well as accreditation standards.
- Analyze, identify and address continuity and coordination of care within treatment plans.
- Analyze, identify and address areas of under and over-utilization, if applicable.
- Monitor, identify and investigate potential Quality of Care/Quality of Service (QOC/QOS) issues. Implement improvement actions as needed.
- Analyze, identify and address areas that will improve patient safety.
- Analyze, identify and address member and practitioner satisfaction information.
- Analyze, identify and address access to and availability of care.
- Solicit member and provider input on performance and QI activities.

2 Organizational Structure and Responsibility

The THP Board of Directors (BOD) designates the QEC as the committee that oversees all quality improvement activities in the organization. The Chief Medical Officer (CMO) chairs the QEC. The QEC is responsible for the annual evaluation of the effectiveness of the CQI and is actively involved in the review, analysis and enhancement of THP's services and quality improvement program. Under the direction of the Chief Quality Officer (CQO), the CQI Work Plan is reviewed and updated annually. The QEC Committee reports directly to the BOD. The BOD has assigned responsibility for overseeing quality improvement, care coordination, utilization management, peer review and any delegated functions to the QEC. The QEC evaluates the results of quality improvement activities, utilization results, and outcomes and takes actions based on the information. The QEC has distinct goals and objectives to accomplish its primary function of oversight of the medical and operational systems as they affect care provided by its providers to its enrollees.

3 Authority and Accountability

3.1 GOVERNING BODY

THP's Governing Body is the Board of Directors (BOD). The BOD assumes overall legal authority and responsibility for all quality assessment and improvement activities. The BOD is responsible for establishing, maintaining and supporting the CQIP The ongoing responsibility for the development and implementation of the Program is delegated by the BOD to the QEC. The BOD provides oversight of the QEC and its activities. It reviews, approves and makes recommendations on the CQI Program and the CQI Plan at least annually.

The QEC derives its authority from the BOD. The BOD has delegated the responsibility to oversee the CQI Program to the QEC.

The CEO, COO, CMO, and program directors have the authority to approve Trusted's programs, policies and procedures.

3.2 CHIEF EXECUTIVE OFFICER

The Chief Executive Officer (CEO) has organizational responsibility for the CQI Program, ensures Program implementation, function and results and provides for adequate resources and staffing. The CEO assigns responsibility for the CQI Program to the Chief Medical Officer (CMO).

3.3 CHIEF MEDICAL OFFICER/CHIEF QUALITY OFFICER

The CMO/CQO is a physician responsible for ensuring that the CQI Program is properly developed, implemented and coordinated and is substantially involved in the function of the Program, including membership on the QEC. The CMO/CQO shall serve as the Chairman of the QEC and reports to the CEO.

The CMO/CQO's responsibilities include, but are not limited to:

- Chairs the QEC
- Manages THP's peer level functions
- Assists in planning and implementation of the annual CQI Work Plan
- Provides assistance in review of member and provider grievances and appeals
- Participates in the evaluation of the THP's provider network
- Acts in the development, coordination and integration of quality management activities and is responsible for assisting the QEC and Management Staff in implementing the CQI Program.
- Monitors and analyzes internal and external data trends and patterns that affect the quality of care and service delivery and prepares quarterly reports for the QEC.

- Monitors the progress of CQI activities throughout the organization and reports study and project results to internal and external audiences.

3.4 BEHAVIORAL HEALTH

Trusted Health Plan delegates selected QI activities to Beacon Health an NCQA-Accredited Managed Behavioral Health Organization. A designated Beacon [psychiatrist] is involved in the implementation of the QI Program. The Beacon practitioner serves on the Trusted QEC.

In addition, Beacon works collaboratively to implement QI activities, review data and identify opportunities for improvement. The Beacon QIP is reviewed annually and approved by the QEC.

3.5 QUALITY EXECUTIVE COMMITTEE

The BOD has delegated responsibility for the oversight of THP's quality improvement activities to the QEC. The QEC is the decision-making body that is ultimately responsible for the implementation, coordination and integration of all quality improvement activities for the health plan. It is an interdisciplinary committee that includes administrative staff involved in monitoring quality of service as well as practitioners that are representative of the provider network.

The mission of the QEC is to ensure quality services are provided by the provider network. This mission is achieved through ongoing monitoring and evaluation of the care/services delivered and the implementation of corrective actions where an opportunity for improvement exists. The QEC meets at least quarterly.

The Chief Medical Officer serves as the QEC Chairperson is responsible for the following:

- Establishing Committee Agenda
- Reporting performance assessment activities to QEC monthly
- Validating review recommendations in relation to priority and impact on patient care
- Communicating recommended plan of action to the provider and the CQO for implementation
- Evaluating the results of corrective actions implemented in conjunction with review committee

3.5.1 QEC Structure/Membership

1. CMO/CQO
2. CEO or designee
3. Physician members including Specialty Providers
4. Representative from the Credentialing Committee

5. Representative from the Utilization Management Workgroup
6. Representative from or Health Promotion/Education
7. Allied Health Providers (Physician Assistants, Nurse Practitioners)
8. Designated Beacon Health Practitioner

Members are rotated bi-annually to assure broad representation but serve staggered terms to ensure continuity within the committee structure.

The QEC, under the direction of the CEO, shall be responsible for integrating and resourcing all quality activities throughout the entire organizational structure of THP. The sole purpose of this committee is to continuously evaluate and improve the appropriateness and quality of care and services rendered to THP's participants.

Additionally, the QEC is responsible for coordinating quality management activities, and ensuring that the objectives contained in the annual work plan are met. Specifically, the Committee is responsible for:

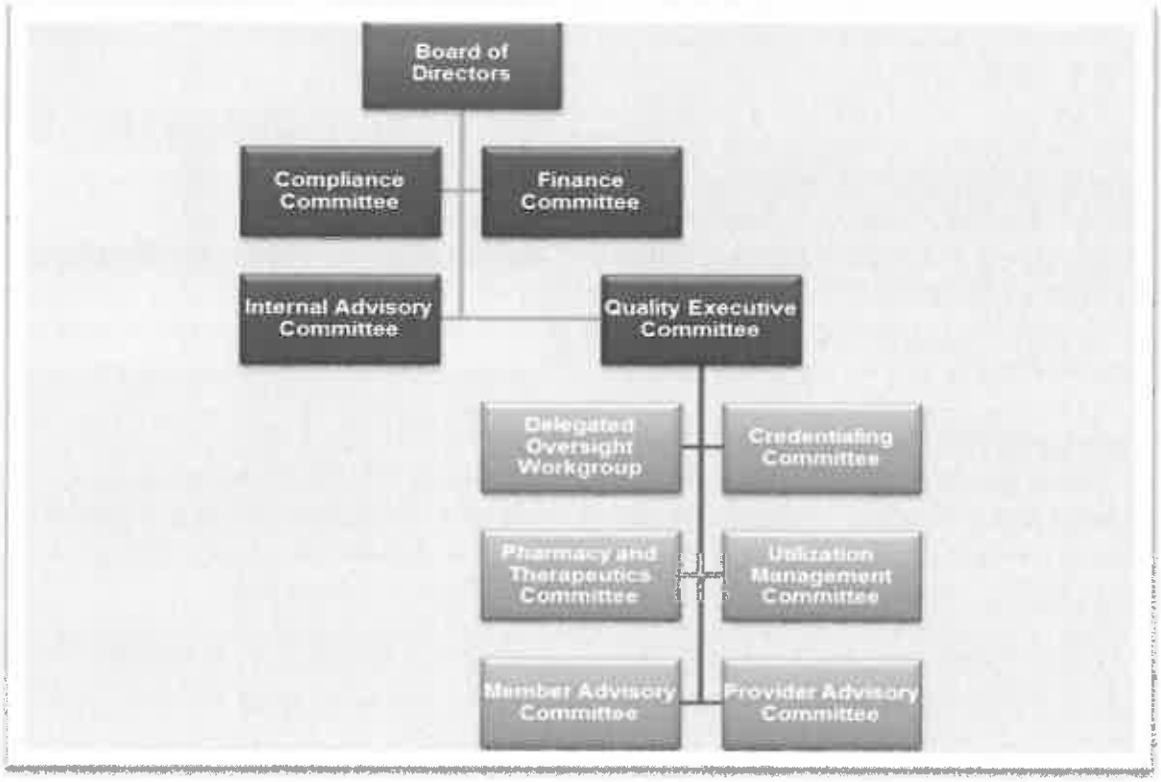
- Developing and maintaining the CQI Program description and developing an annual CQI Work Plan.
- The selection of routine monitoring and evaluation topics and special studies that are relevant to the demographic and epidemiological characteristics, and potentially will have an impact on the participant population served. Topics may include resources utilized as demonstrated by claims and encounter data.
- The development and approval of practice guidelines that are based on scientific evidence, with quality indicators to monitor provider performance, and methods to communicate guidelines as well as individual and group performance to providers.
- Assuring that the information and findings of quality management activities are used to detect trends, patterns of performance or potential problems and to develop and implement corrective action plans. It assures that necessary information is communicated to appropriate individuals, departments, providers or institutions when problems or opportunities to improve care/service are identified.
- The review, necessary research and response when a grievance is filed. After analyzing findings pertinent to grievances, the Committee takes action as appropriate.
- Allocating resources to activities that will have the greatest potential impact on the care and service provided to participants, employers and providers.

- Providing annual reports to the BOD that includes conclusions and recommendations for action and follow-up on identified opportunities to improve care and problems. A standardized format is used for reporting.
- Reporting findings of appropriate quality management activities for inclusion in Provider Quality Profiles (Re-credentialing).
- Promotion/Education programs.
- Reviewing the scope, objectives, organization and effectiveness of the CQI Program at least annually and revises as necessary, reporting to the CEO, Professional Staff and the BOD.

The following sub-committees report to the QEC (Exhibit A). Charters for the QEC and each subcommittee can be found in Attachment A.

1. The Grievance and Appeals Committee
2. Pharmacy & Therapeutics Committee
3. Member Advisory
4. Credentialing Committee
5. Utilization Management Committee
6. Delegated Oversight Committee
7. Provider Advisory

Exhibit A: QEC Committee Structure



4 Quality Improvement Department and Resources

Senior Director of Quality and Accreditation
The Senior Director of Quality and Accreditation is designated and acts with the authority of the CMO/CQO in the development, coordination and integration of quality management activities and is responsible for assisting the CMO/CQO and the QEC and Management Staff in implementing the CQI Program.

The Senior Director of Quality and Accreditation monitors and analyzes internal and external data trends and patterns that affect the quality of care and service delivery and prepares quarterly reports for the QEC. Quality management activities include annual HEDIS data collection and reporting, access and availability monitoring and analysis, member satisfaction assessment, and patient safety initiatives. The Senior Director of Quality Improvement monitors the progress of CQI activities throughout the organization and reports study and project results to internal and external audiences.

Clinical Quality Manager
The Clinical Quality Manager is responsible for the health education and promotion program monitoring and evaluation. He/she conducts QI studies and initiatives to include annual HEDIS rates analyses and coordinates, implements and performs analysis on annual survey findings to include CAHPS, Access and Availability, and Provider Satisfaction surveys.

The Clinical Quality Manager manages QI Committee and Subcommittee meetings, agendas, minutes, presentation materials and other attachments. He/she also assists in the coordination of NCQA survey preparation to include maintenance of policies and procedures in the Health Plan central repository and manages the flow of medical records and other documentation as needed for the HEDIS medical record review process, performance reporting and related interventions to address opportunities for improvement to include data quality.

The Clinical Quality Manager monitors and evaluates quality of care/patient safety related activities and is responsible for managing monthly outreach/care coordination activities utilizing the monthly HEDIS refreshed data (Gaps in Care Report). He/she also works collaboratively with the Compliance Auditor to perform internal monitoring activities utilizing THP's performance dashboard.

Quality Project Coordinator
The HEDIS Project Coordinator works with the Sr. Director of Quality and Accreditation and THP's IT Department to coordinate annual HEDIS audit activities and submission of all required data and forms associated with the annual CAHPS survey. Responsibilities also include working collaboratively with internal/external business owners to ensure completion and submission of the HEDIS Roadmap and annual HEDIS Compliance Audit preparation.

Outreach/Care Coordination Specialists (6)
Outreach/Care Coordination Specialists are responsible for the implementation of member engagement/health improvement activities. The Specialists work collaboratively with the QI department to conduct the analysis, identification of opportunities and action to improve services

to members based on the monthly HEDIS refresh (Gaps in Care), annual CAHPS analysis, member access and availability, and complaints and appeals analyses. Member level detail associated with the monthly Gaps in Care report is utilized to establish the focus and caseload for each specialist.

5 CQI Process and Functional Areas

Continuous Quality Improvement Process is a problem-solving technique that is applied to specific and measurable performance indicators. The CQI Process is used whenever an opportunity for improvement is identified through the monitoring of quality of care or service indicators. The steps in the CQI Process include:

- Determination of relevance to the health plan's population-Define
- Evaluation of baseline measure(s)-Measure
- Analysis to identify opportunities for improvement-Assess
- Analysis to identify possible root causes/barriers to care or service-Assess
- Planning and implementation of strong actions to eliminate root causes/barriers -Improve
- Evaluation of the performance and effectiveness of the interventions through re-measurement-Improve
- Analysis to determine how actions impacted performance-Improve
- Continued re-measurement to determine if impact(s) are sustained.-Improve

All steps in the CQI Process are documented and results and action plans are presented to the QEC for review and approval.

5.1 MONITORING AND EVALUATION OF ACTIVITIES

5.1.1 Development of tools/criteria used for monitoring and evaluation

1. Criteria for use in the monitoring and evaluation process are developed by the QEC using current regulatory and contractual requirements, industry standards as well as the opinion of recognized experts in the field of study.
2. Practice Guidelines are adopted and adapted with the assistance of appropriate members of the provider panel and are communicated to providers. The guidelines are reviewed and updated as at least annually at the Provider Advisory Committee. Guideline sources include:

    - Institute for Clinical Systems Improvement (ICSI)
    - American College of Obstetrics & Gynecology (ACOG)
    - American Academy of Pediatrics (AAP)

- Early and Periodic Screening Diagnosis and Treatment Standards (EPSDT)
- US Preventive Task Force
- Center for Disease Control and Prevention

5.1.2 Clinical monitoring and evaluation

Clinical monitoring and evaluation are conducted over time for services provided by THP. This may include, but not be limited to, care provided in institutional (acute and long term) and outpatient care settings, primary care provider offices, home care, frequently used specialty services, ancillary services (laboratory and radiology), mental health and substance abuse services, drug utilization, as well as critical pathway and preventative services monitoring. High volume, high-risk services (which include under-utilization of preventative and care not provided) are monitored and evaluated. The care of acute and chronic conditions is also monitored. Customer/ Enrollee service issues identified through this process are referred for service review. Clinical monitoring and evaluation is completed the QI Department and Medical Management. Enrollee Services monitors service issues with monthly reporting of member services indicators

5.1.3 Focused Quality Improvement (QI) Activities

Trusted's Quality Improvement Department leads the Quality Improvement Projects that focus on clinical and non-clinical areas. QI activities are designed to objectively and systematically monitor and evaluate the quality and appropriateness of care and service provided to members. Topics for routine monitoring and focused activities are chosen based on the demographic and epidemiological characteristics of the population, and those assigned by regulatory agency as mandated by contract. Data are collected, reviewed, and analyzed for trends and improvement opportunities. These data are documented and presented to the appropriate committee for review and recommendations. Focused activities are completed by the QI department and Medical Management.

5.1.4 Monitoring of Quality Indicators and Performance Improvement Projects (PIPs)

The monitoring of quality indicators is designed to reveal trends and performance opportunities in specific areas and facilitate plan-wide improvement. To this end, a variety of care and service indicators to monitor is derived from as many sources as appropriate. The quality indicators are:

a) Objective, clearly and unambiguously defined, and based on current clinical knowledge or health services research

b) Capable of measuring outcomes such as changes in health status, functional status an enrollee satisfaction, or valid proxies of those outcomes.

Topics for routine monitoring and focused activities are chosen based on the demographic and epidemiological characteristics of the population. Examples of monitoring indicators may include tracking and trending of inpatient or outpatient acute or chronic conditions, access performance measurements, member and claims service, member and provider satisfaction or

unique specific indicators as identified from local epidemiology or demographics. QI activities are designed to objectively and systematically monitor and evaluate the quality and appropriateness of care and service provided to its members and are presented to the appropriate committee for review and recommendation. The QI Department works with functional areas throughout the organization to assess quality indicators in each department.

When applicable, measurements and reporting of performance must use the measurement tools required by CMS, report performance and make available to CMS information on quality and outcomes measures that will enable beneficiaries to compare health coverage options and select among them. THP will conduct and/or participate in at least two (2) Performance Improvement Projects (PIPs) each year for populations with complex heath needs.

Objectives for serving members with complex health needs include:

- Maximizing physical functioning
- Maximizing social and behavioral functioning
- Managing chronic and acute conditions to minimize pain and disability, and achieve optimal functioning
- Coordinating care between multiple medical providers and behavioral health providers

All Complex Case Management members have an annual risk assessment and individualized care plan developed and completed each year to assure the most accurate data is available

5.1.5 Selection of Quality Indicators

Each indicator is well defined for ease and reliability of data collection and is a variable relating to the structure, process or outcome of care/service.

1. **Structure** - measures compliance with conditions, and mechanisms needed to operate and control the system (e.g. policies, organizational and management characteristics, qualifications of personnel, staffing, environment and equipment).
2. **Process** - measures a care activity done for a participant (e.g. functions carried out by staff)
3. **Outcome** - measures what happens [or does not happen] to a participant after something is done [or not done] (e.g. the results of staff activities).

The indicators are objective, measurable, and are based on current knowledge and experience. Indicators will be used as tools to assess specific performance areas and participant outcomes. Indicators are not direct measures of quality, but serve as "flags" for locating areas within the organization that requires further review. Indicators address all key components of quality care and may include the following:

1. Accessibility of care
2. Appropriateness and efficiency of care
3. Continuity of care

4. Competency
5. Safety/risk management
6. Effectiveness of care
7. Timeliness of Care
8. Customer satisfaction

5.2 CLINICAL MEASUREMENT ACTIVITIES AND QUALITY PERFORMANCE REPORTING

THP uses data collection and analysis to track clinical issues that are relevant to our population. At a minimum, THP adopts and establish quantitative measures to assess performance and to identify and prioritize areas for improvement in at least (2) Performance Improvement Projects Annually (PIPs).

1. **Health Plan Effectiveness Data and Information Set (HEDIS®) and Structure and Process Measures** THP actively takes part in annual Health Plan Effectiveness Data and Information Set (HEDIS) and Structure and Process measures. THP CQI Department collects HEDIS and Structure and Process measure data through multiple sources:
    a. Claims and encounter data
    b. Proactive medical record review
    c. Disease Management and Complex Case Management Programs
    d. Proactive Measure Review
        i. Specialized NCQA Certified software program that runs each measure proactively every month during the measurement year.
        ii. Member listings of services that have not been captured are provided to primary care practitioners every six months.
        iii. Quality Outreach Nurses and Coordinators visit primary care practitioners offices every six months to discuss the importance of these services
        iv. Primary care practitioners are provided a quality profile report every six month detailing their specific rates compared to their peers, THP overall and National benchmarks (Report in April-May details previous year, report in September details status of current year).
        v. Medical record reminder sheets are provided in April of each year to PCPs to be placed in the member's record reminding the practitioner on the next visit the specific services that are required.
    e. HEDIS Hybrid Medical Record Review Process

THP utilizes an NCQA Certified software program to generate proactive reports and HEDIS sample frames for the hybrid pursuit process and reporting requirements. THP contracts with an NCQA Certified HEDIS auditor to annually review data systems, such as encounter and claims

systems, supplemental data systems, eligibility, pharmacy, lab repository, and all HEDIS processes related to medical record review and data collection efforts to assure they conform to specific NCQA standards. THP must pass this audit process to be able to report HEDIS measures publicly. The certified software program generates final measure reports for reporting to NCQA, which are audited by the NCQA certified auditor and signed off prior to submission. These reports are uploaded through a web based portal to NCQA and the plan applies a lock. When the plan locks the reports the auditor can then access these reports through the NCQA portal to audit and approve these reports. The auditor will apply the auditor lock and the reports then are marked as final. Specific Non-HEDIS specialty measures can be developed within the software program but are not considered certified by NCQA.

All HEDIS® performance measures will be submitted to DHCF and DHCF's agents as required by DHCF in accordance with time frames established by NCQA for submission of these measures to DHCF. THP has systems in place to analyze performance on these measures. THP will report to DHCF any continuous quality management projects planned.

Every measure is compared to national benchmarks (or if a benchmark is not available a goal is established) and final rates are reported through Medical Services Committee. All measures that do not meet minimum performance levels (75th percentile of the national rate, or not meeting goal) or have a significant drop in rate will have a formal corrective action plan developed. All other measures will be prioritized and those selected for improvement will have an improvement plan written that details specific actions or processes aimed at improving rates.

5.2.1 Threshold of Action

The threshold of action is the specified, pre-established level that signals the need for organization response to indicator data and the initiation of a process to determine the plan of action necessary to improve the care or service. Thresholds are established for each indicator as expectations of what constitutes good care and desirable performance. When thresholds of action are reached, qualified staff in the particular activity evaluates the care/service provided and determines if an opportunity to improve care/service exists. Thresholds are used to denote need for further investigation and/or analysis of the important aspect of care.

5.2.2 Monitoring of Performance

Monitoring of selected indicators is based on systematic ongoing collection and analysis of valid and reliable data. Interventions implemented to improve performance, must achieve demonstrable improvement and the results of each PIP will be communicated to DHCF and CMS as required. At a minimum the following, in addition to the aforementioned QIAs will be monitored:

2. **Enrollee service monitoring and evaluation** is conducted for all THP customers and includes service provided to enrollees, employers and providers. Important aspects of service for routine monitoring, evaluation and special study are identified through member satisfaction surveys, complaints/grievances and appeals reviewed by THP, and provider site

visit findings. Clinical issues identified through these processes are referred for clinical review.

a) THP assures member satisfaction and is assessed by:
   i) Member satisfaction surveys
   ii) Patient complaint and appeal evaluations
   iii) Evaluation of requests to change providers or sites
   iv) Evaluation of voluntary dis-enrollments

b) Appropriate methods are used to collect data for the assessment activities:
   i) The appropriate population is identified
   ii) Appropriate samples are drawn from the affected population
   iii) Valid and reliable data are collected

3. **Continuity and coordination of and access to the care and service** members receive, health promotion activities and performance on approved practice guidelines is included in monitoring and evaluation.

   a) THP establishes standards for appointment accessibility:
      1.Timeliness of preventive care appointments
      2.Timeliness of routine primary care appointments
      3.Timeliness of urgent care appointments
      4.Timeliness of emergency care
      5.Access to after hour care
      6.Key elements of telephone service (responsiveness)

   b) THP provides Health Education Programs that addresses issues relevant to the enrolled member population. Health promotion activities are designed to meet the needs of various populations.

   c) Transitions of care or settings. Trusted monitors and takes action to improve continuity and coordination of care across the health care network.

4. **Credentialing/Recredentialing**- All participating practitioners and providers undergo a careful review of their qualifications. Practitioner review includes but is not limited to; education and training, board certification status, license status, hospital privileges, and malpractice and sanction history. Provider review includes but is not limited to licensure, accreditation and certification. All practitioners undergoing initial credentialing and triennial recredentialing are reviewed and approved by the QEC.

5. **Peer Review-** is the mechanism utilized to review potential substandard/inappropriate care or inappropriate professional behavior by a practitioner while providing care to a member. If the findings of an independent investigation indicate that a practitioner has provided

substandard or inappropriate care, has exhibited inappropriate professional conduct, or has been sanctioned, THP will take appropriate action, as defined by policies addressing quality of care referrals as well as the Health Care Quality Improvement Act of 1986, including the applicable appeal process. The scope of actions that may be taken if a quality issue is identified include, but are not limited to, development of an improvement action plan with time frames for improvement, education, counseling, monitoring and trending of data, decredentialing, and referral to the appropriate state and/or federal agencies. All peer review information is confidential.

6. **Provider Accessibility and Availability Monitoring-**Provider accessibility, and availability monitoring is conducted annually to ensure that established standards for reasonable geographic location of practitioners, number of practitioners, appointment availability, provision for emergency care, and after hours services are measured. The cultural, ethnic, racial, and linguistic needs of members for general needs and as they relate to the practitioner network are assessed at least annually. The objectives for serving a culturally and linguistically diverse membership include:

   - Eliminating disparities in health care services
   - Promoting communication between members and their health care providers so language is not a barrier to achieving optimal health and receiving health care services
   - Providing culturally competent services to our diverse membership to eliminate alienation of these populations from the health care system

7. Monitoring activities may include practitioner and member surveys, on-site visits, evaluation of member satisfaction, and evaluation of complaints andgeo-access surveys. Specific deficiencies are addressed with an improvement action plan, and follow-up activity is conducted to reassess compliance. THP's Quality Management staff present data for review to the QEC for final recommendations.

8. **Utilization Management-**The QEC oversees the implementation of comprehensive, systematic, continuous processes, which make the Utilization Management Program effective. The QEC monitors quality, continuity, and coordination of care as well as over-utilization and under-utilization of services.. Treatment guidelines on which UM decisions are made are evidence-based, and are reviewed, revised, approved and utilized by the QEC.

9. **Complaints, Appeals, and Grievances** review objectives are to:

   - Monitor, evaluate, and effectively resolve member concerns in a timely manner.
   - Identify opportunities for improvement in the quality of care and service provided to members.

- Identify opportunities for improvement in the appeal and grievance process.
- Assure that health plan member's grievances and appeals are managed in accordance with state and CMS established regulations and THP policies on the subject.

Quality of care and service concerns can be identified by any health plan department, member, or practitioner. Data related to quality of care, quality of service, and administrative issues are collected, reviewed, and trended to identify opportunities for improvement. Analysis is presented to the QEC for review of aggregate trends and identification of actions for improvement.

10. **Member Satisfaction** is assessed through member satisfaction surveys (CAHPS) and complaint data. Member satisfaction surveys are conducted annually. Member survey data are used to:

    - Measure organizational performance
    - Establish benchmarks against national performance data and monitor performance
    - Assess overall levels of satisfaction to determine if the health plan is meeting member expectations
    - Assess service performance compared to competitors

Based on the findings, a Corrective Action Plan or PIP may be developed to improve performance. All Corrective Action Plans or PIP are approved and monitored by the QEC.

11. **Practitioner/Provider Satisfaction** surveys are designed to:

    - Assess which services are important to providers
    - Determine provider satisfaction with THP's processes, including the utilization management process.

Provider satisfaction surveys are conducted annually. The survey results are summarized and reviewed by the QEC to identify areas for improvement and develop action plans.

12. **Telephone Service and behavioral health referral and triage** responsiveness is monitored on continuous basis and is reported to the QEC at least annually. When service goals are not met, improvement activities are initiated.

5.2.3 Health Management Systems

THP identifies members with chronic conditions such as hypertension, asthma and diabetes and offers appropriate services and programs to assist in the management of these conditions. For 2015, THP selected Asthma and Diabetes to develop and implement disease management programs. These conditions were identified utilizing claims data, preliminary HEDIS rates, pharmacy data, and case management participation data.

5.2.4 Health Risk Assessment

THP created a standardized Health Risk Assessment questionnaire that evaluates the physical, psychosocial, cognitive, and functional needs of all new members. The questionnaire is designed to help identify key care needs. It does not replace the need for a comprehensive physical exam conducted by the primary care practitioner. THP has a comprehensive health risk assessment process in place, which assesses member health status and applies an acuity that helps direct nursing staff to appropriate services the member might need or require. The assessment includes but is not limited to:

- Health history
- Special care needs (DME, home health, social worker, etc.)
- Specialty care needs
- Living situation
- Activities of daily living (ADLs)
- Safety issues
- Mental status
- Functional assessment
- Pain assessment
- Medication history
- Health educational needs

This information is entered into CareConnect Software, which directs the nurse on specific actions (referrals), but is not limited to:

- Case Management

- Complex Case Management
- Disease Management Programs
- Utilization Management review
- Pharmacist review
- Health Education
- Cultural or linguistic support
- Member Services or Benefit explanations

The main goal of the risk assessment process is to assess the member and identify specific needs based on the individual responses. THP will contact newly enrolled and current THP dual-eligible beneficiaries to perform the survey telephonically or via face-to-face home visits. THP will initiate the survey calls based on a list of new enrollees provided shortly after the beneficiary's enrollment transaction is confirmed by CMS. If the vendor is unable to contact the beneficiary by phone, the survey will be mailed to the beneficiary; last resort will be a home visit. All calls and visits, successful and unsuccessful will be documented. Beneficiary responses to the survey calls and responses to mailed surveys will be entered into the CareConnect system. THP will monitor adherence to conducting all initial assessments within 90 days of enrollment.

5.2.5 Potential Quality Issues (PQI)

A major component of the CQI Program is the identification and review of potential quality issues and the implementation of appropriate corrective action to address confirmed quality of care issues.

A PQI is a deviation or suspected deviation from expected Practitioner performance, clinical care or outcome of care that cannot be determined to be justified without additional review. Such issues must be referred to the Quality Improvement Department for review and investigation.

Peer Review

- Peer review is conducted in any situation where peers are needed to assess the appropriateness or necessity of a particular course of treatment, to review or monitor a pattern of care provided by a specific practitioner or to review aspects of care, behavior or practice, as may be deemed inappropriate.
- The Chief Medical Officer is responsible for authorizing the referral of cases for peer review.
- All peer review consultants (including members of the Credentials/Peer Review or ad-hoc Peer Review Committees) are duly licensed professionals in active practice.

- At least one consultant will be a Practitioner with the same or similar specialty training as the Practitioner whose care is being reviewed, except in those cases where there is no applicable board certification for the specialty.

- The Chief Medical Officer can send cases out for a specialty review and consultation to be used for the peer review process.

- The Chief Medical Officer will confirm that the peer review consultants have the necessary experience and qualifications for the review at hand.

- The CQI prepares all materials for review by the Peer Review Committee and conducts all follow-ups, as required by the Committee.

5.2.6 Patient Safety

Patient safety issues are addressed in several ways:

1. Critical Incidents/ Sentinel Events P&P: Our CQI team tracks and trends all other reportable incidents, and when necessary, investigates patterns or prevalence of incidents. The investigation of sentinel events is the shared responsibility of the quality departments of THP and all of its subcontractors for root cause analysis, which is performed in collaboration with THP's clinical and network departments.

2. Drug prescribing issues: all prescriptions are reviewed for member allergies, polypharmacy and interactions with other drugs. When predefined prescribing criteria are exceeded, a notice is forwarded to Trusted, the pharmacist and ordering physician.

3. Administration of childhood vaccines: to minimize the possibility of delayed or missed vaccines in childhood, Trusted monitors the timely administration of vaccines from birth to 18 years of age.

4. Review of all inpatient suicides, suicide attempts and elopements,

The Peer Review Committee is delegated the responsibility to monitor practitioner competency by incorporating monitoring and evaluation activities which validate medical staff credentials. All Peer Review findings will be summarized and reported to the QEC. Peer review issues are de--identified for provider/ member confidentiality.

The Risk Management/ Compliance Department is responsible for identifying sources of potential and actual risks, evaluation and control, thus reduce the frequency and severity of adverse events, minimize loss and contribute to quality care and safety for members, providers, employees and visitors.

The Appeals and Grievance Committee is responsible for the monitoring of member issues. The grievance process is outlined in detail in the grievance protocols. This Committee creates a forum for the following:

- Grievance Resolution and calibration of health services on complex grievance issues;
- Coordinating policy and developing and implementing action plans to correct administrative and clinical deficiencies within THP which contribute to grievances;
- Documenting and bringing deficiencies to the attention of the QEC and the BOD with respect to clinical services provided by THP;
- Final level of review prior to arbitration of Small Claims action for members or providers dissatisfied with a THP grievance disposition.

5.2.7 Delegation

In the event that Trusted identifies a vendor who wishes to assume selected responsibilities, the entity may be considered for delegation. An initial delegation readiness assessment is performed on all potential delegates .A site visit is conducted to verify that the entity is compliant with Trusted requirements and NCQA standards. Materials which are reviewed prior to delegation include a written description of the delegated activity, policies and procedures, reports and other materials. In the case of UM and CR processes, a file review of up to 30 UM and CR files is conducted using NCQA's 8/30 rule. If the delegate successfully passes the pre-delegation audit, the director who manages the function at Trusted either approves or denies the delegation. S/he may seek the approval of the QEC. If the delegation is approved, Trusted oversees the delegated activities. The delegate must submit performance and other reports to Trusted as specified in their contract. An evaluation of the delegation occurs annually, including an annual audit of files, P&Ps and other documents. If the organization is certified/ accredited by NCQA, Trusted may opt to forgo these audit activities, as specified in the NCQA standards.

Trusted delegates selected behavioral health QI activities to Beacon Health including availability of practitioners, accessibility of services, member experience, assessment of SPMI in population, behavioral health related questions in the CM assessment and adoption of BH clinical practice guidelines. In addition, Trusted delegates claims processing and utilization management activities to Beacon, DentaQuest, EyeQuest and Meridian PBM and credentialing activities to Beacon Health, Medical Faculty Associates, Inc, Children's National Medical Center, Mary's Center for Maternal and Child Care and Unity Health Care, Inc.

4.2.8 Collaboration

In addition to delegating activities to Beacon Health, Trusted collaborates with Beacon Health to complete its annual evaluation of continuity and coordination of care between medical and behavioral health by assessing exchange of information,

Communication

Communication of QI Program activities to members, practitioners and providers is accomplished through various mechanisms, including but not limited to:

- Member, provider newsletters and secure portals
- Member and Provider Handbooks
- Regulatory body reports and surveys

6 CQI Work Plan and Evaluation

6.1 CQI WORK PLAN

A CQI Work Plan (attached) is developed and implemented annually by the QEC and approved by the BOD. The Plan describes its scope and THP's quality management goals and objectives, planned projects and activities for the year including continued follow-up on previously identified quality issues and a mechanism for adding new activities to the plan as the need is identified. It delineates who is responsible and the time frame in which planned activities will be achieved. It provides a mechanism for annual review, evaluation and revision of the Plan with quality management reports on effectiveness and outcomes, including recommendations for approval, to the CEO and the BOD.

6.1.1 Measuring Effectiveness of Care Management Programs

Care Management Programs, such as Model of Care, QIPs, Disease Management Programs, Complex Case Management, HEDIS, CAHPS, HOS, grievances and PQIs, are measured on a consistent basis to demonstrate effectiveness of the interventions established. These measurements are established through the QEC and specific timeframes for re-measurement and methodology vary. All measurements and studies are presented to the QEC and summarized on the annual evaluations, which are available for regulatory agency review. Quarterly reports are an evaluation of the progress of the quality improvement activities, as outlined in the Work Plan, and are submitted to the QEC and Board of Directors for review, comment and approval annually.

6.2 ANNUAL EVALUATION

An annual evaluation of the CQI Program is conducted by the CQO or designee to assess the overall effectiveness of THP's quality improvement processes. The evaluation reviews all aspects of the medical and service improvement initiatives, emphasizing whether there have been demonstrated improvements in the quality of care and service provided to members. The annual evaluation includes:

- An assessment of how the year's goals and objectives were met
- A review of human and technological resources
- A summary of quality improvement activities
- The impact the CQI process had on improving the care and service provided to members
- Potential and actual barriers to achieving established goals
- Recommendations for CQI Program revisions based on the evaluation.
- Evaluation of quality improvement activities with recommendations

- Summary and trending of monitoring and evaluation activities
- Follow-up on previous studies and reports
- Actions taken
- Effectiveness of those actions and demonstrated improvement in the quality of care and service provided

The annual evaluation is reviewed and approved by the QEC and the BOD. The results of the annual evaluation are used to develop and prioritize the next year's annual work plan.

The evaluation also makes recommendations on future CQI activities, Work Plan revision and changes to the overall quality program. The report may include graphs, charts and narratives that emphasize key findings and results. The Executive Committee reviews and approves the evaluation and subsequent year's work plan.

6.3 CONFIDENTIALITY

The CQI program and documentation, an integral part of the program, is confidential. All data and information acquired by this review body, in the exercise of its duties and functions, shall be held in confidence, and not disclosed to anyone; except to the extent necessary to carry out the purpose of the review organization. All data will be coded and identifiable patient information will be destroyed once data is summarized.

All Committee meeting minutes are confidential and any person involved in their review must have an oath of confidentiality on record. All members of the Committee shall be required to sign the confidentiality agreement annually.

THP adheres strictly to HIPAA Regulations. No voluntary disclosure of identifiable member information or Personal Health Information (PHI) is made without obtaining prior consent from the member except as required by law. Member information is used only as necessary to meet the administrative and legal obligations of THP.

6.4 APPROVAL

Sr. Director of Quality and Accreditation	Date
Chief Medical Officer/Chief Quality Officer	Date
Chief Executive Officer	Date



Compliance Plan

* * * * *

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PURPOSE

The purpose of Trusted Health Plans, Inc's ("Trusted") Corporate Compliance Plan ("Plan") is to ensure that incidents of suspected fraud and abuse, or violations of Trusted's Corporate Code of Conduct ("Code"), are reported investigated and resolved in a timely manner. Implementation of the compliance plan will help to ensure that the integrity and ethics of Trusted remain intact.

Key components of the plan:

1. Trusted will make all efforts to comply with applicable Federal and local laws and regulations.
2. Trusted will promote an organizational culture of compliance and adherence to the Code.
3. Trusted will establish and maintain policies and procedures designed to reasonably prevent and detect noncompliant behavior and incidents.
4. Trusted will have a Compliance Officer designated with high level authority and access and overall responsibility for implementation of this Plan.
5. Trusted will provide education and training to all employees, including the governing authority, on the Trusted Code of Conduct and this Plan at time of hire and annually thereafter.
6. Trusted will make available methods to for employees, providers, and vendors report anonymously incidents of suspected waste, fraud, and abuse of State, Federal, or company resources, and/or other compliance violations – without fear of retaliation.
7. Trusted will use reasonable efforts not to hire, contract or otherwise include into their business individual(s) whom the organization knows, or should have known has engaged in illegal activities or other conduct inconsistent with an effective compliance program.
8. Trusted will engage in auditing and reporting functions that are designed to measure the organization's actual compliance with and the effectiveness of the Plan, to identify problems as quickly and efficiently as possible, and to promptly remediate those problems identified.

Code of Conduct

The Code of Conduct (Code) provides guidance to all Trusted Health Plans, Inc. (Trusted) employees and assists in the completion of daily activities within appropriate ethical and legal

standards. These obligations apply to our relationships with enrollees, network providers, third-party payors, subcontractors, independent contractors, vendors, consultants, and each other.

The Code is a critical component of the overall Compliance Program. We have developed the Code to ensure that we comply with applicable laws and regulations and help Trusted to maintain high ethical standards.

The Code is a statement that is both comprehensive and easily understood. In some instances, the Code deals fully with the subject covered. In many cases, however, the subject discussed has so much complexity that additional guidance is necessary for those directly involved with the particular area to have sufficient direction. Though we promote the concept of management empowerment, the policies set forth in this Code are mandatory and must be followed.

Scope

This Code applies to all Trusted employees (to include sub-contractors, vendors, and providers).

Vision Statement

Trusted's corporate vision is to maximize outreach to underserved urban populations. We attempt to empower our members with the requisite knowledge to assume greater responsibility for their own health and well-being, to establish healthy lifestyles, and to take full advantage of available medical care and benefits. At the same time, Trusted seeks to play an integral role in the economic development of the city by investing human capital and other resources into the communities in which it operates.

Mission Statement

The mission of Trusted Health Plans, Inc. (TRUSTED) is to become the Health Maintenance Organization of choice by delivering quality care to our community; to ensure the provision of culturally sensitive and linguistically competent services through our providers, by treating our enrollees and/or customers with respect, consideration and dignity; by encouraging, developing and setting high performance standards for our employees and provider community; and by controlling costs.

The Trusted Code of Conduct provides guidance to all Trusted employees and assists in the completion of daily activities within appropriate ethical and legal standards. These obligations apply to our relationships with enrollees, network providers, third-party payors, subcontractors, independent contractors, vendors, consultants, and one another.

The Compliance Officer shall develop, implement, and enforce this written Plan regarding Trusted's commitment to full and comprehensive compliance with its obligations under the contract, consistent with this Plan, and with all applicable, published Federal and local health care statutes, regulations, contract terms, and conditions.

The Corporate Code of Conduct shall be maintained and updated regularly to ensure that Trusted and each of its directors, officers, and employees conduct themselves with the honesty and integrity required of a Government contractor. The Code shall be comprehensive, containing at a minimum, guidelines for managed care contracting and beneficiary services which are specific to marketing, enrollment/disenrollment, provider contracting, provider relations, member services, grievances, appeals, claims payments, benefits provision, reimbursement, and quality of care. Trusted shall review its current disciplinary guidelines and revise them as appropriate to comply with the terms of this Plan. Executive staff and senior management shall have an affirmative duty to report suspected incidents of waste, fraud, and abuse, as well as violations of the Code or Plan.

Trusted will be responsible to ensure that all employees have signed a certificate of acknowledgement that shall represent that he/she has read the Plan and agrees to abide by it. All new employees shall, within fifteen (15) business days of employment, be given a copy of the Plan to read and will be required to sign the certificate of acknowledgement. The certificate will be maintained in each employee's personnel file in the Human Resources Department. The certificates shall be made available to the contracted monitoring entity during annual compliance audits.

Within thirty (30) business days of the execution of this Plan, Trusted shall post, (in areas visible to all employees) a notice stating the Company's commitment to compliance with all applicable Federal and local health care regulations and procedures, a statement that the Company's Code is available to all employees, and a statement that the Compliance Officer is available to all employees via the Compliance hotline.

The Company's Provider Relations personnel shall notify all hospitals and providers with which it is contractually obligated, in connection with its contracts, of its commitment to fair and proper contracting procedures and compliance with federal and local law, as well as this Plan and the

Code. This procedure shall be effective no greater than thirty (30) days after the execution of this Plan.

Trusted shall require its officers, managers and directors to promote and encourage adherence to this Plan and the Code, and shall make promotion and adherence to the Company's compliance initiative a part of their performance standards.

Trusted shall implement an annual certification requirement in which each of its officers, managers, and directors attests that he/she has: (1) discussed with each subordinate under his/her direct supervision the content and application of the Code; (2) informed each subordinate that strict compliance with the Code is a condition of employment or continued employment and (3) informed each subordinate that Trusted shall take disciplinary action, up to and including termination, for violation of the Code, any health care statute or regulation, or terms of its Government contract.

Annually, or more frequently if deemed necessary, Trusted shall either amend or ratify the Code.

Scope

The regulatory compliance plan applies to all full and part time employees, consultants, contractors, network providers and hospitals, and vendors of Trusted.

Framework

Trusted's compliance program will consist of a systematic process aimed at ensuring that Trusted and its employees, and business partners, comply with applicable laws, regulations, and standards. The principal focus will be on health care specific laws and regulations; however, the program will extend to business practices as well. The program will have two basic components – structural and substantive.

1. The structural component includes the basic framework necessary to build and operate an effective compliance program. The structural component includes those elements articulated by the Office of Inspector General as necessary elements of a compliance program. These elements would typically be included in any compliance program, regardless of the issues that Trusted addresses. This program will include standards

(policies and procedures), oversight, reporting, screening, education, auditing/monitoring, enforcement, and prevention.

2. The substantive component relates to the specific body of laws or regulations (i.e. Medicare, Medicaid, privacy, HIPAA) with which Trusted is trying to comply with.

Foundation for Program

I. US Sentencing Guidelines

While Federal law does not require an organization to meet the Guidelines, these seven elements provide the backbone of a well-designed compliance program. An organization that is found guilty of violating federal criminal laws and has a compliance program in accord with the Guidelines may reduce assessed penalties against the fines that the law requires.

1. **Compliance Standards** "The Organization must have established compliance standards and procedures to be followed by its employees and other agents that are reasonable capable of reducing the prospect of criminal conduct".
2. **High Level Responsibility** "Specific individuals within high level personnel of the organization must have been assigned overall responsibility to oversee compliance with such standards and procedures".
3. **Trustworthy Individuals** "The organization must have used due care not to delegate substantial discretionary authority to individuals whom the organization knew, or should, have known through the exercise of due diligence, had a propensity to engage in illegal activities".
4. **Education** "The organization must have taken steps to communicate effectively its standards and procedures to all employees and agents, by requiring participation in training programs or by disseminating publications that explain in a practical manner what is required."
5. **Monitoring and Auditing** "The organization must have taken reasonable steps to achieve compliance with the standards, by utilizing monitoring and auditing systems reasonable designed to detect criminal conduct by its employees and other agents, and by having in place and publicizing a reporting system whereby employees and other agents could report criminal conduct by to others within the organization without fear of retribution".

6. **Enforcement and Discipline** "The standards must have been consistently enforced through appropriate disciplinary mechanisms, including, as appropriate, discipline of individuals responsible for the failure to detect an offence. Adequate discipline of individuals responsible for an offence is a necessary component of enforcement; however, the form of discipline that will be appropriate will be case specific".
7. **Response and Prevention** " After an offense has been detected, the organization must have taken all reasonable steps to respond appropriately to the offense and to prevent further similar offenses – including any necessary modifications to its programs and detect violations of law".

II. Medicare + Choice Components for an Effective Compliance Program

All Medicaid Managed care organizations must comply with the 1997 Balanced Budget Act Medicaid Managed Care Regulation by August 13th, 2003. These regulations include provisions for establishing a compliance program consistent with those required for Medicare + Choice managed care organizations. The requirements are that such managed care organizations are engaged in:

1. Implementing written policies and procedures that promote and support the organization's commitment to compliance.
2. Designation of compliance officer and compliance committee.
3. Conducting effective training and certification.
4. Developing effective lines of communication between the compliance officer and all employees.
5. Enforcing standards through well-publicized disciplinary guidelines and developing policies addressing dealings with sanctioned individuals.
6. Conducting internal monitoring and auditing.
7. Responding promptly to detected offenses, developing corrective action, and reporting to the government.

Elements of the TRUSTED Health Plans, Inc. Compliance Plan

Element 1: Standards

Trusted will develop and implement policies and procedures designed to address principal business risks, including evaluation of such risks. These policies include, but are not limited to, those relating to the operation of the compliance program (e.g. internal handling of compliance hotline calls, compliance reporting structure, compliance education requirements, how the organization will investigate complaints or problems, remediation efforts) as well as policies and procedures addressing the organization's legal risks. (e.g. laws and regulations applicable to health care, Trusted audits, investigations, other reviews and assessments).

1. Trusted will develop and implement policies and procedures that describe how its compliance program operates and the consequences of non-compliance (e.g. Code of Conduct, processes to rectify non-compliance).

2. Trusted will ensure that relevant employees and agents are promptly oriented to applicable new and revised policies and procedures (ensure prompt orientation to applicable employees; policies for new employees, ensures prompt distribution and comprehension of revised policies for existing employees).

3. Trusted will ensure that the organization's policies and procedures are periodically reviewed and are updated to reflect changes in laws, regulations, or processes.

4. Trusted will monitor adherence to its policies and procedures. (including review at regular intervals, adopting a process to monitor changes in law and modify policies as appropriate, and appropriately disciplines employees who do not adhere to policies.

Element 2: Designation of Compliance Officer and Compliance Committee

Formal designation of a Compliance Officer and a committee helps formalize the compliance process for Trusted. Trusted has appointed and will maintain a Compliance Officer. The Compliance Officer shall also chair the Trusted Compliance Committee, which shall meet monthly and shall review issues, risks, developments, and concerns related to the health care and business operations of Trusted, and any laws and regulations affecting those issues, risks and developments.

Compliance Officer: Trusted shall specifically designate an individual to serve as the Compliance Officer ("CO") for the contract. An individual may be designated for the position that has other organizational responsibilities. The CO shall assume such duties and responsibilities as deemed necessary to fulfill the obligations undertaken in this Plan. The CO shall be a senior position within Trusted and shall have direct access to the Chief Executive Officer ("CEO") and the Governing Board. The CO will not be an employee of a first tier, downstream provider or related entity.

Compliance Committee: Trusted shall designate a compliance committee that will regularly meet and review compliance issues, concerns, policies and procedures, reports, and other items that fall under this Plan.

Duties: Compliance Officer

Duties of the Compliance Officer shall include, but not be limited to:

- Implementing, documenting and maintaining a legislative and regulatory compliance program that meets the expectations of State and Federal regulators and corporate governance programs.
- Collaborating with the Compliance Committee to effectively incorporate the compliance program into the health plan.
- Coordinating resources to ensure the ongoing effectiveness of the compliance program.
- Presenting periodic reports and an annual evaluation on the compliance program to the compliance committee, CEO, and Board of Directors.
- Organizing the compliance committee, including developing appropriate agendas, reports, and information as requested by the committee, CEO, and/or Board.
- Communicating the importance of compliance and the compliance programs to senior staff, the compliance committee, and health plan staff, including promoting (1) use of the compliance hotline, (2) increased awareness of the Code of Conduct and Compliance, and (3) understanding of new and existing compliance issues and related policies and procedures.
- Implementing with appropriate management education programs affecting compliance.
- Identifying and assessing areas of compliance risk for the health plan.
- Developing and/or ensuring internal controls are capable of preventing and detecting significant instances or patters of illegal, unethical, or improper conduct.

- Monitoring the performance of the compliance plan on an ongoing basis, taking appropriate steps to improve its effectiveness.
- Monitoring compliance with laws, rules, and regulations, as well as health plan policies and procedures.
- Conducting or overseeing investigations regarding compliance, as appropriate.
- Overseeing and providing follow-up and, as applicable, implementing corrective action plans to investigations and other issues generated by the compliance program.
- Tracking all issues referred to the compliance unit up to and including resolution.

Element 3: Ongoing Education and Training

The existence of an education and training program is an important component of compliance programs for a number of reasons, including the following:

- To prompt an understanding of with relevant federal, state and local laws and regulations.
- To enable implementation of the compliance program's policies and procedures and ensure that employees understand their role in the compliance process.
- To demonstrate the organization's commitment to compliance and ensure that commitment is carried out throughout the organization.
- To communicate the effect that industry standards and government requirements have on an organization's business activities and to improve skills for identifying potential compliance issues.

Each Trusted employee (including newly appointed chief executive, manager, or governing body member), first tier, downstream and related entity shall be required to have three-four hours of training annually. First Tier, downstream, and related entities who have met the fraud, waste and abuse certification requirements through enrollment into the Medicare program are deemed to have met the training and educational requirements for fraud, waste, and abuse.

Trusted utilizes MyComply online training modules to administer and track completion of compliance training at hire and annually thereafter (abbreviated compliance/FWA training will be required on a quarterly basis). At minimum it will include:

1. General Training - All employees – Three hours
    a. One hour - Code of Conduct
    b. One hour - HIPAA Privacy and Security Requirements
    c. One-half hour – Confidentiality

d. One-half hour – Healthcare Fraud & Abuse
e. One-half hour - Whistleblowing

2. Department Specific Training – One Hour
   - Each employee shall be required to maintain and/or improve the knowledge about his or her own job or profession by participating in at least one hour of training in their specific job function.
3. Documentation of training will be maintained for each employee, provider, and/or vendor.
   a. The documentation shall include:
      i. Name and position of each employee.
      ii. Date and duration of each program.
      iii. A brief description of the subject matter of the education.

Education activities include, but are not necessarily limited to, organization –sponsored programs or educational sessions, viewing educational videos, participation in department or company meetings in which compliance issues are specifically addressed, attendance at government-sponsored educational sessions, attendance at seminars, conferences and workshops.

Element 4: Open Lines of Communication

Compliance programs operate most efficiently in organizations that encourage employees and business partners to report suspected wrongdoing so that it can be investigated and properly addressed. An organization that encourages open communication will be more effective in identifying risk areas on which to concentrate its performance improvement areas. To achieve an open environment, employees at every level of the organization must believe that their good faith report of possible non-compliance will be taken seriously, and that the organization will not tolerate retaliation.

Trusted will create mechanisms to encourage and facilitate candid communication. Trusted will accomplish this by:

1. Creating a culture of Open Communication.
2. Establishing and publicizing the existence, intent, process of its compliance hotline, as well as other mechanisms available for raising compliance concerns.
3. Ensuring that the reporting mechanisms are convenient to employees and those associated with the organization, including having at least one mechanism available at all times.

4. Publicizing the ability to receive reports of non-compliance form employees and others affiliated with the organization.
5. Enforcing a no-tolerance policy for retaliation or retribution against an employee or associate who reports suspected compliance violations or misconduct.

To this end, Trusted shall maintain a toll-free hotline for employees, (including newly appointed chief executive, manager, or governing body members), first tier, downstream and related entities to report suspected waste, fraud and abuse, or other violations of the Plan or Code directly to the Compliance Officer or his/her designee. The Hotline number shall be provided to all officers, directors, and employees and shall be posted in a prominent place accessible to each of its employees. All Trusted Compliance Hotline callers shall remain anonymous. Every attempt will be made to notify callers of the results of the investigation within thirty (30) business days of receipt of the Hotline call.

Based on the results of any investigation undertaken, Trusted shall effect such corrective action as may be deemed necessary to ensure the Company's compliance with the provisions of this Plan and all applicable statutes, regulations, and its contracts. This corrective action shall include, when appropriate, the Company's prompt reimbursement of any financial loss the misconduct has caused the Medicaid program or program beneficiaries. Any call received on that hotline that credibly alleges a material violation of criminal or civil law by Trusted relating to its contract, will be investigated by the Compliance Officer in accordance with the terms set forth in this Plan. If during the investigation it is discovered that the allegations represent an actual criminal offense or violation of the Company's Code, mandates, or federal statutes, the individual(s) involved may be terminated and (if necessary) prosecuted to the fullest extent of the law.

Trusted will establish a process to track and document reported concerns, including the statues of related investigations and corrective action. Trusted will regularly inform leadership of reported concerns, seriousness of allegations, and otherwise, to allow organizational leaders to assess whether trends in use of the reporting mechanisms or in organizations operation suggest that improvements may be required.

Element 5: Ongoing Monitoring and Auditing

The Compliance Department shall maintain a log of all calls received, and shall conduct a preliminary review, and if necessary, an internal investigation of any allegation of misconduct received over the Hotline.

Compliance personnel will report confirmed incidents of fraud, waste, and abuse to the Department of Healthcare Finance and the Office of the Inspector General within twenty-four (24) business hours of receipt and confirmation, in accordance with federal and local laws and regulations.

Effective compliance programs involve proactive monitoring and auditing functions that are designed to test and confirm compliance with legal requirements and with the organization's written compliance standards. These functions serve to test compliance with internal policies and procedures and with federal, state, and local laws, regulations or rules.

Self-evaluation that occurs as a result of a compliance auditing and monitoring program is often critical in identifying areas where compliance standards have not been fully understood or fully implemented. Audits are a formal review of compliance with a particular set of internal (e.g. compliance policies or external (e.g. laws and regulations) standards.

To this end, Trusted will develop and implement an internal auditing and monitoring plan, setting out the areas that will be the focus of auditing or monitoring activity for a given period of time, such as a calendar or fiscal year. Trusted shall be engaged in internal audit activity at least once a year. Trusted monitoring and auditing plans will be constructed based upon a review of risk areas that are either generic to all health care organizations, or those risk specific areas pertain to Trusted. Past organizational performance, patients' complaints, and guidance from the Office of Inspector General are examples of resources that an organization uses to identify issues for audit.

To the extent practicable, audit personnel who have expertise in the areas being audited should conduct Trusted compliance audit activities, and who are independent from the activities being reviewed.

Trusted may collect information using a variety of methods to increase its ability to identify improper proceeds or activities.

When auditing or monitoring activities identify opportunities for improvement or compliance failures, it is often appropriate and/or necessary to take corrective action to address the findings. When corrective action is taken, follow-up auditing and/or monitoring should be conducted to confirm the effectiveness of the corrective action. Findings of significant noncompliance will be

reported promptly to the organization's leadership, and will also determine the necessity of self-reporting to governmental entities.

Trusted shall also establish an audit committee within its Board of Directors to oversee such activity. External audits of its first tier entities' compliant with CMS requirements and overall effectiveness of the compliance program will be conducted annually by the Compliance Department.

Element 6: Enforcement and Discipline

The effectiveness of Trusted's Compliance Program will be tied directly to its ability to affect the conduct of each individual in or associated with Trusted. Building and maintaining meaningful structures of accountability is critical to this effort. When compliance failures occur, there must be a process for enforcing compliance standards and for disciplining responsible individuals when discipline is appropriate. Enforcing standards and disciplining the individuals who violate them underscores Trusted's commitment to compliance.

Implementation of Trusted's enforcement and discipline standards shall include:

1. **Screening employees and business partners.**

   Trusted will include a process for avoiding relationships with individuals or entities that have a tendency towards inappropriate conduct. This process generally includes some of the following:

   a. Review of the Office of Inspector General (OIG) list of individuals and entities that are excluded from participation in government health care programs, and of the General Service Administration's (GSA) list of individuals and entities that are excluded from participating in government contracts.
   b. Criminal records checks when appropriate or as required by contract or law.
   c. Standard reference checks.
   d. Review of the National Practitioner Databank, for practitioners.

Trusted represents that to the best of its knowledge and belief it has disciplined, up to and including termination, such employees it had reason to believe were involved in misconduct while Trusted was under Government contract. Trusted also represents that, should further disciplinary action be necessary, Trusted shall take such action to the fullest extent of the law.

Records of discipline for compliance violations shall be maintained and reviewed periodically by appropriate oversight to promote consistency and fairness.

Element 7: Investigation, Response and Prevention-Right to Inspect, Audit and Interview

If there is discovery or evidence of misconduct related to payment or delivery of items or services under the contract, Trusted will conduct a timely, reasonable inquiry into that conduct. Appropriate Corrective Actions (e.g. recoupment of overpayments, disciplinary actions against responsible employees, etc.) in response to the potential violation will be taken. Trusted has a process outline in its Code of Conduct for individuals to voluntary self-report potential fraud or misconduct related to the contract to CMS, DHCF or its designees.

1. ***Right to Inspect:*** The Compliance Department reserves the right to enter into a contractual arrangement with an entity to examine the Company's books, records, and other documents for the purpose of evaluating the Company's compliance with:
    a. The terms of this Plan;
    b. Federal procurement policies as set forth in Federal regulations;
    c. Managed care contracting guidelines and procedures as determined by CMS;
    d. The requirements of its contracts; and
    e. The monitoring of key risk areas within Trusted.

Trusted shall make all requested materials available during annual examination, audit or reproduction. All Departments are expected to file copies of their external reports to government agencies with the Compliance Officer.

2. ***Right to Interview:*** The Compliance Department reserves the right to interview any employee, consultant, beneficiary, contractor, or sub-contractor who consents. The interview may be conducted at a mutually agreed upon time and location. Employees may elect to be interviewed in the presence of any person of their choice, including a Company representative. An employee may decline to be interviewed without penalty from either the Company's Compliance Department or the Government.

Trusted's compliance program will include a process by which the organization can respond to actual or potential violations. When an instance of potential non-compliance is reported or suspected, Trusted will generally take some or all of the following steps:

a. Promptly halt the non-compliance and halt or mitigate to the extent possible any ongoing harm caused by the suspecting noncompliance;
b. Fairly and expeditiously investigate to determine the existence, scope and seriousness of the non-compliance, and identify the underlying conduct or process that caused non-compliance;
c. Respond with appropriate corrective action to conformed non-compliance; and
d. Implement preventative measures to avoid similar instances or issues of misconduct in the future.

Trusted has an investigation protocol outlining how the organization will respond to reported, suspected, or confirmed non-compliance. Such protocol addresses issues as to who in the organization is responsible for and authorized to determine non-compliance and subsequent investigation, and what form the investigation will take; guidelines for policies for determining when legal counsel or external experts should be involved in an investigation; safeguards for preventing the inappropriate or inadvertent disclosure of confidential information that is obtained as part of the investigation; record retention requirements for investigative reports and files; clear delineation of who has the authority to close an internal investigation; and process for reporting findings of investigations to appropriate authorities.

In response to discovered non-compliance with appropriate corrective actions, Trusted will implement appropriate responses to discovered non-compliance that might require Trusted to take affirmative steps to address the non-compliance and to correct any harm that may have been caused by the non-compliance. Trusted shall also respond to discovered non-compliance with preventative measures and monitoring.

Reviewed & Approved by:

Chief Compliance Officer — **Date Approved:** 06/30/2015

Chief Executive Officer — **Date Approved:** 06/30/2015

General Counsel — **Date Approved:** 06/30/2015

Appendix A: Code of Conduct

Trusted Health Plans, Inc.
Corporate Policies and Procedures
Section: Regulatory Compliance -
Code of Conduct

PURPOSE

The Code of Conduct (Code) provides guidance to all TRUSTED employees and assists in the completion of daily activities within appropriate ethical and legal standards. These obligations apply to relationships with patients, network providers, third-party payors, subcontractors, independent contractors, vendors, consultants, and coworkers.

The Code is a critical component of the overall Compliance Program. TRUSTED has developed the Code to ensure that ethical standards are met and that we comply with applicable laws and regulations.

The Code is a statement that is both comprehensive and easily understood. In some instances, the Code deals fully with the subject covered. In many cases, however, the subject discussed has so much complexity that additional guidance is necessary for those directly involved with the particular area to have sufficient direction. Though we promote the concept of management empowerment, the policies set forth in this Code are mandatory and must be followed.

SCOPE

This policy and procedure applies to all TRUSTED employees (to include sub-contractors).

MISSION STATEMENT

The mission of Trusted Health Plans, Inc. (TRUSTED) is to become the Health Maintenance Organization of choice by delivering quality care to our community; to ensure the provision of culturally sensitive and linguistically competent services through our providers, by treating our enrollees and/or customers with respect, consideration and dignity; by encouraging, developing and setting high performance standards for our employees and provider community; and by controlling costs.

LEADERSHIP RESPONSIBILITIES

While all TRUSTED employees are obligated to follow the Code, leaders are expected to set the example, to be in every respect a model. They must ensure that those on their respective teams have sufficient information to comply with law, regulation, and policy and the resources to resolve ethical dilemmas. They must help to create a culture within TRUSTED which promotes the highest standards of ethics and compliance. This culture must encourage everyone in the organization to voice concerns when situations arise. TRUSTED will never sacrifice ethical and compliant behavior for business objectives.

RELATIONSHIPS WITH OUR HEALTHCARE PARTNERS

Patients

Patient Care and Rights

Our mission is to ensure the provision of quality health care to all patients. We treat all patients with respect and dignity and ensure the provision of care that is both necessary and appropriate. We make no distinction in the admission, transfer or discharge of patients or in the care we provide based on race, color, religion, or national origin. Clinical care is based on identified patient healthcare needs, not on the financial condition of the company.

Patients and their representatives will be afforded appropriate confidentiality, privacy, security and protective services, and an opportunity to resolve complaints

Patients are treated in a manner that preserves their dignity, autonomy, self-esteem, civil rights, by ensuring their involvement in their own care. TRUSTED employees will receive training about patient rights in order to clearly understand their role in supporting them.

Patient Information

We collect information about the patient's medical condition, history, medication, and family illnesses to provide the best possible care. We realize the sensitive nature of this information and are committed to maintaining its confidentiality. We do not release or discuss patient-specific information with others unless it is necessary to serve the patient or required by law.

TRUSTED employees must never disclose confidential information that violates the privacy rights of our patients. No TRUSTED employee, affiliated physician, or other healthcare partner has a right to any patient information other than that necessary to perform his or her job. All TRUSTED employees are required to sign a Confidentiality Agreement upon hire.

Patients can expect that their privacy will be protected and that patient specific information will be released only to persons authorized by law or by the patient's written consent.

In an emergency situation, when requested by an institution or provider other than those treating the patient, the patient's consent is not required, but the name of the institution and the person requesting the information must be verified.

Confidential Information; HIPAA Compliance

When conducting administrative operations, TRUSTED Employees often obtain access to and use confidential information. Various statutes and regulations, both state and Federal, require that TRUSTED take reasonable steps to protect the individually identifiable health and demographic information of our enrolled patients. TRUSTED uses multiple approaches to fulfill this obligation. Each Employee must sign a confidentiality agreement upon commencement of his or her employment at TRUSTED. TRUSTED has also adopted a TRUSTED-wide policy and procedure, which limits access and use of patient information to those purposes permitted by law. In addition, each TRUSTED department has a department-specific policy and procedure assuring that such information will be stored, accessed and used only to the extent minimally necessary to accomplish legitimate business purposes, including treatment, payment, operations, response to government oversight and disclosure as required by law.

Employees must become familiar with and abide by the confidentiality rules that apply to their job duties. In particular, all employees must ensure that patient specific information is not disclosed to anyone outside of TRUSTED unless that disclosure is permissible under the applicable confidentiality policies and procedures. Routine audits and reviews conducted by government representatives or

their designees must be performed in compliance with the applicable department policies and procedures. In addition, all periodic departmental reporting to government agencies must be performed in accordance with the company's policies regarding protection of patient health information communicated and/or incorporated into each department's confidentiality policies as applicable.

Privacy issues also arise when Employees, who do not have a legitimate business need to access particular patient information, are made aware of such information. No employee shall access or request access to information regarding patients, providers or operations unless the employee has a legitimate business need for such information and then may only access information minimally necessary to meet his/her business need. Employees should also be aware of their obligation to respect and protect the confidential nature of records regarding drug abuse, alcoholism or alcohol abuse or other personal information of other Employees.

Any suspected violation of TRUSTED'S privacy rules must be reported, either to the employee's supervisor or to the CO. Employees may also report such concerns to the Compliance Officer. Violations of the confidentiality policy will be subject to discipline, up to an including termination of employment.

Network Providers

Any business arrangement with a provider must be structured to ensure precise compliance with legal requirements. Such arrangements must be in writing and approved by the Compliance Officer (CO).

In order to ethically and legally meet all standards regarding referrals, TRUSTED will adhere strictly to one primary rule: Patient referrals are based solely on the patient's clinical needs and our provider's ability to render the needed services.

TRUSTED does not accept payments for referrals. No TRUSTED employee or any other person acting on behalf of the organization is permitted to solicit or receive anything of value, directly or indirectly, in exchange for the referral of patients. All TRUSTED employees are required to sign a Conflict of Interest Statement upon hire.

Third-Party Payors

Coding and Billing for Services

TRUSTED will take care to assure that all billings to the government reflect truth and accuracy and conform to all pertinent Federal and State laws/ regulations. We prohibit any employee or agent of TRUSTED from knowingly presenting or causing to be presented data which is false, fictitious, or fraudulent.

TRUSTED will operate oversight systems designed to verify that encounter data is submitted only for services actually provided. These systems will emphasize the critical nature of complete and accurate documentation of services provided. As part of our documentation effort, we will maintain current and accurate medical records.

Any subcontractors who engage other agencies to perform billing or coding services must have the necessary skills, quality assurance processes, systems, and appropriate procedures to ensure that all billings to government affiliated agencies are accurate and complete. TRUSTED prefers to contract with such entities that have adopted their own Regulatory Compliance Programs. Third-party billing entities, contractors, and preferred vendors that we consider must be approved consistent with the corporate policy on this subject.

REGULATORY COMPLIANCE

TRUSTED provides or arranges for the provision of healthcare services. These services generally may be provided only pursuant to appropriate Federal, state, and local laws and regulations. Such laws and regulations may require providers to obtain certificates of need, licenses, permits, accreditation, ensure access to treatment, consent to treatment, medical record-keeping, access to medical records and confidentiality, patients' rights, terminal care decision-making protocols, medical staff-patient relationship and clinical privileges, corporate practice of healthcare restrictions, and Medicare and Medicaid regulations. The organization is subject to numerous other laws in addition to these healthcare regulations.

TRUSTED will comply with all applicable laws and regulations. All employees and contract service providers must be knowledgeable about and ensure compliance with all laws and regulations; and should immediately report violations or suspected violations to a supervisor or patient of management, the Human Resources Manager, or the CO, via the Compliance Hotline.

TRUSTED will be forthright in dealing with any claim inquiries. Requests for information will be answered with complete, factual, and accurate information. We will cooperate with and be courteous to all government inspectors and provide them with the information to which they are entitled during an inspection.

During a government inspection, TRUSTED will never conceal, destroy, or alter any documents, lie, or make misleading statements to the government representative. We will not attempt to cause another employee to fail to provide accurate information or obstruct, mislead, or delay the communication of information or records relating to a possible violation of law.

TRUSTED will provide its employees with the information and education they need to comply fully with all applicable laws and regulations.

BUSINESS INFORMATION AND INFORMATION SYSTEMS

Accuracy, Retention, and Disposal of Documents and Records

Each TRUSTED employee is responsible for the integrity and accuracy of our organization's documents and records, not only to comply with regulatory and legal requirements but also to ensure that records are available to defend our business practices and actions. No one may alter or falsify information on any record or document.

Medical and business documents and records are retained in accordance with Federal and State law and TRUSTED policies regarding this topic. Medical and business documents include paper documents such as letters and memos, computer-based information such as e-mail or computer files on disk or tape, and any other medium that contains information about the organization or its business activities. It is important to retain and destroy records appropriately according to our policy. You must not tamper with records, nor remove or destroy them prior to the specified date.

Confidential Information

Confidential information about TRUSTED'S strategies and operations is a valuable asset. Although employees may use confidential information to perform their duties, it must not be shared with others outside of TRUSTED or the departments unless the individual has a legitimate need to know this information and have agreed to maintain the confidentiality of the information. Confidential information includes personnel data maintained by the organization, patient lists and clinical information, pricing and cost data, information pertaining to acquisitions, divestitures,

affiliations and mergers, financial data, research data, strategic plans, marketing strategies, techniques, employee lists and data maintained by the organization, supplier and subcontractor information, and proprietary computer software.

This provision also restricts the right of an employee to disclose or discuss information about his or her own compensation, benefits, or terms and conditions of employment with other TRUSTED employees.

Electronic Media

All communications systems, electronic mail, Internet access, or voice mail are the property of the organization and are to be primarily used for business purposes. Highly limited reasonable personal use of the TRUSTED communications systems is permitted; however, it should be assumed that these communications are not private. Patient or confidential information should not be sent through the Internet because its confidentiality cannot be assured.

TRUSTED reserves the right to periodically access, monitor, and disclose the contents of e-mail, and voice mail messages. Access and disclosure of individual employee messages may only be accomplished with the approval of the TRUSTED Governing Board.

Employees may not use internal communication channels or access to the Internet at work to post, store, transmit, download, or distribute any threatening, knowingly reckless, or maliciously false or obscene materials including anything constituting or encouraging a criminal offense, giving rise to civil liability, or otherwise violating any laws.

Additionally, these channels of communication may not be used to send chain letters, personal broadcast messages, or copyrighted documents that are not authorized for reproduction; nor are they to be used to conduct a job search or open misaddressed mail.

Employees who abuse TRUSTED communications systems or use them excessively for non-business purposes may lose these privileges and become subject to disciplinary action.

Financial Reporting and Records

TRUSTED has established and maintained a high standard of accuracy and completeness in the documentation and reporting of all financial records. These records serve as a basis for managing our business and are important in meeting our obligations to patients, employees, owners, suppliers, and others. They are also necessary for compliance with tax and financial reporting requirements.

All financial information must reflect actual transactions and conform to generally accepted accounting or statutory accounting principles. No undisclosed or unrecorded funds or assets may be established. TRUSTED maintains a system of internal controls to provide reasonable assurances that all transactions are executed in accordance with management's authorization and are recorded in a proper manner so as to maintain accountability for the organization's assets.

WORKPLACE CONDUCT AND EMPLOYMENT PRACTICES

Conflict of Interest

A conflict of interest may occur if outside activities or personal interests influence or appear to influence your ability to make objective decisions in the course of your job responsibilities. A conflict of interest may also exist if the demands of any outside activities hinder or distract employees from the performance of their duties or cause them to use company resources for other than TRUSTED purposes.

It is the obligation of each employee to ensure that he/she remains free of conflicts of interest in the performance of their responsibilities at TRUSTED. If anyone has questions regarding whether an outside activity might constitute a conflict of interest, approval must be obtained by the department supervisor before pursuing the activity.

Copyrights

TRUSTED employees may only make copies of copyrighted materials pursuant to the organization's policy on such matters.

Diversity and Equal Employment Opportunity

TRUSTED employees provide us with a wide complement of talents which contribute greatly to our success. We are committed to providing an equal opportunity work environment where everyone is treated with fairness, dignity, and respect. We will comply with all laws, regulations, and policies related to non-discrimination in all of our personnel actions. Such actions include hiring, staff reductions, transfers, terminations, evaluations, recruiting, compensation, corrective action, discipline, and promotions.

No one shall discriminate against any individual with a disability with respect to any offer, or term or condition, of employment. We will make reasonable accommodations to the known physical and mental limitations of otherwise qualified individuals with disabilities.

Harassment and Workplace Violence

Each employee has the right to work in an environment free of harassment. TRUSTED will not tolerate harassment by anyone based on the diverse characteristics or cultural backgrounds of those who work with us. Degrading or humiliating jokes, slurs, intimidation, or other harassing conduct is not acceptable in our workplace.

Any form of sexual harassment is strictly prohibited. This prohibition includes unwelcome sexual advances or requests for sexual favors in conjunction with employment decisions. Moreover, verbal or physical conduct of a sexual nature that interferes with an individual's work performance or creates an intimidating, hostile, or offensive work environment has no place at TRUSTED.

Harassment also includes incidents of workplace violence. Workplace violence includes robbery and other commercial crimes, stalking cases, violence directed at the employer, terrorism, and hate crimes committed by current or former employees.

As part of our commitment to a safe workplace for our employees, we prohibit employees from possessing firearms, other weapons, explosive devices, or other dangerous materials on TRUSTED premises. Employees who observe or experience any form of harassment or violence should report the incident to their supervisor, the Human Resources Department, the Compliance Officer, or the Compliance Hotline.

Flagrant violators of this policy will be subject to termination and prosecution to the fullest extent of the law.

Health and Safety

TRUSTED facilities must comply with all government regulations and rules and with TRUSTED policies or required facility practices that promote the protection of workplace health and safety. Our policies have been developed to protect employees from potential workplace hazards. Employees are encouraged to become familiar with and understand how these policies apply to their specific job responsibilities and seek advice from their supervisor or the CO whenever there is a question or concern. It is important to advise the supervisor or the CO of any serious workplace

injury or any situation presenting a danger of injury so that timely corrective action may be taken to resolve the issue.

Non-Employment or Retention of Sanctioned Individuals

No individual who has been convicted of a criminal offense related to health care fraud or the regulations governing the health care industry or who is listed by a Federal or state agency as debarred, excluded or otherwise ineligible for participation in federally funded health care programs shall be employed by or contracted to TRUSTED. No individual who is charged with criminal offenses related to health care or proposed for exclusion or debarment shall have direct responsibility for or involvement in any federally or state funded health care program in which TRUSTED participates.

In order to carry out the provisions of this section, TRUSTED as applicable shall make reasonable inquiry into the status of any current or potential employee or consultant. Such inquiry shall include, at a minimum, the OIG's Cumulative Sanction Report and the General Services Administration's (GSA) list of parties excluded from Federal Procurement Programs. TRUSTED conducts background checks on all individuals offered employment in a position responsible for or involving federal or state funded programs upon hire and at least annually thereafter.

Inside Information and Securities Trading

In the course of your employment, you may become aware of non-public information about TRUSTED material to an investor's decision to buy or sell the organization's stocks. Non-public, material information may include plans for mergers, marketing strategy, financial results, or other business dealings. You may not discuss this type of information with anyone outside of the organization. Within the organization, this information should only be discussed on a strictly "need to know" basis only with other employees who require this information to perform their jobs.

Should anyone obtain access to non-public, material information about the organization while performing your job, you may not use that information to buy, sell, or retain stocks of any other company. Even if you do not buy or sell securities based on what you know, discussing the information with others, such as family patients, friends, vendors, suppliers, and other outside acquaintances is prohibited until the information is considered to be public. Information is considered to be public three days after a general release of the information to the media.

License and Certification Renewals

Employees and individuals retained as independent contractors in positions which require professional licenses, certifications, or other credentials are responsible for maintaining the current status of their credentials and shall comply at all times with Federal and State requirements applicable to their respective disciplines. To assure compliance, TRUSTED will verify licensure of the individual to ensure they have a current license or credential status prior to employment. TRUSTED will not allow any employee or independent contractor to work without valid, current licenses or credentials.

Personal Use of TRUSTED Resources

It is the responsibility of each TRUSTED employee to preserve our organization's assets including time, materials, supplies, equipment, and information. Organization assets are to be maintained for business related purposes. As a general rule, the personal use of any TRUSTED asset without the prior approval of your supervisor is prohibited. The occasional use of items, such as copying facilities or telephones, where the cost to TRUSTED is insignificant, is permissible. Any community or charitable use of organization resources must be approved in advance by your supervisor. Any unauthorized use of organization resources for personal financial gain either related or unrelated to TRUSTED's business is prohibited.

Relationships among TRUSTED Employees

In the normal day-to-day functions of an organization like TRUSTED, there are issues that arise which relate to how people in the organization deal with one another. It is impossible to foresee all of these, and many do not require explicit treatment in a document like this. A few routinely arise, however. One involves gift giving among employees for certain occasions.

While we wish to avoid any strict rules, no one should ever feel compelled to give a gift to anyone, and any gifts offered or received should be appropriate to the circumstances. A *lavish* gift to anyone in a supervisory role would clearly violate organization policy. Another situation, which routinely arises, is fund-raising or similar effort, in which no one should ever be made to feel compelled to participate.

Relationships with Subcontractors, Suppliers, and Educational Institutions

TRUSTED must manage its subcontractor and vendor relationships in a fair and reasonable manner, consistent with all applicable laws and good business practices. We promote competitive

procurement to the maximum extent practicable. Our selection of subcontractors, suppliers, and vendors will be made on the basis of objective criteria including quality, technical excellence, price, delivery, adherence to schedules, service, and maintenance of adequate sources of supply. Our purchasing decisions will be made on the supplier's ability to meet our needs, and not on personal relationships and friendships. We will always employ the highest ethical standards in business practices in source selection, negotiation, determination of contract awards, and the administration of all purchasing activities. We will not communicate to a third-party confidential information given to us by our suppliers unless directed in writing to do so by the supplier. We will not disclose contract pricing and information to any outside parties (See: "Business Courtesies" of this Code).

Research

All personnel performing research of any type are responsible for maintaining the highest ethical standards in any written or oral communications regarding their research projects as well as following appropriate research guidelines. As in all accounting and financial record keeping, our policy is to submit only true, accurate, and complete costs related to research grants. Reported violations of this policy will result in immediate termination of the employee.

Substance Abuse and Mental Acuity

To protect the interests of our employees and patients, we are committed to an alcohol and drug-free work environment. All employees must report for work free of the influence of alcohol and illegal drugs. Reporting to work under the influence of any illegal drug or alcohol, having an illegal drug in your system, or using, possessing, or selling illegal drugs while on TRUSTED work time or property will result in immediate termination. Drug testing will be used as a means of enforcing this policy.

Criminal Background Check (D.C. Code § 44-552)

TRUSTED will not employ or contract with any unlicensed person until a criminal background check has been conducted for that person. TRUSTED shall inform each prospective employee or contract worker that they will be required to undergo a criminal background check before employment or services are provided. TRUSTED shall include in any Provider agreement the requirements of D.C. Code § 44-552.

MARKETING PRACTICES

Antitrust

Antitrust laws are designed to create a level playing field in the marketplace and to promote fair competition. These laws could be violated by discussing TRUSTED business with a competitor, such as how our rates are set, disclosing the terms of supplier relationships, allocating markets among competitors, or agreeing with a competitor to refuse to deal with a supplier. Our competitors are other Managed Care Organization's in markets where we operate.

At external meetings, be alert to potential situations where it may not be appropriate for you to participate in discussions regarding prohibited subjects with our competitors. Prohibited subjects include any aspect of rate setting, our services in the market, key costs such as labor costs, and marketing plans. If a competitor raises a prohibited subject, end the conversation immediately. Document your refusal to participate in the conversation by requesting that your objection be reflected in the meeting minutes and notify the CO of the incident.

In general, avoid discussing sensitive topics with competitors or suppliers, unless you are proceeding with the advice of the CO. Employees must also not provide any information in response to oral or written inquiry concerning an antitrust matter without first consulting the CO.

Gathering Information about Competitors

It is not unusual to obtain information about other organizations, including our competitors, through legal and ethical means such as public documents, public presentations, journal and magazine articles, and other published and spoken information. However, it is not acceptable for you to obtain proprietary or confidential information about a competitor through illegal means. It is also not acceptable to seek proprietary or confidential information when doing so would require anyone to violate a contractual agreement, such as a confidentiality agreement with a prior employer.

Marketing and Advertising

We may use marketing and advertising activities to educate the public, provide information to the community, increase awareness of our services, and to recruit employees. We will present only truthful, fully informative, and non-deceptive information in these materials and announcements.

They will only reflect services available and the level of licensure and certification as well as comply with DHCF regulations.

BUSINESS COURTESIES

Receiving Business Courtesies

TRUSTED recognizes that there will be times when employees may wish to accept from a current or potential business associate an invitation to attend a social event in order to further develop your business relationship. These events must not include expenses paid for any travel costs (other than in a vehicle owned privately or by the host company) or overnight lodging. The cost associated with such an event must be reasonable and appropriate. As a general rule, this will mean that the cost will not exceed $100.00 per person.

Sometimes a business associate will extend training and educational opportunities that include travel and overnight accommodations to you at no cost to you or TRUSTED. Similarly, there are some circumstances where you are invited to an event at a vendor's expense to receive information about new products or services. Prior to accepting any such invitation, employees must receive approval to do so consistent with the Code on this subject.

As a TRUSTED employee, you may accept gifts with a total value of $50.00 or less in any one year from any individual or organization who has a business relationship with TRUSTED. For purposes of this paragraph, providers participating with TRUSTED are considered to have such a relationship. Perishable or consumable gifts given to a department or group are not subject to any specific limitation. Employees may never accept cash or cash equivalents, such as gift certificates. Finally, under no circumstances may an employee solicit a gift.

Extending Business Courtesies to Non-referral Sources

There may be times when an employee may wish to extend to a current or potential business associate (other than someone who may be in a position to make a patient referral) an invitation to attend a social event in order to further or develop your business relationship. The purpose of the entertainment must never be to induce any favorable business action. During these events, topics of a business nature must be discussed and the host must be present. These events must not include expenses paid for any travel costs (other than in a vehicle owned privately or by the host entity) or

overnight lodging. The cost associated with such an event must be reasonable and appropriate. As a general rule, this will mean that the cost will not exceed $100.00 per person. Moreover, such business entertainment with respect to any particular individual must be infrequent, which, as a general rule, means not more than quarterly, and preferably less often.

With regard to the $100.00 guideline, if circumstances arise where an entertainment event was contemplated prior to the event to meet the guideline but unforeseeably exceeded it, a report to that effect with the relevant details must be filed consistent with the Code on this subject. If you anticipate an event that will exceed the $100.00 guideline, employees must obtain advance approval from the department director. The request must show the business necessity and appropriateness of the proposed entertainment.

TRUSTED will under no circumstances sanction participation in any business entertainment that might be considered lavish. Variances from the $100.00 guideline are highly discouraged.

TRUSTED facilities will routinely sponsor events with a legitimate business purpose. Provided that such events are for business purposes, reasonable and appropriate meals and entertainment may be offered. In addition, transportation and lodging can be paid for. However, all elements of such events, including these courtesy elements, must be consistent with the Code on this subject.

It is critical to avoid the appearance of impropriety when giving gifts to individuals who do business or are seeking to do business with TRUSTED. We will never use gifts or other incentives to improperly influence relationships or business outcomes. Gifts to business associates who are not employees must not exceed $50.00 per year per recipient. You may never give cash or cash equivalents, such as gift certificates. The Code on business courtesies may from time to time provide modest flexibility in order to permit appropriate recognition of the efforts of those who have spent meaningful amounts of volunteer time on behalf of TRUSTED.

TRUSTED's policy is to not provide any gifts, entertainment, meals, or anything else of value to any federal or state/local agency, except for refreshments in connection with business discussions or promotional items with TRUSTED or facility logo valued at no more than $10.00. With regard to gifts, meals, and other business courtesies involving any other category of government official or employee, you must determine the particular rules applying to any such person and carefully follow them.

Extending Business Courtesies to Possible Referral Sources

Any entertainment or gift involving providers or other persons who are in a position to refer patients to our network must be undertaken in accordance with the Code. We will comply with all Federal and State laws, regulations, and rules regarding these practices.

THE CORPORATE COMPLIANCE PROGRAM

Program Structure

The Compliance Program is intended to demonstrate in the clearest possible terms the absolute commitment of the organization to the highest standards of ethics and compliance. That commitment permeates all levels of the organization. TRUSTED's Compliance Officer is a representative of the Regulatory Compliance Department as a member of the Governing Board.

Resources for Guidance and Reporting Violations

To obtain guidance on an ethics or compliance issue or to report a suspected violation, you may choose from several options. We encourage the resolution of issues at a local level whenever possible. It is an expected good practice, when you are comfortable with it and think it appropriate under the circumstances, to raise concerns first with your supervisor. If this is uncomfortable or inappropriate, another option is to discuss the situation with another person in management in the organization. You are always free to contact the Compliance Hotline.

TRUSTED will make every effort to maintain, within the limits of the law, the confidentiality of the identity of any individual who reports possible misconduct. There will be no retribution or discipline for anyone who reports a possible violation in good faith. Any employee who deliberately makes a false accusation with the purpose of harming or retaliating against another employee will be subject to discipline up to and possibly including termination.

Personal Obligation to Report

We are committed to ethical and legal conduct that is compliant with all relevant laws and regulations and to correcting wrongdoing wherever it may occur in the organization. Each employee has an individual responsibility for reporting any activity by any employee, physician, subcontractor, or vendor that appears to violate applicable laws, rules, regulations, or this Code.

Non-Retaliation Policy

No employee will be disciplined or suffer any adverse employment action or other retaliation by TRUSTED solely for making a compliance report or complaint in good faith that there has been a compliance violation. The CO and the employee's manager/supervisor must enforce this non-retaliation policy. However, discipline will be imposed if TRUSTED reasonably determines that any complaint or report was knowingly fabricated knowingly exaggerated, distorted or minimized so as to injure another or to protect the reporting party or others who might be subject to discipline for a compliance violation.

Further, any person whose compliance report or complaint admits personal misconduct is not insulated from appropriate discipline simply by virtue of filing the complaint or report. However, the self-reporting, if timely, complete and truthful, may be considered a mitigating factor when imposing discipline in such a case.

No employee will be disciplined or suffer any adverse employment action or other retaliation by TRUSTED for lawfully providing information to a federal, state or local regulatory or law enforcement agency or otherwise assisting in a government investigation.

Internal Investigations of Reports

We are committed to investigate all reported concerns promptly and confidentially to the extent possible. The CO will coordinate any findings from the investigations and immediately recommend corrective action or changes that need to be implemented. All TRUSTED employees are encouraged to cooperate with investigational efforts.

Corrective Action

Where an internal investigation substantiates a reported violation, it is the policy of the organization to initiate corrective action, including, as appropriate, making prompt restitution of any overpayment amounts, notifying the appropriate governmental agency, instituting whatever disciplinary action is necessary, and implementing systemic changes to prevent a similar violation from recurring in the future at TRUSTED or any network facility.

Discipline

All violators of the Code will be subject to disciplinary action. The precise discipline utilized will depend on the nature, severity, and frequency of the violation and will result in any of the following disciplinary actions:

- Verbal warning
- Written warning
- Written reprimand
- Suspension
- Termination
- Restitution.

Internal Compliance Monitoring

TRUSTED is committed to the aggressive monitoring of compliance with its policies. This monitoring effort is specifically designed to target the key, risk areas within TRUSTED. The service will be provided by an unbiased legal entity, which will conduct monthly monitoring of issues that have regulatory or compliance implications. The following areas within TRUSTED will be subject to compliance audits:

1. **Data Submissions**
2. **Avoided and Recovered Amounts**
3. **Benefit Administration**
4. **Complaint Process**
5. **Provider Network and Access Issues**
6. **Compliance with Federal and State Privacy Act Provisions and HIPAA Privacy and Security regulations**
7. **Quality Improvement Activities**
8. **Fraud and Abuse Obligations**

A report of all findings from the compliance audits will be presented to the TRUSTED Governing Board by the Compliance Officer. Audit reports will be stored in the Regulatory Compliance

Department and will be accessible for review at any time by Federal and State external review agencies.

The organization will routinely seek other means of ensuring and demonstrating compliance with laws, regulations, and TRUSTED policy. Employees are encouraged to submit suggestions regarding ways to improve compliance within TRUSTED programs.

Acknowledgment Process

TRUSTED requires all employees to sign an acknowledgment confirming they have received the Code, completed the training session, and understand it represents mandatory policies of TRUSTED. New employees will be required to sign this acknowledgment as a condition of employment. A signed copy of this acknowledgement must be maintained within employee personnel files. All TRUSTED employees will be required to attend Code of Conduct refresher training annually.

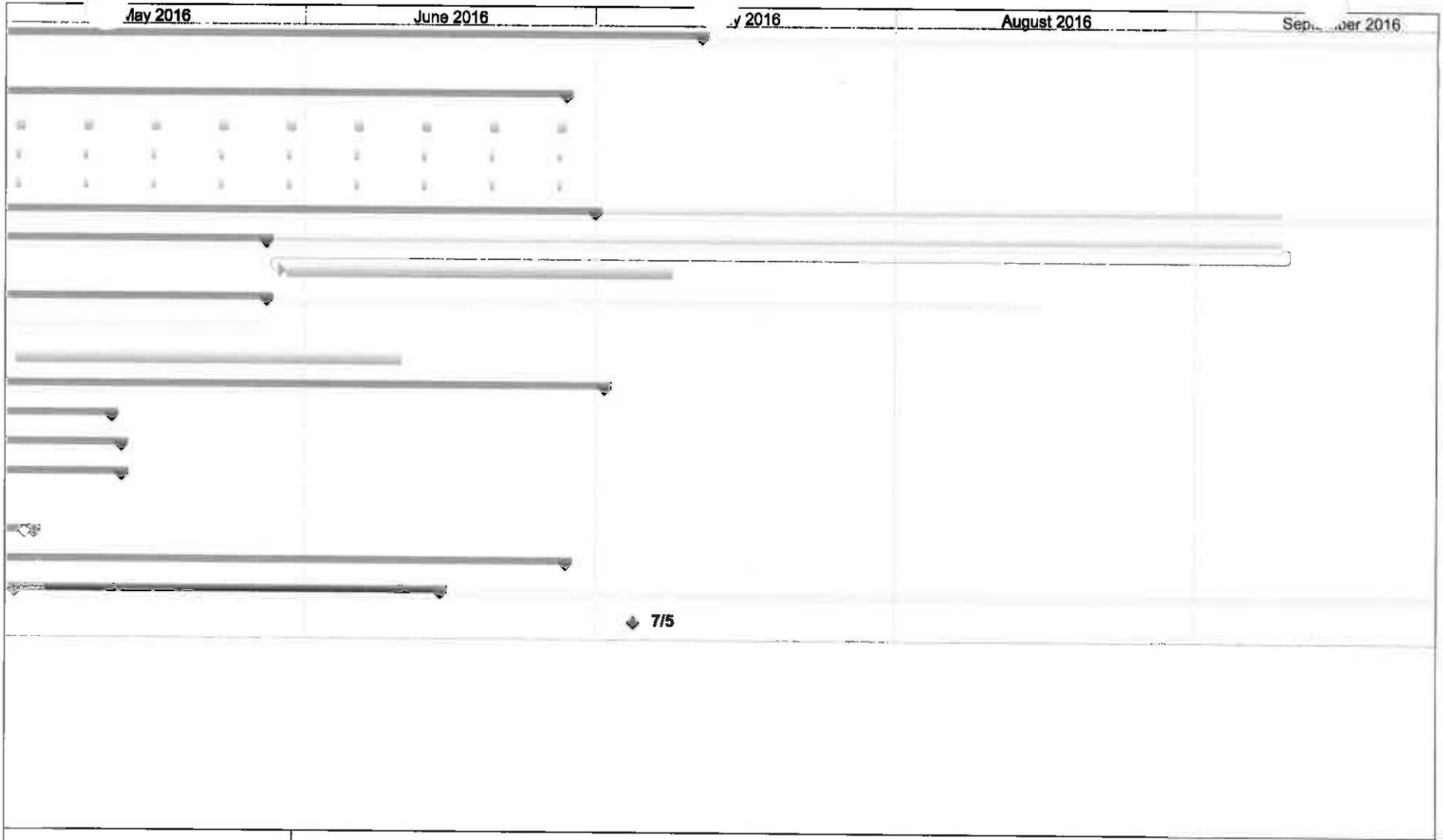
Adherence to and support of TRUSTED'S Code of Conduct and participation in related activities and training will be considered in decisions regarding hiring, promotion, and compensation for all candidates and employees.

ID	Task Name	Duration	Start	Finish
1	**Trusted WV Implementation Work Plan**	**61 days**	**Mon 4/18/16**	**Mon 7/11/16**
2	Conduct Kick-Off Meeting	4 hrs	Mon 4/18/16	Mon 4/18/16
3	**Planning/Oversight Phase**	**51 days**	**Mon 4/18/16**	**Mon 6/27/16**
4	**Conduct Status Meetings**	**51 days**	**Mon 4/18/16**	**Mon 6/27/16**
16	**Update/Monitor Work Plan**	**51 days**	**Mon 4/18/16**	**Mon 6/27/16**
28	**Document and Manage Risks**	**51 days**	**Mon 4/18/16**	**Mon 6/27/16**
40	**Execution Phase**	**54 days**	**Mon 4/18/16**	**Thu 6/30/16**
41	**HMO License**	**30 days**	**Mon 4/18/16**	**Fri 5/27/16**
44	Provider Network and Credentialing	30 days	Mon 5/30/16	Fri 7/8/16
45	**Vendor Implementation**	**30 days**	**Mon 4/18/16**	**Fri 5/27/16**
56	Call Center Implementation	30 days	Mon 4/18/16	Fri 5/27/16
57	CPP Implementation	30 days	Mon 5/2/16	Fri 6/10/16
58	**Wellness Center Design and Construction (3)**	**55 days**	**Mon 4/18/16**	**Fri 7/1/16**
83	**Implement Accounting System**	**18 days**	**Mon 4/18/16**	**Wed 5/11/16**
89	**Implement DST System**	**19 days**	**Mon 4/18/16**	**Thu 5/12/16**
94	**Define Plans, Policies and Procedures**	**19 days**	**Mon 4/18/16**	**Thu 5/12/16**
99	**Training**	**6 days**	**Mon 4/18/16**	**Mon 4/25/16**
103	**Quality Assurance**	**6 days**	**Tue 4/26/16**	**Tue 5/3/16**
107	**HR/Compliance, Recruiting and Training**	**51 days**	**Mon 4/18/16**	**Mon 6/27/16**
114	**Testing**	**32 days**	**Mon 5/2/16**	**Tue 6/14/16**
157	**Close Out Phase**	**5 days**	**Tue 7/5/16**	**Mon 7/11/16**



Project: Infrastructure Deployment
Date: Wed 3/9/16

Task	Inactive Task	Manual Summary	
Split	Inactive Task	Start-only	
Milestone	Inactive Milestone	Finish-only	
Summary	Inactive Summary	Progress	
Project Summary	Manual Task	Deadline	
External Tasks	Duration-only		
External Milestone	Manual Summary Rollup		



Project: Infrastructure Deployment
Date: Wed 3/9/16

Task		Inactive Task		Manual Summary	
Split		Inactive Task		Start-only	
Milestone		Inactive Milestone		Finish-only	
Summary		Inactive Summary		Progress	
Project Summary		Manual Task		Deadline	
External Tasks		Duration-only			
External Milestone		Manual Summary Rollup			

TRUSTED Health Plan
THP

Application for License As A Foreign Health Maintenance Organization In West Virginia









March 4, 2016

Jamie Taylor
West Virginia Offices of the Insurance Commissioner
Financial Conditions Division
PO Box 50540
Charleston, WV 25305-0540

Regarding: Trusted Health Plan, (District of Columbia), Inc.

Dear Mr. Taylor:

Trusted Health Plan, (District of Columbia) Inc. ("Trusted") is a Medicaid health maintenance organization that is currently operating in the District of Columbia. Trusted is a wholly owned subsidiary of Trusted Health Plans, Inc. who owners are Thomas Scully, Morgan Noble Healthcare Partners, Juggernaut Capital Partners, Bruce Anderson and Thomas Duncan.

Thomas (Tom) Scully is the former Head of Centers for Medicare and Medicaid Services ("CMS") and the former President and Chief Executive Officer of the Federation of American Hospitals. As a part of Trusted's ownership and executive leadership team, Tom serves as the Chairman of Trusted's Board of Directors. Trusted ownership team is strengthened by the inclusion of Morgan Noble Healthcare Partners ("Morgan Noble"), a Washington, D.C. based principal investment firm focused on keeping patients healthy by investing in and working closely with healthcare service and healthcare IT companies. Like Tom Scully, Morgan Noble's Managing Partner, Robert Haft, brings his considerable healthcare experience and expertise, having been the former Chief Executive Officer of Vitamins.com, Phar-Mor Drugs ($1.5 billion drug retail chain) and Dart Group ($1 billion healthcare company), to Trusted's Board, as a Director. Juggernaut Capital Partners ("JCP"), a Maryland based investment firm with over $600 million of capital under management, is also an owner of Trusted. Finally, Bruce Anderson, co-founder of Welsh, Carson, Anderson & Stowe ("WCAS"), one of the nation's largest healthcare investors with over $20 billion under management, is an investor and thought leader. Trusted's founder and Chief Executive Officer, Thomas Duncan, is also a shareholder. Mr. Duncan holds an MBA in Finance, and completed the Key Executives Program at Harvard Business School.

Morgan Noble's current investment holdings include:

- **Continuum Health Alliance**: A physician enablement and population health management company working with payers and providers to drive higher clinical quality, lower cost of care and higher patient satisfaction.

- **Privia Health:** A physician practice management and population health technology company that partners with top doctors to keep people healthy, prevent disease and improve care coordination in-between office visits.
- **Mindoula Health:** A behavioral health collaborative care technology and services platform that partners with providers and payers to provide individualized, 24/7 access to dedicated case management support.
- **Ambient Healthcare:** A specialty pharmacy and home infusion services company supporting disease treatment programs for individuals with acute and chronic diseases.

  Prior representative investments made by the Morgan Noble principals include: behavioral health specialty managed care, diabetes focused supplies and care management, correctional healthcare services, community behavioral health services and skilled nursing provider services.

Juggernaut Capital Partners ("Juggernaut") has a 14 year track record in growing middle market companies with proven management teams. Juggernaut targets industries where they have extensive knowledge and experience. Juggernaut and its Principals have substantial expertise investing in the healthcare and insurance industries: Investment examples include:

- **BenefitMall:** underwrites over $5 billion in health insurance premiums
- **Studer Group:** improves clinical outcomes and patient satisfaction
- **Navicure:** health insurance payment solutions
- **Cranford Pharmaceuticals:** specialty prescription pharmaceutical company
- **Foundation Consumer Healthcare:** over-the-counter health brands
- **Ceuta Healthcare Group:** sales and marketing services to healthcare companies

Trusted is responding to a Centralized Request for Quotation ("CRFQ"), solicitation number BMS1600000002, which has been issued by the West Virginia Department of Administration, Purchasing Division, for managed care services. In the event that Trusted is successful through the award of a contract by West Virginia Department of Health and Human Services, Juggernaut and Morgan Noble intend to provide Trusted with the capital required to achieve no less than 300% of Health Risk-Based capital reserves ("RBC"). Based on our actuarial estimates, upon award of a contract with the State of West Virginia, we will need to initially fund $15.5 million to achieve this goal. Therefore, we have committed the $15.5 million to this project.

If you have any questions, please contact me at cslade@trustedhp.com or (202)-821-1070.

Thank you,

Cleveland Slade
Chief Financial Officer

STATE OF WEST VIRGINIA
Offices of the Insurance Commissioner
Financial Conditions Division

Mailing Address:
Financial Conditions
PO Box 50540
Charleston, WV 25305-0540

Telephone: (304) 558-2100
Facsimile: (304) 558-1365
Email: financial.conditions@wvinsurance.gov
www.wvinsurance.gov

Location:
Financial Conditions
1124 Smith Street, Rm 102
Charleston, WV 25301

Requirements and Procedures for becoming Licensed as a Foreign Health Maintenance Organization in West Virginia

License Instructions and Application

Mail completed application to:

West Virginia Offices of the Insurance Commissioner
Financial Conditions Division
PO Box 50540
Charleston, WV 25305-0540

Pursuant to Chapter 33, Article 25A, of the West Virginia Code, the application is hereby submitted to form and operate a Health Maintenance Organization ("HMO").

Name, trade name and address of the Health Maintenance Organization Applicant:

Name:	Trusted Health Plan (District of Columbia) Inc.				
Trade Name:					
Address:	1100 New Jersey Avenue, SE, Suite 840				
City:	Washington	State:	DC	Zip Code:	20003
Phone:	(202) 821-1070				

Attorney or Principal filing this application on behalf of the HMO applicant:

Name:	Thomas M. Duncan, II, CEO				
Address:	(same as above)				
City:		State:		Zip Code:	
Phone:					

E-mail requests to: financial.conditions@wvinsurance.gov

Important Links:
W. Va. Code
Insurance Rules
Informational Letters

STATE OF WEST VIRGINIA
Offices of the Insurance Commissioner
Financial Conditions Division

Mailing Address:
ancial Conditions
Box 50540
harleston, WV 25305-0540

Telephone: (304) 558-2100
Facsimile: (304) 558-1365
Email: financial.conditions@wvinsurance.gov
www.wvinsurance.gov

Location:
Financial Conditions
1124 Smith Street, Rm 102
Charleston, WV 25301

INTRODUCTION

A Health Maintenance Organization (HMO) is a public or private organization which provides or otherwise makes available basic health care services to enrollees. Factors to consider in determining if an organization is an HMO include, but are not limited to, whether it: (1) receives premiums for the provision of basic health care services to enrollees on a prepaid per capita or prepaid aggregate fixed sum basis excluding copayments; (2) provides physician services through doctors who are either employees or partners of the organization and/or through arrangements with individual or group practice doctors; (3) assures the availability, accessibility, quality and effective utilization of the health care services which it provides; and (4) offers services through an organized delivery system in which a primary care physician is designated for each subscriber upon enrollment.

To operate in West Virginia, an HMO must apply for and receive a Certificate of Authority from the Insurance Commissioner. Each application must set forth and be accompanied by the information and documentation requested. The Commissioner shall issue or deny a Certificate of Authority to any person filing an application within one hundred twenty days after receipt of the completed application. IMPORTANTLY: An application will not be considered complete until all information and documentation requested have been submitted to the Commissioner, and the applicant has fully complied with all provisions or requirements of these guidelines or applicable laws. Prior to receiving a Certificate of Authority, an applicant will be contacted by the Insurance Commission to initiate the depositing of cash or government securities with the West Virginia Treasurer's Office in compliance with W. Va. Code §33-25A-4(2)(h).

NSTRUCTIONS

A completed application checklist and appropriate verification must be submitted.

2. All information provided should be placed in three-inch binder(s) and be separated by numbered tabs which correspond to the numbered requests in the application checklist. For example: Application Question No. 5 asks for a copy of the Articles of Incorporation. The copy should be placed under Tab No. 5 in the binder.

3. Documents must have page numbers which should begin with the corresponding Tab No. and a dash (-). For Example: If the Articles of Incorporation are four pages long, each page should be numbered 5-1, 5-2, 5-3 and 5-4.

4. Replacement pages should specifically note what pages are being replaced. For example: If the Articles of Incorporation were incorrect and had to be replaced, they should be numbered Replacement 5-1, Replacement 5-2, etc. If the documents merely supplement existing documents, they should be marked Supplemental and should use a letter of the alphabet. For example: If page 5-1 of the Articles of Incorporation is being supplemented it should be numbered Supplemental 5-1(a).

5. Each application box should be check-marked (1) if the information requested has been provided. REMEMBER: Each application must be verified to make sure that the documents and information have been provided before completing and sending the checklist and verification.

6. Page numbers indicating the information and/or document location(s) must be clearly marked on the space provided.

OTE: The information requested by the Application Checklist constitutes the minimum necessary to begin the 120-day Certificate of Authority review cycle. The Commissioner reserves the right to ask for and obtain additional information and/or documents from applicant at any time prior to the deemer date in order to determine whether to grant a Certificate of Authority.

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Offices of the Insurance Commissioner
Financial Conditions Division

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1124 Smith Street, Rm 102
Charleston, WV 25301

I. CERTIFICATE OF AUTHORITY

Page(s)
Location

☒ ____ 1. Each application for a Certificate of Authority must be verified by an officer or authorized representative of the applicant.

☒ ____ a. A verification form entitled "CERTIFICATION" is included with this application packet and must be completed and filed with each application.

☒ ____ b. Attach a copy of the corporate resolution appointing the individual as the authorized representative of the HMO.

☒ ____ 2. Attach a check in the amount of $200 made payable to the "WV Offices of the Insurance Commissioner."

☐ ____ 3. File an original and two copies of the application with the West Virginia Insurance Commissioner. The Commissioner may request additional copies.

☐ ____ 4. File a copy of the cover page of this application with:

Health Care Cost Review Authority
100 Dee Drive, Suite 201
Charleston, WV 25311-1692

II. ORGANIZATIONAL/MANAGERIAL

☒ ____ 5. Submit Articles of Incorporation and all amendments certified by the Secretary of State.

☒ ____ a. The Articles of Incorporation must state that the applicant will operate as a Health Maintenance Organization.

☐ ____ b. The Secretary of State's certificate must be dated no later than thirty (30) days before the first submission of this application.

☒ ____ c. Certificate of Authority from the domiciliary insurance regulator indicating that the company is an authorized HMO in its state of domicile.

☒ ____ 6. List and submit a copy of each type of security issued by the applicant to acquire necessary start-up capital.

☒ ____ 7. State the amount of applicant's capital and/or surplus:

☒ ____ a. For profit stock corporation:

☒ Fully paid-in capital stock (at least $1,000,000) $_____

☒ Additional surplus (at least $1,000,000) $_____

☐ ____ b. For non-profit corporation:

☐ Statutory surplus (at least $1,000,000) $_____

☐ Additional surplus (at least $1,000,000) $_____

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☒ ____ 8. Submit in chronological order a legal history listing predecessor corporations and/or organizations, mergers, reorganizations and changes of ownership. Be specific as to dates and parties involved.

☒ ____ 9. Submit the names, addresses and official capacities of all officers, directors, managers, administrators and persons holding 5% or more of the common stock of the organization responsible for the applicant's conduct.

☒ ___ a. Include a completed BIOGRAPHICAL STATEMENT AND AFFIDAVIT for each name listed above.

☒ ___ b. Each individual named above must fully disclose to the Insurance Commissioner and the applicant's Board of Directors the nature and extent of all contracts or arrangements with the applicant. The disclosure shall include any and all possible conflicts of interest.

☒ ___ c. Persons holding 5% or more of the applicant's common stock must disclose the nature and extent of any ownership interest in all parent organizations, subsidiaries and affiliated companies. The disclosure must include an organizational chart depicting all levels of ownership including all subsidiaries and parent organizations along with all affiliated companies and corresponding percentages of ownership.

☒ ___ d. Submit independent investigation reports on all individuals identified above.

1. The reports must be forwarded directly to the Financial Conditions Division of the Offices of the West Virginia Insurance Commissioner from the independent investigators.

2. Person(s) required to furnish an investigation report may use:

☐ Equifax Services, Inc.
PO Box 2729
Jacksonville, FL 32203
(904) 733-7550

☐ Another investigative organization approved by the Insurance Commissioner prior to the filing of the application.

☒ ____ 10. Submit a statement describing:

☒ ____ a. Proposed operations.

☒ ____ 1. State whether the applicant will be a Staff Model, IPA Model or Combination Model HMO.

☒ ____ 2. Describe the method of compensation for providers, e.g. fee-for-service, capitated, etc.

☒ ____ b. The proposed service area(s). "Service area" means the county or counties to be approved by the Commissioner within which the applicant may provide or arrange for health care services for its subscribers.

II. MARKETING

☒ ____ 11. Describe the marketing strategy for each major category of enrollment:

☐ ____ Group

☐ Criteria for selection of primary and secondary targets;

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☐ Use of underwriting guidelines;

☐ Plans for community education and public relations.

☐ ____ Small Group

☐ Criteria for selection of primary and secondary targets;

☐ Use of underwriting guidelines;

☐ Plans for community education and public relations.

☐ ____ Individual

☐ Criteria for selection of primary and secondary targets;

☐ Use of underwriting guidelines;

☐ Plans for community education and public relations.

☐ _____ Medicare

☐ Use of underwriting guidelines;

☐ Plans for community education and public relations.

☒ ____ Medicaid

☒ Use of underwriting guidelines;

☒ Plans for community education and public relations.

☐ ____ Public Employees Insurance Agency

☐ Use of underwriting guidelines;

☐ Plans for community education and public relations.

☐ Other

☐ Criteria for selection of primary and secondary targets;

☐ Use of underwriting guidelines;

☐ Plans for community education and public relations.

IV. INSURANCE

☒ ____ 12. Describe any limitation of the applicant's financial risk. An HMO may either obtain reinsurance or make other arrangements acceptable to the Commissioner:

☒ ____ For the cost of providing to any enrollee health care services the aggregate value of which exceeds $4,000.00 in any year;

☒ ____ For the cost of providing health care services on a non-elective emergency basis or for coverage outside the service area; or

☒ ____ For not more than 95% of the amount by which the applicant's costs for any of its fiscal years exceed 105% of its income for those fiscal years.

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☒ Other

☒ ____ 13. Describe any risk sharing arrangements with provider(s) or other parties. Provide a copy of and reference the applicable sections of each provider contract pertaining to the risk- sharing arrangements. See WV CSR §114-43.

☒ ____ 14. All directors, officers, administrators, persons holding 5% or more common stock of the organization and employees who receive, collect, disburse or invest funds in connection with the HMO must be appropriately bonded.

☐ ____ Submit the enclosed "FIDELITY BOND WORKSHEET" (Form HM0-FID-1).

☐ ____ Obtain fidelity bond(s) in the amount prescribed by the worksheet.

☐ ____ Submit a copy of each fidelity bond obtained. Each bond must be current and must be relevant to applicant's proposed operations.

☒ ____ 15. Describe any arrangements to guarantee the continuation of benefits and payments to providers of services rendered to and after insolvency for the duration of the contract period for which premiums have been paid or until their discharge for members confined to an inpatient facility on the date of insolvency.

7. FEASIBILITY STUDY and FINANCIAL

☒ ____ 16. Submit a comprehensive feasibility study:

☒ ____ a. Performed by a qualified independent actuary in conjunction with a certified public accountant;

☒ ____ b. Containing certification by the qualified actuary as to the feasibility of the proposed organization;

☐ ____ c. Containing an opinion by the certified public accountant as to the feasibility of the proposed organization;

☒ ____ d. Covering the greater of three years or until the HMO has been projected to be profitable for twelve consecutive months;

☒ ____ e. Demonstrating that the HMO would not, at the end of any month of the projection period, have less than the minimum capital and surplus;

☒ ____ f. Stating that the rates are not inadequate, excessive or unfairly discriminatory;

☒ ____ g. Demonstrating that the rates are appropriate for the classes of risk for which they have been computed;

☒ ____ h. Outlining the appropriate rating methodology;

☒ ____ i. Demonstrating the HMO is actuarially sound:

☒ ____ 1. The certification shall consider the rates, benefits and expenses of the organization.

☒ ____ 2. The rates that are or will be charged are actuarially adequate to the end of the period for which rates have been guaranteed.

☒ ____ 3. Incurred but not reported claims and claims reported but not fully paid have been adequately provided; and

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☒ ____ j. Indicating that the HMO is knowledgeable about the competitors, market and service areas for the geographic location(s) where it will operate.

☒ ____ 17. Submit the latest CPA Audit, Quarterly and Annual Financial Statements filed with the NAIC.

☒ ____ 18. Submit a statement declaring all investments have been valued for asset purposes on a basis currently approved by the National Association of Insurance Commissioners (NAIC). If any investments have been valued for asset purposes in a manner other than one currently approved by the NAIC, describe each item so valued and the basis of value indicated on the "Asset Page" of the balance sheet.

VI. ENROLLMENT

☒ ____ 19. Submit a description of the following assumptions underlying enrollment projections:

- ☒ ____ A projection of enrollment;
- ☒ ____ Number of eligible persons residing within the service area;
- ☒ ____ Contract size assumptions (contract distribution and content);
- ☒ ____ Penetration assumptions and rationale, including initial and re-enrollments;
- ☐ ____ Allowance for voluntary/involuntary disenrollment and group contract additions during the year;
- ☒ ____ Projection by month and year of the break-even date; and
- ☒ ____ A plan outlining the provisions made for emergency and out-of-area health care.

VII. CONTRACTUAL

☐ ____ 20. Submit copies of all:

- ☐ ____ Enrollment contracts.
- ☒ ____ Member handbooks.
- ☐ ____ Benefit packages, riders and endorsements. At a minimum, benefits shall include:
  - ☐ ____ TMJ
  - ☐ ____CMD
  - ☐ ____ Mammography
  - ☐ ____ Pap Smears
  - ☐ ____ Rehabilitation
  - ☐ ____ Child Immunizations
  - ☐ ____ Basic Health Care Services as defined in W. Va. Code §33-25A- 2(1).

☒ ____ 21. Submit a copy of each type of provider contract utilized by the applicant. The contracts must include:

- ☒ ____ Hold Harmless Clause (see recommended HMO Hold Harmless language attached hereto).
- ☒ ____ Sixty-day notification to the HMO and Insurance Commissioner prior to termination of the contract.
- ☒ ____ All provider contracts must include provisions required by W. Va. Code §33-45-2.

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☐ ____ Note: If documents are intermediary contracts, provide evidence that the HMO has met all other requirements contained in WV CSR §114-43-3.

☒ ____ 22. Submit a list of all physicians, hospitals and other providers with whom the applicant has contracted for services and the corresponding signature pages from each executed provider contract. The list and the corresponding signature pages must be alphabetized and sorted by county and specialty.

VIII. GRIEVANCES & APPEALS

☒ ____ 23. Submit a detailed description of applicant's subscriber grievance and appeal procedures and include a statement that the HMO shall have someone with decision-making authority at each level of the process.

☒ ____ 24. Provide samples of group and individual contracts and certificate or member handbooks given to subscribers. Each shall include:

☒ ____ a. Formal and informal steps to resolve grievances;

☒ ____ b. Toll-free telephone numbers for the subscriber to call to present an informal grievance or to contact the grievance coordinator;

☒ ____ c. An address for written grievances;

☒ ____ d. A detailed description of the appeal process;

☒ ____ e. A description of the statute of limitations for filing grievances;

☒ ____ f. A statement outlining the time frame in which grievances shall be processed;

☒ ____ g. A statement that there is physician involvement in the review of medically-related grievances; and

☒ ____ h. A statement that time sensitive grievances will be handled on an expedited basis.

☒ ____ 25. Submit a copy of the policies and procedures for administering formal and informal grievances.

☒ ____ 26. Provide the name, address and telephone number of the grievance coordinator(s) who is/are responsible for the implementation of the grievance procedure.

IX. QUALITY ASSURANCE

☒ ____ 27. For health maintenance organizations that have been in existence at least three (3) years:

☒ ____ a. A copy of the current quality assurance report submitted to the HMO by a nationally recognized accreditation and review organization approved by the commissioner; or

☒ ____ b. Proof sufficient to demonstrate that the HMO has timely applied for and reasonably pursued a review of its quality assurance program; or

☒ ____ c. Indicate date the last quality assurance report was filed with and approved by the Commissioner:_____

(mm/dd/yyyy)

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Important Note:

• If the HMO has not been in existence at least three (3) years, documentation as required by the standards set forth in this section must be submitted to verify compliance.

• If the HMO has been in existence three (3) years or more, a copy of an Accreditation Report performed by a nationally recognized accreditation and review organization may be submitted to verify compliance. That report must, however, contain evidence that the quality assurance standards listed below in this section have been met. When necessary, separate documentation, as required by those standards, may be submitted to supplement the quality assurance report.

• If the HMO has undergone a pre-accreditation review (PAR), the PAR report may be submitted and supplemented, if necessary, by separate documentation as required by the standards set forth in this section. The PAR report and any additional documentation must verify compliance with the quality assurance standards.

• Please check those standards listed below which have been met by the quality assurance program and indicate where in the quality assurance report or in separate documentation those standards can be found. Subsequent to approval of the quality assurance program, any modification of the program must be immediately filed with and approved by the Commissioner.

☐ ___ 28. To establish quality management and improvement provide:

- ☐ ____ a. Written description of the Quality Improvement (QI) program that outlines program structure and design.
- ☐ ____ b. Statement that description is reviewed annually and updated as necessary.
- ☐ ____ c. Name, address and telephone number of senior executive responsible for program implementation.
- ☐ ____ d. Name, address and telephone number of the Medical Director.
- ☐ ____ e. Is Medical Director full time or part time?
- ☐ ____ f. Evidence that medical director has substantial involvement in QI activities.
- ☐ ____ g. Evidence of a committee that oversees and is involved in QI activities.
- ☐ ____ h. Description of the role, structure and function, including frequency of meetings, of the QI Committee.
- ☐ ____ i. Evidence that providers participate actively in the QI committee.
- ☐ ____ j. Evidence of contemporaneous records reflecting actions of the committee.
- ☐ ____ k. A copy of the annual QI work plan, or schedule of activities, that includes the following:
  - ☐ ____ 1. Objectives, scope, and planned projects or activities for the year;
  - ☐ ____ 2. Planned monitoring of previously identified issues, including tracking thereof over time; and
  - ☐ ____ 3. Planned evaluation of the QI program.

☐ ___ 29. To establish accountability to the governing body provide:

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☐ ____ a. Documentation that the governing body has approved the QI Committee's overall QI program and the annual QI work plan.

☐ ____ b. Evidence that the governing body or designated committee receives regular written reports from the QI program delineating actions taken and improvements made.

☐ ____ c. Evidence that the governing body reviews a written annual report on the QI program.

☐ ____ d. Evidence that QI information is used in recredentialing, recontracting, and/or annual performance evaluations.

☐ ___ 30. To establish coordination with other management activities provide:

☐ ____ a. Evidence that QI activities are coordinated with other performance monitoring activities, including utilization management, risk management and resolution and monitoring of member complaints and grievances.

☐ ____ b. Evidence of linkage between QI and other management functions of the managed care organization, e.g. network changes, benefits redesign, medical management systems, practice feedback to providers and patient education.

☐ ___ 31. Provider contracts should contain or include:

☐ ____ a. Requirements to participate in QI activities are incorporated into all provider contracts and employment agreements.

☐ ____ b. A specification the hospitals and other contractors will allow the managed care organization access to the medical records of their members.

☐ ____ c. A provision that the health maintenance organization allows open provider-patient communication regarding appropriate treatment alternatives and that it does not penalize the provider for discussing medically necessary or appropriate care for the patient.

☐ ___ 32. To establish that the quality assurance program is designed to objectively and systematically monitor and evaluate the quality and appropriateness of care provide:

☐ ____ a. Evidence of member participation in QI.

☐ ____ b. Evidence that the monitoring and evaluation of clinical issues reflect the population served by the managed care organization in terms of age groups, disease categories, and special risk status. Identify the following:

☐ ____ 1. Services provided in institutional settings;

☐ ____ 2. Services provided in noninstitutional settings, including but not limited to, practitioner offices and home care.

☐ ____ 3. Primary care and major specialty services, including mental health.

☐ ____ 4. High-volume, high-risk services, and the care of acute and chronic conditions.

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☐ ___ 33. To establish important aspects of care and service provide:

☐ ___ a. The process for periodically updating the practice guidelines.

☐ ___ b. The mechanism for communicating the practice guidelines to managed care organization providers has been implemented.

☐ ___ c. How performance is assessed against the practice guidelines.

☐ ___ d. A description of the evaluation process for member continuity and coordination of care.

☐ ___ e. A description of mechanisms to detect under and over utilization.

☐ ___ f. A description of mechanisms used to assess patient outcomes.

☐ ___ 34. To establish access to care and service provide:

☐ ___ a. A copy of the standards for the availability of or access to primary care providers, e.g., routine, urgent and emergency care.

☐ ___ b. A description of the process for identifying members with chronic/high-risk illnesses and implementing appropriate programmatic responses.

☐ ___ c. A description of the procedures for handling/scheduling appointments by telephone and the use of advice and member service lines.

☐ ___ 35. To establish quality measurement and improvement provide evidence that HMO has developed quality indicators that are objective, measurable and based on current knowledge and clinical experience and are used to monitor and evaluate each important aspect of care and service identified.

☐ ___ a. Identify performance goals and/or a bench-marking process for each indicator.

☐ ___ b. Identify the appropriate methods and frequency of data collection for each indicator.

☐ ___ c. Evidence that results of evaluations are used to improve clinical care and service.

☐ ___ d. The method of tracking areas for improvement to assure that appropriate action is taken and improvements are effective.

☐ ___ 36. To establish utilization management provide:

☐ ___ a. Description of the UM program including policies and procedures to evaluate medical necessity, criteria used, information sources, and the process used to review and approve the provision of medical services.

☐ ___ b. Mechanism for updating the UM program description on a periodic basis.

☐ ___ c. Evidence that qualified medical professionals supervise review decisions where procedures are used for preauthorization and concurrent review.

☐ ___ d. Evidence that a duly licensed physician conducts a review for medical appropriateness on any denial.

☐ ___ e. Evidence that the managed care organization utilizes, as needed, licensed physician consultants from appropriate specialty areas of medicine.

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☐ ____ f. Written utilization review decision protocols.

☐ ____ g. The mechanism for checking the consistency of application of criteria across reviewers.

☐ ____ h. The mechanism for periodically updating review criteria.

☐ ____ i. Description of information intake including pertinent clinical information and consultation with the treating physician.

☐ ____ j. Evidence that reasons for denial notification of appeal process are clearly documented and available to the member.

☐ ____ k. Written policies and procedures to evaluate the appropriate use of new medical technologies or new applications of established technologies, including medical procedures, drugs and devices.

☐ ____ l. Written policies and procedures for evaluating the effects of the program using member satisfaction data, provider satisfaction data, and/or other appropriate means.

☐ ____ m. If any delegation of QI or UM activities to contractors, provide evidence of oversight of the contracted activity including:

- ☐ _____ 1. the delegated activities;
- ☐ _____ 2. the delegate's accountability for these activities;
- ☐ _____ 3. the frequency of reporting to the HMO;
- ☐ _____ 4. the process by which delegation will be evaluated;
- ☐ _____ 5. approval of the delegate's UM program; and
- ☐ _____ 6. evaluation of the regularly specified reports.

☐ ___ 37. To establish that a system of credentialing is in place provide:

☐ ____ a. A copy of the written policies and procedures for the credentialing process.

☐ ____ b. Evidence of a credentialing committee or other peer review body that makes recommendations regarding credentialing decisions.

☐ _____ c. Evidence that provider doctors serve as voting members of the credentialing committee.

☐ _____ d. The name, address, telephone number and area(s) of practice of each practitioner who falls under the HMO' s scope of authority and action.

☐ _____ e. Evidence that the initial credentialing process is ongoing and up-to-date and that HMO obtains review verification of the following:

- ☐ _____ 1. A current valid license to practice;
- ☐ _____ 2. When applicable clinical privileges in good standing at the hospital designated by the practitioner as the primary admitting facility;
- ☐ _____ 3. A valid DEA certificate, as applicable;

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☐ ____ 4. Graduation from medical school or appropriate graduate school and completion of a residency, specialty training or board certification, as applicable;

☐ ____ 5. Complete work history;

☐ ____ 6. Current adequate malpractice insurance according to the HMO's policy; and

☐ ____ 7. Complete professional liability claims history.

☐ ____ f. A copy of the form application for membership including a statement by the applicant regarding:

☐ ____ 1. Reasons for any inability to perform the essential functions of the position with or without accommodation;

☐ ____ 2. Lack of present illegal drug use and alcohol abuse;

☐ ____ 3. History of loss of license and/or felony convictions;

☐ ____ 4. History of loss or limitation of privileges or disciplinary activity; and

☐ ____ 5. An attestation to the correctness/completeness of the application.

☐ ____ g. Evidence that the HMO requests information on the practitioner during credentialing and re-credentialing from the following recognized monitoring organizations:

☐ ____ 1. National Practitioner Data Bank;

☐ ____ 2. The appropriate State licensing boards such as the Board of Medicine, Chiropractic Board, Osteopathic Board and/or Dental Board; and

☐ ____ 3. Medicare/Medicaid sanctioning.

☐ ____ h. Evidence of an initial visit to each potential primary care practitioner's office and to the offices of obstetricians/gynecologists and other high-volume specialists resulting in documentation of a structured review of the site and of medical record keeping practices to ensure conformance with HMO's standards.

☐ ____ i. Evidence of the periodic verification of credentials that is ongoing and up-to-date and implemented at least every two years.

☐ ____ j. Evidence that recredentialing, recertification, or reappointment process includes verification from primary sources of:

☐ ____ 1. Current valid license to practice;

☐ ____ 2. When applicable, clinical privileges in good standing at the hospital designated by the practitioner as the primary admitting facility;

☐ ____ 3. A valid DEA certificate, as applicable;

☐ ____ 4. Board certification, as applicable;

☐ ____ 5. Current, adequate malpractice insurance according to the HMO's policy; and

☐ ____ 6. Professional liability claims history.

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☐ ____ k. Evidence that the recredentialing process includes a current statement by the applicant regarding:

☐ ____ 1. Inability to perform the essential functions of the position, with or without accommodation; and

☐ ____ 2. Lack of present illegal drug use or alcohol abuse.

☐ ____ 1. Evidence that the recredentialing, recertification or performance appraisal process includes review data from:

☐ ____ 1. member complaints and grievances;

☐ ____ 2. results of quality reviews;

☐ ____ 3. utilization management;

☐ ____ 4. member satisfaction surveys

☐ ____ 5. medical record reviews; and

☐ _____ m. Evidence that the recredentialing process includes an on-site visit to the offices of all primary care providers and OB/GYNs.

☐ ____ n. Copies of policies and procedures for reducing, suspending or terminating practitioner privileges which shall include:

☐ ____ 1. a mechanism for reporting to the appropriate authorities serious quality deficiencies resulting in suspension or termination; and

☐ ____ 2. an appeal process for and notice thereof to the provider.

☐ _____ o. Copies of written policies and procedures for the initial quality assessment of all health delivery organizations including but not limited to hospitals, home health agencies, behavioral health agencies, nursing homes, skilled nursing facilities and free-standing surgical centers with which the HMO intends to contract.

☐ ____ 1. When applicable, confirmation that health delivery organizations have been reviewed and approved by a recognized accrediting body and are in good standing with state and federal regulatory bodies.

☐ ____ 2. A copy of the standards of participation for health delivery organizations who have not been approved by a recognized accrediting body.

☐ _____ p. Evidence of oversight of any delegated credentialing/re-recredentialing activity to contractors including a written description of:

☐ ____ 1. the delegated activities; and

☐ ____ 2. the delegate's accountability for these activities.

☐ ____ q. Evidence that HMO monitors the effectiveness of the delegate's credentialing and reappointment or recertification processes at least annually.

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Email: financial.conditions@wvinsurance.gov
www.wvinsurance.gov

Location:
Financial Conditions
1124 Smith Street, Rm 102
Charleston, WV 25301

☐ ___ 38. To establish that members' rights and responsibilities are delineated in the quality process provide:

☐ ____ a. A copy of the HMO's written policy recognizing the right of members to:

☐ ____ 1. voice grievances about the HMO or care provided;

☐ ____ 2. have information concerning the HMO, its services, the practitioners providing care, and members' rights and responsibilities;

☐ ____ 3. participate in decision-making regarding health care; and

☐ ____ 4. be treated with respect and recognition of their dignity and need for privacy.

☐ ____ b. A copy of the HMO's written policy addressing members' responsibilities for cooperating with those health care providers by:

☐ ____ 1. giving needed information to professional staff to ensure appropriate care; and

☐ ____ 2. following instructions and guidelines given by health care providers.

☐ ____ c. A statement that the HMO provides a copy of policies on members' rights and responsibilities to all participating providers and directly to members.

☐ ____ d. Evidence that members are given written statements that are clear and concise and at a minimum address:

☐ ____ 1. how to submit a claim for covered services;

☐ ____ 2. how to obtain primary and specialty care, behavioral health services and hospital services;

☐ ____ 3. after-hours and emergency coverage including the HMO' s policy on when to directly access emergency care or use 911 type services:

☐ ____ 4. benefits and services included and excluded from membership;

☐ _____ 5. obtaining out of area coverage;

☐ ____ 6. special benefit provisions such as co-payment, higher deductibles and rej ection of claims that may apply to services outside the system;

☐ ____ 7. members charges

☐ ____ 8. procedures for notifying those members affected by:

☐ ____ a. termination or change in any benefits,

☐ ____ b. termination of any services, or

☐ _____ c. termination of any service delivery office/site;

☐ ____ 9. notification of termination of a primary care or specialty provider and the process for selecting a new provider;

☐ ____ 10. procedures for appealing decisions adversely affecting the member's coverage, benefits, or relationship to the organization;

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☐ ____ 11. procedures for changing practitioners;

☐ ____ 12. procedures for disenrollment of nongroup subscribers;

☐ ____ 13. procedures for voicing complaints, grievances and appeals;

☐ ____ 14. procedures for recommending changes in policies and services;

☐ ____ 15. points of access to primary care, specialty care and hospital services;

☐ ____ 16. the process by which a managed care organization determines whether or not to include new and emerging technology or treatment as a covered benefit;

☐ ____ 17. information on provider names, qualifications and titles;

☐ ____ 18. a copy of written policies and procedure pertaining to confidentiality; and

☐ ____ 19. a compilation of the results of the member satisfaction survey including an assessment of:

☐ ____ a. patient complaints;

☐ ____ b. requests to change practitioners and/or facilities; and

☐ ____ c. disenrollments by members.

☐ _____ 20. Procedure by which a member can receive a standing referral to a specialist

☐ _____ e. Submit a detailed description and evidence as to how enrollees are afforded an opportunity to participate in matters of policy and operation pursuant to W. Va. Code §33- 25A-6.

☐ _____ f. Evidence of oversight of any delegated member service activities to contractors including a written description of:

☐ ____ 1. delegated activities;

☐ ____ 2. delegate's accountability for these activities;

☐ ____ 3. frequency of reporting complaints and grievances and member survey data;

☐ ____ 4. process by which the delegation will be evaluated;

☐ ____ 5. approval of the delegate's member services program; and

☐ ____ 6. evaluation of regularly specified reports.

☐ ___ 39. To establish that the HMO engages in preventive health services provide:

☐ ____ a. Copies of practice guidelines and all updates for the use of preventive health services.

☐ ____ b. A statement that the guidelines are provided in writing to all providers and members.

☐ ____ c. Evidence that the HMO monitors, evaluates and takes action to improve a minimum of two of the following:

☐ ____ Childhood immunizations recognized by the American Academy of Pediatrics or as required by state or federal law.

☐ ____ Adult immunizations:

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☐ ____ Influenza vaccine;

☐ ____ Pneumococcal vaccine;

☐ ____ Hepatitis B vaccine;

☐ ____ Diphtheria and tetanus toxoid; and

☐ ____ Rubella screening for women of childbearing age.

☐ ____ Any other required by state or federal law.

☐ ____ Coronary artery disease risk factor screening and/or counseling for smoking, cholesterol, exercise and hypertension:

☐ ____ Cancer screening:

☐ ____ Breast; and

☐ ____ Cervix.

☐ ____ Counseling for prevention of motor vehicle injury;

☐ ____ Lead toxicity screening;

☐ ____ Sexually transmitted disease screening/prevention;

☐ ____ Prenatal care;

☐ ____ Human immunodeficiency virus (HIV)/ Aids counseling, screening and education;

☐ ____ Prevention of unintended pregnancy; and/or

☐ ____ Alcohol and other drug abuse screening/prevention.

☐ ____ 40. To establish that medical records are maintained in a manner that is current, detailed, organized, and permits effective patient care and quality review provide:

☐ ____ a. A statement that records are available to health care practitioners at each patient visit and to nationally and state recognized reviewing bodies sanctioned by the Commissioner;

☐ ____ b. A copy of standards and all updates for maintaining medical records, the systematic review for conformance and the institution of corrective action when standards are not met; and

☐ ____ c. A statement that copies of all standards and goals and any updates are provided in writing to all providers.

X. MISCELLANEOUS

☒ ____ 41. Submit a description of enrollee participation in matters of policy and operation.

☒ ____ 42. Submit the attached "ACKNOWLEDGMENT AND WAIVER OF CHIEF EXECUTIVE OFFICER ON BEHALF OF HMO APPLICANT" which shall contain notarized acknowledgments that:

☒ ____ A delinquency proceeding or supervision by the Insurance Commissioner constitutes the sole and exclusive method for the liquidation, rehabilitation, reorganization or conservation.

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☒ ___ Waives any right to file or be subject to any federal bankruptcy proceeding.

☒ ___ Comes from the CEO acknowledging that he/she has read and understands his/her obligations to report any impairment of the HMO to the Insurance Commissioner.

CERTIFICATION

State of _____

County of _____

To-wit:

I, _____, do swear or affirm that I have carefully examined each of the questions asked in the **HEALTH MAINTENANCE ORGANIZATION APPLICATION AND CHECKLIST** and each of the responses thereto and, to the best of my knowledge and ability, all responses, information, exhibits, and documentary evidence submitted in support thereof are true and correct.

_____
(Type or Print Name)

_____
(Title)

_____
(Signature)

_____
(Date)

Sworn to and subscribed before me this _____ day of _____ 20__.

My commission expires: _____

_____
(Notary Public)

(Notary Seal)

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RECOMMENDED HMO HOLD HARMLESS LANGUAGE

No Billing of Members

1. No Charges. Participating Provider shall hold harmless and not impose any charges on HMO Members for Plan benefits and shall regard the HMO payment as payment in full for all benefits covered by this Agreement with the exception of co-payments specifically authorized in the applicable Evidence of Coverage and any non plan benefits. Participating Provider shall also be entitled to receive payment for third party claims. Participating Provider will never, under any circumstances, including non-payment by HMO, the insolvency of HMO, or breach or termination of this Agreement, seek compensation from, have any recourse against, or impose any additional charge on any HMO Member for Plan benefits. Participating Provider shall look only to HMO for payment for plan benefits. If HMO receives notice that a Participating Provider has billed or collected from a Member for any covered or non- authorized benefit, HMO may refund that amount to Member and may offset that amount from any payment to Participating Provider, with prior notice to the Participating Provider.

2. No Collection Action Against Members. Neither Participating Provider, trustees or assignees, may maintain any action at law against Member to collect sums owed by HMO.

3. Survival of Covenants. Participating Provider further agrees that these provisions 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 these provisions supersede any oral or written agreement to the contrary now existing or hereafter entered into between Participating Provider and Member or any persons acting on their behalf.

4. Collections of Co-payments. These provisions shall not preclude Participating Provider form collecting the Copayments that are specifically authorized by the Member's Evidence of Coverage.

5. Non-Covered Services. A Participating Provider may bill a Member for services if: (i) prior to receiving such services the Member is advised that such services are not Covered services; and (ii) after being so advised the Member nevertheless elects in writing to receive such non-Covered Services.

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Suggested Minimum amounts of:
FIDELITY INSURANCE

Fidelity Bonds provide coverage to the insured business or individual for money or other property lost because of dishonest acts of its bonded employees. While the need for fidelity bond coverage can vary from company to company, it is recommended that those who have access to cash and investments be bonded. This includes the people who have the ability to authorize wire transfers, write checks and those who can buy, sell, or transfer investments. The terms of each policy may vary; however, it is recommended that the policy be written to cover material acts of theft or dishonestly by bonded employees.

The following table indicates the exposure index amount with the recommended fidelity bond amount:

Exposure Index		Bracket No. *	Amount of Bond		
$1,000	$25,000	1	$15,000	-	$25,000
25,000	125,000	2	25,000	-	50,000
125,000	250,000	3	50,000	-	75,000
250,000	500,000	4	75,000	-	100,000
500,000	750,000	5	100,000	-	125,000
750,000	1,000,000	6	125,000	-	150,000
1,000,000	1,375,000	7	150,000	-	175,000
1,375,000	1,750,00	8	175,000	-	200,000
1,750,000	2,125,000	9	200,000	-	225,000
2,125,000	2,500,000	10	225,000	-	250,000
2,500,000	3,325,000	11	250,000	-	300,000
3,325,000	4,175,000	12	300,000	-	350,000
4,175,000	5,000,000	13	350,000	-	400,000
5,000,000	6,075,000	14	400,000	-	450,000
6,075,000	7,150,000	15	450,000	-	500,000
7,150,000	9,275,000	16	500,000	-	600,000
9,275,000	11,425,000	17	600,000	-	700,000
11,425,000	15,000,000	18	700,000	-	800,000
15,000,000	20,000,000	19	800,000	-	900,000
20,000,000	25,000,000	20	900,000	-	1,000,000
25,000,000	50,000,000	21	1,000,000	-	1,250,000
50,000,000	87,500,000	22	1,250,000	-	1,500,000
87,500,000	125,000,000	23	1,500,000		1,750,000
125,000,000	187,500,000	24	1,750,000	-	2,000,000
187,500,000	250,000,000	25	2,000,000	-	2,250,000
250,000,000	333,325,000	26	2,250,000	-	2,500,000
333,325,000	500,000,000	27	2,500,000	-	3,000,000
500,000,000	750,000,000	28	3,300,000	-	3,500,000
750,000,000	1,000,000,000	29	3,500,000	-	4,000,000
1,000,000,000	1,250,000,000	30	4,000,000	-	4,500,000
1,250,000,000	1,500,000,000	31	4,500,000	-	5,000,000

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Calculation of Bond Amount

1. Total Admitted Assets

   $____ X 5% = $____

2. Gross Income*

   $____ X 10% = $____

   Exposure Index = $____ **

3. Minimum Amount of Bond

   Bracket No.____ $____

*Include gross premium written and assumed plus interest and dividend income.

** Amount is calculated by adding the results of number 1 and 2 above.

The exposure index is calculated using all insured companies named on the fidelity bond. The fidelity bond policy limits listed above are not a substitute for the risk assessment that should be made by company management in establishing a reasonable level of insurance coverage. Similarly, company management should evaluate its business needs for other insurance coverages such as general liability and property, if applicable.

The insurance examiner, therefore, in evaluating the amount of the fidelity bond coverage amount, should not rely on the schedule above as an absolute guide, but instead, should review the internal controls that serve to mitigate the exposures covered by such insurance policies. In evaluating the fidelity bond the examiner should also consider if the reporting entity has the ability to meet the deductible.

Note: Fidelity bonds are written to cover material acts of theft or dishonestly by bonded employees. Thus, if a crime is committed by an employee who is not bonded, the company may have to bear the costs of that loss. Alternatively, companies may buy a general fidelity insurance policy commonly referred to as crime coverage. Crime coverage is an acceptable alternative to fidelity bonds so that it provides coverage that is at least as broad as the coverage provided by a fidelity bond. Keep in mind that both fidelity bonds and crime coverage will vary from policy to policy, so the examiner should use professional judgment when analyzing the individual policy and the risk that the policy hedges.

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ACKNOWLEDGEMENT AND WAIVER BY CHIEF EXECUTIVE OFFICER ON BEHALF OF HEALTH MAINTENANCE ORGANIZATION APPLICANT

I, _____, the _____ [Chief Executive Officer] of _____ [HMO Applicant], hereinafter referred to as the "Organization", having the authority to bind said Organization, do hereby:

(1) ACKNOWLEDGE, on behalf of the Organization, that a delinquency proceeding brought pursuant to the provisions of Article 10, Chapter 33 of the West Virginia Code of 1931, as amended [W. Va. Code §§33-10-I et seq.], or the administrative supervision provisions of article thirty-four of said chapter [W. Va. Code §§33-34-1 et seq.] constitutes the sole and exclusive method for the liquidation, rehabilitation, reorganization or conservation of a health maintenance organization licensed under the laws of this State; and

(2) WAIVE, on behalf of the Organization, any right to file or to be subject as a debtor to any bankruptcy proceedings;

(3) AFFIRM that I have read and do hereby understand the obligation imposed upon me as the chief executive officer of the Organization by the provisions of Article thirty-five of Chapter 33 of said Code [W. Va. Code §§33-35-1 et seq.] dealing with the criminal sanctions for the failure to timely report to the Insurance Commissioner an impairment of the Organization.

ated this _____ day of _____, 20__.

_____
(HMO Applicant)

BY: _____
(Signature)

ITS: _____
(Title)

State of _____
County of _____, to wit;

I, _____, a Notary Public in and for the county and state aforesaid, hereby certify that _____ whose name is signed to the foregoing document, bearing date the _____, day of 20__, for _____ (HMO Applicant), has this day in said county, personally appeared before me in said county and acknowledged the said writing to be the act and deed of said corporation.

Given under my hand this _____, day of _____, 20__.

My commission expires on _____.

SEAL)

_____
Notary Public

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☐ ___ Waives any right to file or be subject to any federal bankruptcy proceeding.

☐ ___ Comes from the CEO acknowledging that he/she has read and understands his/her obligations to report any impairment of the HMO to the Insurance Commissioner.

CERTIFICATION

State of _____

County of _____

To-wit:

I Thomas M. Duncan, do swear or affirm that I have carefully examined each of the questions asked in the **HEALTH MAINTENANCE ORGANIZATION APPLICATION AND CHECKLIST** and each of the responses thereto and, to the best of my knowledge and ability, all responses, information, exhibits, and documentary evidence submitted in support thereof are true and correct.

Thomas M Duncan
(Type or Print Name)

Chief Executive Officer
(Title)

(Signature)

3/4/16
(Date)

Sworn to and subscribed before me this 4 day of March 2016.

My commission expires: 8-14-20

(Notary Seal)

(Notary Public)

Meeting Minutes

Thrive Health Plans, Inc. d/b/a/ Trusted Health (Trusted) Plan Special Meeting of the Board of Directors

June 17, 2013

Attendees: Thomas M. Duncan; Dennis S. Ellis, Chika Duru, Eddie Hall (via teleconference); Dr. Guy Williams (via teleconference).

1. The Board of Directors (Board) was formally appointed.

    a. The Board is comprised of the following persons: Thomas M. Duncan, Dennis S. Ellis, Dr. Guy Williams, and Eddie Hall.

    b. A quorum was present for this Special Meeting.

2. By a unanimous vote, the Board adopted a resolution naming Thomas Duncan as Chief Executive Officer (CEO) of Trusted and Chairman of the Board.

    a. By a unanimous vote, the Board approved CEO's annual salary of $235,000.00, with a 30% bonus contingent on profit margin of greater than or equal to 2.5%.

    b. By a unanimous vote, the Board granted CEO authority to set compensation schedule.

3. By a unanimous vote, the Board adopted a resolution naming Dennis Ellis as Treasurer of Trusted and Vice-Chairman of the Board.

    a. By a unanimous vote, the Board adopted a resolution granting Treasurer authority to establish and maintain Trusted's bank accounts.

    b. By a unanimous vote, the Board adopted a resolution granting Treasurer special power and sole authority to direct certain 3rd party investments.

    c. By a unanimous vote, the Board nominated and approved Dennis Ellis as Chair of Finance Committee.

4. By a unanimous vote, the Board adopted a resolution naming Chika Duru as Secretary to the Board and General Counsel of Trusted.

5. Treasurer updated the Board regarding Trusted's finances, including potential investors: Magic Johnson Enterprises, a California physician group specializing in neonatal care, and a hedge fund.

6. CEO updated the Board regarding upcoming Readiness Review.

7. By a unanimous vote, the Board approved a plan to establish an employee stock option plan.

8. CEO briefed the Board regarding status of operations.

9. By a unanimous vote, the Board adopted a resolution approving all of Trusted's medical policies and procedures, which are National Committee for Quality Assurance (NCQA) compliant.

10. By a unanimous vote, the Board nominated and approved Thomas Duncan as of Chair of Compliance Committee and Internal Advisory Committee.

11. By a unanimous vote, the Board nominated and approved Dr. Guy Williams as Chair of Quality & Utilization Committee.

12. CEO presented a six-month outlook.

    a. Trusted anticipates approximately $48 million in revenue, with approximately $975,000.00 in profit.

    b. Trusted hopes to add approximately 4,000.00 members, growing from approximately 25,000.00 members to approximately 29,000.00 members.

13. By a unanimous vote, the Board approved a resolution to change the company's name from Thrive Health Plans, Inc. to Trusted Health Plan (District of Columbia), Inc.

Print Name: CHIKA DUPH

Signature: [signature]

Title: SECRETARY & GENERAL COUNSEL

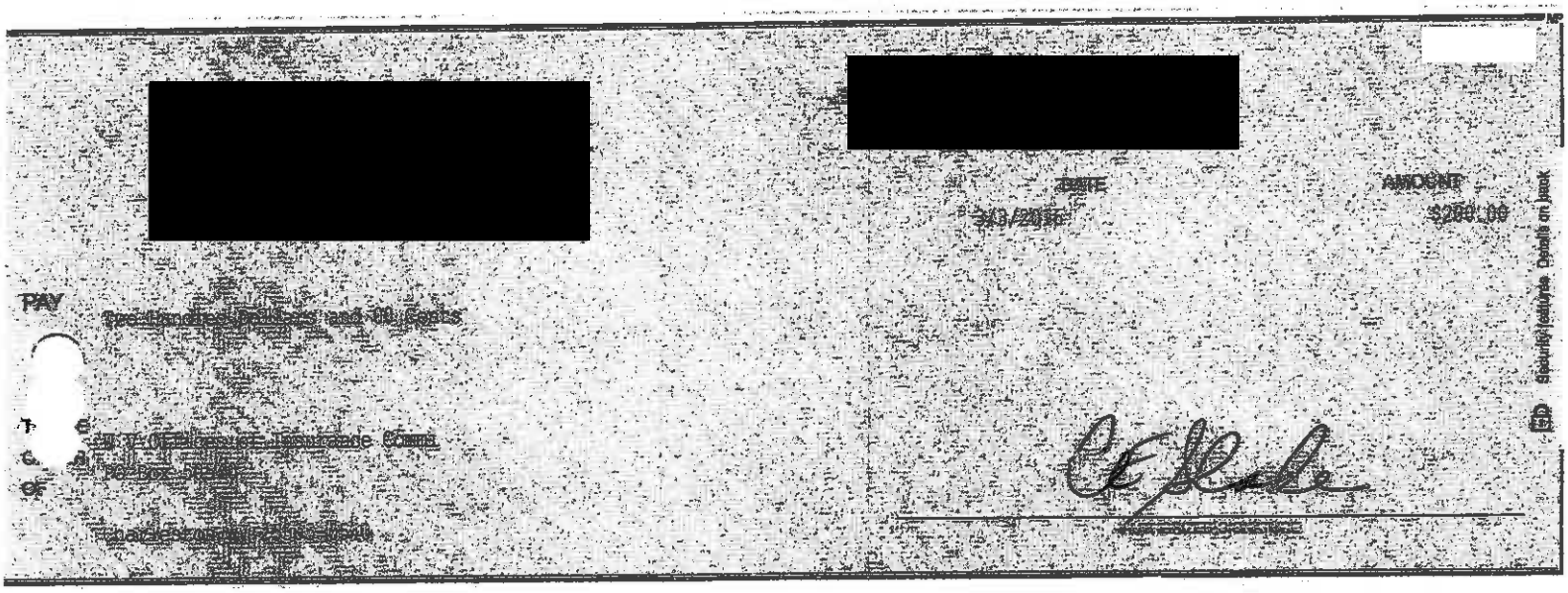
Date: 6/17/13

RUSTED HEALTH PLAN (DISTRICT OF COLUMBIA), INC. 8668

VENDOR ID	NAME	PAYMENT NUMBER	CHECK DATE
WVOFFICES	W V Offices of Insurance Commi	00000000000007411	3/3/2016

OUR VOUCHER NUMBER	YOUR VOUCHER NUMBER	DATE	AMOUNT	AMOUNT PAID	DISCOUNT	WRITE-OFF	NET
0000000006457	3.3.16	3/3/2016	$200.00	$200.00	$0.00	$0.00	$200.00
			$200.00	$200.00	$0.00	$0.00	$200.00

COMMENT



TRUSTED HEALTH PLAN (DISTRICT OF COLUMBIA), INC.
Trusted Health Plans (DC), Inc 8668

VENDOR ID	NAME	PAYMENT NUMBER	CHECK DATE
WVOFFICES	W V Offices of Insurance Commi	[redacted]	3/3/2016

OUR VOUCHER NUMBER	YOUR VOUCHER NUMBER	DATE	AMOUNT	AMOUNT PAID	DISCOUNT	WRITE-OFF	NET
[redacted]	[redacted]	3/3/2016	$200.00	$200.00	$0.00	$0.00	$200.00
			$200.00	$200.00	$0.00	$0.00	$200.00

COMMENT

2-1

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DEPARTMENT OF CONSUMER & REGULATORY AFFAIRS
District of Columbia Government
Corporations Division

DCRA Corp. Div.
NOV 2 2 2013
FILE COPY

[redacted]

1. Corporation Name.

Trusted Health Plan (District of Columbia), Inc.

2. The text of the restated articles of incorporation. (may attach the statement)

See attached.

[redacted]

6. Name of the Governor or Authorized Person.

Thomas Dudan

7. Signature of the Governor or Authorized Person.

[redacted]

Please check dcra.dc.gov to view organizations required to register, to search business names, to get step-by-step guidelines to register an organization, to search registered organizations, and to download forms and documents. Just click on "Corporate Registrations."

AMENDED AND RESTATED ARTICLES OF INCORPORATION OF TRUSTED HEALTH PLAN (DISTRICT OF COLUMBIA), INC.

Thomas M. Duncan, II hereby certifies that:

1. He is the duly elected and acting Chief Executive Officer of Trusted Health Plan (District of Columbia), Inc., a District of Columbia corporation.

2. The date of filing of this corporation's original Articles of Incorporation with the Mayor of the District of Columbia was May 16, 2011, as amended on August 13, 2013.

3. The Articles of Incorporation of this corporation are hereby amended and restated to read as follows:

ARTICLE I

The name of the corporation is Trusted Health Plan (District of Columbia), Inc. (formerly known as, Thrive Health Plans INC) (the "**Corporation**").

ARTICLE III

The address of the registered office of the Corporation in the District of Columbia is 1090 Vermont Avenue, NW, Washington D.C., District of Columbia, 20005. The name of the registered agent of the Corporation in the District of Columbia is Corporation Service Company.

ARTICLE II

The purpose of the Corporation is to operate a Health Maintenance Organization to arrange for and coordinate the delivery of health care services for Medicaid recipients and to engage in any lawful act or activity for which a corporation may be organized under the Business Corporation Act of 2010 of the District of Columbia (the "Act").

ARTICLE IV

A. The Corporation is authorized to issue 1,000,000 shares of Class A Stock. Each share of Class A Stock has a par value of $0.01 per share.

B. The shares of Class A Stock will have the following rights and privileges attached to them and are subject to the following conditions and limitations:

i. The holders of shares of Class A Stock will be entitled to receive, as and when declared by the Board of Directors out of the monies of the Corporation properly applicable to the payment of dividends, non-cumulative, cash dividends, at the rate to be set by the Board of Directors.

ii. The shares of Class A Stock may from time to time be issued as a class without series or, may from time to time be issued in one or more series. If the shares of Class A Stock are issued in one or more series, the Board of Directors may from time to time, by resolution before issuance, fix the number of shares in each series, determine the designation and fix the rights, privileges, restrictions, limitations and conditions attaching to the shares of each series but always subject to the limitations set out in the Articles of Incorporation.

iii. The holders of shares of Class A Stock will be entitled to one vote for each share of Class A Stock held, and will be entitled to receive notice of and to attend all meetings of the shareholders of the Corporation.

iv. In the event of liquidation, dissolution, or winding up of the Corporation, the holders of Class A Stock will be entitled to share equally, share for share, in the distribution of the assets of the Corporation.

ARTICLE V

A. The Board of Directors and officers of the Corporation will not be personally liable to the Corporation or its shareholders for any mistake or error in judgment or for any act or omission believed in good faith to be within the scope of authority conferred or implied by the Act, these Amended and Restated Articles of Incorporation or by the Corporation. The Board of Directors and officers will be liable for any expenses or damages incurred by the Corporation or its shareholders resulting from any and all acts or omissions involving fraud or intentional wrongdoing.

B. The Board of Directors, officers, employees and agents of the Corporation will be indemnified and held harmless by the Corporation and its shareholders from and against any and all claims of any nature, whatsoever, arising out of the individual's participation in the affairs of the Corporation. The Board of Directors, officers, employees and agents of the Corporation will not be entitled to indemnification under this section for liability arising out of gross negligence or willful misconduct of the individual or the breach by the individual of any provisions of this Amended and Restated Articles of Incorporation.

C. Any repeal or modification of this Article V will only be prospective and will not affect the rights or protections or increase the liability of any director under this Article V in effect at the time of the alleged occurrence of any action or failure to act giving rise to liability.

ARTICLE VI

The name and address of the incorporator is Thomas Duncan, 1929 Bayou, Bloomfield Hills, Michigan 48302.

4. These Amended and Restated Articles of Incorporation have been duly approved by the Board of Directors of the Corporation in accordance with the Act.

5. These Amended and Restated Articles of Incorporation were approved by the holders of the requisite number of shares of the Corporation in accordance with Act. These Amended and Restated Articles of Incorporation have been duly adopted in accordance with the provisions of the Act by the stockholders of the Corporation.

Dated: Nov 4, 2013

Trusted Health Plan (District of Columbia), Inc.

By: _____
Name: Thomas M. Duncan, II
Title: Chief Executive Officer

Initial File #: C0000001168

GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT OF CONSUMER AND REGULATORY AFFAIRS
CORPORATIONS DIVISION

CERTIFICATE

THIS IS TO CERTIFY that all applicable provisions of the District of Columbia Business Organizations Code have been complied with and accordingly, this ***CERTIFICATE OF RESTATED ARTICLES*** is hereby issued to:

TRUSTED HEALTH PLAN (DISTRICT OF COLUMBIA), Inc.

Effective Date: 11/8/2013

IN WITNESS WHEREOF I have hereunto set my hand and caused the seal of this office to be affixed as of 11/8/2013 2:15 PM

Business and Professional Licensing Administration

PATRICIA E. GRAYS
Superintendent of Corporations
Corporations Division

Vincent C. Gray
Mayor

Tracking #: oxFt17Ng

File #: C0000001168

GOVERNMENT OF THE DISTRICT OF COLUMBIA

DEPARTMENT OF CONSUMER AND REGULATORY AFFAIRS
CORPORATIONS DIVISION

CERTIFICATE

THIS IS TO CERTIFY that all applicable provisions of the District of Columbia Business Corporation Act have been complied with and accordingly, this ***CERTIFICATE OF AMENDMENT*** is hereby issued to:

THRIVE HEALTH PLANS, INC.

Name Changed To

TRUSTED HEALTH PLAN (DISTRICT OF COLUMBIA), INC.

IN TESTIMONY WHEREOF I have hereunto set my hand and caused the seal of this office to be affixed as of **08/13/2013**

Business and Professional Licensing Administration

PATRICIA E. GRAYS
Superintendent of Corporations
Corporations Division

Vincent C. Gray
Mayor

Tracking #: AU96DLAI7U

5-6

File #: C0000001168

GOVERNMENT OF THE DISTRICT OF COLUMBIA

DEPARTMENT OF CONSUMER AND REGULATORY AFFAIRS
CORPORATIONS DIVISION

CERTIFICATE

THIS IS TO CERTIFY that all applicable provisions of the District of Columbia Business Corporation Act have been complied with and accordingly, this ***CERTIFICATE OF INCORPORATION*** is hereby issued to:

THRIVE HEALTH PLANS, Inc.

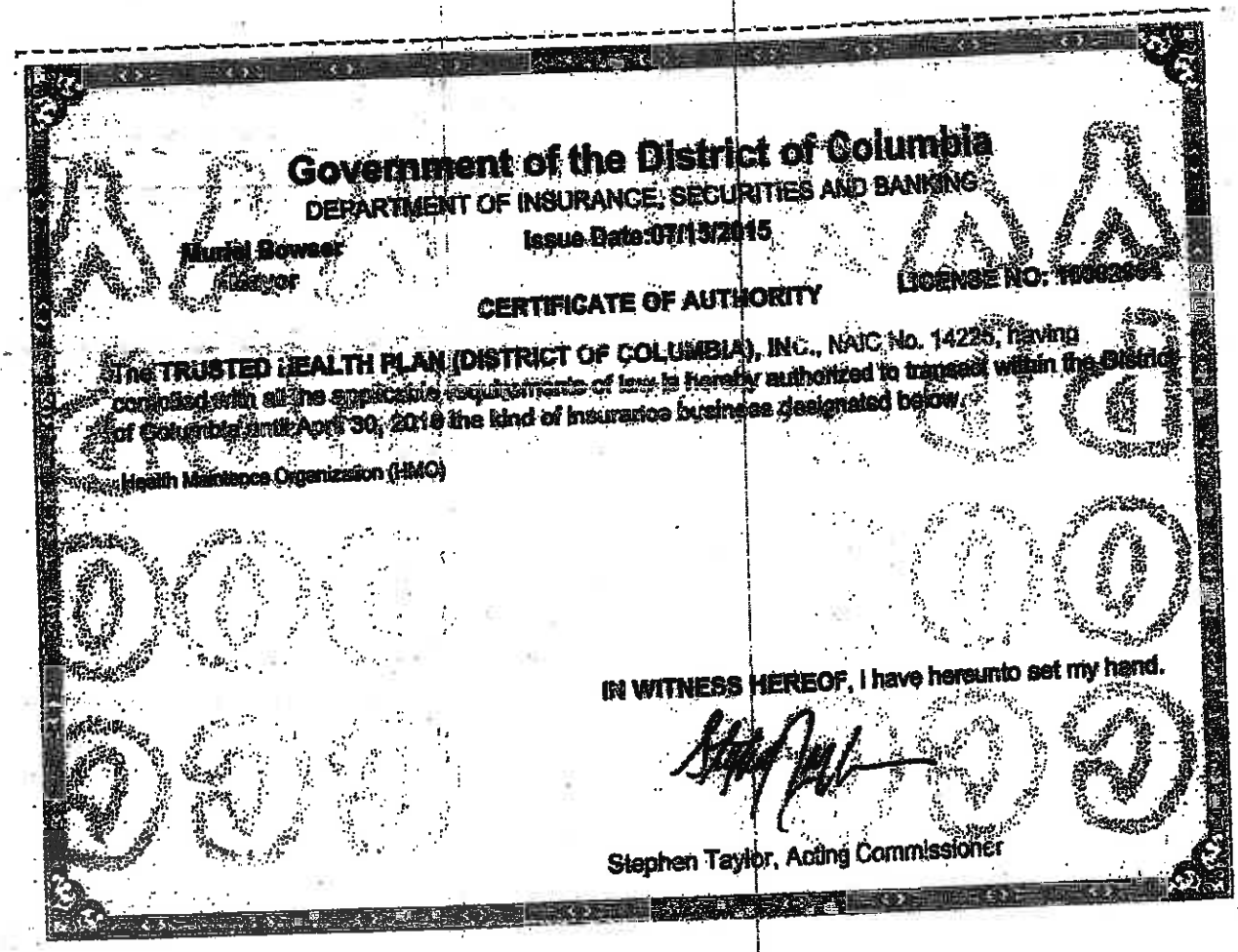
IN WITNESS WHEREOF I have hereunto set my hand and caused the seal of this office to be affixed as of **05/16/2011 15:33:16**

Business and Professional Licensing Administration

PATRICIA E. GRAYS
Superintendent of Corporations
Corporations Division

Vincent C. Gray
Mayor

Tracking #: 4GDQJ025E7



Government of the District of Columbia

DEPARTMENT OF INSURANCE, SECURITIES AND BANKING

Muriel Bowser
Mayor

Issue Date:07/13/2015

LICENSE NO: [illegible]

CERTIFICATE OF AUTHORITY

The TRUSTED HEALTH PLAN (DISTRICT OF COLUMBIA), INC., NAIC No. 14225, having complied with all the applicable requirements of law is hereby authorized to transact within the District of Columbia until April 30, 2016 the kind of insurance business designated below:

Health Maintence Organization (HMO)

IN WITNESS HEREOF, I have hereunto set my hand.

Stephen Taylor, Acting Commissioner

Government of the District of Columbia
Department of Insurance, Securities and Banking

Stephen C. Taylor
Commissioner

CERTIFICATE OF COMPLIANCE

This is to certify that Trusted Health Plan (District of Columbia), Inc. incorporated under the laws of the District of Columbia, has complied with all the laws of the District of Columbia applicable to said Company.

NOW THEREFORE, I, Stephen C. Taylor, Commissioner of the Department of Insurance, Securities and Banking for the District of Columbia do hereby certify that said Company is authorized to transact the appropriate business of a Health Maintenance Organization in this District, in accordance with the laws thereof for the license year expiring April 30, 2016.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed the official seal, at the City of Washington, D.C. this 29th day of January in the year 2016.

Stephen C. Taylor
Commissioner

Trusted Health Plan (District of Columbia), Inc. (the "Company") is a Medicaid health maintenance organization ("HMO") and was incorporated as Thrive Health Plan, Inc. on May 23, 2011 under the laws of the District of Columbia (the "District"). The Company subsequently changed its name from Thrive Health Plans, Inc. to Trusted Health Plan (District of Columbia), Inc. during August 2013. The Company is owned by Trusted Health Plan, Inc (the "Parent").

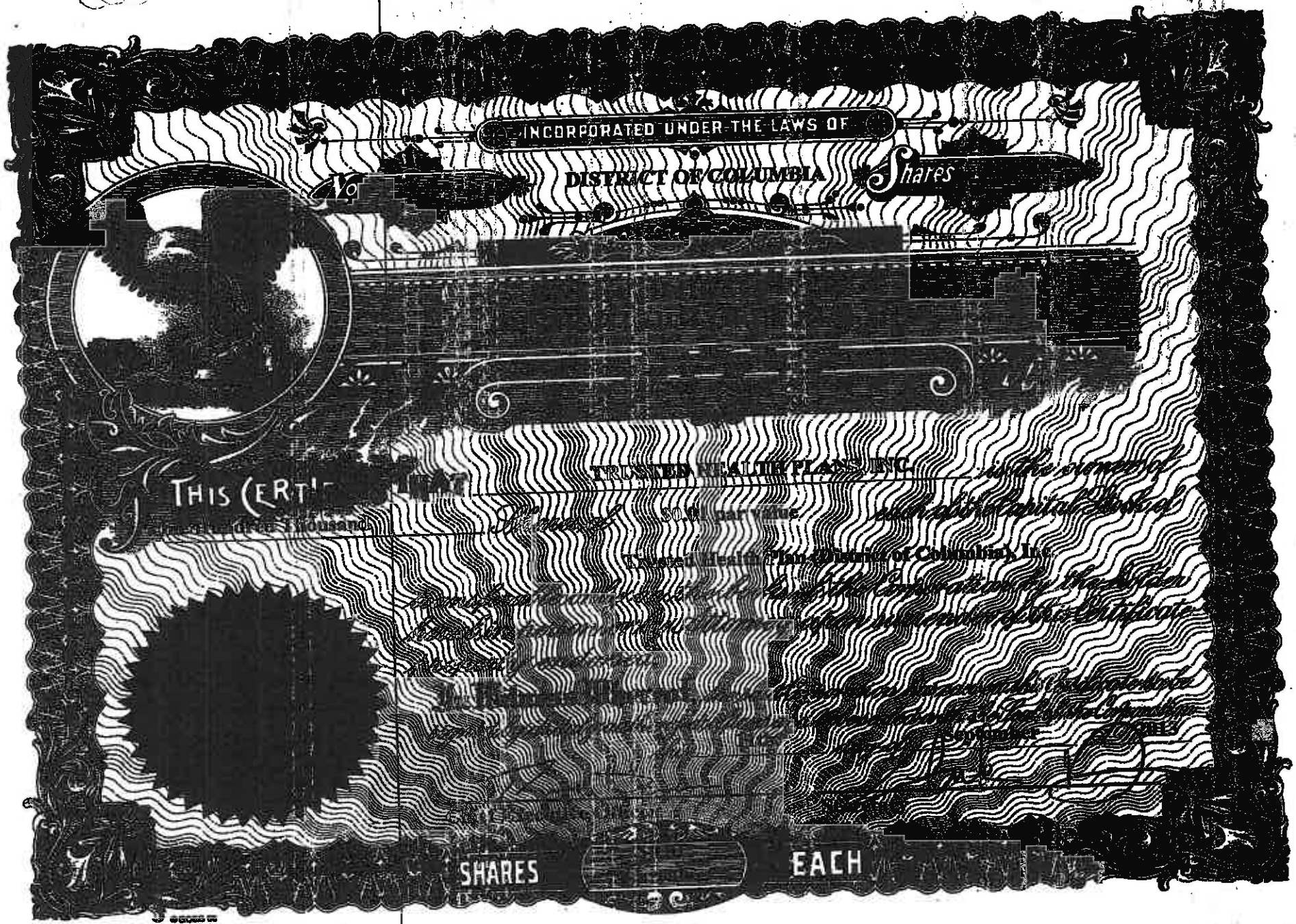
From inception to date, the Company has received $6.8 million in capital from the Parent which owned 100% of the 100,000 shares of Class A common stock shares authorized, issued and outstanding. The Company has earned $5.5 million from operations to create $12.2 million in Capital and Surplus as of December 31, 2015.

The following chart illustrates the capital formation of the Parent and the Company as of December 31, 2015.

	% Ownership	Capital Infustion	Working Capital Loan	Capital Formation
Capital Structure				
Mosby, LLC	35%			
Invested Capital		125,000		125,000
Frost LLC	35%			
invested Capital		125,000		125,000
KBD	30%			
Invested Capital		2,250,000		2,250,000
Jun-13			3,000,000	3,000,000
Mar-14			2,000,000	1,335,000
	100%	2,500,000	5,000,000	6,835,000
Capital Stock		1,000		1,000
Paid In Capital		2,499,000		6,834,000
		2,500,000		6,835,000

TRUSTED HEALTH PLAN (DISTRICT OF COLUMBIA), INC.
December 31, 2015

Capital and Surplus		
Class A common stock - $0.01 par value, 100,000 shares authorized, issued and outstanding	$	1,000
Additional paid-in surplus		6,834,000
Retained earning (accumulated deficit)		3,723,676
Special surplus funds		1,723,486
Total Capital and Surplus	$	12,282,162


INCORPORATED UNDER THE LAWS OF
DISTRICT OF COLUMBIA
Shares
No.
THIS CERTI
TRUSTED HEALTH PLANS, INC.
Trusted Health Plan (District of Columbia), Inc.
SHARES
EACH

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THE SHARES REPRESENTED BY THIS CERTIFICATE HAVE NOT BEEN ISSUED AND SOLD WITHOUT REGISTRATION UNDER THE SECURITIES ACT OF 1933 (FEDERAL ACT) OR THE BLUE SKY LAWS OF ANY STATE (STATE ACTS) PURSUANT TO CERTAIN EXEMPTIVE PROVISIONS OF SAID ACTS. SAID SECURITIES CANNOT BE SOLD OR TRANSFERRED UNLESS IN THE OPINION OF COUNSEL REASONABLY ACCEPTABLE TO THE ISSUER SUCH SALE OR TRANSFER WOULD BE PURSUANT TO AN EFFECTIVE REGISTRATION STATEMENT UNDER THE FEDERAL ACT OR PURSUANT TO AN EXEMPTION FROM SUCH REGISTRATION AND IN COMPLIANCE WITH THE PERTINENT PROVISIONS OF ANY APPLICABLE STATE ACT.

SHARES

For Value Received, ____ *hereby sell, assign and transfer unto* _____

_____ *Shares of the Capital Stock represented by the within Certificate, and do hereby irrevocably constitute and appoint* _____

_____ *to transfer the said Stock on the books of the within named Corporation with full power of substitution in the premises.*

Dated _____

In presence of

_____

_____

NOTICE: THE SIGNATURE TO THIS ASSIGNMENT MUST CORRESPOND WITH THE NAME AS WRITTEN UPON THE FACE OF THE CERTIFICATE, IN EVERY PARTICULAR, WITHOUT ALTERATION OR ENLARGEMENT OR ANY CHANGE WHATEVER.

Year	Entity	Description of Events
2011	Thrive Health Plans, Inc.	Incorporated under the laws of the District of Columbia as a Health Maintenance Organization Company ownership T.C. Mosby LLC (sole member Dennis S. Ellis) 35.00% Frost BPO, LLC (sole member Thomas M. Duncan) 35.00% New World TMT (via KBD) 30.00% 100.00%
2013	Trusted Health Plan (District of Columbia), Inc.	Due to a name copyright issue with the "Thrive" name, Thrive changed it's name to Trusted Health Plan in August 2013. (District of Columbia) Inc. in August 2013. The company's tax identification number was not changed. However, a holding company was formed, Trusted Health Plans, Inc. (the "THP") The previous ownership of Thrive moved up to own 100% of the holding company in the same ownership relationship as they had owned Thrive. Trusted Health Plan (District of Columbia), Inc. became a wholly owned subsidary of Trusted Health Plans, Inc. by the issuing of 100,000 shares of its authorized common stock to THP.
2016	Trusted Health Plan (District of Columbia), Inc.	On January 27, 2016, T.C. Mosby, LLC and New World TMT sold its interest in Trusted Health Plans, Inc. The new ownership for Trusted Health Plans, Inc. is as follows: Frost BPO, LLC (sole member Thomas M. Duncan) 41.50% Juggernaut Capital Partners, III, LP 34.37% Morgan Noble Healthcare Partners 16.13% Bruce Anderson 6.40% Tom Scully 1.60% 100.00% Trusted Health Plans, Inc. still owns 100% of the outstanding stock of Trusted Health Plan (District of Columbia), Inc.

Applicant Company Name : Trusted Health Plan (District of Columbia) Inc. NAIC No. [illegible]
FEIN: 45-2375150

BIOGRAPHICAL AFFIDAVIT

To the extent permitted by law, this affidavit will be kept confidential by the state insurance regulatory authority.

(Print or Type)

Full name, address and telephone number of the present or proposed entity under which this biographical statement is being required (Do Not Use Group Names).

Trusted Health Plan (District of Columbia), Inc.
1100 New Jersey Avenue, SE, Suite 840
Washington, DC 20003

In connection with the above-named entity, I herewith make representations and supply information about myself as hereinafter set forth. (Attach addendum or separate sheet if space hereon is insufficient to answer any question fully.) IF ANSWER IS "NO" OR "NONE," SO STATE.

1. Affiant's Full Name (Initials Not Acceptable): First: Thomas Middle: Michael Last: Duncan II

2. a. Are you a citizen of the United States?

   Yes [X] No [ ]

   b. Are you a citizen of any other country?

   Yes [ ] No [X]

   If yes, what country? _____

3. Affiant's occupation or profession: Chief Executive Officer

4. Affiant's business address: 1100 New Jersey Avenue, SE, Suite 840, Washington, DC 20003

   Business telephone: (202) 821-1100 Business Email: tduncan@trustedhp.com

5. Education and training:

College/University	City/State	Dates Attended (MM/YY)	Degree Obtained
Florida A&M	Tallahassee, Florida	08/98 to 5/03	MBA
Graduate Studies	College/University	City/State	Dates Attended (MM/YY)	Degree Obtained
Other Training: Name	City/State	Dates Attended (MM/YY)	Degree/Certification Obtained

Note: If affiant attended a foreign school, please provide full address and telephone number of the college/university. If applicable, provide the foreign student Identification Number in the space provided in the Biographical Affidavit Supplemental Information.

Revised 8/18/14

FORM 1

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Applicant Company Name : Trusted Health Plan (District of Columbia) Inc. NAIC No. 14225 FEIN: 45-2375150

6. List of memberships in professional societies and associations:

Name of Society/Association	Contact Name	Address of Society/Association	Telephone Number of Society/Association
Medicaid Health Plans of America	Jeff Myers	1150 18th Street, NW Suite 1010, Washington, DC	(202) 857-5720
Young Presidents Organization	Lisa Shanle	1117 Pool Rd, Cokeysville Maryland, 21030	(410) 584-2598

7. Present or proposed position with the Applicant Company: Chief Executive Officer

8. List complete employment record for the past twenty (20) years, whether compensated or otherwise (up to and including present jobs, positions, partnerships, owner of an entity, administrator, manager, operator, directorates or officerships). Please list the most recent first. Attach additional pages if the space provided is insufficient. It is only necessary to provide telephone numbers and supervisory information for the past ten (10) years.

Beginning/Ending
Dates (MM/YY): 05/13- PRESENT Employer's Name: Trusted Health Plan (District of Columbia) Inc.

Address: 1100 New Jersey Avenue, SE, Suite 840 City: Washington State/Province: DC

Country: USA Postal Code: 20003 Phone: (202) 821-1100 Offices/Positions Held: CEO

Type of Business: Health Maintenance Organization Supervisor/Contact: _____

Dates (MM/YY): 07/13- 04/13 Employer's Name: Accretive Health.

Address: 401 N. Michigan Avenue #2700 City: Chicago State/Province: Illinois

Country: USA Postal Code: 60611 Phone: (312) 324-7820 Offices/Positions Held: Senior Director/Vice-President

Type of Business: Hospital Revenue Cycle Supervisor/Contact: _____

Beginning/Ending
Dates (MM/YY): 03/06 - 06/07 Employer's Name: Care Compensation Specialist, Inc.

Address: 243 West Congress City: Detroit State/Province: Michigan

Country: USA Postal Code: 48226 Phone: (313) 962-0692 Offices/Positions Held: CEO

Type of Business: Medicaid Enrollment Supervisor/Contact: _____

Beginning/Ending
Dates (MM/YY): 05/04 - 02/016 Employer's Name: United Community Hospital

Address: 2401 20th Street City: Detroit State/Province: Michigan

Country: USA Postal Code: 48216 Phone: _____ Offices/Positions Held: Vice President

Type of Business: Hospital Supervisor/Contact: _____

9. a. Have you ever been in a position which required a fidelity bond?

Yes [ ] No [X]

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If any claims were made on the bond, give details: _____

b. Have you ever been denied an individual or position schedule fidelity bond, or had a bond canceled or revoked?

Yes [ ] No [X]

If yes, give details: _____

10. List any professional, occupational and vocational licenses (including licenses to sell securities) issued by any public or governmental licensing agency or regulatory authority or licensing authority that you presently hold or have held in the past. For any non-insurance regulatory issuer, identify and provide the name, address and telephone number of the licensing authority or regulatory body having jurisdiction over the license (s) issued. If your professional license number is your Social Security Number (SSN) or embeds your SSN or any sequence of more than five numbers that are reasonably identifiable as your SSN, then write SSN for that portion of the professional license number that is represented by your SSN. (For example, "SSN", "12-SSN-345" or "1234-SSN" (last 6 digits)). Attach additional pages if the space provided is insufficient.

Organization/Issuer of License: _____ Address: _____

City: _____ State/Province: _____ Country: ____ Postal Code: _____

License Type: _____ License #: _____ Date Issued (MM/YY): _____

Date Expired (MM/YY): _____ Reason for Termination: _____

Non-Insurance Regulatory Phone Number (if known): _____

Organization/Issuer of License: _____ Address: _____

City: _____ State/Province: _____ Country: _____ Postal Code: _____

License Type: _____ License #: _____ Date Issued (MM/YY): _____

Date Expired (MM/YY): _____ Reason for Termination: _____

Non-Insurance Regulatory Phone Number (if known): _____

11. In responding to the following, if the record has been sealed or expunged, and the affiant has personally verified that the record was sealed or expunged, an affiant may respond "no" to the question. Have you ever:

a. Been refused an occupational, professional, or vocational license or permit by any regulatory authority, or any public administrative, or governmental licensing agency?

Yes [ ] No [X]

b. Had any occupational, professional, or vocational license or permit you hold or have held, been subject to any judicial, administrative, regulatory, or disciplinary action?

Yes [ ] No [X]

c. Been placed on probation or had a fine levied against you or your occupational, professional, or vocational license or permit in any judicial, administrative, regulatory, or disciplinary action?

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Yes [X] No [ ]

d. Been charged with, or indicted for, any criminal offense(s) other than civil traffic offenses?

Yes [ ] No [X]

e. Pled guilty, or nolo contendere, or been convicted of, any criminal offense(s) other than civil traffic offenses?

Yes [ ] No [X]

f. Had adjudication of guilt withheld, had a sentence imposed or suspended, had pronouncement of a sentence suspended, or been pardoned, fined, or placed on probation, for any criminal offense(s) other than civil traffic offenses?

Yes [ ] No [X]

g. Been subject to a cease and desist letter or order, or enjoined, either temporarily or permanently, in any judicial, administrative, regulatory, or disciplinary action, from violating any federal, state law or law of another country regulating the business of insurance, securities or banking, or from carrying out any particular practice or practices in the course of the business of insurance, securities or banking?

Yes [ ] No [X]

h. Been, within the last ten (10) years, a party to any civil action involving dishonesty, breach of trust, or a financial dispute?

Yes [ ] No [X]

i. Had a finding made by the Comptroller of any state or the Federal Government that you have violated any provisions of small loan laws, banking or trust company laws, or credit union laws, or that you have violated any rule or regulation lawfully made by the Comptroller of any state or the Federal Government?

Yes [ ] No [X]

j. Had a lien or foreclosure action filed against you or any entity while you were associated with that entity?

Yes [X] No [ ]

If the response to any question above is yes, please provide details including dates, locations, disposition, etc. Attach a copy of the complaint and filed adjudication or settlement as appropriate.

d. Bad checks under $250

j. home foreclosure in 2009

12. List any entity subject to regulation by an insurance regulatory authority that you control directly or indirectly. The term "control" (including the terms "controlling," "controlled by" and "under common control with") means the possession, direct or indirect, of the power to direct or cause the direction of the management and policies of a person, whether through the ownership of voting securities, by contract other than a commercial contract for goods or non-management services, or otherwise, unless the power is the result of an official position with or corporate office held by the person. Control shall be presumed to exist if any person, directly or indirectly, owns, controls, holds with the power to vote, or holds proxies representing, ten percent (10%) or more of the voting securities of any other person.
Trusted Health Plan (District of Columbia) Inc.

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If any of the stock is pledged or hypothecated in any way, give details.

13. Do [Will] you or members of your immediate family individually or cumulatively subscribe to or own, beneficially or of record, 10% or more of the outstanding shares of stock of any entity subject to regulation by an insurance regulatory authority, or its affiliates? An "affiliate" of, or person "affiliated" with, a specific person, is a person that directly, or indirectly through one or more intermediaries, controls, or is controlled by, or is under common control with, the person specified.

Yes [X] No [ ]

If yes, please identify the company or companies in which the cumulative stock holdings represent 10% or more of the outstanding voting securities.
Trusted Health Plan (District of Columbia) Inc.

If any of the shares of stock are pledged or hypothecated in any way, give details.

14. Have you ever been adjudged a bankrupt?

Yes [ ] No [X]

If yes, provide details:

15. To your knowledge has any company or entity for which you were an officer or director, trustee, investment committee member, key management employee or controlling stockholder, had any of the following events occur while you served in such capacity?

a. Been refused a permit, license, or certificate of authority by any regulatory authority, or governmental-licensing agency?

Yes [ ] No [X]

b. Had its permit, license, or certificate of authority suspended, revoked, canceled, non-renewed, or subjected to any judicial, administrative, regulatory, or disciplinary action (including rehabilitation, liquidation, receivership, conservatorship, federal bankruptcy proceeding, state insolvency, supervision or any other similar proceeding)?

Yes [ ] No [X]

c. Been placed on probation or had a fine levied against it or against its permit, license, or certificate of authority in any civil, criminal, administrative, regulatory, or disciplinary action?

Yes [ ] No [X]

Applicant Company Name : Trusted Health Plan (District of Columbia) Inc. NAIC No. 14225
FEIN: 45-2375150

If the answer to any of the above is yes, please indicate and give details. When responding to questions (b) and (c), affiant should also include any events within twelve (12) months after his or her departure from the entity. _____

Note: If an affiant has any doubt about the accuracy of an answer, the question should be answered in the positive and an explanation provided.

Dated and signed this _____ day of _____ 20 ____ at _____. I hereby certify under penalty of perjury that I am acting on my own behalf and that the foregoing statements are true and correct to the best of my knowledge and belief.

(Signature of Affiant)

State of: District of Columbia County of: _____

The foregoing instrument was acknowledged before me this 24 day of February, 20 16 by Thomas M. Duncan

and:

who is personally known to me, or

who produced the following identification: DC 3294252.

Notary Public

Salome' Ortiz-Dyren
Printed Notary Name

9-14-20
My Commission Expires

[SEAL]

SALOME ORTIZ-DYREN NOTARY PUBLIC EXP. 9-14-20 DISTRICT OF COLUMBIA

Revised 8/18/14
FORM 11

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Applicant Company Name : Trusted Health Plan (District of Columbia) Inc. NAIC No. 14225
FEIN: 45-2375150

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BIOGRAPHICAL AFFIDAVIT
Supplemental Personal Information

(Print or Type)

To the extent permitted by law, this affidavit will be kept confidential by the state insurance regulatory authority.

Full name, address, and telephone number of the present or proposed entity under which this biographical statement is being required (Do Not Use Group Names).

Trusted Health Plan (District of Columbia), Inc.
1100 New Jersey Avenue, SE, Suite 840
Washington, DC 20003

1. Affiant's Full Name (Initials Not Acceptable): Fir[redacted]
   IF ANSWER IS "NONE," SO STATE.

2. Have you ever used any other name, including first, middle or last name, nickname, maiden name or aliases?

   Yes [ ] No [X]

   If yes, give the reason if any, if none indicate such, and provide the full name(s) and date(s) used.

Beginning/Ending Date(s) Used (MM/YY)	Name(s) Specify: First, Middle or Last Name	Reason (If none, indicate such)

Note: Dates provided in response to this question may be approximate. Parties using this form understand that there could be an overlap of dates when transitioning from one name to another.

3. Affiant's Social Security Number: [redacted]

4. Government Identification Number if not a U.S. Citizen: _____

5. Foreign Student ID# (if applicable): _____

6. Date of Birth: (MM/DD/YY): 01/11/80 Place of Birth, City: Detroit
   State/Province: Michigan Country: USA

7. Name of Affiant's Spouse (if applicable): [redacted]

8. List your residences for the last ten (10) years starting with your current address, giving:

Revised 8/18/14

Applicant Company Name : Trusted Health Plan (District of Columbia) Inc. NAIC No. 14225
FEIN: 45-2375150

Beginning/Ending Dates (MM/YY)	Address	City	State/ Province	Country	Postal Code
07/15 to Present	[redacted]			USA	20016
07/13 to 06/14	[redacted]			USA	20008
07/10 to 06/13	[redacted]			USA	48302
09/04 to 06/10	[redacted]			USA	48207

Note: Dates provided in response to this question may be approximate, except for current address. Parties using this form understand that there could be an overlap of dates when transitioning from one address to another.

Dated and signed this _____ day of _____, 20____ at _____. I hereby certify under penalty of perjury that I am acting on my own behalf and that the foregoing statements are true and correct to the best of my knowledge and belief.

[redacted]
(Signature of Affiant)

State of: District of Columbia County of: _____

The foregoing instrument was acknowledged before me this 24 day of January, 2016 by Thomas M. Duncan II and:

who is personally known to me, or

who produced the following identification: DC 329 4252

Notary Public
Salome Ortiz
Printed Notary Name
8-14-20
My Commission Expires

[SEAL]



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Applicant Company Name : Trusted Health Plan (District of Columbia) Inc. NAIC No. 14225
FEIN: 45-2375150

DISCLOSURE AND AUTHORIZATION CONCERNING BACKGROUND REPORTS

(All states except California, Minnesota and Oklahoma)

This Disclosure and Authorization is provided to you in connection with pending or future application(s) of Trusted Health Plan (District of Columbia) Inc. ("Company") for licensure or a permit to organize ("Application") with a department of insurance in one or more states within the United States. Company desires to procure a consumer or investigative consumer report (or both)("Background Reports") regarding your background for review by a department of insurance in any state where Company pursues an Application during the term of your functioning as, or seeking to function as, an officer, member of the board of directors or other management representative ("Affiant") of Company or of any business entities affiliated with Company ("Term of Affiliation") for which a Background Report is required by a department of insurance reviewing any Application. Background Reports requested pursuant to your authorization below may contain information bearing on your character, general reputation, personal characteristics, mode of living and credit standing. The purpose of such Background Reports will be to evaluate the Application and your background as it pertains thereto. To the extent required by law, the Background Reports procured under this Disclosure and Authorization will be maintained as confidential.

You may obtain copies of any Background Reports about you from the consumer reporting agency ("CRA") that produces them. You may also request more information about the nature and scope of such reports by submitting a written request to Company. To obtain contact information regarding CRA or to submit a written request for more information, contact _____ **[company's designated person, position, or department, address and phone]**.

Attached for your information is a "Summary of Your Rights Under the Fair Credit Reporting Act."

AUTHORIZATION: I am currently an Affiant of Company as defined above. I have read and understand the above Disclosure and by my signature below, I consent to the release of Background Reports to a department of insurance in any state where Company files or intends to file an Application, and to the Company, for purposes of investigating and reviewing such Application and my status as an Affiant. I authorize all third parties who are asked to provide information concerning me to cooperate fully by providing the requested information to CRA retained by Company for purposes of the foregoing Background Reports, except records that have been erased or expunged in accordance with law.

I understand that I may revoke this Authorization at any time by delivering a written revocation to Company and that Company will, in that event, forward such revocation promptly to any CRA that either prepared or is preparing Background Reports under this Disclosure and Authorization. This Authorization shall remain in full force and effect until the earlier of (i) the expiration of the Term of Affiliation, (ii) written revocation as described above, or (iii) twelve (12) months following the date of my signature below.

A true copy of this Disclosure and Authorization shall be valid and have the same force and effect as the signed original.

Thomas M. Duncan, II 4370 Westover Place NW, Washington, DC 20016
(Printed Full Name and Residence Address)

[redacted] 2/24/16
(Signature) (Date)

State of: District of Columbia County of: _____

The foregoing instrument was acknowledged before me this 24 day of February, 2016 by [redacted], and:

who is personally known to me, or

who produced the following identification: [redacted]

[SEAL]

Notary Public
Salome Ortiz Dibos
Printed Notary Name
8-14-20
My Commission Expires

Trusted Health Plan (District of Columbia) Inc. (the "Trusted") is a Medicaid health maintenance organization which enters into hospital service contracts to provide the necessary inpatient and outpatient hospital services to its enrollees. Under these contracts, the Trusted pays the participating hospitals at a fee-for-service rates in effect at the time the services were provided to its enrollees. Trusted also enters into agreement with network physicians and suppliers to provide medical services and supplies to Trusted enrollees at agreed upon fee-for-service rate or at fixed fees per member per month ("capitation" or "PMPM")an independent practice association (IPA).

Trusted will be responding to a solicitation number BMS1600000002, Centralized Request For Quotation (CRFQ) for managed care services which has been issues by the West Virginia Department of Administration, Purchasing Division. Trusted bid will be to provide the request services throughout the State of West Virginia.

TRUSTED Health Plan
THP

STATE OF WEST VIRGINIA MARKETING PLAN
Executive Summary

1. "Targeted High Touch"

Trusted Health Plan (District of Columbia) Inc. (the "Trusted") plans to execute a comprehensive marketing plan that will

1) Focus on hosting and partnering with local community, social services, faith-based and local government organizations to bring culturally relevant and appropriate community health, wellness and "life" events and programs into every county.

2) Build partnerships with community, government and media organizations that can help us tailor our community focused programs, events and messages to the specific age, race and ethnic groups that are prevalent in each of the individual communities we plan to serve.

3) Provide access to rural communities through use of mobile health units.

4) Establish Health and Wellness Customer Service Centers in Kanawha and Marshall counties.

5) Establish a "Wellness Warrior" Outreach Coordinator that represents Trusted in every County.

Specifically, Trusted will execute a proven grass roots marketing strategy by bringing meaningful and impactful health, wellness and life events, programs and services with our community partners deep into the target markets and associated communities. Through our grass roots marketing campaign and Trusted Road Show, we will define the "Trusted" brand for the new markets we plan to enter. Trusted will be known as a "life care" company that cares for those it serves by reliably facilitating access to high quality health care and social services that truly make a difference in people's lives. We are therefore very confident that our community focus and mission to be that bridge for "life" services will help the plan grow steadily and achieve our membership goals in 2016 and beyond.

Trusted believes in "Targeted High Touch" strategies to improve our members health status by encouraging them to proactively make positive health decisions.

Below, we have outlined the highlights of our marketing strategy. The details for each leg of the plan are contained later in this document.

1. **Provide Comparable Benefits and Services**

   - Trusted will provide comparable benefits to those offered by each of the other MCOs, ensuring that the services offered by one of our competitors will not be an obstacle for a member who is considering a change to Trusted. Approximately 60 days prior to the contract go-live date, Trusted will begin promoting and highlighting the benefits and services that it plans, using approved advertisements and benefit documentation.

2. **Execute Major Advertising and Promotional Campaigns**

   - Shortly after award or approximately 3 months before the 2016 go-live date (if awarded the contract), Trusted will execute a major advertising and promotional campaign to include radio, television, newspaper/circular and Internet advertising (ad) and promotion through the appropriate timing and advertisement placement. This campaign will include sponsorship of radio and television health segments and programs that promote healthy lifestyles.

3. **Leverage Relationships with Existing Community Partners and Providers**

   - Shortly after contract award, Trusted will begin leveraging relationships with local and rural organizations, including churches, schools, community colleges, local health departments, NAACP and other community based organizations.

4. **Trusted Road Show Campaign**

   - In the days that immediately follow contract award, Trusted will engage a prominent West Virginia base grass roots marketing and public relations (PR) firm to design and help staff a series of community events throughout West Virginia, from Hancock to Jefferson to McDowell counties to include community fun days, health fairs, and other activities. These events will be executed utilizing mobile units to raise brand awareness and affinity for Trusted.

   - Trusted will use the PR firm to design the wrapping for and chauffeur a large passenger bus that will be "wrapped" in inspiring images, murals and themes that will evoke warm emotions about Trusted. The "Trusted Cares" bus will serve as a mobile billboard helping to establish a high level of awareness and affinity for the Trusted brand as it travels from event to event.

   - Trusted staff and providers will participate, providing health education and assisting members get preventive and screening exams.

5. **Health and Wellness Customer Service Centers**

- Trusted will establish at Health and Wellness Customer Service Center in Kanawha and Marshall Counties. The centers provide a community-based brick-and-mortar resource that focuses on consumer empowerment through health literacy, nutrition education and cooking classes, prevention screening and testing, chronic disease and care coordination. Case Managers, disease managers, health educators and member services staff will be available to help members face-to-face. Social worker staff and EPSDT outreach staff will also be housed at the centers. Trusted has experienced significant return on investment by providing face to face case management and customer service.

6. **Trusted Health Plan" Wellness Warrior" Outreach Coordinators**

- Trusted will establish a "Wellness Warrior" Outreach Coordinator in each county that Trusted is approved to serve. The Wellness Warriors will be trained as community health workers. They will assist members navigate the system, assist with member services functions like changing a PCP, arranging transportation, referring to case or disease management programs and assuring that members get their preventive tests and wellness exams. The "Wellness Warriors" that are selected will have improved their health behaviors, i.e. Stopped smoking, lost weight, controlled their diabetes, etc.

2. **PROJECTED MEMBERSHIP**

Current Medicaid Managed Care Market

Medicaid Managed Care enrollment in Mountain Health Trust has increased by nearly 90 percent in 2015, due to the Medicaid expansion. Additionally, approximately 78,000 Medicaid SSI beneficiaries will be covered in July, 2016 due to the new bid.

The current managed care participants are:

Unicare (Anthem)	126,051	34.3%
Carelink (Aetna)	121,085	32.9%
Health Plan of the Upper Ohio Valley	67,492	18.4%
West Virginia Family Health (Highmark)	53,030	14.4%

3. Immediate Future

Trusted anticipates receiving 37,500 members through auto assignment or approximately 10% of the total existing Mountain Health Trust population. The addition of SSI recipients will increase the eligible population to approximately 445,000. Based on the actuarial analysis, Trusted believes this projection for membership is conservative.

Trusted anticipates 5% annual growth based on the number of new members becoming eligible for Medicaid and Trusted's public relations campaigns. Potential members will be able to select Trusted when DHHS announces that Trusted is participating with the Mountain Health Trust program. Potential members will have the opportunity opt out of their current health plan to select Trusted, and new Medicaid recipients will have the option to select Trusted or be auto assigned.

STATE OF WEST VIRGINIA
Offices of the Insurance Commissioner
Financial Conditions Division

Mailing Address:
Financial Conditions
P.O. Box 50540
Charleston, WV 25305-0540

Telephone: (304) 558-2100
Facsimile: (304) 558-1365
Email: financial.conditions@wvinsurance.gov
www.wvinsurance.gov

Location:
Financial Conditions
1124 Smith Street, Rm 102
Charleston, WV 25301

ACKNOWLEDGEMENT AND WAIVER BY CHIEF EXECUTIVE OFFICER ON BEHALF OF HEALTH MAINTENANCE ORGANIZATION APPLICANT

I [redacted], the _____ [Chief Executive Officer] of Trusted Health Plan (District of Columbia), Inc. [HMO Applicant], hereinafter referred to as the "Organization", having the authority to bind said Organization, do hereby:

(1) ACKNOWLEDGE, on behalf of the Organization, that a delinquency proceeding brought pursuant to the provisions of Article 10, Chapter 33 of the West Virginia Code of 1931, as amended [W. Va. Code §§33-10-I et seq.], or the administrative supervision provisions of article thirty-four of said chapter [W. Va. Code §§33-34-1 et seq.] constitutes the sole and exclusive method for the liquidation, rehabilitation, reorganization or conservation of a health maintenance organization licensed under the laws of this State; and

(2) WAIVE, on behalf of the Organization, any right to file or to be subject as a debtor to any bankruptcy proceedings;

(3) AFFIRM that I have read and do hereby understand the obligation imposed upon me as the chief executive officer of the Organization by the provisions of Article thirty-five of Chapter 33 of said Code [W. Va. Code §§33-35-1 et seq.] dealing with the criminal sanctions for the failure to timely report to the Insurance Commissioner an impairment of the Organization.

Dated this _____ day of _____, 20__.

Trusted Health Plan (District of Columbia), Inc.
(HMO Applicant)

BY: [redacted]
(Signature)

ITS: Chief Executive Officer
(Title)

State of District of Columbia
County of _____, to wit;

I, [redacted], a Notary Public in and for the county and state aforesaid, hereby certify that [redacted] whose name is signed to the foregoing document, bearing date the March 4, day of 20 16, for Trusted Health Plan (HMO Applicant), has this day in said county, personally appeared before me in said county and acknowledged the said writing to be the act and deed of said corporation.

Given under my hand this 4, day of March, 2016

My commission expires on 8-14-20

(SEAL)

[redacted]
Notary Public

Trusted Health Plan (District of Columbia) Inc. ("Trusted") is financially responsible for the cost of each enrollee's medical services. Trusted reinsured certain risks related to these services through PartnerRe America Insurance Company. Trusted's reinsurance coverage is as follows:

Effective Date	Insured Copayment
July 1, 2013 through June 30, 2014	$300,000 per covered person
July 1, 2014 through June 30, 2015	$300,000 per covered person
July 1, 2015 through June 30, 2016	$500,000 per covered person

The reinsurer provides coverage above these deductible amounts. The maximum reimbursement per enrollee is limited to $2 million, in the aggregate, for the contract periods beginning July 1, 2015, July 1, 2014 and July 2013. The Company's reinsurer, PartnerRe America Insurance Company is rated A+ by A.M. Best.

For the years ended December 31, 2015, 2014 and 2013, Trusted had incurred reinsurance premium expense of $520,372, $650,022 and $283,868, respectively. For the year ended December 31, 2015 the company had one claim for $32,803 that pierced the reinsurance layer, for the year ended December 31, 2014 three claims for $647,518 that pierced the reinsurance layer; and, for the year ended December 31, 2013 had no reinsured claims or recoveries.4

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PartnerRe

HMO Specific Excess Loss Reinsurance Agreement

[redacted]

PartnerRe America Insurance Company ("Company")
Wilmington, DE
NAIC# 11835

Mailing Address:
199 Fremont, 11th Floor
San Francisco, CA 94105

This HMO Specific Excess Loss Reinsurance Agreement is issued to:

Reinsured: **Trusted Health Plan**

Agreement Term: **Effective Date: July 1, 2015**

Expiration Date: July 1, 2016

(Reinsurance begins and ends at 12:01 A.M. Standard Time at the Reinsured's Principal Address as shown in the Schedule of Reinsurance.)

Agreement Number: [redacted]

In consideration of the mutual promises and covenants in this Agreement, and upon the terms and conditions set forth in this Agreement, the Parties do hereby agree as provided and specified.

In Witness whereof, the Reinsured and the Company, by their respective officers, executed and delivered this Agreement, effective from the date set out in the Schedule of Reinsurance

Trusted Health Plan

Dated: 7/31/15

By: [signature]

Title: CFO

PartnerRe America Insurance Company

Dated: 7/28/2015

By: Genevieve Laughman

Title: VP Managing Underwriter

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HMO SPECIFIC EXCESS LOSS REINSURANCE AGREEMENT

SCHEDULE OF REINSURANCE

AGREEMENT NUMBER: P0312446003

1. REINSURED: Trusted Health Plan
   Principal Address: 1100 New Jersey Avenue, Suite 840
   Washington, District of Columbia 20003

2. AGREEMENT TERM:

   a. Effective Date: July 1, 2015

   b. Expiration Date: July 1, 2016

   Both days at 12:01 a.m. local standard time at the Principal Address of the Reinsured.

3. COVERED MEMBERSHIP SERVICES AGREEMENTS:

   DCHFP (Medicaid TANF) Covered Persons

4. SPECIFIC EXCESS LOSS REINSURANCE:

   a. Specific Deductible per Covered Person: $500,000

   b. Maximum Payable per Covered Person: $2,000,000

   c. Maximum Aggregate Limit of the Company's Liability: Not Applicable

5. PREMIUM RATES:

   a. Premium Payable: $0.86 per Covered Person

   b. Due Date: First day of each month of the Agreement Term

   c. Minimum Premium: $235,000

   d. Deposit Premium: Not Applicable

6. CLAIMS BASIS:

a. Covered Expenses Incurred from July 1, 2015 to July 1, 2016.

b. Covered Expenses Paid from July 1, 2015 to January 1, 2017.

If the Agreement terminates prior to the Expiration Date, the Covered Expenses Incurred period, 6. a. above will end on the termination date and the Covered Expenses Paid period, 6. b. above, will end 3 months after the termination date of the Agreement.

All days at 12:01 a.m. local standard time at the Principal Address of the Reinsured.

7. COVERED EXPENSES – LIMITS:

a. Covered Expenses:

Hospital Inpatient Services – Acute Care Services

Skilled Nursing Facility Services at "Hospital for Sick Children - (HSCSN)" only

b. Covered Expenses – Exclude:

Hospital Inpatient Services – Sub-Acute Care Services (extended care services, skilled nursing, rehabilitation)

Sub-Acute Care Facility Services/Extended Care Facility Services/Skilled Nursing Facility Services (except as noted above)/Rehabilitation Facility Services/Hospice/Home Health Care Services

Long Term Acute Care Hospital Services

Hospital Outpatient Services

Physician Services

Ambulance Services

All organ and tissue transplant related services

HIV/AIDS drugs

Retail prescription drugs

7. COVERED EXPENSES – LIMITS (CONTINUED):

b. Covered Expenses – Exclude (continued):

NICU Babies that meet the following criteria:

1. Any child < 1,200 grams
2. 37-40 weeks< 2,000 grams
3. 36 weeks< 1,875 grams
4. 35 weeks< 1,700 grams
5. 34 weeks< 1,500 grams
6. 33 weeks< 1,325 grams

Capitated arrangements and services that are not eligible under the Membership Services Agreement

All other Medicaid type populations are excluded unless specifically noted under Item 3. of the Schedule of Reinsurance.

All state, federal, or partnership health insurance exchange membership is excluded unless specifically identified as such in Item 3. of the Schedule of Reinsurance.

c. Covered Expenses – Limits:

Hospital Inpatient Services – Acute Care Services: the lesser of the amount Paid, the contracted rate provided to the Company on March 30, 2015 and updated contracts provided May 21, 2015 or Medicaid Allowable where a contracted rate does not exist.

Skilled Nursing Facility Services at "Hospital for Sick Children- (HSCSN)" only: the lesser of the amount Paid, the contracted rate provided to the Company on March 30, 2015 and updated contracts provided May 21, 2015, Medicaid Allowable where a contracted rate does not exist or subject to a maximum stay of 45 days per Covered Person per Agreement Term.

8. COVERED EXPENSES – REIMBURSEMENT PERCENTAGE:

a. Reimbursement Percentage if the complete claim is received by April 1, 2017: 90%

b. Reimbursement Percentage if the complete claim is not received by April 1, 2017: 50%

A complete claim submission consists of the following electronic data elements:

Request for Reimbursement includes: a claim summary which includes all claims and requested amounts by claimant, an initial claim filing and any subsequent claim filings as required.

8. COVERED EXPENSES – REIMBURSEMENT PERCENTAGE (CONTINUED):

Proof of Eligibility documentation to include: a copy of the original enrollment form or claim eligibility screen print in which the following information is included: subscriber and Covered Persons' unique member ID, last name and first name, date of birth, effective date of coverage, Covered Person's policy identification (group, individual, Medicare, Exchange Individual, Exchange Small Group etc.), coverage status and Covered Person's termination date, if applicable

Proof of Loss Claim data to include: subscriber's and Covered Person's name, member ID, subscriber and Covered Persons' unique identifier, claim or other reference #, dates of service, Provider name, Provider type (in or out of network), procedure code (CPT, HCPCS, revenue code) and modifiers, units, billed amount, Paid amount, date Paid, DRG code (if applicable), diagnosis code, place of service code (standard CMS POS code), type of bill (field locator 4 on UB04), two digit discharge code (field locator 17 on UB04).

If the Agreement terminates prior to the Expiration Date, the complete claim must be received by the Company within 6 months after the date of Agreement Termination, otherwise the Reimbursement Percentage will be reduced from 90% to 50%.

All days at 12:01 a.m. local standard time at the Principal Address of the Reinsured.

9. ENDORSEMENTS:

No. One: Experience Refund

No. Two: Continuation of Coverage In the Event of Insolvency
Maximum Aggregate Continuation Limit: $250,000

ARTICLE I - DEFINITIONS

The following definitions apply to the terms used within this Agreement. In the event of conflict in the meaning of terms or the content of provisions between this Agreement and the Membership Services Agreement(s), Provider contracts or management service contracts, the definitions herein and the provisions of this Agreement will govern.

The inclusion of a definition of a type of facility, service or Provider in this Article or anywhere else in this Agreement, does not automatically mean that reinsurance is provided with respect to that facility, service or Provider herein. Only those Covered Expenses shown on the Schedule will be considered covered by the reinsurance provided herein.

ACUTE CARE SERVICES means Medically Necessary services provided to treat Covered Persons medically or surgically with an immediate and/or severe injury or illness in a Hospital.

AGREEMENT means this HMO Specific Excess Loss Reinsurance Agreement as further defined in ARTICLE IV- GENERAL PROVISIONS

AGREEMENT TERM means the period of time, stated in the Schedule, for which reinsurance coverage is extended.

AMBULANCE SERVICES means Licensed Professional Ambulance ground transportation services to the nearest appropriate facility as medically necessary for treatment of medical emergency or inter-health care facility transfer. Air ambulance transportation only as medically necessary due to inaccessibility by ground transport and/or if the use of ground transport would be detrimental to the health status of the patient. This does not include transportation for non-emergency medical services.

APPLICATION means any information provided, or any written representations made by the Reinsured during the negotiations concerning the terms of this Agreement.

APPROVED TRANSPLANT PROVIDER means a Provider that has been specifically noted on the Schedule of Reinsurance, Item 7, or is agreed to in writing by the Company during the course of the Agreement Term as "Approved" for the purposes of this Agreement.

CASE RATE means a fixed fee per procedure, DRG, or confinement for services, treatments, and/or supplies negotiated between the Reinsured and Participating Provider. Case Rate will not include contracts which revert to a day outlier, cost outlier or discounted rate for billed charges once an outlier or stop loss threshold is reached, or any amounts that exceed an outlier or stop loss threshold and are paid by the Reinsured at a discounted rate, unless specifically agreed to by the Company.

CLAIM(S) means the amount the Reinsured paid to a Provider provided that:

1. such costs are Reasonable and Customary;
2. such services are the responsibility of the Reinsured with respect to members;
3. such services are Medically Necessary; and
4. such expenses are listed as eligible for coverage by the Reinsurer at the time the service was incurred.

COVERED EXPENSES means the cost of services provided to Covered Persons under the Membership Services Agreements and listed on the Schedule, provided that:

1. such costs are Reasonable and Customary;
2. such services are the responsibility of the Reinsured with respect to Covered Persons;
3. such services are Medically Necessary; and
4. such expenses are subject to ARTICLE VIII- LIMITATIONS and the ARTICLE IX- EXCLUSIONS.

Covered Expenses will be subject to the limits shown on the Schedule.

COVERED PERSON means any individual subscriber or any individual dependent of a subscriber who is enrolled in or who subscribes to and is covered under the Membership Services Agreement shown in the Schedule during the Agreement Term.

The time at which any individual subscriber or any individual dependent of a subscriber becomes not eligible for coverage under, and per the terms of, the Membership Services Agreement, such person will not be considered a Covered Person under this Agreement.

EMERGENCY OUT-OF-AREA SERVICES means those Hospital Services or Physicians Services provided to a Covered Person and that, due to an emergency, are provided outside the Service Area of the Reinsured. An emergency exists when there is a sudden onset of illness or accidental injury that occurs outside the Service Area of the Reinsured and requires such immediate treatment that the life of the Covered Person might be jeopardized if taken to a Hospital, Physician, or surgeon within the Service Area of the Reinsured.

EXPERIMENTAL means any medical procedure, equipment, treatment, course of treatment, drugs or medicine that is determined by the Company to be:

1. investigative in nature and limited to research;
2. not proven in an objective study to have therapeutic value or benefit;
3. restricted to use at those centers capable of carrying out disciplined clinical efforts and scientific studies; or
4. medically questionable as to effectiveness.

The Company determines what is considered Experimental through studies, opinions and references to or by the American Medical Association, the Federal Drug Administration, the Department of Health and Human Services, the National Institutes of Health, the Council of Medical Specialty Societies and any other association or federal program or agency that has the authority to approve medical testing or treatment.

EXTENDED CARE FACILITY means an institution that meets all of the following criteria:

1. is primarily engaged in providing skilled nursing care to sick and injured persons as registered inpatients under 24 hours a day supervision of a Physician or professional nurse;
2. has available 24 hours a day the services of a Physician who is a staff member of a Hospital;
3. has on duty 24 hours a day a professional registered nurse (R.N.) or licensed practical nurse and has on duty at least eight hours a day a professional registered nurse (R.N.);
4. maintains a daily medical record for each patient;
5. complies with all licensing and other legal requirements;
6. is not, other than incidentally, a facility of rest, a facility for the treatment and care of alcoholics, a facility for the care of the mentally ill or person with nervous disorders, a facility for the care of senile or mentally deficient persons, or a hotel or similar institution, or otherwise a facility for custodial care.

HOME HEALTH CARE SERVICES means part-time or intermittent nursing care by or under the supervision of a registered nurse (R.N.); part-time or intermittent services or supplies rendered in the home that meet CMS's (formerly HCFA) Medicare standards and criteria provided through a federally certified and state licensed Home Health Care Agency (excluding general housekeeping services); physical, occupational and speech therapy; medical supplies; and laboratory services by or on behalf of a Hospital.

Home Health Care shall not include prescription pharmaceuticals unless specified in the Schedule.

HOME HEALTH CARE AGENCY means an agency or organization that:

1. is primarily engaged in and is federally qualified or state certified as a home health agency and duly licensed, if such licensing is required, by the appropriate licensing authority, to provide nursing and other therapeutic services;
2. has policies that are established by a professional group associated with such agency or organization, including at least one Physician and at least one registered Nurse (R.N.);
3. provides for full-time supervision of such services by a Physician or by a registered Nurse (R.N.); and
4. maintains a complete medical record on each patient; and has its own administrator.

HOSPITAL means an institution that:

1. is licensed and operated as a Hospital under the laws or the jurisdiction where it is located;
2. provides, as its primary functions, on an inpatient basis;
   a) facilities for medical and surgical diagnosis and therapy;
   b) treatment and care for the sick and injured; and
3. is under the direction of a staff of Physicians;
4. provides 24-hour-a-day nursing services by registered nurses (R.N.s); and
5. has facilities on the premises for major surgery.

An institution that lacks surgical facilities may still be considered a Hospital if it has a written contractual arrangement with an accredited Hospital for the performance of major surgery.

HOSPITAL INPATIENT SERVICES means the Medically Necessary services provided to a Covered Person who is a registered bed patient in a Hospital, for which there is a room and board charge. These services may be provided on an Acute Care or Sub-Acute Care basis.

HOSPITAL OUTPATIENT SERVICES means the Medically Necessary services incurred at an outpatient Hospital, dialysis center, ambulatory surgical facility or other freestanding facility by a Covered Person.

INCURRED means an expense is incurred on the date on which a service is performed or provided.

INSOLVENCY DATE means the date on which the Reinsured is found and declared Insolvent.

INSOLVENT means that a final determination is made by a court of competent jurisdiction that the Reinsured is Insolvent, and all operations of the Reinsured cease.

LONG TERM ACUTE CARE HOSPITAL may be a separate institution or within a Hospital. A Long Term Acute Care Hospital as a separate institution must meet the following requirements:

1. licensed and operated as an acute care or specialty Hospital under the laws of the jurisdiction where it is located; and
2. certificated by Medicare as a Long Term Care Hospital; and
3. under the direction of a staff of Physicians; and
4. provide 24-hour-a-day nursing services by registered nurses (R.N.); and
5. maintain at least a 25-day average length of stay (ALOS); and

Long Term Acute Care Hospitals within Hospitals must meet the following requirements:

1. maintain at least a 25-day ALOS; and
2. focus on patients with specialized long-term needs in Hospital setting; and
3. utilize interdisciplinary teams; and
4. pass a six month qualification period; and
5. less than 25% of patients come from host Hospital; and
6. lease space from the host Hospital; and
7. purchase ancillary services from the host Hospital; and
8. maintain separate acute care license, Medicare certification, JCAHO accreditation; and
9. maintain a governing body, administrator, medical director, and medical staff separate from host Hospital.

Long Term Acute Care Hospital will not include an institution used as a facility for:

1. rest; or
2. custodial care; or
3. nursing; or
4. care for the aged; or
5. care for alcoholics or drug addicts.

MAXIMUM AGGREGATE LIMIT OF COMPANY'S LIABILITY means the maximum amount payable to the Reinsured under this Agreement identified in the Schedule as Item 4c. with respect to any Agreement Term, regardless of the number of claims, or the total amount by which all claims exceed the Specific Deductible and the Aggregated Specific Deductible.

MAXIMUM PAYABLE PER COVERED PERSON means the maximum amount payable to the Reinsured per Agreement Term under Item 4b. of the Schedule with respect to any one Covered Person.

MEDICALLY NECESSARY means that a treatment, service, supply or medicine:

1. is appropriate and essential for the diagnosis or treatment of the member's symptoms;
2. is within the scope, duration or intensity of that level of care that is needed to provide safe, adequate and appropriate diagnosis or treatment;
3. is in accordance with generally accepted current professional medical practice, based on consultation with an appropriate service Provider; or
4. involves only the use of any drugs or substances formally approved by the United States Food and Drug Administration.

A treatment, service, supply or medicine will not be considered Medically Necessary if:
1. It is part of a treatment plan that is considered to be Experimental or for research purposes; or
2. It is provided primarily as a convenience to the patient, the patient's family or the provider of care.

The fact that a Physician may prescribe, order, recommend or approve a treatment, service, supply or medicine does not, of itself, make it Medically Necessary.

MEMBERSHIP SERVICES AGREEMENT(S) means those contractual agreements under which the Reinsured provides services to Covered Persons. Applicable Membership Services Agreement(s), as specified in Item 3 of the Schedule and on file with the Company, are made a part of this Agreement.

NON-APPROVED TRANSPLANT PROVIDER means any Provider that has not been specifically noted on the Schedule of Reinsurance, Item 7, or has not been agreed to in writing by the Company during the course of the Agreement Term as "Approved" for the purposes of this Agreement.

PAID means the date on which the Reinsured tenders a draft or check in payment of Covered Expenses incurred with respect to a Covered Person.

PARTICIPATING PROVIDER means a Provider who has entered a written agreement with the Reinsured to provide health care services to Covered Persons in exchange for predetermined compensation, and with an expectation of receiving payment, directly or indirectly, from the Reinsured. It also includes any Provider in which the Reinsured has an ownership interest, or that has an ownership interest in the Reinsured.

PER DIEM HOSPITAL means a Hospital that has agreed to limit the amount charged for inpatient services to a fixed dollar amount per day.

PHYSICIAN means a practitioner of the healing arts who is duly licensed and who is treating within the scope and limitation of that license the injury or illness for which a claim is made.

PHYSICIAN SERVICES means those services provided to a Covered Person:
1. that are generally and customarily provided by a licensed Physician and/or surgeon;
2. for which a Physician generally and customarily makes a charge; and
3. that are prescribed, directed, or authorized by or on behalf of the Reinsured in accordance with the terms of the applicable Membership Services Agreement.

PROVIDER means any Hospital, Physician or other person or facility that is licensed or otherwise authorized to provide health care services.

REASONABLE AND CUSTOMARY means the usual charge made by a group, entity or person who renders or furnishes covered services, treatments or supplies; provided the charge is not in excess of the general level of charges made by others who render or furnish the same or similar services, treatment or supplies to persons:
1. who reside in the same geographical area; and
2. whose illness or injury is comparable in nature and severity.

REFERRAL SERVICES means those Hospital Services or Physician Services provided to a Covered Person for treatment, aid, information or decision that, due to the specialized nature of the service or facility required, cannot be provided by a Provider contracting with the Reinsured. These services must be specifically authorized by the Reinsured.

REHABILITATION FACILITY means an institution that provides the education and therapy necessary to overcome the effects of an illness or handicap. The services include physical therapy, speech pathology, occupational therapy and other specialized services ordered by a Physician.

REIMBURSEMENT PERCENTAGE means the percentage of Covered Expenses to be reimbursed by the Company after the application of Covered Expense limits and Specific Deductible and Aggregated Specific Deductible as outlined in ARTICLE II- REINSURANCE PROVISION. This percentage appears on the Schedule.

SCHEDULE means the Schedule of Reinsurance included in this Agreement.

SERVICE AREA means the geographic area within which health care services are provided to Covered Persons on a regular basis by Participating Providers as of the effective date of this Agreement.

SKILLED NURSING FACILITY has the same meaning as Extended Care Facility.

SPECIFIC DEDUCTIBLE means the amount of Covered Expenses that are the responsibility of the Reinsured with respect to each Covered Person and during each Agreement Term, before any reimbursement becomes due under this Agreement.

SUB-ACUTE CARE SERVICES means Medically Necessary services, provided to treat Covered Persons medically, which are rehabilitative, restorative in nature, specialized and/or post surgical care associated with the transition between a Hospital and home.

TERRORISM OR TERRORIST ACTS means an activity that 1) involves any violent act or any act dangerous to human life, tangible or intangible property, and that threatens or causes damage to property or injury to persons; and 2) appears to be in any way intended to: a) intimidate or coerce a civilian population; or b) disrupt any segment of a nation's economy; or c) influence the policy of a government by intimidation or coercion; or d) affect the conduct of a government by mass destruction, assassination, kidnapping or hostage-taking; or e) respond to governmental action or policy. It includes the use of any nuclear weapon or device or the emission, discharge, dispersal, release or escape of any solid liquid or gaseous chemical or biological agent. It shall also include any incident declared to be an act of terrorism by an official, department or agency that has been specifically authorized by federal statute to make such a determination.

TRANSITIONAL CARE FACILITY means the services provided to a Covered Person at a Transitional Care Facility for an inpatient confinement occurring immediately after discharge or transfer from a Hospital for Medically Necessary continuous inpatient care at a free standing or distinct wing of a Hospital for Sub-Acute, Care Services, skilled nursing, rehabilitative, or extended care and that includes a specified treatment outcome, and is not custodial care.

ARTICLE II - REINSURANCE PROVISION

Subject to the terms, conditions, definitions, exclusions and limitations set forth herein, the Company hereby agrees to reinsure a portion of the Reinsured's Covered Expenses under the Membership Services Agreement(s) as shown in the Schedule.

When Covered Expenses, with respect to any Covered Person, exceed the Specific Deductible as specified in the Schedule during the Agreement Term, Covered Expenses will be reimbursed by the Company in an amount equal to Covered Expenses less the Specific Deductible and then multiplied by the Reimbursement Percentage, provided that:

1. Covered Expenses are incurred and Paid during the periods specified in the Schedule;
2. Covered Expenses are subject to the Covered Expenses Limits specified in the Schedule.

The amount reimbursable by the Company with respect to any one Covered Person is limited to the Maximum Payable Per Covered Person as specified in the Schedule. The overall amount reimbursable by the Company during an Agreement Term with respect to all Covered Persons is limited to the Maximum Aggregate Limit Of Company's Liability as specified in the Schedule.

Any reimbursement hereunder is subject to payment of reinsurance premiums when due, receipt by the Company of adequate proof of loss, as determined by the Company, and payment of Covered Expenses by the Reinsured and compliance by the Reinsured with all other terms and conditions of this Agreement.

The Company is not a direct insurer with respect to this Agreement. The Reinsured is solely responsible for providing all health care services to its members and for all liability and payment of all expenses. The Company shall not have any responsibility or obligation to provide any direct service or payment to any member through the plan or any person or facility, there being no relationship, contractual or otherwise, between the Company and any member of the Reinsured or party contracting with the Reinsured.

ARTICLE III - PREMIUMS

PREMIUM AMOUNT. The premium rates and due dates for the reinsurance coverage provided herein are as stated in the Schedule.

PAYMENT OF PREMIUMS. For coverage under this Agreement to remain in effect, each premium must be paid on or before its due date. The Reinsured is responsible for paying premiums as they become due, and the premium payments must be accompanied by a statement providing the number of Covered Persons for the corresponding period.

GRACE PERIOD. A Grace Period of thirty-one (31) days from the premium due date will be allowed for the payment of each premium due after the first. If any premium is not paid before the end of the Grace Period, this reinsurance will automatically terminate at the end of the period for which premiums have been paid. In this event, the Company will not be liable for any claims incurred during the period for which premium has not been paid.

PREMIUM CHANGE. The Company has the right to change the premium as a result of:

1. a change in the coverage provided herein;
2. a change in the majority ownership of the Reinsured;
3. a change in existing management service contracts, including Provider contracts, or Membership Services Agreement(s) that materially affects the Company's liability under this Agreement or whenever the number of Covered Persons decreases by 25% or more from the number of Covered Persons used to calculate the premium rates in effect for the Agreement, retroactive to the month in which the decrease occurs.; or
4. a change in statute or regulation, or the enactment of a new statute or regulation that increases the liability of the Company under this Agreement.

The Reinsured must give the Company at least thirty-one (31) days prior notice with respect to (2) and (3) above. The Company may, at its option, by giving the Reinsured thirty-one (31) days written notice:

1. exclude such change from Reinsurance coverage hereunder,
2. charge an additional premium, or
3. terminate this Agreement.

The Reinsured must notify the Company of any changes with respect to (4) above, immediately upon receipt of notice thereof.

TAXES, ASSESSMENTS AND SURCHARGES. The Reinsured is liable for all taxes, assessments and/or surcharges on premium ceded to the Company under this Agreement. If the Company is obligated to pay any taxes, assessments and/or surcharges on such premium, the Reinsured shall reimburse the Company or the Company shall have the right to offset the amount from any payments to the Reinsured.

ARTICLE IV - GENERAL PROVISIONS

Subject to the provisions of ARTICLE VII- ARBITRATION, this Agreement shall be governed by and interpreted in accordance with the laws of the State of New York.

The Reinsured shall give the Company at least thirty-one (31) days advance written notice in the event that the Reinsured shall:

1. acquire the assets and/or liabilities of any other company, corporation or foundation; or
2. be acquired, come under the control or be merged with any other company, corporation or foundation; or
3. have a change in existing Membership Service Agreements or Provider agreements, that materially affect the Company's liability under this Agreement; or
4. experience a change in majority ownership.

With respect to items 1 through 4 listed above, the Company retains the right to charge an additional premium to the Reinsured, amend the terms of, or terminate this Agreement by giving the Reinsured 31 days written notice.

This Agreement including the claims disclosure statement executed on behalf of the Company (attached hereto as Exhibit A) and any Endorsement(s) or Amendments shall constitute the entire agreement between the parties with respect to the business reinsured hereunder. There are no understandings between the parties other than expressed in this Agreement and any change or modification of this Agreement shall be null and void unless made by Amendment to the Agreement and signed by both Parties.

This Agreement shall not be assignable without the express written consent of the Company.

If any payment is made by the Company under this Agreement, the Company shall be subrogated to all the Reinsured's right to recover such payment against any Covered Person or entity, and the Reinsured shall execute and deliver instruments and do whatever is necessary to preserve and secure such rights. The Reinsured hereby agrees to enforce its right of recovery relating to any expense, if it is in the Reinsured's or Company's economic best interest, and to prosecute all claims arising out of such rights. Any recovery made by the Reinsured shall be reimbursed to the Company to the extent of payment made by the Company under this Agreement.

The Company shall have, and may exercise at any time and from time to time, the right to offset any balance or balances, whether on account of premiums, losses or otherwise, due from the Reinsured under the terms of this Agreement.

Notice to any agent or knowledge possessed by any agent or by any other person shall not effect a waiver or a change in any part of this Agreement or stop the Company from asserting any right under the terms of this Agreement.

No action shall lie against the Company by the Reinsured unless, as a preceding condition, the Reinsured shall have fully complied with all of the terms of this Agreement. Nothing contained in this Agreement shall give any person or entity other than the Reinsured any right, benefit or duty hereunder, nor shall any person or entity except the Reinsured maintain an action hereunder.

Clerical error shall not place in force coverage not provided, void any valid coverage or extend coverage that is terminated. If a clerical error is discovered, an equitable adjustment in premium will be made.

If any provision of this Agreement shall be rendered illegal or unenforceable by the laws, regulations or public policy of any jurisdiction, the parties hereto agree to renegotiate in good faith the terms and conditions of such provision as it applies to such jurisdiction, and to renegotiate in good faith such other terms and provisions of this Agreement, if any, that are affected by the illegality or unenforceability of such provision as it applies to such jurisdiction.

ARTICLE V - REPORTS, RECORDS AND AUDITS

The Reinsured shall submit a monthly report to the Company, in a form mutually acceptable to both parties that provides information regarding Covered Persons who have incurred Covered Expenses during the Agreement Term exceeding fifty percent (50%) of the Specific Deductible shown in the Schedule.

The Reinsured shall keep a record of the monthly enrollment of Covered Persons by Membership Services Agreements and the services received by each Covered Person while covered under this Agreement. Such record shall be kept during the time this Agreement is in effect and for a five (5) year period after its termination.

The Reinsured shall make available to the Company any books and records pertaining to matters covered under, or relevant to, this Agreement for inspection and audit in a reasonable time during the period this Agreement is in effect and for a five (5) year period after its termination.

All information disclosed to the Company by the Reinsured or to the Reinsured by the Company, either in the course of conducting negotiations or as the result of complying with the terms and conditions of this Agreement, shall be considered to be privileged information by both parties. The submission of this Agreement to any Department of Insurance or any governmental agency, whether local, state or federal, shall not be considered a violation of this provision.

Without limiting the generality or effect of the foregoing, Company and Reinsured agree that each will: (i) not disclose nonpublic personal information to any other person other than as permitted by this Agreement or by Law; (ii) not use any nonpublic personal information for any purpose other than the implementation and fulfillment of this Agreement or as permitted by Law; (iii) require its affiliates, sublicensees, and subcontractors to comply with the same treatment and use of nonpublic personal information as set forth in clauses (i) and (ii) above; and (iv) maintain the security of nonpublic personal information in accordance with the applicable laws and regulations.

As requested by the Company, the Reinsured shall provide annual and quarterly financial statements. If the Reinsured fails to provide the Company with financial statements as requested, the Company shall, at its option, have the right to terminate this Agreement by giving written notice by registered mail that shall set forth the date of such termination.

ARTICLE VI - NOTICE OF CLAIM AND REIMBURSEMENT

The Reinsured shall give the Company written notice of any loss or potential loss that may result in reimbursement under this Agreement. Such notice shall be provided within sixty (60) days from the date the Reinsured has reason to believe such a loss has been or is likely to be incurred.

The Reinsured shall report a claim by submitting the reimbursement request claim form to the Company, together with proof of eligibility, copies of the various bills, listings of itemized expenses, other documentation as reasonably requested by the Company and proofs of payment. A claim will not be deemed to have been received by or reported to the Company until such information is received by the Company. Further, the monthly report required by ARTICLE V- REPORTS, RECORDS AND AUDITS shall not constitute receipt or report of a claim by the Company.

Failure to submit a claim in a timely manner will result in a reduction to the Reimbursement Percentage stated in the Schedule. In no event, however, shall the Company be liable to the Reinsured for any losses reinsured hereunder if such losses are not reported and submitted to the Company within 30 months from the Effective Date of the Agreement Term.

In the event that Covered Expenses exceed, or are expected to exceed, the Specific Deductible or Aggregated Specific Deductible, the Company shall have the right to appoint an administrator to represent its interest in the ongoing administration of the Covered Expense. Any additional cost incurred for the administration of the Covered Expense shall be borne by the Company. The Reinsured shall fully cooperate with the Company or its representative in the ongoing administration of the Covered Expense(s).

Within a timely manner after the receipt of a Claim with complete documentation as detailed above, the Company shall provide its written adjudication and any applicable reimbursements to the Reinsured or as soon as reasonably possible.

If the Reinsured shall knowingly offer any false claim(s) as regards amount or otherwise, this Agreement shall terminate on the date such false claim(s) is offered, and the Reinsured shall reimburse the Company for any amounts paid under such false claim(s), and any claims paid for incurred Covered Expenses occurring on or after the termination date, together with interest and attorney's fees. Interest will accrue at a rate determined by the 26-week United States Treasury bill rate for the first business day of the calendar month in which the false claim(s) is offered, as published in the Wall Street Journal, plus 1% per annum, to be calculated weekly.

ARTICLE VII - ARBITRATION

As a condition precedent to any right of action hereunder, any dispute arising out of the interpretation, performance or breach of this Agreement, including the formation or validity thereof, shall be submitted for decision to a panel of three arbitrators. Notice requesting arbitration will be in writing and sent certified or registered mail, return receipt requested.

One arbitrator shall be chosen by each party, and the two arbitrators shall, before instituting the hearing, choose an impartial third arbitrator who shall preside at the hearing. If either party fails to appoint its arbitrator within thirty (30) days after being requested to do so by the other party, the latter, after ten (10) days notice by certified or registered mail of its intention to do so, may appoint the second arbitrator.

If the two arbitrators are unable to agree upon the third arbitrator within thirty (30) days of their appointment, the arbitrators may, upon mutual agreement, implement the ARIAS-U.S. Umpire Appointment Procedure to select the third arbitrator. Alternatively, each arbitrator shall nominate three individuals and the other shall then decline two of the nominations. The third arbitrator shall then be chosen from the remaining two nominations by drawing lots.

All arbitrators shall be disinterested active or former officers of insurance or reinsurance companies or Underwriters at Lloyd's, London.

Within thirty (30) days after notice of appointment of all arbitrators, the panel shall meet and determine timely periods for briefs, discovery procedures and schedules for hearings.

The panel shall be relieved of all judicial formality and shall not be bound by the strict rules of procedure and evidence. Unless the panel agrees otherwise, arbitration shall take place in New York, New York, but the venue may be changed when deemed by the panel to be in the best interest of the arbitration proceeding. Insofar as the arbitration panel looks to substantive law, it shall consider the law of the State of New York. The decision of any two arbitrators when rendered in writing shall be final and binding. The panel is empowered to grant interim relief as it may deem appropriate.

The panel shall interpret this Agreement as an honorable engagement rather than as merely a legal obligation and shall make its decision considering the custom and practice of the applicable insurance and reinsurance business within forty-five (45) days following the termination of the hearings. Judgment upon the award may be entered in any court having jurisdiction thereof.

Each party shall bear the expense of its own arbitrator and shall jointly and equally bear with the other party the cost of the third arbitrator. The remaining costs of the arbitration shall be allocated by the panel. The panel may, at its discretion, award such further costs and expenses as it considers appropriate, including but not limited to attorney's fees, to the extent permitted by law, and interest.

If more than one reinsurer is involved in the same dispute, all reinsurers involved in the dispute shall constitute and act as one party for purposes of this clause, and communications shall be made by the Company to each of the reinsurers constituting the one party, provided however, that nothing herein shall impair the rights of such reinsurers to assert several rather than joint defenses or claims, nor be construed as changing the liability of the reinsurers under the terms of this Agreement from several to joint. If more than one reinsurer is involved in the Arbitration as respondent, the time for appointing the arbitrators will be extended to six (6) weeks.

The provisions of this Article shall survive the termination of this Agreement.

ARTICLE VIII - LIMITATIONS

This Agreement is subject to the following limitations:

1. The amount of reimbursement under this Agreement shall not exceed the maximum amounts shown on the Schedule;
2. In the event that a Covered Expense can be calculated in more than one way under the terms and provisions of this Agreement, only the amount calculated to generate the lesser amount of Covered Expense will be considered covered hereunder;
3. This Agreement is a legal contract between the Company and Reinsured. Nothing contained herein reflects any right, obligation or contractual relationship between the Company and any Provider or person covered under Membership Services Agreement(s) or other entity contracting with, or in relation to, the Reinsured.
4. The Reinsured shall not hold the Company liable and instead shall indemnify and save the Company harmless from any amount paid by the Reinsured in excess of its contracted rates as provided in the applicable Membership Services Agreement as a result of the Reinsured's failure to pay a provider within the time frame established in the Membership Services Agreement or as a result of the Reinsured's failure to meet any other obligation under the Membership Services Agreements.

ARTICLE IX - EXCLUSIONS

This Agreement shall not cover any cost or charge that:

1. Is noted under Item 7 COVERED EXPENSES - LIMITS (b) Covered Expenses – Exclude in the Schedule of Reinsurance;
2. is paid or liable to be paid by the Reinsured with respect to professional or general liability claims against the Reinsured; or any penalties, damages, court costs or attorney fees imposed upon the Reinsured or awarded to any person or entity for whatever reason;
3. Includes administration costs or salaries paid to employees of the Reinsured;
4. Is in excess of Reasonable and Customary, or that are in excess of or not provided for in Membership Services Agreements, or that are in excess of any limitation noted in the Schedule, or that have not been Paid by the Reinsured;
5. Trade or economic sanctions or regulations that prohibit the Company from providing reinsurance, including, but not limited to, the payment of Claims.
6. is recoverable by the Reinsured from any other source including, but not limited to, coordination of benefits provisions, any right of subrogation and the Health Care Finance Administration, or is reimbursed for any reason by any person or entity;
7. reflects a reduction in charges to the Reinsured through negotiated agreements with Providers;
8. results from the commission of a crime, illegal act or noncompliance with any federal or state statue or regulation unless covered in the Covered Membership Services Agreement;

9. is covered under federal, state or local government social welfare program or services, for which in the absence of any Membership Services Agreements or insurance, no charge would be made to the Covered Person;
10. results from war or acts of war, civil war, rebellion, insurrection, military or usurped power or martial law or confiscation by order of any government or public authority;
11. is an expense for an illness or injury for which the Covered Person is eligible for benefits from, or receives benefits from, a workers compensation, occupational disease, or similar government law;
12. results from any treatment, service, supply, or medicine that is not Medically Necessary;
13. is assumed by the Reinsured in excess of the liability under the Membership Services Agreements or that is assumed by reason of any contract or agreement other than the Membership Services Agreements;
14. results from any procedure or treatment to change physical characteristics to those of the opposite sex; and any other treatment or studies related to sex change;
15. is the result of an injury or illness that is a result of a nuclear or radioactive accident;
16. is excluded in or not covered by the Membership Services Agreements;
17. results from for services done for cosmetic purposes, unless:
    a. performed to correct functional disorders or congenital anomalies; or
    b. due to accidental injury occurring while the Individual is a Covered Person;
18. is incurred for Experimental procedures as defined, or for research or studies or for any services or supplies not considered legal in the United States of America.

ARTICLE X - TERMINATION

This Agreement shall be effective for the Agreement Term shown in the Schedule, at the end of which it shall terminate, unless terminated sooner as otherwise provided herein.

This Agreement shall also terminate:
1. the date premium is not paid when due.
2. the Insolvency Date as defined herein;
3. in accordance with, and as provided for in ARTICLE IV- GENERAL PROVISIONS, ARTICLE V- REPORTS, RECORDS AND AUDITS, and ARTICLE VI- NOTICE OF CLAIM AND REIMBURSEMENT.

Except as otherwise specified in the Agreement, termination of this Agreement shall not reduce the rights or liabilities of either the Reinsured or the Company arising during any period when this Agreement was in force, provided that nothing herein shall be construed to extend the Company's liability for reimbursement under this Agreement for any expenses incurred by the Reinsured after the date of termination except as may be provided by endorsement.

ARTICLE XI - CARRYOVER PROVISION

Any Covered Expenses incurred by the Reinsured for a Covered Person during the last thirty-one (31) days of the prior Agreement Term, that did not result in a claim only because the Specific Deductible was not met in full with respect to that Covered Person, shall be applied toward the Specific Deductible in this Agreement Term.

ARTICLE XII - INSOLVENCY

In the event of the insolvency of the Reinsured, this Agreement shall be payable directly to the Reinsured or to its liquidator, receiver, conservator or statutory successor on the basis of the liability of the Reinsured without diminution because of the insolvency of the Reinsured.

It is agreed, however, that the liquidator, receiver, conservator or statutory successor of the Reinsured shall give written notice to the Company of the pendency of a claim against the Reinsured indicating the Covered Expenses reinsured which claim would involve a possible liability on the part of the Company within a reasonable time after such claim is filed in the conservation or liquidation proceeding or in the receivership, and that during the pendency of such claim, the Company may investigate such claim and interpose, at its own expense, in the proceeding where such claim is to be adjudicated, any defense of defenses that it may deem available to the Reinsured or its liquidator, receiver, conservator or statutory successor. The expense thus incurred by the Company shall be chargeable, subject to the approval of the Court, against the Reinsured as part of the expense of conservation or liquidation to the extent of a pro rata share of the benefit which may accrue to the Reinsured solely as a result of the defense undertaken by the Company.

ARTICLE XIII - WARRANTY AND REPRESENTATIONS

The Reinsured warrants and represents that the information provided during the underwriting and claims disclosure process and on the claims disclosure statement attached hereto and made a part of this Agreement is, to the best of its knowledge and belief, complete and accurate.

Any omission, misrepresentation, concealment or fraud relating, directly or indirectly, to:

1. the information supplied during the underwriting and claims disclosure process and on the claims disclosure statement with respect to this Agreement;
2. any statement, warranty or declaration made by the Reinsured or its representatives whether in writing or otherwise, to the Company; or
3. the making of a claim hereunder,

shall render this Agreement null and void at the sole discretion of the Company, and the Reinsured agrees to reimburse the Company for all claims paid by the Company and for any other liability the Company incurred or incurs as a result of such.

EXHIBIT A

CLAIMS DISCLOSURE STATEMENT

PartnerRe

DISCLOSURE STATEMENT

[redacted]

Reinsured: Trusted Health Plan

Effective Date: July 1, 2015

Please perform a diligent review for potential Serious Claim(s) by consulting with your claim administration, utilization review and case management units, internally or externally if the function is delegated, to review information including, but not limited to, pre-certification information, discharge and/or utilization review data, case management records, hospital inpatient logs and transplant waiting list(s).

Serious Claim(s) means a claim on any potential Covered Person insured, Paid, pended or expected to be incurred that may reasonably be assumed will exceed the specific Deductible based on their diagnosis/prognosis, transplant status or use of high cost specialty drugs or factor products/blood derivatives.

Disclosure request the Company's receipt and acceptance of the following: member name, date of birth, admission date, estimated discharge date, diagnosis, prognosis and paid/incurred claims to date. For specialty drugs, blood factor products/blood derivatives, platelet infusion if used prophylactically or as needed and provide drug name, dosage, frequency/cost per treatment, site of administration, hospital admissions and any planned surgeries.

Reinsured Attestation:

Based upon the review of claim information, please confirm the following statements:

☒ Yes, I have Serious Claim(s) to Disclose. Please refer to claims information submitted to PartnerRe on 7-15-15.

☐ No, I have no Serious Claim(s) to Disclose.

Serious Claim(s) known by the Reinsured either internally or from a delegated authority as of the date the Binder is signed, will be excluded from coverage unless disclosed to and accepted by the Company. The Company retains the right to exclude or reject terms on Covered Persons regarding this disclosure.

Disclosure should include current information for Covered Persons who may have been disclosed during underwriting who meet the definition of Serious Claim at the time of binding.

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I hereby represent and warrant that the Disclosure Statement and the information provided is complete and accurate to the best of my knowledge and belief and that nothing has been intentionally omitted.

[redacted]

Date 7.20.15

[redacted]

Title CSR

Accepted by Partnerre America Insurance Company:

☒ Yes

or

☐ Yes, the following Special Conditions of Coverage will apply:

Special Conditions of Coverage:

[redacted]

Date 7/20/2015

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PartnerRe

Experience Refund Endorsement

[redacted]

PartnerRe America Insurance Company
Wilmington, DE

Mailing Address:
199 Fremont, 11th Floor
San Francisco, CA 94105

Endorsement No.: One

Effective Date: July 1, 2015

Reinsured: Trusted Health Plan

Attached to and forming a part of Agreement No.: P0312446003

It is hereby understood and agreed that the following changes are made and incorporated into the Agreement:

The Company may refund to the Reinsured a portion of the net profit from the Agreement Term beginning July 1, 2015 and ending July 1, 2016 if the following conditions are satisfied:

1. The gross premium due and Paid for the Agreement Term is not less than $500,000, and
2. The Company renews the Agreement for the subsequent Agreement Term, and
3. The results of the refund calculation are a positive balance. If the refund calculation results in a negative balance, no refund will be Paid.

The amount of the refund will be 35% of the result of the following calculation:

1. 60% of gross premium due and Paid by the Reinsured for the Agreement Term, minus
2. 100% of the Company's Liability for the Agreement Term, minus
3. Any deficit carried forward from the previous Agreement Term.

For purposes of this Endorsement only, Company's Liability means the total amount reimbursed by the Company under this Agreement for the Agreement Term shown above. It includes any loss that was reimbursed under this Agreement, audit fees, organ and tissue transplant access fees, eligible claim expenses and loss reserves established by the Company for the Agreement Term. The Company has the sole discretion in determining the amount of the loss reserves.

The calculation of the Experience Refund will be completed on the later of twelve (12) months after the end of the Agreement Term or when the Company's Liability for the Agreement Term is finally determined and the Company and Reinsured have agreed to settle and commute their interests and liabilities under this Agreement.

All other terms, conditions and limitations of the Agreement apply to this Endorsement.

In the event of a conflict between the terms, conditions and limitations of this Endorsement and the Agreement, this Endorsement will control.

This Endorsement is made part of the Agreement to which it is attached.

Issue Date 07/28/2015

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PartnerRe

Continuation of Coverage in the Event of Plan Insolvency Endorsement

[redacted]

PartnerRe America Insurance Company
Wilmington, DE

Mailing Address:
199 Fremont, 11th Floor
San Francisco, CA 94105

Endorsement No.: Two

Effective Date: July 1, 2015

Reinsured: Trusted Health Plan

Attached to and forming a part of Agreement No.: P0312446003

The liability of the Company under this Agreement shall terminate on the Insolvency Date, as defined in this Agreement; however, the provisions of this Endorsement will continue to be operative.

In the event that the Reinsured shall become insolvent while the Agreement is in force, the Reinsured or its legal representative shall notify all applicable Covered Persons of this provision and the following shall apply:

1. The Company will continue to provide the benefits covered under the applicable Membership Services Agreement with respect to each Covered Person who is confined in a Hospital on the Insolvency Date for expenses incurred and payable by such Covered Person on or after such date until the earlier of:

   a. the Covered Person's discharge from the Hospital; or

   b. the date the Covered Person becomes eligible for health insurance coverage or benefits under another group or blanket policy or plan or any federal, state or local governmental plan or program. The Company shall pursue any coordination of benefits, subrogation or any other right of recovery that may be available to the Company as a result of the Covered Persons being covered under two or more health care policies or plans.

2. The Company will continue the benefits for any other Covered Person with respect to expenses incurred for medical services or treatment by Providers received after the Insolvency Date until the end of the period for which applicable premium was received by the Reinsured for that Covered Person, prior to the Insolvency Date, but in no event to extend beyond the end of the calendar month in which the Insolvency Date occurs as long as such expenses are payable for such Covered Person.

Issue Date 07/28/2015

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3. Paragraphs 1 and 2 herein create a liability of the Company for payment of benefits that should have been paid or provided by the Reinsured for claims incurred with respect to Covered Persons after the Insolvency Date. All premiums paid to the Reinsured that are applicable to the period on and after the Insolvency Date shall belong to the Company and reimbursement hereunder shall be pursued by the Company as an unsecured creditor.

4. As a condition to this Endorsement, the Reinsured agrees that it has furnished to the Company its most recent audited and un-audited financial statements. As a condition to the continuation of the provisions of this Endorsement, the Reinsured agrees to furnish the Company access to un-audited financial statements or the state filed report pertaining to any quarter within the term of this agreement within sixty (60) days of Reinsured's receipt of Company's request for such information.

5. In no event shall the Company's liability under this Endorsement be greater than that which the Reinsured would have been obligated to provide under the Membership Services Agreements between the Reinsured and its Covered Persons.

MAXIMUM AGGREGATE CONTINUATION LIMIT:

In the event the Reinsured shall become Insolvent while this Agreement is in force, the maximum amount payable by the Company under this Endorsement is the Maximum Aggregate Continuation Limit pursuant to the Continuation of Coverage in Event of Insolvency Provision is shown on the Schedule.

All other terms, conditions and limitations of the Agreement apply to this Endorsement.

In the event of a conflict between the terms, conditions and limitations of this Endorsement and the Agreement, this Endorsement will control.

This Endorsement is made part of the Agreement to which it is attached.

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PartnerRe

[redacted]

PARTNERRE AMERICA INSURANCE COMPANY

HIPAA NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Understanding Your Protected Health Information

This notice tells you about the ways in which PartnerRe America Insurance Company may collect, use, and disclose your protected health information, and your rights concerning your protected health information. "Protected health information" is information about you, including demographic information, that can reasonably be used to identify you and that relates to your past, present, or future physical or mental health or condition, the provision of the health care to you, or the payment for that care.

Your Health Information Rights

Inspect and Obtain Copies. You have the right to inspect or obtain copies of your protected health information records, with some limited exceptions. Usually the records include enrollment, billing, claims payment, or case/medical management records. Your request to inspect and/or obtain a copy of your protected health information record must be made in writing. We may charge a fee for the costs of producing, copying and mailing your requested information, but we will tell you the cost in advance.

Amendment. If you feel that protected health information maintained by us is incorrect or incomplete, you may request that we amend the information. Your request must be made in writing and must include the reason you are seeking a change. We may deny your request if, for example, you ask us to amend information that was not created by us, or if you ask to amend a record that is already accurate and complete. If we deny your request to amend your protected health information, we will notify you in writing. You have the right to submit to us a written statement of disagreement with our decision and we have the right to disagree with that statement.

Accounting of Disclosures. You have the right to request an accounting of disclosures we have made of your protected health information. The list will not include our disclosures related to your treatment, to payment, to health care operations, or disclosures made to you or with your authorization. The list may also exclude certain other disclosures, such as for national security purposes. Your request for an accounting disclosure must be made in writing and must state a time for which you want an accounting. This time period may not be longer than six years and may not include dates before April 14, 2004. Your request should indicate in what form you want to receive the list (for example, on paper or electronically). The first accounting that you request within a 12-month period will be free. For additional lists within the same time period, we may charge for providing the account but we will tell you the cost in advance.

Request a Restriction. You have the right to request that we restrict or limit how we use or disclose your protected health information for treatment, payment or health care operations. We may not agree to your request. If we agree, we will comply with your request unless the information is needed for an emergency. Your request for a restriction must be made in writing. In your request, you must tell us what information you want to limit; whether you want to limit how we use or disclose your information, or both; and to whom you want the restrictions to apply.

Confidential Communications. You have the right to request that we use a certain method to communicate with you, such as paper or electronic communication, or that we send information to a certain location if the communication could endanger you. Your request to receive confidential communications must be made in writing. Your request must clearly state that all or part of the communication from us could endanger you. We

will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

Paper Copy of this Notice. You have a right at any time to request a paper copy of this notice, even if you had previously agreed to receive an electronic copy.

Revoke Your Authorization. You may revoke an authorization at any time in writing, except to the extent that we have already taken action on the information disclosed or if we are permitted by law to use the information to contest a claim or coverage under a health plan.

Unauthorized Access. You are entitled to receive notification of unauthorized access to your PHI. We maintain physical, electronic and procedural safeguards that are compliant with applicable federal and state privacy laws. However, if your PHI is ever compromised, we will notify you of the incident.

Our Responsibilities

PartnerRe America Insurance Company is required by federal and state laws to maintain the privacy of your protected health information, and provide you with this notice about our legal duties and privacy practices with respect to your protected health information. We must follow the terms of this notice while it is in effect. We will notify you if we are unable to agree to a requested restriction. We will accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations. We reserve the right to change our privacy practices as outlined in this notice and to make the new provisions effective for all protected health information we maintain. Should we make such a change, we will mail a revised notice to the address you have supplied us. We will not use or disclose your protected health information without your authorization, except as described in this notice.

Uses and Disclosures of Your Protected Health Information

We may use and disclose your protected health information for different purposes. We will keep our uses and disclosures of your personal health information to the minimum necessary to accomplish the purposes for which we are making use or disclosure of the information. The following describe these and other uses and disclosures, together with some examples.

Treatment. We may use and disclose your protected health information to assist your health care providers (doctors, mental health practitioners, pharmacies, hospitals, ambulance services and others) in your diagnosis and treatment. For example, we may disclose your protected health information to a provider to whom you have been referred to ensure that the provider has the necessary information to treat you.

Payment. We may use and disclose your protected health information in order to pay for your covered health expenses. For example, we may use your protected health information to process claims or be reimbursed by another insurer that may be responsible for payment.

Health Care Operations. We may use and disclose your protected health information as necessary to operate our business. Health care operations include rating our risk and determining our premium for your insurance; conducting quality assessment and improvement activities; conducting or arranging for medical review, legal services, audit services, fraud and abuse detection and compliance programs; and business planning and development. We are prohibited from using genetic information for underwriting.

Business Associates. Certain aspects and components of our business are performed through contracts with outside persons or organizations. Examples of these outside persons and organizations include our duly appointed insurance agents, third party administrators, financial auditors, actuarial and underwriting services, reinsurers, legal services, enrollment and billing services, claim payment and medical management services and collection agencies. At times it may be necessary for us to provide your protected health information to one or more of these outside persons or organizations who assist us with our payment or health care operations. In all cases, we require these business associates to appropriately safeguard the privacy of your information.

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Notification. We may use or disclose your name, location and general condition or death to notify, or assist in the notification of (including identifying or locating), a person involved in your care.

Communication with Family. We may disclose your protected health information to a family member, other relative, close personal friend, or any other person you identify if it is relevant to that person's involvement in your health care or the payment related to your health care.

Research. We may disclose your protected health information to researchers when their research has been approved by an institutional review board or privacy board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information.

Funeral Directors. We may disclose your protected health information to funeral directors consistent with applicable law to carry out their duties.

Organ Procure Organizations. Consistent with applicable law, we may disclose protected health information to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of organs for the purpose of tissue donation and transplant.

Marketing. We may contact you to provide information or services that may be of interest to you.

Fundraising. We may contact you as part of a fundraising effort.

Plans Sponsors. We may use or disclose protected health information to the plan sponsor of a group health plan.

Food and Drug Administration (FDA). We may disclose to the FDA protected health information relative to adverse events with respect to food, supplements, products and product defects, or post-marketing surveillance information to enable product recalls, repairs, or replacement.

Workers' Compensation. We may disclose protected health information to the extent authorized by and to the extent necessary to comply with laws relating to workers' compensation or other similar programs established by law.

Public Health. As required by law, we may disclose your protected health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.

Correctional Institutions. Should you be an inmate of a correctional institution, we may disclose to the institution or agents thereof protected health information necessary for your health and the health and safety of other individuals.

Law Enforcement. We may disclose protected health information for law enforcement purposes as required by law or in response to a valid subpoena. Federal law makes provision of your protected health information to be released to an appropriate health oversight agency, public health authority, or attorney, provided that a workforce member or business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more customers, workers or the public.

Authorization. Other uses or disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law.

For More Information or to Report a Problem

If you have any questions regarding this notice or need further assistance regarding this notice, please contact us. If you believe that your privacy rights have been violated, you may file a complaint with us and/or the

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Secretary of Health and Human Services. You will not be subject to any retaliation for filing a complaint.

Contact Information:
PartnerRe America Insurance Company
Attn: Risk Management & Compliance Officer
7101 College Blvd. Suite 200
Overland Park, Kansas 66210
1-913-871-7200
1-913-871-7201 - Fax

Effective Date

This notice takes effect on September 23, 2013 and will remain in effect until we replace it.

12-8-1

Trusted Health Plan (District of Columbia) Inc. ("Trusted") current has no risk sharing arrangements.

Trusted Health Plan (District of Columbia) Inc. ("Trusted") currently has no director, officers, administrators, persons holding 5% or more common stock of the organization or employee who receives, collections, disburse or invest funds in connection with the health maintenance organization.

Trusted Health Plan (District of Columbia) Inc. ("Trusted") currently has no arrangements to guarantee the continuation of benefits and payments to providers of services rendered to an after insolvency for the duration of the contract period for which premiums have been paid or until their discharge for members confined to an inpatient facility on the date of insolvency.

However, we believe on Incurred But Not Report (IBNR) liability is actuarially sound and provide Trusted with a reasonable estimate of on-going claims liability which could be use in a wind down situation.

Limited Benefit Plans (Individual and Group Combined)

		Annual Statement Source	(1) Amount	Factor	(2) RBC Requirement
39.	Hospital Indemnity and Specified Disease	Included in Page 7, Col. 9, Line 1 and 2 in part		0.035	
39.1	50,000 if Line 39 is Greater than Zero				
39.2	TOTAL Hospital Indemnity and Specified Disease	Lines (39) + (39.1)			
40.	Accidental Death & Dismemberment	Included in Page 7, Col. 9, Line 1 and 2 in part			
40.1	First 10 Million Earned Premium of Line 40			0.055	
40.2	Over 10 Million Earned Premium of Line 40			0.015	
40.3	Maximum Retained Risk for Any Single Claim	Company Records			
40.4	Three times Line 40.3				
40.5	Lesser of Line 40.4 or $300,000				
40.6	TOTAL AD&D	Lines (40.1) + (40.2) + (40.5)			
41.	Other Accident	Included in Page 7, Col. 9, Line 1 and 2 in part		0.050	
42.	Premium Stabilization Reserves	Included in U & I, Part 2D, Col. 1, Line 4		(0.500) *	
43.	TOTAL, Other Underwriting Risk	Lines (22.2)+(23.3)+(24.3)+(25.3)+(26.3)+(27.6) +(28.3)+(29.3)+(38)+(39.2)+(40.6)+(41)+(42)			

* This is limited to the total Net Underwriting RBC on XR012, Col (6), Line (18) less Col (4), and XR014, Col (2), Lines (22.2), (23.3), (24.3), (25.3), (26.3), (27.6), (28.3), (29.3), XR015 Col (2), Line (33) and XR016 Col (2), Lines (39.2), (40.6) and (41).

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UNDERWRITING RISK - Managed Care Credit Calculation

	Managed Care Claims Payments	Annual Statement Source	(1) Factor	(2) Paid Claims	(3) Weighted Claims (a)	(4) Part D Weighted Claims (b)
1.	Category 0 - Arrangements not Included in Other Categories	Exhibit 7, Pt 1, Col 1, Line 5, in part (c)	0.000			
2.	Category 1 - Payments Made According to Contractual Arrangements	Exhibit 7, Pt 1, Col 1, Line 6, in part (c)	0.150	90,301,136	13,545,170	
3.	Category 2a - Subject to Withholds or Bonuses - Otherwise Category 0	Exhibit 7, Pt 1, Col 1, Line 7, in part (c)	*			
4.	Category 2b - Subject to Withholds or Bonuses - Otherwise Category 1	Exhibit 7, Pt 1, Col 1, Line 8, in part (c)	0.150 *			
5.	Category 3a - Capitated Payments Directly to Providers		0.600	2,218,887	1,331,332	
5.1	Capitation Payments - Medical Group - Category 3a	Exhibit 7, Pt 1, Col 1, Line 1, in part (c)				
5.2	Capitation Payments - All Other Providers - Category 3a	Exhibit 7, Pt 1, Col 1, Line 3, in part (c)		2,218,887		
6.	Category 3b - Capitated Payments to Regulated Intermediaries	Included in Exhibit 7, Pt 1, Col 1, Line 2 (c)	0.600			
7.	Category 3c - Capitated Payments to Non-Regulated Intermediaries	Included in Exhibit 7, Pt 1, Col 1, Line 2 (c)	0.600	1,443,840	866,304	
8.	Category 4 - Medical & Hospital Expense Paid as Salary to Providers		0.750			
8.1	Non-Contingent Salaries - Category 4	Exhibit 7, Pt 1, Col 1, Line 9, in part (c)				
8.2	Aggregate Cost Arrangements - Category 4	Exhibit 7, Pt 1, Col 1, Line 10, in part (c)				
8.3	Less Fee For Service Revenue from ASC or ASO	Company Records				
9.	Subtotal Paid Claims	Exhibit 7, Pt 1, Col 1, Line 13-Line 11-Line (8.3)-Line (12)-Line (13)		93,963,863	15,742,806	
	Stand-Alone Medicare Part D Coverage Claims Payments					
10.	Category 0 - No Federal Reinsurance or Risk Corridor Protection	Company Records	XXX	XXX		XXX
11.	Category 1 - Federal Reinsurance but no Risk Corridor Protection	Company Records	XXX	XXX		XXX
12.	Category 2a - No Federal Reinsurance but Risk Corridor Protection	Company Records	0.667			
13.	Category 3a - Federal Reinsurance and Risk Corridor Protection Apply	Company Records	0.767			
14.	SUBTOTAL Paid Claims	Sum of Lines (10) through (13)				
15.	TOTAL Paid Claims	Sum of Lines (9) and (14)		93,963,863		
16.	Weighted Average Managed Care Discount				0.168	
17.	Weighted Average Managed Care Risk Adjustment Factor				0.832	1.00

XR017

(a) This column is for a single result for the Comprehensive Medical & Hospital, Medicare Supplement and Dental/Vision managed care discount factor.
(b) This column is for the Medicare Part D managed care discount factor.
(c) Stand-alone Medicare Part D business reported in Lines (12) and (13) would be excluded from these amounts.
* The factor is calculated on page XR018.

	*Calculation of Category 2 Managed Care Factor	Annual Statement Source	(1) Amount
18.	Withhold & Bonus Payments, Prior Year	Company Records	
19.	Withhold & Bonuses Available, Prior Year	Company Records	
20.	MCC Multiplier - Average Withhold Returned [Line (18) / Line (19)]		
21.	Withholds & Bonuses Available, Prior Year	Company Records	
22.	Claims Payments Subject to Withhold, Prior Year	Company Records	
23.	Average Withhold Rate, Prior Year [Line (21) / Line (22)]		
24.	MCC Discount Factor, Category 2 Minimum {.25, [Line (20) x Line (23)]}		

* The Factor is pulled into Lines (3) and (4) on page XR017.

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CREDIT RISK

	Annual Statement Source	(1) Amount	Factor	(2) RBC Requirement
Reinsurance Ceded				
1. Recoverables on Paid Losses - 100% Owned Affiliates	Included in Sch S, Pt 2, Col 6, Line 1899999			
2. Recoverables on Paid Losses - Other Affiliates	Included in Sch S, Pt 2, Col 6, Line 1899999		0.005	
3. Recoverables on Paid Losses - Non-affiliates (excluding ACA Reinsurance)	Included in Sch S, Pt 2, Col 6, Line 2199999			
4. Recoverables on Paid Losses - Affordable Care Act	Notes to Financial Statement 24E(2)b1			
5. Recoverables on Paid Losses - Non-Affiliates	Lines (3) + (4)		0.005	
6. TOTAL Recoverables on Paid Losses	Lines (1) + (2) + (5) (Sch S, Pt 2, Col 6, Line 2299999)			
7. Recoverables on Unpaid Losses - 100% Owned Affiliates	Included in Sch S, Pt 2, Col 7, Line 1899999			
8. Recoverables on Unpaid Losses - Other Affiliates	Included in Sch S, Pt 2, Col 7, Line 1899999		0.005	
9. Recoverables on Unpaid Losses - Non-Affiliates (excluding ACA Reinsurance)	Included in Sch S, Pt 2, Col 7, Line 2199999			
10. Recoverables on Unpaid Losses - Affordable Care Act	Notes to Financial Statement 24E(2)b2			
11. Recoverables on Unpaid Losses - Non-affiliates	Lines (9) + (10)		0.005	
12. TOTAL Recoverables on Unpaid Losses	Lines (7) + (8) + (11) (Sch S, Pt 2, Col 7, Line 2299999)			
13. Unearned Premiums - 100% Owned Affiliates	Included in Sch S, Pt 3, Sn 2, Col 9, Line 0799999 + Line 1899999 + Line 2999999			
14. Unearned Premiums - Other Affiliates	Included in Sch S, Pt 3, Sn 2, Col 9, Line 0799999 + Line 1899999 + Line 2999999		0.005	
15. Unearned Premiums - Non-Affiliates	Included in Sch S, Pt 3, Sn 2, Col 9, Line 1099999 + Line 2199999 + Line 3299999		0.005	
16. TOTAL Unearned Premiums	Lines (13) + (14) + (15)			
17. Other Reserve Credits - 100% Owned Affiliates	Included in Sch S, Pt 3, Sn 2, Col 10, Line 0799999 + Line 1899999 + Line 2999999			
18. Other Reserve Credits - Other Affiliates	Included in Sch S, Pt 3, Sn 2, Col 10, Line 0799999 + Line 1899999 + Line 2999999		0.005	
19. Other Reserve Credits - Non-affiliates	Included in Sch S, Pt 3, Sn 2, Col 10, Line 1099999 + Line 2199999 + Line 3299999		0.005	
20. TOTAL Other Reserve Credits	Lines (17) + (18) + (19)			
21. TOTAL Reinsurance RBC	Lines (6) + (12) + (16) + (20)			
Capitations to Intermediaries				
22. TOTAL Capitations Paid Directly to Providers	XR017, Col (2), Line (5)	2,218,887		
23. Less Secured Capitations to Providers	Company Records			
24. Capitations to Providers Subject to Credit Risk Charge	Lines (22) - (23)	2,218,887	0.020	44,378
25. TOTAL Capitations to Intermediaries	XR017, Col (2), Line (6) + (7)	1,443,840		
26. Less Secured Capitations to Intermediaries	Company Records			
27. Capitations to Intermediaries Subject to Credit Risk Charge	Lines (25) - (26)	1,443,840	0.040	57,754
28. Capitation Credit Risk RBC	Lines (24) + (27)			102,132

XR019

CREDIT RISK - Other Receivables

		Annual Statement Source	(1) Amount	Factor	(2) RBC Requirement
Other Receivables					
29.	Investment Income Receivable	Page 2, Col 3, Line 14		0.010	
30.	Health Care Receivables	Exhibit 3, Col. 7, Line 0799999	819,669		
30.1	Pharmaceutical Rebate Receivables	Exhibit 3, Col. 7, Line 0199999		0.050	
30.2	Claim Overpayment Receivables	Exhibit 3, Col. 7, Line 0299999	819,669	0.050	40,983
30.3	Loan and Advances to Providers	Exhibit 3, Col. 7, Line 0399999		0.050	
30.4	Capitation Arrangement Receivables	Exhibit 3, Col. 7, Line 0499999		0.050	
30.5	Risk Sharing Receivables	Exhibit 3, Col. 7, Line 0599999		0.050	
30.6	Other Health Care Receivables	Exhibit 3, Col. 7, Line 0699999		0.050	
31.	Amounts Receivable Relating to Uninsured Accident and Health Plans	Included in Page 2, Col. 3, Line 17		0.050	
32.	Amounts Due from Parents, Subs, and Affiliates	Page 2, Col. 3, Line 23		0.050	
33.	Aggregate Write-Ins for Other Than Invested Assets	Page 2, Col. 3, Line 25		0.050	
34.	TOTAL Other Receivables RBC	Line (29) + Sum of Lines (30.1) through (33)			40,983
35.	TOTAL Credit RBC	Lines (21) + (28) + (34)			143,115

XR020

e9.7.1

BUSINESS RISK

		Annual Statement Source	(1) Amount	Factor	(2) RBC Requirement
Administrative Expense Risk					
1.	Claims adjustment expenses	Page 4, Col. 2, Line 20	6,301,366		
2.	General administrative expenses	Page 4, Col. 2, Line 21	14,235,571		
3.	Less the Net amount of ASC Revenue and Expenses Included in Line 1 and Line 2	Company Records			
4.	Less the Net amount of ASO Revenue and Expenses Included in Line 1 and Line 2	Company Records			
5.	Less Administrative Expenses for Commission & Premium Taxes	U & I, Part 3, Line 3, in part	3,032,975		
6.	Administrative Expenses Base RBC	Lines (1) + (2) - (3) - (4) - (5)	17,503,962	0.046 *	805,182
7.	Proration of Administrative Expense to Experience Fluctuation Risk	Lines (6) x (20) / ((21) + (22))			805,182
Non-Underwritten and Limited-Risk					
8.	Administrative Expenses for ASC Arrangements	Company Records		0.020	
9.	Administrative Expenses for ASO Arrangements	Company Records		0.020	
10.	Medical Costs paid through ASC Arrangements (Including Fee-for Service Received from Other Health Entities)	Company Records		0.010	
11.	Non-Underwritten and Limited Risk Business RBC				
Guaranty Fund Assessment Risk					
12.	Premiums Subject to Guaranty Fund Assessment	Included in Sch T - Company Records		0.005	
Excessive Growth Risk					
13.	Underwriting Risk Revenue, Prior Year	2014 XR012, Col (6), Line (5) (manual entry)	119,092,512		
14.	Underwriting Risk Revenue, Current Year	2015 XR012, Col (6), Line (5)	131,563,782		
15.	Net Underwriting Risk RBC, Prior Year	2014 XR012, Col (6), Line (18) (manual entry)	8,338,639		
16.	Net Underwriting Risk RBC, Current Year	2015 XR012, Col (6), Line (18)	8,744,954		
17.	RBC Growth Safe Harbor	[Line (14) / Line (13) + .10] x Line (15)	10,045,718		
18.	Excess of RBC Growth Over Safe Harbor	Max {0, Line (16) - Line (17)}			
19.	Excessive Growth Risk RBC	.5 x Line (18)			

XR021

*The factor for the Administrative Expenses Base RBC is calculated as a weighted average, based on premium volume from XR012

		Annual Statement Source	(1) Premium	Weight	(2) Weighted Premium
20.	Experience Fluctuation Risk Revenue	XR012, Col (6), Line (5)	131,563,782		
21.	Premiums Earned	Page 4, Col 2, Line 2 + 3	131,563,782		
22.	Risk Revenue	Page 4, Col 2, Line 5			
23.	Tier 1 - $0 to $25 million of Line (20)		25,000,000	0.070	1,750,000
24.	Tier 2 - Amount over $25 million of Line (20)		106,563,782	0.040	4,262,551
25.	TOTAL Experience Fluctuation Risk Revenue	Lines (23) + (24)	131,563,782		6,012,551
26.	Administrative Expenses Base RBC Factor	Col (2), Line (25) / Col (1), Line (25)			0.046

OPERATIONAL RISK
(For Informational Purposes Only)

	Reference	(1) Statement Value	Factor	(2) RBC Requirement
1. Net Written Premium	U&I, Part 1, Premiums, C4, L12	131,563,782	0.003	394,691
2. Net Claim Liability Reserves	U&I, Part 2A, Claims Liab. CY, C1, L4.4	21,448,292	0.035	750,690
3. Base Operational Risk Charge	Greater of C(2)L(1) or C(2)L(2)			750,690
Growth Operational Risk:				
4. Current Year Direct Premiums Written	U&I, Part 1, Premiums, C1, L12	132,084,154		
5. Current Year Reinsurance Assumed from Affiliates	Sch. S, Part 1, Section 2, C7, L0799999 + Life Sup. Sch. S, Part 1, Section 1, C3, L0799999 + P&C Sup. Sch. F, Part 1, C5, L0899999			
6. Current Year Reinsurance Assumed from Non-Affiliates	Sch. S, Part 1, Section 2, C7, L1099999 + Life Sup. Sch. S, Part 1, Section 1, C9, L1099999 + P&C Sup. Sch. F, Part 1, C5, L0999999			
7. Current Year Gross Premiums Written Excluding Reinsurance Assumed from Affiliates	C(1), L(4) + (6)	132,084,154		
8. Prior Year Direct Premiums Written	PY U&I, Part 1, Premiums, C1, L12	119,742,533		
9. Prior Year Reinsurance Assumed from Affiliates	PY Sch. S, Part 1, Section 2, C7, L0799999 + PY Life Sup. Sch. S, Part 1, Section 1, C9, L0799999 + PY P&C Sup. Sch. F, Part 1, C5, L0899999			
10. Prior Year Reinsurance Assumed from Non-Affiliates	PY Sch. S, Part 1, Section 2, C7, L1099999 + PY Life Sup. Sch. S, Part 1, Section 1, C9, L1099999 + PY P&C Sup. Sch. F, Part 1, C5, L0999999			
11. Prior Year Gross Premiums Written Excluding Reinsurance Assumed from Affiliates	C(1), L(8) + (10)	119,742,533		
12. Gross Written Premium in Excess of 125% of Prior Year's Gross Written Premium	C(1), L(7) - 1.25 x C(1), L(11)		0.020	
13. Operational Risk Charge (Tentatively as H5 - covariance treatment to be determined later)	C(2), L(3) + C(2), L(12)			750,690
Alternate Base Operational Risk Charge - Capital Add-on Approach (Tentatively as potential capital add-on after covariance)				
14. RBC After Covariance	Page XR025, L(37)	8,787,247	0.030	263,617
15. Total Operational Risk Charge Based on Capital Add-on and Growth Charges	C(2), L(12) + C(2), L(14)			263,617

FEDERAL ACA RISK ADJUSTMENT AND RISK CORRIDOR SENSITIVITY TEST

	Annual Statement Source	(1) Amount	Sensitivity Percentage	(2) Subtotal Col. (1) * Col. (2)	Factor	(3) RBC Result	(4) Adjusted Capital
Overestimation of 25%							
1. Premium Adjustments Receivable Due to ACA Risk Adjustment	Notes to Financial Statement 24E2a1		0.75		0.500		
2. Premium Adjustments Payable Due to ACA Risk Adjustment	Notes to Financial Statement 24E2a3		0.75		0.500		
3. Total ACA Risk Adjustments Payable less Receivable	Line (2) - Line (1)						
4. Accrued Retrospective Premium Due to ACA Risk Corridors	Notes to Financial Statement 24E2c1		0.75		0.500		
5. Reserve for Rate Credits or Policy Experience Rating Refunds Due to ACA Risk Corridors	Notes to Financial Statement 24E2c2		0.75		0.500		
6. Total ACA Risk Corridor Retrospective Premium and Rate Credits or Policy Experience Rating Refunds (Net)	Line (5) - Line (4)						
7. Total Risk Adjustment and Risk Corridor	Absolute Value of (Line (3) + Line (6))						
8. Total Adjusted Capital, Post-Deferred Tax	XR026, Col. (2), Line (6)						12,282,162
9. Total Adjusted Capital Stressed for Risk Adjustments	Line (8) - Line (7)						12,282,162
10. Authorized Control Level RBC	XR027 Comparison of Total Adjusted Capital to Risk-Based Capital Line (4)						4,393,624
11. ACA Risk Adjusted ACL RBC Ratio	Line (9)/Line (10)						279.545
Underestimation of 25%							
12. Premium Adjustments Receivable Due to ACA Risk Adjustment	Col. (1), Line (1)		1.25		0.500		
13. Premium Adjustments Payable Due to ACA Risk Adjustment	Col. (1), Line (2)		1.25		0.500		
14. Total ACA Risk Adjustments Payable less Receivable	Line (13) - Line (12)						
15. Accrued Retrospective Premium Due to ACA Risk Corridors	Col. (1), Line (4)		1.25		0.500		
16. Reserve for Rate Credits or Policy Experience Rating Refunds Due to ACA Risk Corridors	Col. (1), Line (5)		1.25		0.500		
17. Total ACA Risk Corridor Retrospective Premium and Rate Credits or Policy Experience Rating Refunds (Net)	Line (16) - Line (15)						
18. Total Risk Adjustment and Risk Corridor	Absolute Value of (Line (14) + Line (17))						
19. Total Adjusted Capital, Post-Deferred Tax	XR026, Col. (2), Line (6)						12,282,16
20. Total Adjusted Capital Stressed for Risk Adjustments	Line (19) - Line (18)						12,282,16
21. Authorized Control Level RBC	XR027 Comparison of Total Adjusted Capital to Risk-Based Capital Line (4)						4,393,62
22. ACA Risk Adjusted ACL RBC Ratio	Line (20)/Line (21)						279.545

Footnote: If it is the belief of the company that the factors are not appropriate, provide an explanation as to why the factors are inappropriate.:

XR023

Calculation of Total Risk-Based Capital After Covariance

		(1) RBC Amount
H0 - ASSET RISK - AFFILIATES W/RBC		
1. Off-Balance Sheet Items	XR005, Off-Balance Sheet Page, Line 21	3,304
2. Directly Owned Insurer Subject to RBC	XR003, Affiliates Page, Line 1	
3. Indirectly Owned Insurer Subject to RBC	XR003, Affiliates Page, Line 2	
4. Directly Owned Health Entity Subject to RBC	XR003, Affiliates Page, Line 3	
5. Indirectly Owned Health Entity Subject to RBC	XR003, Affiliates Page, Line 4	
6. Directly Owned Alien Insurer	XR003, Affiliates Page, Line 7	
7. Indirectly Owned Alien Insurers	XR003, Affiliates Page, Line 8	
8. TOTAL H0	Sum of Lines 1 through 7	3,304
H1 - ASSET RISK - OTHER		
9. Investment Affiliates	XR003, Affiliates Page, Line 5	
10. Holding Company Excess of Subsidiaries	XR003, Affiliates Page, Line 6	
11. Investment in Parent	XR003, Affiliates Page, Line 9	
12. Other Affiliates	XR003, Affiliates Page, Line 10	
13. Fair Value Excess Affiliate Common Stock	XR003, Affiliates Page, Line 11	
14. Fixed Income Assets	XR006, Off-Balance Sheet Collateral, Line 9 + Line 19 + Line 20 + Line 21 + XR007, Fixed Income Assets Page, Line 34	111,710
15. Replication & Mandatory Convertible Securities	XR008, Replication/MCS Page, Line 9999999	
16. Unaffiliated Preferred Stock and Hybrid Securities	XR006, Off-Balance Sheet Collateral, Line 16 + XR009, Equity Assets Page, Line 15	
17. Unaffiliated Common Stock	XR006, Off-Balance Sheet Collateral, Line 17 + XR009, Equity Assets Page, Line 21	
18. Property & Equipment	XR006, Off-Balance Sheet Collateral, Line 18 + XR010, Prop/Equip Assets Page, Line 9	9,257
19. Asset Concentration	XR011, Grand Total Asset Concentration Page, Line 23	
20. TOTAL H1	Sum of Lines 9 through 19	120,967
H2 - UNDERWRITING RISK		
21. Net Underwriting Risk	XR012, Underwriting Risk Page, Line 18	8,744,954
22. Other Underwriting Risk	XR014, Underwriting Risk Page, Line 22.2	
23. Disability Income	XR014, Underwriting Risk Page, Lines 23.3 + 24.3 + 25.3 + 26.3 + 27.6 + 28.3 + 29.3	
24. Long-Term Care	XR015, Underwriting Risk Page, Line 38	
25. Limited Benefit Plans	XR016, Underwriting Risk Page, Lines 39.2 + 40.6 + 41	
26. Premium Stabilization Reserve	XR016, Underwriting Risk Page, Line 42	
27. TOTAL H2	Sum of Lines 21 through 26	8,744,954

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Calculation of Total Risk-Based Capital After Covariance (continued)

		(1) RBC Amount
H3 - CREDIT RISK		
28. TOTAL Reinsurance RBC	XR019, Credit Risk Page, Line 21	
29. Intermediaries Credit Risk RBC	XR019, Credit Risk Page, Line 28	102,132
30. TOTAL Other Receivables RBC	XR020, Credit Risk Page, Line 34	40,983
31. TOTAL H3	Sum of Lines 28 through 30	143,115
H4 - BUSINESS RISK		
32. Administrative Expense RBC	XR021, Business Risk Page, Line 7	805,182
33. Non-Underwritten and Limited Risk Business RBC	XR021, Business Risk Page, Line 11	
34. Premiums Subject to Guaranty Fund Assessments	XR021, Business Risk Page, Line 12	
35. Excessive Growth RBC	XR021, Business Risk Page, Line 19	
36. TOTAL H4	Sum of Lines 32 through 35	805,182
37. RBC After Covariance	H0 + Square Root of ($H1^2 + H2^2 + H3^2 + H4^2$)	8,787,247
38. Authorized Control Level RBC	.50 x RBC after Covariance	4,393,624

CALCULATION OF TOTAL ADJUSTED CAPITAL

	Annual Statement Source	(1) Amount	Factor	(2) Adjusted Capital
Company Amounts				
1. Capital and Surplus	Page 3, Col 3, Line 33	12,282,162	1.000	12,282,162
Subsidiary Adjustments				
2. AVR - Life Subsidiaries	Affiliate's statement §		1.000	
3. Dividend Liability - Life Subsidiaries	Affiliate's statement		0.500	
4. Tabular Discounts - P&C Subsidiaries	Affiliate's statement		(1.000)	
5. Non-Tabular Discounts - P&C Subsidiaries	Affiliate's statement		(1.000)	
6. TOTAL Adjusted Capital, Post-Deferred Tax				12,282,162
SENSITIVITY TEST:				
7. DTA Value for Company	Page 2, Col. 3, Line 18.2	58,946	1.000	58,946
8. DTL Value for Company	Page 3, Col. 3, Line 10.2		1.000	
9. DTA Value for Insurance Subsidiaries	Company Records		1.000	
10. DTL Value for Insurance Subsidiaries	Company Records		1.000	
11. TOTAL Adjusted Capital, Pre-Deferred Tax (Sensitivity)	Lines (6) - (7) + (8) - (9) + (10)			12,223,216
Ex DTA ACL RBC Ratio Sensitivity Test				
12. Deferred Tax Asset	Page 2, Col. 3, Line 18.2	58,946	1.000	58,946
13. TOTAL Adjusted Capital Less Deferred Tax Asset	Line (6) less Line (12)			12,223,216
14. Authorized Control Level RBC	XR027 Comparison of Total Adjusted Capital to Risk-Based Capital Line (4)			4,393,624
15. Ex DTA ACL RBC Ratio	Line (13) / Line (14)			278.204
ACA Fee RBC Ratio Sensitivity Test				
16. ACA Fee (Data Year Amount to be Paid in the Fee Year)	Note 22B	1,723,486	1.000	1,723,486
17. Total Adjusted Capital Less ACA Fee	Line (6) less Line (16)			10,558,676
18. Authorized Control Level RBC	XR027 Comparison of Total Adjusted Capital to Risk-Based Capital Line (4)			4,393,624
19. ACA Fee RBC Ratio	Line (17) / Line (18)			240.300

§ The portion of the AVR that can be counted as capital is limited to the amount not utilized in asset adequacy testing in support of the Actuarial Opinion for reserves.

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COMPARISON OF TOTAL ADJUSTED CAPITAL TO RISK-BASED CAPITAL

		Abbreviation	(1) Amount
1.	TOTAL Adjusted Capital, Post Tax		12,282,162
2.	Company Action Level = 200% of Authorized Control Level	CAL	8,787,248
3.	Regulatory Action Level = 150% of Authorized Control Level	RAL	6,590,436
4.	Authorized Control Level = 100% of Authorized Control Level	ACL	4,393,624
5.	Mandatory Control Level = 70% of Authorized Control Level	MCL	3,075,537
6.	Level of Action, if Any		None
THE FOLLOWING NUMBERS MUST BE REPORTED IN THE FIVE YEAR HISTORY EXHIBIT ON THE INDICATED LINE			
	TOTAL Adjusted Capital on Line 14 of the Five-Year Historical Data Page		12,282,162
	Authorized Control Level Risk-Based Capital on Line 15 of the Five-Year Historical Data Page		4,393,624

TREND TEST

		Annual Statement Source	(1) Amount	(2) Result
7.	TOTAL Revenue	Page 4, Line 8	131,563,782	
8.	Underwriting Deductions	Page 4, Line 23	124,548,789	
9.	Combined Ratio	Line (8) / Line (7)	94.668	
10.	RBC Ratio	Line (1) / Line (4)	279.545	
11.	Trend Test Result	If Line (10) is between 200% and 300% and Line (9) > 105%, then "Yes", otherwise "No".		Yes[ ] No[X]
12.	Level of Action, if any, Including Trend Test		None	

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ANNUAL STATEMENT

For the Year Ending DECEMBER 31, 2015

OF THE CONDITION AND AFFAIRS OF THE

Trusted Health Plan (District of Columbia), Inc.

NAIC Group Code 0000 (Current Period) 0000 (Prior Period) NAIC Company Code 14225 Employer's ID Number 45-2375150

Organized under the Laws of District of Columbia State of Domicile or Port of Entry District of Columbia

Country of Domicile United States of America

Licensed as business type: Life, Accident & Health[ ] Property/Casualty[ ] Hospital, Medical & Dental Service or Indemnity[ ]
Dental Service Corporation[ ] Vision Service Corporation[ ] Health Maintenance Organization[X]
Other[ ] Is HMO Federally Qualified? Yes[ ] No[X] N/A[ ]

Incorporated/Organized 05/16/2011 Commenced Business 07/01/2013

Statutory Home Office 1100 New Jersey Avenue SE Suite 840 (Street and Number) Washington, DC, US 20003 (City or Town, State, Country and Zip Code)

Main Administrative Office 1100 New Jersey Avenue SE Suite 840 (Street and Number)
Washington, DC, US 20003 (City or Town, State, Country and Zip Code) (202)821-1100 (Area Code) (Telephone Number)

Mail Address 1100 New Jersey Avenue SE Suite 840 (Street and Number or P.O. Box) Washington, DC, US 20003 (City or Town, State, Country and Zip Code)

Primary Location of Books and Records 1100 New Jersey Avenue SE Suite 840 (Street and Number)
Washington , DC, US 20003 (City or Town, State, Country and Zip Code) (202)821-1100 (Area Code) (Telephone Number)

Internet Website Address www.trustedhp.com

Statutory Statement Contact Cleveland Eugene Slade (Name) (202)821-1070 (Area Code)(Telephone Number)(Extension)
cslade@trustedhp.com (E-Mail Address) (202)821-1099 (Fax Number)

OFFICERS

Name	Title
Thomas Michael Duncan	CEO
Cleveland Eugene Slade	CFO
Richard Eugene Gillette	COO
Douglas MacArthur Redd	CIO #

OTHERS

DIRECTORS OR TRUSTEES

Dennis Gean Ellis
Eddie Leon Hall
Bruce Robert Kaiser
Thomas Michael Duncan
Jack Mitt Martin

State of
County of ss

The officers of this reporting entity being duly sworn, each depose and say that they are the described officers of the said reporting entity, and that on the reporting period stated above, all of the herein described assets were the absolute property of the said reporting entity, free and clear from any liens or claims thereon, except as herein stated, and that this statement, together with related exhibits, schedules and explanations therein contained, annexed or referred to, is a full and true statement of all the assets and liabilities and of the condition and affairs of the said reporting entity as of the reporting period stated above, and of its income and deductions therefrom for the period ended, and have been completed in accordance with the NAIC Annual Statement Instructions and Accounting Practices and Procedures manual except to the extent that: (1) state law may differ; or, (2) that state rules or regulations require differences in reporting not related to accounting practices and procedures, according to the best of their information, knowledge and belief, respectively. Furthermore, the scope of this attestation by the described officers also includes the related corresponding electronic filing with the NAIC, when required, that is an exact copy (except for formatting differences due to electronic filing) of the enclosed statement. The electronic filing may be requested by various regulators in lieu of or in addition to the enclosed statement.

(Signature)	(Signature)	(Signature)
Thomas Michael Duncan	Cleveland Eugene Slade	Richard Eugene Gillette
(Printed Name)	(Printed Name)	(Printed Name)
1.	2.	3.
Chief Executive Officer	Chief Financial Officer	Chief Operating Officer
(Title)	(Title)	(Title)

Subscribed and sworn to before me this 26 day of January, 2016

(Notary Public Signature)

a. Is this an original filing? Yes[X] No[ ]
b. If no, 1. State the amendment number
2. Date filed
3. Number of pages attached

SALOMÉ TIL ORTEN NOTARY PUBLIC EXP. 9-14-20 DISTRICT OF COLUMBIA

ASSETS

		Current Year			Prior Year
		1	2	3	4
		Assets	Nonadmitted Assets	Net Admitted Assets (Cols.1-2)	Net Admitted Assets
1.	Bonds (Schedule D)				
2.	Stocks (Schedule D)				
	2.1 Preferred stocks				
	2.2 Common Stocks				
3.	Mortgage loans on real estate (Schedule B):				
	3.1 First liens				
	3.2 Other than first liens				
4.	Real estate (Schedule A):				
	4.1 Properties occupied by the company (less $.....0 encumbrances)				
	4.2 Properties held for the production of income (less $.....0 encumbrances)				
	4.3 Properties held for sale (less $.....0 encumbrances)				
5.	Cash ($.....37,236,745, Schedule E Part 1), cash equivalents ($.....0, Schedule E Part 2) and short-term investments ($.....0, Schedule DA)	37,236,745		37,236,745	21,698,191
6.	Contract loans (including $.....0 premium notes)				
7.	Derivatives (Schedule DB)				
8.	Other invested assets (Schedule BA)				
9.	Receivables for securities				
10.	Securities Lending Reinvested Collateral Assets (Schedule DL)				
11.	Aggregate write-ins for invested assets				
12.	Subtotals, cash and invested assets (Lines 1 to 11)	37,236,745		37,236,745	21,698,191
13.	Title plants less $.....0 charged off (for Title insurers only)				
14.	Investment income due and accrued				
15.	Premiums and considerations:				
	15.1 Uncollected premiums and agents' balances in the course of collection	1,639,436		1,639,436	3,818,872
	15.2 Deferred premiums, agents' balances and installments booked but deferred and not yet due (including $.....0 earned but unbilled premiums)				
	15.3 Accrued retrospective premiums ($.....0) and contracts subject to redetermination ($.....0)				
16.	Reinsurance:				
	16.1 Amounts recoverable from reinsurers				
	16.2 Funds held by or deposited with reinsured companies				
	16.3 Other amounts receivable under reinsurance contracts				
17.	Amounts receivable relating to uninsured plans				
18.1	Current federal and foreign income tax recoverable and interest thereon				
18.2	Net deferred tax asset	318,658	259,712	58,946	35,948
19.	Guaranty funds receivable or on deposit				
20.	Electronic data processing equipment and software	367,065	274,500	92,565	220,748
21.	Furniture and equipment, including health care delivery assets ($.....0)	173,500	173,500		
22.	Net adjustment in assets and liabilities due to foreign exchange rates				
23.	Receivables from parent, subsidiaries and affiliates				
24.	Health care ($.....819,669) and other amounts receivable	819,669		819,669	200,803
25.	Aggregate write-ins for other than invested assets	175,063	175,063		
26.	TOTAL Assets excluding Separate Accounts, Segregated Accounts and Protected Cell Accounts (Lines 12 to 25)	40,730,136	882,775	39,847,361	25,974,362
27.	From Separate Accounts, Segregated Accounts and Protected Cell Accounts				
28.	TOTAL (Lines 26 and 27)	40,730,136	882,775	39,847,361	25,974,362
DETAILS OF WRITE-INS					
1101.					
1102.					
1103.					
1198.	Summary of remaining write-ins for Line 11 from overflow page				
1199.	TOTALS (Lines 1101 through 1103 plus 1198) (Line 11 above)				
2501.	Prepaid Expenses	106,197	106,197		
2502.	Employee Advances	1,569	1,569		
2503.	Deposits	16,735	16,735		
2598.	Summary of remaining write-ins for Line 25 from overflow page	48,572	48,572		
2599.	TOTALS (Lines 2501 through 2503 plus 2598) (Line 25 above)	175,063	175,063		

LIABILITIES, CAPITAL AND SURPLUS

		Current Year			Prior Year
		1 Covered	2 Uncovered	3 Total	4 Total
1.	Claims unpaid (less $.....0 reinsurance ceded)	21,448,292		21,448,292	11,981,448
2.	Accrued medical incentive pool and bonus amounts				
3.	Unpaid claims adjustment expenses	416,910		416,910	
4.	Aggregate health policy reserves, including the liability of $.....0 for medical loss ratio rebate per the Public Health Service Act				
5.	Aggregate life policy reserves				
6.	Property/casualty unearned premium reserves				
7.	Aggregate health claim reserves				
8.	Premiums received in advance				
9.	General expenses due or accrued	4,773,383		4,773,383	4,865,579
10.1	Current federal and foreign income tax payable and interest thereon (including $.....0 on realized capital gains (losses))	814,772		814,772	442,786
10.2	Net deferred tax liability				
11.	Ceded reinsurance premiums payable				
12.	Amounts withheld or retained for the account of others	5		5	
13.	Remittances and items not allocated				
14.	Borrowed money (including $.....0 current) and interest thereon $.....0 (including $.....0 current)				
15.	Amounts due to parent, subsidiaries and affiliates	111,837		111,837	
16.	Derivatives				
17.	Payable for securities				
18.	Payable for securities lending				
19.	Funds held under reinsurance treaties (with $.....0 authorized reinsurers, $.....0 unauthorized reinsurers and $.....0 certified reinsurers)				
20.	Reinsurance in unauthorized and certified ($.....0) companies				
21.	Net adjustments in assets and liabilities due to foreign exchange rates				
22.	Liability for amounts held under uninsured plans				
23.	Aggregate write-ins for other liabilities (including $.....0 current)				
24.	TOTAL Liabilities (Lines 1 to 23)	27,565,199		27,565,199	17,289,813
25.	Aggregate write-ins for special surplus funds	XXX	XXX	1,723,486	445,722
26.	Common capital stock	XXX	XXX	1,000	1,000
27.	Preferred capital stock	XXX	XXX		
28.	Gross paid in and contributed surplus	XXX	XXX	6,894,000	6,894,000
29.	Surplus notes	XXX	XXX		
30.	Aggregate write-ins for other than special surplus funds	XXX	XXX		
31.	Unassigned funds (surplus)	XXX	XXX	3,723,576	1,403,827
32.	Less treasury stock, at cost:				
	32.1 .....0 shares common (value included in Line 25 $.....0)	XXX	XXX		
	32.2 .....0 shares preferred (value included in Line 27 $.....0)	XXX	XXX		
33.	TOTAL Capital and Surplus (Lines 25 to 31 minus Line 32)	XXX	XXX	12,282,162	8,684,549
34.	TOTAL Liabilities, Capital and Surplus (Lines 24 and 33)	XXX	XXX	39,847,361	25,974,362
DETAILS OF WRITE-INS					
2301.					
2302.					
2303.					
2398.	Summary of remaining write-ins for Line 23 from overflow page				
2399.	TOTALS (Lines 2301 through 2303 plus 2398) (Line 23 above)				
2501.	ACA 9010 Tax Payable for 2015	XXX	XXX		445,722
2502.	ACA 9010 Tax Payable for 2016	XXX	XXX	1,723,486	
2503.		XXX	XXX		
2598.	Summary of remaining write-ins for Line 25 from overflow page	XXX	XXX		
2599.	TOTALS (Lines 2501 through 2503 plus 2598) (Line 25 above)	XXX	XXX	1,723,486	445,722
3001.		XXX	XXX		
3002.		XXX	XXX		
3003.		XXX	XXX		
3098.	Summary of remaining write-ins for Line 30 from overflow page	XXX	XXX		
3099.	TOTALS (Lines 3001 through 3003 plus 3098) (Line 30 above)	XXX	XXX		

STATEMENT OF REVENUE AND EXPENSES

		Current Year		Prior Year
		1 Uncovered	2 Total	3 Total
1.	Member Months	XXX	365,118	350,497
2.	Net premium income (including $.....0 non-health premium income)	XXX	131,583,782	119,092,512
3.	Change in unearned premium reserves and reserve for rate credits	XXX		
4.	Fee-for-service (net of $.....0 medical expenses)	XXX		
5.	Risk revenue	XXX		
6.	Aggregate write-ins for other health care related revenues	XXX		
7.	Aggregate write-ins for other non-health revenues	XXX	131,583,782	119,092,512
8.	TOTAL Revenues (Lines 2 to 7)			
Hospital and Medical:				
9.	Hospital/medical benefits		84,816,553	83,038,750
10.	Other professional services		10,920,286	8,894,150
11.	Outside referrals			
12.	Emergency room and out-of-area			
13.	Prescription drugs		8,307,836	6,720,744
14.	Aggregate write-ins for other hospital and medical			
15.	Incentive pool, withhold adjustments and bonus amounts			
16.	Subtotal (Lines 9 to 15)		104,044,655	98,453,644
Less:				
17.	Net reinsurance recoveries		32,803	647,518
18.	TOTAL Hospital and Medical (Lines 16 minus 17)		104,011,852	97,806,126
19.	Non-health claims (net)			
20.	Claims adjustment expenses, including $.....3,485,588 cost containment expenses		6,301,368	4,852,663
21.	General administrative expenses		14,235,571	12,110,183
22.	Increase in reserves for life and accident and health contracts (including $.....0 increase in reserves for life only)			
23.	TOTAL Underwriting Deductions (Lines 18 through 22)		124,548,789	114,768,972
24.	Net underwriting gain or (loss) (Lines 8 minus 23)	XXX	7,014,993	4,323,640
25.	Net investment income earned (Exhibit of Net Investment Income, Line 17)		4,394	2,253
26.	Net realized capital gains (losses) less capital gains tax of $.....0			
27.	Net investment gains (losses) (Lines 25 plus 26)		4,394	2,253
28.	Net gain or (loss) from agents' or premium balances charged off [(amount recovered $.....0) (amount charged off $.....0)]			
29.	Aggregate write-ins for other income or expenses			(25,450)
30.	Net income or (loss) after capital gains tax and before all other federal income taxes (Lines 24 plus 27 plus 28 plus 29)	XXX	7,019,387	4,300,443
31.	Federal and foreign income taxes incurred	XXX	2,691,304	1,299,832
32.	Net income (loss) (Lines 30 minus 31)	XXX	4,328,083	3,000,611
DETAILS OF WRITE-INS				
0601.		XXX		
0602.		XXX		
0603.		XXX		
0698.	Summary of remaining write-ins for Line 6 from overflow page	XXX		
0699.	TOTALS (Lines 0601 through 0603 plus 0698) (Line 6 above)	XXX		
0701.		XXX		
0702.		XXX		
0703.		XXX		
0798.	Summary of remaining write-ins for Line 7 from overflow page	XXX		
0799.	TOTALS (Line 0701 through 0703 plus 0798) (Line 7 above)			
1401.				
1402.				
1403.				
1498.	Summary of remaining write-ins for Line 14 from overflow page			
1499.	TOTALS (Lines 1401 through 1403 plus 1498) (Line 14 above)			(25,450)
2901.	Penalties			
2902.				
2903.				
2998.	Summary of remaining write-ins for Line 29 from overflow page			(25,450)
2999.	TOTALS (Line 2901 through 2903 plus 2998) (Line 29 above)			

STATEMENT OF REVENUE AND EXPENSES (Continued)

		1 Current Year	2 Prior Year
	CAPITAL & SURPLUS ACCOUNT		
33.	Capital and surplus prior reporting year	8,684,549	3,485,284
34.	Net income or (loss) from Line 32	4,328,083	3,000,611
35.	Change in valuation basis of aggregate policy and claim reserves		
36.	Change in net unrealized capital gains (losses) less capital gains tax of $ 0		
37.	Change in net unrealized foreign exchange capital gain or (loss)		
38.	Change in net deferred income tax	216,612	102,046
39.	Change in nonadmitted assets	(364,928)	1,053,554
40.	Change in unauthorized and certified reinsurance		
41.	Change in treasury stock		
42.	Change in surplus notes		
43.	Cumulative effect of changes in accounting principles		
44.	Capital Changes:		
	44.1 Paid in		
	44.2 Transferred from surplus (Stock Dividend)		
	44.3 Transferred to surplus		(6,000)
45.	Surplus adjustments:		
	45.1 Paid in		1,343,000
	45.2 Transferred to capital (Stock Dividend)		
	45.3 Transferred from capital		
46.	Dividends to stockholders	(314,417)	
47.	Aggregate write-ins for gains or (losses) in surplus	(277,734)	(291,944)
48.	Net change in capital and surplus (Lines 34 to 47)	3,597,616	5,199,267
49.	Capital and surplus end of reporting year (Line 33 plus 48)	12,282,165	8,684,551
DETAILS OF WRITE-INS			
4701.	Prior Period Adjustments	(277,734)	(291,944)
4702.			
4703.			
4798.	Summary of remaining write-ins for Line 47 from overflow page		
4799.	TOTALS (Lines 4701 through 4703 plus 4798) (Line 47 above)	(277,734)	(291,944)

CASH FLOW

		1 Current Year	2 Prior Year
	Cash from Operations		
1.	Premiums collected net of reinsurance	133,743,018	116,490,648
2.	Net investment income	4,394	2,253
3.	Miscellaneous income		
4.	TOTAL (Lines 1 through 3)	133,747,412	116,492,901
5.	Benefit and loss related payments	94,545,008	93,715,686
6.	Net transfers to Separate Accounts, Segregated Accounts and Protected Cell Accounts	5	
7.	Commissions, expenses paid and aggregate write-ins for deductions	20,212,221	13,636,069
8.	Dividends paid to policyholders		
9.	Federal and foreign income taxes paid (recovered) net of $.....0 tax on capital gains (losses)	2,319,318	857,046
10.	TOTAL (Lines 5 through 9)	117,076,552	108,208,820
11.	Net cash from operations (Line 4 minus Line 10)	16,670,860	8,284,081
	Cash from Investments		
12.	Proceeds from investments sold, matured or repaid:		
	12.1 Bonds		
	12.2 Stocks		
	12.3 Mortgage loans		
	12.4 Real estate		
	12.5 Other invested assets		
	12.6 Net gains or (losses) on cash, cash equivalents and short-term investments		
	12.7 Miscellaneous proceeds		
	12.8 TOTAL investment proceeds (Lines 12.1 to 12.7)		
13.	Cost of investments acquired (long-term only):		
	13.1 Bonds		
	13.2 Stocks		
	13.3 Mortgage loans		
	13.4 Real estate		
	13.5 Other invested assets		
	13.6 Miscellaneous applications		
	13.7 TOTAL investments acquired (Lines 13.1 to 13.6)		
14.	Net increase (decrease) in contract loans and premium notes		
15.	Net cash from investments (Line 12.8 minus Line 13.7 minus Line 14)		
	Cash from Financing and Miscellaneous Sources		
16.	Cash provided (applied):		
	16.1 Surplus notes, capital notes		
	16.2 Capital and paid in surplus, less treasury stock		1,335,000
	16.3 Borrowed funds		
	16.4 Net deposits on deposit-type contracts and other insurance liabilities		
	16.5 Dividends to stockholders	314,417	
	16.6 Other cash provided (applied)	(817,889)	258,298
17.	Net cash from financing and miscellaneous sources (Lines 16.1 to 16.4 minus Line 16.5 plus Line 16.6)	(1,132,306)	1,593,298
	RECONCILIATION OF CASH, CASH EQUIVALENTS AND SHORT-TERM INVESTMENTS		
18.	Net change in cash, cash equivalents and short-term investments (Line 11, plus Lines 15 and 17)	15,538,554	9,877,379
19.	Cash, cash equivalents and short-term investments:		
	19.1 Beginning of year	21,698,191	11,820,812
	19.2 End of year (Line 18 plus Line 19.1)	37,236,745	21,698,191

Note: Supplemental Disclosures of Cash Flow Information for Non-Cash Transactions:

20.0001			

ANALYSIS OF OPERATIONS BY LINES OF BUSINESS

		1	2	3	4	5	6	7	8	9	10
		Total	Comprehensive (Hospital & Medical)	Medicare Supplement	Dental Only	Vision Only	Federal Employees Health Benefits Plan	Title XVIII Medicare	Title XIX Medicaid	Other Health	Other Non-Health
1.	Net premium income	[illegible]	[illegible]						[illegible]		
2.	Change in unearned premium reserves and reserve for rate credits	[illegible]	[illegible]						[illegible]		
3.	Fee-for-service (net of $ [illegible] medical expenses)										[illegible]
4.	Risk revenue										XXX
5.	Aggregate write-ins for other health care related revenues										XXX
6.	Aggregate write-ins for other non-health care related revenues	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX
7.	TOTAL Revenues (Lines 1 to 6)	[illegible]	[illegible]						[illegible]		
8.	Hospital/medical benefits	[illegible]	[illegible]						[illegible]		XXX
9.	Other professional services	[illegible]	[illegible]						[illegible]		XXX
10.	Outside referrals										XXX
11.	Emergency room and out-of-area										XXX
12.	Prescription drugs	[illegible]	[illegible]						[illegible]		XXX
13.	Aggregate write-ins for other hospital and medical										XXX
14.	Incentive pool, withhold adjustments and bonus payments										XXX
15.	Subtotal (Lines 8 to 14)	[illegible]	[illegible]						[illegible]		XXX
16.	Net reinsurance recoveries	[illegible]							[illegible]		XXX
17.	TOTAL Hospital and Medical (Lines 15 minus 16)	[illegible]	[illegible]						[illegible]		XXX
18.	Non-health claims (net)		XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	
19.	Claims adjustment expenses, including $ [illegible] cost containment expenses	[illegible]	[illegible]						[illegible]		
20.	General administrative expenses	[illegible]	[illegible]						[illegible]		
21.	Increase in reserves for accident and health contracts										XXX
22.	Increase in reserves for life contracts	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	
23.	TOTAL Underwriting Deductions (Lines 17 to 22)	[illegible]	[illegible]						[illegible]		
24.	Net underwriting gain or (loss) (Line 7 minus Line 23)	[illegible]	[illegible]						[illegible]		
	DETAILS OF WRITE-INS										
0501.											XXX
0502.											XXX
0503.											XXX
0504.	Summary of remaining write-ins for Line 5 from another page										XXX
0505.	TOTALS (Lines 0501 through 0503 plus 0598) (Line 5 above)										XXX
0601.		XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	
0602.		XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	
0603.		XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	
0604.	Summary of remaining write-ins for Line 6 from another page	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	
0605.	TOTALS (Lines 0601 through 0603 plus 0698) (Line 6 above)	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	
1401.											XXX
1402.											XXX
1403.											XXX
1404.	Summary of remaining write-ins for Line 14 from another page										XXX
1405.	TOTALS (Lines 1401 through 1403 plus 1498) (Line 14 above)										XXX

UNDERWRITING AND INVESTMENT EXHIBIT

PART 1 - PREMIUMS

	Line of Business	1 Direct Business	2 Reinsurance Assumed	3 Reinsurance Ceded	4 Net Premium Income (Columns 1 + 2 - 3)
1.	Comprehensive (hospital and medical)	8,084,446		46,899	8,037,547
2.	Medicare Supplement				
3.	Dental only				
4.	Vision only				
5.	Federal Employee Health Benefits Plan				
6.	Title XVIII - Medicare				
7.	Title XIX - Medicaid	122,949,709		473,514	122,476,195
8.	Other health				
9.	Health subtotal (Lines 1 through 8)	132,034,154		520,413	131,513,742
10.	Life				
11.	Property/casualty				
12.	TOTALS (Lines 9 to 11)	132,034,154		520,413	131,513,742

UNDERWRITING AND INVESTMENT EXHIBIT

PART 2 - CLAIMS INCURRED DURING THE YEAR

	1 Total	2 Comprehensive (Hospital & Medical)	3 Medicare Supplement	4 Dental Only	5 Vision Only	6 Federal Employees Health Benefits Plan	7 Title XVIII Medicare	8 Title XIX Medicaid	9 Other Health	10 Other Non-Health
1. Payments during the year:										
1.1 Direct	45,468,820	7,667,732						37,801,088		
1.2 Reinsurance assumed										
1.3 Reinsurance ceded	32,820							32,820		
1.4 Net	45,436,000	7,667,732						37,768,268		
2. Paid medical incentive pools and bonuses										
3. Claim liability December 31, current year from Part 2A:										
3.1 Direct	21,449,292	3,657,157						17,791,135		
3.2 Reinsurance assumed										
3.3 Reinsurance ceded										
3.4 Net	21,449,292	3,657,157						17,791,135		
4. Claim reserve December 31, current year from Part 2D:										
4.1 Direct										
4.2 Reinsurance assumed										
4.3 Reinsurance ceded										
4.4 Net										
5. Accrued medical incentive pools and bonuses, current year										
6. Net healthcare receivables (a)	(513,045)							(513,045)		
7. Amounts recoverable from reinsurers December 31, current year										
8. Claim liability December 31, prior year from Part 2A:										
8.1 Direct	11,981,440	1,018,884						10,962,554		
8.2 Reinsurance assumed										
8.3 Reinsurance ceded										
8.4 Net	11,981,440	1,018,884						10,962,554		
9. Claim reserve December 31, prior year from Part 2D:										
9.1 Direct										
9.2 Reinsurance assumed										
9.3 Reinsurance ceded										
9.4 Net										
10. Accrued medical incentive pools and bonuses, prior year										
11. Amounts recoverable from reinsurers December 31, prior year										
12. Incurred benefits:										
12.1 Direct	164,044,668	10,485,655						39,618,820		
12.2 Reinsurance assumed										
12.3 Reinsurance ceded	32,820							32,820		
12.4 Net	164,011,848	10,485,655						39,586,000		
13. Incurred medical incentive pools and bonuses										

(a) Explain: 0 ..... 0 items or amounts in positive and (or) negative amount.

UNDERWRITING AND INVESTMENT EXHIBIT

PART 2A - CLAIMS LIABILITY END OF CURRENT YEAR

	1 Total	2 Comprehensive (Hospital & Medical)	3 Medicare Supplement	4 Dental Only	5 Vision Only	6 Federal Employees Health Benefits Plan	7 Title XVIII Medicare	8 Title XIX Medicaid	9 Other Health	10 Other Non-Health
1. Reported in Process of Adjustment										
1.1 Direct	8,829,791	1,795,119						8,054,910		
1.2 Reinsurance assumed										
1.3 Reinsurance ceded								8,054,910		
1.4 Net	8,829,791	1,795,119						8,054,910		
2. Incurred but Unreported										
2.1 Direct	11,627,551	2,091,044						9,536,507		
2.2 Reinsurance assumed										
2.3 Reinsurance ceded								9,536,507		
2.4 Net	11,627,551	2,091,044								
3. Amounts Withheld from Paid Claims and Capitations										
3.1 Direct										
3.2 Reinsurance assumed										
3.3 Reinsurance ceded										
3.4 Net										
4. TOTALS										
4.1 Direct	21,449,268	3,957,457						17,591,417		
4.2 Reinsurance assumed										
4.3 Reinsurance ceded								17,591,417		
4.4 Net	21,449,268	3,957,457								

UNDERWRITING AND INVESTMENT EXHIBIT

PART 2B - ANALYSIS OF CLAIMS UNPAID-PRIOR YEAR-NET OF REINSURANCE

Line of Business	Claims Paid During the Year		Claim Reserve and Claim Liability December 31 of Current Year		5	6
	1 On Claims Incurred Prior to January 1 of Current Year	2 On Claims Incurred During the Year	3 On Claims Unpaid December 31 of Prior Year	4 On Claims Incurred During the Year	Claims Incurred in Prior Years (Columns 1 + 3)	Estimated Claim Reserve and Claim Liability December 31 of Prior Year
1. Comprehensive (hospital and medical)	1,360,543	8,307,199	89,453	3,267,748	1,449,996	1,616,934
2. Medicare Supplement						
3. Dental only						
4. Vision only						
5. Federal Employees Health Benefits Plan						
6. Title XVIII - Medicare						
7. Title XIX - Medicaid	12,109,242	76,388,914	488,647	17,105,889	12,598,789	10,982,804
8. Other health						
9. Health subtotal (Lines 1 to 8)	13,469,785	84,706,113	578,099	20,373,637	14,048,785	12,599,738
10. Healthcare receivables (a)		610,676				205,721
11. Other non-health						
12. Medical incentive pool and bonus amounts						
13. TOTAL (Lines 9 - 10 + 11 + 12)	13,469,785	84,095,437	578,099	20,373,637	14,048,785	12,393,917

(a) Excludes $ ..... 0 loans or advances to providers not yet expensed.

UNDERWRITING AND INVESTMENT EXHIBIT

PART 2C - DEVELOPMENT OF PAID AND INCURRED HEALTH CLAIMS ($000 Omitted)

Grand Total

Section A - Paid Health Claims

Year in Which Losses Were Incurred	Cumulative Net Amounts Paid				
	1 2011	2 2012	3 2013	4 2014	5 2015
1. Prior					
2. 2011					
3. 2012	XXX				
4. 2013	XXX	XXX	87,444	49,209	49,883
5. 2014	XXX	XXX	XXX	61,695	85,451
6. 2015	XXX	XXX	XXX	XXX	81,095

Section B - Incurred Health Claims

Year in Which Losses Were Incurred	Sum of Cumulative Net Amounts Paid and Claim Liability, Claim Reserve and Medical Incentive Pool and Bonuses Outstanding at End of Year				
	1 2011	2 2012	3 2013	4 2014	5 2015
1. Prior					
2. 2011					
3. 2012	XXX				
4. 2013	XXX	XXX	95,129	49,209	49,883
5. 2014	XXX	XXX	XXX	85,697	85,555
6. 2015	XXX	XXX	XXX	XXX	101,695

Section C - Incurred Year Health Claims and Claims Adjustment Expense Ratio

Year in Which Premiums were Earned and Claims were Incurred	1 Premiums Earned	2 Claims Payments	3 Claim Adjustment Expense Payments	4 (Col. 3/2) Percent	5 Claim and Claim Adjustment Expense Payments (Col. 2 + 3)	6 (Col. 5/1) Percent	7 Claims Unpaid	8 Unpaid Claims Adjustment Expenses	9 Total Claims and Claims Adjustment Expenses Incurred (Col. 5 + 7 + 8)	10 (Col. 9/1) Percent
1. 2011										
2. 2012										
3. 2013	83,836	46,999	2,888	5.912	91,859	102.533			91,859	102.533
4. 2014	113,032	85,451	7,678	8.633	100,130	88.579	694		100,824	37.370
5. 2015	131,268	81,095	6,589	8.547	88,395	85.385	20,894	417	107,679	81.844

12 Total

UNDERWRITING AND INVESTMENT EXHIBIT

PART 2C - DEVELOPMENT OF PAID AND INCURRED HEALTH CLAIMS ($000 Omitted)

Hospital and Medical

Section A - Paid Health Claims

Year in Which Losses Were Incurred	Cumulative Net Amounts Paid 1 2011	2 2012	3 2013	4 2014	5 2015
1. Prior					
2. 2011					
3. 2012	XXX				
4. 2013	XXX	XXX		4,256	
5. 2014	XXX	XXX	XXX		7,463
6. 2015	XXX	XXX	XXX	XXX	6,307

Section B - Incurred Health Claims

Year in Which Losses Were Incurred	Sum of Cumulative Net Amounts Paid and Claim Liability, Claim Reserve and Medical Incentive Pool and Bonuses Outstanding at End of Year 1 2011	2 2012	3 2013	4 2014	5 2015
1. Prior					
2. 2011					
3. 2012	XXX				
4. 2013	XXX	XXX		4,256	
5. 2014	XXX	XXX	XXX		7,907
6. 2015	XXX	XXX	XXX	XXX	12,056

Section C - Incurred Year Health Claims and Claims Adjustment Expense Ratio

Years in Which Premiums were Earned and Claims were Incurred	1 Premiums Earned	2 Claims Payments	3 Claim Adjustment Expense Payments	4 (Col. 2/1) Percent	5 (Claims and Claim Adjustment Expense Payments (Col. 2 + 3)	6 (Col. 5/1) Percent	7 Claims Unpaid	8 Unpaid Claim Adjustment Expenses	9 Total Claims and Claim Adjustment Expenses Incurred (Col. 5 + 7 + 8)	10 (Col. 9/1) Percent
1. 2011										
2. 2012										
3. 2013	2,576	3,845	177	4,614	4,020	156.067			4,020	156.067
4. 2014	7,463	7,655	884	8,539	8,537	111.180	59		8,651	112.457
5. 2015	6,307	6,317	655	6,972	6,968	79.856	3,758		10,651	119.352

12 Underwriting Invest Exh Pt 2C Sn A - Paid Claims - Medicare Supplement .... NONE

12 Underwriting Invest Exh Pt 2C Sn B - Incur. Claims - Medicare Supplement ... NONE

12 Underwriting Invest Exh Pt 2C Sn C - Expns Ratios - Medicare Supplement ... NONE

12 Underwriting Invest Exh Pt 2C Sn A - Paid Claims - Dental Only ..... NONE

12 Underwriting Invest Exh Pt 2C Sn B - Incur. Claims - Dental Only ..... NONE

12 Underwriting Invest Exh Pt 2C Sn C - Expns Ratios - Dental Only ..... NONE

12 Underwriting Invest Exh Pt 2C Sn A - Paid Claims - Vision Only ..... NONE

12 Underwriting Invest Exh Pt 2C Sn B - Incur. Claims - Vision Only ..... NONE

12 Underwriting Invest Exh Pt 2C Sn C - Expns Ratios - Vision Only ..... NONE

12 Underwriting Invest Exh Pt 2C Sn A - Paid Claims - Fed Emp HBPP ..... NONE

12 Underwriting Invest Exh Pt 2C Sn B - Incur. Claims - Fed Emp HBPP ..... NONE

12 Underwriting Invest Exh Pt 2C Sn C - Expns Ratios - Fed Emp HBPP ..... NONE

12 Underwriting Invest Exh Pt 2C Sn A - Paid Claims - Title XVIII-Medicare ..... NONE

12 Underwriting Invest Exh Pt 2C Sn B - Incur. Claims - Title XVIII-Medicare ..... NONE

12 Underwriting Invest Exh Pt 2C Sn C - Expns Ratios - Title XVIII-Medicare ..... NONE

UNDERWRITING AND INVESTMENT EXHIBIT

PART 2C - DEVELOPMENT OF PAID AND INCURRED HEALTH CLAIMS (000 Omitted)

Title XIX - Medicaid

Section A - Paid Health Claims

Year in Which Losses Were Incurred	Cumulative Net Amounts Paid				
	1 2011	2 2012	3 2013	4 2014	5 2015
1. Prior					
2. 2011					
3. 2012	XXX				
4. 2013	XXX	XXX			
5. 2014	XXX	XXX	XXX		
6. 2015	XXX	XXX	XXX	XXX	

Section B - Incurred Health Claims

Year in Which Losses Were Incurred	Sum of Cumulative Net Amount Paid and Claim Liability, Claim Reserve and Medical Incentive Pool and Bonuses Outstanding at End of Year				
	1 2011	2 2012	3 2013	4 2014	5 2015
1. Prior					
2. 2011					
3. 2012	XXX				
4. 2013	XXX	XXX			
5. 2014	XXX	XXX	XXX		
6. 2015	XXX	XXX	XXX	XXX	

Section C - Incurred Year Health Claims and Claims Adjustment Expense Ratio

Years in Which Premiums were Earned and Claims were Incurred	1 Premiums Earned	2 Claims Payments	3 Claim Adjustment Expense Payments	4 (Col. 3/2) Percent	5 Claims and Claims Adjustment Expense Payments (Col. 2+3)	6 (Col. 5/1) Percent	7 Claims Unpaid	8 Unpaid Claims Adjustment Expenses	9 Total Claims and Claims Adjustment Expenses Incurred (Col. 5 + 7 + 8)	10 (Col. 9/1) Percent
1. 2011										
2. 2012										
3. 2013	47,994	45,129	2,716	6.020	47,845	99.690			47,845	99.690
4. 2014	911,480	87,865	6,674	7.599	94,537	94.261	469		95,042	95.216
5. 2015	102,570	74,779	4,783	6.399	79,562	84.864	17,128	417	97,655	78.178

12 Underwriting Invest Exh Pt 2C Sn A - Paid Claims - Other ..... NONE

12 Underwriting Invest Exh Pt 2C Sn B - Incur Claims - Other ..... NONE

12 Underwriting Invest Exh Pt 2C Sn C - Expns Ratios - Other ..... NONE

13 Underwriting Invest Exh Pt 2D - A & H Reserve ..... NONE

UNDERWRITING AND INVESTMENT EXHIBIT

PART 3 - ANALYSIS OF EXPENSES

		Claim Adjustment Expenses		3	4	5
		1 Cost Containment Expenses	2 Other Claim Adjustment Expenses	General Administrative Expenses	Investment Expenses	Total
1.	Rent ($.....0 for occupancy of own building)			478,708		478,708
2.	Salaries, wages and other benefits	2,190,128	1,892,361	4,566,373		8,648,862
3.	Commissions (less $.....0 ceded plus $.....0 assumed)					
4.	Legal fees and expenses		201,752	550,027		751,779
5.	Certifications and accreditation fees	49,409	17,856	48,681		115,946
6.	Auditing, actuarial and other consulting services		131,952	359,737		491,689
7.	Traveling expenses	41,023	167,542	449,169		657,887
8.	Marketing and advertising	12,003	80,367	219,102		311,469
9.	Postage, express and telephone	1,300	56,465	153,666		211,431
10.	Printing and office supplies	9,498	102,327	278,565		390,390
11.	Occupancy, depreciation and amortization		37,700	102,781		140,481
12.	Equipment		4,604	12,551		17,155
13.	Cost or depreciation of EDP equipment and software	92,157	78,444	213,857		384,458
14.	Outsourced services including EDP, claims, and other services	916,068		3,290,242		4,206,310
15.	Boards, bureaus and association fees					
16.	Insurance, except on real estate		28,182	76,831		105,013
17.	Collection and bank service charges				465	465
18.	Group service and administration fees					
19.	Reimbursements by uninsured plans					
20.	Reimbursements from fiscal intermediaries					
21.	Real estate expenses					
22.	Real estate taxes					
23.	Taxes, licenses and fees:					
	23.1 State and local insurance taxes					
	23.2 State premium taxes			2,845,482		2,845,482
	23.3 Regulatory authority licenses and fees			486,464		486,464
	23.4 Payroll taxes	153,890	99,776	232,686		486,392
	23.5 Other (excluding federal income and real estate taxes)					
24.	Investment expenses not included elsewhere					
25.	Aggregate write-ins for expenses		(63,647)	70,659		7,012
26.	TOTAL Expenses Incurred (Lines 1 to 25)	3,465,586	2,835,781	14,296,571	465	(a) 20,597,403
27.	Less expenses unpaid December 31, current year			4,773,383		4,773,383
28.	Add expenses unpaid December 31, prior year			4,805,579		4,805,579
29.	Amounts receivable relating to uninsured plans, prior year					
30.	Amounts receivable relating to uninsured plans, current year					
31.	TOTAL Expenses Paid (Lines 26 minus 27 plus 28 minus 29 plus 30)	3,465,586	2,835,781	14,327,767	465	20,629,599
DETAILS OF WRITE-INS						
2501.	Contributions and Sponsorships			18,450		18,450
2502.	Government Relations			51,500		51,500
2503.	Miscellaneous Administrative Expenses		(63,647)	709		(62,938)
2598.	Summary of remaining write-ins for Line 25 from overflow page					
2599.	TOTALS (Lines 2501 through 2503 plus 2598) (Line 25 above)		(63,647)	70,659		7,012

(a) Includes management fees of $.....757,504 to affiliates and $.....0 to non-affiliates.

EXHIBIT OF NET INVESTMENT INCOME

		1 Collected During Year	2 Earned During Year
1.	U.S. Government bonds	(a)	
1.1	Bonds exempt from U.S. tax	(a)	
1.2	Other bonds (unaffiliated)	(a)	
1.3	Bonds of affiliates	(a)	
2.1	Preferred stocks (unaffiliated)	(b)	
2.11	Preferred stocks of affiliates	(b)	
2.2	Common stocks (unaffiliated)		
2.21	Common stocks of affiliates		
3.	Mortgage loans	(c)	
4.	Real estate	(d)	
5.	Contract loans		
6.	Cash, cash equivalents and short-term investments	(e) 4,859	4,859
7.	Derivative instruments	(f)	
8.	Other invested assets		
9.	Aggregate write-ins for investment income		
10.	TOTAL Gross investment income	4,859	4,859
11.	Investment expenses		(g) 465
12.	Investment taxes, licenses and fees, excluding federal income taxes		(g)
13.	Interest expense		(h)
14.	Depreciation on real estate and other invested assets		(i)
15.	Aggregate write-ins for deductions from investment income		
16.	TOTAL Deductions (Lines 11 through 15)		465
17.	Net investment income (Line 10 minus Line 16)		4,394
DETAILS OF WRITE-INS			
0901.			
0902.			
0903.			
0998.	Summary of remaining write-ins for Line 9 from overflow page		
0999.	TOTALS (Lines 0901 through 0903 plus 0998) (Line 9 above)		
1501.			
1502.			
1503.			
1598.	Summary of remaining write-ins for Line 15 from overflow page		
1599.	TOTALS (Lines 1501 through 1503 plus 1598) (Line 15 above)		

(a) Includes $.....0 accrual of discount less $.....0 amortization of premium and less $.....0 paid for accrued interest on purchases.
(b) Includes $.....0 accrual of discount less $.....0 amortization of premium and less $.....0 paid for accrued dividends on purchases.
(c) Includes $.....0 accrual of discount less $.....0 amortization of premium and less $.....0 paid for accrued interest on purchases.
(d) Includes $.....0 for company's occupancy of its own buildings; and excludes $.....0 interest on encumbrances.
(e) Includes $.....0 accrual of discount less $.....0 amortization of premium and less $.....0 paid for accrued interest on purchases.
(f) Includes $.....0 accrual of discount less $.....0 amortization of premium.
(g) Includes $.....0 investment expenses and $.....0 investment taxes, licenses and fees, excluding federal income taxes, attributable to segregated and Separate Accounts.
(h) Includes $.....0 interest on surplus notes and $.....0 interest on capital notes.
(i) Includes $.....0 depreciation on real estate and $.....0 depreciation on other invested assets.

EXHIBIT OF CAPITAL GAINS (LOSSES)

		1 Realized Gain (Loss) on Sales or Maturity	2 Other Realized Adjustments	3 Total Realized Capital Gain (Loss) (Columns 1 + 2)	4 Change in Unrealized Capital Gain (Loss)	5 Change in Unrealized Foreign Exchange Capital Gain (Loss)
1.	U.S. Government bonds					
1.1	Bonds exempt from U.S. tax					
1.2	Other bonds (unaffiliated)					
1.3	Bonds of affiliates					
2.1	Preferred stocks (unaffiliated)					
2.11	Preferred stocks of affiliates					
2.2	Common stocks (unaffiliated)					
2.21	Common stocks of affiliates					
3.	Mortgage loans					
4.	Real estate	NONE				
5.	Contract loans					
6.	Cash, cash equivalents and short-term investments					
7.	Derivative instruments					
8.	Other invested assets					
9.	Aggregate write-ins for capital gains (losses)					
10.	TOTAL Capital gains (losses)					
DETAILS OF WRITE-INS						
0901.						
0902.						
0903.						
0998.	Summary of remaining write-ins for Line 9 from overflow page					
0999.	TOTALS (Lines 0901 through 0903 plus 0998) (Line 9 above)					

EXHIBIT OF NONADMITTED ASSETS

		1 Current Year Total Nonadmitted Assets	2 Prior Year Total Nonadmitted Assets	3 Change in Total Nonadmitted Assets (Col. 2 - Col. 1)
1.	Bonds (Schedule D)			
2.	Stocks (Schedule D):			
	2.1 Preferred stocks			
	2.2 Common stocks			
3.	Mortgage loans on real estate (Schedule B):			
	3.1 First liens			
	3.2 Other than first liens			
4.	Real estate (Schedule A):			
	4.1 Properties occupied by the company			
	4.2 Properties held for the production of income			
	4.3 Properties held for sale			
5.	Cash (Schedule E-Part 1), cash equivalents (Schedule E-Part 2) and short-term investments (Schedule DA)			
6.	Contract loans			
7.	Derivatives (Schedule DB)			
8.	Other invested assets (Schedule BA)			
9.	Receivables for securities			
10.	Securities lending reinvested collateral assets (Schedule DL)			
11.	Aggregate write-ins for invested assets			
12.	Subtotals, cash and invested assets (Lines 1 to 11)			
13.	Title plants (for Title insurers only)			
14.	Investment income due and accrued			
15.	Premiums and considerations:			
	15.1 Uncollected premiums and agents' balances in the course of collection			
	15.2 Deferred premiums, agents' balances and installments booked but deferred and not yet due			
	15.3 Accrued retrospective premiums and contracts subject to redetermination			
16.	Reinsurance:			
	16.1 Amounts recoverable from reinsurers			
	16.2 Funds held by or deposited with reinsured companies			
	16.3 Other amounts receivable under reinsurance contracts			
17.	Amounts receivable relating to uninsured plans			
18.1	Current federal and foreign income tax recoverable and interest thereon			
18.2	Net deferred tax asset	269,712	66,098	(193,614)
19.	Guaranty funds receivable or on deposit			
20.	Electronic data processing equipment and software	274,500	165,839	(108,661)
21.	Furniture and equipment, including health care delivery assets	173,500	196,230	22,730
22.	Net adjustment in assets and liabilities due to foreign exchange rates			
23.	Receivables from parent, subsidiaries and affiliates			
24.	Health care and other amounts receivable		4,918	4,918
25.	Aggregate write-ins for other than invested assets	175,063	94,762	(80,301)
26.	TOTAL Assets excluding Separate Accounts, Segregated Accounts and Protected Cell Accounts (Lines 12 to 25)	892,775	527,847	(364,928)
27.	From Separate Accounts, Segregated Accounts and Protected Cell Accounts			
28.	TOTAL (Lines 26 and 27)	892,775	527,847	(364,928)
DETAILS OF WRITE-INS				
1101.				
1102.				
1103.				
1198.	Summary of remaining write-ins for Line 11 from overflow page			
1199.	TOTALS (Lines 1101 through 1103 plus 1198) (Line 11 above)			
2501.	Prepaid Expenses	108,197	66,846	(41,351)
2502.	Employee Advances	1,559		(1,559)
2503.	Deposits	16,735	16,735	
2598.	Summary of remaining write-ins for Line 25 from overflow page	48,572	11,181	(37,391)
2599.	TOTALS (Lines 2501 through 2503 plus 2598) (Line 25 above)	175,063	94,762	(80,301)

EXHIBIT 1 - ENROLLMENT BY PRODUCT TYPE FOR HEALTH BUSINESS ONLY

	Reporting Entity Enrollment	Total Members at End of					
		1 Prior Year	2 First Quarter	3 Second Quarter	4 Third Quarter	5 Current Year	6 Current Year Member Months
1.	Health Maintenance Organizations	31,944	30,297	30,180	30,269	31,259	365,118
2.	Provider Service Organizations						
3.	Preferred Provider Organizations						
4.	Point of Service						
5.	Indemnity Only						
6.	Aggregate write-ins for other lines of business						
7.	TOTAL	31,944	30,297	30,180	30,269	31,259	365,118
	DETAILS OF WRITE-INS						
0601.							
0602.							
0603.							
0698.	Summary of remaining write-ins for Line 6 from overflow page						
0699.	TOTALS (Lines 0601 through 0603 plus 0698) (Line 6 above)						

Notes to Financial Statements

1. Summary of Significant Accounting Policies

A. Accounting Practices

The financial statements of Trusted Health Plan, (District of Columbia), Inc. (THP) are presented on the basis of accounting practices prescribed or permitted by the District of Columbia Department of Insurance, Securities and Banking (DISB).

The DISB recognizes only statutory accounting practices prescribed or permitted by the District of Columbia (District) for determining and reporting the financial condition and results of operations of an insurance company and for determining its solvency under the District of Columbia Insurance Code. The DISB has adopted the National Association of Insurance Commissioners' (NAIC) *Accounting Practices and Procedures Manual* as a component of prescribed and permitted practices for the District. The DISB has the right to permit specific practices that deviate from prescribed practices. There is no deviation from the NAIC *Accounting Practices and Procedures Manual*.

A reconciliation of the Company's net income and capital and surplus between NAIC SAP and practices prescribed and permitted by the District of Columbia Department of Insurance, Securities and Banking is shown below:

		State of Domicile	2015	2014
NET INCOME				
(1)	State basis (Page 4, Line 32, Columns 2 & 3)	DC	$4,328,083	$3,000,611
(2)	State Prescribed Practices that increase/(decrease) NAIC SAP:			
(201)				
(299)	Total		$0	$0
(3)	State Permitted Practices that increase/(decrease) NAIC SAP:			
(301)				
(399)	Total		$0	$0
(4)	NAIC SAP (1-2-3=4)		$4,328,083	$3,000,611
SURPLUS				
(5)	State basis (Page 3, Line 33, Columns 3 & 4)	DC	$12,282,162	$8,684,549
(6)	State Prescribed Practices that increase/(decrease) NAIC SAP:			
(601)				
(699)	Total		$0	$0
(7)	State Permitted Practices that increase/(decrease) NAIC SAP:			
(701)				
(799)	Total		$0	$0
(8)	NAIC SAP (5-6-7=8)		$12,282,162	$8,684,549

B. Use of Estimates in the Preparation of the Financial Statements

The preparation of the financial statements in conformity with Statutory Accounting Principles requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities. It also requires disclosure of contingent assets and liabilities at the date of the financial statements and the reported amounts of revenue and expenses during the period. Actual results could differ from those estimates.

C. Accounting Policy

THP writes only Medicaid contracts primarily through a contract with the District of Columbia Department of Health Care Finance (DHCF). Medicaid premiums from the DHCF are due monthly and are recognized as revenue during the period in which THP is obligated to provide service to members.

In addition, the Company uses the following accounting policies:

(1) Short-term investments – None

(2) Bonds not backed by other loans - None

Notes to Financial Statements

(3) Common stocks – None

(4) Preferred stocks – None

(5) Mortgage loans on real estate – None

(6) Loan-backed securities – None

(7) Investments in subsidiaries, controlled or affiliated companies – None

(8) Investments in joint ventures, partnerships and limited liability companies – None

(9) Derivatives instruments – None

(10) THP does not carry a premium deficiency reserve and consequently does not utilize anticipated investment income as a factor in the premium deficiency calculation.

(11) Medical and hospital costs are accrued based on claims received but unpaid and an estimate for claims incurred but not yet received (IBNR). These estimates are projected through an actuarial model, which calculates the outstanding liability based on payment trends and membership. THP uses actuarially sound methodologies developed by its actuarial consultants, Lewis & Ellis, Inc. to calculate its medical liability. Claims and claims adjustment expenses are expensed as incurred.

The Company establishes an unpaid claims liability for claims in the process of review and for claims incurred but not reported. The liability for claims incurred but not reported is actuarially estimated based on the most current historical claims experience, changes in number of members and participants and estimates of health care trend (cost, utilization and intensity of services) changes. Estimates for claims incurred but not reported are continually reviewed and revised as changes in these factors occur and revisions are reflected in the current year's statements of revenue and expenses.

(12) THP has not modified its capitalization policy from the prior period.

(13) THP does not have any pharmacy rebate receivables.

D. Going Concern - None

2. Accounting Changes and Corrections of Errors

The Company made corrections to the 2014 financial statements related to the following items:

ACA and DC Exch Tax Adjustment	1,713,481
Data Warehouse	(63,000)
Adjustment based on the new provision	(17,232)
Accrual of DST invoice	117,828
Adjustment made to the deferred rent liability	(16,638)
Reversing the ACA tax for 2014 recorded in 1st quarter of 2015	(447,455)
MCO Tax adjustment due to reversing entry made for the ACA tax	(14,207)
Reversing the DC exchange tax for January to October 2014	(964,792)
Adjustment based on the new provision	(25,606)
Adjustment based on the new provision	(4,645)
	277,734

3. Business Combinations and Goodwill

A. Statutory Purchase Method - None

B. Statutory Merger - None

C. Assumption Reinsurance – None

D. Impairment Loss – None

4. Discontinued Operations

None

5. Investments

A. Mortgage Loans, including Mezzanine Real Estate Loans – None

B. Debt Restructuring – None

C. Reverse Mortgages – None

D. Loan-Backed Securities – None

Notes to Financial Statements

E. Repurchase Agreements and/or Securities Lending Transactions

(1) Policy for requiring collateral or other security – None

(2) Carrying amount and classification of both those assets and associated liabilities – None

(3) Collateral accepted that it is permitted by contract or custom to sell or repledge:

a. Aggregate amount of contractually obligated open collateral positions – None

b. Fair value of that collateral and of the portion of that collateral that it has sold or repledged – None

c. Information about the sources and uses of that collateral – None

(4) Aggregate value of the reinvested collateral which is "one-line" reported and the aggregate reinvested collateral which is reported in the investment schedules – None

(5) Reinvestment of the cash collateral and any securities which it or its agent receives as collateral that can be sold or repledged – None

(6) Collateral accepted that it is not permitted by contract or custom to sell or repledge – None

(7) Collateral for transactions that extend beyond one year from the reporting date – None

F. Real Estate – None

G. Low-Income Housing Tax Credits (LIHTC) – None

H. Restricted Assets - No Material Change

(1) Restricted Assets (Including Pledged)

Restricted Asset Category	1 Total Gross Restricted from Current Year	2 Total Gross Restricted From Prior Year	3 Increase/ (Decrease) (1 minus 2)	4 Total Current Year Admitted Restricted	5 Percentage Gross Restricted to Total Assets	6 Percentage Admitted Restricted to Total Admitted Assets
a. Subject to contractual obligation for which liability is not shown	$	$	$	$	%	%
b. Collateral held under security lending agreements						
c. Subject to repurchase agreements						
d. Subject to reverse repurchase agreements						
e. Subject to dollar repurchase agreements						
f. Subject to dollar reverse repurchase agreements						
g. Placed under option contracts						
h. Letter stock or securities restricted as to sale – excluding FHLB capital stock						
i. FHLB capital stock						
j. On deposit with states	$300,886	$300,664	$222	$300,886	0.74%	0.76%
k. On deposit with other regulatory bodies						
l. Other restricted assets Pledged as collateral to FHLB (including assets backing funding agreements)						
m. Pledged as collateral not captured in other categories						
n. Other restricted assets						
o. Total Restricted Assets	$300,886	$300,664	$222	$300,886	0.74%	0.76%

(2) Detail of Assets Pledged as Collateral Not Captured in Other Categories – None

(3) Detail of Other Restricted Assets - None

I. Working Capital Finance Investments

(2) Aggregate Book/Adjusted Carrying Value – None

Notes to Financial Statements

(3) Events of Default – None

J. Offsetting and Netting of Assets and Liabilities -- None

K. Structured Notes – None

6. Joint Ventures, Partnerships and Limited Liability Companies

A. THP has no investments in joint ventures, partnerships or limited liability companies.

B. THP does not have any investments in impaired Joint Ventures, Partnerships or Limited Liability Companies.

7. Investment Income

A. Due and accrued income was excluded from surplus on the following basis:

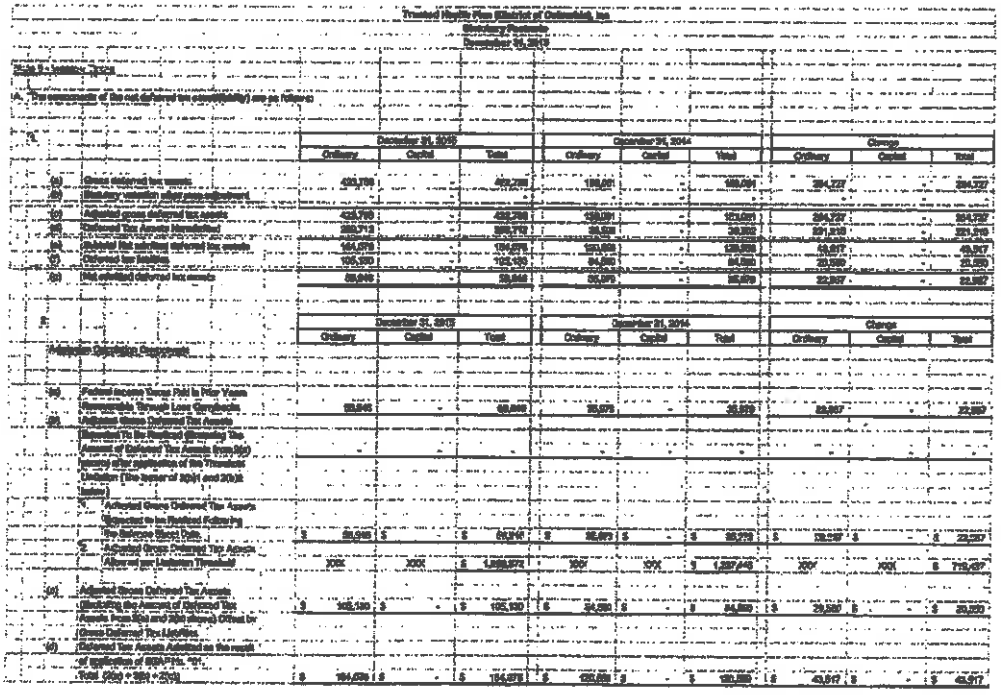
All investment income due or accrued with amounts that are over 90 days past due, with the exception of mortgage loans in default, are excluded from surplus.

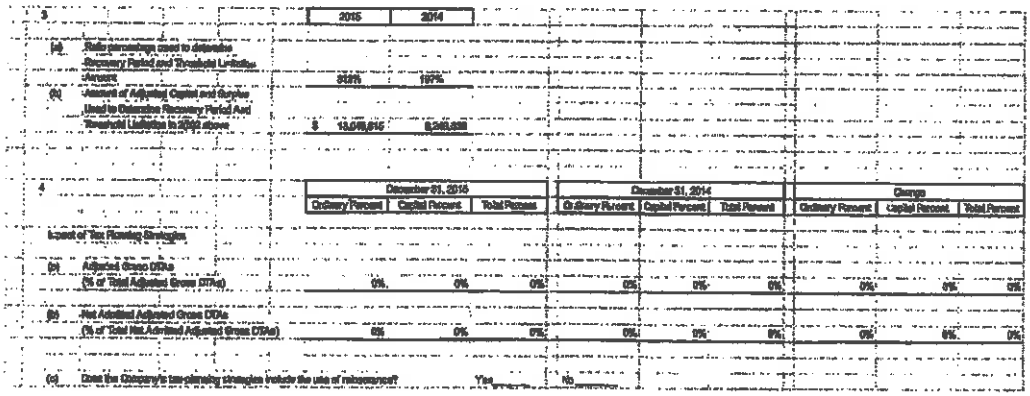
B. The Company has no investment income due and accrued excluded from surplus.

8. Derivative Instruments

A. – C. THP does not have any derivative instruments.

9. Income Taxes





Notes to Financial Statements

B. Unrecognized DTLs

Not applicable.

C. Current income taxes incurred consist of the following major components:

			12/31/15	12/31/14	Change
1.	Current income tax				
	(a)	Federal	2,579,646	1,172,160	1,407,486
	(b)	Foreign			
	(c)	Subtotal	2,579,646	1,172,160	1,407,486
	(d)	Federal income tax on net capital gains			
	(e)	Utilization of capital loss carry-forwards			
	(f)	Other	(33,299)		(33,299)
	(g)	Federal and foreign income taxes incurred	2,546,347	1,172,160	1,374,187
2.	Deferred Tax Assets:				
	(a)	Ordinary:			
		(1) Discounting of unpaid losses	58,946	35,979	22,967
		(2) Unearned premium reserve			
		(3) Policyholder reserves			
		(4) Investments			
		(5) Deferred Compensation			
		(6) Policyholder dividends			
		(7) Fixed assets			
		(8) Compensation and benefits accrual	153,000		153,000
		(9) Pension accrual			
		(10) Nonadmitted assets	211,812	128,092	83,720
		(11) Net operating loss carry-forward			
		(12) Tax credit carry-forward			
		(13) Other (including items <5% of total ordinary tax assets)			
		Subtotal	423,758	159,091	264,727
	(b)	Statutory valuation allowance adjustment			
	(c)	Nonadmitted	259,713	38,902	221,210
	(d)	Admitted ordinary deferred tax assets	164,076	120,589	43,517
	(e)	Capital:			
		(1) Investments			
		(2) Net capital loss carry-forward			
		(3) Real estate			
		(4) Other (including items <5% of total capital tax assets)			
		Subtotal			
	(f)	Statutory valuation allowance adjustment			
	(g)	Nonadmitted			
	(h)	Admitted capital deferred tax assets			
	(i)	Admitted deferred tax assets	164,076	120,589	43,517
3.	Deferred Tax Liabilities:				
	(a)	Ordinary			
		(1) Investments			
		(2) Fixed assets	105,138	84,590	20,550
		(3) Deferred and uncollected premium			
		(4) Policyholder reserves			
		(5) Other (including items <5% of total ordinary tax assets)			
		Subtotal	105,138	84,590	20,550
	(b)	Capital:			
		(1) Investments			
		(2) Real estate			
		(3) Other (including items <5% of total capital tax assets)			
		Subtotal			
	(c)	Deferred tax liabilities	105,138	84,590	20,550
4.	Net deferred tax assets/liabilities		58,946	35,979	22,967

Notes to Financial Statements

D. Reconciliation of Federal Income Tax Rate to Actual Effective Rate

The provision for federal income taxes incurred is different from that which would be obtained by applying the statutory federal income tax rate to income before income taxes. The significant items causing this difference are as follows:

Description	Amount	Tax Effect @ 34%	Effective Tax Rate
Income before taxes	7,040,524	2,393,778	34.00%
DRD deduction and tax-exempt interest, net	-	-	0.00%
Prior year underaccrual/(overaccrual)	(97,939)	(33,299)	-0.47%
Change in nonadmitted assets	(261,059)	(88,760)	-1.26%
Meals and entertainment	65,979	22,433	0.32%
Change in valuation allowance	-	-	0.00%
Other, including expiration of charitable contribution c/f	23,583	8,018	0.11%
Total	6,771,088	2,302,170	32.70%
Federal income taxes incurred [expense/(benefit)]		2,546,347	36.17%
Tax on capital gains		-	0.00%
Change in net deferred income tax [charge/(benefit)]		(244,177)	-3.47%
Total statutory income taxes		2,302,170	32.70%

E. Operating Loss and Tax Credit Carryforwards

(1) At December 31, 2015 the Company had $0 of net operating loss carryforwards and $0 of AMT credit carryforwards.

(2) The following is income tax expense for 2015 and 2014 that is available for recoupment in the event of future net losses:

Year	Amount
2015	1,138,881
2014	2,579,646

F. Consolidated Federal Income Tax Return

(1) The Company's federal income tax return is consolidated with the following entities:

Trusted Health Plans, Inc.

(2) The method of allocation among companies is subject to a written agreement, approved by the Board of Directors, whereby allocation is made primarily on a separate return basis with current credit given for any net operating losses or other items utilized in the consolidated tax return.

10. Information Concerning Parent, Subsidiaries, Affiliates and Other Related Parties

A. THP is a wholly owned subsidiary of Trusted Health Plan, Inc., a Delaware holding company. All outstanding shares of THP are owned by the parent company, Trusted Health Plans, Inc., a holding company domiciled in the state of Delaware. THP holds no assets or shares of stock in Trusted Health Plans, Inc.

B. and C. The Company paid cash dividends to Trusted Health Plans, Inc. (Parent Company) on June 22, 2015, totaling $314,417.

D. THP does not have any affiliated or subsidiary or related parties other than Trusted Health Plans, Inc., the parent company.

E. There are no guarantees or undertakings that exist with affiliates or non-affiliates that would expose the Company's assets or liabilities.

F. Office lease agreements and material management contracts

In April, 2015 the District of Columbia, Department of Insurance, Securities and Banking (DISB) approved a Management and Administrative Services Agreement between Trusted Health Plan (District of Columbia), Inc. and its' Parent Company, Trusted Health Plans, Inc.

Notes to Financial Statements

The Agreement has a January 1, 2015 effective date.

The Parent Company has agreed to provide certain financial reporting, accounting, staffing, and related management and administrative support services for a Minimum Fixed Fee payment of $400,000 per year, or $33,333 monthly.

G. THP is a wholly owned subsidiary of Trusted Health Plans, Inc.

H. The Company had no ownership in any upstream intermediate entities or ultimate parent companies owned.

I. Investment in SCA - None

J. Investment in impaired SCAs - None

K. Investment in Foreign Insurance Subsidiary - None

L. Investment in Downstream Noninsurance Holding Company – None

M. SCA Investments disclosure of SCA Balance Sheet – None

N. Investment in Insurance SCA departure from NAIC SAP - None

12. Retirement Plans, Deferred Compensation, Postemployment Benefits and Compensated Absences and Other Postretirement Benefit Plans.

A. Defined Benefit Plan

(1) Change in benefit obligation – None

(2) Change in plan assets- None

(3) Funded status - None

(4) Components of net periodic benefit cost - None

(5) The amount included in unassigned funds (surplus) for the period arising from a change in the additional minimum pension liability recognized - None

(6) Amounts in unassigned funds (surplus expected to be recognized in the next fiscal year as components of net periodic benefit cost - None

(7) Amounts in unassigned funds (surplus) that have not been recognized as components of net periodic benefit cost - None

(8) Weighted-average assumptions used to determine net period benefit cost - None

(9) The amount of accumulated benefit obligation for defined benefit pension plans - None

(10) – (11) The defined benefit pension plan asset allocation as of the measurement date, and the target asset allocation, presented as a percentage of total plan assets - None

(12) Estimated future payments, which reflect expected future service, as appropriate, are expected to be paid in the years- None

(13) Regulatory contribution requirements - None

(14) – (21) - None

B. Narrative Description of Investment Polices and Strategies – Not applicable

C. Fair Value of Plan Assets – Not applicable.

D. Narrative Description of Basis Used to Determine Expected L-T Rate-of Return – Not applicable.

E. Defined Contribution Plans - THP sponsored a 401K plan (The "Plan") for its employees beginning in 2013. Employees were eligible to participate in the Plan if they were at least 18 years of age and had completed three consecutive months of employment at the Company. The Company may make a discretionary matching contribution to the Plan. For the year ended December 31, 2014, the Company did not make any matching contributions. During the quarter ended June 30, 2015, the Company funded the 401K employee match. $51,126 was made as a matching contribution into the plan, retroactive back to July 1, 2013. For the period ended December 31, 2015 the Plan has contributed $105,985. At December 31, 2015, the fair value of plan assets was $305,086.

Notes to Financial Statements

F. Multi-Employer Plan – None

G. Consolidated/Holding Company Plans – None

H. Post-Employment Benefits and Compensated Absences – None

I. Impact of Medicare Modernization Act on Postretirement Benefits (INT 04-12) – None

13. Capital and Surplus, Dividend Restrictions and Quasi-Reorganizations

1. Capital stock authorized, issued and outstanding – No Material Change

2. THP has not issued any preferred stock.

3. Dividend restrictions

   Pursuant to D.C. Code §31-706(b), THP is required to receive prior approval from the DC DISB Commissioner before declaring a dividend in excess of 10% of prior year's capital and surplus balance or the prior year's net income balance amount.

4. The Company paid ordinary cash dividends of $314,417 on June 22, 2015.

5. Portions of Company's profit paid as ordinary dividends to stockholders

   Within the limitations of (3) above, there are no restrictions placed on the portion of Company profits that may be paid as ordinary dividends to stockholders.

6. Description of any restrictions on unassigned funds: None

7. Total amount of advances to surplus not repaid: None

8. Total amount of stock held by the company for special purposes: None

9. Reasons for changes in the balances of any special surplus funds: None

10. Portion of unassigned funds represented or reduced by unrealized gains or losses is $0.-

11. The company issued the following surplus debentures: None

12. Impact of restatement in a quasi-reorganization: None

13. Effective date of quasi-reorganization: None

14. Contingencies

A. Contingent Commitments – None

B. Assessments – None

C. Gain Contingencies – None

D. Claims Related Extra Contractual Obligation and Bad Faith Losses Stemming from Lawsuits – None

E. Joint and Several Liabilities - None

F. All Other Contingencies – None

15. Leases

A. Lease Operating Lease

(1) THP is obligated under several non-cancelable operating leases for office space and office equipment. Total rent expense was $404,801 for the year ended December 31, 2015.

(2) At December 31, 2015, the minimum aggregate rental commitments are as follows:

2016	$428,105
2017	$467,562
2018	$438,386
2019	$393,685
2020	$404,490
Total	$2,132,228

(3) The Company is not involved in any material sales-leaseback transactions.

Notes to Financial Statements

B. Lessor Leases – None

16. Information About Financial Instruments With Off-Balance-Sheet Risk And Financial Instruments With Concentrations of Credit Risk

None

17. Sale, Transfer and Servicing of Financial Assets and Extinguishments of Liabilities

A. Transfers of Receivables reported as Sales – None

B. Transfer and Servicing of Financial Assets

(1) Description of loaned securities – None

(2) Servicing Assets and Liabilities

a. Risks inherent in servicing assets and servicing liabilities – None

b. Amount of contractually specified servicing fees, late fees and ancillary fees earned for each period – None

c. Assumptions used to estimate the fair value – None

(3) Servicing assets and servicing liabilities are subsequently measured at fair value – None

(4) For securitizations, asset-backed financing arrangements, and similar transfers accounted for as sales when the transferor has continuing involvement (as defined in the glossary of the Accounting Practices & Procedures Manual) with the transferred financial assets:

a. Each income statement presented – None

b. Each statement of financial position presented, regardless of when the transfer occurred – None

(5) Transfers of financial assets accounted for as secured borrowing value – None

(6) Transfers of receivables with recourse – None

(7) Securities underlying repurchase and reverse repurchase agreements – None

C. Wash Sales – None

18. Gain or Loss to the Reporting Entity from Uninsured Plans and the Uninsured Portion of Partially Insured Plans

A. ASO Plans – None

B. ASC Plans – None

C. Medicare or Other Similarly Structured Cost Based Reimbursement Contract – None

19. Direct Premium Written/Produced by Managing General Agents/Third Party Administrators

None

20. Fair Value Measurements

A. Fair Market Value at Reporting Date

1. Fair Value Measurements at Reporting Date – None
2. Fair Value Measurements in (Level 3) of the Fair Value Hierarchy – None
3. The Company does not have any securities valued at fair value.
4. The Company has not valued any securities at a Level 3.
5. Derivative assets and liabilities – None

B. Fair Value information under SSAP No. 100 combined with Fair Value information Under Other Accounting Pronouncements – None

C. Aggregate Fair Value of All Financial Instruments - None

D. Not Practicable to Estimate Fair Value – None

Notes to Financial Statements

21. Unusual or Infrequent Items

A. Unusual or Infrequent Items – None

B. Troubled Debt Restructuring – None

C. Other Disclosures – None

D. Business Interruption Insurance Recoveries – None

E. State Transferable and Non-transferable Tax Credits – None

F. Subprime-Mortgage-Related Risk Exposure – None

G. Retained Assets – None

H. Insurance Linked Securities - None

22. Events Subsequent

Type I – Recognized Subsequent Events

Subsequent events have been considered through February 28, 2016 for the Statutory statement issued on December 31, 2015.

None.

Type II – Nonrecognized Subsequent Events

Subsequent events have been considered through February 28, 2016 for the Statutory statement issued on December 31, 2015.

On January 1, 2016, the Company became subject to an annual fee under section 9010 of the Affordable Care Act (ACA). This annual fee is allocated to individual health insurers based on the ratio of the amount of the entity's net premiums written during the preceding calendar year to the amount of health insurance for any U.S. health risk that is written during the preceding calendar year. A health insurance entity's portion of the annual fee becomes payable once the entity provides health insurance for any U.S health risk for each calendar year beginning on or after January 1 of the year the fee is due. As of December 31, 2015, the Company has written health insurance subject to the ACA assessment, expects to conduct health insurance business in 2016, and estimates their portion of the annual health insurance industry fee to be payable on September 30, 2016 to be $1,723,486. This amount is reflected in special surplus. Reporting the ACA assessment as of December 31, 2015, would not have triggered and RBC action level.

		Current Year	Prior Year
A.	Did the reporting entity write accident and health insurance premium that is subject to Section 9010 of the Federal Affordable Care Act (Yes/No)?	Yes	
B.	ACA fee assessment payable for the upcoming year	$1,723,486	$445,722
C.	ACA fee assessment paid	$1,570,754	$191,380
D.	Premium written subject to ACA 9010 assessment	$132,084,154	$119,742,533
E.	Total Adjusted Capital before surplus adjustment *(Five Year Historical – Line 14)*	12,232,161	
F.	Total Adjusted Capital after surplus adjustment *(Five Year Historical – Line 14 minus 22B above)*	10,558,676	
G.	Authorized Control Level (*Five Year Historical – Line 15)*	4,393,624	
H.	Would reporting the ACA assessment as of December 31, 2015, have triggered an RBC action level (Yes/NO)?	No	

23. Reinsurance

A. Ceded Reinsurance Report

Section 1 – General Interrogatories

(1) Are any of the reinsurers, listed in Schedule S as non-affiliated, owned in excess of 10% or controlled, either directly or indirectly, by the company or by any representative, officer, trustee, or director of the company?

Yes ( ) No (X)

(2) Have any policies issued by the company been reinsured with a company THP in a country other than the United States (excluding U.S. Branches of such companies) that is owned in excess of 10% or controlled directly or indirectly by an insured, a beneficiary, a creditor or an insured or any other person not primarily engaged in the insurance business?

Yes ( ) No (X)

Notes to Financial Statements

Section 2 – Ceded Reinsurance Report – Part A

(1) Does the company have any reinsurance agreements in effect under which the reinsurer may unilaterally cancel any reinsurance for reasons other than for nonpayment of premium or other similar credits?

Yes ( ) No (X)

(2) Does the reporting entity have any reinsurance agreements in effect such that the amount of losses paid or accrued through the statement date may result in a payment to the reinsurer of amounts that, in aggregate and allowing for offset of mutual credits from other reinsurance agreements with the same reinsurer, exceed the total direct premium collected under the reinsured policies?

Yes ( ) No (X)

Section 3 – Ceded Reinsurance Report – Part B

(1) The estimated amount of the aggregate reduction in surplus, of termination of all reinsurance agreements, by either party, as of the date of this statement is zero.

(2) Have any new agreements been executed or existing agreements amended, since January 1 of the year of this statement, to include policies or contracts that were in force or which had existing reserves established by the company as of the effective date of the agreement?

Yes ( ) No (X)

B. Uncollectible Reinsurance – None

C. Commutation of Ceded Reinsurance – None

D. Certified Reinsurer Rating Downgraded or Status Subject to Revocation – None

24. Retrospectively Rated Contracts & Contracts Subject to Redetermination

A. The method used by the reporting entity to estimate accrued retrospective premium adjustments – Not applicable

B. Accrual of retrospective premiums recorded through written premium or as an adjustment to earned premium – Not applicable.

C. Amount of net premiums written that are subject to retrospective rating features, as well as the corresponding percentage to total net premiums written – Not applicable.

D. Medical loss ratio rebates required pursuant to the Public Health Service Act - Not Applicable

E. Risk-Sharing Provisions of the Affordable Care Act (ACA)

(1) Did the reporting entity write accident and health insurance premiums that is subject to the Affordable Care Act risk-sharing provisions (YES/NO)? No

(2) Impact of Risk-Sharing Provisions of the Affordable Care Act on Admitted Assets, Liabilities, and Revenue for the Current Year - None

(3) Rollfoward of prior year ACA risk-sharing provisions for the following asset (gross of any nonadmission) and liability balances, along with the reason for any adjustments to prior year balance. - None

25. Changes in Incurred Losses and Loss Adjustment Expenses

Reserves as of December 31, 2014 were $11,981,448 for unpaid claims and $0 for unpaid claims adjustment expenses. At June 30, 2015, the Company reported a $202,118 favorable prior year development for the period December 31, 2014 to June 30, 2015. During the third quarter, as a result of CMS approval of the State Plan that resulted in an increase in inpatient reimbursement retroactive to October 1, 2014, the Company re-processed all inpatient claims for the period October 1, 2014 through December 31, 2014 which had been previously paid prior to December 31, 2014 and/or included in the Reserves as of December 31, 2014.

As of December 31, 2015, $13,458,755 has been paid for incurred claims and claims adjustment expenses attributable to insured events of prior years. Reserves remaining for prior years are now $584,999 as a result of re-estimation of unpaid claims and claim adjustment expenses which the Company attributes mainly to the impact of the CMS retroactive approval of the State Plan. Therefore there has been a $1,683,028 unfavorable prior year development since December 31, 2014 to December 31, 2015.

In anticipation of the financial impact of the retroactive approval of the State Plan the District of Columbia Department of Health Care Finance (the "DHCF") increased the Company's capitation rate at May 1, 2015 to account for the increase in inpatient cost on a going forth basis, and has agreed to cover the Company's increase in costs for re-adjudication of the inpatient claims for the period October 1, 2014 through April 30, 2015. Management anticipates that DHCF coverage of the increase in cost will offset the unfavorable prior year development.

Notes to Financial Statements

26. Intercompany Pooling Arrangements

None

27. Structured Settlements

None

28. Health Care Receivables

A. Pharmaceutical Rebate Receivables - None

B. Risk Sharing Receivables - None

29. Participating Policies

None

30. Premium Deficiency Reserves

1. Liability carried for premium deficiency reserves	$ 0
2. Date of the most recent evaluation of this liability	12/31/2015
3. Was anticipated investment income utilized in the calculation? (Yes / No)	No

31. Anticipated Salvage and Subrogation

THP's subrogation recoveries are considered immaterial as a result of the population served. Plan members are almost entirely TANF recipients eligible only for Medicaid health coverage. Recoveries typically result from non-routine healthcare matters, such as auto accidents. During the years ended December 31, 2014 and 2015, THP recorded $0 in subrogation recoveries as reductions in medical costs.

GENERAL INTERROGATORIES

PART 1 - COMMON INTERROGATORIES

GENERAL

1.1 Is the reporting entity a member of an Insurance Holding Company System consisting of two or more affiliated persons, one or more of which is an insurer? Yes[X] No[ ]

If yes, complete Schedule Y, Parts 1, 1A and 2.

1.2 If yes, did the reporting entity register and file with its domiciliary State Insurance Commissioner, Director or Superintendent or with such regulatory official of the state of domicile of the principal insurer in the Holding Company System, a registration statement providing disclosure substantially similar to the standards adopted by the National Association of Insurance Commissioners (NAIC) in its Model Insurance Holding Company System Regulatory Act and model regulations pertaining thereto, or is the reporting entity subject to standards and disclosure requirements substantially similar to those required by such Act and regulations? Yes[X] No[ ] N/A[ ] District of Columbia

1.3 State Regulating? Yes[ ] No[X]

2.1 Has any change been made during the year of this statement in the charter, by-laws, articles of incorporation, or deed of settlement of the reporting entity? .....

2.2 If yes, date of change: .....12/31/2013.....

3.1 State as of what date the latest financial examination of the reporting entity was made or is being made. .....01/01/2012.....

3.2 State the as of date that the latest financial examination report became available from either the state of domicile or the reporting entity. This date should be the date of the examined balance sheet and not the date the report was completed or released. .....03/06/2012.....

3.3 State as of what date the latest financial examination report became available to other states or the public from either the state of domicile or the reporting entity. This is the release date or completion date of the examination report and not the date of the examination (balance sheet date).

3.4 By what department or departments? District of Columbia Department of Insurance, Securities and Banking

3.5 Have all financial statement adjustments within the latest financial examination report been accounted for in a subsequent financial statement filed with departments? Yes[X] No[ ] N/A[ ]

3.6 Have all of the recommendations within the latest financial examination report been complied with? Yes[X] No[ ] N/A[ ]

4.1 During the period covered by this statement, did any agent, broker, sales representative, non-affiliated sales/service organization or any combination thereof under common control (other than salaried employees of the reporting entity) receive credit or commissions for or control a substantial part (more than 20 percent of any major line of business measured on direct premiums) of: Yes[ ] No[X]

4.11 sales of new business? Yes[ ] No[X]

4.12 renewals?

4.2 During the period covered by this statement, did any sales/service organization owned in whole or in part by the reporting entity or an affiliate, receive credit or commissions for or control a substantial part (more than 20 percent of any major line of business measured on direct premiums) of: Yes[ ] No[X]

4.21 sales of new business? Yes[ ] No[X]

4.22 renewals?

5.1 Has the reporting entity been a party to a merger or consolidation during the period covered by this statement? Yes[ ] No[X]

5.2 If yes, provide the name of the entity, NAIC company code, and state of domicile (use two letter state abbreviation) for any entity that has ceased to exist as a result of the merger or consolidation.

1 Name of Entity	2 NAIC Company Code	3 State of Domicile

6.1 Has the reporting entity had any Certificates of Authority, licenses or registrations (including corporate registration, if applicable) suspended or revoked by any governmental entity during the reporting period? Yes[ ] No[X]

6.2 If yes, give full information:

7.1 Does any foreign (non-United States) person or entity directly or indirectly control 10% or more of the reporting entity? 0.000%

7.2 If yes,

7.21 State the percentage of foreign control

7.22 State the nationality(s) of the foreign person(s) or entity(s); or if the entity is a mutual or reciprocal, the nationality of its manager or attorney-in-fact and identify the type of entity(s) (e.g., individual, corporation, government, manager or attorney-in-fact).

1 Nationality	2 Type of Entity

8.1 Is the company a subsidiary of a bank holding company regulated by the Federal Reserve Board? Yes[ ] No[X]

8.2 If response to 8.1 is yes, please identify the name of the bank holding company. Yes[ ] No[X]

8.3 Is the company affiliated with one or more banks, thrifts or securities firms?

8.4 If response to 8.3 is yes, please provide the names and location (city and state of the main office) of any affiliates regulated by a federal financial regulatory services agency [i.e., the Federal Reserve Board (FRB), the Office of the Comptroller of the Currency (OCC), the Federal Deposit Insurance Corporation (FDIC) and the Securities Exchange Commission (SEC)] and identify those affiliates primary federal regulator.

1 Affiliate Name	2 Location (City, State)	3 FRB	4 OCC	5 FDIC	6 SEC
		Yes[ ] No[X]	Yes[ ] No[X]	Yes[ ] No[X]	Yes[ ] No[X]

What is the name and address of the independent certified public accountant or accounting firm retained to conduct the annual audit?
Brown, Smith, Wallace, LLC 8 City Place Drive Suite 300, St. Louis, MO 63141

Has the insurer been granted any exemptions to the prohibited non-audit services provided by the certified independent public accountant requirements as allowed in Section 7H of the Annual Financial Reporting Model Regulation (Model Audit Rule), or substantially similar state law or regulation? Yes[ ] No[X]

If response to 10.1 is "yes," provide information related to this exemption:

Has the insurer been granted any exemptions related to the other requirements of the Annual Financial Reporting Model Regulation as allowed for in Section 18A of the Model Regulation, or substantially similar state law or regulation? Yes[ ] No[X]

If response to 10.3 is "yes," provide information related to this exemption:

Has the reporting entity established an Audit Committee in compliance with the domiciliary state insurance laws? Yes[X] No[ ] N/A[ ]

If the response to 10.5 is "NO" or "N/A" please explain:

What is the name, address and affiliation (officer/employee of the reporting entity or actuary/consultant associated with an actuarial consulting firm) of the individual providing the statement of actuarial opinion/certification?
Jason Shores, FSA, MAAA Lewis & Ellis, Inc. 11225 College Blvd., Suite 320 Overland Park, KS 66210

GENERAL INTERROGATORIES (Continued)

12.1 Does the reporting entity own any securities of a real estate holding company or otherwise hold real estate indirectly? Yes[ ] No[X]
12.11 Name of real estate holding company
12.12 Number of parcels involved 0
12.13 Total book/adjusted carrying value $ 0
12.2 If yes, provide explanation

13. FOR UNITED STATES BRANCHES OF ALIEN REPORTING ENTITIES ONLY:
13.1 What changes have been made during the year in the United States manager or the United States trustees of the reporting entity? Yes[ ] No[ ] N/A[X]
13.2 Does this statement contain all business transacted for the reporting entity through its United States Branch on risks wherever located? Yes[ ] No[ ] N/A[X]
13.3 Have there been any changes made to any of the trust indentures during the year? Yes[ ] No[ ] N/A[X]
13.4 If answer to (13.3) is yes, has the domiciliary or entry state approved the changes?

14.1 Are the senior officers (principal executive officer, principal financial officer, principal accounting officer or controller, or persons performing similar functions) of the reporting entity subject to a code of ethics, which includes the following standards? Yes[X] No[ ]
a. Honest and ethical conduct, including the ethical handling of actual or apparent conflicts of interest between personal and professional relationships;
b. Full, fair, accurate, timely and understandable disclosure in the periodic reports required to be filed by the reporting entity;
c. Compliance with applicable governmental laws, rules and regulations;
d. The prompt internal reporting of violations to an appropriate person or persons identified in the code; and
e. Accountability for adherence to the code.
14.11 If the response to 14.1 is no, please explain:
14.2 Has the code of ethics for senior managers been amended? Yes[ ] No[X]
14.21 If the response to 14.2 is yes, provide information related to amendment(s).
14.3 Have any provisions of the code of ethics been waived for any of the specified officers? Yes[ ] No[X]
14.31 If the response to 14.3 is yes, provide the nature of any waiver(s).

15.1 Is the reporting entity the beneficiary of a Letter of Credit that is unrelated to reinsurance where the issuing or confirming bank is not on the SVO Bank List? Yes[ ] No[X]
15.2 If the response to 15.1 is yes, indicate the American Bankers Association (ABA) Routing Number and the name of the issuing or confirming bank of the Letter of Credit and describe the circumstances in which the Letter of Credit is triggered.

	1 American Bankers Association (ABA) Routing Number	2 Issuing or Confirming Bank Name	3 Circumstances That Can Trigger the Letter of Credit	4 Amount
15.2001				

BOARD OF DIRECTORS

16. Is the purchase or sale of all investments of the reporting entity passed upon either by the Board of Directors or a subordinate committee thereof? Yes[X] No[ ]

17. Does the reporting entity keep a complete permanent record of the proceedings of its Board of Directors and all subordinate committees thereof? Yes[X] No[ ]

18. Has the reporting entity an established procedure for disclosure to its board of directors or trustees of any material interest or affiliation on the part of any of its officers, directors, trustees or responsible employees that is in conflict or is likely to conflict with the official duties of such person? Yes[X] No[ ]

FINANCIAL

19. Has this statement been prepared using a basis of accounting other than Statutory Accounting Principles (e.g., Generally Accepted Accounting Principles)? Yes[ ] No[X]

20.1 Total amount loaned during the year (inclusive of Separate Accounts, exclusive of policy loans):
20.11 To directors or other officers $ 0
20.12 To stockholders not officers $ 0
20.13 Trustees, supreme or grand (Fraternal only) $ 0
20.2 Total amount of loans outstanding at end of year (inclusive of Separate Accounts, exclusive of policy loans):
20.21 To directors or other officers $ 0
20.22 To stockholders not officers $ 0
20.23 Trustees, supreme or grand (Fraternal only) $ 0

21.1 Were any assets reported in this statement subject to a contractual obligation to transfer to another party without the liability for such obligation being reported in the statement? Yes[ ] No[X]
21.2 If yes, state the amount thereof at December 31 of the current year:
21.21 Rented from others $ 0
21.22 Borrowed from others $ 0
21.23 Leased from others $ 0
21.24 Other $ 0

22.1 Does this statement include payments for assessments as described in the Annual Statement Instructions other than guaranty fund or guaranty association assessments? Yes[ ] No[X]
22.2 If answer is yes:
22.21 Amount paid as losses or risk adjustment $ 0
22.22 Amount paid as expenses $ 0
22.23 Other amounts paid $ 0

23.1 Does the reporting entity report any amounts due from parent, subsidiaries or affiliates on Page 2 of this statement? Yes[ ] No[X]
23.2 If yes, indicate any amounts receivable from parent included in the Page 2 amount: $ 0

INVESTMENT

24.01 Were all the stocks, bonds and other securities owned December 31 of current year, over which the reporting entity has exclusive control, in the actual possession of the reporting entity on said date? (other than securities lending programs addressed in 24.03) Yes[X] No[ ]
24.02 If no, give full and complete information, relating thereto
24.03 For security lending programs, provide a description of the program including value for collateral and amount of loaned securities, and whether collateral is carried on or off-balance sheet. (an alternative is to reference Note 17 where this information is also provided)
24.04 Does the Company's security lending program meet the requirements for a conforming program as outlined in the Risk-Based Capital Instructions? Yes[ ] No[ ] N/A[X]
24.05 If answer to 24.04 is yes, report amount of collateral for conforming programs. $ 0
24.06 If answer to 24.04 is no, report amount of collateral for other programs. $ 0
24.07 Does your securities lending program require 102% (domestic securities) and 105% (foreign securities) from the counterparty at the outset of the contract? Yes[ ] No[ ] N/A[X]
24.08 Does the reporting entity non-admit when the collateral received from the counterparty falls below 100%? Yes[ ] No[ ] N/A[X]

GENERAL INTERROGATORIES (Continued)

24.09 Does the reporting entity or the reporting entity's securities lending agent utilize the Master Securities Lending Agreement (MSLA) to conduct securities lending? Yes[ ] No[ ] N/A[X]

24.10 For the reporting entity's security lending program, state the amount of the following as of December 31 of the current year:

24.101 Total fair value of reinvested collateral assets reported on Schedule DL, Parts 1 and 2.	$ 0
24.102 Total book/adjusted carrying value of reinvested collateral assets reported on Schedule DL, Parts 1 and 2.	$ 0
24.103 Total payable for securities lending reported on the liability page.	$ 0

25.1 Were any of the stocks, bonds or other assets of the reporting entity owned at December 31 of the current year not exclusively under the control of the reporting entity, or has the reporting entity sold or transferred any assets subject to a put option contract that is currently in force? (Exclude securities subject to Interrogatory 21.1 and 24.03). Yes[X] No[ ]

25.2 If yes, state the amount thereof at December 31 of the current year:

25.21	Subject to repurchase agreements	$ 0
25.22	Subject to reverse repurchase agreements	$ 0
25.23	Subject to dollar repurchase agreements	$ 0
25.24	Subject to reverse dollar repurchase agreements	$ 0
25.25	Placed under option agreements	$ 0
25.26	Letter stock or securities restricted as to sale - excluding FHLB Capital Stock	$ 0
25.27	FHLB Capital Stock	$ 0
25.28	On deposit with states	$ 300,886
25.29	On deposit with other regulatory bodies	$ 0
25.30	Pledged as collateral - excluding collateral pledged to an FHLB	$ 0
25.31	Pledged as collateral to FHLB - including assets backing funding agreements	$ 0
25.32	Other	$ 0

25.3 For category (25.26) provide the following:

1 Nature of Restriction	2 Description	3 Amount

26.1 Does the reporting entity have any hedging transactions reported on Schedule DB? Yes[ ] No[X]

26.2 If yes, has a comprehensive description of the hedging program been made available to the domiciliary state? Yes[ ] No[ ] N/A[X]
If no, attach a description with this statement.

27.1 Were any preferred stocks or bonds owned as of December 31 of the current year mandatorily convertible into equity, or, at the option of the issuer, convertible into equity? Yes[ ] No[X]

27.2 If yes, state the amount thereof at December 31 of the current year. $ 0

28. Excluding items in Schedule E - Part 3 - Special Deposits, real estate, mortgage loans and investments held physically in the reporting entity's offices, vaults or safety deposit boxes, were all stocks, bonds and other securities, owned throughout the current year held pursuant to a custodial agreement with a qualified bank or trust company in accordance with Section 1, III - General Examination Considerations, F. Outsourcing of Critical Functions, Custodial or Safekeeping Agreements of the NAIC Financial Condition Examiners Handbook? Yes[ ] No[X]

28.01 For agreements that comply with the requirements of the NAIC Financial Condition Examiners Handbook, complete the following:

1 Name of Custodian(s)	2 Custodian's Address

28.02 For all agreements that do not comply with the requirements of the NAIC Financial Condition Examiners Handbook, provide the name, location and a complete explanation:

1 Name(s)	2 Location(s)	3 Complete Explanation(s)
Branch Banking & Trust Co.	815 Connecticut Ave NW Washington DC 20006	The Company currently only has cash bank accounts

28.03 Have there been any changes, including name changes, in the custodian(s) identified in 28.01 during the current year? Yes[ ] No[X]

28.04 If yes, give full and complete information relating thereto:

1 Old Custodian	2 New Custodian	3 Date of Change	4 Reason

28.05 Identify all investment advisors, broker/dealers or individuals acting on behalf of broker/dealers that have access to the investment accounts, handle securities and have authority to make investments on behalf of the reporting entity:

1 Central Registration Depository Number(s)	2 Name	3 Address

29.1 Does the reporting entity have any diversified mutual funds reported in Schedule D, Part 2 (diversified according to the Securities and Exchange Commission (SEC) in the Investment Company Act of 1940 [Section 5 (b)(1)])? Yes[ ] No[X]

29.2 If yes, complete the following schedule:

1 CUSIP #	2 Name of Mutual Fund	3 Book/Adjusted Carrying Value
29.2999 Total		

29.3 For each mutual fund listed in the table above, complete the following schedule:

GENERAL INTERROGATORIES (Continued)

1 Name of Mutual Fund (from above table)	2 Name of Significant Holding of the Mutual Fund	3 Amount of Mutual Fund's Book/Adjusted Carrying Value Attributable to the Holding	4 Date of Valuation

30. Provide the following information for all short-term and long-term bonds and all preferred stocks. Do not substitute amortized value or statement value for fair value.

	1 Statement (Admitted) Value	2 Fair Value	3 Excess of Statement over Fair Value (-), or Fair Value over Statement (+)
30.1 Bonds			
30.2 Preferred stocks			
30.3 Totals			

30.4 Describe the sources or methods utilized in determining the fair values

31.1 Was the rate used to calculate fair value determined by a broker or custodian for any of the securities in Schedule D? Yes[ ] No[X]

31.2 If the answer to 31.1 is yes, does the reporting entity have a copy of the broker's or custodian's pricing policy (hard copy or electronic copy) for all brokers or custodians used as a pricing source? Yes[ ] No[ ] N/A[X]

31.3 If the answer to 31.2 is no, describe the reporting entity's process for determining a reliable pricing source for purposes of disclosure of fair value for Schedule D:

32.1 Have all the filing requirements of the Purposes and Procedures Manual of the NAIC Investment Analysis Office been followed? Yes[X] No[ ]

32.2 If no, list exceptions:

OTHER

33.1 Amount of payments to Trade Associations, Service Organizations and Statistical or Rating Bureaus, if any? $ 1,384

33.2 List the name of the organization and the amount paid if any such payment represented 25% or more of the total payments to Trade Associations, Service Organizations and Statistical or Rating Bureaus during the period covered by this statement.

1 Name	2 Amount Paid
KC Consulting	1,384

34.1 Amount of payments for legal expenses, if any? $ 230,621

34.2 List the name of the firm and the amount paid if any such payments represented 25% or more of the total payments for legal expenses during the period covered by this statement.

1 Name	2 Amount Paid
Reed Smith, LLP	98,512

35.1 Amount of payments for expenditures in connection with matters before legislative bodies, officers or department of government, if any? $ 0

35.2 List the name of firm and the amount paid if any such payment represented 25% or more of the total payment expenditures in connection with matters before legislative bodies, officers or departments of government during the period covered by this statement.

1 Name	2 Amount Paid

GENERAL INTERROGATORIES (Continued)

PART 2 - HEALTH INTERROGATORIES

1.1 Does the reporting entity have any direct Medicare Supplement Insurance in force? Yes[ ] No[X]
1.2 If yes, indicate premium earned on U.S. business only: $ 0
1.3 What portion of Item (1.2) is not reported on the Medicare Supplement Insurance Experience Exhibit? $ 0
1.31 Reason for excluding:
1.4 Indicate amount of earned premium attributable to Canadian and/or Other Alien not included in Item (1.2) above. $ 0
1.5 Indicate total incurred claims on all Medicare Supplement Insurance. $ 0
1.6 Individual policies - Most current three years:
1.61 TOTAL Premium earned $ 0
1.62 TOTAL Incurred claims $ 0
1.63 Number of covered lives 0
All years prior to most current three years:
1.64 TOTAL Premium earned $ 0
1.65 TOTAL Incurred claims $ 0
1.66 Number of covered lives 0
1.7 Group policies - Most current three years:
1.71 TOTAL Premium earned $ 0
1.72 TOTAL Incurred claims $ 0
1.73 Number of covered lives 0
All years prior to most current three years:
1.74 TOTAL Premium earned $ 0
1.75 TOTAL Incurred claims $ 0
1.76 Number of covered lives 0

2. Health Test

		1 Current Year	2 Prior Year
2.1	Premium Numerator	131,563,782	119,092,512
2.2	Premium Denominator	131,563,782	119,092,512
2.3	Premium Ratio (2.1 / 2.2)	1.000	1.000
2.4	Reserve Numerator	20,983,802	11,981,446
2.5	Reserve Denominator	21,448,282	11,981,446
2.6	Reserve Ratio (2.4 / 2.5)	0.978	1.000

3.1 Has the reporting entity received any endowment or gift from contracting hospitals, physicians, dentists, or others that is agreed will be returned when, as and if the earnings of the reporting entity permits? Yes[ ] No[X]
3.2 If yes, give particulars:

4.1 Have copies of all agreements stating the period and nature of hospitals', physicians', and dentists' care offered to subscribers and dependents been filed with the appropriate regulatory agency? Yes[X] No[ ]
4.2 If not previously filed furnish herewith a copy(ies) of such agreement(s). Do these agreements include additional benefits offered? Yes[ ] No[ ] N/A[X]

5.1 Does the reporting entity have stop-loss reinsurance? Yes[X] No[ ]
5.2 If no, explain:
5.3 Maximum retained risk (see instructions):
5.31 Comprehensive Medical $ 545,000
5.32 Medical Only $ 0
5.33 Medicare Supplement $ 0
5.34 Dental & Vision $ 0
5.35 Other Limited Benefit Plan $ 0
5.36 Other $ 0

6. Describe arrangement which the reporting entity may have to protect subscribers and their dependents against the risk of insolvency including hold harmless provisions, conversion privileges with other carriers, agreements with providers to continue rendering services, and any other agreements:
Provider agreements contain hold-harmless provisions. The Company also has insolvency protection in its stop loss reinsurance contract.

7.1 Does the reporting entity set up its claim liability for provider services on a service date basis? Yes[X] No[ ]
7.2 If no, give details:

8. Provide the following information regarding participating providers:
8.1 Number of providers at start of reporting year 2,503
8.2 Number of providers at end of reporting year 2,561

9.1 Does the reporting entity have business subject to premium rate guarantees? Yes[ ] No[X]
9.2 If yes, direct premium earned:
9.21 Business with rate guarantees between 15-36 months 0
9.22 Business with rate guarantees over 36 months 0

10.1 Does the reporting entity have Incentive Pool, Withhold or Bonus Arrangements in its provider contracts? Yes[ ] No[X]
10.2 If yes:
10.21 Maximum amount payable bonuses $ 0
10.22 Amount actually paid for year bonuses $ 0
10.23 Maximum amount payable withholds $ 0
10.24 Amount actually paid for year withholds $ 0

11.1 Is the reporting entity organized as:
11.12 A Medical Group/Staff Model, Yes[ ] No[X]
11.13 An Individual Practice Association (IPA), or, Yes[ ] No[X]
11.14 A Mixed Model (combination of above)? Yes[X] No[ ]
11.2 Is the reporting entity subject to Statutory Minimum Capital and Surplus Requirements? Yes[X] No[ ]
11.3 If yes, show the name of the state requiring such minimum capital and surplus.
District of Columbia
11.4 If yes, show the amount required. $ 4,130,310
11.5 Is this amount included as part of a contingency reserve in stockholder's equity? Yes[ ] No[X]
11.6 If the amount is calculated, show the calculation.
Per DC Code § 31-3412 (a)(2) " . . . every health maintenance organization must maintain a minimum net worth equal to the greater of: (A) $1,000,000; ...(D) 8% of health care expenditures ($9,237,002 x 8%=$738,960) plus 4% of annual hospital expenditures ($84,783,750 x 4% = $3,391,350). Total $4,130,310

12. List service areas in which the reporting entity is licensed to operate:

1 Name of Service Area
District of Columbia

13.1 Do you act as a custodian for health savings accounts? Yes[ ] No[X]
13.2 If yes, please provide the amount of custodial funds held as of the reporting date: $ 0
13.3 Do you act as an administrator for health savings accounts? Yes[ ] No[X]
13.4 If yes, please provide the balance of the funds administered as of the reporting date: $ 0

GENERAL INTERROGATORIES (Continued)

14.1 Are any of the captive affiliates reported on Schedule S, Part 3 as authorized reinsurers? Yes[ ] No[ ] NA[X]
14.2 If the answer to 14.1 is yes, please provide the following:

1	2	3	4	Assets Supporting Reserve Credit		
				5	6	7
Company Name	NAIC Company Code	Domiciliary Jurisdiction	Reserve Credit	Letters of Credit	Trust Agreements	Other

15. Provide the following for individual ordinary life insurance* policies (U.S. business only) for the current year (prior to reinsurance assumed or ceded)

15.1 Direct Premium Written	$ 0
15.2 Total Incurred claims	$ 0
15.2 Number of covered lives	0

*Ordinary Life Insurance Includes
Term (whether full underwriting, limited underwriting, jet issue, "short form app")
Whole Life (whether full underwriting, limited underwriting, jet issue, "short form app")
Variable Life (with or without Secondary Guarantee)
Universal Life (with or without Secondary Guarantee)
Variable Universal Life (with or without Secondary Guarantee)

FIVE-YEAR HISTORICAL DATA

	1 2015	2 2014	3 2013	4 2012	5 2011
BALANCE SHEET (Pages 2 and 3)					
1. TOTAL Admitted Assets (Page 2, Line 28)	39,847,361	26,974,362	12,709,040	1,540,253	
2. TOTAL Liabilities (Page 3, Line 24)	27,565,199	17,289,813	9,223,757		
3. Statutory minimum capital and surplus requirement	4,130,310	2,394,851	1,015,739		
4. TOTAL Capital and Surplus (Page 3, Line 33)	12,282,162	8,684,549	3,485,284	1,540,253	
INCOME STATEMENT (Page 4)					
5. TOTAL Revenues (Line 8)	131,563,782	119,092,512	50,503,059		
6. TOTAL Medical and Hospital Expenses (Line 18)	104,011,852	97,808,128	46,129,102		
7. Claims adjustment expenses (Line 20)	6,301,366	4,852,563	1,723,403		
8. TOTAL Administrative Expenses (Line 21)	14,235,571	12,110,163	3,872,788		
9. Net underwriting gain (loss) (Line 24)	7,014,993	4,323,640	(222,234)		
10. Net investment gain (loss) (Line 27)	4,394	2,253	(1,335)		
11. TOTAL Other Income (Lines 28 plus 29)		(25,460)			
12. Net income or (loss) (Line 32)	4,328,093	3,000,811	(223,569)		
Cash Flow (Page 6)					
13. Net cash from operations (Line 11)	16,670,960	9,284,061	7,758,380		
RISK-BASED CAPITAL ANALYSIS					
14. TOTAL Adjusted Capital	12,282,162	8,684,549	4,702,092		
15. Authorized control level risk-based capital	4,393,624	4,181,196	2,248,679		
ENROLLMENT (Exhibit 1)					
16. TOTAL Members at End of Period (Column 5, Line 7)	31,328	31,044	26,710		
17. TOTAL Members Months (Column 6, Line 7)	365,118	360,497	182,210		
OPERATING PERCENTAGE (Page 4)					
(Item divided by Page 4, sum of Lines 2, 3 and 5) x 100.0					
18. Premiums earned plus risk revenue (Line 2 plus Lines 3 and 5)	100.0	100.0	100.0	100.0	100.0
19. TOTAL Hospital and Medical plus other non-health (Lines 18 plus Line 19)	79.1	82.1	89.4		
20. Cost containment expenses	2.6	1.9	1.8		
21. Other claims adjustment expenses	2.2	2.2	1.6		
22. TOTAL Underwriting Deductions (Line 23)	94.7	96.4	100.4		
23. TOTAL Underwriting Gain (Loss) (Line 24)	5.3	3.6	(0.4)		
UNPAID CLAIMS ANALYSIS					
(U&I Exhibit, Part 2E)					
24. TOTAL Claims Incurred for Prior Years (Line 13, Column 5)	14,043,754	11,854,756			
25. Estimated liability of unpaid claims-[prior year (Line 13, Column 6)]	11,775,727	7,685,266			
INVESTMENTS IN PARENT, SUBSIDIARIES AND AFFILIATES					
26. Affiliated bonds (Sch. D Summary, Line 12, Column 1)					
27. Affiliated preferred stocks (Sch. D Summary, Line 18, Column 1)					
28. Affiliated common stocks (Sch. D Summary, Line 24, Column 1)					
29. Affiliated short-term investments (subtotal included in Sch. DA Verification, Col. 5, Line 10)					
30. Affiliated mortgage loans on real estate					
31. All other affiliated					
32. TOTAL of Above Lines 26 to 31					
33. TOTAL Investment in Parent included in Lines 26 to 31 above					

NOTE: If a party to a merger, have the two most recent years of this exhibit been restated due to a merger in compliance with the disclosure requirements of SSAP No. 3, Accounting Changes and Correction of Errors? Yes[ ] No[ ] N/A[X]

If no, please explain::

SCHEDULE T - PREMIUMS AND OTHER CONSIDERATIONS

ALLOCATED BY STATES AND TERRITORIES

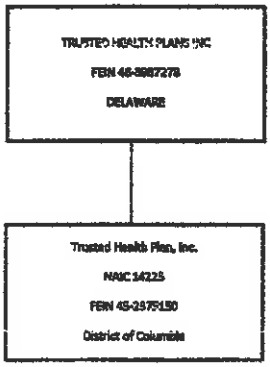
State, Etc.	1 Active Status	Direct Business Only 2 Accident & Health Premiums	3 Medicare Title XVIII	4 Medicaid Title XIX	5 Federal Employees Health Benefits Plan Premiums	6 Life & Annuity Premiums & Other Considerations	7 Property/ Casualty Premiums	8 Total Columns 2 Through 7	9 Deposit - Type Contracts
1. Alabama (AL)	N								
2. Alaska (AK)	N								
3. Arizona (AZ)	N								
4. Arkansas (AR)	N								
5. California (CA)	N								
6. Colorado (CO)	N								
7. Connecticut (CT)	N								
8. Delaware (DE)	N								
9. District of Columbia (DC)	L	9,034,445		123,049,709				132,084,154	
10. Florida (FL)	N								
11. Georgia (GA)	N								
12. Hawaii (HI)	N								
13. Idaho (ID)	N								
14. Illinois (IL)	N								
15. Indiana (IN)	N								
16. Iowa (IA)	N								
17. Kansas (KS)	N								
18. Kentucky (KY)	N								
19. Louisiana (LA)	N								
20. Maine (ME)	N								
21. Maryland (MD)	N								
22. Massachusetts (MA)	N								
23. Michigan (MI)	N								
24. Minnesota (MN)	N								
25. Mississippi (MS)	N								
26. Missouri (MO)	N								
27. Montana (MT)	N								
28. Nebraska (NE)	N								
29. Nevada (NV)	N								
30. New Hampshire (NH)	N								
31. New Jersey (NJ)	N								
32. New Mexico (NM)	N								
33. New York (NY)	N								
34. North Carolina (NC)	N								
35. North Dakota (ND)	N								
36. Ohio (OH)	N								
37. Oklahoma (OK)	N								
38. Oregon (OR)	N								
39. Pennsylvania (PA)	N								
40. Rhode Island (RI)	N								
41. South Carolina (SC)	N								
42. South Dakota (SD)	N								
43. Tennessee (TN)	N								
44. Texas (TX)	N								
45. Utah (UT)	N								
46. Vermont (VT)	N								
47. Virginia (VA)	N								
48. Washington (WA)	N								
49. West Virginia (WV)	N								
50. Wisconsin (WI)	N								
51. Wyoming (WY)	N								
52. American Samoa (AS)	N								
53. Guam (GU)	N								
54. Puerto Rico (PR)	N								
55. U.S. Virgin Islands (VI)	N								
56. Northern Mariana Islands (MP)	N								
57. Canada (CAN)	N								
58. Aggregate other alien (OT)	XXX								
59. Subtotal	XXX	9,034,445		123,049,709				132,084,154	
60. Reporting entity contributions for Employee Benefit Plans	XXX								
61. TOTAL (Direct Business)	(a) 1	9,034,445		123,049,709				132,084,154	
DETAILS OF WRITE-INS									
58001.	XXX								
58002.	XXX								
58003.	XXX								
58998. Summary of remaining write-ins for Line 58 from overflow page	XXX								
58999. TOTALS (Lines 58001 through 58003 plus 58998) (Line 58 above)	XXX								

(L) Licensed or Chartered - Licensed Insurance Carrier or Domiciled RRG; (R) Registered - Non-domiciled RRGs; (Q) Qualified - Qualified or Accredited Reinsurer; (E) Eligible - Reporting Entities eligible or approved to write Surplus Lines in the state; (N) None of the above - Not allowed to write business in the state.

(a) Insert the number of L responses except for Canada and Other Alien.
Explanation of basis of allocation of premiums by states, etc.: Situs of the contract

SCHEDULE Y - INFORMATION CONCERNING ACTIVITIES OF INSURER MEMBERS OF A HOLDING COMPANY GROUP

PART 1 - ORGANIZATIONAL CHART



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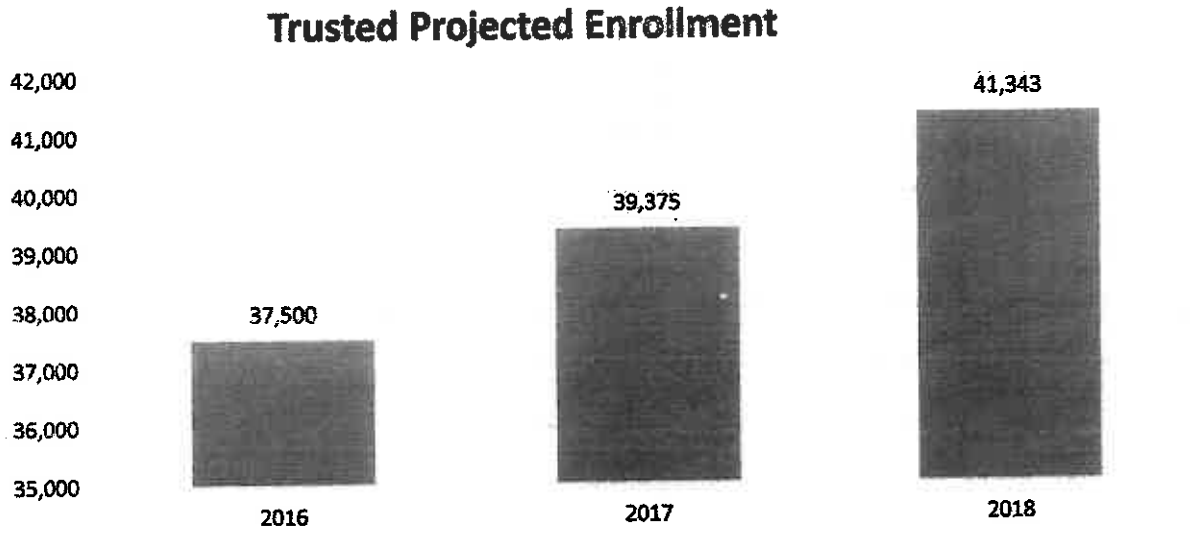
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ENROLLMENT

Trusted has established a baseline enrollment projection of 37,500 members which it expects to receive primarily through auto-assignment by the Department of Health and Human Resources.

Based on Trusted experience in the Washington DC market where it experience a 16.2% in 2014, the year of Medicaid expansion, and a 4.2% increase in the year following expansion, Trusted has assumed an annual growth in membership of 5%.



We anticipate 35% membership in the North region, 15% East region and 50% South region. This analysis is based on the current distribution of Medicaid lives in West Virginia, and urban centers to include assumptions regarding the increase in Medicaid members based on expansion, voluntary/involuntary disenrollment. Again, based on Trusted Washington DC market experience it expect to receive 90% of its members in the first 90 days of operation.

MEMBERSHIP ASSUMPTION

01-BARBOUR	1,714	367
02-BERKELEY	8,915	1908
03-BOONE	2,935	628
04-BRAXTON	1,520	327
05-BROOKE	1,609	344
06-CABELL	9,939	2127
07-CALHOUN	793	170
08-CLAY	1,287	275
09-DODDRIDGE	689	147
10-FAYETTE	5,032	1077
11-GILMER	662	142
12-GRANT	940	201
13-GREENBRIER	3,767	806
14-HAMPSHIRE	2,053	439
15-HANCOCK	2,430	520
16-HARDY	1,294	277
17-HARRISON	5,473	1171
18-JACKSON	2,513	538
19-JEFFERSON	3,732	799
20-KANAWHA	18,377	3934
21-LEWIS	1,756	376
22-LINCOLN	2,762	591
23-LOGAN	5,245	1123
24-MARION	4,859	1040
25-MARSHALL	2,525	540
26-MASON	2,460	527
27-MERCER	7,582	1623
28-MINERAL	2,076	444
29-MINGO	3,631	777
30-MONONGALIA	5,031	1077
31-MONROE	1,105	237
32-MORGAN	1,490	319
33-MCDOWELL	2,962	634
34-NICHOLAS	3,099	663
35-OHIO	3,401	728
36-PENDLETON	686	147
37-PLEASANTS	515	110
38-POCAHONTAS	925	198
39-PRESTON	2,838	607
40-PUTNAM	3,565	763
41-RALEIGH	8,432	1805
42-RANDOLPH	2,690	576
43-RITCHIE	840	180
44-ROANE	1,518	325
45-SUMMERS	1,385	296
46-TAYLOR	1,453	311
47-TUCKER	575	123
48-TYLER	788	169
49-UPSHUR	2,421	518
50-WAYNE	4,144	887
51-WEBSTER	1,360	291
52-WETZEL	1,504	322
53-WIRT	566	121
54-WOOD	8,065	1,726
55-WYOMING	2,845	609

Trusted will provide access to emergency room care at any hospital in the State of West Virginia, and will provide members with access to specialists not included in the area, or not convenient to the member through Letters of Agreement. Further, Trusted will approve out of area health care that is deemed emergent or medically necessary.

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CONTRACTUAL- ENROLLMENT CONTRACT

Trusted is responding to a Centralized Request for Quotation ("CRFQ"), solicitation number BMS1600000002, which has been issued by the West Virginia Department of Administration, Purchasing Division, for managed care services. In the event that Trusted is successful through the award of a contract by West Virginia Department of Health and Human Services, Trusted will provide a copy of the Enrollment contract.

TRUSTED Health Plan

THP

West Virginia Medicaid Member Handbook

DRAFT

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What are my Rights Under Federal Law with Respect to my PHI?
May I Complain about Your Privacy practices?
How will I know if my rights change?
Medicare Part D Notice to Members
For Members with both Medicare and Medicaid
What Some Words Mean



Welcome to Trusted Health Plan

Thank you for choosing Trusted Health Plan (Trusted) as your Medicaid Managed Care Organization (MCO). Our commitment is to provide you with access to quality health care with excellent customer service.

This Member Handbook contains important information about Trusted and how our plan works. We urge you to review it carefully. As a Trusted member you will obtain great benefits and services. If Trusted changes how it works or learns information about its medical providers that you need to know (such as which doctors are taking new patients and the doctors' office hours), you will be informed about the change 30 days before it occurs.

New members will receive an invitation in your New Member packet to our New Members Orientation as well as a new member welcome call. The New Member Orientation is our way of providing you with a personal way for you to learn how to best use our health care system and to ask any questions you may have.

How this Handbook Works

It is important that you understand how your plan works. This Member Handbook tells you what you need to know about your Trusted Health Plan benefits. Please read and keep in a safe place.

Trusted Health Plan services the following counties in West Virginia.

COUNTIES	
Barbour	McDowell
Berkeley	Mercer
Boone	Mineral
Braxton	Mingo
Brooke	Monongalia
Cabell	Monroe
Calhoun	Morgan
Clay	Nicholas
Doddridge	Ohio
Fayette	Pendleton
Gilmer	Pleasants
Grant	Pocahontas
Greenbrier	Preston
Hampshire	Putnam
Hardy	Raleigh
Harrison	Ritchie
Jackson	Summers
Jefferson	Tucker
Kanawha	Tyler
Lewis	Upshur
Lincoln	Wayne
Logan	Webster
Marion	Wetzel
Marshall	Wirt
Mason	Wood
Wyoming	

If you ever have any questions about things you read in this book or other questions about Trusted you can call Trusted Member Services at 1-800 or visit www.Trustedhp.com we will do our best to help you.

How this Member Handbook Can Help You

This Member Handbook tells you:

- How to get health care
- What Services we will pay for (we call this, what Services are "covered" by us)
- What Services we can't pay for
- How to pick your Primary Care Provider (your PCP)
- What to do if you get sick
- What you should do if you have a Complaint (also called a "Grievance") or want to change ("Appeal") a decision by Trusted

This Member Handbook gives you basic information about how Trusted works and its rules. Please call Trusted Member Services if you have any questions 24 hours a day, seven days a week.

- Be treated with respect and dignity.
- Know that when you talk with your doctors and other providers its private.
- Have an illness or treatment explained to you in a language you can understand.
- Participate in decisions about your care.
- Refuse treatment or care.
- Be able to see your medical records and to request that they be fixed if they are wrong.
- Choose an eligible PCP from within Trusted's network and to change your PCP.
- Make a Complaint ("Grievance") about the care provided to you and receive an answer.
- Request an Appeal or a Fair Hearing if you believe Trusted was wrong in denying, reducing or stopping a service or item.
- Obtain medical care without unnecessary delay
- Receive information on advance directives and choose not to have or continue any life-sustaining treatment.
- Receive a copy of Trusted Member Handbook.
- Continue treatment you are currently receiving until you have a new treatment plan.
- Receive interpretation and translation services free of charge if you need them.
- Refuse oral interpretation services.
- Get an explanation of prior authorization procedures.
- Obtain summaries of customer satisfaction surveys
- Receive Trusted's "Dispense As Written" policy for prescription drugs.
- Receive family planning services and supplies from the provider of your choice.
- Be free from any form of restrain or seclusion used as coercion, discipline, convenience or retaliation, as specified in other federal regulations on the use of restrains and seclusion.
- Receive information about benefits available under the state plan, but not covered by Trusted.
- To a candid discussion of appropriate or medically necessary treatment options for your conditions regardless of cost and benefit coverage.
- Have direct access to a women's health specialist within the network for the covered care necessary to provide women's routine and preventive healthcare services. Also, female enrollees have a right to designate as their PCP a participating provider or an advanced practicing registered nurse who specializes in obstetrics (OB) and gynecology (GYN).
- Ask for a chaperone to be present when you receive health care.
- Receive information about Trusted Health Plan's financial condition and any special ways we pay our doctors.

You have a right to:

- Received information about Trusted Health Plan, our services, our providers and other health care workers, our facilities, and your rights and responsibilities as a member.
- Receive a second opinion from a qualified health care provider within the network, or arrange for the enrollee to obtain one outside the network, at no cost to you.
- Be informed about how and where to access any benefits available under the state plan but not covered under the contract, including any cost sharing, and how transportation is provided upon enrollment, annually an at least 30 days prior to any change.
- Not be held liable for the Trusted Health Plan's debts in the event of the Trusted Health Plan's insolvency.
- Use any hospital or other setting for emergency care.
- Be treated no differently by providers or by Trusted Health Plan for exercising your rights listed here.

Your Rights and Responsibilities –Continue

You are responsible for:

- Treating those providing your care with respect and dignity.
- Following the rules of the Medicaid Managed Care Program and Trusted Health Plan.
- Following plans and instructions you receive from your doctors and other providers.
- Going to Appointments you schedule or that Trusted schedules for you.
- Telling your doctor at least 24 hours before the Appointment if you have to cancel.
- Asking for more explanation if you do not understand your doctor's instructions.
- To make recommendations regarding Trusted Health Plan's Member Rights and Responsibilities policy.
- Going to the Emergency Room only if you have a medical emergency.
- Telling Trusted and your PCP about medical and personal problems that may affect your health, to help them to provide you care.
- Reporting to DHHR and Trusted if you or a family member have other health insurance.
- Trying to understand your health problems and participate in developing treatment goals to help Trusted and

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Access to Care

Travel Time

Your PCP and specialist doctors' offices should be within 30 minutes, by car, of your home. Basic hospital services should not be more than 45 minutes away. Tertiary services (specialist doctors or providers) should be within 60 minutes. This may vary depending on the availability of specialty care in general. If you have a problem finding a doctor this close to your home, call our Member Service Department.

Scheduling Standards

You PCP should be able to schedule an appointment for you within a certain number of days, depending on what kind of appointment it is.

- Routine Care -within 21 days
- Urgent Care -within 48 hours
- Emergency Care- immediately

If your provider does not give you an appointment within these time frames, call your Customer Service Department. Trusted Health Plan covers court ordered services.

Appointment Waiting Time

Trusted Health Plan wants to make sure your waiting times at provider offices are short. All Trusted Health Plan members should have the same access to medical care.



COMPLIANCE REPORTING

855 – 228 – 1700

The THP Compliance Program offers a confidential and anonymous telephone hotline available 24/7 to voice your concerns about any situation that may conflict with Compliance Program principles. If you want to report concerns or suspicions regarding:

- ✓ Compliance with federal or WV law
- ✓ Compliance with THP policies
- ✓ Suspected fraud, waste or abuse
- ✓ Possible ethical or code of conduct violations

You may also send a message to our inbox:

ReportFraud@TrustedHP.com

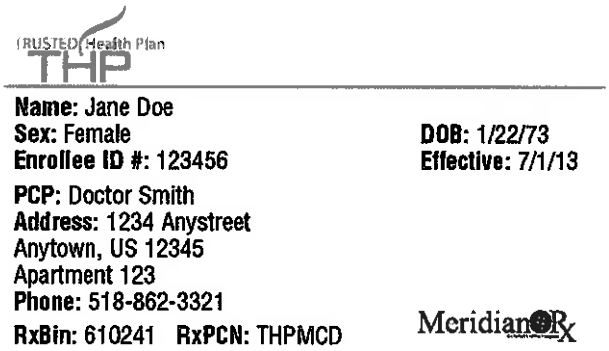
You may also come speak to our Compliance Officer, George Aloth, directly.

Your report will remain confidential and your privacy will be respected! No individual who reports Compliance Plan violations or suspected fraud and abuse is retaliated against by anyone who is employed by or contracts with THP. Anyone who believes that he or she has been retaliated against may report this violation to the Department Health and Human Resources and/or the U.S. Office of Inspector General.

Your Member ID Card

After you sign up for Trusted and you have picked a primary care provider (PCP), we will send you a Member ID Card in the mail. This card lets your doctors, hospitals, pharmacies and others know that you are a Member of Trusted. Please make sure that the information on your Member Identification Card is correct. If there are any problems, or if you have lost your card, call Member Services.

Your Member ID Card Looks Like This



Each Trusted Member has his or her own card. Your children will also have their own cards, you must keep your children's cards so they don't get lost. It is against the law to let anyone else use your Member ID Card or Medicaid card.

Please remember to carry your Member ID Card with you all the time. Always show your card before receiving any medical care or getting medicine at a pharmacy.
Be sure to keep your Medicaid Card too.

Your Primary Care Provider (PCP) - 24 Hour Care

When you join Trusted, one of our doctors will be your main doctor. This doctor is called your **Primary Care Provider** or PCP. Your PCP will help you and your family get the health care you need.

It is important to call your PCP first when you need care. If you had a doctor before you signed up with Trusted please call Member Services at 1-800. Call your PCP for care anytime, day, night or weekend and holidays. When your PCP is out they have someone to take their place. Your PCP, or the on-call doctor for your PCP, will help you at any time, 24 hours a day. We can help you stay with that doctor if you want to.

To find more information about Trusted doctors, go to our website or call Member Services at 1-800. You will find information about the doctors'

- Name, Address and telephone numbers
- Professional qualifications
- Specialty
- Education including the medical school attended
- Residency
- Board Certification Status

Picking your PCP

1. **Pick a PCP at the time you enroll in Trusted.** This person will be your PCP while you are a member of Trusted.
    - If your current PCP is a member of Trusted' s network, you may stay with that doctor.
    - If you don't have a PCP, you can choose from a list of doctors in our Provider Directory or at www.Trustedhp.com
    - Call Member Services at 1-800 if you need help in picking a doctor.

- If you do not pick a PCP within the first 10 days of being in our plan, we will choose a doctor for you. If you do not like the PCP we pick for you, you may change your PCP. Call Member Services at 1-800 to change your PCP.
- Trusted will send you a Member ID Card. Your card will have your PCP's name and phone number on it.

2. **Choose a PCP for each family member in our plan, including your children.** Your PCP may be one of these kinds of doctors:
   - Family and General Practice Doctor - usually can see the whole family
   - Internal Medicine Doctor - usually sees only adults and children 14 years and older
   - Pediatrician - sees children from newborn up to adult
   - Obstetrician/Gynecologist (OB/GYN) - specializes in women's health and Maternity care
   - If you or your child has Special Health Care Needs, a specialist may be your PCP but you need to call us as and let us know that you would like this. We will try to help you get a specialist to be your PCP, but the specialist would have to agree to it.

3. **When you pick your PCP, please:**
   - Pick a doctor who is close to your home or work.
   - Try to pick a doctor who can send you to the hospital you want. Not all doctors can send patients to all hospitals. Our provider directory lists which hospitals a PCP can send you to. You can also call Member Services for help.
   - Sometimes the PCP you choose won't be able to take new patients. We will let you know if you need to pick a different doctor.

4. **How to change your PCP**

You can change your PCP anytime. Just pick a new PCP from the Provider Directory. Call Member Service 1-800 once you have picked a new PCP. If you need help picking a new PCP, Member Services can help you.

Routine Care, Urgent Care and Emergency Care

There are three kinds of health care you may need: Routine Care, Urgent Care, or Emergency Care.

Routine Care is the regular care you get from your PCP. Routine Care is also care you get from other doctors that your PCP sends you to. Routine Care can be Check-Ups, physicals, health Screenings, and care for health problems like diabetes, hypertension, and asthma. If you need Routine Care, call your PCP's office and ask to make an Appointment.

Urgent Care is medical care you need within 24 hours, but not right away. Some Urgent Care issues are:

- A sprain or a strain
- Throwing Up
- Lice, scabies or ringworm
- An earache
- A cough or cold
- Refills for medicine
- Diarrhea
- A cut or scrape
- A sore throat
- Diaper rash
- Mild Headache

If you need Urgent Care, Call your PCP or your 24-Hour Nurse Help Line at (855) 872-1852. A nurse will help you decide if you need to go to the doctor right away. The nurse will tell

you how to get care. You do not have to go to the Emergency Room or use an ambulance for routine or Urgent Care.

Emergency Care is medical care you need right away for a serious, sudden (sometimes life-threatening) injury or illness. Emergency Medical Conditions are:

- Miscarriage/pregnancy with vaginal bleeding
- Bleeding that won't stop
- A broken bone
- A bad burn
- You are in labor
- Drug overdose
- Shock (you may sweat, feel thirsty or dizzy or have pale skin)
- Seizures
- Poisoning
- Fainting/unconsciousness
- Gun or knife wounds
- Suddenly not able to see, move or speak

WHAT TO DO IF YOU HAVE AN EMERGENCY:

1. **Call 9-1-1 or go to your nearest emergency room.**
2. **Show the Emergency Room (ER) your Trusted Member I.D. Card.**
3. **As soon as you can, call your PCP.**

When you are Out of Town:

When you need to see a doctor or get medicine when you are out-of-town, you should:

For Routine Care: You must call us and ask if we will pay for you to see a doctor or other provider when you are out of town because doctors who are not in the West Virginia are not a part of Trusted. If Trusted does not say it is okay before you get the care, you will have to pay for the care yourself. If you need medicine from a doctor while you are out-of-town, please call our Member Services Department or Nurse Advice Line for help.

For Urgent Care: Call your PCP. If your PCP's office is closed, call the Nurse Help Line (855) 872-1852. A nurse will help you decide if you need to go to the doctor right away. The nurse can tell you how to get care. You do not have to go to the Emergency Room or use an ambulance for routine or Urgent Care.

For Emergency Care: If you have an emergency, including a mental health or alcohol or other drug emergency, go to the nearest Emergency Room (ER) to get care right away. If you go to the emergency room, you should ask the ER staff to call your PCP. If you go to the emergency room, you should call Member Services as soon as you can.

If your child does not live at home and needs to see a doctor, please call Member Services.

Trusted Providers and Providers who are not part of Trusted

Trusted will pay for the care you get when you go to one of our doctors or other health care providers. We call these doctors and other health care providers our "network" providers. All these "In-Network" doctors can be found in your Provider Directory. A doctor or provider who is not one of ours is called an "Out-of-Network" Provider.

If you go to an "Out-of-Network" doctor, hospital or lab, you may have to pay for the care you get. You will not have to pay if you have asked us first and we have told you, usually in writing, that it is okay. We call this "prior written authorization."

Prior authorization (or prior approval) means approval for a health service that is not routinely covered by Trusted. You must get this approval before you receive the service.

You may go to a Family Planning provider who is out-of–network even if you do not have prior authorization.

You may go to an Emergency Room which is out-of–network even if you do not have prior authorization.

Remember: You need to go to a provider in Trusted's network.

Utilization Management (UM)

If you have a question about an approval or denial of medical services or procedures, call the Member Services Department at 1-800, Monday – Friday 8:30am – 5:00pm. TDD/TTY 711 and language services are available.

Decisions about whether Trusted covers a service are based on well-known and agreed upon rules on what is best for your health and what is covered by your Medicaid plan (your benefits). Trusted does not give bonuses to doctors for saying no to (denying) your request. Money is not used to reward doctors that deny or limit health services you may feel you want or need.

Making an Appointment

Making an Appointment with your PCP

1. Have your Member ID Card and a pencil and paper close by.
2. Call your PCP's office. Look for your PCP's phone number on the front of your Member ID Card. You can also find it in your Provider Directory or online at www.Trustedhp.com
3. Tell the person who answers that you are a Trusted Member. Tell them you want to make an Appointment with your PCP.
4. Tell the person why you need an Appointment. For example:
    a. You or a family member is feeling sick
    b. You hurt yourself or had an accident
    c. You need a check- up or follow-up care
5. Write down the time and date of your Appointment.
6. Go to your Appointment on time, and bring your Member ID Card with you.
7. If you need help making an Appointment, please call Member Services

If you are a new Member of Trusted, you should make an Appointment for your first health Check-Up as soon as possible.

Changing or canceling an Appointment

It is very important to go to your Appointment and to be on time.

- If you need to change or cancel your Appointment, please **call the doctor at least 24 hours before your Appointment**.
- For some Appointments, you may have to call more than 24 hours before to cancel.

- If you do not show up for your Appointment or if you are late, your doctor may decide you cannot be his or her patient.

Getting care when your PCP's office is closed

If you need to speak to your PCP when the office is closed, call your PCP's office and leave a message with the person who answers the phone when the office is closed. Be sure to give the person who answers your phone number. Someone will call you back as soon as possible. You can also call the Nurse Help Line 24 hours a day at: (855) 872-1852. If you think you have an emergency, call 911 or go to the Emergency Room.

How long it takes to see your doctor

Your doctor's office must give you an Appointment within a certain number of days after you call. The table below shows how long it will take to get an Appointment. Please call Member Services if you cannot get an Appointment during these time periods.

Type of visit	Your condition	How long it takes to see your doctor
Urgent Visit	You are hurt or sick and need care within 24 hours to avoid getting worse, but you don't need to see a doctor right away Some examples of when you need urgent care are: a sprain or strain, diarrhea, throwing up, a cut or scrape, an earache, a sore throat, a cough or cold, diaper rash, refills for medicine, mild headache, lice, scabies, or ringworm.	Within 24 hours
Routine Visit	You have a minor illness or injury or you need a regular checkup, but you don't need an urgent Appointment.	Within 30 days
Follow-up Visit	You need to see your doctor after a treatment you just had to make sure you are healing well.	Within 1-2 weeks depending on the kind of treatment
Adult Wellness Visits	• You are having your first Appointment with a new doctor • You are due for a regular adult checkup • You are due for a prostate exam, a pelvic exam, a PAP smear or a breast exam	Within 30 days or sooner if necessary
Non-urgent Appointments with specialists (by Referral)	Your PCP referred you to see a specialist for a non-urgent condition	Within 30 days

Child EPSDT checkups -not urgent	Your child is due for an EPSDT checkup	Initial checkup: within 60 days Additional checkups: within 30 days of due dates for children under age two; within 60 days of due dates for children age two and older
Immigrant Children well-child checkups – not urgent	Your child is due for a well-child checkup	Initial checkup: within 60 days Additional checkups: within 30 days of due dates for children under age two; within 60 days of due dates for children age two and older
(Early Intervention) assessments	Tests ("assessments") for children up to age 3 at risk of developmental delay or disability	Within 30 days

Support Services

Interpretation & Translation Services/Services for the hearing and visually impaired

Interpretation and translation Services and Services for the hearing and visually impaired are FREE.

Interpretation Services

Trusted will provide oral interpretation Services if you need them, including at the hospital

Please call Member Services to get Interpretation Services. Please call Trusted before your doctor's Appointment if you need interpretation Services.

Interpreter Services are usually provided over the telephone. If you need an interpreter to be with you at your doctor's Appointment, you must let us know 2 days or 48 hours before the Appointment.

Translation Services

If you get information from Trusted and need it translated into another language, please call the Member Services Department.

Services for the Hearing and Visually Impaired

If you have trouble hearing, call Member Services at 711.

If you have trouble seeing, call Member Services. We can give you information on an audio tape, in Braille or in large print.

Transportation Services

Trusted will provide transportation to doctor's appointments for you if you need it.

- Call MTM Transportation to tell them what time and what day you need to be picked up.
- You must call at least two (2) business days (not including Saturday and Sunday) before your Appointment to get transportation. If you need transportation to EPSDT visits or urgent visits, you can call the day before the Appointment to ask for transportation.
- The types of transportation are bus, Metro, tickets to pay for a taxi, wheelchair vans, and ambulances. The type of transportation you get depends on your medical needs.
- Give MTM Transportation your Member ID, phone number and address where you can be picked up. Also tell them the name, address, and phone number of the medical/dental facility or doctor's office you are going to.

Specialty Care and Referral

How to get specialty care

Specialty care is when care is given by a specialist doctor who has extra training and cares for a specific condition or part of the body. For example, a Cardiologist cares for the heart and a Podiatrist cares for the feet.

Your PCP will help you know when you need to see a specialist and give you a referral. A referral is a written note given to you by your PCP to see a different doctor. You must get a referral to see a doctor other than your PCP except for well-women visits, family planning, and some mental health services.

If you want to see a specialist, but Trusted said it wouldn't pay for the visit, you can:

- Make an Appointment with another doctor in the Trusted network and get a second opinion
- Appeal our decision

- Ask for a Fair Hearing

Self-Referral Services

There are certain services you can get without getting prior permission from your PCP. These are called self-referral services and are listed below.

You DO NOT need a Referral to:

- See your PCP
- Get care when you have an emergency
- Receive services from your OB/GYN doctor in your network for routine or preventive services (females only)
- Receive Family Planning Services
- Receive services for sexually transmitted diseases (STDs)
- Receive Immunizations (shots)
- Visit a vision provider in the network
- Take your child to a dental provider in the network
- Receive emergency mental health or services for problems with alcohol or other drugs
- Receive up to 10 mental health sessions (A treatment plan is required after 10 visits.)

Mental Health Services

Mental health care is for both adults and children. This care helps when you feel depressed or anxious.

If you need help, or someone from your family needs help, call

- The crisis hotline at Beacon Behavioral Health

You can get up to 10 mental health Appointments without a Referral.

Services for alcohol or other drug problems

Problems with alcohol or other drugs are dangerous to your health and can be dangerous to the health of people around you. It is important to go to the doctor if you need help with these problems. Trusted will help you arrange for detoxification services and provide care coordination to help you get other services. To get services for these problems, you can:

- Call Member Services 24 hours a day, 7 days a week.

Birth control and other Family Planning Services

You do NOT need a Referral to receive birth control or other Family Planning Services.

You can get birth control and other Family Planning Services from any provider you pick. You may choose an "out of network" provider. You do not need a referral to get these services. If you choose a Family Planning Services doctor other than your PCP, tell your PCP. It will help your PCP take better care of you. Talk to your PCP or call Trusted Member Services for more information on birth control or other Family Planning Services.

All birth control and other Family Planning Services are confidential.

Family Planning Services include:

- Pregnancy Testing
- Counseling for the Woman and the Couple
- Routine and Emergency Contraception
- Counseling and Immunizations
- Screening for all Sexually Transmitted Diseases
- Treatment for all Sexually Transmitted Diseases

- Sterilization Procedures
- HIV/AIDS Testing and Counseling

Family Planning Services do not include:

- Routine infertility studies or procedures
- Hysterectomy for sterilization
- Reversal of voluntary sterilization
- HIV/AIDs Treatment
- Abortion Services

HIV/AIDS testing, counseling and treatment

You can get HIV/AIDS testing and counseling:

- When you have Family Planning Services
- From your PCP
- From an HIV testing and counseling center
- For information on where you can get for HIV testing and counseling, call Member Services. If you need HIV treatment, your PCP will help you get the care you need.

Pharmacy Services and prescription drugs

Pharmacies are where you pick up your medicine (drugs). If your doctor gives you a prescription, you must go to a pharmacy in Trusted's network. Trusted's network includes most pharmacies in the West Virginia.

You can find the full list of pharmacies in the Trusted network online at www.Trustedhp.com

If you are out of town and you have an emergency or need Urgent Care and need a prescription filled, just contact our Member Services Department or Nurse Help Line

To get a prescription filled:

- Pick a pharmacy that is part of the Trusted network and is close to your work or home.
- When you have a prescription, go to the pharmacy and give the pharmacist your prescription and your Trusted Member ID Card.
- If you need help, please call Member Services.

Things to remember:

- **You should not be asked to pay for your medicines. Call Trusted Member Services if the pharmacy or drug store asks you to pay.**
- Sometimes, your doctor may need to get permission from Trusted for a drug. While your doctor is waiting for the permission, you have a right to get the medication:
  - For up to 72 hours OR
  - For one full round of the medicine if you take it less than once a day

Case Management and Disease Management

If you have a chronic illness or special health care need such as asthma, high blood pressure or mental illness, you may be eligible for our Case Management or Disease Management Program. This means you will have a Care Manager. A Care Manager is someone who works for Trusted and who will help you get the services and information you need to manage your illness and be healthier. Your doctor can refer you for this program using the form at http://www.trustedhp.com/referrals.html. You can refer yourself or a family member by calling Member Services.

Services to Keep Adults from Getting Sick

Trusted wants you to take care of your health. We also want you to sign up for health and wellness services we offer to you. Health and wellness services include screenings, counseling and immunizations.

Recommendations for Checkups ("Screenings")

Please make an appointment and go see your PCP at least one time every year for a checkup. The list below tells you the type of things to talk with your PCP about during your checkup.

Please make an appointment to see your PCP at least once a year for a checkup.

Adult Screening Recommendations
Blood pressure and cholesterol (lipid disorder) Screening
Sexually transmitted diseases
HIV/AIDS Screening & testing
Diabetes Screening
Tobacco Use
Alcohol and Other Drug Use
Depression
Colorectal Cancer (50 years and older)
Obesity
Hepatitis C

Screenings for Women Only
Breast cancer Screening (mammogram)
Cervical Cancer
Osteoporosis (post-menopausal women)
HPV Screening
Chlamydia

Screenings for Men Only
Prostate Cancer Screening
Abdominal Aortic Aneurysm

Preventive counseling

Preventive counseling is available to help you stay healthy. You can get preventive counseling on:

- Diet and exercise
- Alcohol and drug use
- Smoking cessation
- HIV/AIDS prevention
- Obesity

Adult Immunizations

If you are an adult, you may need some immunizations (shots). Please talk to your PCP about which ones you may need.

Pregnancy

If you are pregnant or think you are pregnant, it is very important that you go to your OB/GYN doctor right away. You ***do not*** need to see your PCP before making this appointment.

If you are pregnant, please call:

- Member Services
- Your PCP

There are certain things that you need to get checked if you are pregnant. These will help make sure that you have a healthy pregnancy, delivery, and baby. This is called prenatal care. You get prenatal care before your baby is born.

Remember, if you are pregnant or think you are pregnant do not drink alcohol, use drugs or smoke.

Prenatal and Post-Partum Care

When you register with Trusted's OB hotline, you get these services:

- Pregnancy Case Manager
- Assistance obtaining WIC
- Prenatal Information & Classes

Once you have had your baby, call member services to report when your baby is born. Babies born in the Trusted Health Plan Medicaid program will be enrolled in the program in for a minimum of 60 and 90 days. The newborn s enrolled on the first day of the month of their birth. The 60 day minimum starts from their date of birth.

Your Child's Health

Health Check Program for Children (EPSDT)

Trusted wants to help your children grow up healthy. If your child is in the (Medicaid) program, your child will be in the Health Check Program, also called Early and Periodic Screening, Diagnosis and Treatment (EPSDT). This program starts right after your child is born and lasts until your child turns 21. The Health Check Program gives your child a number of important checkups.

There is a Health Check (EPSDT) information sheet in this handbook. You can also ask your doctor, call Member Services, or visit our website www.Trustedhp.com for a copy of the Health Check (EPSDT) Periodicity Schedule. The schedule tells you when your child needs to go to the doctor.

In addition to Health Check/EPSDT services, your child can also get the benefits described in the "Member Health Benefits" section below.

Immigrant Children

If your child is in the Immigrant Children's Program, your child will get well-child care. This program starts right after your child is born and lasts until your child turns 21.

In addition to well-child care, your child can also get the benefits described in the "Member Health Benefits" section below.

You do not have to pay anything for these Services for your child – they are free. If you have any questions or need help with transportation or scheduling an appointment, please call Member Services.

Care for your children's teeth

All dental health checkups and treatments are free for Trusted Members under age 21.

Dentists can prevent cavities and teach you and your child how to care for their teeth.

- From birth up to age 3, your child's PCP may provide dental care during regular check-ups. The PCP may decide to send the child to a dentist.
- Beginning at age 3, all children should see a dentist in the Trusted network for a checkup every year. Look in Trusted's Provider Directory or online at www.Trustedhp.com to pick a dentist near you. Please call the dentist's office for an appointment.

Children with Special Health Care Needs

When children have -- or are at risk of having -- physical, developmental, behavioral, or emotional conditions that are permanent or that last a long time, they can have Special Health Care Needs. These children may need health care and other services that are more than or different from what other children need.

Trusted will check to see if your child has Special Health Care Needs. Please be sure your child has been checked for this. If your child has not been checked to see if they have special healthcare needs, call Member Services.

- If your child has Special Health Care Needs, your child has the right to have a PCP who is a specialist
- Be sure your child with a special health care need has a Treatment Plan. Call Trusted Member Services to ask for a treatment plan for your child.

For more information please contact Member Services

The IDEA program

IDEA stands for the Individuals with Disabilities Education Act. IDEA is a federal law. The IDEA program provides special services for your child with developmental delays, disabilities or special needs. Children up to age 3 get early intervention services from Trusted. Children age 3 and older get special educational services from the public school system.

Growth Chart:

Here are some of the things that you should be looking for as your child grows. Every child develops at his or her own pace. Your child may reach these milestones slightly before or after other children of the same age. Use this as a guide. If you have any concerns, talk to your child's doctor.

By the end of 7 months, many children are able to: • Turn head when name is called • Smile back at another person • Respond to sounds with sounds • Enjoy social play (such as peek-a-boo)	**By the end of 2 years (24 months), many children are able to:** • Use 2- to -4 word phrases • Follow simple instructions • Become more interested in other children • Point to an object or picture when named.
By the end of 1 year (12 months), many children are able to: • Use simple gestures (waving "bye-bye") • Make sounds such as "ma" and "da" • Imitate actions in their play (clap when you clap) • Respond when told "no"	**By the end of 3 years (36 months), many children are able to:** • Show affection for playmates • Use 4- to- 5 word sentences • Imitate adults and playmates (run when other children run) • Play make-believe with dolls, animals, and people ("feed" a teddy bear)
By the end of 1 ½ years (18 months), many children are able to: • Do simple pretend play ("talk" on a toy phone) • Point to interesting objects • Look at object when you point at it and tell them to look • Use several single words unprompted	**By the end of the 4 years (48 months)many children are able to :** • Use 5- to 6- word sentences • Follow 3-step commands ("Get dressed, comb your hair and wash your face") • Cooperate with other children

If you think your child is not growing the way he or she should, have your child tested ("IDEA evaluation"). To get an IDEA evaluation, call your PCP. If your child needs IDEA Services, your PCP will refer your child to the state Government's Early Intervention Program. Trusted has case managers who can tell you more about IDEA and the other services your child can get.

Trusted covers the services listed below if your child is in the IDEA program:

- For children up to age 3, Trusted covers all health care services even if the service is in your child's treatment plan.
- For children aged 3 and older, Trusted:
  - Pays for all health care services and services in your child's treatment plan that your child needs when not in school—even on evenings, weekends and holidays.
  - Coordinates services that are not provided through the school's treatment plan.

For more information on the services your child can get through the IDEA program, contact your child's school.

Immunizations (shots) for children and teens

Immunizations (shots) are important to keep your child healthy! When your child is very young, your child will need shots every few months. The shots start at birth. These shots protect them from diseases.

Your PCP and Trusted will schedule appointments for your child's shots.

Shots are free. The shot schedule for children is:

AGE	IMMUNIZATION
Birth	HepB #1
2 months	HepB#2, DTaP#1, RV#1, Hib#1, PCV#@1, IPV#1
4 months	DTaP#2, RV#2, Hib#2, PCV#2, IPV#2
6 months	HepB#3, Hib#3, DTaP#3, RV#3, PCV#3, IPV#3
12 months	HiB#4, MMR#1, Varicella#1, PCV#4, HepA#2

15 months	Varicella #2
18 months	Hep A#2
4 years-6 years	DTAP, MMR, IPV
13 years or older	Varicella
11 years-12 years	HPV, MCV4
13 years – 18 years	Tdap, HPV
18 years or younger	MCV4
Every Year	Beginning at 6 months, Seasonal Influenza ("flu") vaccine as recommended each year

Your Health Benefits

Health Services covered by Trusted

The list below shows the health care services and benefits for all Trusted Members. For some benefits, you have to be a certain age or have a certain need for the service. You may need a Prior Authorization for the service. Trusted will not charge you for any of the health care services in this list if you go to a network provider or hospital. You will not have a co-pay, or need to file a claim.

If you have a question about whether Trusted covers certain health care, call Trusted Member Services.

BENEFIT	WHAT YOU GET	WHO CAN GET THIS BENEFIT
Primary Care Services	• Preventive, acute, and chronic health care Services generally provided by your PCP	All Members

BENEFIT	WHAT YOU GET	WHO CAN GET THIS BENEFIT
Specialist Services	• Health care Services provided by specially trained doctors or advanced practice nurses. • Referrals are usually required • Does not include cosmetic Services and surgeries except for surgery required to correct a condition resulting from surgery or disease, created by an accidental injury or a congenital deformity, or is a condition that impairs the normal function of your body	All Members
Laboratory & X-ray Services	• Lab tests and X-rays	All Members
Hospital Services	• Outpatient Services (preventive, diagnostic, therapeutic, rehabilitative, or palliative Services) • Inpatient Services (hospital stay)	Any Member with a Referral from their PCP or who has an emergency
Pharmacy Services (prescription drugs)	• Prescription drugs included on the Trusted drug formulary. You can find the drug formulary at www.Trustedhp.com or by calling Member Services. • Only includes medications from network pharmacies • Includes the following non-prescription (over-the-counter) medicines: - Fever and Pain relievers like Tylenol or Advil - Sinus and Allergy Medicines like Benadryl - Cough and Cold Medicines - Hydrocortisone 1% for Rashes	All Members other than dually eligible(Medicaid/Medicare) Members whose prescriptions are covered under Medicare Part D
Emergency Services	• A Screening exam of your health condition and stabilization if you have an Emergency Medical Condition, regardless if the Provider is in or out of the Trusted network. • Treatment for emergency conditions	All Members

BENEFIT	WHAT YOU GET	WHO CAN GET THIS BENEFIT
Family Planning	• Pregnancy Testing: Counseling for the woman • Routine and Emergency Contraception • Voluntary sterilizations for Members over 21 years of age (requires signature of an approved sterilization form by the Member 30 days prior to the procedure) • Screening, Counseling and Immunizations (including for HPV) • Screening and preventive treatment for all sexually transmitted diseases • Does not include sterilization procedures for Members under age 21	All Members as appropriate
Podiatry	• Special care for foot problems • Regular foot care when medically needed.	All Members
Rehabilitation Services	Rehabilitation Services, including physical, speech and occupational therapy	All Members
Prosthetic devices	• Replacement, corrective, or supportive devices prescribed by a licensed provider	All Members
Vision Care	• Eye exams at least once every year and as needed; and eye glasses (corrective lenses) as needed	Members under age 21
	• One pair of eyeglasses every two years except when the Member has lost his or her eyeglasses or when the prescription has changed by more than 0.5 diopter	Members age 21 and older

BENEFIT	WHAT YOU GET	WHO CAN GET THIS BENEFIT
Home Health Services	In-home health care Services, including: • Nursing and home health aide care • Home health aide Services provided by a home health agency • Physical therapy, occupational therapy, speech pathology and audiology Services	All Members
Hospice Care	• Support Services for people who are dying	All Members
Transportation Services	• Transportation to and from medical Appointments	All Members
Adult Wellness Services	• Immunizations • Routine Screening for Sexually Transmitted Diseases • HIV/AIDS Screening, testing and counseling • Breast cancer Screening (women only) • Cervical cancer Screening (women only) • Osteoporosis Screening (post-menopausal women) • HPV Screening (women only) • Prostate cancer Screening (men only) • Abdominal aortic aneurysm Screening (men only) • Screening for obesity • Diabetes Screenings and Management • Screening for high blood pressure and cholesterol (lipid disorders) • Screening for depression • Colorectal cancer Screening (Members 50 years and older) • Smoking cessation counseling • Diet and exercise counseling • Mental Health counseling • Alcohol and drug Screening	Members over age 21 as appropriate

BENEFIT	WHAT YOU GET	WHO CAN GET THIS BENEFIT
Child Wellness Services	Whatever is needed to take care of sick children and to keep healthy children well, including Screening and assessments such as: • Health and development history and Screenings • Physical and mental health development and Screenings • Comprehensive health exam • Immunizations • Lab tests including of blood lead levels • Health education • Dental Screening Services • Vision Screening Services • Hearing Screening Services • Alcohol and drug Screening and counseling • Mental health Services Does not include any health Services furnished to a child in a school setting	Members under age 21
Dental Benefits	• General dentistry (including regular and emergency treatment) and orthodontic care for special problems • Check-Ups twice a year with a dentist are covered for children ages 3 through 20. • A child's PCP can perform dental Screenings for a child up to age 3 • Does not include routine orthodontic care	Members under age 21 (Members 21 years and older can get dental services from Medicaid. Call MCO Dental Help Line at 1-866-758-6807)
Hearing Benefits	Diagnosis and Treatment of conditions related to hearing, including hearing aids and hearing aid batteries	All Members

BENEFIT	WHAT YOU GET	WHO CAN GET THIS BENEFIT

Mental Health Services	• Services provided by mental health providers, including:
	  • Diagnostic and assessment services
	  • Physician and mid-level visits, including:
	  o Individual counseling
	  o Group counseling
	  o Family counseling
	• Medication/Somatic treatment
	• Crisis Services
	• Inpatient Hospitalization and Emergency Department Services
	• Day Services
	• Intensive Day Treatment
	• Case management Services
	• Treatment for any mental condition that could complicate pregnancy
	• Mental health Services for children that are included in an IEP or IFSP during holidays, school vacations, or sick days when the child is not in school
		All Members

Alcohol & Drug Abuse Treatment	• Inpatient detoxification	All Members
	• Inpatient and outpatient substance abuse treatment • Residential Treatment	Members under age 21
Dialysis	• Hemodialysis • Peritoneal Dialysis	All Members
Durable Medical Equipment (DME) & Disposable Medical Supplies (DMS)	• Durable Medical Equipment (DME) • Disposable medical supplies (DMS)	All Members

The services below are covered through Medicaid, but are not provided through your plan.

- Nursing Home Services
- Non-Emergency Transportation
- Birth to three Services
- Abortion
- Personal Care Services
- School Base Services

Services We Do Not Pay For

Exclusions are benefits and/or services that are not paid for by Trusted or WV Medicaid. They include the following:

- Cosmetic surgery
- Experimental or investigational services, surgeries, treatments, and medications
- Services that are part of a clinical trial protocol
- Infertility treatment
- Elective Surgery, which is not medically needed to restore of materially improve a body function, This includes surgery for breast reduction
- Sterilizations for persons under the age of 21
- Shots needed for travel and or work that are not related to the
- Services that are not medically necessary

After clinical review based on scientific evidence, new technology is evaluated by Trusted for inclusion as a covered benefit. Technology assessment decisions are published in the form of medical policies and are posted to our website for your doctor to access and use in their practice. In addition, members may request a copy of a medical policy by contacting our Member Services. All existing medical policies are reviewed at least annually and updated accordingly.

How to change your Managed Care Organization

You can change your MCO once a year, or at any time if you have a good reason.

You can change your MCO once a year during the 90 days before your anniversary date—the month and date you first joined Trusted.

State Medicaid will send you a letter two months before your anniversary date. The letter tells you how to change MCOs.

Changing Your MCO If You Have a Good Reason
You have the right to change your MCO at any time after the first 90 days if you have a good reason. Examples of good reasons are poor quality of care and you can't see the providers you need.

You will not be allowed to get health care from Trusted anymore if you:

- Lose your Medicaid eligibility
- Establish Social Security Income (SSI) eligibility

A child will be removed from Trusted if the child:

- Becomes a ward of the state

The state government may remove you from Trusted if you:

- Let someone else use your Member ID Card;
- The state finds you committed Medicaid fraud
- You do not follow your Member responsibilities.

What to do if you get a bill for a covered service

If you get a bill for a covered service that is in the list above, call Member Services

Paying for Non-Covered Services

- If you decide to get a service that we do not pay for, you must sign a statement that you agree to pay for the service yourself.
- Remember to always show your Member ID Card and tell doctors that you are a Member of Trusted ***before*** you get services.

Advance directives

An advance directive is a legal document you sign that lets others know your health care choices. It is used when you are not able to speak for yourself. Sometimes this is called a **"living will"** or a **"durable power of attorney."**

An advance directive can let you pick a person to make choices about your medical care for you. An advance directive also lets you say what kind of medical treatment you want to receive if you become too ill to tell others what your wishes are.

- It is important to talk about an advance directive with your family, your PCP, or others who might help you with these things.
- If you want to fill out and sign an advance directive, ask your PCP for help during your next appointment, or call Member Services and they will help you.
- Trusted will tell you about any changes in State law about advance directives within 90 days.

What to do if you have other insurance

If you are a Member of Trusted and eligible for Medicaid, you must tell us right away if you have any other health insurance. Please call Member Services and tell us right away.

What to do if you are eligible for both Medicaid and Medicare

If you have Medicare and Medicaid, please tell Trusted so you can pick Medicare providers. If you have Medicare, you will have to sign up for Medicare Part D for your prescription drugs. Medicaid will pay your co-pays. See page 44 of this handbook for more information.

Physician (doctor) incentive plan disclosure

You have the right to find out if Trusted has special financial arrangements with Trusted's doctors.

Please call Trusted Member Services for this information.

Complaints/Grievances, Appeals and Fair Hearings

Trusted and the state government both have ways that you can complain about the care you get or the Services Trusted provides to you. You may choose how you would like to complain as described below.

Complaints/Grievances

- If you are unhappy with something that happened to you, you can file a Complaint/Grievance. Examples of why you might file a Complaint/Grievance include:
    - You feel you were not treated with respect
    - You are not satisfied with the health care you got
    - It took too long to get an Appointment
- To file a Compiaint/Grievance, you should call Member Services at

- To file a written Complaint/Grievance, send to:
- Your doctor can also file a Complaint/Grievance for you. If your doctor files the complaint for you, you need to give them permission in writing.

You should file a Complaint/Grievance as soon as possible and no later than 90 days after the event or thing that makes you unhappy. Trusted will usually give you a decision within 30 days but may ask for extra time (but not more than 44 days total) to give a decision.

If Trusted Health Plan wasn't able to help you, contact the Bureau for Medical Services (BMS). If you are unhappy with the BMS decision you may appeal to the West Virginia Insurance Commissioner.

Bureau for Medical Services Office of Medicaid Managed Care 350 Capitol Street, Room 251 Charleston, WV 25301-3708	The Office of the Insurance Commissioner P.O. Box 50540 Charleston, WV 25305-0540

The BMS decision will be sent in writing.

If you are not satisfied with the decision of the Office of the Commissioner, you may appeal to the Circuit Court. Your appeal must be filed within 30 days after the Insurance Commissioners order has been mailed.

Appeals and State Fair Hearings

If you believe your benefits were unfairly denied, reduced, delayed or stopped, you have a right to file an Appeal with Trusted and request a "State Fair Hearing" with the State Office of Administrative Hearings.

- adlines
  - You must file an **Appeal** or request a **State Fair Hearing** within 90 days of getting Trusted' s notice of action.

- If you want to continue receiving the benefit during your **State Fair Hearing or Appeal**, you must request the Fair Hearing or Appeal by the following:
  - Within 10 days from Trusted postmark of the Notice of Action or
  - The intended effective date of Trusted's proposed action (or, in other words, when the benefit is to stop).

- Your provider may file an Appeal or request for a Fair Hearing on your behalf. You will need to request this is writing.

Appeals

- If you call and give your Appeal over the phone, Trusted will summarize your Appeal in a letter and send you the letter for you to sign. Be sure to read the letter carefully. You must sign the letter and return it to the Trusted in order to have an Appeal.

- Your Appeal will be decided by Trusted within 30 calendar days from the date your Appeal was received.

- If Trusted needs more time to get information and the state decides this would be best for you, or if you or your Advocate requests more time, Trusted may increase this time period for the decision by 14 calendar days. Trusted must give you written notice of the extension.

- You will receive written notice of Trusted's decision about your Appeal in the mail.

- If you are not happy with Trusted's decision about your Appeal you may request a Fair Hearing.

Expedited (Emergency) Complaints/Grievances and Appeals process

If your Appeal is determined to be an emergency, Trusted will give you a decision within 3 calendays. An Appeal is considered an emergency if it would be harmful or painful to you if had to wait for the standard time frame of the Appeal procedure.

All Appeals filed by Members with HIV/AIDS, mental illness or any other condition that requires attention right away, will be resolved and communicated back to the Member within 24 hours of filing the Appeal.

Your rights during the Complaints/Grievances, Appeals and State Fair Hearings process

- **You have the right to a State Fair Hearing.** You may request a State Fair Hearing at any time before, during or after you have filed an Appeal with Trusted, but no more than ninety (90) days from the date Notice of Action is mailed.
- **You can request a State Fair Hearing by contacting your local DHHR office.** Your local DHHR office will have a form for you to complete to request the State Fair Hearing. You may represent yourself or use legal counsel, a relative, friend, or other spokesperson.
- If a State Fair Hearing is requested, the State will hear your case and give you a decision in writing within 90 days of the date you asked for a State Fair Hearing. If you are still not happy with the decision, you can take your case to Circuit Court. If you want to take a case to Circuit Court, you must file within 120 days of your notice of the State Fair Hearing decision. If you choose to request a State Fair Hearing, you can continue the services, but if you lose you will have to pay the entire cost of those services.
- You have a right to keep receiving the benefit we denied while your Appeal or Fair Hearing is being reviewed. To keep your benefit during a Fair Hearing, you must request the Fair Hearing within a certain number of days - This could be as short as 10 days.
- You have the right to have someone from Trusted help you through the Grievance and Appeals process.

- You have a right to represent yourself or be represented by your family caregiver, lawyer, or other representative.
- You have a right to have accommodations made for any special health care need you have.
- You have a right to adequate TTY/TTD capabilities, and Services for the visually impaired.
- You have a right to adequate translation Services and an interpreter.
- You have a right to see all documents related to the Complaint/Grievance, Appeal or Fair Hearing.
- You have a right to present evidence in person or in writing. If it is an expedited (emergency) appeal, you must do it within the 3 day timeframe.

If you have any questions about the Complaints/Grievances and Appeals/Fair Hearings process, please call Member Services.

Notice of Privacy Practices

This Notice describes how medical information about you may be used and disclosed, and how you can get this information. Please read it carefully.

Why Are You Giving This Notice to Me?

Trusted Health Plan knows that information about you and your health is personal, and we are required by the federal Health Insurance Portability and Accessibility act (HIPAA) to tell you what your responsibilities are and what rights you have under the law. Trusted Health Plan has internal procedures to protect oral, written and electronic protected health information across the organization.

What is Trusted Health Plan Required to do Under HIPAA?

- Make sure that your protected health information is kept private;
- Give you this notice to tell you about our legal duties and privacy practices with respect to your PHI; and
- Follow the terms of this notice.

What is Protected Health Information (PHI)

Protected Health Information (PHI) is defined as any oral, written or electronic information that:

- Identifies you or can be used to identify you.
- Either comes from you or has been created or received by a health care provider, a health plan, or a healthcare clearinghouse.
- Has to do with your physical and/or mental health or condition, providing health care to you, or paying for providing health care to you.

In this notice, "protected health information" will be written as PHI.

How Can You Use or Share my PHI?

There are laws that allow or require us to use or disclose your PHI for many reasons. This Notice tells you how we may use and disclose your PHI. While not every use or disclosure is listed, the ways we may use to share your PHI falls within one of the descriptions below.

For Treatment:

We may use and share your PHI for treatment. For example, we may use or share your PHI to enroll you in a disease management program, or to share it with your case manager.

For Payment to Caregivers:

We may use and share your PHI in order to pay for health care you receive. For example, a bill that we may receive from your doctor may have information on it that identifies you, the nature of your illness, the treatment or tests given to you and the supplies that might have been used.

For Health Care Operations:

We may use and share your PHI to run our business. We protect your PHI by limiting access to it within our Plan. Only our employees directly involved in our business activities that require access to your PHI are authorized to see or discuss your PHI. For example, we may use your PHI to review and improve the quality of healthcare services you receive. In addition, Trusted shares your PHI with our business partners; however, they are under the same obligations to protect your PHI as Trusted is.

For Another Covered Entity's Needs:

We may share your PHI with another covered entity, such as a doctor or health plan, for their treatment or payment use. For example, we may share your PHI with a health plan to help them pay for your care. We may also share your PHI with them so that they can do certain business tasks if you have or have had a relationship with them.

To remind you of appointments and health-related benefits or services:

We may use your PHI to send you appointment reminders. We may use PHI to tell you about other health care treatment, services, or benefits.

To comply with the law:

We will share your PHI when we are required by law to do so. We will share PHI when we are required to in a court or other legal proceeding. For example, we will disclose PHI if a law says that we must report PHI about people who have been abused.

To report public health activities:

We will share PHI with government officials in charge of collecting certain PHI. For example, we may share PHI about births, deaths, and some diseases.

For health oversight activities:

We may share PHI if a government agency conducting activities approved or required by law, such as audits, investigations, licensure or disciplinary actions. Oversight agencies include government agencies that look after the health care system, benefit programs, including Medicaid, SCHIP, or Healthy Kids, and government regulation programs.

For purposes of disposition of your remains:

We may share your PHI with coroners, medical examiners, and funeral directors. If permitted by law, we may also share PHI with organizations that help find organs, eyes, and tissue to be donated or transplanted.

To avoid harm:

In order to avoid a serious threat to the health or safety of a person or the public, we may provide PHI to law enforcement or others who may be able to stop or lessen the harm.

For certain government functions:

We may share PHI for national security reasons. For example, we may share PHI to protect the President of the United States.

For Workers' Compensation:

We may share PHI to obey workers' compensation laws.

Lawsuits and disputes:

If you are involved in a lawsuit or a dispute, we may share PHI about you in response to a court or administrative order or other lawful process.

For research:

We may share your PHI with researchers when an institutional review board or privacy board as followed the HIPAA information requirements.

Other Uses and Sharing of Your Health Information:

We will ask for your written permission, before we make any use or disclosure of your PHI not described in this notice. If you give us your written permission, you may still decide later that you no longer want us to use or disclose your PHI in that way. If you change your mind, you must tell us in writing. We will then stop using your PHI in that way.

Will You Give my PHI to my Family, Friends, or Others?

We may share PHI about you with a friend or family member who is involved with your care or who helps pay for your care when you are present if you agree to do so. For example, if one of our case managers visits you in the hospital and your mother is with you, we may discuss your PHI with you in front of her if you approve. We will not discuss your PHI with others unless you have given permission. There may be times when you are not present or are unable to make healthcare decisions. If this should happen, we may share your PHI with the next of kin or a relative you have given permission for us to speak for

you. For example, we may share PHI with your emergency contact on file if you are unable to speak, so that you can receive care.

What are my Rights Under Federal Law with Respect to my PHI?

The law gives you the following rights regarding your PHI. To receive these rights, please call Member Services.

1. **You can see or get copies of some of your PHI** – Sometimes your right to see or get copies of your PHI may be limited. You must ask us in writing. We may charge a fee for copying and mailing the PHI.

2. **You may ask us to limit our uses and disclosures for purposes of treatment, payment or healthcare operations.** – We are not required to agree to the request. You may also ask us to limit disclosures to someone who is involved in our care or payment for your care, like a family member or friend.

3. **You may ask us to send your PHI to another address if it is necessary to protect you from danger. You may ask us to communicate with you in a certain way if it is necessary to protect you from danger.** – For example, you may ask us to send PHI to you at work instead of at home. You may ask us to send your PHI by e-mail rather than regular mail. You must tell us in writing what you want. You must tell us that you could be in danger if we do not agree to your request.

4. **You can get a list of certain disclosures we have made of your PHI.** – The list will only include disclosures made after April 14, 2003. The list will not include certain types of disclosures. We will give you one list free during any 12 month period. You will need to pay for any additional lists during that time.

5. **You may ask us to correct your PHI if you think there is a mistake.** You must ask us in writing and tell us why you want us to correct the information.

6. **You may get a paper copy of this notice at any time.** To obtain a paper copy of this notice, please call Member Services.

May I Complain about Your Privacy practices?

Yes! YOU WILL NOT BE PUNISHED FOR FILING A COMPLAINT. If you think we violated your privacy rights you may file a complaint. You must send your written complaint to:

Trusted Health Plan
1100 New Jersey Ave
Ste. 840

How will I know if my rights change?

We may change this notice and our privacy policies at any time. Then the new notice will apply to all of your PHI. We will make the new notice available to you at all times. The new notice will contain the new effective date.

Medicare Part D Notice to Members

For Members with both Medicare and Medicaid

If you get Medicare and Medicaid at the same time, beginning on January 1, 2006, you will get your medicines from the Medicare Part D program.

Trusted will only cover your medicines for

- Certain over -the -counter drugs
- Barbiturates
- Benzodiazepines

What Some Words Mean

Advance Directive	A written, legal paper that you sign that lets others know what health care you want, or do not want, if you are very sick or hurt and cannot speak for yourself
Advocate	A person who helps you get the health care and other Services you need
Appeal	An appeal is a special kind of complaint you make if you disagree with a decision Trusted makes to deny a request for health care services or payment for services you already received. You may also make this kind of complaint if you disagree with a decision to stop services that you are receiving
Appointment	A certain time and day you and your doctor set aside to meet about your health care needs
Care Manager	Someone who works for Trusted and will help those people in the Disease Management Program get the care and information they need to stay healthy
Check-Up	See Screening
Complaint	See Grievance
Contraception	Birth control
Covered Services	Health care Services that Trusted will pay for
Detoxification	Getting rid of harmful substances from the body such as drugs and alcohol
Development	The way in which your child grows
Disease Management Program	A program to help people with chronic illnesses or Special Health Care Needs such as asthma, high blood pressure or mental illness get the care and Services they need

Durable Medical Equipment	Special medical equipment that your doctor may ask or tell you to use in your home
Emergency Care	Care you need right away for an Emergency Medical Condition.
Emergency Medical Condition	A serious, sudden, sometimes life-threatening condition
EPSDT	Early, Periodic Screening, Diagnosis and Treatment Program (also called Health Check Program) that gives health care to members under 21 years old
Fair Hearing	If you file a Grievance/Complaint you can ask for a hearing with State Office of Administrative Hearings
Family Planning	Services such as pregnancy tests, birth control, testing and treatment for sexually transmitted diseases, and HIV/AIDs testing and counseling
Family and General Practice Doctor	A doctor that can treat the whole family
Grievance	If you are unhappy with the care you get or the health care services Trusted gives you, you can call Member Services to file a Grievance/Complaint
Handbook	This book that gives you information about Trusted and our services
Health Check Program	See EPSDT
Hearing Impaired	If you cannot hear well, or if you are deaf
IDEA	Individuals with Disabilities Education Act; a federal law that gives services to children with developmental delays and special health care needs
Immunization	Shot, vaccine
Internal Medicine Doctor	Doctor for adults and children over 14 years old

Interpretation/Translation Services	Help from Trusted when you need to talk to someone who speaks your language, or you need help talking with your doctor or hospital
Managed Care Organization (MCO)	A company that is paid by the state to give you health care and health services
Managed Care Plan	A plan that gives you a list of Providers that you can see
Maternity	The time when a woman is pregnant
Member	The person who gets health care from Trusted
Member Advocate	The person who will work with members providers, and plan personnel to facilitate the provision of Medicaid benefits to members.
Member Identification Card	The card that lets your doctors, hospitals, drug stores, and others know that you are a member of Trusted
Mental Health	How a person thinks, feels and acts in different situations
Network Providers	Doctors, nurses, dentists, and other people who take care of your health who are a part of Trusted
Non-Covered Services	Health care that Trusted does not pay for
OB/GYN	Obstetrician/Gynecologist; a doctor who is trained to take care of a woman's health, including when she is pregnant
Out-of-Network Providers	Doctors, nurses, dentists, and other people who take care of your health who are not a part of Trusted
Pediatrician	A children's doctor
Pharmacy	The store where you pick up your medicine
Physician Incentive Plan	Tells you if your doctor has any special arrangements with Trusted
Post Partum Care	Health care for a woman after she has her baby

Post-Stabilization Care	Health care to stabilize a patient after an emergency
Prenatal Care	Care that is given to a pregnant woman the whole time she is pregnant
Prescription	The order that your doctor writes for Medicine; you must take it to the pharmacy/drugstore to pick up the medicine.
Preventive Counseling	When you want to talk to someone about ways to help you stay healthy or keep you from getting sick or hurt
Primary Care Provider (PCP)	The doctor that takes care of you most of the time
Prior Authorization	Written permission from Trusted to get health care or treatment that is not usually paid for by Trusted
Provider Directory	A list of all providers who are part of the Trusted
Providers	Doctors, nurses, dentists, and other people who take care of your health
Referral	When your main doctor gives you a written note that sends you to see a different doctor
Routine Care	The regular care you get from your primary care provider or a doctor that your primary care provider sends you to. Routine Care can be a Check-Up, physical, health screen, and regular care for health problems like diabetes, asthma and hypertension
Screening	A test that your doctor or other health care provider may do to see if you are healthy. This could be a hearing test, vision test, or a test to see if your child is developing normally
Self-Referral Services	Certain services you can get without getting a written note or Referral from your main doctor
Services	The care you get from your doctor or other health care Provider
Special Health Care Needs	Children and adults who need health care and other services that are more than or different from what other children and adults need

Specialist	A doctor who is trained to give a special kind of care like an ear, nose and throat doctor or a foot doctor
Specialty Care	Health care provided by doctors or nurses trained to give a specific kind of health care
Sterilization Procedures	A surgery you can have if you do not want children in the future
Transportation Services	Help from Trusted to get to your appointment, which can include bus or metro tickets, tickets to pay for a taxi, wheel chair vans, or ambulances. The type of transportation you get depends on your medical needs
Treatment	The care you get from your doctor
Urgent Care	Care you need within 24 hours, but not right away
Visually Impaired	If you cannot see well or you are blind

TRUSTED HEALTH PLAN (DISTRICT OF COLUMBIA), INC.

PLAN/ SPECIALIST AGREEMENT

This Plan/Provider Agreement (this "**Agreement**") is made and entered into this _____ day of _____, 2016, between Trusted Health Plan, (District of Columbia) Inc. ("**Plan**"), a Washington, D.C. corporation licensed as a Health Maintenance Organization ("HMO") in the State of West Virginia, whose business address is 1100 New Jersey Avenue, S.E., Suite 840, Washington, D.C., 20003, and [PROVIDER NAME] ("**Provider**"), whose business address is [BUSINESS ADDRESS].

In consideration of their mutual covenants and promises contained in this Agreement, the parties agree as follows:

ARTICLE I: DEFINITIONS

For purposes of this Agreement and its exhibits, the following words and phrases shall have the following meaning:

i. "**Clean Claim**" means a claim that has no defect, impropriety, lack of any required substantiating documentation or particular circumstance requiring special treatment that prevents timely payment.

ii. "**Covered Services**" means those properly authorized services that are covered by a Program and that Plan has committed to provide to Members under a Program/Plan Agreement.

iii. "**Covering Physician**" means a contracted licensed physician of medicine or osteopathy who agrees to provide services to another contracted licensed physician's patients when that other physician is not available.

iv. **"DHHS"** means the State of West Virginia Department of Health and Human Resources.

v. "**Effective Date**" means the date this Agreement is executed by Plan.

vi. "**Emergency**" shall have the meaning defined for that term in a Program, and shall include the sudden onset of a medical condition that manifests itself by acute symptoms of sufficient severity (including severe pain), such that the absence of immediate medical attention could reasonably be expected to result in: (a) placing the health of the individual (or regarding a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, (b) serious impairment to bodily functions, or (c) serious dysfunction of any bodily organ or part. Payment shall not be denied hereunder for services provided to a Member up to the point of stabilization of an Emergency because of the final diagnosis or because prior authorization was not given before such services were provided.

vii. "**External Quality Review**" means a validation of performance/quality improvement measures and activities; compliance with local standards for access to care, structure and operations; and validation of consumer or provider surveys of quality of care.

viii. "**Government Program Fraud Control Unit**" means the Program Integrity Division and/or its authorized agent/s; the United States Department of Health and Human Services ("HHS"), Office of Inspector General ("OIG"); the Centers for Medicare and Medicaid Services ("CMS"); the Federal Bureau of Investigation ("FBI"); or any other West Virginia, state, or federal agency with proper jurisdiction, charged with identifying, investigating, or prosecuting suspected fraud, waste, or abuse.

ix. "**Government Program**" means a Program funded in whole or in part by federal, state or local government funds other than any program such government unit provides to its employees or retirees, and including, but not limited to, programs such as Medicare, and Medicaid.

x. "**Member**" means any individual determined eligible for a Program who has enrolled or been enrolled with Plan for the provision of Covered Services.

xi. "**Never Event**" means reportable adverse events that are serious, largely preventable, and of concern to both the public and health care providers for the purpose of public accountability.

xii. "**Participating Hospital**" means a facility with an established contract with the Plan to provide Covered Services to members.

xiii. "**Participating Provider**" means a qualified and licensed physician or allied health professional who has been accepted by Plan to provide certain Covered Services to Members hereunder.

xiv. "**Provider Manual**" means a manual made available to Provider by Plan, which includes Plan's procedures and forms, requirements for record keeping and treating members, referral procedures, prior authorization requirements, appeal procedures, and information relating to benefits, co-payments, coordination of benefits, and other operational policies and procedures. Plan may make this manual (and any updates to this manual) available on line on its web site.

xv. "**Primary Care Provider ("SPECIALIST")**" means a qualified and licensed physician, allied health professional, and multi-specialty primary care practitioner engaged in the areas of Family Practice, Internal Medicine, Pediatrics or such other area as may be determined by Plan, and is selected by a Member to provide Primary Care Services.

xvi. "**Primary Care Services**" means those Covered Services customarily provided by a Primary Care Provider.

xvii. "**Program**" means any health coverage program offered through an employer, association or other entity, including Government Programs, which enters into a contract with Plan for the provision of Covered Services and any non-group health coverage program offered by Plan.

xviii. "**Program/Plan Agreement**" means any agreement between a Program and Plan pursuant to which Plan agrees to arrange for the provision of Covered Services to Members. A list of the Program/Plan Agreements covered by this Agreement is set forth on Exhibit E.

xix. "**Referral Provider**" means a health care professional or provider who or which provides a Covered Service pursuant to authorization from a Primary Care Provider or Plan.

xx. "**Referral Service**" means a Covered Service which is prior authorized by a Primary Care Provider or Plan.

xxi. "**Regulatory Agencies**" means the Centers for Medicare and Medicaid Services ("CMS"), the State of West Virginia, Department of Insurance, which has regulatory authority over Plan, and the Department of Health and Human Resources, which oversees contractual compliance for the Medicaid Program and any other governmental entities with regulatory authority over the Plan or any of its contractors or activities.

xxii. "**Specialist**" means where applicable and appropriate, Provider, and any individual Specialist contracted with Plan pursuant to this Agreement with Provider, who is board certified or board eligible or approved as a Specialist physician by Plan, in a particular medical specialty, from whom a Member may receive Referral Services in the Specialist physician's particular medical specialty, upon referral from his or her Primary Care Provider.

xxiii. "**Specialist Physician Services**" means those Covered Services that fall within the specialty that Specialist is qualified to perform as a physician.

ARTICLE II: DUTIES AND OBLIGATIONS OF PROVIDER

1. Specialist agrees to provide Specialty Physician Services to Plan Members who are referred for diagnosis or treatment for Emergency Services or Referral Services that have been pre-approved by Primary Care Provider or Plan's utilization management program. Specialist will not deny Specialty Physician Services to eligible Members. Specialist agrees to provide Specialty Physician Services to Plan Members on a twenty-four (24) hours a day, seven (7) days a week basis or make arrangements with a Covering Physician who is also a Specialist, when Specialist is otherwise absent or unavailable to provide such services. For Specialty Physician Services that are not Emergency Services or urgent care, Specialist shall schedule appointment with Members within thirty (30) days or sooner, if medically necessary, of receipt of a referral from the Member's Primary Care Provider or from Plan's utilization management department. For any Member admitted by Specialist to a Participating Hospital, Specialist agrees to coordinate information and services with the Member's Primary Care Provider and with Plan's utilization management programs. Specialist agrees to perform Specialty Physician Services for Members only for the specified types of services for which he or she is qualified to perform, if he or she has been credentialed by Plan's physician credentialing committee in the specialty or received advanced written permission of Plan's medical director. For services rendered by a Covering Physician, Specialist shall be solely responsible to make arrangements with the Covering Physician to accept as full payment, the fee payable to Specialist in accordance with all conditions set forth in this Agreement regarding billing or treatment of Members. Any fee billed by a Covering Physician in excess of Plan's fee schedule shall be the sole responsibility of Specialist. Specialist shall cooperate with any after-hours triage program established by Plan.

2. Specialist shall perform Specialty Physician Services upon receipt of a referral. In coordinating with Primary Care Provider, Specialist shall submit referral reports and/or furnish copies of medical records to the Primary Care Provider from whom referrals were made in order to maintain an integrated medical record for assigned Members. Plan shall monitor Specialist to ensure he or she submits referral reports to the Primary Care Provider in a timely manner. In the

event that Specialist fails to submit referral reports in a timely manner, Specialist shall be subject to monetary sanctions.

3. Except for Emergency Services, Specialist agrees not to refer Members to other physicians, including other Specialist physicians, without prior authorization of Member's Primary Care Provider or Plan's utilization management program. Whenever Specialist must refer a Member for Emergency Services or has approval from the Primary Care Provider or Plan's utilization management program, he or she agrees to refer the Member to providers/practitioners under contract with Plan, where possible. If Specialist refers a Member to a provider/practitioner in a manner contrary to the Plan's utilization management or quality management programs, the cost of such services shall be the financial responsibility of Specialist. Plan, at its option, may reduce future payments to Specialist due to Specialist's failure to follow Plan's policies and procedures.

4. Specialist shall provide Specialty Physician Services in accordance with generally accepted standards of medical practice and the standards established by the Plan's quality management program. Specialist shall maintain a competent level of experience through continuing education programs in his or her particular discipline and shall participate in any continuing education program established or recommended by Plan that is appropriate to his or her practice.

5. Specialist warrants that (i) he or she is board-certified or board-eligible to perform services in the specialty discipline designated in his or her application to Plan's credentialing committee or its delegate, and has had the requisite education from an accredited physician residency program in his or her discipline; or (ii) he or she has the requisite experience to qualify to perform Specialty Physician Services and has received written permission from Plan's medical director to perform Specialty Physician Services. Any Specialist that fails to meet Plan's credentialing requirements will not be permitted to provide Covered Services under this Agreement.

6. Specialist shall also comply with any corrective action plan established by Plan related to the provision, arrangement, or failure to provide Specialty Physician Services at the level commensurate with other practices in his or her specialty.

7. Specialist agrees to maintain and demonstrate to Plain upon request, throughout the term of this Agreement, compliance with the following:

    a. Licensure as appropriate under the laws of the State West Virginia;

    b. Board certification or board eligibility in each and every one of Specialist's specialties or proof that each and every Specialist is seeking board certification within one (1) year of execution of this Agreement, unless exempted by Plan's medical director;

    c. Written assurances that all nurses and other ancillary and paramedical personnel employed by, associated with and/or under contract with Specialist, are properly licensed or certified to practice in the State of West Virginia and

    d. The credentialing standards of Plan as set forth in the Provider Manual, by providing, upon request, information concerning Specialist's education, training, residency, malpractice liability insurance, pending malpractice claims, and, if applicable, hospital staff status, hospital clinical privileges, and hospital staff reappointment dates. Specialist

shall immediately notify Plan in writing of any adverse action, proceeding or decision, or any sanctions imposed by a state or federal regulatory or licensing agency, court, or other governmental entity, or of any other situation regarding Specialist that could materially affect Specialist's ability to carry out his/her or its duties and obligations under this Agreement, and provide a copy of any notification and/or documents relating thereto. Specialist shall also immediately notify Plan in the event that any certifying authority takes any action adversely affecting Specialist's board certification.

8. Specialist shall implement all activities necessary (including, but not limited to, cooperating in the review and auditing of Members' medical records) to assist Plan in obtaining external accreditation by the National Committee for Quality Assurance ("NCQA") or any other similar organization selected by Plan. Such reviews and audits may include on-site visits; Specialist staff and Member interviews; claim and encounter data reviews, reviews of Specialist continuous quality improvement plans, credentialing and re-credentialing activities, corrective actions and follow-up plans, Member satisfaction surveys, Specialist satisfaction surveys, Specialist and Specialist staff qualifications.

9. Specialist hereby represents and warrants that:

   a. All Specialists are certified to participate in the Medicaid program; and

   b. Neither Specialist nor any employee or agent of Specialist is excluded from participating in Medicaid, under Title XIX of the Social Security Act.

10. Specialist hereby agrees that in no event, including, but not limited to nonpayment by Plan, insolvency by Plan, or breach of this Agreement, shall Specialist bill, charge, collect a deposit from, seek compensation, remuneration, or reimbursement from, or have any recourse against Members or persons other than Plan for Covered Services provided pursuant to this Agreement. Specialist further agrees that (i) this provision shall survive the termination of this Agreement irrespective of the cause giving rise to such termination and shall be construed to be for the benefit of Plan's Members, and that (ii) this provision supersedes any oral or written agreement to the contrary now existing or hereafter entered into between Specialist and the Member or persons acting on Member's behalf.

11. Specialist agrees to perform his or her duties under this Agreement in a manner consistent with the reasonable administrative guidelines provided by Plan in its Provider Manual. In the event of conflict between such manual and this Agreement, the terms of this Agreement shall prevail.

12. Specialist agrees cooperate with Plan's reasonable fraud, waste, and abuse efforts, as well as participate in the utilization management and quality management programs adopted by Plan. These programs shall include, among other things, preadmission certification and concurrent and retrospective review, and the use of care management teams. In cases where a Member requires a hospital admission for a non-Emergency Service, Specialist agrees to obtain prior authorization for such admission in accordance with Plan's utilization management program. Specialist agrees that in order for Plan to provide coverage for any extension of a length of stay for a hospital admission, Specialist must obtain prior authorization from Plan's utilization management program.

13. Specialist shall provide on-site access to Plan representatives upon reasonable notice and shall furnish pertinent sections of Member's medical records as may be required to administer relevant Programs. Specialist shall comply with all final determinations rendered by the utilization management and quality management programs. Final determinations may include monetary or other sanctions against Specialist, as provided for in Plan's policies, procedures, rules, and regulations; including, but not limited to, the sanction provisions in Plan's Provider Manual.

14. Specialist shall provide Plan with encounter data by type of Specialty Physician Service(s) in a computer readable form in 837P format in accordance with any additional reporting requirements. The encounter data shall be the property of Plan. In the event Specialist fails to provide encounter data to Plan as provided in this section, Plan may in its sole discretion, require re-education procedures, or may impose monetary sanctions after the established deadline that Specialist fails to submit such data. In the event of continued or repeated violations of this section, Plan, in its sole discretion, may impose a range of additional sanctions, including not allowing new referrals to Specialist, limiting Specialist's participation in any or all Plan incentive payment programs, or termination of this Agreement. The cost of preparing and submitting such encounter data to Plan shall be borne solely by Specialist.

15. Specialist shall cooperate with Plan in resolving any Member grievances or complaints related to the provision of Specialty Care Services, and shall provide Plan with notice of any Member complaints involving Specialist. Specialist agrees to participate in and cooperate with Plan's Member grievance and complaint procedures, as set forth in the Provider Manual, and to comply with all final determinations rendered in accordance with those procedures.

16. Plan may use Specialist's name, address, and telephone number in Plan materials, including Plan's provider directory. In the event Specialist wants to use Plan's name in any context or for any purpose, other than general administrative purposes as specified by Plan, Specialist shall obtain written consent from Plan, which consent shall not be unreasonably withheld. Specialist may post a notice in its offices and acknowledge to his or her patients that Specialist participates in Plan.

17. Specialist represents and assure that they shall not discriminate against any Plan Members on the basis of race, color, creed, national origin, ancestry, sex, age, disability, sexual orientation, personal appearance, family responsibilities, income, Medicaid status, political affiliation, religion, place of residence, marital status, health status, lawful occupation, source of payment, handicap, membership in Plan, or frequency of utilization of Covered Services. Specialist shall comply with all applicable federal and District laws relating to non-discrimination and equal employment opportunity, and assure physical and program accessibility of all services to persons with physical and sensory disabilities pursuant to Section 504 of the Federal Rehabilitation Act of 1973, as amended (29 U.S.C. § 794), all requirements imposed by the applicable regulations (45 C.F.R. Part 84), and all guidelines and interpretations issued pursuant thereto, and the provisions of the Age Discrimination and Employment Act of 1967 and the Age Discrimination Act of 1975. In connection with performance under the Agreement, Specialist agrees not to discriminate against any employee or applicant for employment because of age, race, religion, color, handicap, sex, physical condition, income, Medicaid status, place of residence, developmental disability,

marital status, personal appearance, sexual orientation, family responsibility, matriculation, political affiliation, or national origin. Specialist shall comply with the provisions of Executive Order 11246 "Equal Employment Opportunity" as amended by Executive Order 11375 and supplemented by the United States Department of Labor regulations (41 C.F.R. § 60).

18. Specialist may not impose any limitations on the acceptance of Members for care or treatment that it does not impose on other patients of Specialist. Specialist may not require the transfer, discharge, or removal of any Member because of the Member's need for, or utilization of, medically necessary services.

19. If any services provided by Specialist are not Covered Services, Specialist may bill Members at a rate not in excess of the rate which he/she bills the general public after first notifying the Member in writing in advance of rendering the service that the service is not covered and obtaining the Member's written consent to be billed. Specialist agrees to provide Plan with such documentation upon request. Specialist shall, in no event, charge or attempt to recover from Plan or the Member for any Covered Services which are not Medically Necessary. Prior to billing Members for non-Covered Services, Specialist agrees to verify with Plan that the claim is the Member's responsibility.

20. Specialists who are also Primary Care Providers shall not refer Members to him or herself in a capacity as a Specialist unless Specialist has secured the prior approval of Plan's medical director or his or her designee or in accordance with the method set forth in Plans' Provider Manual.

21. Specialist agrees that in connection with all actions taken on behalf of Members and in all communications with Members in connection with this Agreement, Specialist shall avoid actions and communications that could or shall undermine the confidence of the Member, a potential Member, employers, unions, governmental or licensing or certifying entities, or the general public, in Plan or in the quality of care Plan provides. Notwithstanding the foregoing, nothing in this Agreement shall limit the rights of Specialist to: (i) communicate with Members regarding medical treatment options; (ii) recommend a course of treatment to a Member, even if the course of treatment is not covered, or approved by Plan; (iii) file an appeal or complaint on a Member's behalf, pursuant to the procedures of Plan; (iv) supply accurate, relevant factual information to a Member in connection with an appeal or complaint filed by such Member; or (v) object to policies, procedures, or decisions made by Plan. If a recommended course of treatment is not covered, e.g., not approved by Plan, Specialist must notify the Member if Specialist intends to charge the Member for such non-Covered Services.

22. Specialist shall provide Plan with at least thirty (30) days prior written notice of any changes in Specialist's name, office locations, addresses, hours of operation, telephone numbers and other relevant information relating to Specialist's operations. Specialist agrees to provide written notice of such changes(s) to all Plan Members on existing practice appointment schedules at the time of such change(s).

23. If this Agreement terminates for any reason, within fifteen (15) days of the notice of termination or thirty (30) days before the effective date of termination, whichever is sooner, Provider will notify its Members in writing of such termination. The notice will include:

a. the effective date of termination;

b. instructions to the Member(s) to contact the Plan regarding securing a new Provider;

c. a brief description of the Provider's process for transferring the Member's Protected Health Information ("PHI"); and if applicable

d. future contact information for the Provider.

24. Provider shall adhere to the below marketing conditions:

a. Any marketing information distributed by Provider directed at Plan's Members shall be limited to general information about Plan and notification that Provider participates in Plan's network. Any such materials must be submitted to Plan for review and approval prior to distribution to Members (Plan will ultimately submit such materials to DHHS for review and approval).

b. Provider will not utilize written information that is false or misleading in any material respect, including information regarding the Provider's network, the availability of services, the Provider's qualifications, hours, and location of services.

c. Provider shall not host marketing events within the Provider's office.

d. Provider shall not offer to Members gifts of more than a de minimus value or other insurance products designed to induce persons to enroll in Plan.

e. Provider shall not enter into compensation agreements with marketing personnel that utilize any type of payment structure in which compensation is tied to the number (or classes) of persons who enroll in Plan.

ARTICLE III: DUTIES AND OBLIGATIONS OF PLAN

25. Plan shall provide all administrative services under this Agreement, including quality management, utilization management, budgeting, administration of Specialist claims, coordination of benefits, funds management, and compliance with all Federal and State HMO regulatory requirements.

26. Plan shall provide Specialist with a Provider Manual setting forth the policies and procedures that Plan has adopted in administering its Programs. Plan shall also provide written notice to Specialist of changes to its Provider Manual at least thirty (30) days prior to the effective date of such changes.

27. Plan shall apprise all Members concerning the type, scope, and duration of benefits and services to which Members are entitled under the Plan. Plan shall retain final authority regarding benefits determinations for its Members.

28. Plan agrees to assist Specialist in the development and initial implementation of procedures necessary to carry out the terms of this Agreement.

29. Plan shall not terminate Specialist on the basis of gender, race, age, religion, national origin, or any protected category under the Americans with Disabilities Act.

30. Plan reserves the right immediately transfer any of its Members to another Specialist if Plan reasonably determines that Specialist is jeopardizing a Member's health or safety.

ARTCILE IV: COMPENSATION

31. Plan shall provide compensation to Specialist as set forth in the relevant compensation Exhibits A , B, and C to this Agreement, which shall be full compensation for Specialist's services under this Agreement.

32. Specialist agrees to accept payment from Plan, together with authorized copayments, as provided herein as full payment for Covered Services, and shall not pursue or collect charges for such services from third parties. However, Specialist agrees to cooperate and use best efforts in the effective implementation of any coordination of benefits procedures and other procedures for handling third party claims, as set forth in the Provider Manual, including collecting information from Members regarding other health coverage.

33. Specialty Physician Services are to be provided to Members by Specialist on a fee-for-service basis, and Specialist agrees to submit claims to Plan, on CMS 1500 forms or in electronic form compliant with 837P format as set forth in Exhibit A. Such bills shall include all diagnostic and/or procedure codes applicable to services performed for each Member's encounters

ARTICLE V: MEDICAL RECORDS

34. Specialist shall prepare and maintain appropriate and detailed medical records relating to the provision of services to Members as required by Plan and applicable law, and to make such records available to Plan, Regulatory Agencies and their respective agents involved in assessing the quality of care or investigating Member grievances or complaints.

35. Specialist agrees that until the expiration of ten (10) years after the furnishing of services pursuant to this Agreement, Specialist shall make available to Plan, DHHS, the State of West Virginia Department of Health ("DOH"), HHS, CMS, the OIG, and their respective designees, any medical records; required data; reports of services, complaints, grievances, quality or utilization issues; and any books, documents and other records of Specialist as necessary to certify the nature and extent of services provided and the cost thereof. Specialist agrees that in the event of

termination of this Agreement for any reason, Specialist will provide copies of the medical records of any Member to the Primary Care Provider selected by the Member, within ten (10) business days following a written request from the Member or the Plan. Specialist agrees to allow any Government Program Fraud Control Unit access to Specialist's place of business as required by the contract between the Government Program and Plan.

36. Notwithstanding any other provision of this Agreement, the parties agree that the medical records of all Members shall be treated as confidential consistent with all federal and district laws regarding the privacy and confidentiality of medical records.

ARTICLE VI: TERM AND TERMINATION

37. The term of this Agreement begins on the Effective Date and shall remain in effect for an initial period ending December 31 of the calendar year in which it becomes effective, unless terminated earlier under the provisions of this Agreement. Each December 31, this Agreement shall automatically be renewed for an additional calendar year unless either party provides the other party with written notice of its desire to terminate the Agreement at least sixty (60) days before the expiration of the then current term. Each party acknowledges and accepts the right of the other party to decide, in its sole discretion, to terminate the Agreement.

38. Either party may terminate this Agreement following thirty (30) days prior written notice to the other party of a material breach of this Agreement, provided that if such material breach is cured within fifteen (15) days of the written notice of material breach, then such notice of termination shall be of no force and effect. It shall be considered a material breach by a party: (i) if a party substantially fails to perform its duties under this Agreement in accordance with the terms and conditions set forth herein, (ii) if the party's failure to perform its duties under this Agreement causes the other party to suffer material financial damages, (iii) if the party commits an illegal or fraudulent act, or (iv) if there is a filing by the party or its creditors of any petition of bankruptcy or insolvency with the bankruptcy court pursuant to any federal or state law which may be in effect from time to time, which petition is not discharged or dismissed within thirty (30) days after such filing. In addition, Plan may terminate this Agreement immediately upon written notice to Specialist if Plan reasonably determines that Specialist poses a threat to the health or safety of any Member or to the license, certification, or reputation of Plan.

39. Plan's approval of a Specialist shall be revoked and Specialist shall no longer be authorized to provide services hereunder: (i) if such individual acts or fails to act in a manner that may result in imminent danger to the health of a Member, (ii) upon the loss of such individual's license to practice his/her profession in the State of West Virginia, or (iii) upon notice to Plan that such individual has been suspended, expelled, excluded or terminated from participation under Medicare, Medicaid, or any other Government Program. No payment will be made hereunder for services provided by any individual that has been so excluded or whose license has been revoked. In addition, Plan may require Provider to terminate any Specialist immediately upon written notice to Provider if Plan determines that such Specialist poses a threat to the health or safety of any Member or to the license, certification, or reputation of Plan. Where Plan

reasonably determines that a Specialist has acted or failed to act in a manner that may jeopardize a Member's safety or health, Provider shall cooperate with Plan to transfer the relevant Member(s) to a different Specialist.

40. This Agreement shall automatically terminate with respect to any specific Program, upon termination of the relevant Program/Plan agreement.

41. This Agreement shall automatically terminate in its entirety: (i) if Specialist acts or fails to act in a matter that may result in imminent danger to the health of a member, (ii) upon loss by Specialist of the legal right to render health care services in the State of West Virginia, or (iii) upon notice to Plan that Specialist has been suspended, expelled, excluded, or terminated from participation under Medicare, Medicaid, or any other Government Program. No payment will be made hereunder for services provided by Specialist if Specialist has been so excluded or has lost the legal right to render health care services in the State of West Virginia.

42. Either party may terminate this Agreement without cause following sixty (60) days prior written notice to the other party.

43. Notwithstanding any other provision of this Agreement, Plan, in its discretion, may suspend Specialist's ability to accept newly enrolled Members for the provision of services due to illness or disability of Specialist, pending investigation of any allegations of fraud, abuse, or other serious improper action by Specialist, or due to the inability of Specialist to provider Members reasonable access to services, as described in the Provider Manual. Plan shall conduct any investigation as expeditiously as reasonably possible, and limit the length of any suspension by either removing the suspension or giving notice of termination.

44. In the event of termination of this Agreement, Members in an ongoing course of treatment with Specialist shall be permitted to continue such treatment with Plan's authorization as follows:

    a. For a period of ninety (90) days from the date the Member is notified of the termination.

    b. If the Member is in the second or third trimester of pregnancy, treatment shall continue through post-partum care.

    c. If it is determined that the Member is terminally ill as defined under Section 5653 of the Public Health Code, treatment will continue for the remainder of the Member's life care directly related to the treatment of the terminal illness.

45. Specialist shall continue to be responsible for providing Specialty Physician Services to Members under active treatment as of the effective date of termination, until the earlier of: (a) completion of active treatment, or (b) Plan's orderly transition of the Member's care to another Participating Provider or Specialist. Member may request that ongoing care continue by Specialist for up to ninety (90) days even if Plan can arrange for an orderly transfer of Member's care. In such case, Specialist shall continue to provide Specialty Physician Services for a period of up to ninety (90) calendar days. If Specialist is providing obstetrical care, Specialist shall be responsible for

providing obstetrical care through the postpartum period for Members in their second or third trimester of pregnancy at the time the contract terminates. Payment for any continued Specialty Physician Services as described in this section shall be at the rates set forth under Exhibits A, B, and C.

46. If this Agreement terminates because of insolvency or the cessation of operations of Plan, Specialist shall continue to provide Specialist Physician Services to Members through the period for which premiums have been paid to Plan under the Program/Plan agreement, and for Members confined in an inpatient facility on the date of insolvency or other cessation of operations, until medically necessary appropriate discharge from the inpatient facility.

47. Within five (5) days of notice of termination, Specialist shall provide Plan with a list of all patients undergoing treatment by Specialist. Plan shall notify Members of termination of this Agreement upon receipt of the listing from Specialist. Should Specialist discover it has not submitted a complete list to Plan, Specialist shall immediately supply Plan with the additional information. Minimum information supplied to Plan shall include Member name, date of birth, Member I.D number, parent or guardian name (if applicable), most current address, telephone number, date of next schedule visit, diagnosis, current therapy and any other information reasonably required by Plan. This provision also applies if a Specialist leaves the Provider; however, in such a case, Plan and Specialist shall work together to ensure continuity of care within practice of Specialist if clinically appropriate and consistent with desires of the Member.

ARTICLE VII: RESOLUTION OF DISPUTES

48. In the event of a dispute concerning the construction, interpretation, performance under, or breach of this Agreement, which the parties, in good faith are unable to resolve within thirty (30) days after written notice of a dispute has been given by the party raising the dispute, the dispute shall be subject to Arbitration. All arbitration proceedings or litigation (to the extent the remedy requested is not, by law, available through arbitration [e.g., injunctive relief] relating to any claims or disputes arising under or relating to this agreement shall be brought in the county in which the principal executive office of the party not initiating such action or proceeding (i.e. the defendant or responding party) is located. The parties irrevocably submit and consent to the exercise of subject matter jurisdiction and personal jurisdiction over each of the parties by the federal and/or state courts in such jurisdiction (the "Selected Jurisdiction"). The parties hereby irrevocably waive any and all objections that any party may now or hereafter have to the exercise of personal and subject matter jurisdiction in the Selected Jurisdiction and to the laying of venue of any such proceeding or action brought in the Selected Jurisdiction. Any order or determination of the arbitral tribunal shall be final and binding upon the parties to the arbitration and may be entered in any court having jurisdiction. Each party will bear its own costs of arbitration, including counsel and support in connection with the arbitration, irrespective of the final arbitration award or judgment.

ARTICLE VIII: CONFIDENTIAL RECORDS, PROPRIETARY INFORMATION

49. Specialist shall not disclose or release any of the data or information obtained by virtue of this Agreement to any other person, firm, or corporation without the written consent of the Plan or where required to carry out obligations under this Agreement, and where applicable, the written consent of the Member(s).

50. Each party recognizes and agrees that the other party's name; assumed names; logos; financial and other identifying information; its business methods; forms; marketing methods and plans; the names, addresses and identifying information of the Members; Member lists; business contacts; and any other information concerning the business, property, and affairs of the other party; including, without limitation, all memoranda, notes, records, lists or other documents made available by the disclosing party to the receiving party during the term of this Agreement concerning the Members or anything covered under this Agreement, are confidential and constitute valuable property and proprietary information that is the exclusive property of the disclosing party (hereinafter, "Proprietary Information"). Neither party shall copy, use, or disseminate any of the disclosing party's Proprietary information in any manner for its direct or indirect economic gain or advantage, or that of any other person or entity whatsoever, except as expressly permitted in this Agreement for the purpose of the receiving party's compliance with the terms hereof. Each party expressly agrees that the other party shall, in addition to any other right or remedy that may be available, be entitled to injunctive and other equitable relief to prevent a breach of these provision of this Agreement and to secure its enforcement, in addition to any other rights and remedies provided by law or in equity. Each party further agrees that this Article VIII shall not be subject to arbitration under Article VII. Upon expiration or termination of this Agreement, or at any time upon the demand of the disclosing party, the receiving party shall promptly return to the disclosing party all Proprietary Information which the disclosing party made available to receiving party, and the receiving party shall destroy or continue to hold in confidence any notes or other information the receiving party, or a person or entity acting on its behalf, derived from the Proprietary Information.

ARTICLE IX: INSURANCE

51. Specialist agrees to maintain or to be at all times covered under policies of insurance with insurance companies approved by Plan or a program of self-insurance acceptable to Plan for the following types of coverage:

a. Specialist shall maintain throughout the term of this Agreement, professional liability insurance and general liability insurance in the minimum amounts of one million dollars ($1,000,000.00) per occurrence and three million dollars ($3,000,000.00) combined single limits coverage for Specialist, its agents, and employees. In the event Specialist procures a "claims made" policy as distinguished from an occurrence policy, Specialist shall procure and maintain prior to termination of such insurance, continuing "tail" coverage. Specialist shall immediately notify Plan of any material changes to insurance coverage and shall provide a certificate of insurance of such coverage to Plan upon Plan's request.

b. Unemployment compensation insurance and worker's compensation insurance in accordance with the requirements of all applicable federal and State of West Virginia laws and regulations.

c. Specialist shall furnish plan with evidence of all insurance coverage and riders required herein before the Effective Date of this Agreement and thereafter at Plan's request. Specialist shall notify Plan in writing within two (2) days of the cancellation of a policy of insurance maintained by Specialist. Specialist shall give Plan written notice of any material changes to an insurance policy at least thirty (30) days before the effective date of any such change initiated by Specialist and within two (2) business days after Specialist receives notice of material changes initiated by the insurer. To the extent available, all insurance policies shall contain riders requiring the carrier to notify Plan of cancellation or material changes. In the event that coverage is of a "claims made" variety, Specialist shall continue to arrange to maintain policies of insurance in effect to cover claims which occur during the term of the Agreement.

d. Failure on the part of Specialist to maintain any coverage required hereunder shall be grounds for immediate termination of this Agreement.

e. If any insurance policy required to be maintained hereunder is purchased on a "claims made" basis, such insurance policy shall include a provision stating that in the event such insurance policy is terminated, Specialist shall have the right to purchase a three (3) year extended reporting or discovery period insurance policy ("Extended Policy").

ARTICLE X: RELATIONSHIP BETWEEN PLAN AND SPECIALIST

52. Plan and Specialist shall at all times maintain an effective liaison and close cooperation with each other, to the end of providing required benefits to each Member at the most reasonable cost consistent with high standards of Covered Services, including cooperation of both parties in Plan's quality improvement activities.

53. In the event DHHS fails to provide or delays payment to Plan for the provision of Covered Services to Members, Plan shall suspend payment to Specialist until such time as Plan receives payment from DHHS. Plan shall compensate Specialist in a timely manner once payment is

received from DHHS. To the extent that DHHS or CMS reduces payments provided to Plan under the Medicaid or Medicare Advantage programs in any manner, Plan may notify Specialist in writing of such reduction and both parties agree to negotiate in good-faith a revised fee schedule. If the parties are unable to agree upon a revised fee schedule within sixty (60) days of Plan's notice of reduction to Specialist, Plan reserves the right to terminate this Agreement under Article VI above.

54. Plan and Specialist shall at all times feely and fully exchange information regarding all matters necessary to carry out their obligations under this Agreement.

55. Plan shall have the right to monitor the compliance of Specialist, with all rules, regulations, and procedures that may come into effect regarding the care and treatment of Members.

56. Plan shall have the right to utilize Plan's peer review program for review of the nature and extent of Covered Services provided by Specialist to Members. Specialist agrees to cooperate in such peer review and in such grievance procedures as Plan shall establish for the purpose of achieving amicable resolution of disputes or claims of Members.

57. Under the Plans' Mountain Trust Program, Plan must provide DHHS with detailed utilization reports that set forth information regarding utilization of Covered Services by Members. In addition, Plan must collect data to provide to DHHS regarding compliance with the Early and Periodic Screening, Diagnosis and Treatment ("EPSDT") requirements for Members under the age of twenty-one (21). Specialist shall provide Plan with information regarding utilization by Members of EPSDT and non-EPSDT services provided by Specialist on an ongoing basis no later than thirty (30) calendar days after the date service(s) are performed. Specialist shall provide such information to Plan electronically. Plan must provide information regarding its Members and regarding public health issues affecting its Members to DHHS upon request. Specialist must cooperate with Plan in meeting these reporting requirements by providing Plan with information upon request or as provided hereunder, which will include, without limitation, the following (to the extent applicable to Specialist's area of practice):

    a. Within seventy two (72) hours, known deaths of Members;

    b. Members treated by Specialist who are diagnosed with HIV/AIDS;

    c. Members with developmental delays;

    d. Members diagnosed as tuberculosis cases or tuberculosis-infected;

    e. Members with vaccine-preventable diseases and other communicable diseases;

    f. Female Members and Members up to the age of five (5) who have or are at risk for nutritional deficiencies or have nutrition-related medical conditions; and

g. Members under the age of twenty one (21) who have an elevated blood lead level (greater than 10 ug/dl), which information is to be reported to Plan within forty eight (48) hours after identification.

58. Specialist shall cooperate with Plan in meeting the EPSDT requirements for Members under the age of twenty-one (21), including, without limitation:

a. Notifying Members of the availability of transportation services;

b. Providing follow-up on missed appointments;

c. Contacting Members to schedule screenings and appointments;

d. Making follow-up telephone calls; and

e. Specialist shall comply with the EPSDT periodicity schedule to be provided to Specialist by Plan.

59. Specialist shall schedule appointments for health assessments, first physical examinations, general physical examinations, and health screenings in connection with EPSDT requirements, within thirty (30) days or sooner, if medically necessary, of the date of the request. For Members who are newly assigned to a Specialist and who are eligible for EPSDT services, Specialist shall offer initial health screenings within forty-five (45) days of request, or sooner if required to comply with the periodicity schedule, and shall complete such screenings within three (3) months of the Member's initial enrollment date with Plan. EPSDT screens, laboratory tests, and immunizations provided by Specialist shall be furnished within thirty (30) days of the due date established in the periodicity schedule for children under two (2) years of age, and within sixty (60) days of the due date established in the periodicity schedule for children over two (2) years of age.

60. Specialist Group shall ensure that all Specialists meet the EPSDT participation ratio, as defined by the CMS State Medicaid Manual, for Members under the age of twenty-one (21) assigned to each Specialist, according to the following schedule: 80% participation.

61. Plan is responsible to DHHS or its designee for compliance with all activities of the External Quality Review ("EQR") process. To the extent Specialist is responsible for data, information , or other requirements of the EQR, Specialist shall:

a. Submit requested pre-site survey documents and/or information in accordance with published timelines;

b. Submit documents and/or information required during the on-site reviews within specified timelines;

c. Submit requested Member medical records/information for annual clinical studies within specified timeliness;

d. Comply with 42 C.F.R. Part 2, the HIPAA Privacy and Security Rules.

Maintain quality improvement programs and plans that focus on meting and/or exceeding the performance standards with guidelines and timely access to care services and satisfaction standards, required by DHHS or its designee;

e. Submit Corrective Action Plans ("CAP") within pre-established timelines;

f. Make available Specialist's patient clinical records and/or information requested by Plan or designee;

g. Collect and report the data required by an EQR organization in support of Plan's obligation under 1902(a)(30)(C) and 1932(c)(2) of the Social Security Act, 42 U.S.C. 1396a(a)(30)(C) and 42 U.S.C. 139u-2(c)(2).

62. Plan will make available to Specialist, the results of each annual external independent quality review conducted by DHHS or its designee

63. Section 1932(b)(3) of the Social Security Act requires that a "Medicaid managed care organization shall not prohibit or otherwise restrict a covered health care professional from advising such an individual (Member) who is a patient of the professional about the health status o the individual or medical care or treatment for the individual's conditions or disease, regardless of whether benefits for such are or treatment are provided under the contract, if the professional is acting within the lawful scope of practice." In accordance with subsection (b) as required by 1903(m)(2)(A)(xi) of the Social Security Act, Plan does not interfere with such communications between covered health care professional and Members who are a patient of the professional.

64. Specialist shall comply with the requirements of 1932(b)(6) of the Social Security Act, which provides that an enrolled individual or the individual's family or caregiver may not be held liable or be subject to collection efforts for:

a. Debts or other obligations of the Plan or any Specialist participating in the Provider's network in the event of insolvency;

b. The cost of items and services covered under the contract in the event that the Plan fails to receive payment from the State of West Virginia; and

c. The cost of items and services covered under the contract if Specialist fails to receive payment from Plan.

65. Specialist is prohibited from imposing any cost-sharing or similar charge on a Member for Covered Services provided to a Member. Specialist is prohibited from referring any amounts due to a collection agency or other party for collection if payment is being sought from Member for Covered Services.

66. Specialist shall cooperate in determining where third party liability exists, and if notified by Plan or a Member that a third party has primary liability for Covered Services provided to a Member, Specialist shall bill the third party first for Covered Services. This provision includes, but is not limited to, cases involving coordination of benefits, workers compensation, and Medicare and Medicaid benefits.

67. Specialist shall provide to Plan all information necessary for any Member appeal within a time frame established by DHHS, upon notification by Plan, DHHS, that such information is required.

68. Specialist may direct a Member to an emergency facility under this Agreement. If Specialist makes such a referral, Specialist shall document referral and notify Plan within two (2) business days of such referral. The notification received by Plan shall constitute authorization to pay for the emergency or urgent care services provided as required under the Program/Plan agreement.

ARTICLE X: MISCELLANEOUS

69. This Agreement, together with any exhibits hereto, constitutes the entire agreement between the parties with respect to Specialist's provision of services to Members and supersedes any and all prior agreements between the parties, whether written or oral, or representations made by the parties with respect to Specialist's provision of services to Members.

70. This Agreement may not be assigned by any party without the prior written consent of the other party. Any assigned subcontractor approved by Plan under this section shall be subject to every provision of this Agreement.

71. Any and all notices or other communications provided for or required by this Agreement shall be directed to the party to be so notified, in writing, by registered or certified mail, return receipt requested, or by electronic mail, and addressed to the applicable party at its respective business or electronic addresses shown on the first page of this Agreement, or such other address of which the other party has received written notice; provided, however, that any notice posted on Plan's website shall constitute notice for all purposes hereunder. For purposes of clarification, and without limiting the generality of the foregoing, notice sent via electronic mail shall constitute written notice for all purposes hereunder. Each party shall notify the other party promptly and in writing of any change in its respective business and/or email address.

72. Specialist consents to the use of its name, address, and specialty in any marketing, advertising, or media materials distributed by Plan.

73. Specialist must adhere to the following disclosure requirements:

    a. Within thirty-five (35) days upon request of DHHS or the Secretary of HHS, Specialist must disclose the business transaction information identified under 42 C.F.R. § 455.106, including:

i. The ownership of any independent contractor with whom Specialist has had business transactions totaling more than $25,000.00 during the twelve (12) month period ending on the date of the request;

ii. Any significant business transactions between the Specialist and any wholly owned supplier during the five (5) year period ending on the date of the request; and

iii. Any significant business transaction between the Specialist and any independent contractor during the five (5) year period ending on the date of the request.

b. At any time upon request by Plan or DHHS, Specialist must disclose:

i. The name of any person who has ownership or a controlling interest in Specialist who has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or the Title XX services program, since the inception of those programs; and

ii. The name of any person who is an agent or managing employee of Specialist who has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or the Title XX services program since its inception of those programs.

74. Plan will not reimburse Specialist for procedures relating to the following Health Care Acquired Conditions ("HCAC"), identified in the Affordable Care Act of 2010, Public Law 111-148, when any of the following conditions are not present upon admission in any inpatient setting, but subsequently acquired in that setting:

a. Foreign object retained after surgery;

b. Air embolism;

c. Blood incompatibility;

d. Catheter associated urinary tract infection;

e. Pressure ulcers (decubitus ulcers);

f. Vascular catheter associated infection;

g. Mediastinitis After Coronary Artery Bypass Graft ("CABG")

h. Hospital acquired injuries (fractures, dislocations, intracranial injury, crushing injury, burn or other unspecified effects of external causes);

i. Manifestations of poor glycemic control;

j. Surgical site infection following certain orthopedic procedures;

k. Surgical site infection following bariatric surgery for obesity; and

l. Deep vein thrombosis and pulmonary embolism following certain orthopedic procedures except for pediatric (individuals under the age of 21 years) and obstetric populations.

75. Plan will not reimburse Specialist for any of the following Never Events in any inpatient or outpatient setting:

a. Surgery performed on the wrong body party;

b. Surgery performed on the wrong patient; and

c. Wrong surgical procedure performed on a patient.

76. Any section or paragraph title or caption contained in this Agreement is for convenience only, and in no way defines limits or describes the scope or intent of this Agreement or any of its provisions.

77. This Agreement, including, without limitation, any of its exhibits or attachments, may be revoked, altered, amended, or modified at any time by written agreement executed by the parties hereto.

78. This Agreement, including, without limitation, any of its exhibits or attachments, may be amended by Plan by providing Specialist no less than thirty (30) days prior written notice of the effective date of the amendment. If Specialist provides written acceptance of the amendment, Specialist shall be bound by the amendment as of the effective date set forth in the notice of the amendment from Plan. If Specialist does not provide written acceptance or timely objects in writing to the amendment, Specialist and Plan shall attempt in good faith to resolve the matter to their mutual satisfaction for a period not to exceed fifteen (15) days following Plan's written notice of the amendment or Plan's receipt of Specialist's written objection to the amendment. In the absence of such resolution, and notwithstanding anything in this Agreement to the contrary, either Specialist or Plan may terminate this Agreement or the participation of an individual Specialist in the provision of Covered Services under the applicable Program/Plan agreement, upon written notice to the other party within five (5) days after the expiration of the fifteen (15) day period described above. The effective date of such termination shall be on the expiration of the five (5) day notice period described above. In the event of such termination, Specialist shall be bound by the amendment from its effective date through the effective date of termination.

79. Each party shall without limit indemnify, hold harmless, and at the non-indemnifying party's election, defend the non-indemnifying party, its officers, agents, employees, and representatives with respect to any and all claims, damages, judgments, actions, and causes of action, arising out of the acts or omissions of the indemnifying party's officers, agents, employees, and representatives, related to the services provided pursuant to this Agreement, including all costs, expenses and attorney's fees incurred in the defense of any and all claims and/or litigation.

80. Any notice hereunder shall be in writing an shall be deemed given when sent by certified United States mail, postage prepaid, by recognized overnight delivery service, or by hand deliver to Plan and Specialist at the addresses set forth below:

To Plan:

Chika Duru
General Counsel
Trusted Health Plan
1100 New Jersey Avenue, S.E.
Suite 840
Washington, D.C. 20003

To Specialist:

81. No waiver of any provisions of this Agreement shall be valid unless in writing and signed by the party against whom such waiver is sought. One or more waivers of any covenant or condition of this Agreement by any of the parties hereto shall not be construed as a waiver of any subsequent breach or of other covenants or conditions.

82. This Agreement is made pursuant to, and shall be governed by the laws and decisions of the State of West Virginia, regardless of its choice of law provisions. This Agreement is subject to all rules and regulation promulgated from time to time by any regulatory agency, and this Agreement shall be deemed to be amended to conform therewith at all times. When amendment is required by federal or district law or regulation or by a regulatory agency, Plan shall provide thirty (30) days advance written notice of the amendment to Specialist. Specialist shall be deemed to have accepted the amendment unless Specialist objects to Plan in writing within thirty (30) days of receipt of the notice of amendment. Either party may terminate this Agreement upon ten (10) days written notice if the parties are unable to reach an agreement on the amendment within thirty (30) days of Plan's receipt of Specialist's objection.

83. The invalidity or unenforceability of any particular provision of this Agreement shall not affect any other provision hereof. This Agreement shall be construed in all respects as if such invalid or unenforceable provision(s) were omitted.

84. When the context of this Agreement requires, the gender of all words shall include the masculine, feminine, and neutral, and number of all words shall include the singular and plural.

85. The parties have not and do not intend to create any rights through this Agreement in any third parties, including Members.

86. Neither party shall be liable nor deemed to be in default for any delay or failure in performance under this Agreement or other interruption of service resulting, directly or indirectly, from acts of

God, civil or military authority, acts of a public enemy, war, accidents, fires, explosions, earthquakes, floods, failure of transportation, strikes or other work interruptions by either party's employees, or any similar or dissimilar cause beyond the reasonable control of either party; provided, however, in the event the provision of Covered Services is substantially interrupted, Plan reserves the right to terminate this Agreement upon ten (10) days prior written notice to Specialist.

87. This Agreement and any amendments hereto may be executed in any number of counterparts, each of which shall be treated as an original, but all of which, collectively, shall constitute a single instrument.

88. To the extent that Specialist is a group practice or is otherwise executing this Agreement on behalf of individual providers, Specialist warrants that it has the authority to bind and hereby binds each individual Specialist to the terms and conditions set forth herein.

IN WITNESS WHEREOF, the parties hereto have caused this Agreement to be executed effective as of the Effective Date.

SPECIALIST (*i.e.*, AUTHORIZED REPRESENTATIVE WITH RESPECT TO THE TAX ID NUMBER LISTED BELOW):

Signature: _____

Print Name:

Title:

Address:

City/State/Zip:

Email Address:

Tax I.D. #:

Dated:

Plan hereby accepts Specialist under this Agreement effective as of the Effective Date.

PLAN:
Trusted Health Plan, Inc.
1100 New Jersey Avenue, S.E., Suite 840
Washington, D.C. 20003
www.Trustedhp.com
45-2375150

_____
Signature: Chika Duru
Title: General Counsel
Date:

COMPENSATION SCHEDULE

1. Covered Services. The Covered Services shall consist of all services that are covered by the Medicaid program, subject to the terms of this Agreement, and all rules, regulations, policies and procedures of the Medicaid program, and the Plan's authorization for referral services.

2. The Plan will pay Specialist for Covered Services at 100% of the then current Medicare fee schedule.

EXHIBIT A

1. The following shall govern the Plan's payment of claims to the Specialist. In accordance with West Virginia Code §33-45-2. **Minimum fair business standards contract provisions required; processing and payment of health care services; provider claims; commissioner's jurisdiction.** (1) The Plan shall either pay or deny a clean claim within forty days of receipt of the claim if submitted manually and within thirty days of receipt of the claim if submitted electronically, except in the following circumstances A) Another payer or party is responsible for the claim; (B) The Plan is coordinating benefits with another payer; (C) The Specialist has already been paid for the claim;(D) The claim was submitted fraudulently; or (E) There was a material misrepresentation in the claim.

(2) The Plan shall maintain a written or electronic record of the date of receipt of a claim. The Plan shall be entitled to inspect the claim record on request and to rely on that record or on any other relevant evidence as proof of the fact of receipt of the claim. If The Plan fails to maintain an electronic or written record of the date a claim is received, the claim shall be considered received three business days after the claim was submitted based upon the written or electronic record of the date of submittal by the person submitting the claim.

(3) The Plan shall, within thirty days after receipt of a claim, request electronically or in writing from the Specialist submitting the claim any information or documentation that the insurer reasonably believes will be required to process and pay the claim or to determine if the claim is a clean claim. The Plan shall use all reasonable efforts to ask for all desired information in one request, and shall if necessary, within fifteen days of the receipt of the information from the first request, only request or require additional information one additional time if such additional information could not have been reasonably identified at the time of the original request or to specifically identify a material failure to provide the information requested in the initial request. Upon receipt of the information requested under this subsection which the insurer reasonably believes will be required to adjudicate the claim or to determine if the claim is a clean claim, The Plan shall either pay or deny the claim within thirty days. The Plan may not refuse to pay a claim for health care services rendered pursuant to a Specialist contract which are covered benefits if The Plan fails to timely notify the person submitting the claim within thirty days of receipt of the claim of the additional information requested unless such failure was caused in material part by the person submitting the claims: *Provided,* That nothing herein shall preclude The Plan from imposing a retroactive denial of payment of such a claim if permitted by the provider contract unless such retroactive denial of payment of the claim would violate subdivision (7), subsection (a) of this section. This subsection does not require an insurer to pay a claim that is not a clean claim except as provided herein.

(4) Interest, at a rate of ten percent per annum, accruing after the forty-day period provided in subdivision (1), subsection (a) of this section owing or accruing on any claim under any provider contract or under any applicable law, shall be paid and accompanied by an explanation of the assessment on each claim of interest paid, without necessity of demand, at the time the claim is paid or within thirty days thereafter.

(5) Every insurer shall establish and implement reasonable policies to permit any provider with which there is a provider contract:

(A) To promptly confirm in advance during normal business hours by a process agreed to between the parties whether the health care services to be provided are a covered benefit; and

(B) To determine the Plan's requirements applicable to the Specialist (or to the type of health care services which the Specialist has contracted to deliver under the provider contract) for:

(i) Precertification or authorization of coverage decisions;

(ii) Retroactive reconsideration of a certification or authorization of coverage decision or retroactive denial of a previously paid claim;

(iii) Provider-specific payment and reimbursement methodology; and

(iv) Other provider-specific, applicable claims processing and payment matters necessary to meet the terms and conditions of the provider contract, including determining whether a claim is a clean claim.

(C) The Plan shall make available to the Specialist within twenty business days of receipt of a request, reasonable access either electronically or otherwise, to all the policies that are applicable to the particular provider or to particular health care services identified by the provider. In the event the provision of the entire policy would violate any applicable copyright law, the insurer may instead comply with this subsection by timely delivering to the provider a clear explanation of the policy as it applies to the provider and to any health care services identified by the provider.

(6) Every insurer shall pay a clean claim if the insurer has previously authorized the health care service or has advised the provider or enrollee in advance of the provision of health care services that the health care services are medically necessary and a covered benefit, unless:

(A) The documentation for the claim provided by the person submitting the claim clearly fails to support the claim as originally authorized; or

(B) The Plan's refusal is because:

1. Another payer or party is responsible for the payment;
2. The Plan has already been paid for the health care services identified on the claim;
3. The claim was submitted fraudulently or the authorization was based in whole or material part on erroneous information provided to the insurer by the provider, enrollee, or other person not related to the insurer;
4. The person receiving the health care services was not eligible to receive them on the date of service and the insurer did not know, and with the exercise of reasonable care could not have known, of the person's eligibility status;
5. There is a dispute regarding the amount of charges submitted; or
6. The service provided was not a covered benefit and the insurer did not know, and with the exercise of reasonable care could not have known, at the time of the certification that the service was not covered.

(7) A previously paid claim may be retroactively denied only in accordance with this subdivision.

1) The Plan may not retroactively deny a previously paid claim unless:

a) The claim was submitted fraudulently;

b) The claim contained material misrepresentations;

c) The claim payment was incorrect because the provider was already paid for the health care services identified on the claim or the health care services were not delivered by the provider;(iv) The Hospital was not entitled to reimbursement;(v) The service provided was not covered by the health benefit plan; or(vi) The insured was not eligible for reimbursement.

(B) A Specialist to whom a previously paid claim has been denied by The Plan in accordance with this section shall, upon receipt of notice of retroactive denial by The Plan, must notify the Plan within forty days of the Specialist's intent to pay or demand written explanation of the reasons for the denial. (i) Upon receipt of explanation for retroactive denial, the Specialist shall reimburse The Plan within thirty days for allowing an offset against future payments or provide written notice of dispute. (ii) Disputes shall be resolved between the parties within thirty days of receipt of notice of dispute. The parties may agree to a process to resolve the disputes in a provider contract. (iii) Upon resolution of dispute, the provider shall pay any amount due or provide written authorization for an offset against future payments.

(C) The Plan may retroactively deny a claim only for the reasons set forth in subparagraphs (iii), (iv), (v) and (vi), paragraph (A) of this subdivision (7) for a period of one year from the date the claim was originally paid. There shall be no time limitations for retroactively denying a claim for the reasons set forth in subparagraphs (i) and (ii) above.

(8) No Specialist contract may fail to include or attach at the time it is presented to the SPECIALIST for execution: (A) The fee schedule, reimbursement policy or statement as to the manner in which claims will be calculated and paid which is applicable to the provider or to the range of health care services reasonably expected to be delivered by that type of provider on a routine basis; and (B) All material addenda, schedules and exhibits thereto applicable to the provider or to the range of health care services reasonably expected to be delivered by that type of provider under the provider contract.

(9) No amendment to any Specialist contract or to any addenda, schedule or exhibit, or new addenda, schedule, exhibit, applicable to the provider to the extent that any of them involve payment or delivery of care by the Specialist, or to the range of health care services reasonably expected to be delivered by that type of provider, is effective as to the provider, unless the provider has been provided with the applicable portion of the proposed amendment, or of the proposed new addenda, schedule or exhibit, and has failed to notify the insurer within twenty business days of receipt of the documentation of the Specialist's intention to terminate the Hospital contract at the earliest date thereafter permitted under the Hospital contract.

(10) In the event that the Specialist's provision of a policy required to be provided under subdivision (8) or (9) of this subsection would violate any applicable copyright law, The Plan may instead comply with this section by providing a clear, written explanation of the policy as it applies to the provider.

(11) The Plan shall complete a credential check of any new Specialist and accept or reject the provider within four months following the submission of the provider's completed application: *Provided,* That time frame may be extended for an additional three months because of delays in primary source verification. The Plan shall make available to Specialist a list of all information required to be included in the application. A Specialist who is permitted by the Plan to provide services and who provides services during the credentialing period shall be paid for the services if the provider's application is approved.

(b) Without limiting the foregoing, in the processing of any payment of claims for health care services rendered by providers under provider contracts and in performing under its provider contracts, every

insurer subject to regulation by this article shall adhere to and comply with the minimum fair business standards required under subsection (a) of this section. The commissioner has jurisdiction to determine if an insurer has violated the standards set forth in subsection (a) of this section by failing to include the requisite provisions in its provider contracts. The commissioner has jurisdiction to determine if the insurer has failed to implement the minimum fair business standards set out in subdivisions (1) and (2), subsection (a) of this section in the performance of its provider contracts.

(c) No insurer is in violation of this section if its failure to comply with this section is caused in material part by the person submitting the claim or if the insurer's compliance is rendered impossible due to matters beyond the insurer's reasonable control, such as an act of God, insurrection, strike, fire, or power outages, which are not caused in material part by the insurer.

PLAN/ PCP AGREEMENT

This Plan/PCP Agreement (this "**Agreement**") is made and entered into this _____ day of _____, 2016 between Trusted Health Plan (District of Columbia) Inc. ("**Plan**"), a Washington, DC corporation licensed as a health maintenance organization, in the State of West Virginia whose business address is 1100 New Jersey Avenue, S.E., Suite 840, Washington, D.C., 20003, and [PCP NAME] ("**PCP**"), whose business address is [BUSINESS ADDRESS].

In consideration of their mutual covenants and promises contained in this Agreement, the parties agree as follows:

ARTICLE I: DEFINITIONS

For purposes of this Agreement and its exhibits, the following words and phrases shall have the following meanings:

xxiv. "**Allied Health Professional**" means a qualified and licensed nurse practitioner, physician assistant, or nurse midwife who is employed by Provider, and has been accepted by Plan to provide certain Covered Services to Members hereunder.

xxv. "**Clean Claim**" means a claim that has no defect, impropriety, lack of any required substantiating documentation or particular circumstance requiring special treatment that prevents timely payment.

xxvi. "**Covered Services**" means those properly authorized services that are covered by a Program and that Plan has committed to provide to Members under a Program/Plan Agreement.

xxvii. "**Covering Physician**" means a contracted licensed physician of medicine or osteopathy who agrees to provide services to another contracted licensed physician's patients when that other physician is not available.

xxviii. "**DHHS Service Agreement**" means the Medicaid contract between the State of West Virginia Department of Health and Human Resources Bureau for Medical Services and Trusted Health Plan.

xxix. "**Effective Date**" means the date the last party to this Agreement executes the Agreement.

xxx. "**Emergency Medical Condition**" means conditions where the presenting symptoms are of sufficient severity that a person with average knowledge of health and medicine would reasonable expect the absence of immediate medical attention to result in placing the individual's health or the health of an unborn child in immediate jeopardy, serious impairment of bodily functions, or serious dysfunction of any bodily organ or part.

xxxi. "**Emergency Care** "-includes inpatient and outpatient services needed immediately and provided

by a qualified Medicaid provider for emergency medical or dental conditions where the presenting symptoms are of sufficient severity that a person with average knowledge of health and medicine would reasonably expect the absence of immediate medical attention to result in placing their health or the health of an unborn child in immediate jeopardy, serious impairment of bodily functions, or serious dysfunction of any bodily organ or part; and that are needed to evaluate r stabilize and emergency medical condition. These include accidental injury and poison related problems and complaints that may be indicative of serious, life threatening medical problems, such as chest or abdominal pain, difficulty breathing or swallowing, or loss of consciousness. If the patient presents at the hospital emergency department and requests an examination a nurse triage screening is always allowed.

xxxii. "**External Quality Review**" means a validation of performance/quality improvement measures and activities; compliance with local standards for access to care, structure and operations; and validation of consumer or provider surveys of quality of care.

xxxiii. "**Government Program Fraud Control Unit**" means the West Virginia Department of Health Human Services and/or its authorized agent/s; the United States Department of Health and Human Services, the Office of Inspector General; the Centers for Medicare and Medicaid Services ("CMS"); the Federal Bureau of Investigation ("FBI"); the Medicaid Fraud Control Unit; or any other state, or federal agency with proper jurisdiction, charged with identifying, investigating, or prosecuting suspected fraud, waste, or abuse.

xxxiv. **"Health Check"** means the well-child screen/visit required under EPSDT.

xxxv. "**Member**" means any individual determined eligible for a Program who has enrolled or been enrolled with Plan for the provision of Covered Services.

xxxvi. "**Participating Hospital**" means a facility with an established contract with the Plan to provide Covered Services to Members.

xxxvii. "**Provider Manual**" means a manual made available to PCP by Plan, which includes Plan's procedures and forms, requirements for record keeping and treating members, referral procedures, prior authorization requirements, appeal procedures, and information relating to benefits, co-payments, coordination of benefits, and other operational policies and procedures. Plan may make this manual (and any updates to this manual) available on line on its web site.

xxxviii. "**Primary Care Provider**" means a qualified and licensed participating physician, Allied Health Professional, or multi-specialty primary care practice who is engaged in the areas of Family Practice, Internal Medicine, Pediatrics or such other area as may be determined by Plan, has been accepted by Plan to provide Covered Services, and is selected by a Member to provide Primary Care Services.

xxxix. "**Primary Care Services**" means those Covered Services customarily provided by a Primary Care Provider. Statements regarding the Covered Services under this Agreement are included herein at Exhibits A and B.

xl. "**Program**" means any health coverage program offered through an employer, association or other entity, including government programs, where the municipality enters into a contract with Plan for the provision of Covered Services and any non-group health coverage program offered by Plan. The Programs applicable to this Agreement are listed under Exhibit E. Exhibit E may be amended by written notice from Plan to Provider of the addition of a new Program unless Provider elects in writing not to participate in such Program, and when necessary and applicable, shall be amended automatically to delete a specific Program(s) effective on the date the DHHR Agreement terminates the relevant program.

xli. "**Referral Provider**" means a health care professional or provider who or which provides a Covered Service pursuant to authorization from a Primary Care Provider or Plan.

xlii. "**Referral Service**" means a Covered Service which is prior authorized by a Primary Care Provider or Plan.

xliii. "**Regulatory Agencies**" means the Centers for Medicare and Medicaid Services, ("CMS"), the State of West Virginia Offices of the Insurance Commissioner that has regulatory authority over Plan; the State of West Virginia Department of Health and Human Resources Bureau for Medical Services which oversees contractual compliance for the Medicaid Program; and any other governmental entities with regulatory authority over the Plan or any of its contractors or activities.

ARTICLE II: DUTIES AND OBLIGATIONS OF PCP

89. **Services**. PCP agrees to be responsible for supervising, coordinating, and providing all Primary Care Services to each assigned Member, to provide or refer Members to other providers or healthcare professionals who have been accepted by Plan to provide services to Members (whether or not such other providers or healthcare professionals are employed by PCP) for Covered Services as medically necessary and appropriate, and to verify the eligibility of Members at the time Covered Services are provided. PCP will not deny Covered Services to Members.

90. **Participation Status and Compliance**. PCP warrants that it and each Allied Health Professional, is a participant in good standing in the Medicare and Medicaid Programs, will maintain this good standing during the term of this agreement, and has not been convicted of a felony or suspended from participating in Medicare and/or Medicaid. PCP agrees to comply with all policies of any Program covered under this Agreement. If for any reason, PCP receives notice of any sanction or proposed sanction from a Program (including, but not limited to, Medicare or Medicaid) relating to itself or any Allied Health Professional, PCP agrees to notify Plan within ten (10) business days, and PCP agrees to discontinue providing Covered Services under this Agreement or discontinue any Allied Health Professional's provision of Covered Services provided hereunder.

91. **Rules and Regulations**. PCP agrees to comply with all federal, State and local laws, rules and regulations, medical laws, and CMS instructions applicable to the provision of Covered Services and with all state laws requiring health care professionals to comply with reporting requirements

for communicable diseases and other health indicators. PCP agrees to comply with all applicable rules, regulations, policies and procedures as set forth in the Provider Manual, and all requirements under any contracts between Plan and any Program that are applicable to Plan's subcontractors, including, but not limited to, cooperating with and complying with Plan's fraud, waste, and abuse efforts; quality improvement programs activities, grievance procedures; appeal procedures; and utilization review activities. All health professionals and laboratories providing services under this Agreement pursuant to an employment or other arrangement with PCP shall be licensed and/or certified as required by law and shall also be required to be in compliance with the requirements of this Agreement.

92. PCP and all other PCPs (where PCP is a group practice or is otherwise executing this Agreement on behalf of individual providers) providing services under this Agreement shall maintain at all times: (a) a valid State of West Virginia license to practice allopathic or osteopathic medicine and surgery or, if appropriate with respect to the services to be rendered, a valid license for another health profession; (b) adequate liability and malpractice insurance coverage of a type and with limits satisfactory to Plan; (c) a current Drug Enforcement Agency registration and West Virginia Controlled Substance License; (d) admitting privileges to at least one licensed, accredited acute care hospital within Plan's service area, unless the PCP is a physician of the type of clinical specialty which does not customarily have admitting privileges or this requirement is otherwise waived in writing by Plan; (e) unless the PCP is a general practitioner, board certification or board qualification in his or her practice specialty; and (f) the authority to participate in Medicare, Medicaid and any other government program with which Plan participates and that are applicable to this Agreement. PCP shall notify Plan in writing within two (2) days of the loss, termination, cancellation, restriction, sanction or other final disciplinary action with respect to any of the foregoing. PCP shall furnish evidence of the foregoing upon request of Plan at any time during the term of this Agreement. PCP agrees to participate in Plan's credentialing and re-credentialing processes and programs for quality improvement, utilization review and peer review. PCP acknowledges and agrees that Plan retains the right to establish additional requirements to comply with Plan's obligations under the DHHS Agreement and as Plan otherwise reasonably determines to be necessary, and agrees to carry out any obligations required of PCPs under the terms of the DHHS Agreement, pertinent parts of which are available from Plan.

93. **Allied Health Professional Obligations**. All Allied Health Professionals providing services under this Agreement shall be treated as PCPs for the purposes of this Agreement (including the assignment of Members and participation in Plan's credentialing and re-credentialing processes and programs for quality improvement, utilization review and peer review), except that where applicable, an Allied Health Professional's authority to provide services under this Agreement shall be directly tied to his/her supervising physician as described below. In addition, all Allied Health Professionals providing services under this Agreement shall maintain at all times: (a) a valid State of West Virginia license to practice within the scope of their profession; (b) adequate liability and malpractice insurance coverage of a type and with limits satisfactory to Plan; (c) a current Drug Enforcement Agency registration; and (d) the authority to participate in Medicare, Medicaid and any other Programs with which Plan participates and that are applicable to this Agreement. PCP shall notify Plan in writing within two (2) days of the loss, termination, cancellation, restriction, sanction or other final disciplinary action with respect to any of the foregoing. PCP shall furnish evidence of the foregoing upon request of Plan at any time during the term of this Agreement. PCP shall ensure that all services provided by Allied Health

Professionals hereunder are within the scope of license held by, and the authority delegated to, such practitioners. No Allied Health Professional is authorized to provide services hereunder, and Plan shall have no obligation to pay for services provided by an Allied Health Professional, unless he/she is supervised (in accordance with all applicable laws, regulations and Program requirements) by the relevant PCP. All services provided by Allied Health Professionals hereunder shall be billed by PCP or its designee under PCP's federal tax identification number (also known as an employer identification number or EIN).

94. **Independent Contractors.** The relationship between Plan and PCP is an independent contractor relationship. Neither PCP nor any employees or agents of PCP are employees, or agents of Plan and neither Plan, nor any employee or agent of Plan is an employee, or agent of PCP. As such, all medical decisions regarding Primary Care Services are rendered solely by PCP and not by Plan. None of the provisions of this Agreement shall be construed to create a relationship of agency, representation, joint venture, ownership, control, or employment between the parties.

95. PCP agrees to provide on a twenty-four (24) hours a day, seven (7) days a week basis, Primary Care Services to Members who are assigned or have designated PCP as their primary provider of care. PCP shall meet or exceed Plan's access standards as set out in the Provider Manual. PCP shall be responsible for determining whether Members are eligible for Primary Care Services on the basis of the most current eligibility list issued for the month in which services are being furnished. PCP agrees that the average waiting time in PCP's office for an appointment scheduled by a Member shall be no greater than thirty (30) minutes.

96. PCP shall make arrangements for coverage by a covering physician whenever PCP is unavailable. PCP may not utilize a non-participating Physician as a covering physician without the express written approval of Plan's medical director. PCP shall be responsible for compensation payments to the covering physician and any non-participating physicians. PCP shall also cooperate with any afterhours triage program established by Plan.

97. In the event a Member assigned to PCP misses a scheduled appointment, PCP shall contact the Member to schedule a new appointment and to inquire as to the reason for his or her failure to appear. Further, PCP shall document such missed appointments. In the event PCP is unable to contact the Member or in the event a Member repeatedly misses scheduled appointments, PCP shall notify Plan's utilization management department and member services departments.

98. PCP shall arrange for Members, Referral Services to Specialists, Participating Hospitals, and ancillary service provider according to the procedures established by Plan as set forth in the Provider Manual. Evidence of referrals made by PCP must be submitted to Plan's utilization management department via immediate facsimile transmission, via U.S. mail, or other pre-approved methodology within three (3) days of the date of arrangement of Referral Services. In coordinating care with physicians, PCP shall request copies of medical records of physicians to whom referrals are made in order to maintain an integrated medical record for assigned Members. In the event a Member needs specialty services and a contracting Specialist is unavailable, PCP shall contact Plan's utilization management department to obtain authorization for the referral of the Member to a non-participating Specialist. Referrals made to non-participating Specialist without authorization from Plan's utilization management department shall be the financial responsibility of PCP. Further, PCP will evaluate the outcome of the Referral Services and coordinate the Member's further medical needs. Notwithstanding the foregoing, PCP shall not

arrange for referrals for mental health and/or substance abuse services, but shall provide notice to Plan in the manner determined by Plan of the need for a referral of a Member for such services, which referral shall be arranged by Plan.

99. Approval by Plan of a particular course of treatment for a Member or for Referral Services, does not automatically include approval and verification by Plan of that Member's eligibility; PCP must confirm each Member's eligibility before performing Covered Services.

100. Management of inpatient hospital referrals - PCP shall manage the referral of Members to participating hospitals for inpatient care. To the extent practicable, PCP shall be the attending physician for its Members receiving inpatient care. If PCP is not the attending physician, PCP shall establish contact with the attending participating physician and monitor the care provided to PCP's Member. PCP shall be responsible for providing updates to Plan's utilization management and case management departments regarding the inpatient care received by its Members, for purposes of continuity of care and for authorization for further inpatient treatment.

101. PCP shall provide Primary Care Services and arrange Referral Services in accordance with generally accepted standards of medical practice and the standards established by the Plan's quality management Program. PCP shall maintain a competent level of experience through continuing education programs in his or her particular discipline and shall participate in any continuing education program established or recommended by Plan that is appropriate to his/her practice. PCP shall also comply with any corrective action plan established by Plan related to the provision, arrangement or failure to provide or arrange for Primary Care Services and Referral Services by PCP. Final approval of this Agreement by Plan is not effective until PCP has met the credentialing requirements of Plan.

102. PCP agrees to maintain and demonstrate to Plan upon request, throughout the term of this Agreement, compliance with the following:

a. Licensure as appropriate under the laws of the State of West Virginia.

b. Where applicable, Board certification or Board eligibility in his/her specialty, unless otherwise approved by Plan's medical director.

c. Written assurances that all nurses and other ancillary and paramedical personnel employed by, associated with and/or under contract with PCP are properly licensed or certified to practice in the State of West Virginia.

d. Medical staff membership and applicable clinical privileges with at least one participating hospital, unless exempted in writing from such requirements by Plan.

103. Within two (2) days, PCP shall notify Plan in writing of any adverse action, proceeding, or decision, or of any sanctions imposed by a state or federal regulatory or licensing agency, court or other governmental entity, or of any other situation with respect to PCP, which could materially affect PCP's ability to carry out his or her duties and obligations under this Agreement, and provide a copy of any notification and/or other documents relating thereto. Within two (2) days, PCP shall also notify Plan in the event that any certifying authority tasks any action adversely affecting the PCP's board certification.

104. PCP shall implement all activities necessary (including, but not limited to, cooperating in the review and auditing of Members' medical records) to assist Plan in obtaining external accreditation by the National Committee for Quality Assurance ("NCQA") or any other similar organization selected by Plan. Such reviews and audits may include on-site visits; PCP staff and Member interviews; claim and encounter data reviews, reviews of PCP continuous quality improvement plans, credentialing and re-credentialing activities, corrective actions and follow-up plans, Member satisfaction surveys, PCP satisfaction surveys, PCP and PCP staff qualifications.

105. PCP shall maintain throughout the term of this Agreement, professional liability insurance and general liability insurance in the minimum amounts of one million dollars ($1,000,000) per occurrence and three million dollars ($3,000,000) combined single limits coverage for PCP, its agents and employees. In the event PCP procures a "claims made" policy as distinguished from an occurrence policy, PCP shall procure and maintain, prior to termination of such insurance, continuing "tail" coverage. PCP shall immediately notify Plan of any material changes in insurance coverage and shall provide a certificate of such insurance coverage to Plan upon Plan's request.

106. PCP hereby agrees that in no event, including, but not limited to nonpayment by Plan, insolvency of Plan, or breach of this Agreement, shall PCP bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against Members or persons other than Plan for services provided pursuant to this Agreement. PCP further agrees that (1) this provision shall survive the termination of this Agreement, irrespective of the cause giving rise to such termination and shall be construed to be for the benefit of Plan's Members; and that (2) this provision supersedes any oral or written agreement to the contrary now existing or hereafter entered into between PCP and the Member or persons acting on Member's behalf.

107. PCP agrees to participate in the utilization management and quality management programs adopted by Plan. These programs shall include, among other things, preadmission certification and concurrent and retrospective review. PCP shall coordinate, through the care management teams, the care of Members with acute or chronic medical conditions or Members who are pregnant, including providing appropriate follow-up after any Participating Hospital discharge of a Member. PCP shall provide on-site access to Plan representatives upon reasonable notice and shall furnish pertinent sections of a Member's medical records as may be required to implement such programs. PCP shall comply with all final determinations rendered by the utilization management and quality management programs.

108. PCP shall cooperate with Plan in resolving any Member grievances or complaints related to the provision of Primary Care Services, and shall provide Plan with notice of any Member complaints involving PCP. PCP agrees to participate in and cooperate with Plan's Member grievance and complaint procedures.

109. PCP agrees to accommodate and accept Plan Members, unless his or her practice is closed to all patients covered by all payers. PCP will notify Plan at least ninety (90) days prior to closing his/her practice to all patients covered by all payers.

110. PCP agrees to assist any Member in completing the required forms to enroll newborns born to the Member under Medicaid. PCP shall advise the Member to enroll the newborn in Plan

to maintain coverage.

111. PCP shall cooperate with any external review organization contracted by the Department or Plan to perform quality studies.

112. Within the limits of PCPs policies of professional and general liability insurance and to the extent not otherwise inconsistent with the laws and regulations of the jurisdiction in which PCP practices, PCP shall be solely responsible for the medical professional services the PCP performs and agrees to defend, indemnify and hold the State of West Virginia, Plan, and all Members free and harmless from any loss, damage, expense, claim, judgment or liability of any kind arising from the provision of Covered Services to Members. Further, PCP shall not seek to recover from any Members or the State of West Virginia, any debt or portion of any debt of Plan in the event of Plan insolvency.

113. Plan may, in its sole discretion, place limits on the number of Members PCP may accept into PCP's practice, or may close PCP's practice to new Members in the event there are documented issues regarding the quality of Primary Care Services and/or administrative services provided to Plan Members by PCP or Covering Physicians.

114. Plan may use PCP's name, address and telephone number in Plan materials, including Plan's provider directory. PCP may provide Members and non-Members who are his/her patients written notice that PCP is a participating Primary Care Physician with Plan, and may post a notice in his/her offices and acknowledge to his/her patients that PCP participates in Plan. In the event PCP wants to use Plan's name in any other context or for any other purpose other than general administrative purposes as specified by Plan, PCP shall obtain the prior written consent of Plan, which consent shall not be unreasonably withheld.

115. PCP shall comply with all applicable federal and West Virginia laws relating to non-discrimination and equal employment opportunity, and assure physical and program accessibility of all services to persons with physical and sensory disabilities pursuant to Section 504 of the Federal Rehabilitation Act of 1973, as amended (29 USC 794), all requirements imposed by the applicable regulations (45 CFR Part 84), and all guidelines and interpretations issued pursuant thereto. PCP shall also comply with the provisions of the Age Discrimination and Employment Act of 1967 and the Age Discrimination Act of 1975. In connection with performance under the Agreement, PCP agrees not to discriminate against any employee or applicant for employment because of age, race, religion, color, handicap, sex, physical condition, income, and Medicaid status, place of residence, developmental disability, marital status, personal appearance, sexual orientation, family responsibility, matriculation, political affiliation, or national origin. PCP shall comply with the provisions of Executive Order 11246 "Equal Employment Opportunity," as amended by Executive Order 11375, and supplemented by the United States Department of Labor regulations (41 CFR Sec 60).

116. PCP may not impose any limitations on the acceptance of Members for care or treatment that it does not impose on other patients of the PCP. PCP may not require the transfer, discharge, or removal of any Member because of the Member's need for, or utilization of, services that are medically necessary, as that term is defined in the Provider Manual.

117. PCP may request in writing to Plan that a Member be transferred to another participating

PCP. PCP shall not seek to have a Member transferred because of the amount of Covered Services required by the Member or because of the health status of the Member. PCP acknowledges that Members have a contractual right with Plan to request a transfer to another participating PCP. Plan's medical director, at his or her sole discretion, shall decide upon the appropriateness of PCP's or Member's transfer request. All decisions regarding such transfers shall be made and become effective as soon as administratively feasible, but in any event, decisions shall be made within sixty (60) days from the date of the request.

118. If any services provided by PCP are not Covered Services, PCP may bill Members at a rate not in excess of the rate which he/she bills the general public after first notifying the Member in writing in advance of rendering the service that the service is not covered and obtaining the Member's written consent to be billed. PCP agrees to provide Plan with such documentation upon request. PCP shall, in no event, charge Plan or the Member for any Covered Services that are not medically necessary. Prior to billing Members for non-Covered Services, PCP agrees to verify with Plan that the claim is the Member's responsibility.

119. PCP agrees to assure that physician on-call services are available to Members twenty-four (24) hours per day, seven (7) days per week, and three hundred sixty-five (365) days per year. PCP agrees to have each PCP providing Covered Services under this Agreement be available to see patients a minimum of twenty (20) hours per practice location per week and will immediately notify Plan in writing if PCP is unable to accept newly enrolled Members, unless this requirement is waived in writing by Plan with the concurrence of any affected government program.

120. PCP shall look only to Plan for compensation for services rendered to a Member when the applicable DHHS Agreement covers such services. PCP agrees not to bill, charge, collect a deposit from, seek compensation from, seek remuneration from, surcharge or have any recourse against any Member or person acting on behalf of a Member (other than Plan), except to the extent that co-payments are specified in the DHHS Agreement. PCP agrees not to collect payment from Members for non-Covered Services unless a Member is given prior notice of such Member's personal financial liability for such non-Covered Services. PCP agrees not to maintain any action at law or in equity against a Member to collect sums that are owed by Plan to PCP under the terms of this Agreement, even in the event Plan fails to pay, becomes insolvent or otherwise breaches the terms and conditions of this Agreement. This section shall survive termination of this Agreement, regardless of the cause of termination and shall be construed to be for the benefit of the Members. This section is not intended to apply to services provided after this Agreement has been terminated, except as otherwise provided in this Agreement, or to non-Covered Services.

121. In the event of insolvency or other cessation of operations by Plan, PCP agrees to provide Covered Services through the last day of the month for which the Plan has received capitation payment for Covered Services from the Member's Program and to provide Covered Services to any Member hospitalized on the date of such insolvency or other cessation of operations until such Member is discharged.

122. PCP agrees to designate in writing to Plan, a person at each of PCP's primary care sites to be responsible for assuring clinical patient records are maintained, completed, and preserved.

123. PCP agrees to submit all claims for payment for Covered Services provided hereunder to

Plan electronically (i.e., rather than in a hard copy paper format).

124. PCP agrees that claims it submits to Plan for Covered Services will include such information as Plan requires to determine that the services were rendered in compliance with Plan's authorization procedures. PCP agrees to accept, as full compensation for Covered Services provided to Members, the compensation to be paid to PCP by Plan pursuant to and under the methodology described in Exhibits a & B. PCP agrees that at all times, such compensation agreement or arrangement shall comply with all requirements applicable to physician incentive plans under 42 CFR 417.479 (d)-(g), as amended from time to time.

125. PCP will confirm in writing to Plan that any and all Health Check provider employed by or under contract with PCP, including PCP, have completed the web-based Health Check training within thirty (30) days of the Effective Date of this Agreement and at least every two (2) years thereafter for the Term of this Agreement. Compliance with this provision shall be a requirement for re-credentialing under this Agreement.

ARTICLE III: DUTIES AND OBLIGATIONS OF PLAN

126. Plan agrees to pay PCP pursuant to and under the payment methodology described in exhibits A & B to this Agreement for providing to Members the Covered Services under the Members' Program, except that if DHHS or CMS reduces any payments to Plan under any Program, Plan may notify PCP in writing of such reduction and both parties agree to negotiate in good-faith a revised fee schedule. If the parties are unable to agree upon a revised fee schedule within sixty (60) days of Plan's notice of reduction to PCP, Plan reserves the right to terminate this Agreement under Article V below.

127. To the extent necessary, payments to PCP may be retroactively denied or adjusted during the one hundred eighty (180) period after the date the claim was originally paid, provided that Plan, as the case may be, may retroactively deny or adjust reimbursement for services subject to coordination of benefits with another payer, DHHS, or the Medicare program during the eighteen (18) month period after the date the claim was originally paid. PCP shall recognize Plan's immediate right to recovery for retroactively denied or adjusted claims and shall repay contested paid claims within twenty (20) days of notice from Plan. The time limits under this Section 39 shall apply if Plan retroactively adjusts or denies a claim because (i) the information submitted to the Plan, upon which the claim was approved was fraudulent; (ii) the information submitted to the Plan was improperly coded; or (iii) the claim submitted to the Plan was a duplicate claim.

128. Plan shall perform all administrative, accounting and other functions that are necessary and appropriate for the administration of this Agreement.

129. PCP and all Allied Health Professionals must, as a condition of participation hereunder, comply with Plan's Provider Manual. Plan shall post any changes to the Provider Manual on its website at least fifteen (15) days prior to the effective date of any such change, after which PCP's compliance will be required. In the event PCP objects to the change, the parties shall attempt in good faith to resolve disputes concerning any proposed change. In the absence of such resolution, PCP may elect to terminate participation in the provision of Covered Services under the applicable Program by giving advance written notice to Plan within ten (10) days after written notice that the proposed change has gone into effect. PCP's election to terminate participation

shall be effective no more than sixty (60) days after the effective date of the change as determined by Plan. PCP shall be bound by such change through the effective date of termination. If such written notice of termination is not timely given, PCP agrees to be bound to comply with the change.

130. Plan may perform any of its obligations under this Article directly or pursuant to a delegation to Plan's designee, subject to any necessary approvals from Regulatory Agencies.

ARTICLE IV: MEDICAL RECORDS

131. PCP shall prepare and maintain appropriate, detailed medical records relating to the provision of services to Members consistent with the requirements in the Provider Manual and applicable law and to make such records available to Plan, Regulatory Agencies and their respective agents involved in assessing the quality of care or investigating Member grievances or complaints.

132. PCP agrees that until the expiration of ten (10) years after the furnishing of services pursuant to this Agreement, PCP shall make available to Plan, DHHS, HHS, CMS, the OIG, and their respective designees, any medical records; required data; reports of services, complaints, grievances, quality or utilization issues; and any books, documents and other records of Specialist as necessary to certify the nature and extent of services provided and the cost thereof. PCP agrees that in the event of termination of this Agreement for any reason, PCP will provide copies of the medical records of any Member to the Primary Care Provider selected by the Member, within ten (10) business days following a written request from the Member or the Plan. PCP agrees to allow any Government Program Fraud Control Unit access to PCP's place of business as required by the DHHS Agreement.

133. Notwithstanding any other provision of this Agreement, the parties agree that the medical records of all Members shall be treated as confidential consistent with all federal and state laws regarding the privacy and confidentiality of medical records.

ARTICLE V: TERM AND TERMINATION

134. The term of this Agreement begins on the Effective Date, and shall remain in effect for an initial period ending December 31 of the calendar year in which it becomes effective, unless terminated earlier under the provisions of this Agreement. Each December 31, this Agreement shall automatically be renewed for an additional calendar year unless either party provides the other party with written notice of its desire not to renew at least sixty (60) days prior to the expiration of the then current term. Each party acknowledges and accepts the right of the other party to decide in its sole discretion not to renew this Agreement.

135. Either party may terminate this Agreement following sixty (60) days prior written notice to the other party of a material breach of this Agreement, provided that if such material breach is cured within fifteen (15) days of the notice of material breach, then such notice of termination shall be of no force and effect. It shall be considered a material breach by a party: (a) if the party substantially fails to perform its duties under this Agreement in accordance with the terms and conditions set forth herein and the Provider Manual (including a failure by PCP to comply with Paragraph 20 hereof); (b) if the party's failure to perform its duties under this Agreement causes

the other party to suffer material financial damages; (c) if the party commits an illegal or fraudulent act; or (d) if there is a filing by the party or its creditors of any petition of bankruptcy or insolvency with the bankruptcy court pursuant to any federal or state law which may be in effect from time to time, which petition is not discharged or dismissed within thirty (30) days after such filing. In addition, Plan may terminate this Agreement immediately upon written notice to PCP if Plan reasonably determines that PCP poses a threat to the health or safety of any Member or to the license, certification, or reputation of Plan.

136. Plan's approval of PCP or an Allied Health Professional shall be revoked, and such individual shall no longer be authorized to provide services hereunder, (i) if such individual acts, or fails to act, in a manner which may result in imminent danger to the health of Member; (ii) upon the loss of such individual's license to practice his/her profession in the State of West Virginia ; or (iii) upon notice to Plan that such individual has been suspended, expelled, excluded or terminated from participation under Medicare, Medicaid or any other government program. No payment will be made hereunder for services provided by any individual that has been so excluded or whose license has been revoked. In addition, Plan may terminate PCP or any Allied Health Professional immediately upon written notice to PCP, if Plan determines such PCP or Allied Health Professional poses a threat to the health or safety of any Member or to the license, certification or reputation of Plan.

137. This Agreement shall automatically terminate with respect to any specific Program upon termination of the applicable Program as a part of the DHHR Agreement. Plan shall provide PCP at least thirty (30) days written notice of such termination.

138. Either party may terminate this Agreement without cause following sixty (60) days prior written notice to the other party.

139. Notwithstanding any other provision of this Agreement, Plan, in its discretion, may suspend PCP's ability to accept newly enrolled Members for the provision of Primary Care Services due to a pending investigation of any allegations of fraud, abuse, or other serious improper action by PCP, or due to the inability of PCP to provide Members reasonable access to Primary Care Services. Plan shall conduct any investigation as expeditiously as reasonably possible, and limit the length of any suspension by either removing the suspension or giving notice of termination.

140. In the event of termination of this Agreement, Members in an ongoing course of treatment with PCP shall be permitted to continue such treatment with Plan's authorization as follows:

a. For a period of ninety (90) days from the date the Member is notified of the termination.

b. If the Member is in the second or third trimester of pregnancy, treatment shall continue through post-partum care.

c. If it is determined that the Member is terminally ill as defined in Section 5653 of the Public Health Code, treatment will continue for the remainder of the Member's life care directly related to the treatment of terminal illness.

141. Plan will reimburse PCP for such services at the prevailing Plan rates according to the

Plan fee schedule, attached hereto as Exhibit A, Exhibit B, and Exhibit C. Notwithstanding the foregoing, if this Agreement is terminated, Plan shall be free to reassign Members immediately.

ARTICLE VI: RESOLUTION OF DISPUTES

142. In the event of a dispute concerning the construction, interpretation, performance under, or breach of, this Agreement, which the parties in good faith are unable to resolve within thirty (30) days after written notice of a dispute has been given by the party raising the dispute, the party raising the dispute may file notice of arbitration request., no later than three (3) years after the dispute originally arose. Plan and PCP shall each choose an arbitrator and the two arbitrators so chosen shall choose the third. All arbitration proceedings or litigation (to the extent the remedy requested is not, by law, available through arbitration [e.g., injunctive relief]) relating to any claims or disputes arising under or relating to this Agreement shall be brought in the county in which the principal executive office of the party not initiating such action or proceeding (i.e. the defendant or responding party) is located. The parties irrevocably submit and consent to the exercise of subject matter jurisdiction and personal jurisdiction over each of the parties by the federal and/or state courts in such jurisdiction (the "Selected Jurisdiction"). The parties hereby irrevocably waive any and all objections that any party may now or hereafter have to the exercise of personal and subject matter jurisdiction in the Selected Jurisdiction and to the laying of venue of any such proceeding or action brought in the Selected Jurisdiction. Any order or determination of the arbitral tribunal shall be final and binding upon the parties to the arbitration and may be entered in any court having jurisdiction. Each party will bear its own costs of arbitration, including counsel and support in connection with the arbitration, irrespective of the final arbitration award or judgment.

ARTICLE VII: CONFIDENTIAL RECORDS, PROPRIETARY INFORMATION

143. PCP shall not disclose or release any of the data or information obtained by virtue of this Agreement to any other person, firm, or corporation without the written consent of Plan or where required to carry out obligations under this Agreement, and where applicable, the written consent of the Member(s).

144. Each party agrees to keep confidential, all individually identifiable information relating to Members pursuant to 42 U.S.C. Section 1396a(a)(7), 42 CFR Part 2 and other regulations promulgated thereunder. Such information may be used by the PCP only for a purpose directly connected with performance of PCP's obligations under this Agreement. The provisions of this section will survive the termination of Plan's participation and/or PCP participation in the Medicaid managed care program and will remain in effect as long as the PCP maintains any individually identifiable information relating to Members. PCP must ensure compliance with the Health Insurance Portability and Accountability Act of 1996 (Public Law 104191, August 21, 1996) and all applicable regulations promulgated thereunder. Such regulations include but are not limited to, the medical privacy rule 45 C.F.R. Parts 160 and 164) and the electronic transactions and code set standards rule, 45 C.F.R. Parts 160 and 162. PCP must also comply PCP shall maintain written procedures for compliance with all applicable privacy, confidentiality, and information security requirements. PCP shall train its physicians, employees, and agents on the requirements for compliance with all applicable privacy, confidentiality, and information security requirements.

145. Each party recognizes and agrees that the other party's name, assumed names, logos, financial and other identifying information, its business methods, forms, marketing methods and plans, and the names, addresses and identifying information of the Members (including those who are not assigned to PCP), business contacts, and any other information concerning the business, property and affairs of the other party, including, without limitation, all memoranda, notes, records, lists or other documents made available by one party to the other party during the term of this Agreement concerning the Members or anything covered under this Agreement, are confidential and constitute valuable property and proprietary information that are the exclusive property of the other party (hereinafter, "Proprietary Information"). Neither party shall copy, use, or disseminate any of the other party's Proprietary Information in any manner for its direct or indirect economic gain or advantage, except as expressly permitted in this Agreement for the purpose of the party's compliance with the terms hereof. Each party expressly agrees that the other party shall, in addition to any other right or remedy that may be available, be entitled to injunctive and other equitable relief to prevent a breach of these provisions of this Agreement and to secure its enforcement, in addition to any other rights and remedies provided by law or in equity. Each party further agrees that this Paragraph 39 shall not be subject to arbitration under Paragraph 36. Upon the expiration or termination of this Agreement, or at any time upon the demand of the other party, a party shall promptly return to the other party all Proprietary Information which the other party made available to the party, and the party shall destroy or continue to hold in confidence any notes or other information which the party, or a person or entity acting on its behalf, derived from the Proprietary Information.

ARTICLE VIII: INSURANCE

146. PCP agrees to maintain or to be at all times covered under policies of insurance with insurance companies approved by Plan or a program of self-insurance acceptable to Plan for the following types of coverage:

a. General liability coverage insuring against any and all insurable claims that may arise directly or indirectly in connection with the acts or omissions of PCP or PCP's employees or agents. Such coverages shall be in amounts meeting any requirements set forth in the DHHS Agreement, which are applicable to Plan's subcontractors.

b. Professional liability insurance which provides a minimum coverage of $1,000,000 per claim and $3,000,000 in the aggregate for PCP, its agents, and employees. In the event PCP procures a "claims made" policy as distinguished from an occurrence policy, PCP shall procure and maintain prior to termination of such insurance, continuing "tail" coverage.

c. Unemployment compensation insurance and worker's compensation insurance in accordance with the requirements of all applicable federal and laws and state regulations, in the event PCP has any employees.

d. PCP shall furnish Plan with evidence of all insurance coverage and riders required herein before the effective date of this Agreement and thereafter at Plan's request. PCP shall notify Plan in writing within two (2) days of the cancellation of a policy of insurance maintained by PCP. PCP shall give Plan written notice of any changes to an insurance policy at least thirty (30) days before the effective date of any changes initiated by PCP

and within two (2) business days after PCP receives notice of changes initiated by the insurer. In the event that coverage is of a "claims made" variety, PCP shall continue to arrange to maintain policies of insurance in effect to cover claims which occur during the term of this Agreement.

e. Failure on the part of PCP to maintain any coverage required in this Agreement shall be grounds for termination by Plan.

f. If any insurance policy required to be maintained hereunder is purchased on a "claims made" basis, such insurance policy shall include a provision stating that, in the event such insurance policy is terminated, PCP shall have the right to purchase a three (3) year extended reporting or discovery period insurance policy ("Extended Policy").

ARTICLE IX: RELATIONSHIP BETWEEN PLAN AND PCP

147. Plan and PCP shall at all times maintain an effective liaison and close cooperation with each other, to the end of providing required benefits to each Member at the most reasonable cost consistent with high standards of Covered Services, including cooperation of both parties in Plan's quality improvement activities.

148. Plan and PCP shall at all times freely and fully exchange information regarding all matters necessary to carry out their obligations under this Agreement.

149. Plan shall have the right to monitor the compliance of PCP, including all Allied Health Professionals, with all rules, regulations and procedures that may come into effect regarding care and treatment of Members.

150. Plan shall have the right to utilize Plan's peer review program for review of the nature and extent of the Covered Services provided by PCP to Members. PCP agrees to cooperate in such peer review and in such grievance procedures as Plan shall establish for the purpose of achieving amicable resolution of disputes or claims of Members.

151. Plan reserves the right to assign and reassign Members to and from PCP and to add physicians to serve Members as it may, in its sole discretion, deem to be in the Members' or Plan's best interests, during the term of this Agreement or upon its expiration or termination for any reason. All such transfers will become effective on the first day of the month following the date of Plan's notice of the change to PCP unless Plan notifies PCP of a different effective date, subject only to any requirements under the DHHS Agreement. Plan shall have the right to immediately transfer Members to another PCP (whether or not such Primary Care PCP is employed by PCP) if Plan has reason to believe in its discretion, that Members' health or safety is in jeopardy.

152. Under the DHHS agreement, Plan must provide the DHHS with detailed utilization reports which set forth information regarding utilization of Covered Services by Medicaid Members. In addition, Plan must collect data to provide to DHHS regarding compliance with the Early and Periodic Screening, Diagnosis and Treatment ("EPSDT") requirements for Members under the age of twenty-one (21). Plan must provide information regarding its Members and regarding public health issues affecting its Members to DHHS upon request. PCP must

cooperate with Plan in meeting these reporting requirements by providing Plan with information, upon request or as provided hereunder, which will include, without limitation, the following (to the extent applicable to PCP's areas of practice):

a. Known deaths of Members within 72 hours.

b. Members treated by PCP who are diagnosed with HIV/AIDS.

c. Members with developmental delays.

d. Members diagnosed as tuberculosis cases or tuberculosis-infected.

e. Members with vaccine-preventable diseases and other communicable diseases.

f. Female Members and Members up to the age of 5 who have or are at risk for nutritional deficiencies or have nutrition-related medical conditions.

g. Members under the age of 21 who have an elevated blood lead level (greater than 10 ug/dl), which information is to be reported to Plan within 48 hours after identification.

153. PCP shall cooperate with Plan in meeting the Early and Periodic Screening, Diagnosis and Treatment ("EPSDT") requirements for Members under the age of twenty-one (21), including, without limitation:

a. Notifying Members of the availability of transportation services.

b. Providing follow-up on missed appointments.

c. Contacting Members to schedule screenings and appointments.

d. Making follow-up telephone calls.

154. PCP shall comply with the EPSDT periodicity schedule to be provided to PCP by Plan.

155. PCP shall schedule appointments for health assessments, first physical examinations, general physical examinations, and health screenings in connection with EPSDT requirements, within thirty (30) days or sooner, if medically necessary, of the date of the request. For Members who are newly assigned to a PCP and who are eligible for EPSDT services, PCP shall offer initial health screenings within forty-five (45) days of request, or sooner if required to comply with the periodicity schedule, and shall complete such screenings within three (3) months of the Member's initial enrollment date with Plan. EPSDT screens, laboratory tests and immunizations provided by PCP shall be furnished within thirty (30) days of the due date established in the periodicity schedule for children under 2 years of age, and within sixty (60) days of the due date established in the periodicity schedule for children over 2 years of age.

156. PCP shall ensure that PCP meets the EPSDT participation ratio, as defined by the CMS State Medicaid Manual, for Members under the age of 21 assigned to each PCP, according to the following schedule: 80% participation.

157. PCP shall schedule appointments for initial assessments for pregnant Members or persons desiring family planning services to take place within ten (10) days of the request. PCP shall understand that a Member may choose instead to receive family planning services from a qualified family planning PCP/practitioner without a Referral from PCP.

158. To comply with the external quality review requirements, Plan is responsible to DHHS or its designee for compliance with all activities of the external quality review (EQR) process. To the extent that PCP is responsible for data, information or other requirements of the EQR, PCP shall:

a. Submit requested pre-site survey documents and/or information in accordance with published timelines.

b. Submit documents and/or information required during the on-site reviews within specified timelines.

c. Submit requested member medical records/information for annual clinical studies within specified timelines.

d. Adhere to HIPAA guidelines when securing and/or submitting consumer-related information.

e. Maintain quality improvement programs and plans that focus on meeting and/or exceeding the performance standards with guidelines and timely access to care, services and satisfaction standards required by DHHS or its designee.

f. Submit corrective action plans (CAPs) within pre-established timelines.

g. Make available PCP's patient clinical records and/or information requested by Plan or its designee.

h. Collect and report the data required by an EQR organization in support of Plan's obligation under 1902(a)(30)(C) and 1932(c)(2) of the Social Security Act 42 U.S.C.1396a(a)(30)(C) and 42 U.S.C.-1396u-2(c)(2).

159. Plan will make available to PCP, the results of each annual external independent Quality Review conducted by the DHHR or its designee.

160. Section 1932(b)(3) of the Social Security Act requires that a "Medicaid managed care organization shall not prohibit or otherwise restrict a covered health care professional from advising such an individual (Member) who is a patient of the professional about the health status of the individual or medical care or treatment for the individual's conditions or disease, regardless of whether benefits for such care or treatment are provided under the contract, if the professional is acting within the lawful scope of practice." In accordance with subsection (b) as required by 1903(m)(2)(A)(xi) of the Social Security Act, 42 U.S.C. 1396b(m)(2)(A)(xi), Plan does not interfere with such communications between covered health care professionals and Members who are a patient of the professional.

161. PCP shall comply with the requirements of 1932(b)(6) of the Social Security Act, 42 U.S.C. 1396u 2(b)(6), that an enrolled individual or the individual's family or caregiver may not be held liable or be subject to collection efforts for:

a. Debts or other obligations of the Plan or any PCP in the event of Plan's insolvency;

b. The cost of Covered Services in the event that the Plan fails to receive payment from the State of West Virginia;

c. The cost of Covered Services if PCP fails to receive payment from the Plan; or

162. PCP is prohibited from imposing any cost-sharing or similar charge on a Member for Covered Services provided to a Member.

163. PCP is prohibited referring any amounts due to a collection agency or other party for collection if payment is being sought from Member for Covered Services.

164. PCP may direct a Member to an emergency or urgent care facility under this Agreement. If PCP makes such a referral, PCP shall document referral and notify Plan within two (2) business days of such referral. The notification received by Plan shall constitute authorization to pay for the emergency of urgent care services provided as required under the DHHS Agreement.

165. PCP shall cooperate in determining where third party liability exists, and if notified by Plan or a Member that a third party has primary liability for Covered Services provided to a Member, PCP shall bill the third party first. This provision includes, but is not limited to, cases involving coordination of benefits, workers compensation, liability coverage's and Medicare and Medicaid benefits.

166. If this Agreement terminates for any reason, within fifteen (15) days of the notice of termination or thirty (30) days before the effective date of termination, whichever is sooner, Provider will notify its Members in writing of such termination. The notice will include:

a. the effective date of termination;

b. instructions to the Member(s) to contact the Plan regarding securing a new Provider;

c. a brief description of the Provider's process for transferring the Member's Protected Health Information ("PHI"); and if applicable

d. future contact information for the Provider.

167. Provider shall adhere to the below marketing conditions:

a. Any marketing information distributed by Provider directed at Plan's Members shall be limited to general information about Plan and notification that Provider participates in Plan's network. Any such materials must be submitted to Plan for review and approval prior to distribution to Members (Plan will ultimately submit such materials to DHHS for

review and approval).

b. Provider will not utilize written information that is false or misleading in any material respect, including information regarding the Provider's network, the availability of services, the Provider's qualifications, hours, and location of services.

c. Provider shall not host marketing events within the Provider's office.

d. Provider shall not offer to Members gifts of more than a de minimums value or other insurance products designed to induce persons to enroll in Plan.

e. Provider shall not enter into compensation agreements with marketing personnel that utilize any type of payment structure in which compensation is tied to the number (or classes) of persons who enroll in Plan.

ARTICLE X: MISCELLANEOUS

168. This Agreement, together with any exhibits hereto, constitutes the entire agreement between the parties with respect to PCP's provision of services to Members and supersedes any and all prior agreements between the parties, whether written or oral, or representations made by the parties with respect to PCP's provision of services to Members.

169. This Agreement may not be assigned by any party without the prior written consent of the other party. Any assigned subcontractor or third party approved by Plan under this section shall be subject to every provision of this Agreement.

170. Each party shall without limit, indemnify, hold harmless and, at the non-indemnifying party's election, defend the non-indemnifying party, its officers, agents, employees, and representatives with respect to any and all claims, damages, judgments, actions, and causes of action, arising out of the acts or omissions of the indemnifying party's officers, agents, employees, and representatives, related to the services provided pursuant to this Agreement, including all costs, expenses and attorney's fees incurred in the defense of any and all claims and/or litigation.

171. PCP shall hold harmless and not impose any charges on the Plan's Members for Plan benefits and shall regard the Plan's payment as payment in full for all benefits covered by this Agreement with the exception of co-payments specifically authorized in the applicable Evidence of Coverage and any non-plan benefits. PCP shall also be entitled to receive payment for third party claims. PCP will never, under any circumstances, including non-payment by the Plan, the insolvency of the Plan, or breach or termination of this Agreement, seek compensation from, have any recourse against, or impose any additional charge on any Plan Member for Plan benefits. PCP shall look only to the Plan for payment for plan benefits. If the Plan receives notice that a PCP has billed or collected from a Member for any covered or non-authorized benefit, the Plan may refund that amount to Member and may offset that amount from any payment to PCP, with prior notice to the PCP.

172. Neither the PCP, trustees nor assignees, may maintain any action at law against Member to collect sums owed by the Plan.

173. PCP further agrees that these provisions 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 these provisions supersede any oral or written agreement to the contrary now existing or hereafter entered into between Participating Provider and Member or any persons acting on their behalf.

174. These provisions shall not preclude PCP form collecting the Co-payments that are specifically authorized by the Member's Evidence of Coverage.

175. A Participating Provider may bill a Member for services if:(i) prior to receiving such services the Member is advised that such services are not Covered services; and, (ii) after being so advised the Member nevertheless elects in writing to receive such non-Covered Services.

176. PCP must adhere to the following disclosure requirements:

a. Within 35 days upon request of DHHS or the Secretary of HHS, PCP must submit the business transaction information identified in 42 C.F.R. § 455.105, including:

i. The ownership of any independent contractor with whom the provider has had business transactions totaling more than twenty-five thousand dollars ($25,000) during the twelve (12) month period ending on the date of request.

ii. Any significant business transaction between the provider and any wholly owned supplier during the five (5) year period ending on the date of the request.

iii. Any significant business transaction between the provider and any independent contractor during the five (5) year period ending on the date of the request.

b. At any time upon request by Plan orDHHS, PCP must disclose:

i. The identity of any person who has ownership or control interest in the provider who has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid or the Title XX services program since the inception of those programs; and

ii. The identity of any person who is an agent or managing employee of the provider who has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or the Title XX services program since the inception of these programs.

177. Plan will not reimburse PCP for procedures relating to the following Health Care Acquired Conditions ("HCAC"), identified in the Affordable Care Act of 2010, Public Law

111-148, when any of the following conditions are not present upon admission in any inpatient setting, but subsequently acquired in that setting:

a. Foreign object retained after surgery;

b. Air embolism;

c. Blood incompatibility;

d. Catheter associated urinary tract infection;

e. Pressure ulcers (decubitus ulcers);

f. Vascular catheter associated infection;

g. Mediastinitis After Coronary Artery Bypass Graft ("CABG")

h. Hospital acquired injuries (fractures, dislocations, intracranial injury, crushing injury, burn or other unspecified effects of external causes);

i. Manifestations of poor glycemic control;

j. Surgical site infection following certain orthopedic procedures;

k. Surgical site infection following bariatric surgery for obesity; and

l. Deep vein thrombosis and pulmonary embolism following certain orthopedic procedures except for pediatric (individuals under the age of 21 years) and obstetric populations.

178. If applicable, Plan will not reimburse PCP for any of the following Never Events in any inpatient or outpatient setting:

a. Surgery performed on the wrong body party;

b. Surgery performed on the wrong patient; and

c. Wrong surgical procedure performed on a patient.

179. Any and all notices or other communications provided for or required by this Agreement shall be directed to the party to be so notified, in writing, by hand delivery; registered or certified mail, postage pre-paid return receipt requested; by a recognized overnight delivery service; or by electronic mail, and addressed to the applicable party at its respective electronic or business addresses shown below. For purposes of clarification, and without limiting the generality of the foregoing, notice sent via electronic mail shall constitute written notice for all purposes hereunder. Each party shall notify the other party promptly and in writing of any change in its respective business and/or email address.

To Plan: Chika Duru
General Counsel
Trusted Health Plan Inc.

1100 New Jersey Avenue, SE, Suite 840
Washington, DC 20003

With a copy To:
To PCP: [PROVIDER]

With a copy To: [PROVIDER]

180. PCP consents to the use of PCP's name, address, and specialty in any marketing, advertising or media materials distributed by Plan.

181. Any section or paragraph title or caption contained in this Agreement is for convenience only, and in no way defines limits or describes the scope or intent of this Agreement or any of its provisions.

182. This Agreement, including, without limitation, any of its exhibits or attachments may be revoked, altered, amended, or modified at any time by written agreement executed by the parties hereto.

183. This Agreement, including without limitation, any of its exhibits or attachments may be amended by Plan by providing to PCP no less than thirty (30) days prior written notice of the effective date of the amendment. If PCP provides written acceptance of the amendment, PCP shall be bound by the amendment as of the effective date set forth in the notice of the amendment from Plan. If PCP does not provide written acceptance of the amendment or objects in writing to the amendment, PCP and Plan shall attempt in good faith to resolve the matter to their mutual satisfaction for a period not to exceed thirty (30) days following Plan's written notice of the amendment or Plan's receipt of PCP's written objection to the amendment. In the absence of such resolution, and notwithstanding anything in this Agreement to the contrary, either PCP or Plan may terminate this Agreement or participation of PCP in the provision of Covered Services under the applicable Program, upon written notice to the other within five (5) days after the expiration of the thirty (30) day period described above. The effective date of such termination shall be on the expiration of the five (5) day notice period described above. In the event of such termination, PCP shall be bound by the amendment from its effective date through the effective date of termination.

184. No waiver of any provisions of this Agreement shall be valid unless in writing and signed by the party against whom such waiver is sought. One or more waivers of any covenant or condition of this Agreement by any of the parties hereto shall not be construed as a waiver of any subsequent breach of other covenants or conditions.

185. This Agreement is made pursuant to, and shall be governed by the laws and decisions of the State of West Virginia, regardless of its choice of law provisions. This Agreement is subject to all rules and regulations promulgated from time to time by any relevant regulatory agency, and this Agreement shall be deemed to be amended to conform therewith at all times. When an amendment is required by federal or state law or regulation or by a regulatory agency, Plan shall provide thirty (30) days advance written notice of the amendment to PCP. PCP shall be deemed to have accepted the amendment unless PCP objects to Plan in writing within thirty (30) days of receipt of the notice of amendment. Either party may terminate this Agreement upon ten (10)

days written notice if the parties are unable to reach agreement on the amendment within thirty (30) days of Plan's receipt of PCP's objection.

186. The invalidity or unenforceability of any particular provision of this Agreement shall not affect any other provision hereof. This Agreement shall be construed in all respects as if such invalid or unenforceable provisions were omitted.

187. When the context of this Agreement requires, the gender of all words shall include the masculine, feminine, and neuter, and the number of all words shall include the singular and plural.

188. The parties have not and do not intend to create any rights through this Agreement in any third parties, including Members.

189. Neither party shall be liable nor deemed to be in default for any delay or failure in performance under this Agreement or other interruption of service resulting, directly or indirectly, from acts of God, civil or military authority, acts of public enemy, war, accidents, fires, explosions, earthquakes, floods, failure of transportation, strikes or other work interruptions by either party's employees, or any similar or dissimilar cause beyond the reasonable control of either party; provided, however, in the event the provision of Covered Services is substantially interrupted, Plan shall have the right to terminate this Agreement upon ten (10) days prior written notice to PCP.

190. This Agreement and any amendments hereto may be executed in any number of counterparts, each of which shall be treated as an original, but all of which, collectively, shall constitute a single instrument.

191. Plan does not prohibit PCP from discussing treatment options with Members or from advocating on behalf of a Member in any grievance or utilization review process, or individual authorization process to obtain health care services.

192. Plan and PCP hereby acknowledge and agree that they intend for this Agreement (and all services furnished hereunder) to comply with all applicable federal and state laws, rules and regulations, including, without limitation, the Stark Law (Section 1877 of the Social Security Act). In furtherance of the foregoing, if during the term of this Agreement, Plan's or PCP's counsel reasonably determines that any changes are required with respect to this Agreement, including without limitation, any changes in the amount of the compensation being provided hereunder, as a result of (a) the enactment of new laws, rules or regulations, or (b) any changes in the interpretation of existing laws, rules or regulations, either as a result of any court or agency decision, or any pronouncement, ruling or other interpretation by any governmental or regulatory agency or body, or otherwise, because of the reasonable likelihood that, in light of such enactment or changed interpretation, proceeding under this Agreement in its current form potentially might:

a. Cause either of the parties to violate any applicable law, rules or regulations;

b. Preclude Plan from presenting or causing to be presented to any payer any bills for services furnished by Plan or PCP;

c. Cause any referrals or potential referrals between the parties to be in violation of any self-referral laws, including, without limitation, the Stark Law, then the parties shall negotiate in good faith changes to this Agreement as shall be reasonably required to address such issue(s).

193. To the extent that PCP is a group practice or is otherwise executing this Agreement on behalf of individual providers, including without limitation, individual Allied Health Professionals, PCP represents and warrants to Plan that it has the authority to bind and hereby binds each such provider to the terms and conditions set forth herein.

-Go to next page-

IN WITNESS WHEREOF, the parties hereto have caused this Agreement to be executed effective as of the Effective Date.

PCP (*i.e.*, AUTHORIZED REPRESENTATIVE WITH RESPECT TO THE TAX ID NUMBER LISTED BELOW):

Signature: _____

Print Name:

Title:

Address:

City/State/Zip:

Email Address:

Tax I.D. #:

Dated:

PLAN:
Trusted Health Plans, Inc.
1100 New Jersey Avenue, SE, Suite 840
Washington, DC, 20003
www.Trustedhp.com
45-2375150

_____
Signature: Chika Duru
Its: General Counsel
Dated:

2. The following shall govern the Plan's payment of claims to the PCP. In accordance with West Virginia Code §33-45-2. **Minimum fair business standards contract provisions required; processing and payment of health care services; provider claims; commissioner's jurisdiction.** (1) The Plan shall either pay or deny a clean claim within forty days of receipt of the claim if submitted manually and within thirty days of receipt of the claim if submitted electronically, except in the following circumstances A) Another payer or party is responsible for the claim; (B) The Plan is coordinating benefits with another payer; (C) The PCP has already been paid for the claim;(D) The claim was submitted fraudulently; or (E) There was a material misrepresentation in the claim.

(2) The Plan shall maintain a written or electronic record of the date of receipt of a claim. The Plan shall be entitled to inspect the claim record on request and to rely on that record or on any other relevant evidence as proof of the fact of receipt of the claim. If The Plan fails to maintain an electronic or written record of the date a claim is received, the claim shall be considered received three business days after the claim was submitted based upon the written or electronic record of the date of submittal by the person submitting the claim.

(3) The Plan shall, within thirty days after receipt of a claim, request electronically or in writing from the PCP submitting the claim any information or documentation that the insurer reasonably believes will be required to process and pay the claim or to determine if the claim is a clean claim. The Plan shall use all reasonable efforts to ask for all desired information in one request, and shall if necessary, within fifteen days of the receipt of the information from the first request, only request or require additional information one additional time if such additional information could not have been reasonably identified at the time of the original request or to specifically identify a material failure to provide the information requested in the initial request. Upon receipt of the information requested under this subsection which the insurer reasonably believes will be required to adjudicate the claim or to determine if the claim is a clean claim, The Plan shall either pay or deny the claim within thirty days. The Plan may not refuse to pay a claim for health care services rendered pursuant to a PCP contract which are covered benefits if The Plan fails to timely notify the person submitting the claim within thirty days of receipt of the claim of the additional information requested unless such failure was caused in material part by the person submitting the claims: *Provided,* That nothing herein shall preclude The Plan from imposing a retroactive denial of payment of such a claim if permitted by the provider contract unless such retroactive denial of payment of the claim would violate subdivision (7), subsection (a) of this section. This subsection does not require an insurer to pay a claim that is not a clean claim except as provided herein.

(4) Interest, at a rate of ten percent per annum, accruing after the forty-day period provided in subdivision (1), subsection (a) of this section owing or accruing on any claim under any provider contract or under any applicable law, shall be paid and accompanied by an explanation of the assessment on each claim of interest paid, without necessity of demand, at the time the claim is paid or within thirty days thereafter.

(5) Every insurer shall establish and implement reasonable policies to permit any provider with which there is a provider contract:

(A) To promptly confirm in advance during normal business hours by a process agreed to between the parties whether the health care services to be provided are a covered benefit; and

(B) To determine the Plan's requirements applicable to the PCP (or to the type of health care services which the PCP has contracted to deliver under the provider contract) for:

(i) Precertification or authorization of coverage decisions;

(ii) Retroactive reconsideration of a certification or authorization of coverage decision or retroactive denial of a previously paid claim;

(iii) Provider-specific payment and reimbursement methodology; and

(iv) Other provider-specific, applicable claims processing and payment matters necessary to meet the terms and conditions of the provider contract, including determining whether a claim is a clean claim.

(C) The Plan shall make available to the PCP within twenty business days of receipt of a request, reasonable access either electronically or otherwise, to all the policies that are applicable to the particular provider or to particular health care services identified by the provider. In the event the provision of the entire policy would violate any applicable copyright law, the insurer may instead comply with this subsection by timely delivering to the provider a clear explanation of the policy as it applies to the provider and to any health care services identified by the provider.

(6) Every insurer shall pay a clean claim if the insurer has previously authorized the health care service or has advised the provider or enrollee in advance of the provision of health care services that the health care services are medically necessary and a covered benefit, unless:

(A) The documentation for the claim provided by the person submitting the claim clearly fails to support the claim as originally authorized; or

(B) The Plan's refusal is because:

7. Another payer or party is responsible for the payment;

8. The Plan has already been paid for the health care services identified on the claim;

9. The claim was submitted fraudulently or the authorization was based in whole or material part on erroneous information provided to the insurer by the provider, enrollee, or other person not related to the insurer;

10. The person receiving the health care services was not eligible to receive them on the date of service and the insurer did not know, and with the exercise of reasonable care could not have known, of the person's eligibility status;

11. There is a dispute regarding the amount of charges submitted; or

12. The service provided was not a covered benefit and the insurer did not know, and with the exercise of reasonable care could not have known, at the time of the certification that the service was not covered.

(7) A previously paid claim may be retroactively denied only in accordance with this subdivision.

2) The Plan may not retroactively deny a previously paid claim unless:

a) The claim was submitted fraudulently;

b) The claim contained material misrepresentations;

c) The claim payment was incorrect because the provider was already paid for the health care services identified on the claim or the health care services were not delivered by the provider;(iv) The Hospital was not entitled to reimbursement;(v) The service provided was not covered by the health benefit plan; or(vi) The insured was not eligible for reimbursement.

(B) A PCP to whom a previously paid claim has been denied by The Plan in accordance with this section shall, upon receipt of notice of retroactive denial by The Plan, must notify the Plan within forty days of the PCP's intent to pay or demand written explanation of the reasons for the denial. (i) Upon receipt of explanation for retroactive denial, the PCP shall reimburse The Plan within thirty days for allowing an offset against future payments or provide written notice of dispute. (ii) Disputes shall be resolved between the parties within thirty days of receipt of notice of dispute. The parties may agree to a process to resolve the disputes in a provider contract. (iii) Upon resolution of dispute, the provider shall pay any amount due or provide written authorization for an offset against future payments.

(C) The Plan may retroactively deny a claim only for the reasons set forth in subparagraphs (iii), (iv), (v) and (vi), paragraph (A) of this subdivision (7) for a period of one year from the date the claim was originally paid. There shall be no time limitations for retroactively denying a claim for the reasons set forth in subparagraphs (i) and (ii) above.

(8) No PCP contract may fail to include or attach at the time it is presented to the PCP for execution: (A) The fee schedule, reimbursement policy or statement as to the manner in which claims will be calculated and paid which is applicable to the provider or to the range of health care services reasonably expected to be delivered by that type of provider on a routine basis; and (B) All material addenda, schedules and exhibits thereto applicable to the provider or to the range of health care services reasonably expected to be delivered by that type of provider under the provider contract.

(9) No amendment to any PCP contract or to any addenda, schedule or exhibit, or new addenda, schedule, exhibit, applicable to the provider to the extent that any of them involve payment or delivery of care by the PCP, or to the range of health care services reasonably expected to be delivered by that type of provider, is effective as to the provider, unless the provider has been provided with the applicable portion of the proposed amendment, or of the proposed new addenda, schedule or exhibit, and has failed to notify the insurer within twenty business days of receipt of the documentation of the PCP's intention to terminate the Hospital contract at the earliest date thereafter permitted under the Hospital contract.

(10) In the event that the PCP's provision of a policy required to be provided under subdivision (8) or (9) of this subsection would violate any applicable copyright law, The Plan may instead comply with this section by providing a clear, written explanation of the policy as it applies to the provider.

(11) The Plan shall complete a credential check of any new PCP and accept or reject the provider within four months following the submission of the provider's completed application: *Provided,* That time frame may be extended for an additional three months because of delays in primary source verification. The Plan shall make available to PCP a list of all information required to be included in the application. A PCP who is permitted by the Plan to provide services and who provides services during the credentialing period shall be paid for the services if the provider's application is approved.

(b) Without limiting the foregoing, in the processing of any payment of claims for health care services rendered by providers under provider contracts and in performing under its provider contracts, every insurer subject to regulation by this article shall adhere to and comply with the minimum fair business

standards required under subsection (a) of this section. The commissioner has jurisdiction to determine if an insurer has violated the standards set forth in subsection (a) of this section by failing to include the requisite provisions in its provider contracts. The commissioner has jurisdiction to determine if the insurer has failed to implement the minimum fair business standards set out in subdivisions (1) and (2), subsection (a) of this section in the performance of its provider contracts.

(c) No insurer is in violation of this section if its failure to comply with this section is caused in material part by the person submitting the claim or if the insurer's compliance is rendered impossible due to matters beyond the insurer's reasonable control, such as an act of God, insurrection, strike, fire, or power outages, which are not caused in material part by the insurer.

EXHIBIT C

EXHIBIT D

AGREED TO:

_____
(Printed Name of Group PCP)

By:_____
Signature

_____
(Printed Name of PCP Representative)

_____
(Title of PCP Representative)

DATE:_____

TRUSTED HEALTH PLAN (DISTRICT OF COLUMBIA), INC.
PLAN/REFERRAL HOSPITAL PARTICIPATION AGREEMENT

This Plan/Referral Hospital Participation Agreement (this "Agreement") is made and entered into as of the Effective Date (as defined on the signature page of this Agreement), between [HOSPITAL NAME], including any Hospital Entity (collectively, "Hospital"), and Trusted Health Plan (District of Columbia) Inc. ("THP"), a Washington, DC corporation licensed as a Health Maintenance organization ("HMO") in the State of West Virginia, and which has contracted with the State of West Virginia to provide certain services under the THP (MCO)-State of West Virginia Department of Health and Human Resources Bureau for Medical Services ("MCO") Contract ("MCO Contract"). Each Hospital Entity providing Covered Services hereunder on behalf of Hospital shall be bound to the terms and conditions of this Agreement to the same extent as Hospital and all duties and obligations of Hospital hereunder shall be the duties and obligations of each Hospital Entity.

In consideration of the mutual obligations and promises set forth herein, the parties agree as follows:

3. DEFINITIONS

a. "Clean Claim" means a claim that has no defect, impropriety, lack of any required substantiating documentation or particular circumstance requiring special treatment that prevents timely payment.

b. "Covered Services" means health care services a Member is entitled to receive under THP's Medicaid program and Medicare program.

c. "Dispute Resolution" means the process set out under paragraph 22(i) below

d. "External Quality Review" means a validation of performance/quality improvement measures and activities; compliance with local standards for access to care, structure and operations; and validation of consumer or provider surveys for quality of care.

e. "Hospital Entity" any Hospital subsidiary entity, business line, or division of Hospital.

f. "Member" means any individual currently eligible to participate in and enrolled in THP's Medicaid program and Medicare program.

g. "Participating Hospital" means a hospital that is an in-network hospital provider for THP.

h. "Provider Manual" means the rules, policies, and procedures applicable to Covered Services provided under this Agreement regarding medical management, utilization review, quality assurance, case management, disease management, quality improvement, provider and member grievance procedures, the appeals process, and the use of THP Participating Hospitals, including reimbursement policies, preauthorization and referral requirements, and credentialing and re-credentialing standards and policies.

i. "Quality Management Program" means THP's program to establish, maintain, and perform quality management reviews of Covered Services provided to Members.

j. "Referral" means the document issued or process used by a Primary Care Physician ("PCP") directing the Member to another health care provider for specialty services, ancillary services, or other Covered Services.

k. "Second Level Appeal" means a provider appeal of an adverse claims determination issued by THP in response to the provider's first appeal.

l. "Sentinel Event Policy" THP's policy, as described in the Provider Manual, regarding an unexpected occurrence involving death or serious physical or psychological injury or risk thereof.

m. "Serious Reportable Events" means an incident involving death or serious harm to a Member resulting from a lapse or error in a healthcare facility.

n. "Utilization Management Program" means THP's program outlining procedures for the efficient use of resources for the provision of Covered Services. The program shall include the review of elective admissions, Referrals and hospital admissions on a concurrent and prospective basis and emergency services on a prospective and retrospective basis. The program shall also include the use of care management teams comprised of utilization management nurse coordinators, nurse case management coordinators, medical outreach representatives and social workers, working in coordination with PCPs to provide multi-disciplinary and comprehensive coordinated care to Members.

4. Hospital agrees to provide the health care services, supplies and/or products described in Exhibit A (attached hereto) of this Agreement ("**Covered Services**") to THP Members. Covered Services will be subject to any restrictions or limitations set forth in the Provider Manual or hospital manuals, bulletins, directives, and other written information received by THP from DHHS. THP will give Hospital notice of any changes to such restrictions or limitations, as well as of any changes in Covered Services, operational policies and procedures, and/or appeal procedures with respect to the policies and administrative decisions that Hospital is required to follow.

5. Hospital warrants that it is a participant in good standing in the Medicaid and Medicare Advantage programs, and it will maintain this good standing during the term of this Agreement. Hospital warrants that it has not been convicted of a felony or suspended from participating in Medicare, Medicaid or any other third-party payer program. Hospital further warrants that it does not now and will not, during the term of this Agreement, employ or contract, directly or indirectly, with any individual or entity that has been excluded from participation in Medicare, Medicaid, or any other third-party payer program. If for any reason Hospital receives notice from Medicare, Medicaid, or any other third-party payer program of any sanction or proposed sanction against Hospital or any individual or entity providing services hereunder, Hospital agrees to notify THP no later than ten (10) days after Hospital receives notice of the sanction or proposed sanction.

6. Neither Hospital, THP, nor any employee, agent, or subcontractor of Hospital or THP, is excluded under Title XIX of the Social Security Act, from participation in Medicaid, Medicare or any other government program and will advise agents and subcontractors of this provision and its requirements.

a. Each party will immediately report to the other party if any of its employees or agents is excluded or debarred as outlined herein.

b. Each party will review or cause to be reviewed the HHS OIG, the GSA Excluded Parties List, and the WV Excluded Parties List, upon employment or contracting with an individual or entity and annually thereafter, and shall immediately terminate from employment or contract an individual or entity that has been excluded.

c. This Agreement is subject to all the rules and regulations promulgated from time to time by the regulatory agencies that oversee the State of West Virginia MCO Program and any other governmental entity with regulatory authority over THP, including, but not limited to, the Department Of Insurance, Securities, and Banking and this Agreement shall be deemed to be amended to conform therewith at all times. When amendment is required by federal or state law or regulation or by a regulatory agency, or when amendment is required to permit THP to do business with another payer program, THP shall provide sixty (60) days advance written notice of the amendment to Hospital. Hospital shall be deemed to have accepted the amendment unless Hospital objects to THP in writing within thirty (30) days of receipt of the notice of amendment. Either party may terminate this Agreement upon ten (10) days written notice if the parties are unable to reach agreement on the amendment within thirty (30) days of THP's receipt of Hospital's objection.

7. THP will pay Hospital for Covered Services provided to Members as set forth in Exhibit A of this Agreement. Claims submitted by Hospital to THP for Covered Services must include such information as THP requires to determine that the services were rendered and in compliance with THP's authorization procedures. Hospital agrees (i) that all encounter information and claims for payment for Covered Services provided hereunder shall be submitted to THP electronically (*i.e.*, rather than in a hard copy paper format); and (ii) that THP shall have the right to terminate this Agreement upon Hospital's failure to do so. Hospital also agrees to allow THP to review and copy all records pertaining to Covered Services provided by Hospital to Members. THP will maintain a current eligibility system for identifying Members and will give Hospital access to the system and provide for reconciliation of errors. THP will provide initial information to Hospital and notice of changes in Covered Services and all operational policies and procedures with which Hospital must comply. The internal appeal procedures for policies or procedures affecting hospitals will be set forth in the THP Provider Manual.

8. Hospital shall only look to THP for payment for services rendered to a Member. Hospital agrees that in no event, including, but not limited to, nonpayment by THP, insolvency of THP or breach of this Agreement, shall Hospital bill, charge, collect a deposit from, seek compensation, remuneration, or reimbursement from, or have any recourse or maintain any action at law or in equity against DHHS, an Member or persons (other than THP) acting on the Member's behalf, for Covered Services. This provision shall not prohibit collection of any applicable copayments or deductibles from Members billed in accordance with the terms of the applicable subscriber agreement or the health plan documents offered by THP. Hospital further agrees that (i) this provision shall survive the termination of this Agreement regardless of the cause giving rise to such termination and shall be construed to be for the benefit of THP's Members and that (ii) this provision supersedes any oral or written agreement to the contrary now existing or hereafter entered into between Hospital and the Member or persons acting on the Member's behalf, insofar as such contrary agreement relates to liability for payment for, or continuation of Covered Services. No changes shall be made in this provision without the prior written approval of DHHS.

a. Hospital shall comply with the requirements of Section 1932(b)(6) of the Social Security Act, 42 U.S.C. 1396u-2 (b)(6), that a Member or the Member's family or caregiver may not be

held liable or be subject to collection efforts for:

i. Debts or other obligations of THP or any hospital participating in the THP's hospital network in the event of insolvency.

ii. The cost of Covered Services under this Agreement in the event that THP fails to receive payment from the State of West Virginia.

iii. The cost of Covered Services under this Agreement if Hospital fails to receive payment from the THP.

b. Hospital is prohibited from imposing any cost-sharing or similar charge on a Member for Covered Services provided to such Member.

c. Hospital is prohibited from referring any amounts due to a collection agency or other party for collection if payment is being sought from Member for Covered Services.

9. Hospital shall cooperate with and comply with all reasonable aspects of THP's fraud, waste, and abuse efforts; quality assurance; quality improvement; and utilization review programs and grievance system, and participate in and cooperate with the decisions, rules, and regulations established by THP's utilization review program, including, but not limited to, precertification of elective admissions and procedures, referral processes, and reporting of clinical encounter data and other THP policies and procedures. Hospital agrees that THP may amend such program, policies and procedures from time to time with fifteen (15) days prior written notice.

10. Hospital shall not discriminate against Members on any grounds prohibited by law, including, without limitation, on the basis of membership in THP, source of payment, physical or mental handicap, sex, age, race, color, creed, religion, national origin, ancestry, marital status, sexual preferences, health status, or disability, in providing health care services under this Agreement. Hospital shall accept all Members and not segregate them in any way or treat them in a location or manner different from other persons enrolled in THP. Hospital shall comply with the provisions of the Americans with Disabilities Act of 1990 (42 USC 12101 et seq. and 47 USC 225) and not discriminate against any employee or applicant for privileges of employment, or any matter directly or indirectly related to employment, because of race, color, religion, national origin, ancestry, age, sex, height, weight, marital status, physical or mental handicap, or disability. Hospital shall comply with all applicable federal and State laws relating to non-discrimination and equal employment opportunity, and assure physical and program accessibility of all services to persons with physical and sensory disabilities, pursuant to Section 504 of the Federal Rehabilitation Act of 1973, as amended, 29 U.S.C. §794, all requirements imposed by the applicable regulations (45 CFR Part 84), and all guidelines and interpretations issued pursuant thereto. Hospital will comply with the provisions of the Age Discrimination and Employment Act of 1967 and the Age Discrimination Act of 1975. In connection with performance under the Agreement, Hospital agrees not to discriminate against any employee or applicant for employment because of age, race, religion, color, handicap, sex, physical condition, income, Medicaid or Medicare status, place of residence, developmental disability, marital status, personal appearance, sexual orientation, family responsibility, matriculation, political affiliation, or national origin. Hospital shall comply with the provisions of Executive Order 11246 "Equal Employment Opportunity" as amended by Executive Order 11375 and supplemented by the United States Department of Labor regulations (41 CFR Sec 60).

11. Hospital's hours of operation for Medicare and Medicaid participants) will be the same as operating hours for other lines of business. Hospital may not impose any limitations on the acceptance of Members for

care or treatment that are available within the hospital that it does not impose on other patients of Hospital.

12. Hospital and each Hospital Entity shall meet THP's credentialing and re-credentialing requirements as they may be amended from time to time, including any requirements regarding licensure, certification, liability, worker's compensation, and malpractice insurance coverages, and provide to THP or its representatives information and documentation to demonstrate compliance with such requirements.

13. Hospital and each Hospital Entity shall secure and maintain all licenses, permits, certificates, and registrations required by state, federal or local laws, rules and regulations to perform its duties hereunder.

14. No individual or entity shall be permitted to provide services hereunder, (i) if such individual or entity acts, or fails to act, in a manner which may result in imminent danger to the health of a Member; (ii) upon the loss of such individual's or entity's license to practice his/her/its profession in the State of West Virginia; or (iii) upon notice to THP that such individual or entity has been suspended, expelled, excluded or terminated from participation under Medicare, Medicaid or any other government program. No payment will be made hereunder for services provided by any individual or entity that has been so excluded or whose license has been revoked. In addition, THP may require Hospital or any Hospital Entity to terminate the provision of services hereunder by any individual or entity immediately upon written notice to Hospital if THP determines such individual or entity poses a threat to the health or safety of any Member or to the license, certification or reputation of THP. Alternatively, THP may immediately transfer out of Hospital, any Member, if THP reasonably determines that any Member's health or safety is in jeopardy at the Hospital.

15. After compliance with the admission procedures set forth below , Hospital agrees to provide, on a twenty-four (24) hour a day, seven (7) days a week basis, Covered Services to Members:

    a. Hospital shall ensure that its Hospital-based physicians comply with the terms and conditions of this Agreement, including participation in THP's Utilization Management Program and Quality Management Program.

    b. Hospital shall provide Covered Services and arrange Hospital-based physician services in accordance with generally accepted standards of medical practice and the standards established by the THP Quality Management Program. Hospital shall ensure that its staff, including its Hospital-based physicians, maintain a competent level of experience and training. Hospital shall also comply with any and all reasonable corrective action plans established by THP related to the provision or failure to provide Covered Services and Hospital-based physician services. Refusal to accept corrective action plan may result in THP initiating termination options available under Section 42 herein. Hospital agrees to maintain and demonstrate to THP, upon request, throughout the term of this Agreement, compliance with the following:

        i. Licensure as appropriate under the laws of the State of West Virginia.

        ii. Accreditation by the Joint Commission on Accreditation of Healthcare Organizations or its successor hospital accrediting organization, unless exempted from this requirement by THP or the State of West Virginia.

        iii. Written assurances that all Hospital-based physicians and nurses and other ancillary and paramedical personnel employed by, associated with, and/or under contract with

Hospital are properly credentialed and licensed or certified to practice in the State of West Virginia.

iv. The quality-related standards of THP, by providing, upon request, information concerning Hospital's malpractice and general liability insurance, medical staff, and clinical privileges. Hospital shall immediately notify THP in writing of any adverse decision of a regulatory body or other governmental entity, or Joint Commission or a successor organization, with respect to Hospital or of any other situation that would materially affect Hospital's ability to carry out its duties and obligations under this Agreement

c. Hospital shall implement all activities reasonably necessary to assist THP to obtain and maintain external accreditation by the National Committee for Quality Assurance ("NCQA") or any other accreditation organization recognized by Health Maintenance Organizations ("HMO") and selected by THP, including, but not limited to, cooperating in the auditing of Members' medical records. Such reviews and audits may include on-site visits, Hospital staff and Member interviews, medical record reviews, claim and encounter data reviews, reviews of Hospital continuous quality improvement policies and procedures, credentialing and re-credentialing activities, corrective actions and follow-up plans, Member satisfaction surveys, Hospital satisfaction surveys, and review of Hospital staff and Hospital provider qualifications.

d. Hospital agrees that it will seek prior authorization from THP for any and every inpatient admission other than for an emergency by contacting THP and giving notice of such admission for purposes of utilization review and quality assurance. Such contact and notification will be conducted by facsimile prior to or on the date of any such admission and will include the applicable admitting ICD-9, ICD-10, or any other revision of the ICD coding standard then in use, and the bed type. Contact and notification for emergency admissions will also be conducted by facsimile and will include the applicable admitting ICD code and bed type. Notification of non-emergency admissions will be provided within one (1) business day for an admission occurring outside of normal business hours or on state or federal holidays. Notification for emergency admissions will be made at the time when such emergency admissions occur during normal business hours and such notice requirement is consistent with applicable law. If such emergency admission occurs at any other time, Hospital will notify THP within one (1) business day after the admission. THP may authorize non-emergency admissions telephonically and will follow the same up with a written authorization sent by first class mail or via other approved methodologies to Hospital within forty-eight (48) hours of the verbal authorization. In the event authorization, in either verbal or written form, is not received from THP prior to a non-emergency admission, THP may not pay Hospital for such admission but may consider extenuating circumstances. In the event prior authorization for a non-emergent inpatient admission was not obtained, hospital shall submit medical record information as needed to make an authorization determination.

e. Hospital shall comply with the following admission procedures for emergencies. THP shall pay Hospital, pursuant to the terms of this Agreement and as mandated by the Emergency Medical Treatment and Active Labor Act ("EMTALA"), for an Emergency Medical Screening ("EMS") needed by a Member. Hospital shall not be required to obtain preauthorization from THP for an EMS. After the EMS and after any existing emergency medical condition has been stabilized, in order for the Hospital to receive reimbursement

for an admission associated with this episode, hospital must obtain from THP an authorization number for treatment or to confirm that the authorization request has been denied. Hospital agrees that THP shall have access to timely information and documentation as needed in order to enable THP to review emergency admissions and to determine the number of inpatient days authorized under the Utilization Management Program. All information requested by THP's Utilization Management staff shall be made available to THP within twenty-four (24) hours, or as soon as reasonably available, of any such request.

f. Except for Emergency Services, Hospital shall request and examine the THP identification of the person seeking admission as a Member. In the event that the person representing himself or herself as a Member does not have THP identification, Hospital shall contact THP by telephone for verification before denying such person admission as a Member. Hospital agrees that in an Emergency, it will follow the foregoing procedures as soon as practicable.

g. Upon admission, every THP Member will be assigned to a licensed, and appropriately credentialed Hospital physician who attends to and will be responsible for the care of the Member until discharge. An attending physician will sign any orders and/or other appropriate admission documents within twenty-four (24) hours of the admission of any member. The attending physician shall maintain responsibility for the Member's care within Hospital unless the attending becomes unavailable through illness, absence from the State of West Virginia, or termination from the Hospital staff.

h. Discharge Planning - Every THP member shall have a discharge plan consistent with industry standards and The Joint Commission guidelines completed by the Hospital and reviewed and signed by the attending physician prior to the discharge. A copy of the discharge plan shall be sent to THP. THP shall be responsible for payment during the period a Member resides in Hospital after Hospital has concluded that the Member should be discharged, but Federal or State laws do not allow discharge, except that during such period, THP will not reimburse Hospital at an acute inpatient level. During this period, THP shall be responsible for locating a new placement for such Member, if necessary.

i. If Hospital fails to comply with the requirements outlined in Section 13, THP may deny payment for such services without recourse against the Member.

j. THP will not reimburse Hospital for procedures relating to the following Health Care Acquired Conditions ("HCAC"), identified in the Affordable Care Act of 2010, Public Law 111-148, when any of the following conditions are not present upon admission in any inpatient setting, but subsequently acquired in that setting:

   i. Foreign object retained after surgery;

   ii. Air embolism;

   iii. Blood incompatibility;

   iv. Catheter associated urinary tract infection;

   v. Pressure ulcers (decubitus ulcers);

vi. Vascular catheter associated infection;

vii. Mediastinitis After Coronary Artery Bypass Graft ("CABG");

viii. Hospital acquired injuries (fractures, dislocations, intracranial injury, crushing injury, burn or other unspecified effects of external causes);

ix. Manifestations of poor glycemic control;

x. Surgical site infection following certain orthopedic procedures;

xi. Surgical site infection following bariatric surgery for obesity; and

xii. Deep vein thrombosis and pulmonary embolism following certain orthopedic procedures except for pediatric (individuals under the age of 21 years) and obstetric populations.

k. THP will not reimburse Hospital for any of the following Never Event in any inpatient or outpatient setting:

i. Surgery performed on the wrong body part;

ii. Surgery performed on the wrong patient; and

iii. Wrong surgical procedure performed on a patient.

l. Throughout the term of this Agreement, Hospital will maintain for itself, its agents, and its employed providers, professional liability and general liability insurance of at least $1 million per occurrence or claim and $3 million in the annual aggregate. This insurance requirement may be met through self-insurance set at an actuarially determined amount established by an independent actuary. Hospital shall also require that any health care professionals which may be employed by or under contract with Hospital to render Covered Services to Members procure and maintain malpractice insurance in the amount of at least $1 million per occurrence or claim and $3 million in the annual aggregate, unless they are covered under the Hospital's insurance policies. Prior to the Effective Date and thereafter, upon reasonable request of THP, and upon any material adverse change in insurance coverage, Hospital shall submit evidence of this coverage to THP, including a Certificate of Insurance. In the event any such professional liability policy for Hospital or for individual providers employed by Hospital is a claims made policy, Hospital will make provisions for "tail" coverage effective upon the termination of the primary policy, or obtain replacement coverage which insures for prior acts, insuring for losses arising from occurrences during the term of this Agreement, which tail policy or prior acts coverage shall have the same policy limits as the primary policy and shall extend the claims reporting period for the longest period for which coverage is available. Hospital shall provide THP with written notice of any cancellation or material adverse change to any such policy. Failure by Hospital to provide THP with proof of adequate insurance coverage within thirty (30) business days of Hospital's receipt of THP's written notice requesting the same will be regarded as a material breach of this Agreement and may be cause for immediate

termination.

m. Hospital agrees to perform its duties under this Agreement in a manner consistent with the reasonable administrative guidelines provided by THP in its Provider Manual, a copy of which shall be provided to Hospital upon execution of this Agreement. Modifications of THP's Provider Manual are not, and shall not be deemed to be, amendments to this Agreement. In the event of conflict between THP's Provider Manual and this Agreement, the terms of this Agreement shall prevail. THP shall provide Hospital with thirty (30) days advance notice of any changes to its Provider Manual, unless such change is required by law or regulation to take place sooner.

16. Hospital agrees to reasonably cooperate in the Utilization Management and Quality Management Programs adopted by THP and communicated to Hospital. These programs shall include, among other things, processes to validate accuracy and appropriateness of coding information submitted, quality of care reviews, quality improvement projects, investigation of Member grievances, pre-admission certification and concurrent and retrospective review. Hospital agrees to reasonably cooperate with quality reviews as soon as reasonably practical after request by THP and once the purpose and scope are clearly defined. Hospital shall make available a designated on-site location for the use of THP employees, use of a telephone for such employees, and pertinent sections of a Member's medical records as may be required to implement such programs. Approval by THP's Utilization Management department of a particular admission or other Hospital service for a Member does not automatically include approval and verification by THP of that Member's eligibility. Hospital must separately request verification of a Member's eligibility from THP. All information requested by Utilization Management staff shall be made available to THP as soon as reasonably possible but not to exceed fifteen (15) business days.

a. Hospital shall report certain events in accordance with THP's Sentinel Event Policy, which will be distributed to Hospital and is incorporated in the Provider Manual. Any changes in the reporting requirements will be communicated through distribution of a revised Sentinel Event Policy. At a minimum, designated events must be reported as soon as possible after event identification and/or patient stabilization.

b. Hospital shall report to THP and applicable local and federal government entities all occurrences defined as Serious Reportable Events ("Never" Events) as outlined by the National Quality Forum. Hospital shall not bill or expect reimbursement for these events.

c. Hospital shall report specific conditions and diseases as required by the Plan.

i. Hospital shall report to THP, infants, toddlers, and school-age children experiencing a developmental delay. Hospital shall send to THP, information on Mountain Health Trust members who are infants, toddlers, and school-age children, whose developmental assessment components of their Early and Periodic Screening, Diagnostic, and Treatment ("EPSDT") periodic or inter-periodic exams reveal evidence of developmental delay.

ii. Hospital shall submit data to THP regarding the occurrence of a Vaccine-preventable illness for any and all members of THP.

iii. Hospital shall report to THP, information and/or data on members with sexually transmitted and other communicable diseases, including HIV.

iv. Hospital shall report to THP within twenty-four (24) hours, information on members suspected as being infected with tuberculosis.

v. Hospital and THP shall comply with reporting requirements of the State of West Virginia registries and programs, including, but not limited to, the Cancer Control Registry and EPSDT Registry.

d. Hospital shall cooperate with THP in resolving any Member complaints and grievances related to the provision of Covered Services. Hospital agrees to participate in and cooperate with THP's Member grievance and complaint procedure, as set forth in THP's Provider Manual and to make best efforts to comply with all reasonable final determinations rendered in accordance with that procedure. Hospital agrees to provide information necessary to investigate, and where reasonably practicable, resolve a grievance or complaint within three (3) calendar days of the request.

e. Hospital understands that nothing in this Agreement shall require Members to utilize Hospital or guarantee any minimum volume of Covered Services.

17. THP may use Hospital's name, address and telephone number in THP materials, including THP's hospital directory. Hospital may provide written notice that Hospital is a Participating Hospital. In the event Hospital wants to use THP's name in any other context or for any other purpose other than general administrative purposes as specified by THP, Hospital shall obtain the prior written consent of THP, which consent shall not be unreasonably withheld. In the event THP wants to use Hospital's name in any other context or for any other purpose, THP shall obtain the prior written consent of Hospital, which consent shall not be unreasonably withheld.

18. If any services provided by Hospital are not Covered Services, Hospital may bill Members at a rate not in excess of the rate which it bills the general public after first obtaining the Member's written consent to receive non-Covered Services and to be billed. Such consent may be a part of the standard documentation found in the facility's conditions of admission or such initial documentation as is customarily utilized by Hospital and completed by the patient. Hospital agrees to provide THP with such documentation upon request. Hospital shall, in no event, charge THP for any Covered Services, which are not medically necessary. Prior to billing Members for non-Covered Services, Hospital agrees to verify with THP that the claim is the Member's responsibility.

19. Notwithstanding any provision or understanding to the contrary, Hospital agrees and warrants that under no circumstances will Hospital or any Hospital employee or Hospital-based physician solicit, influence, persuade, or advise any Member of THP to dis-enroll or to join: (i) another HMO, including an HMO in which Hospital has an ownership interest; (ii) another managed care plan; (iii) a case management arrangement; or (iv) any other similar arrangement, including any other arrangement in which Hospital has an ownership interest (collectively referred to as "Alternative Care Plan"). If THP determines that hospital has violated this clause it shall constitute grounds to initiate actions in accordance with Section 42 herein.

20. Hospital agrees that in connection with all actions taken on behalf of Members, and in all communications with Members in connection with this Agreement, Hospital shall avoid actions and communications that could or shall undermine the confidence of the Member, a potential Member, employers, unions or the public in THP or in the quality of care THP provides. Notwithstanding the foregoing, nothing in this

Agreement shall limit the rights of Hospital to: (i) communicate with patients, including Members, regarding medical treatment options; (ii) recommend a course of treatment to a Member, even if the course of treatment is not covered, or approved, by THP; (iii) file an appeal or complaint pursuant to the procedures of THP; (iv) supply accurate, relevant and factual information to a Member in connection with an appeal or complaint filed by such Member; or (v) object to policies, procedures, or decisions made by THP.

21. Hospital shall make best efforts to provide THP with at least thirty (30) days prior written notice of any material changes in Hospital's location, address, range of services, telephone numbers, and other relevant information relating to Hospital's operations. Hospital shall also be responsible for providing notice of such changes to Members on or before the effective date of such changes, as applicable.

22. Duties of THP - THP shall provide all administrative services under this Agreement, including quality management, utilization management, budgeting, administration of claims from hospitals other than Hospital, coordination of benefits, funds management, and compliance with all federal and State of West Virginia regulatory requirements. THP shall provide Hospital with THP's administrative policies and procedures. THP also shall provide thirty days (30) written notice to Hospital of any significant changes in THP's policies and procedures.

    a. THP shall apprise Hospital and all Members concerning the type, scope, and duration of benefits and services to which Members are entitled under THP. Under all circumstances, THP shall retain final authority regarding coverage or benefit determinations for its Members.

    b. THP agrees to assist Hospital in the development and initial implementation of procedures necessary to carry out the terms of this Agreement.

    c. THP shall provide compensation to Hospital as set forth in the appropriate exhibit to this Agreement at the full and complete contracted amount, which shall be full compensation for Hospital's responsibilities described herein, except for applicable co-payments, including deductibles and co-insurance and as provided in Section 6. Any claims not paid at the full and complete contract amount shall be immediately subject to Dispute Resolution. Hospital's failure to follow the policies and procedures of THP as set forth in this Agreement and the Provider Manual may result in a denial of payment. Hospital shall submit claims in accordance with industry standards.

23. Hospital agrees to submit claims to THP on a completed CMS form UB-92 for facility services (or its successor form), or in such other format as mutually agreed to by the parties, within one-hundred eighty (180) days of the date of discharge for inpatient Hospital Covered Services and within one-hundred eighty (180) days after the date Covered Services are rendered for outpatient Hospital services. THP reserves the right to deny claims that are not submitted within such one-hundred eighty (180) day period, except where Hospital bills a third party payer as primary and extenuating circumstances exist. Hospital agrees to refrain from duplicate billing any claims submitted to THP, unless expressly approved by THP in order to process coordination of benefit claims. THP shall provide payment to Hospital within thirty (30) days of THP's receipt of an uncontested Clean Claim from Hospital, or other specified timeframes as may be required by the DHHS.

24. Hospital must submit a request for appeal of an adverse claims determination made by THP within ninety (90) days after the date of receipt of THP's written notice. THP may deny appeals that are not submitted within that timeframe. THP will respond to all timely appeals within fifteen (15) days to provide a

written decision to the appeal, including the specific basis for the decision. If Hospital disagrees with this determination, Hospital may submit a Second Level Appeal within thirty (30) days of receipt of the initial appeal response. THP shall provide a written decision within thirty (30) days from receipt of Hospital's Second Level Appeal. If the appeal involves a clinical determination, the review shall be conducted by individuals with appropriate qualifications in the applicable specialty. A Second Level Appeal on a clinical determination shall not be conducted by the same individual involved in the initial appeal. If the appeal is not resolved following THP's response to the Second Level Appeal, the matter shall be subject to Dispute Resolution.

25. The following shall govern Hospital's submission of and THP's payment of claims:

    a. Receipt of claim - For purposes of this clause, claims shall be recorded to have been received no later than twenty four (24) hours or one (1) working day, after actual receipt by THP and will be date stamped accordingly.

    b. Payments of clean and complete claims made after thirty (30) days of receipt shall be considered late and subject to interest in accordance with the relevant prompt pay laws.

    c. Subject to the WV Prompt Pay Law, THP may request additional reasonable and necessary documentation when a claim is pended for administrative or medical review. THP shall adjudicate such claims in accordance with the WV Prompt Pay Law. Any portion of a claim that is not in question shall be paid in accordance with WV Prompt Payment Law provisions.

    d. Hospital may submit interim claims if a Member's stay is greater than thirty (30) days. Claims will be settled according to all appropriate contract and reimbursement terms within thirty (30) days of submission of a final, clean discharge claim from the Hospital.

    e. Hospital accepts payment from THP, together with authorized co-payments, as provided Herein, as full payment for Covered Services, and shall not pursue or collect charges for such services from Members or other third parties, except where authorized in this Agreement. However, Hospital agrees to cooperate and use best efforts in the effective implementation of any coordination of benefits procedures and other procedures for handling third party claims, as set forth in THP's Provider Manual, including collecting information from Members regarding other health insurance coverage. In the event Hospital receives payment for Covered Services from third parties, it shall promptly make appropriate adjustments due THP. Hospital shall be responsible for and implement a system for notifying THP of any claims by Members involving coordination of benefits. In any case where a Member admitted to Hospital has primary coverage from any third party payer and Hospital has reason to know of a primary payer other than THP, Hospital shall bill the third party payer and notify THP of the existence of any primary payer source at the time that Hospital submits a claim to THP.

    f. When THP is notified of retroactive dis-enrollments of Members or when THP obtains information from a previous member eligibility report from DHHS that contradicts THP's prior reliance on a Member's eligibility for Covered Services, THP may retroactively deny Covered Services furnished to Members within ninety (90) days of receipt of notice or evidence contradicting a Member's prior eligibility, and shall send immediate written notice of such denial to Hospital with information identifying the proper coverage. Hospital shall recognize THP's immediate right to recovery for retroactively dis-enrolled

Members and shall repay contested paid claims within thirty (30) days of notice from THP.

g. Hospital shall immediately refund to Members any and all sums collected by Hospital from Members, which should not have been collected under the terms of this Agreement. Such refunds shall take the form of payments by check from Hospital to Members. Upon request, Hospital shall provide THP notice of all refunds issued to Members no more than one week after such request from THP. Notice for the purposes of this section shall include, without limitation, the Members' names, refund amounts for each Member and the date paid.

h. THP and Hospital hereto understand that THP's ability to pay the rates in the attached schedules is conditioned upon the payments received from the State of West Virginia To the extent that DHHS or the Centers for Medicare and Medicaid Services ("CMS") reduces payments provided to THP under the Medicaid or Medicare Advantage programs in any manner, Plan may notify Hospital in writing of such reduction and both parties agree to negotiate in good-faith a revised fee schedule. If the parties are unable to agree upon a revised fee schedule within sixty (60) days of Plan's notice of reduction to Hospital, Plan reserves the right to terminate this Agreement under Section 40 below.

i. The parties shall work cooperatively and in good faith to attempt to resolve payment issues on an informal basis. However, either party may notify the other party in writing of a specific dispute, outlining the information and issues involved in such dispute and the party receiving such notification must respond in writing within thirty (30) days of the first notification. If the issue is not resolved successfully in this timeframe, then parties shall attempt to resolve the dispute within an additional 60 (sixty) days of informal negotiations. If the parties do not resolve the dispute within the additional 60 (sixty) days, the parties agree to resolve the dispute through arbitration. All arbitration proceedings or litigation (to the extent the remedy requested is not, by law, available through arbitration [e.g., injunctive relief]) relating to any claims or disputes arising under or relating to this Agreement shall be brought in the county in which the principal executive office of the party not initiating such action or proceeding (i.e. the defendant or responding party) is located. The parties irrevocably submit and consent to the exercise of subject matter jurisdiction and personal jurisdiction over each of the parties by the federal and/or state courts in such jurisdiction (the "Selected Jurisdiction"). The parties hereby irrevocably waive any and all objections that any party may now or hereafter have to the exercise of personal and subject matter jurisdiction in the Selected Jurisdiction and to the laying of venue of any such proceeding or action brought in the Selected Jurisdiction. Any order or determination of the arbitral tribunal shall be final and binding upon the parties to the arbitration and may be entered in any court having jurisdiction.

j. If the parties determine that THP has underpaid Hospital, THP shall pay the underpaid amount to Hospital within sixty (60) days of said determination. If the parties determine that THP has overpaid Hospital, Hospital shall reimburse THP for the overpayment within sixty (60) days of said determination.

k. Neither party shall be permitted to request an adjustment to reimbursement made to Hospital

more than one hundred eighty (180) days from the date of payment.

l. THP or its designee shall have the right to audit records maintained by Hospital regarding claims submitted by Hospital and payments received by Hospital from THP or its designee. Hospital agrees to provide reasonable access to Hospital facilities and records for inspections and audits by THP, DHHS), the U.S. Department of Health and Human Services ("HHS"), the Centers for Medicare and Medicaid Services ("CMS"), the Office of the Inspector General ("OIG"), and their respective designees, and to cooperate with all audits and inspections to the same extent that audits and inspections may be required under law or under THP's contract with DHHS.

26. THP will notify Hospital in writing of any request for Hospital bill audits within 365 days of the paid date. Such audits may include individual cases selected for review or sample cases of a particular category selected for review in conjunction with THP's obligations to CMS to assure the integrity of Medicaid and Medicare program spending. The reason or focus for such review must be outlined, and Hospital will respond in a timely manner and use reasonable efforts to arrange for such audit to be completed within thirty (30) days of request, provided that the claim has been paid in full in accordance with the Agreement. Such audits shall be conducted on site at Hospital and shall be scheduled on a basis that is appropriate and reasonable for the volume and extent of records requested. A bill audit conference or exit interview shall occur prior to finalizing audit results, at which time the preliminary findings and conclusions shall be provided to Hospital. All final audit results shall be net of overcharges, undercharges, unbilled charges and disallowed charges and Hospital shall have an opportunity to address any documentation issues. If the parties are in agreement on the audit findings a summary of the findings will be signed off by the parties to close the audit. Any monies due from one party to the other shall be paid within sixty (60) days of the execution of the audit summary of findings. If the parties cannot agree on the final audit findings, either party may institute Dispute Resolution proceedings pursuant to Section 22(i) above.

27. The following shall govern THP's payment of claims to the hospital. In accordance with West Virginia Code **§33-45-2. Minimum fair business standards contract provisions required; processing and payment of health care services; provider claims; commissioner's jurisdiction.** (1) THP shall either pay or deny a clean claim within forty days of receipt of the claim if submitted manually and within thirty days of receipt of the claim if submitted electronically, except in the following circumstances A) Another payer or party is responsible for the claim; (B) THP is coordinating benefits with another payer; (C) The provider has already been paid for the claim;(D) The claim was submitted fraudulently; or(E) There was a material misrepresentation in the claim.

(2) THP shall maintain a written or electronic record of the date of receipt of a claim. THP shall be entitled to inspect the claim record on request and to rely on that record or on any other relevant evidence as proof of the fact of receipt of the claim. If THP fails to maintain an electronic or written record of the date a claim is received, the claim shall be considered received three business days after the claim was submitted based upon the written or electronic record of the date of submittal by the person submitting the claim.

(3) THP shall, within thirty days after receipt of a claim, request electronically or in writing from the Provider submitting the claim any information or documentation that the insurer reasonably believes will be required to process and pay the claim or to determine if the claim is a clean claim. THP shall use all reasonable efforts to ask for all desired information in one request, and shall if necessary, within fifteen days of the receipt of the information from the first request, only request or require additional information one additional time if such additional information could not have been reasonably identified at the time of the original request or to specifically identify a material failure to

provide the information requested in the initial request. Upon receipt of the information requested under this subsection which the insurer reasonably believes will be required to adjudicate the claim or to determine if the claim is a clean claim, THP shall either pay or deny the claim within thirty days. THP may not refuse to pay a claim for health care services rendered pursuant to a provider contract which are covered benefits if THP fails to timely notify the person submitting the claim within thirty days of receipt of the claim of the additional information requested unless such failure was caused in material part by the person submitting the claims: *Provided,* That nothing herein shall preclude THP from imposing a retroactive denial of payment of such a claim if permitted by the provider contract unless such retroactive denial of payment of the claim would violate subdivision (7), subsection (a) of this section. This subsection does not require an insurer to pay a claim that is not a clean claim except as provided herein.

(4) Interest, at a rate of ten percent per annum, accruing after the forty-day period provided in subdivision (1), subsection (a) of this section owing or accruing on any claim under any provider contract or under any applicable law, shall be paid and accompanied by an explanation of the assessment on each claim of interest paid, without necessity of demand, at the time the claim is paid or within thirty days thereafter.

(5) THP shall establish and implement reasonable policies to permit any Hospital with which there is a provider contract:

(A) To promptly confirm in advance during normal business hours by a process agreed to between the parties whether the health care services to be provided are a covered benefit; and

(B) To determine the THP's requirements applicable to the Hospital (or to the type of health care services which the provider has contracted to deliver under the provider contract) for:

(i) Precertification or authorization of coverage decisions;

(ii) Retroactive reconsideration of a certification or authorization of coverage decision or retroactive denial of a previously paid claim;

(iii) Hospital-specific payment and reimbursement methodology; and

(iv) Other Hospital-specific, applicable claims processing and payment matters necessary to meet the terms and conditions of the Hospital contract, including determining whether a claim is a clean claim.

(C) THP shall make available to the provider within twenty business days of receipt of a request, reasonable access either electronically or otherwise, to all the policies that are applicable to the particular provider or to particular health care services identified by the provider. In the event the provision of the entire policy would violate any applicable copyright law, the insurer may instead comply with this subsection by timely delivering to the provider a clear explanation of the policy as it applies to the provider and to any health care services identified by the provider.

(6) THP shall pay a clean claim if the insurer has previously authorized the health care service or has advised the provider or enrollee in advance of the provision of health care services that the health care services are medically necessary and a covered benefit, unless:

(A) The documentation for the claim provided by the person submitting the claim clearly fails to support the claim as originally authorized; or

(B) The insurer's refusal is because:

13. Another payer or party is responsible for the payment;

14. THP has already been paid for the health care services identified on the claim;

15. The claim was submitted fraudulently or the authorization was based in whole or material part on erroneous information provided to the insurer by the provider, enrollee, or other person not related to the insurer;

16. The person receiving the health care services was not eligible to receive them on the date of service and the insurer did not know, and with the exercise of reasonable care could not have known, of the person's eligibility status;

17. There is a dispute regarding the amount of charges submitted; or

18. The service provided was not a covered benefit and the insurer did not know, and with the exercise of reasonable care could not have known, at the time of the certification that the service was not covered.

(7) A previously paid claim may be retroactively denied only in accordance with this subdivision.

3) THP may not retroactively deny a previously paid claim unless:

a) The claim was submitted fraudulently;

b) The claim contained material misrepresentations;

c) The claim payment was incorrect because the provider was already paid for the health care services identified on the claim or the health care services were not delivered by the provider;(iv) The Hospital was not entitled to reimbursement;(v) The service provided was not covered by the health benefit plan; or(vi) The insured was not eligible for reimbursement.

(B) A Hospital to whom a previously paid claim has been denied by a THP in accordance with this section shall, upon receipt of notice of retroactive denial by THP, notify the THPwithin forty days of the Hospital's intent to pay or demand written explanation of the reasons for the denial. (i) Upon receipt of explanation for retroactive denial, the Hospital shall reimburse THP within thirty days for allowing an offset against future payments or provide written notice of dispute. (ii) Disputes shall be resolved between the parties within thirty days of receipt of notice of dispute. The parties may agree to a process to resolve the disputes in a provider contract. (iii) Upon resolution of dispute, the provider shall pay any amount due or provide written authorization for an offset against future payments.

(C) THP may retroactively deny a claim only for the reasons set forth in subparagraphs (iii), (IV), (v) and (vi), paragraph (A) of this subdivision (7) for a period of one year from the date the claim was originally paid. There shall be no time limitations for retroactively denying a claim for the reasons set forth in subparagraphs (i) and (ii) above.

(8) No Hospital contract may fail to include or attach at the time it is presented to the provider for execution: (A) The fee schedule, reimbursement policy or statement as to the manner in which claims will be calculated and paid which is applicable to the provider or to the range of health care services reasonably expected to be delivered by that type of provider on a routine basis; and (B) All material addenda, schedules and exhibits thereto applicable to the provider or to the range of health care services reasonably expected to be delivered by that type of provider under the provider contract.

(9) No amendment to any Hospital contract or to any addenda, schedule or exhibit, or new addenda, schedule, exhibit, applicable to the provider to the extent that any of them involve payment or delivery of care by the Hospital, or to the range of health care services reasonably expected to be delivered by that type of provider, is effective as to the provider, unless the provider has been provided with the applicable portion of the proposed amendment, or of the proposed new addenda, schedule or exhibit, and has failed to notify the insurer within twenty business days of receipt of the documentation of the Hospital's intention to terminate the Hospital contract at the earliest date thereafter permitted under the Hospital contract.

(10) In the event that the THP's provision of a policy required to be provided under subdivision (8) or (9) of this subsection would violate any applicable copyright law, THP may instead comply with this section by providing a clear, written explanation of the policy as it applies to the provider.

(11) THP shall complete a credential check of any new Hospital provider and accept or reject the provider within four months following the submission of the provider's completed application: *Provided,* That time frame may be extended for an additional three months because of delays in primary source verification. THP shall make available to Hospital a list of all information required to be included in the application. A Hospital provider who is permitted by the THP to provide services and who provides services during the credentialing period shall be paid for the services if the provider's application is approved.

(b) Without limiting the foregoing, in the processing of any payment of claims for health care services rendered by providers under provider contracts and in performing under its provider contracts, every insurer subject to regulation by this article shall adhere to and comply with the minimum fair business standards required under subsection (a) of this section. The commissioner has jurisdiction to determine if an insurer has violated the standards set forth in subsection (a) of this section by failing to include the requisite provisions in its provider contracts. The commissioner has jurisdiction to determine if the insurer has failed to implement the minimum fair business standards set out in subdivisions (1) and (2), subsection (a) of this section in the performance of its provider contracts.

(c) No insurer is in violation of this section if its failure to comply with this section is caused in material part by the person submitting the claim or if the insurer's compliance is rendered impossible due to matters beyond the insurer's reasonable control, such as an act of God, insurrection, strike, fire, or power outages, which are not caused in material part by the insurer.

28. To comply with the Health Insurance Portability and Accountability Act of 1996 (Public Law 104-191, August 1996), both parties must comply with the following:

i. All individually identifiable information relating to Medicare and Medicaid enrollees must be kept confidential pursuant to 42 U.S.C. Section 1396a (a)(7), 42 CFR Part 2 and other regulations promulgated there under. Such information may be used by the hospital only for a purpose directly connected with performance of Hospital's obligations under this program and this Agreement. The provisions of this section will survive the termination of THP's participation and/or Hospital participation in the Medicare program or the Medicaid managed care program and will remain in effect as long as Hospital maintains any individually identifiable information relating to Medicare, Medicaid beneficiaries. Hospital must ensure compliance with the Health Insurance Portability and Accountability Act of 1996 (Public Law 104191, August 21, 1996) and all applicable regulations promulgated there under. Such regulations include, but are not limited to, the medical privacy rule, 45 C.F.R. Parts 160 and 164, and the electronic transactions and code set standards rule, 45 C.F.R. Parts 160 and

162. Hospital shall maintain written procedures for compliance with all applicable privacy, confidentiality, and information security requirements. Hospital shall train its physicians, employees, and agents on the requirements for compliance with all applicable privacy, confidentiality, and information security requirements.

29. Hospital shall comply with the following advanced directives:

i. Not discriminate against a Medicare or Medicaid Member on the basis of whether the Member has executed an advance directive.

ii. Comply with State of West Virginia law (whether statutory or recognized by the courts of competent jurisdiction) on advance directives.

iii. Cooperate with THP's educational efforts regarding advance directives.

30. Hospital agrees to assist any Medicaid Member in completing the required forms to enroll newborns born to the Medicaid Member under Medicaid.

31. Hospital shall cooperate with any external review organization contracted by DHHS or THP to perform quality studies.

32. In addition, THP must provide information regarding its Members and regarding public health issues affecting its Members to DHHS upon request. Hospital must cooperate with THP in meeting these reporting requirements by providing THP with information, upon request or as provided hereunder, which will include, without limitation, the following (to the extent applicable to Hospital's areas of practice):

i. Known deaths of Members within 72 hours.

ii. Members treated by Hospital who are diagnosed with HIV/AIDS.

iii. Members with developmental delays.

iv. Members diagnosed as tuberculosis cases or tuberculosis-infected.

v. Members with vaccine-preventable diseases and other communicable diseases.

vi. Female Members and Members up to the age of 5 who have or are at risk for nutritional deficiencies or have nutrition-related medical conditions.

vii. Members under the age of 21 who have an elevated blood lead level (greater than 10 ug/dl), which information is to be reported to THP within 48 hours after identification.

33. Hospital shall ensure that Hospital schedules appointments for initial assessments for pregnant Members or persons desiring family planning services to take place within ten (10) days of the request. Hospital understands that a Member may choose instead to receive family planning services from a qualified family planning hospital without a Referral from Hospital. Hospital shall ensure that urgent care services are provided within twenty four (24) hours of receipt of a valid request.

a. THP is responsible to DHHS or its designee for compliance with all activities of the External Quality Review (EQR) process. To the extent that Hospital is responsible for data, information or other requirements of the EQR, Hospital shall:

i. Submit requested pre-site survey documents and/or information in accordance with published timelines.

ii. Submit documents and/or information required during the on-site reviews within specified timelines.

iii. Submit requested Member medical records/information for annual clinical studies within specified timelines.

iv. Adhere to HIPAA guidelines when securing and/or submitting consumer-related information.

v. Maintain quality improvement programs and plans that focus on meeting and exceeding the performance standards, services and satisfaction standards, required by the State of West Virginia or their designee.

vi. Ensure that it meets or exceeds THP's access standards as set out in the Provider Manual.

vii. Submit corrective action plans (CAPs) within pre-established timelines.

viii. Make available Hospital's patient clinical records and/or information requested by THP.

34. Hospital shall collect and report the data required by an EQR organization in support of THP's obligation under sections 1902(a)(30)(C) and 1932(c)(2) of the Social Security Act, 42 U.S.C. U.S.C.1396a(a)(30)(C) and 42 U.S.C.-139u-2(c)(2).

35. THP will make available to Hospital, the results of each annual external independent quality review conducted by the DHHS or its designee.

36. Section 1932(b)(3) of the Social Security Act requires that a "Medicaid managed care organization shall not prohibit or otherwise restrict a covered health care professional from advising such an individual (Member) who is a patient of the professional about the health status of the individual or medical care or treatment for the individual's conditions or disease, regardless of whether benefits for such care or treatment are provided under the contract, if the professional is acting within the lawful scope of practice." As required by 1903(m)(2)(A)(xi) of the Social Security Act, 42 U.S.C. 1396b(m)(2)(A)(xi), THP will not interfere with such communications between covered health care professionals and Members who are a patient of the professional.

37. Hospital shall not be prohibited from advising an individual about the individual's health status or medical care or treatment for the individual's condition or disease, regardless of whether items and services for such care or treatment are covered under the Contract, if the professional is acting within their lawful scope of practice. In addition, the Hospital may not refuse an assignment or seek to discharge from care, a Member, or otherwise discriminate against a Member on the basis of age, sex, race, gender, physical or mental handicap/developmental disability, national origin, or type of illness or condition,

except when that condition can better be treated by another hospital type.

38. If Hospital receives a Referral for, or identifies a request for experimental treatment, Hospital must submit the request to THP within twenty (24) hours of identifying or receiving the request, even if Hospital chooses not to recommend the requested experimental treatment.

39. THP is responsible for actively conducting valid reviews of Members' medical records as a regular, consistent component of THP's Quality Management Program. Hospital will cooperate with such reviews by ensuring that Members' medical records are maintained in a manner that allows THP to be in compliance with this provision. Medical record reviews will be conducted on a population sample of sufficient size so as to yield valid and reliable statistical information. All medical record reviews and evaluation will be conducted pursuant to HIPPA regulations and accepted industry standards for quality assurance and quality improvement related to:

    a. The diagnosis and treatment of injury, illness and disease.

    b. Disease prevention, health promotion and health education activities.

    c. The appropriate documentation of care in clinical records.

40. Hospital is responsible for submitting Members' medical records for review pursuant to a request from THP, DHHS or their designee.

41. Members are entitled to hearings before the State of West Virginia DHHR offices. As a part of that process, THP is required to provide all information necessary for a Member appeal. Hospital shall provide to the Member all information necessary for the Member's appeal within a time frame established by the Department of Health and Human Resources upon notification by THP, DHHS or any other State agency, that such information is required.

42. Hospital shall comply with CMS guidelines for observation care. CMS defines observation status as a "well defined set of specific, clinically appropriate services, which include ongoing short-term treatment, assessment, and reassessment, before a decision can be made regarding whether patients will require further treatment as hospital inpatients or whether they can be discharged from the hospital."

    a. Observation time must be documented in the medical record. THP will utilize its standard criteria to determine whether a case qualifies for observation status upon receipt of notification of the admission decision from the Hospital. Time begins with the patient's admission to an observation bed. THP will only cover observation up to 23 (twenty-three) hours.

    b. When both emergency department charges, and observation charges appear on the claim, the payment shall be based on the observation revenue code and be paid at the observation rate for up to 23 (twenty-three) hours.

43. Until the expiration of ten (10) years (or longer, to the extent required by applicable law) after the furnishing of services pursuant to this Agreement, Hospital shall maintain medical records, required data, reports of services, reports on complaints and grievances, records of quality or utilization issues and any books, documents and records, electronic or paper, for the purpose of assessing quality of care, conducting medical care evaluations and audits, and determining on a concurrent basis, the medical

necessity, appropriateness, nature and extent of care provided to Members, and to permit representatives of THP, DHHS, or the Department of Inspector General to inspect the premises and equipment used by Hospital and to review and copy records pertaining to the provision of Covered Services under this Agreement to Members. Such records shall be maintained in compliance with applicable State laws and administrative rules and federal laws and regulations related to privacy and confidentiality of medical records. Such records shall be maintained in a detailed and comprehensive manner, which conforms to good professional medical practice, permits effective professional medical review and medical audit processes and facilitates an adequate system for follow-up treatment, and shall be signed and dated.

44. THP and Hospital agree that they are independent contractors and that this Agreement is not intended to create the relationship of employer and employee, or principal and agent.

45. Either party may terminate this Agreement with or without cause upon ninety (90) days written notice to the other party. THP may terminate this Agreement immediately when it reasonably determines that continuation of the contract may negatively affect patient care. This Agreement may be terminated automatically by THP without the requirement of advance notice when: (a) THP's contract with DHHS terminates; (b) Hospital fails to maintain all licenses, permits, certificates, and registrations required by state, federal or local laws, rules and regulations to perform its duties hereunder or fails to remain in compliance with all of THP's credentialing requirements; (c) Hospital fails to maintain the insurance coverage required under this Agreement; or (d) Hospital is suspended or terminated from participation in the Medicare, Medicaid, any other federal health program. In the event of insolvency or other cessation of operations by THP, Hospital agrees to provide Covered Services through the last day of the month for which THP has received capitation payment for Covered Services from DHHS whether or not Hospital receives any payments for such month, and to provide Covered Services to any Member hospitalized on the date of such insolvency or other cessation of operations until such Member is discharged.

46. Hospital agrees not to subcontract or delegate its duties or assign any of its rights or obligations under this Agreement except to a Hospital Entity or as otherwise expressly permitted by this Agreement. Any subcontract, delegation or assignment in violation of the foregoing will be void, unless approved in writing by THP. THP may subcontract or delegate its duties without prior approval of Hospital. At its option, Hospital may contract with a management company to perform certain management and administrative functions on behalf of Hospital under the direction and control of Hospital. However, Hospital shall at all times be responsible for compliance with the terms of this Agreement.

47. THP does not prohibit Hospital or any individual providing services hereunder on behalf of Hospital from discussing treatment options with Members that may not reflect THP's position or may not be covered by THP, or from advocating on behalf of a Member in any grievance, utilization review, or individual authorization process to obtain health care services.

48. This Agreement shall remain in effect for an initial period of twelve (12) months, unless sooner terminated pursuant to the terms of this Agreement. Thereafter, this Agreement shall automatically be renewed for successive twelve (12) month terms unless either party provides the other party with written notice of its intent not to renew at least ninety (90) days prior to the expiration of the then current term.

49. Hospital must adhere to the following disclosure requirements:

    a. Within thirty-five (35) days upon request of DHHS or the Secretary of HHS, Hospital must disclose the business transaction information identified in 42 C.F.R. § 455.105, including:

i. The ownership of any independent contractor with whom Hospital has had business transactions totaling more than twenty-five thousand dollars ($25,000.00) during the twelve (12) month period ending on the date of the request.

ii. Any significant business transactions between the Hospital and any wholly owned supplier during the five (5) year period ending on the date of the request.

iii. Any significant business transaction between the Hospital and any independent contractor during the five (5) year period ending on the date of the request.

b. At any time upon request by THP or DHHS, Hospital must disclose:

i. The identity of any person who has ownership or a controlling interest in Hospital who has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or the Title XX services program since the inception of those programs; and

ii. The identity of any person who is an agent or managing employee of Hospital who has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or the Title XX services program since the inception of those programs.

50. Hospital shall adhere to the below marketing conditions:

a. Any marketing information distributed by Hospital directed at THP's Members shall be limited to general information about THP and notification that Hospital participates in Plan's network. Any such materials must be submitted to THP for review and approval prior to distribution to Members (THP will ultimately submit such materials to DHHS for review and approval).

b. Hospital will not utilize written information that is false or misleading in any material respect, including information regarding the Hospital's network, the availability of services, the Hospital's qualifications, hours, and location of services.

c. Hospital shall not host marketing events within the Hospital's facility.

d. Hospital shall not offer to Members gifts of more than a de minimums value or other insurance products designed to induce persons to enroll in THP.

e. Hospital shall not enter into compensation agreements with marketing personnel that utilize any type of payment structure in which compensation is tied to the number (or classes) of persons who enroll in THP.

51. Each party shall, without limit, indemnify, hold harmless, and at the non-indemnifying party's election, defend the non-indemnifying party, its officers, agents, employees, and representatives, with respect to any and all claims, damages, judgments, actions, and causes of action, arising out of the acts or omissions of the indemnifying party's officers, agents, employees, and representatives, related to the services

provided pursuant to this Agreement, including all costs, expenses and attorney's fees incurred in the defense of any and all claims and/or litigation.

52. Any and all notices or other communications provided for or required by this Agreement shall be directed to the party to be so notified, in writing, by registered or certified mail, return receipt requested, or by electronic mail, and addressed to the applicable party at its respective business or electronic addresses shown on the first page of this Agreement, or such other address of which the other party has received written notice; provided, however, that any notice posted on THP's website shall constitute notice for all purposes hereunder. For purposes of clarification, and without limiting the generality of the foregoing, notice sent via electronic mail shall constitute written notice for all purposes hereunder. Each party shall notify the other party promptly and in writing of any change in its respective business and/or email address. Any notice hereunder shall be in writing and shall be deemed given when sent by certified United States mail, postage prepaid, by recognized overnight delivery service, or by hand delivery to THP and Hospital at the addresses set forth below:

To THP: Chika Duru
General Counsel
Trusted Health Plans, Inc.
1100 New Jersey Avenue, SE, Suite 840
Washington, DC 20003

To Hospital:

_____

_____

_____

_____

53. Any amendment to this Agreement shall be in writing and signed by both parties to this Agreement, except as provided in this paragraph. This Agreement, including, without limitation, any of its exhibits, may be amended by THP by providing to Hospital no less than sixty (60) days prior written notice of the effective date of the amendment. Hospital shall have up to sixty (60) days immediately thereafter during which to notify THP in writing of any objection to the amendment. If Hospital fails to timely object to the amendment, Hospital shall be bound by the amendment as of the effective date set forth in the notice of the amendment from THP. If Hospital timely objects in writing to the amendment, Hospital and THP shall attempt in good faith to resolve the matter to their mutual satisfaction for a period not to exceed fifteen (15) days following THP's receipt of Hospital's written objection to the amendment. In the absence of such resolution, and notwithstanding anything in this Agreement to the contrary, either Hospital or THP may terminate this Agreement upon written notice to the other within five (5) days after the expiration of the fifteen (15) day period described above. The effective date of such termination shall be on the expiration of the five (5) day notice period described above. In the event of such termination, Hospital shall be bound by the amendment from its effective date through the effective date of termination.

54. No waiver of any provision of this Agreement shall be valid unless in writing and signed by the party against whom such waiver is sought. One or more waivers of any covenant or condition of this

Agreement by any of the parties hereto shall not be construed as a waiver of any subsequent breach or of other covenants or conditions.

55. To the extent Hospital is executing this Agreement on behalf of any subsidiary entity, business line or division of Hospital (each a "**Hospital Entity**") each such Hospital Entity is listed on Exhibit C hereof. With respect to each such Hospital Entity, Hospital represents and warrants to THP that it has the authority to bind and hereby binds each such Hospital Entity to the terms and conditions set forth herein. In furtherance of the foregoing, Hospital shall cause an authorized representative of each such current and future Hospital Entity to acknowledge such Hospital Entity's duties and obligations hereunder by executing the form attached hereto as Exhibit D. Copies of such exhibits for each Hospital Entity shall be provided to THP upon request.

56. **No Billing of Members** No **Charges.** Hospital shall hold harmless and not impose any charges on THP members for Plan benefits and shall regard the THP payment as payment in full for all benefits covered by this Agreement with the exception of co-payments specifically authorized in the applicable Evidence of Coverage and any non-plan benefits. Hospital shall also be entitled to receive payment for third party claims. Hospital will never, under any circumstances, including non-payment by THP, the insolvency of THP, or breach or termination of this Agreement, seek compensation from, have any recourse against, or impose any additional charge on any THP member for Plan benefits. Hospital shall look only to THP for payment for plan benefits. If THP receives notice that Hospital has billed or collected from a Member for any covered or non-authorized benefit, THP may refund that amount to Member and may offset that amount from any payment to Hospital, with prior notice to the Hospital.

57. **No Collection Action against Members.** Neither Hospital, trustees nor assignees, may maintain any action at law against Member to collect sums owed by HMO.

58. **Survival of Covenants.** Participating Provider further agrees that these provisions 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 these provisions supersede any oral or written agreement to the contrary now existing or hereafter entered into between Participating Provider and Member or any persons acting on their behalf.

59. **Collections of Co-payments.** These provisions shall not preclude Participating Provider form collecting the Co-payments that are specifically authorized by the Member's Evidence of Coverage.

60. **Non-Covered Services.** A Participating Provider may bill a Member for services if:(i) prior to receiving such services the Member is advised that such services are not Covered services; and,(ii) after being so advised the Member nevertheless elects in writing to receive such non-Covered Services.

61. This Agreement constitutes the entire understanding and agreement between the parties regarding the subject matter hereof, and supersedes all prior agreements, oral or written, regarding the subject matter hereof.

62. Notwithstanding anything to the contrary herein, Hospital shall be fully responsible for the acts and omissions of each Hospital Entity as if they were the acts and omissions of Hospital. In furtherance of the foregoing, Hospital represents and warrants that each Hospital Entity is either a legitimate business line or division of Hospital or a separate legal entity duly formed and in good standing under the laws of the State of West Virginia and is owned or controlled by Hospital. Hospital further represents and warrants to THP that all information provided by or on behalf of each Hospital Entity, including, without limitation, all information provided on Exhibits B and C are true, accurate and complete.

-go to next page

IN WITNESS WHEREOF, the parties hereto have caused this Agreement to be executed to be effective as of date THP executes this Agreement (the "**Effective Date**").

TRUSTED HEALTH PLANS, INC.
1100 New Jersey Avenue, SE, Suite 840
Washington, D.C. 20003

By:_____
Chika Duru
General Counsel

Date:_____

HOSPITAL

By:_____

Date:_____

EXHIBIT A

COVERED SERVICES AND PAYMENT ARRANGEMENT FOR MEDICAID SERVICES

1. Covered Services. The Covered Services shall consist of all services that are covered by the West Virginia Department of Health and Human Resources Bureau for Medical Services Medicaid programs, subject to the terms of this Agreement, and all rules, regulations, policies and procedures of the Medicaid Program, and THP's authorization for referral services.

(FEE SCHEDULE)

EXHIBIT B

COVERED SERVICES AND PAYMENT ARRANGEMENT FOR MEDICARE SERVICES

3. Covered Services. The Covered Services shall consist of all services that are covered by the Medicare Advantage program, subject to the terms of this Agreement, and all rules, regulations, policies and procedures of the Medicare program, and THP's authorization for referral services.

4. THP will pay Hospital for Covered Services at 100% of the then current Medicare fee schedule.

EXHIBIT C

HOSPITAL ENTITIES

Entity/Division Name: _____

Tax ID (indicate if same as Hospitals): _____

Street Address: _____

City, State, Zip: _____

E-Mail: _____

Phone: _____

Entity/Division Name: _____

Tax ID (indicate if same as Hospitals): _____

Street Address: _____

City, State, Zip: _____

E-Mail: _____

Phone: _____

Entity/Division Name: _____

Tax ID (indicate if same as Hospitals): _____

Street Address: _____

City, State, Zip: _____

E-Mail: _____

Phone: _____

-make additional copies if necessary

EXHIBIT D

ACKNOWLEDGEMENT AND AGREEMENT

The undersigned acknowledges and agrees that (i) he/she is an authorized representative of the entity, business line or division listed below, (the "**Hospital Entity**"); (ii) he/she has been provided with a copy of the Plan/Referral Hospital Participation Agreement ("**Agreement**") between THP and Hospital; (iii) the Hospital Entity provides or will be providing services pursuant to such Agreement on behalf of Hospital; (iv) the Hospital Entity agrees to be bound by the terms and conditions of the Agreement with respect to its provision of services thereunder; and (v) neither the Hospital Entity nor any individual or entity employed by or under contract with the Hospital Entity is or has ever been excluded from Medicare, Medicaid or any other third party payer program, and the Hospital Entity will promptly notify THP and Hospital of any change in its or any such individual's or entity's participation status with any such program. The Hospital Entity is responsible for notifying THP of any changes to the information contained in this acknowledgement. Amendments to this exhibit may be submitted to THP's Credentialing Department by sending a written notice to the attention of the Credentialing Department 1100 New Jersey Avenue, SE, Suite 840, Washington, DC 20003.

Entity/Division Name:

Tax ID (indicate if same as Hospitals):

Signature:

Print Name: _____

Date:

-make additional copies if necessary

AGREEMENT AND LETTER OF INTENT BETWEEN
MULTIPLAN, INC AND TRUSTED HEALTH PLANS, INC.

This Agreement and Letter of Intent ("Agreement and LOI") is entered into between MultiPlan, Inc., on behalf of itself and its subsidiaries (collectively referred to herein as "MPI") and Trusted Health Plans, Inc. ("Client"), effective March 1, 2016.

1. **Background and Purpose.**

MPI has entered into and maintains commercial health networks of professional, ancillary and facility providers ("Network Providers") who have agreed to provide covered health care services to MPI's client participants at contracted rates as reimbursement for such health care services ("Network Provider Agreement"). Client desires to purchase and utilize certain MPI developed and maintained demographic extract files containing data elements of its Network Providers ("Data Information") for the purpose of: (1) filing the Data Information in its application to the West Virginia Department of Insurance ("DOI") for a Certificate of Authority ("COA") to offer commercial health plan; and (2) submitting a bid to the West Virginia Department of Health and Human Services, Bureau for Medical Services ("BMS") to offer health plan services to the West Virginia Mountain Health Trust Managed Medicaid Program ("WV Managed Medicaid Program") members, (collectively referred to as "Filing Services") (Client's commercial health plan and WV Managed Medicaid Programs are collectively referred to as "Programs"). Upon award by DOI and/or BMS, the Client will be authorized to arrange for provisions of the services for its members enrolled in the Program(s) ("Participants"). Both parties acknowledge that an agreement (the "Final Agreement") is being negotiated between MPI and Client for the purpose of providing Client with access to the MPI's various health care cost management services, including but not limited to access to MPI's network(s) of Network Providers for covered services under the Client's Program(s)("Network Services"). The purpose of this Agreement and LOI is to set forth the parties' understandings with respect to the terms and conditions of the Filing Services, outline the terms and conditions of the Final Agreement, and to evidence the intent of each party to proceed in good faith to complete the negotiation of such Final Agreement consistent with the terms of this Agreement and LOI.

Proposed Scope of Final Agreement.

If parties are able to agree on and execute the Final Agreement, it shall include, but shall not limited to, the following terms:

Client's Obligations:

Client shall pay Network Providers for covered services rendered to Participants in accordance with Network Provider Agreements for the Program(s), except that Client shall not be required to accept all MPI's Network Providers for participation in Client's Program(s) network. Upon written request by Client, with or without cause (unless prohibited by law), MPI shall exclude from participation under the Final Agreement any Network Provider identified by Client.

TRUSTED Health Plan
THP

Trusted is responding to a Centralized Request for Quotation ("CRFQ"), solicitation number BMS1600000002, which has been issued by the West Virginia Department of Administration, Purchasing Division, for managed care services. Trusted has contracted with MultiPlan to provide provider services. In the event that Trusted is successful through the award of a contract by West Virginia Department of Health and Human Services, Trusted will contract with Hospitals in the state.

See Electronic Network Analysis and Provider list.

TRUSTED Health Plan
THP

POLICY TITLE: APPEALS

PURPOSE: Trusted maintains a process for enrollees to appeal any delayed, modified, or denied request for health care service, if the enrollee believes that health care services have been improperly denied, modified, or delayed. An appeal is a request to change a previous decision made by the organization, including the outcome of a complaint.

Trusted maintains a process for enrollees to request an independent medical review ("IMR") of disputed health care services if the enrollee believes that health care services have been improperly denied, modified, or delayed.

SCOPE: This policy document is applicable to all staff, as well as delegated entities. This policy applies to complaints, as well as benefit and medical necessity appeals for pre-service, post-service, concurrent, expedited and external appeals.

DEFINITIONS:

1. Appeals are defined as a request for review of an action. An action is defined as:
    a. The denial or limited authorization of a requested service, including the type or level of service.
    b. The reduction, suspension, or termination of a previously authorized service.
    c. The denial, in whole or in part, of payment for a service.
    d. The failure to provide services in a timely manner, as defined by the State of West Virginia.
    e. The denial, for a resident of a rural area with only one contractor, of a Medicaid enrollee's request to exercise his or her right to obtain services out of network.

2 Eligibility for expedited appeals: Requests for expedited appeals are evaluated for the following. If the case meets any of these criteria, the case is handled in an expedited manner, per the procedures and timelines delineated in this procedure.
    a. A delay that could seriously jeopardize the life or health of the member or the member's ability to regain maximum function, based on a prudent layperson's judgment;
    b. In the opinion of a practitioner with knowledge of the member's medical condition, would subject the member to severe pain that cannot be adequately managed without the care or treatment that is the subject of the request.
    c. All requests concerning admissions, continued stay or other health care services for a member who had received emergency services but has not been discharged from a facility.

    If a case is deemed to meet the expedited appeal criteria above, Trusted does not require an enrollee to file their request in writing. If Trusted denies an enrollee's request for an expedited appeal, the appeal is processed according to the standard appeal timeframe. The enrollee is notified, in writing, within two business days of the decision not to expedite the appeal. An

attempt is also made to notify the appellant telephonically. No punitive action is taken against an enrollee for filing or supporting an expedited appeal.

For concurrent review cases, Trusted allows the appellant continued coverage under their medical benefit pending the outcome of their appeal. This policy applies to cases where Trusted has approved an ongoing course of treatment and subsequently decides to deny, reduce or terminate the approved course of treatment.

PROCEDURE:

1 Appeals are accepted up to one year after the notification of the denial. Appeals may be received from a member, practitioner on the member's behalf, legal representatives of a deceased enrollee's estate, or the member's authorized representative. Providers must have the enrollee's written consent to file an appeal on their behalf.

1.1 Trusted will continue enrollee benefits pending resolution in the enrollee or provider files the appeal timely. The request for a continuation of benefits must be made within 10 days of the NOA.

1.2 Trusted will continue the enrollee's benefits pending resolution if the services were ordered by an authorized provider.

1.3 If an appeal request is received more than one year after the initial notification of denial, the appeals coordinator documents this fact and informs the appellant that Trusted cannot process the appeal, as the request exceeded the allowed timeframe. The notification is both telephonic and in writing.

1.4 If the request is made outside of business hours, the appeals request is received by the on-call nurse response line. The on-call nurse evaluates the urgency of the expedited request.

1.4.1 The request qualifies for an expedited process if either of the following circumstances is met:

- Could seriously jeopardize the life or health of the member or the member's ability to regain maximum function, based on a prudent layperson's judgment; or
- In the opinion of a practitioner with knowledge of the member's medical condition, would subject the member to severe pain that cannot be adequately managed without the care or treatment that is the subject of the request.
- All requests concerning admissions, continued stay or other health care services for a member who had received emergency services but has not been discharged from a facility.

1.4.2 If the request meets any of these criteria, the case is treated as expeditiously as the medical condition requires, and is resolved within 72 hours of the request.

The procedural steps for the appeal outlined below are all completed within this time frame.

1.4.3 If the request fails to meet the qualifications for an expedited process the case proceeds within the standard timeframes.

1.4.4 The after-hours, on-call nurse informs the appeals coordinator (or Director of the Quality Management Department) of receipt of the appeal request after-hours, and the determination about whether the case shall be handed within the expedited timeframes or under the standard appeal timeframes.

2 The appeals coordinator documents the substance of the appeal in the Care Connect system. The appeals coordinator acknowledges receipt of the appeal request within two business days of receipt by sending a written acknowledgement letter to the appellant, which includes the enrollee's rights during the appeal process. Trusted uses the date that an appeal was received orally to establish the earliest possible filing date. Enrollee rights are listed below.

2.1 Enrollees have the right to participate in Trusted's appeal process, as well as present and review information and documents relevant to their case, either in person or via telephone.

2.2 With the exception of an expedited appeal, oral appeals must be followed by a written, signed request for appeal by the enrollee or his authorized representative within ten business days.

2.3 If the appeal request is verbal and the appellant has difficulty or cannot document the appeal in writing, the appeals coordinator assists the member in documenting the appeal by completing an appeal request form. If a language barrier is evident, the appeals coordinator arranges for translation services to assist in documentation of the appeal.

2.4 If the appellant has difficulty expressing the appeal to the appeal coordinator either verbally or in writing, cultural or linguistic issues may be involved.

For linguistic issues the translation vendor is immediately contacted via telephone and a three-way conversation takes place to elicit the information needed to document the appeal. The appeal coordinator assesses for any cultural sensitivities regarding the member's appeal.

2.4.1 If cultural barriers are identified, the appeals coordinator identifies a culturally appropriate staff member or other resource (e.g., female for a female appellant, male for a male appellant, someone of the same cultural background as the appellant, someone familiar with the cultural preferences of the appellant, etc.), who discusses the case with the member and documents the appeal in writing. The appellant's cultural preferences are included in this documentation.

2.4.2 The member's cultural and linguistic preferences are documented in the appeal case file for all staff involved to review and follow going forward.

2.4.3 If language barriers are present and the language the member is able to read can be identified, future member correspondence regarding the appeal is translated into the member's preferred language.

3 If the appeal is received by an employee other than the appeals coordinator, upon receipt of a written appeal, the appeal is time- and date-stamped and forwarded immediately to the appeals unit within the Quality Management Department. and the appeals coordinator, for processing.

4 The Appeals Coordinator logs the appeal request into the appeals database, prepares an acknowledgement response letter for the member and/or practitioner, and faxes and mails the acknowledgment within 2 calendar days of receipt of the request.

4.1 The acknowledgment letter includes the estimated date that a decision regarding the appeal will be made.

4.2 The member is provided the opportunity to submit written comments, documents records and other information relevant to the appeal.

4.3 The member may be represented in the appeals process by anyone they choose, including an attorney. Members are informed of this right in the appeal acknowledgement letter.

4.4 Members are allowed reasonable access to and copies of all documents relevant to the appeal, free of charge, upon request.

4.4.1 After a request is received by the appellant or representative for access to the documents relevant to the appeal, the appeal coordinator notified the chief privacy officer of the request for case files

4.4.2 The appeals coordinator gathers all documents relevant to the appeal which were requested and forwards them to the chief privacy officer for review.

4.4.3 The chief privacy officer reviews the documents to ensure that the materials to be forwarded are consistent with HIPAA requirements. S/he consults the medical director as needed. The documents are prepared for the member's review.

4.4.4 The appeals coordinator arranges for the member to either review the documents on-site, or to forward the documents to the appellant via certified, return receipt mail.

4.4.5 If the member chooses an on-site review, a clinician is available to the member during the document review to answer any questions the member may have. The meeting is located in a private location within the Trusted's office space.

4.5 If the appeal request is for an expedited appeal, the Appeals Coordinator verbally acknowledges the receipt of the appeal and follows with the written acknowledgement within 24 hours.

5 The Appeals Coordinator compiles all the information relevant to the appeal, including any aspects of clinical care involved, as well as any additional information received from the member or his/her authorized representative and forwards the case to the Clinical Quality Manager for review.

6 A full investigation of the substance of the appeal ensues, including any aspects of clinical care involved.

6.1 If the information meets benefit or medical necessity criteria, the Clinical Quality Manager may overturn the prior decision and approve the request.
6.2 If the information fails to meet benefit or medical necessity criteria, the Clinical Quality Manager forwards the case to the medical director, or designee, for further investigation and research.

7 The file is forwarded to a medical director (or designee) who determines the correct practitioner to review the appeal.
7.1 Benefit determinations may be made by a Trusted staff member not involved in the initial denial. A qualified consultant with experience and familiar with Trusted benefits may be asked to review the case and provide their opinion. The Trusted medical director (or physician designee) will make the final benefits appeal decision.
7.2 If the case is a medical necessity decision, it is assigned and reviewed by a board certified, licensed physician (or other appropriate licensed practitioner, such as an oral surgeon for oral surgery cases, chiropractor for chiropractic cases, physical therapist for physical therapy cases, psychologist for psychological testing cases, etc.):
- With appropriate expertise to evaluate the case
- Who practices in a same or similar specialty that typically treats the medical condition, performs the procedure or provides the treatment (for medical necessity appeals only)
- Who was not a prior decision-maker in the case, and
- Who is not the subordinate of any person who made a prior determination in the case.

7.3 If Trusted's CMO was originally involved in the initial denial and must recuse him or herself, the file is forwarded to a physician reviewer via overnight mail or secured fax or email to the appropriate contracted peer review organization for review and decision.

8 The reviewing practitioner evaluates the request, conducts additional research as necessary (such as requesting additional information, contacting the treating practitioners), consults Trusted UM decision criteria and benefit materials, evaluates network capacity, etc., then renders a decision on the appeal.
8.1 The decision, as well as the documentation supporting the decision, is communicated to the appeals coordinator.
8.2 If the case was sent to an outside agency for decision, the case materials are returned or destroyed.
8.3 In all cases, the deciding practitioner documents and communicates the rationale for the decision, including relevant case facts and the associated medical necessity criteria used to make the decision.

9 The Appeals Coordinator ensures prompt notice to the enrollee and the enrollee's treating practitioner of the decision.
9.1 The appeals coordinator communicates the appeal decision via telephone within 24 hours.

10 Written notification is transmitted within 3 working days of the decision, and within the timeframes in the table below. Written notification is provided to the member/guardian/member representative/legal representatives of a deceased enrollee's estate, and the treating practitioner and/or facility (as appropriate).

11 The Appeals Coordinator prepares and issues the written appeal decision. The appeal decision letter includes the following:

a. The specific reasons for the appeal decision, in easily understandable language;
b. A reference to the benefit provision, guideline, protocol, or other similar criterion on which the appeal decision was based
c. Notification that the member, upon request, can obtain a copy of the actual benefit provision, guideline, protocol, or other similar criterion on which the appeal decision was based
d. Notification that the member is entitled to receive, upon request, free of charge, reasonable access to and copies of all documents relevant to the appeal. Relevant documents include documents or records relied upon in making the appeal decision and documents and records submitted in the course of making the appeal decision.
e. Notification to the member about further appeal rights
f. Notification to the member about the right to request to continue to receive benefits while the Bureau for Medical Services is pending.
g. A list of titles and qualifications, including the specialty of the individual conducting the medical necessity review, and of individuals participating in the appeal review. NOTE: Appeal participant names do not need to be included in the written notification to members, but must be provided to members upon request
h. Specific notification to the member of the right to submit the appeal to the Bureau of Medical Services
i. Specific notification to the member of the right to submit the appeal to the Office of the Insurance Commissioner.
j. Specific notification to the member of the right to request a State Fair Hearing, by contacting the local DHHR office.
k. If Trusted completely overturns the denial, the appeal notice will state the decision and the date of decision, and may not include the items listed above

12 The Appeal Coordinator logs the information into the appeal database, including the date of the decision, date(s) of notification, the parties notified, and the decision rendered.

13 **Independent Review Organization Review**

In the event a denial is upheld in the appeal process, the appellant is offered the option of review by an independent review organization (IRO). Instructions on how to initiate a case review by the IRO are included in the denial and appeal decision letters.

13.1 If the member chooses to initiate a IRO review of the case, all case information is copied and forwarded to the IRO. Any further assistance is provided upon request.

13.2 Members are notified annually and with each appeal request of the availability of the right to independent review. Members with eligible internal appeals receive specific notification via mail detailing independent review rights and processes, including contact information for the IRO.

14 Appeal Timeframes

Timeframes for urgent (expedited) and non-urgent appeals are contained in the table below.

Appeal Type	[illegible] Request to Decision and Written Notification
Non-urgent, pre-service and post-service	30 calendar
Expedited/urgent pre-service and concurrent*	72 hours

* Urgent appeals are resolved as expeditiously as the medical condition requires, and no later than the timeframes specified.

Appeal timeframes noted may be extended by up to five calendar days upon enrollee request or where Trusted demonstrates to the Department of Health the need for additional information and that the extension is in the enrollee's best interest. Where Trusted decides the decision timeframe should be extended, a grievance and appeals team member sends a letter to the enrollee informing them of the delay in decision and the reason for such delay. Trusted must notify the member of his/her right to file a grievance if he/she disagrees with a decision to extend the timeframe for the authorization decision. Trusted will issue and carry out its determination as expeditiously as the enrollee's health condition requires and no later than the date on which the extension expires.

For service authorization decisions not reached within the periods specified, a decision will be made on the date on which the extended period expires.

15 Continued Coverage for Concurrent Cases

For concurrent care UM cases, Trusted allows the appellant continued coverage under their medical benefit, pending the outcome of their appeal. This policy applies to cases where Trusted has approved an ongoing course of treatment and subsequently decides to deny, reduce or terminate the course of treatment. If the enrollee requests an extension of benefits, Trusted will continue or reinstate the enrollee's benefits pending resolution or until the enrollee withdraws the appeal.

15.1 In rare circumstances a concurrent review case may be reviewed as part of ongoing UM processes and the reviewing physician determines that the previously approved length of treatment or the number of services case should be changed.
15.2 In these cases Trusted will continue to cover and pay for the previously approved services.
15.3 At the end of the term of the approved services the case will be evaluated for additional services, per the procedures above.

16 Continuation of coverage

Trusted will continue to provide benefits to the enrollee while the appeal and the state fair hearing are pending.

1. Trusted will continue the enrollee's benefits pending resolution if the enrollee requests an extension of benefits. The request for the continuation of benefits must be made within ten (10) days of the NOA.
2. Trusted will continue the enrollee's benefits pending resolution if the appeal involves the termination, suspension, or reduction of a previously authorized course of treatment.
3. Trusted will continue the enrollee's benefits pending resolution if the services were ordered by an authorized provider.
4. Trusted will continue the enrollee's benefits pending resolution if the period covered by the original authorization has not expired.
5. Trusted will continue or reinstate the enrollee's benefits while the appeal is pending until the enrollee withdraws the appeal.
6. If Trusted continues or reinstates the enrollee's benefits while the appeal is pending, the following applies:
    a. The benefits must be continued until a State Fair Hearing Officer issues a hearing decision adverse to the enrollee.
    b. The benefits must be continued until the time period or service limit of a previously authorized service has been met.
    c. The benefits need not be continued past 10 days after Trusted mails notice of an adverse resolution unless the enrollee has requested continuation of benefits pending a state fair hearing decision.
7. Trusted will not recover payment for continuation of benefits during a pending appeal or State Fair Hearing.

17 Effectuation of Appeals Decisions

If Trusted reverses or modifies a decision through the appeals process or is notified of the State Fair Hearing decision to reverse a decision, the service shall be authorized, provided, and paid for as promptly and as expeditiously as the member's health condition requires, but

no later than two (2) working days after reversal or notification of reversal from the State of West Virginia. In the case of an expedited appeal, services must begin within 24 hours of the reversal.

17.1 Notification from the appeals process or State Fair Hearing office is forwarded to the UM department.

17.2 A clinician in the UM department processes the service approval/s electronically.

17.3 The clinician notifies the member/guardian/authorized representative and treating practitioner or facility of the approval via telephone and in writing. If a delegate which is responsible for approval/claims payment is involved (such as the PBM), the Trusted appeals coordinator or clinician notifies the responsible party at Trusted or at the delegate that service/payment has been authorized for the payment.

17.4 The service for the member ensues (if a prior authorization or concurrent review decision).

17.5 If a retrospective decision, the claim is paid electronically. If the service is a prior authorization or concurrent review decision, the claim is paid when received.

TRUSTED Health Plan
THP

Grievances and Appeals

Trusted is responding to a Centralized Request for Quotation ("CRFQ"), solicitation number BMS1600000002, which has been issued by the West Virginia Department of Administration, Purchasing Division, for managed care services. In the event that Trusted is successful through the award of a contract by West Virginia Department of Health and Human Services, Trusted will provide to enrollees the following Grievances and Appeals information:

- Formal and informal steps to resolve grievances
- Toll-free number to call to present an informal grievance or to contact a grievance coordinator
- An address for written grievances

Trusted member handbook provides enrollees with the following:

- A detailed description of the appeal process
- A description of the statute of limitations for filing grievances
- A statement outlining the timeframe in which grievances are processes
- A statement that there is physician involvement in the review of medical – related grievances
- A statement that time sensitive grievances will be handled on an expedited basis.

See Section 20- Member Handbook- Appeals and Grievances

TRUSTED Health Plan
THP

POLICY TITLE: Complaints and Grievances

PURPOSE: THP recognizes that an effective complaint and grievance protocol is essential to the quality improvement process. Therefore, THP has a multi-level mechanism in place in which it processes inquiries, complaints and grievances. This policy is designed to comply with the requirement of accrediting bodies and other regulatory agencies.

The purpose is to ensure that the right of all participating members and providers to seek recourse when dissatisfied with THP, or its services is respected.

SCOPE: This policy applies to all departments within THP. The outlined responsibilities are the assignment of the designated Complaints and Grievances Coordinator.

DEFINITIONS:

I. Complaint: An expression of dissatisfaction about any matter related to the provision of health care delivery other than an Action.

2. Action:
   i. The denial or limited authorization of a requested service, including the type or level of service;
   ii The reduction, suspension, or termination of a previously authorized service,
   iii. The denial, in whole or in part of payment for a service;
   iv. The failure to provide services in a timely manner as defined by DHHS: or
   v. The failure of THP to act within the timeframes for resolution and notification of complaints and grievances.
3. Grievance: A written expression of dissatisfaction about any matter other than an Action. The term is also used to refer to the overall system that includes grievances and appeals at THP and access to the Fair Hearing Process.

4. Medicaid Member Advocate: Employee of Trusted Health Plan that serves as an advocate for members, and makes recommendation to Plan regarding resolution of complaint and/or grievance.
5. Timeframes: A telephonic response will be provided within the timeframes indicated below:
   - Medical emergency related issues will be resolved within twenty-four (24) business hours.
   - Quality of service and care issues will be resolved within fourteen (14) business days.

- Administrative issues will be resolved within thirty (30) business days. THP may extend the thirty (30) day timeframe by up to fourteen (14) days if the member or the member's representative requests an extension or if THP shows to the satisfaction of DHHS that there is a need for additional information and how the delay is in the member's interest. The member will be given written notice of the reason for the delay.
- Inquiries will be processed immediately.

PROCEDURE:

Complaints and Grievance Tracking system

THP maintains a record-keeping and tracking system to document all Complaints and Grievances and will make available to DHHS and supporting documentation upon request. The system will capture:

1. Whether the matter is a complaint or a grievance;
2. The subject/ category of each complaint or grievance;
3. The member's PCP and the provider involved in the complaint or grievance (if different from PCP);
4. How the matter was resolved; and
5. What, if any, corrective action was taken by THP.

Function:

1. When a complaint is administrative in nature, THP staff documents the complaint on the complaint intake form or electronically in MHC and routes the complaint to the Complaints and Grievances Coordinator who will:
   a. Document all pertinent information pertaining to the call/correspondence on the complaint log;
   b. Investigate the concerns;
   c. Coordinate with other departments within THP if necessary to reach a solution;
   d. Document the nature of the issue, the intervention, and the resolution in the complaint database;
   e. The following individuals will be notified, telephonically (in writing upon request) of the actions taken and resolution and right to appeal:
      - Member.

- Physician or Hospital.
- Department Head.
- West Virginia Department of Health and Human Services

2. THP will notify enrollees and potential enrollees that oral interpretation is available for any language and written information is available in prevalent languages and how to access those services during the complaint process.

3. When a call is medical in nature, such as issues regarding injury, medical misadventure, neglect or abuse, the call is classified as a "Risk Management Event" and forwarded to the Clinical Quality Manager who will:

a. Report the issue to the Senior Director of Quality Management within twenty-four (24) hours of receipt for investigation;
b. Document all pertinent information related to the call on the Complaint Intake Form;
c. Follow-up with the Senior Director of Quality Management for closure.

4. When an issue is related to a medical emergency or regarding the authorization of medical services, the Complaints and Grievance Coordinator will:

a. Coordinate with the Utilization Management Department/Chief Medical Officer for investigation and resolution.
b. Inform the Chief Medical Officer when an urgent determination of medical appropriateness has been requested.
c. Document the nature of the problem and the resolution in the database.
d. Follow-up with the Chief Medical Officer for closure.

5. If an issue has not been resolved in a timely manner to the satisfaction of the enrollee or provider, the complainant may present a grievance to an ad hoc First Level Grievance Review Committee. This Committee will be comprised of no less than three employees of THP. Members of this Committee will be chosen at the discretion of the Chief Medical Officer depending on the nature of the grievance.

6. A grievance may be filed in writing or orally with THP. All grievances will be acknowledged upon receipt, both orally and in writing, utilizing the Grievance Acknowledgement Letter. Any of the following may invoke the grievance procedure under this section by filing with THP within ninety (90) days of determination notice:

a. The enrolled individual affected by the determination (or in the case of an enrolled adolescent);

4. The Satisfaction Survey data gathered in the complaint tracking database will be utilized during the analysis of annual member survey data to ensure that accurate scores are acquired for the complaint handling section of the survey.

5. The complaint process will be reviewed annually by the Quality Executive Committee to ensure continuous improvement.

6. Results and recommendations of the evaluation will be communicated to the respective directors, managers and staff.

7. Complaint and Grievance Reports will be submitted to the Department of Healthcare Finance on a monthly basis.

TRUSTED Health Plan
THP

Grievances and Appeals Staff

Trusted is responding to a Centralized Request for Quotation ("CRFQ"), solicitation number BMS1600000002, which has been issued by the West Virginia Department of Administration, Purchasing Division, for managed care services. In the event that Trusted is successful through the award of a contract by West Virginia Department of Health and Human Services, Trusted will provide the name of the responsible employee for implementation of the Grievance procedure.

Judith Hinton, M.B.A., B.S.N., RN, Senior Director of Clinical Program is responsible for Grievances and Appeals at Trusted Health Plan DC market.

NCQA
Measuring quality
Improving health care.

February 29, 2016

Thomas Duncan
Chief Executive Officer
DC Trusted Health Plan, INC.
1100 New Jersey Avenue, SE Suite 840
Washington, DC 20003

Dear Mr. Duncan:

We are pleased to inform you that based on the information gathered during your recent HP survey, the National Committee for Quality Assurance (NCQA) Review Oversight Committee has awarded DC Trusted Health Plan, INC. the accreditation status(es) listed below. The final assessment report, which incorporates relevant changes made in response to your organization's earlier comments, is now ready for your review. You may now access the final report and results online by visiting https://iss.ncqa.org and looking under the section entitled Survey and Results.

Product Line/ Product	Accreditation Status	Effective Date	Expiration Date
Medicaid-HMO	Accredited	February 29, 2016	March 1, 2019

The NCQA Health Plan Report Card will be updated to reflect this status by no later than the 15th of March. A certificate reflecting your accreditation status(es) is enclosed in recognition of your achievement. Also, for your convenience, you may download the NCQA accreditation seal by visiting our Web site at www.ncqa.org. Please refer to the 'Guidelines for Advertising NCQA HPA Survey Accreditation,' enclosed.

If you have reason to believe that the compliance scoring of any standard or standards does not accurately reflect your organization's compliance with the standards, you have the opportunity to request a reconsideration of compliance designations and/or accreditation outcome by the NCQA Reconsideration Committee. To proceed with reconsideration, NCQA must receive within the next 30 days a written request for reconsideration that addresses at least one of the grounds for appeal identified in the Reconsideration section of the "Administrative Policies and Procedures" of the 2015 *Standards and Guidelines for the Accreditation of Health Plans*. This request must not exceed five pages in length and must include a listing of the standards for which reconsideration is being requested. A fee, as specified in the Agreement for HP Accreditation Survey, "Pricing Methodology and Cancellation Policy" (Exhibit A), is charged for reconsideration. The fee must be paid at the time reconsideration is requested.

NCQA
Measuring quality. Improving health care

National Committee for Quality Assurance

has awarded

DC Trusted Health Plan, INC.

Medicaid HMO

an accreditation status of

ACCREDITED

for service and clinical quality that meet or exceed NCQA's rigorous requirements for consumer protection and quality improvement.

Doris Chin, MD
CHAIR, BOARD OF DIRECTORS

Margaret Scott
PRESIDENT

CHAIR, REVIEW OVERSIGHT COMMITTEE

February 29, 2016
DATE GRANTED

March 1, 2019
EXPIRATION DATE

e-LE

Summary and Detailed Results

Organization: DC Trusted Health Plan, INC. **Stage:** Final Report
Project: 27117 **Evaluation option:** First Survey
Product Medicaid HMO **Date:** 3/1/2016
Line/Product:

[Note * indicates a Must Pass element]

Total Received: 48.93 out of a Possible: 50.69

Quality Management and Improvement	Points Received	Possible Points	Percentage Score (%)
QI1 A	0.27	0.27	100.00
QI1 B	0.17	0.17	100.00
QI1	**0.44**	**0.44**	
QI2 A	0.36	0.36	100.00
QI2 B	0.09	0.09	100.00
QI2	**0.45**	**0.45**	
QI3 A	0.32	0.32	100.00
QI3 B *	0.17	0.17	100.00
QI3 C	0.32	0.32	100.00
QI3	**0.83**	**0.83**	
QI4 A	0.32	0.32	100.00
QI4 B	0.36	0.36	100.00
QI4 C	0.36	0.36	100.00
QI4 D	0.36	0.36	100.00
QI4	**1.42**	**1.42**	
QI5 A	0.29	0.36	80.00
QI5 B	0.45	0.45	100.00
QI5 C	0.45	0.45	100.00
QI5	**1.20**	**1.27**	
QI6 A	1.32	1.32	100.00
QI6 C	0.31	0.31	100.00
QI6	**1.64**	**1.64**	
QI7 A	0.27	0.27	100.00
QI7 B	0.08	0.08	100.00
QI7 C	0.10	0.13	80.00
QI7 D	0.13	0.13	100.00
QI7 E	0.04	0.08	50.00
QI7 F	0.16	0.16	100.00
QI7 G	0.04	0.08	50.00
QI7 H	0.08	0.08	100.00
QI7 I	0.08	0.08	100.00
QI7 J	0.00	0.27	0.00
QI7	**1.06**	**1.44**	
QI8 A	0.15	0.30	50.00
QI8 B	0.01	0.15	10.00
QI8 C	0.00	0.00	0.00
QI8 D	0.15	0.15	100.00
QI8 E	0.20	0.20	100.00
QI8 F	NA	NA	NA
QI8 G	0.20	0.20	100.00
QI8 H	0.04	0.20	20.00
QI8 I	0.07	0.08	80.00
QI8 J	0.24	0.30	80.00
QI8	**1.10**	**1.73**	

Utilization Management	Points Received	Possible Points	Percentage Score (%)
UM1 A	0.09	0.09	100.00
UM1 B	0.09	0.09	100.00
UM1 C	0.09	0.09	100.00
UM1 D	0.09	0.09	100.00
UM1	**0.36**	**0.36**	
UM2 A	0.18	0.36	50.00
UM2 B	0.36	0.36	100.00
UM2 C	0.36	0.36	100.00
UM2	**0.90**	**1.16**	
UM3 A	0.36	0.36	100.00
UM3	**0.36**	**0.36**	
UM4 A	0.24	0.24	100.00
UM4 B	0.24	0.24	100.00
UM4 C *	0.24	0.24	100.00
UM4 D	0.24	0.24	100.00
UM4 E	0.14	0.14	100.00
UM4 F	0.14	0.14	100.00
UM4	**1.27**	**1.27**	
UM5 A	0.36	0.36	100.00
UM5 B	0.36	0.36	100.00
UM5 C	0.36	0.36	100.00
UM5 D	0.36	0.36	100.00
UM5	**1.67**	**1.67**	
UM6 A	0.34	0.34	100.00
UM6 B	0.19	0.19	100.00
UM6	**0.54**	**0.54**	
UM7 A	0.19	0.19	100.00
UM7 B *	0.19	0.19	100.00
UM7 C *	0.29	0.29	100.00
UM7 D	0.09	0.09	100.00
UM7 E	0.19	0.19	100.00
UM7 F	0.19	0.19	100.00
UM7	**1.16**	**1.16**	
UM8 A	0.76	0.76	100.00
UM8 B	NA	NA	NA
UM8 C	NA	NA	NA
UM8	**0.76**	**0.76**	
UM9 A	NA	NA	NA
UM9 B	NA	NA	NA
UM9 C	NA	NA	NA
UM9 D *	NA	NA	NA
UM9 E	NA	NA	NA
UM9 F	NA	NA	NA
UM9	**NA**	**NA**	

Organization:	DC Trusted Health Plan, INC.
Evaluation Option:	First Survey
Project:	27117
Standards Year:	2015
Product Line:	Medicaid HMO

View All Recommendations

Quality Management and Improvement

QI1 - Program Structure

Element A
- Recommendation: None

Element B
- Recommendation: None

QI2 - Program Operations

Element A
- Recommendation: None

Element B
- Recommendation: None

QI3 - Health Services Contracting

Element A
- Recommendation: None

Element B
- Recommendation: None

Element C
- Recommendation: None

QI4 - Availability of Practitioners

Element A
- Recommendation: None

Element B
- Recommendation: None

Element C
- Recommendation: None

Element D
- Recommendation: None

QI6 - Accessibility of Services

Element A
- Recommendation: None

Element B
- Recommendation: None

Element C
- Recommendation: None

QI8 - Member Experience

Element A
- Recommendation: None

Element C
- Recommendation: None

QI7 - Complex Case Management

Element A
- Recommendation: None

Element B
- Recommendation: None

Element C
- Recommendation: None

Element D
- Recommendation: None

Element E
- Recommendation:

  Use case management systems that support: -- automated prompts for follow-up, as required (QI 7E.3).

Element F
- Recommendation: None

Element G
- Recommendation:

  Ensure case management files demonstrate that the organization follows its documented processes for: - initial assessment of members' health status, including condition-specific issues (QI 7G.1), - documentation of clinical history, including medications (QI 7G.2), - initial assessment of activities of daily living (QI 7G.3), - initial assessment of mental health status, including cognitive functioning (QI 7G.4), - evaluation of cultural and linguistic needs, preferences or limitations (QI 7G.5), evaluation of visual and hearing needs, preferences or limitations (QI 7G.6, - evaluation of caregiver resources and involvement (QI 7G.7), - evaluation

of available benefits from within the organization and from other community resources (QI 7 G.8), - initial assessment of life planning activities (QI 7G.9).

Element H
- Recommendation: None

Element I
- Recommendation: None

Element J
- Recommendation:

Annually measure the effectiveness of case management program using three measures. For each measure: - identify a relevant process or outcome (QI 7J.1), - use valid methods that provide quantitative results (QI 7J.2), - set a performance goal (QI 7J.3), - have clearly identified measure specifications (QI 7J.4), - collects data and analyze results (QI 7J.5) and - identify opportunities for improvement (QI 7J.6).

QI8 - Disease Management

Element A
- Recommendation:

Ensure the content of the organization's programs addresses the following for each condition:
-Medical and behavioral health comorbidities and other health conditions (e.g., cognitive deficits, physical limitations) (QI 8A.3), Psychosocial issues (QI 8A.5), depression screening (QI 8A.6), Information about the patient's condition provided to caregivers for whom the patient gives consent (QI 8A.7) , , and additional resources external to the organization, as appropriate (QI 8A.9).

Element B
- Recommendation:

Identify members who qualify for DM programs using the following data sources:
- claims or encounter data (QI 8B. 1),
- pharmacy data (if applicable) (QI 8B. 2),
- health appraisal results (QI 8B. 3),
- laboratory results, if applicable (QI 8B. 4),
- data collected through the UM, case management process or care management process (QI 8B. 5), - data from health management, wellness or health coaching programs (QI 8B.6), information from electronic health records (EHR) (QI 8B.7), - member and practitioner referral (QI 8B. 8).

Element C
- Recommendation:

Demonstrate that the organization systematically identifies members who qualify for DM programs:
- at least monthly (QI 8C).

Element D
- Recommendation: None

Element E
- Recommendation: None

Element F
- Recommendation: None

Element G
- Recommendation: None

Element H
- Recommendation:

  Integrate information from the following systems to facilitate access to member health information for continuity of care:
  a health information line (QI 8H.1),
  a UM or care management program (QI 8H.4) and
  a wellness program, if applicable (QI 8H.5).

Element I
- Recommendation: None

Element J
- Recommendation: None

QI9 - Practice Guidelines

Element A
- Recommendation: None

Element B
- Recommendation: None

Element C
- Recommendation: None

Element D
- Recommendation: None

QI10 - Continuity and Coordination of Medical Care

Element A
- Recommendation:

  Identify opportunities to improve coordination of medical care by: Collecting data (QI 10A.1), quantitative and causal analysis of data to identify improvement opportunities (QI 10A.2), identification and selection of four opportunities for improvement (QI10A.4, QI 10A.5, and QI 10A.6).

Element D
- Recommendation: None

Element E
- Recommendation: None

Element F
- Recommendation: None

QI11 - Continuity and Coordination Between Medical Care and Behavioral Healthcare

Element A
- Recommendation: None

Element B
- Recommendation: None

QI12 - Marketplace Network Transparency and Experience

Element A
- Recommendation: None

Element B
- Recommendation: None

Element C
- Recommendation: None

QI13 - Delegation of QI

Element A
- Recommendation: None

Element B
- Recommendation:

  The organization provides the following information to its delegates when requested: member experience data, if applicable (QI13B.1) and clinical performance data (QI 13B.2).

Element C
- Recommendation: None

Element D
- Recommendation: None

Element E
- Recommendation: None

Element F
- Recommendation: None

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Utilization Management

UM1 - UM Program Structure

Element A
- Recommendation: None

Element B
- Recommendation: None

Element C
- Recommendation: None

Element D
- Recommendation: None

UM2 - Clinical Criteria for UM Decisions

Element A
- Recommendation:

  Ensure that the organization: Has written UM decision-making criteria that involves appropriate practitioners in developing, adopting and reviewing criteria (UM 2A.4), and has a process for annually reviewing and updating UM criteria and the procedures for applying them (UM 2A.5).

Element B
- Recommendation: None

Element C
- Recommendation: None

UM3 - Communication Services

Element A
- Recommendation: None

UM4 - Appropriate Professionals

Element A
- Recommendation: None

Element B
- Recommendation: None

Element C
- Recommendation: None

Element D
- Recommendation: None

Element E
- Recommendation: None

Element F
- Recommendation: None

UM5 - Timeliness of UM Decisions

Element A
- Recommendation: None

Element B
- Recommendation: None

Element C
- Recommendation: None

Element D
- Recommendation: None

UM6 - Clinical Information

Element A
- Recommendation: None

Element B
- Recommendation: None

UM7 - Denial Notices

Element A
- Recommendation: None

Element B
- Recommendation: None

Element C
- Recommendation: None

Element D
- Recommendation: None

Element E
- Recommendation: None

Element F
- Recommendation: None

UM8 - Policies for Appeals

Element A
- Recommendation: None

Element B
- Recommendation: None

Element C
- Recommendation: None

UM9 - Appropriate Handling of Appeals

Element A
- Recommendation: None

Element B

- Recommendation: None

Element C
- Recommendation: None

Element D
- Recommendation: None

Element E
- Recommendation: None

Element F
- Recommendation: None

UM10 - Evaluation of New Technology

Element A
- Recommendation: None

Element B
- Recommendation: None

UM11 - Experience With the UM Process

Element A
- Recommendation:

  Annually assess satisfaction with the UM process by: Collecting and analyzing data collecting and analyzing data on practitioner satisfaction for improvement opportunities (UM 11A.2), taking action designed to improve member satisfaction based on its assessment of member data (UM 11A.3) and taking action designed to improve practitioner satisfaction based on its assessment of practitioner data (UM 11A.4).

UM12 - Emergency Services

Element A
- Recommendation: None

UM13 - Procedures for Pharmaceutical Management

Element A
- Recommendation: None

Element B
- Recommendation: None

Element C
- Recommendation: None

Element D
- Recommendation: None

Element E
- Recommendation: None

UM14 - Triage and Referral for Behavioral Healthcare

Element A
- Recommendation: None

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Element B
- Recommendation: None

UM16 - Delegation of UM

Element A
- Recommendation: None

Element B
- Recommendation: None

Element C
- Recommendation: None

Element D
- Recommendation: None

Element E
- Recommendation: None

Element F
- Recommendation: None

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Members' Rights and Responsibilities

RR1 - Statement of Members' Rights and Responsibilities

Element A
- Recommendation: None

Element B
- Recommendation: None

RR2 - Policies and Procedures for Complaints and Appeals

Element A
- Recommendation: None

Element B
- Recommendation: None

RR3 - Subscriber Information

Element A
- Recommendation: None

Element B
- Recommendation: None

RR4 - Physician and Hospital Directories

Element A
- Recommendation: None

Element B
- Recommendation: None

Element C
- Recommendation: None

Element D
- Recommendation: None

Element E
- Recommendation: None

Element F
- Recommendation: None

Element G
- Recommendation: None

Element H
- Recommendation: None

Element I
- Recommendation:

  Ensure the organization evaluates its Web-based physician and hospital directories for understandability and usefulness to members and prospective

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members including: font size (RR 4I.1), reading level (RR 4I.2), intuitive content organization (RR 4I.3), ease of navigation (RR 4I.4), directories in additional languages, if applicable to the membership (RR 4I.5)

Element J
- Recommendation: None

RR5 - Privacy and Confidentiality

Element A
- Recommendation: None

Element B
- Recommendation: None

Element C
- Recommendation: None

Element D
- Recommendation: None

Element E
- Recommendation: None

Element F
- Recommendation: None

Element G
- Recommendation: None

Element H
- Recommendation: None

RR6 - Marketing Information

Element A
- Recommendation: None

Element B
- Recommendation: None

Element C
- Recommendation: None

RR7 - Delegation of RR

Element A
- Recommendation: None

Element B
- Recommendation: None

Element C
- Recommendation: None

Element D
- Recommendation: None

Element E

- Recommendation:

Demonstrate that for delegation arrangements in effect for 12 months or longer, the organization: evaluated regular reports, as specified in Element B (RR 7E.1) and annually evaluates delegate performance against NCQA standards (RR 7E.2).

Element F

- Recommendation:

Provide evidence, for delegation arrangements that have been in effect for more than 12 months, at least once in each of the past 2 years that the delegation has been effect, the organization has identified and followed up on opportunities for improvement (RR 7F).

Member Connections

MEM1 - Health Appraisals

Element A
- Recommendation: None

Element B
- Recommendation: None

Element C
- Recommendation: None

Element D
- Recommendation: None

Element E
- Recommendation: None

Element F
- Recommendation: None

Element G
- Recommendation: None

MEM2 - Self-Management Tools

Element A
- Recommendation: None

Element B
- Recommendation: None

Element C
- Recommendation: None

Element D
- Recommendation: None

MEM3 - Functionality of Claims Processing

Element A
- Recommendation: None

Element B
- Recommendation: None

MEM4 - Pharmacy Benefit Information

Element A
- Recommendation: None

Element B
- Recommendation: None

Element C
- Recommendation:

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Develop a quality improvement process for pharmacy benefit information that:
- collects data on quality and accuracy of pharmacy benefit information (MEM 4C.1),
- analyzes data results (MEM 4C.2),
- takes action on identified deficiencies (MEM 4C.3).

Element D
- Recommendation: None

MEM5 - Personalized Information on Health Plan Services

Element A
- Recommendation: None

Element B
- Recommendation: None

Element C
- Recommendation: None

Element D
- Recommendation: None

MEM6 - Member Support

Element A
- Recommendation: None

MEM7 - Health Information Line

Element A
- Recommendation: None

Element B
- Recommendation: None

Element C
- Recommendation: None

MEM8 - Support for Healthy Living

Element A
- Recommendation: None

Element B
- Recommendation: None

Element C
- Recommendation: None

MEM9 - Delegation of MEM

Element A
- Recommendation: None

Element B
- Recommendation: None

Element C

- Recommendation: None

Element D
- Recommendation: None

Element E
- Recommendation: None

Element F
- Recommendation: None

Medicaid

MED1 - Medicaid Benefits and Services

Element A
- Recommendation: None

Element B
- Recommendation: None

Element C
- Recommendation:

  Adequately and timely covers out-of network services when the organization is unable to provide the service within the network (MED 1C).

Element D
- Recommendation:

  Coordinates payment with the out-of-network provider and ensures that the cost to the member is no greater than it would be if the services were furnished in-network when it approves out-of-network services (MED1D).

Element E
- Recommendation:

  Requires the hours of operation that providers offer to Medicaid members to be no less than those offered to commercial members.

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TRUSTED Health Plan
THP

Miscellaneous- Member Advisory Committee

Trusted is responding to a Centralized Request for Quotation ("CRFQ"), solicitation number BMS1600000002, which has been issued by the West Virginia Department of Administration, Purchasing Division, for managed care services. In the event that Trusted is successful through the award of a contract by West Virginia Department of Health and Human Services, Trusted will develop an Advisory Committee for enrollees to participate in matters of policy and operations.

Trusted has developed a Member Advisory Committee in the DC market. The purpose of the Member Advisory Committee is to address the needs of Trusted's membership and ensure optimal service delivery through effective communications and by improved service delivery processes resulting in improved member satisfaction.

Scope

The Committee has responsibility for providing feedback and suggestions for improving the service Trusted Health Plan provides its members. The Committee scope includes all aspects of Trusted's member services. The Committee's purpose is to enhance collaboration between Trusted, District of Columbia agencies and community members in improving Trusted's operational systems.

The Mission of the Member Advisory is to ensure that the members' voice is heard and is a factor in all of Trusted's operational decisions.

1. Committee Composition

The Member Advisory Committee has representation from all major functional areas within Trusted.

2. Responsibilities

The Member Advisory Committee will:

- Review all member related data (i.e. complaint and call type information, CAHPS, etc.) and address trends to improve member satisfaction
- Provide feedback on member services and on member, practitioner and provider communications
- Develop methods to gather member feedback as it relates to Trusted services
- Act as a forum for issues raised in other quality committees
- Evaluate and assess service delivery methods

- Ensure that member feedback is captured
- Recommend policy and process improvement strategies
- Recommend communication strategies
- Monitor Membership Levels
- Address, implement, and find solutions to improve member satisfaction.

3. Authority and Reporting Relationships:

The Member Advisory Committee will report to the Quality Executive Committee (QEC) and the CMO. The committee has the authority to implement initiatives based on the business needs to improve member satisfaction.

4. Meeting Frequency

The Member Advisory Committee will meet quarterly and have ad hoc meetings as necessary.

5. Confidentiality

Committee proceedings are confidential. At the initial meeting and annually thereafter, all participants must sign a confidentiality agreement. All external MAC participants will sign a confidentiality agreement that will be maintained by the Trusted's QI Department.

6. Conflict of Interest

All committee members will execute a conflict of interest Statement at the time of joining the Member Advisory Committee.

7. Reporting/Accountability

This committee operates under the auspices of Trusted's Quality Improvement Program. The committee reports quarterly and annually to the Quality Executive Committee

STATE OF WEST VIRGINIA
Offices of the Insurance Commissioner
Financial Conditions Division

Mailing Address:
ncial Conditions
Box 50540
Charleston, WV 25305-0540

Telephone: (304) 558-2100
Facsimile: (304) 558-1365
Email: financial.conditions@wvinsurance.gov
www.wvinsurance.gov

Location:
Financial Conditions
1124 Smith Street, Rm 102
Charleston, WV 25301

ACKNOWLEDGEMENT AND WAIVER BY CHIEF EXECUTIVE OFFICER ON BEHALF OF HEALTH MAINTENANCE ORGANIZATION APPLICANT

I, Thomas M. Duncan, the _____ [Chief Executive Officer] of Trusted Health Plan District of Columbia, Inc. [HMO Applicant], hereinafter referred to as the "Organization", having the authority to bind said Organization, do hereby:

(1) ACKNOWLEDGE, on behalf of the Organization, that a delinquency proceeding brought pursuant to the provisions of Article 10, Chapter 33 of the West Virginia Code of 1931, as amended [W. Va. Code §§33-10-I et seq.], or the administrative supervision provisions of article thirty-four of said chapter [W. Va. Code §§33-34-1 et seq.] constitutes the sole and exclusive method for the liquidation, rehabilitation, reorganization or conservation of a health maintenance organization licensed under the laws of this State; and

(2) WAIVE, on behalf of the Organization, any right to file or to be subject as a debtor to any bankruptcy proceedings;

(3) AFFIRM that I have read and do hereby understand the obligation imposed upon me as the chief executive officer of the Organization by the provisions of Article thirty-five of Chapter 33 of said Code [W. Va. Code §§33-35-1 et seq.] ealing with the criminal sanctions for the failure to timely report to the Insurance Commissioner an impairment of the rganization.

ted this _____ day of _____, 20__.

Trusted Health Plan District of Columbia, Inc
(HMO Applicant)

BY: _____
(Signature)

ITS: Chief Executive Officer
(Title)

State of District of Columbia.
County of _____, to wit;

I, Sabine Ortolan, a Notary Public in and for the county and state aforesaid, hereby certify that Thomas Duncan whose name is signed to the foregoing document, bearing date the March 4, day of 2016 for Trusted Health Plan (HMO Applicant), has this day in said county, personally appeared before me in said county and acknowledged the said writing to be the act and deed of said corporation.

Given under my hand this 4, day of March, 2016

y commission expires on 8-14-20

EAL)

_____
Notary Public

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