MERIDIANCOMPLETE (MEDICARE-MEDICAID PLAN) PROVIDER MANUAL

2021

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USING THE MERIDIANCOMPLETE PROVIDER MANUAL

The MeridianComplete Provider Manual is designed specifically for MeridianComplete providers. This manual will assist the provider in understanding the specific policies, procedures, and protocols of the Health Maintenance Organization (HMO) contracted with the State and the Centers for Medicare and Medicaid Services (CMS) to deliver and manage health care for members.

Updates and Revisions

The Provider Manual is a dynamic tool that evolves with MeridianComplete.

Major revisions of the information in the Provider Manual will result in publication of a revised edition that will be distributed to all providers. **This Provider Manual is pending legal review and may be amended at a later date.**

MERIDIANCOMPLETE CONTACT INFORMATION

CONTACT AND SERVICE FUNCTION	MeridianComplete
Utilization Management	
• Process referrals • Perform corporate pre-service review of select services • Collect supporting clinical information for select services • Conduct inpatient review and discharge planning activities • Coordinate case management services	IL: **1-855-580-1689**
Member Services	
• Verify member eligibility • Obtain member schedule of benefits • Obtain general information and assistance • Determine claims status • Encounter inquiry • Record member personal data change • Obtain member benefit interpretation • File complaints and grievances • Coordination of Benefits questions	IL: **1-855-580-1689**
Provider Services	
• Fee schedule assistance • Discuss recurring problems and concerns • Contractual issues • Provider education assistance • Primary care administration • Initiate provider affiliation, disaffiliation & transfer	IL: **1-855-580-1689**
Quality Improvement (QI)	
• Requests and questions about Clinical Practice Guidelines (CPGs) ○ Find the CPGs on our website at **www.mhplan.com.** Located under Training and Education or through the Provider Portal • Requests and questions about Preventive Healthcare Guidelines • Questions about QI initiatives • Questions about QI regulatory requirements • Questions about Disease Management Programs	IL: **1-855-580-1689**
Pharmacy Benefit Manager	
• Prior authorize non-formulary medications	IL: **1-855-898-1480**

Member Services Department

The MeridianComplete Member Services department exists for the benefit of our members and providers, to respond to all questions about benefits, services, policies, and procedures. Full-time professional Member Services Representatives are available from 8 a.m. to 8 p.m. Alternative technologies are used outside of business hours for Utilization Management inquiries and requests.

MeridianComplete Member Services Department - Illinois
Toll-Free: 1-855-580-1689

MERIDIANCOMPLETE MEDICARE-MEDICAID MEMBERSHIP

Member Eligibility and Enrollment

Beneficiaries who wish to enroll in MeridianComplete's Medicare-Medicaid plans should reach out to their local Department of Health and Human Services office**. MeridianComplete does not actively submit enrollment or disenrollment for Medicare-Medicaid plans (MMP) to the State or to CMS.** Members who wish to enroll in MeridianComplete MMPs must meet the following criteria:

- Be entitled to Medicare Part A
- Be enrolled in Medicare Part B
- Have full Medicaid benefits
- Are ages 21 or older
- Permanently reside in the MeridianComplete Medicare-Medicaid service areas
- Not enrolled in hospice
- Be a U.S. citizen or lawfully present in the United States

In addition to the criteria above, individual must meet all of the following criteria to be eligible to enroll:

- Enrolled in the Medicaid Aid to the Aged, Blind, and Disabled (AABD) category of assistance

The following populations will be excluded from enrollment in the demonstration:

- Individuals under the age of 21
- Individuals previously disenrolled because of Special Disenrollment from Medicaid managed care
- Individuals not living in a Demonstration region
- Individuals with Additional Low Income Medicare Beneficiary/Qualified Individuals (ALMB/QI)
- Individuals without full Medicaid coverage (spend-downs or deductibles)
- Individuals with Medicaid who reside in a state psychiatric hospital
- Individuals with commercial HMO coverage
- Individuals with elected hospice services
- Individuals who are incarcerated
- Individuals who have Presumptive Eligibility
- Individuals receiving developmental disability institutional services or participate in the HCBS waiver for Adults with Developmental Disabilities
- Individuals in the Illinois Medicaid Breast and Cervical Cancer program
- Individuals enrolled in partial benefit programs
- Individuals who have Comprehensive Third-Party Insurance

MeridianComplete will accept all members that meet the criteria in this section at any time without reference to race, color, national origin, sex, religion, age, disability, political affiliations, sexual orientation, or family

status. Additionally, we will not limit or condition coverage of plan benefits based on any factor that is related to the member's health status. Including but not limited to medical condition, claims history, receipt of health care, medical history, genetic information, evidence of insurability or disability.

Disenrollment
MeridianComplete Medicare staff may never, verbally, in writing, or by any other action or inaction, request or encourage a Medicare member to disenroll, except when the member:

- Permanently moved outside the geographic service area
- Committed fraud
- Abused their membership card
- Displayed disruptive behavior
- Lost Medicaid eligibility
- Lost Medicare Parts A or B
- Is deceased

When members permanently move out of the service area, we encourage them to notify Medicare-Medicaid, Social Security Administration, and the local Department of Health and Human Service office as soon as possible to update their address information. Members will be submitted for disenrollment once confirmation of relocation outside of the service area is confirmed. If a member leaves the service area for over six consecutive months, they are involuntarily disenrolled from our plan. There are several ways that MeridianComplete staff may be informed that the member has relocated:

- Out-of-area notification will be received from CMS on the daily Transaction Reply Report (TRR)
- Other means of notification can be made through the Claims department, if out-of-area claims are received with a residential address other than the one on file
- Provider notification to the plan
- Directly from the member or member's responsible party

Members may request disenrollment from MeridianComplete. Members should call Illinois' Client Enrollment Services to request disenrollment, or go online at **https://enrollhfs.illinois.gov/enroll**, but may request disenrollment directly by calling **1-877-912-8880** or by enrolling directly in a new Medicare Advantage, MMP or Medicare prescription drug plan, or MLTSS plan (if eligible).

The effective date for all voluntary disenrollments are the first day of the month following the State's receipt of the disenrollment request. The State has a reconciliation process to address any retroactive enrollment changes.

Medicare-Medicaid plans, such as MeridianComplete, may not accept enrollment, disenrollment, or opt-out requests directly from members and process such requests themselves but must refer members or prospective members to call Illinois' Client Enrollment Services.

Requested Disenrollment
MeridianComplete will request disenrollment of members only as allowed by CMS regulations and state regulations. Requests will be placed to the State that a member be disenrolled under one of the following circumstances:

- The member provided fraudulent information

- The member has engaged in disruptive behavior, which is defined as behavior that substantially impairs the plan's ability to arrange for or provide services to the individual or other plan members. An individual cannot be considered disruptive if such behavior is related to the use of medical services or compliance (or noncompliance) with medical advice or treatment

Other reasons the plan may submit a request to the State for a member's disenrollment:

- The member abuses the enrollment card by allowing others to use it to obtain fraudulent services
- The member leaves the service area and directly notifies us of the permanent change of residence
- The member has NOT informed the plan of a permanent move, but has been out of the service area for six months or more
- The member loses entitlement to Medicare Part A or Part B benefits
- The member is deceased
- MeridianComplete loses or terminates its contract with CMS. In the event of plan termination by CMS, we will send CMS-approved notices to the member and a description of alternatives for obtaining benefits. The notice will be sent in accordance with CMS regulations, prior to the termination of the plan
- MeridianComplete discontinues offering services in specific service areas where the member resides

In all circumstances, a written notice will be provided to the member or member's estate with an explanation of the reason for the disenrollment. All notices will comply with CMS rules and regulations.

MeridianComplete MMPs will not directly submit requests for enrollment or disenrollment to the State or to CMS per the three-way contract agreement. MeridianComplete can initiate requests to the State, but enrollment and disenrollment processing is handled solely by Illinois' Client Enrollment Services.

Member Rights and Responsibilities

- Members have a right to receive information about the Medicare-Medicaid managed care organization, its services, its providers, and members' rights and responsibilities
- Members have a right to privacy and to be treated with respect and dignity
- Members have a right to participate with providers in decision-making regarding their health care
- Members have a right to a candid discussion of appropriate or medically necessary treatment options for their conditions, regardless of cost or benefit coverage
- Members have a right to file complaints or appeals about the managed care organization (MCO) or the care provided
- Members have a right to make recommendations regarding the organization's members' rights and responsibilities policies
- Members have a right to change their Primary Care Provider (PCP) at any time. Changes that occur on or before the tenth of the month will be effective for the current month. Changes that occur after the tenth of the month will be effective on the first of the following month
- Members have a responsibility to provide, to the extent possible, information that the MCO and its providers need in order to care for them
- Members have a responsibility to follow the plans and instructions for care that they have agreed on with their providers, including referral and authorization rules
- Members have a responsibility to understand their health problems and participate in developing mutually agreed upon treatment goals to the degree possible
- Members have the right to receive information in a way that works for them. MeridianComplete

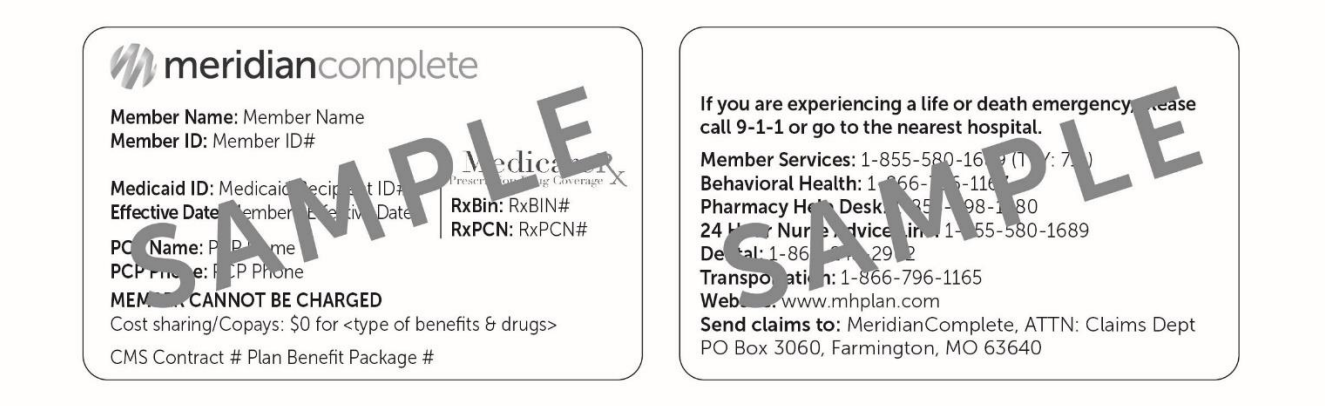
provides member materials in alternate formats, languages other than English and provides a language line for members who speak languages other than English

- Members have the right to get timely access to covered services
- Members have the right to directly access through self-referral: screening mammography, influenza vaccine, and pneumococcal vaccine through contracted providers at no cost
- Members have the right to adequate access to plan providers, and as such MeridianComplete will maintain and monitor a network of providers including but not limited to: primary care providers, specialists, hospitals, skilled nursing facilities, home health agencies, ambulatory clinics and other providers. Furthermore, MeridianComplete will ensure that members have access to network providers that can furnish all plan benefits, including supplemental benefits. If a network provider cannot perform a medically necessary service for a member, then MeridianComplete will arrange for an out-of-network provider to furnish the service
- Members have the right to direct access to an in-network women's health specialist without having to obtain a referral from their PCP or plan authorization
- Members have the right to out-of-network specialty care if network providers are unavailable or inadequate to meet a member's medical needs
- Members have the right to a continuation of benefits for the contract period the plan has with CMS. Furthermore, if the member is hospitalized on the date the plan's contract ends with CMS, the plan will still be responsible for furnishing a continuation of benefits per MeridianComplete's contractual obligation with CMS
- Meridian maintains policies to protect enrollees from incurring liability (for example, as a result of organizational insolvency or other financial difficulties) for payment or fees for covered services/benefits through the member's enrollment period with the plan. Per contractual agreements, providers may not hold members liable for covered services
- Members have the right to receive upon enrollment and annually thereafter an evidence of coverage that explains all plan benefits, rights, and responsibilities of the plan and rights and responsibilities of the member, including but not limited to appeal rights, cost sharing and plan premium responsibilities and how to locate and select providers in MeridianComplete's network. Members can also call Member Services if they have questions about their rights and responsibilities, think they are being treated unfairly or want more information about the plan
- Members have the right to be notified in writing at least 30 days in advance before a provider that they are currently receiving care from is terminated. MeridianComplete will assist the member in finding a new provider prior to the termination date of their current one

MeridianComplete Medicare staff and contracted providers must comply with all requirements concerning member rights.

Member Identification

All members receive an ID card at the time of enrollment that has MeridianComplete's Member Services phone number and pharmacy contact information on it. Below are examples of a MeridianComplete Member Identification Card.



Eligibility Verification

How to Identify a Member's Eligibility

Providers must verify member eligibility prior to rendering services to a member.

To verify if a member is currently eligible to receive services as a MeridianComplete member, the following steps must be followed:

1. Request that the member present his/her member ID card at each encounter
2. Review your PCP monthly eligibility report each time the member presents at your office for care or referrals
3. Call the Member Services department at the number listed on the member's ID card for assistance with eligibility determinations
4. Utilize the Meridian Managed Care System (MCS)
5. Verify eligibility through state Medicaid enrollment systems (e.g., MEDI)

If you find any discrepancies between a member's ID card, an Eligibility Verification System and/or your monthly eligibility report, please contact the Member Services department for further assistance.

Changes that occur on or before the tenth of the month will be effective for the current month. Changes that occur after the tenth of the month will be effective on the first of the following month.

Notice of Privacy Practices

Meridian is regulated under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy and Security Rules. In accordance with these regulations, Meridian provides a Notice of Privacy Practices on our websites that describes member rights and responsibilities to safeguard protected health information.

While providers must have their own Notice of Privacy Practices per the HIPAA Privacy and Security Rules, a copy of our Privacy Practices may be accessed on our website:

MeridianComplete:
https://corp.mhplan.com/ContentDocuments/default.aspx?x=uCSuG/Wg/qgkJrHugWXEk3gEOMWkdUXfsSL4MRTsGO8xws9EWLyJ5t/ZBCE9/YWewRroYSpaK1POcAV0uQKwZA==
You may contact Meridian's Privacy Officer with questions regarding member privacy or if you wish to file a privacy-related complaint.

Attn: Privacy Officer
MeridianComplete
1 Campus Martius, Suite 700
Detroit, MI 48226

Notice of privacy practices can be viewed at:
https://corp.mhplan.com/ContentDocuments/default.aspx?x=uCSuG/Wg/qgkJrHugWXEk3gEOMWkdUXfsSL4MRTsGO8xws9EWLyJ5t/ZBCE9/YWewRroYSpaK1POcAV0uQKwZA==

Email: privacy.il@mhplan.com

Phone: 1-313-324-3700

ADVANCE DIRECTIVES

MeridianComplete providers are responsible for maintaining written policies and procedures regarding Advance Directives, educating members regarding Advance Directives, providing members with Advance Directive forms and obtaining forms from members for attachment to the member's medical record. Providers must have written information available to members explaining their rights while describing the provider's role and limitations in implementing the Advance Directive. All completed Advance Directive forms must be maintained in the front of each member's health record.

MEDICARE OVERVIEW

Medicare Program
The Centers for Medicare & Medicaid Services (CMS) administers Medicare, the nation's largest health insurance program, which covers 43 million Americans. Medicare is a health insurance program for people 65 years of age and older, some disabled people under 65 years of age and people with end-stage renal disease (permanent kidney failure treated with dialysis or a transplant). Original Medicare is divided into two parts: Hospital Insurance (Part A) and Medical Insurance (Part B). Part A helps pay for care in a hospital, skilled nursing facility, home health care, and hospice care. Part B helps pay provider bills, outpatient hospital care and other medical services not covered by Part A.

Part A
Part A is financed by part of the Social Security payroll withholding tax paid by workers and their employers. There is no monthly premium for Part A if the Medicare eligible or spouse has worked at least 10 years in Medicare-covered employment, is age 65 or older, and a citizen or permanent resident of the United States. Certain younger disabled people and kidney dialysis and transplant patients qualify for premium-free Part A.

When all program requirements are met, Medicare Part A helps pay for medically necessary inpatient care in a hospital or a skilled nursing facility after a hospital stay. Part A also pays for home health and hospice care, and 80 percent of the approved cost for wheelchairs, hospital beds and other durable medical equipment (DME) supplied under the home health benefit. Coverage is also provided for whole blood or units of packed cells, after the first three pints, when given by a hospital or skilled nursing facility during a covered stay.

Part B

Medicare Part B pays for many medical services and supplies, including coverage for provider's bills. Medically necessary services of a provider are covered no matter where received — at home, in the provider's office, in a clinic, in a nursing home or in a hospital. The Medicare beneficiary pays a monthly premium for Part B coverage. The amount of premium is set annually by CMS. Part B also covers:

- Outpatient hospital services
- X-rays and laboratory tests
- Diagnostic services and tests
- Certain ambulance services
- Durable medical equipment
- Services of certain specially qualified practitioners who are not providers
- Physical and occupational therapy
- Speech/language pathology services
- Partial hospitalization for mental health care
- Mammograms and pap smears
- Home health care if a beneficiary does not have Part A

Part C

The Balanced Budget Act of 1997 (BBA) established Medicare Part C, also referred to as **Medicare Advantage**. Prior to January 1, 1999, Medicare HMOs existed as Medicare Risk or Medicare Cost plans. The BBA was intended to increase the range of alternatives to the traditional fee-for-service program for Medicare beneficiaries. The options included HMOs and Preferred Provider Organizations (PPOs).

Under the Medicare Modernization Act of 2003 (MMA), Congress created a new type of Medicare Advantage coordinated care plan focused on individuals with special needs. **Special Needs Plans (SNPs)** are allowed to target enrollment to one or more types of special needs individuals identified by Congress as: 1) institutionalized; 2) dually eligible; and/or 3) individuals with severe or disabling chronic conditions.

SNPs offer the opportunity to improve care for Medicare beneficiaries with special needs, primarily through improved coordination and continuity of care. Dual eligible SNPs also offer the opportunity of enhanced benefits by combining those available through Medicare and Medicaid. SNPs focus on monitoring health status, managing chronic diseases, avoiding inappropriate hospitalizations, and helping beneficiaries move from higher risk to lower risk on the care continuum. Meridian offers Medicare plans that target **special needs individuals** who are dually eligible for both Medicare and Medicaid.

Medicare Star Ratings

The Centers for Medicare and Medicaid Services (CMS) created the Medicare star rating system to provide quality and performance information to beneficiaries when choosing a health and drug plan. CMS grades all Medicare Advantage and prescription drug plans on the care that is provided. The score is based on

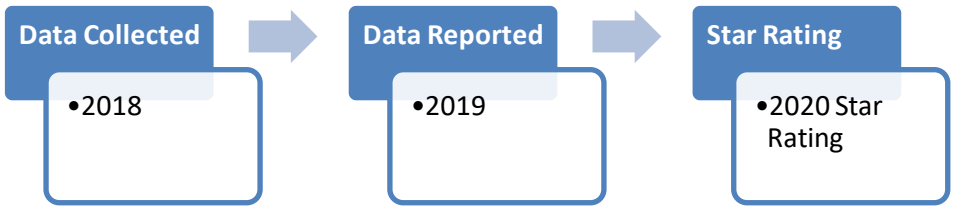
performance from Healthcare Effectiveness Data and Information Set (HEDIS®) quality scores and member satisfaction reported through the Health Outcome Survey (HOS) and Consumer Assessment of Healthcare Providers and Systems (CAHPS®). The purpose of the star rating system is to help beneficiaries, family members and caregivers compare the quality of Medicare plans in their area.

The grade is publicly available, influences member perception and is tied to large financial incentives. The grading scale is a five star scale with five being the best, one being poor and a score of four stars or higher making the plan eligible for quality bonus payments from CMS. These bonus payment funds are used to provide better benefits to members; this includes lower co-pays and premiums for the member.

The overall rating is broken up by Part C and Part D ratings, which are based on a combination of 48 measures. Examples of these measures are breast cancer screenings, improving mental health, all-cause readmissions, and appeals. The measures fall under nine domains, including Staying Healthy (screening, preventive services), Managing Chronic Conditions (diabetes, hypertension), Member Experience, Member Complaints, Drug Safety, and Customer Service.

Star Rating Timeline

The star rating is based on data from two years prior. The timeline below shows the development of the 2020 star rating. The data from 2018 is collected and reported in 2019, which comprises the 2020 star rating. The star rating for 2020 is released in October 2019 for prospective members to evaluate the plan before the next year begins.



The Provider Impact

More than half of the star rating measures are influenced by the providers. Each provider impacts the success of a plan's star rating by influencing the patient's experience. On average, providers have a higher impact on keeping the member satisfied than the Medicare Advantage plan.

Medicare-Medicaid plans (MMPs) do not gain a star rating. However, there are currently two member surveys sent out each year: Health Outcome Survey (HOS) and CAHPS. The HOS measures members' reported physical and mental health status. It also asks members about physical activity, improving bladder control, and fall risk management. The CAHPS measures patient satisfaction. The patient experience could include communication

with providers, if medications were reviewed clearly, and if the provider showed respect for what the patient said.

Our partnership goals with our providers are to:

- Increase member engagement at provider offices through tailored member outreach
- Improve member outcomes by addressing open care gaps at every visit

PROVIDER PARTICIPATION IN MERIDIANCOMPLETE

Provider Credentialing and Recredentialing

Credentialing and recredentialing requirements of 42 C.F.R. §422.504(i)(4)(iv) may be waived for providers enrolled in the state's IMPACT system.

Meridian has written policies and procedures for the selection and evaluation of providers. There is a documented process with respect to providers and suppliers who have signed contracts or participation agreements. Meridian will not prohibit a provider from informing members of the provider's affiliation or change in affiliation.

For physician group practices, PHOs, IPAs, etc., CMS requires copies of the arrangements/contracts between the contracting entity and the providers covered under the Medicare Advantage agreement with Meridian. CMS requires copies of each of these downstream contracts as part of the application to apply for a Medicare Advantage contract with CMS.

The provider credentialing and recredentialing processes require that all providers keep Meridian Credentialing Specialists updated with changes in credentials. In conjunction with this, providers should respond promptly to any requests to update information so that all credentialing files can be maintained appropriately.

All providers shall be notified within 30 days of any substantial discrepancies between credentialing verification information obtained by Meridian and information submitted by the provider. The applicant shall have 30 days to respond in writing to the Credentialing Specialist regarding discrepancies.

All providers will be given 30 days to correct any erroneous information obtained by Meridian during the credential verification process. The provider must inform Meridian in writing of his or her intent to correct any erroneous information.

Meridian recredentials each provider in the network at least every three years. Approximately six months prior to the provider's three-year anniversary date, the provider will be notified of the intent to recredential. All necessary forms will be sent for completion. In certain instances, a site visit will also be scheduled.

The provider recredentialing process also includes the review of quality improvement studies, member surveys, complaints and grievances, utilization data, and member transfer rates.

Appeals Process

There is a formal method of appeal for a provider/applicant who is denied participation within the MeridianComplete Network. The request for reconsideration or appeal must be submitted to the Credentialing Manager in the Credentialing department, who will submit it to the Credentialing Committee.

- **A.** The provider/applicant who is denied participation in the MeridianComplete Network may submit a request for reconsideration within 21 days of the date of his or her participation denial, with additional supportive information or evidence of his or her professional qualifications or abilities to meet the accepted credentialing criteria.
- **B.** The request for reconsideration and the additional information will be submitted to the Credentialing Committee at the next scheduled meeting date.
- **C.** The Credentialing Committee will review the appeal request and additional information and will make a final determination of the appeal.
- **D.** The appealing provider/applicant will be notified of the appeal determination by the Credentialing Committee, through the Medical Director, by certified letter, within five working days of the Credentialing Committee meeting.
- **E.** If the denial is overturned, the applicant will continue with the new participation notification process outlined in this policy.
- **F.** Denied applications are maintained in a confidential manner in a Denied Participation file and are maintained for a period of four years from the date of denial. Denials of participation are kept confidential except where reportable by Meridian under federal or state regulation.

Member Access and Availability Guidelines

Meridian contracted providers are responsible and accountable to Meridian members/patients 24 hours a day, seven days a week. Providers will be expected to abide by state and federal standards of timeliness of access to care and services based on the urgency of member's needs and when medically necessary.

The following guidelines will be continuously monitored to ensure compliance to these standards within the network.

1) PCPs and specialists must be available to address member/patient medical needs 24 hours a day, seven days a week. The PCP may delegate this responsibility to another Meridian provider on a contractual basis for after-hours, holiday, and vacation coverage. Voicemail alone is not acceptable.

2) If the PCP or specialist site uses a different contact phone number for an on-call or after-hours service, the PCP site must provide Meridian with the coverage information and the contact phone or beeper number. Please notify the Meridian Provider Services department with any changes in PCP medical care coverage.

3) PCPs may employ other licensed providers who meet the credentialing requirements of Meridian for patient coverage as required and necessary. It is the responsibility of the PCP to notify Meridian each time a new provider is added to a PCP's practice to ensure that all providers are credentialed to Meridian standards. PCPs may employ licensed/certified Physician's Assistants (PAs) or Registered Nurse Practitioners (RNPs) to assist in the care and management of their patient practice. If PAs or RNPs are utilized, the PCP or the designated and credentialed provider must be readily available for

consultation via telephone or beeper, within a 15-minute call back time. They must also be able to reach the site where the PA or RNP is within 30 minutes.

4) Non-professional healthcare staff shall perform their functions under the direction of the licensed PCP, credentialed provider, or other appropriate healthcare professionals such as a licensed PA or ARNP.

REMINDER: Failure to provide 24-hour medical coverage and/or make the appropriate arrangements for member/patient medical coverage constitutes a breach of the Meridian Practitioner Agreement, placing the provider at risk of due consequences.

Meridian recognizes that providing medical care is not always a predictable experience. Emergencies and episodic increases in the demand for services will challenge the ability of an office to meet the expectations for medical care access. However, in the normal course of providing medical care, provider offices should regularly meet these expectations. Office hours offered to Meridian members must be the same hours made available to other insurance types, such as commercial products.

In addition, the following requirements must also be met:

Office Visit Appointments

1) Emergency services are available immediately
2) Urgently needed (nonemergency) services are scheduled immediately
    a. or within one business day
    b. Routine and symptomatic appointments are scheduled within 48—72 hours
3) Preventive care appointments are scheduled within 30—45 calendar days
    a. routine and preventive care appointments are scheduled within five weeks
4) Nonurgent and nonemergent visits are scheduled within three weeks
5) Initial prenatal visits:
    a. Appointments for members in 1st trimester are available within two weeks
    b. Appointments for members in 2nd trimester are available within one week
    c. Appointments for members in 3rd trimester are available within three days

Behavioral Health Office Visit Appointments

1) Life-threatening emergency appointments are scheduled immediately
2) Non-life-threatening emergency/urgent visits are scheduled within six hours
3) Urgent visits are scheduled within 48 hours
4) Initial routine office visits are scheduled within 10 business days
5) Follow-up routine visits are scheduled within 14 business days

Office Waiting Time

To ensure that members have *timely access to patient care and services*, Meridian providers are expected to monitor waiting room times on a continual basis. PCP offices will be surveyed periodically regarding this process. **Member waiting room times should be less than 30 minutes to be seen by a provider with no more than six scheduled appointments made for a provider per hour.** Supervising providers may routinely account for more than six visits. If a longer wait is anticipated, office staff members should explain the reason for the delay and offer to book the patient for another appointment.

After-Hours Access Standards

Meridian has established acceptable mechanisms for use by PCPs, specialists, and behavioral health providers to ensure telephone access and service for members 24 hours a day. All provider agreements require providers to supply members with access to care 24 hours a day, seven days a week.

Acceptable after-hours access mechanisms include:

- Answering service
- On-call beeper
- Call forwarded to provider's home or other location
- Recorded telephone message with instructions for urgent or non-life-threatening conditions and instructions to call 911 or go to the emergency room in the event of a life-threatening condition or serious trauma

This message should not instruct members to obtain treatment at the emergency room for non-life-threatening emergencies.

Facility Site Reviews

As part of the MeridianComplete annual monitoring audits, a sampling of provider office facilities will be evaluated against MeridianComplete site review and medical record-keeping requirements.

GUIDELINES FOR FACILITY SITE REVIEWS
ACCESS TO SERVICE
• Is each PCP available 20 hours per week • Is the provider available 24 hours a day, 7 days a week • Does the provider have mechanisms in place to meet MeridianComplete after-hours access standards
PROVISIONS FOR PEOPLE WITH DISABILITIES
• Are there designated handicap parking spaces close to building entrance • Is the building entrance accessible by wheelchair, walker, etc. • Are interior building spaces including but not limited to office hallways, doorways, bathrooms, office reception areas and exam rooms accessible to wheelchairs, walkers, etc. (all hallways should have a minimum of 42 inches clearance) • Are doors able to be operated by people with physical limitations • Are there accommodations for sight- or hearing-impaired patients
GENERAL OFFICE APPEARANCE
• Are NO SMOKING signs and Patient's Rights posted • Is business conducted at the registration desk in a confidential manner (discussion, sign-in sheet, etc.) • Is staff aware of the office's confidentiality policy • Are restroom facilities available for waiting patients • Are hours of operation posted • Are all public and patient care areas clean, orderly, and ample enough to accommodate patients • Is teaching literature available for the patient

GUIDELINES FOR FACILITY SITE REVIEWS

STAFF COMPETENCY

- Personnel file for each employee contains a copy of his or her current licensure, if applicable, or documentation of formal training or certification
- Each personnel file contains documentation of orientation to the facility, duties of the position, office medical equipment, and procedures
- Each personnel file contains documentation of regular evaluations
- There is documentation of ongoing education for all staff (e.g., office in-services, staff meetings, conferences)
- There is documentation of annual Occupational Safety and Health Administration (OSHA) training for blood borne pathogens/hazardous materials
- Job descriptions are available for each position
- Staff has current CPR Training
- There is documentation of acceptance or denial of hepatitis B immunization

DOCUMENTS

- Current Clinical Laboratory Improvement Amendments (CLIA) License
- Written medical waste plan reviewed annually
- Current radiology registration
- Written emergency preparedness and disaster plan with disaster drill documentation
- Copies of appropriate Material Safety Data Sheets (MSDS) sheets for the office
- Blood borne pathogen exposure control plan
- Manifests from material waste processing company
- Documented Quality Improvement efforts
- Documentation of well water safety, if appropriate
- Documentation of Septic System Maintenance if appropriate
- Documentation of quarterly fire drills and yearly disaster drill

POLICIES

- Confidentiality
- Conflict resolution
- Staff competency and orientation
- Medication storage and administration (include narcotics and method to dispose of expired medication)
- Infection control
- Radiology (e.g., pregnancy, safety apparel, maintenance of equipment, use of dosimeters, verification of proper technique)
- Maintenance of medical equipment (plan for broken equipment and routine maintenance and calibration — include emergency box, if appropriate)
- Staffing plan (to include call-in vacation coverage and delegation of responsibilities)
- Purging and storing of records
- Sterilization/high-level disinfectant
- Advance directives
- Abuse and neglect
- Policy for reporting communicable diseases to the state
- Sentinel events
- Documentation of “no-show” follow-up and phone contacts

MEDICATIONS

- All stock and sample medications stored in a secure area away from patient access and in an appropriate location (shelf, refrigerator)
- No oral and injectable medications stored together

GUIDELINES FOR FACILITY SITE REVIEWS
• Documentation of regular review of all medications for expiration dates • A log is kept of all sample medications dispensed (to include patient name, drug, lot number, and name of person giving the medication) • Multi-dose vials are marked with the initials of the person opening the vial and the date opened • Medications and laboratory specimens are stored in separate refrigerators • All narcotics are stored under double lock system and the key is secure • A narcotic log is maintained each working day (to include current number of each item, name of drug and dosage given, name of patient given medication, date, medication given, and number remaining). All wastage should also be documented. Any count should be accomplished using two staff people • No medication identified for an individual is stored with stock medication • Medication is not stored in a refrigerator with food or drink and a temperature log for the fridge is maintained (staff should be aware of the proper temperature to be maintained) • The office participates in the Vaccines for Children Program and submits data to the MICR database
DIAGNOSTIC MEDICAL EQUIPMENT
• Thermometers • Pulse Oximetry • EKG Machine • Glucometer • Treadmill • Oxygen Tanks • Aerosol Machines • Cryocautery Machine • Colposcopy Equipment • Ultrasound Machine • Peak Flow Meter • Autoclave • Other • Equipment manuals are available for all medical equipment
SAFETY
• All emergency exits are indicated. Emergency lights and electric exit signs are in working order • Universal precautions are always observed • Fire extinguishers are inspected at least yearly and have current markings • Staff is aware of the location of fire pulls and fire extinguishers • All fire exits are free of obstruction on both sides of the door (open all doors to check) • Staff has been educated regarding the use and accessibility of MSDS sheets • Appropriate staff has received annual blood borne pathogen training and is aware of the exposure control plan • Appropriate protective apparel is provided (e.g., gowns, marks, gloves, face shields) • All gases are stored appropriately (intact tanks, upright and secured position). Staff is aware of the process for determining volume • Sharps containers are used and discarded when ¾ full (disposed of with biohazard material) and not within reach of children
LABORATORY
• Quality checks are done and documented on each waived lab test each day used • No food, drink, or medication is ingested near or stored with collected lab specimens (lab reagents may be stored with them in a separate container) • No lab reagent is kept or used beyond its expiration date (proper disposal) • All specimens are discarded properly after use • All specimens should be labeled with the patient's name or ID number when multiple specimens are being tested
X-RAY
• Pregnancy precautions for X-ray are posted • Protective apparel is available and maintained, including dosimeters • Written plan for disposal of old films and developing agents

GUIDELINES FOR FACILITY SITE REVIEWS
• X-ray room is identified with a system to protect other staff from exposure
STERILIZATION/HIGH-LEVEL DISINFECTANT
• All items to be sterilized or disinfected are first cleaned with an enzymatic detergent, dried, and then processed, maintaining a soiled-to-clean workflow • Sterilized items are packaged appropriately, marked with a chemical test strip, the date processed, an expiration date, and then stored appropriately • A log documenting each run and the chemical test strip is maintained, including the date and the signature of the person processing the run • A monthly spore check is done and documented • All containers holding chemical solutions are marked with the name of the solution, date of expiration, and the date solution was mixed • Solution strength documentation exists for each day the solution is used • Staff is aware of when sterilization with autoclave vs. high-level disinfectant should be done • Glass thermometers are cleaned with alcohol and disposable probe covers are used for electronic thermometers • Work surfaces soiled with biohazard materials are wiped down with commercial disinfectant material or a 10% bleach solution after the completion of testing • There are sinks with soap and paper towels available in patient care areas. (Bar soap on the sink is not acceptable.) Liquid hand disinfectants may be used in instances where the activity has taken place in an area not supplied with a sink and then hands are washed as soon as a sink is available • Hand washing is an expected practice before and after each patient encounter • No food or beverage is consumed in any work area • All equipment and surfaces are cleaned appropriately after patient use • The staff is aware of the process for reporting communicable diseases to the State • Staff has been educated for the instance of tuberculosis and the screening process
EXAM ROOMS
• Each room ensures patient privacy • No medications, needles, or syringes are stored in exam rooms unless in a locked cabinet • Exam room is childproofed as appropriate (e.g., electrical outlet covers, no harmful solutions within reach) • Area is clean and organized with opaque bags in wastebaskets • No patient care supplies or cardboard boxes stored on the floor or under the sinks • There is an 18-inch clearance for sprinkler heads • Clean laundry is covered • No outdated material is stored
MEDICAL RECORDS
• The medical record is retrievable for review for 10 years • Patient information is kept confidential. Files are maintained away from accessibility of other patients, as are fax machines. Desktops do not have identifiable information in sight of other patients. Sign-in sheet is not left in view of others • There is organization of the medical record, with dividers by type of service (e.g., lab, X-ray, consultations, discharge summaries, preventive services, progress notes, durable power of attorney/advance directives, informed consent) • All diagnostic and therapeutic services for which the provider referred the member are documented in the chart (e.g., home health nursing reports, consults, hospital discharges, physical therapy) • There is a Problem List of significant illnesses and medical conditions with date of onset • Medication allergies and adverse reactions or NKDA as appropriate are prominently displayed in the medical record

GUIDELINES FOR FACILITY SITE REVIEWS
• A past medical history for patients seen more than three times that is easily identified and includes serious accidents, operations and illnesses. For children 18 and under, past medical history relates to prenatal care, birth, operations and childhood illnesses • The medical record is a unit record • There is an appropriately signed and dated Release of Information in the medical record • The entries in the medical record are legible • The entries in the medical record are signed and dated by the author • There is an acknowledgement of receipt of privacy notice in the record (if not in individual records, there is a central file with an acknowledgement of receipt of notice) • All medical records requested by Meridian are to be provided at no cost from the provider. This includes administrative fees, copying fees, paper fees, and fees delegated from a third-party vendor • Medical records should be provided to Meridian within 10 business days of request, unless otherwise agreed • Accommodations can be arranged for individuals designated by Meridian to assist in extracting medical records to ease the burden on providers for this request • Where possible, electronic access to medical records should be arranged

OSHA Training

Employee training and annual in-service education must include:

1. Universal precautions
2. Proper handling of blood spills
3. HBV and HIV transmission and prevention protocol
4. Needle stick exposure and management protocol
5. Blood borne pathogen training
6. Sharps handling
7. Proper disposal of contaminated materials
8. Information concerning each employee's at-risk status

At-risk employees must be offered hepatitis B vaccination free of charge. Each employee file of an at-risk employee must contain informed consent or informed refusals for hepatitis B vaccines. Personal protective equipment must be provided to each at-risk employee. Necessary equipment must be provided for the administration of mouth-to-mouth resuscitation.

Documents to be posted in the facility are:

1. Pharmacy Drug Control license issued by the State, if dispensing drugs other than samples
2. Section 17757a from the Board of Pharmacy (if dispensing drugs other than samples)
3. Controlled Substances License from State of Illinois and the U.S. Drug Enforcement Administration (DEA)
4. CLIA certificate or waiver
5. Medical Waste Management certificate
6. X-ray equipment registration
7. R-H 100 notice
8. Radiology protection rules
9. OSHA poster (#2010)

Provider Roles and Responsibilities

CMS requires providers to provide care to members in a culturally competent manner, being sensitive to language, cultural, and reading comprehension capabilities. Meridian offers a language service to members speaking a non-English language. There is no charge to members for this service. To access this service for Meridian members in your practice, please contact Member Services at the numbers listed in the contact information section of this booklet and ask for language services.

Providers must ensure that their hours of operation are convenient for the aged, disabled, chronically ill, and low-income populations that they serve. Providers must provide all plan benefits covered by Medicare and by Meridian in a manner consistent with professionally recognized standards of health care. Providers must also ensure continuity of care and develop procedures that ensure that members are informed of their healthcare needs that require follow-up visits or provide training in self-care as necessary.

Providers must provide to Meridian, upon request, member's medical records both in support of complete and accurate risk adjustment data and for the validation of risk adjustment data for auditing purposes.

Providers shall not distribute any marketing materials that mention Meridian or include Meridian's logos without first obtaining approval from both Meridian and CMS. Providers must comply with all CMS marketing requirements in Chapter 3 of the Medicare Managed Care Manual.

Providers must make a good faith effort to provide 60 calendar days' notice prior to effective date to plan regarding contract changes and terminations. Providers must make a good faith effort to provide written notice of request to terminate or contract changes to MeridianComplete at least 30 calendar days before the termination or change effective date, irrespective of whether the termination was for cause or without cause. When a contract termination involves a primary care provider, MeridianComplete will notify all enrollees who are patients of that primary care provider. Provider shall also make a good faith effort to provide appropriate notification to members.

Primary Care Provider (PCP) Roles and Responsibilities

Each Meridian member selects a PCP who is responsible for coordinating the member's total health care. PCPs are required to work 20 hours per week per location, and be available 24 hours a day, seven days a week.

Except for required direct access benefits or self-referral services, all covered health services are either delivered by the PCP or are referred/approved by the PCP and/or Meridian.

Specialty Care Provider Roles and Responsibilities

Meridian recognizes that the specialty provider is a valuable team member in delivering care to MeridianComplete members. Some key specialty provider roles and responsibilities include:

- Rendering services requested by the PCP by referral
- Communicating with the PCP regarding the findings in writing
- Obtaining prior authorization from the PCP and plan before rendering any additional services not specified on the original referral form
- Confirming member eligibility and benefit level prior to rendering services
- Providing a consultation report to the PCP within 60 days of the consult

- Providing the lab or radiology provider with:
    - The PCP and/or corporate prior authorization number
    - The member's ID number

Hospital Roles and Responsibilities
Meridian recognizes that the hospital is a valuable team member in delivering care to MeridianComplete members. Some essential hospital responsibilities include:

- Coordination of discharge planning with MeridianComplete Utilization Management staff
- Coordination of mental health/substance abuse care with the appropriate state agency or provider
- Obtaining the required prior authorization from the plan before rendering services
- Communication of all pertinent patient information to Meridian and to the PCP
- Communication of all hospital admissions to the MeridianComplete Utilization Management staff within one business day of admission
- Issuing all appropriate service denial letters to identified members

Ancillary/Organization Provider Roles and Responsibilities
Meridian recognizes that the ancillary provider is another valuable team member in delivering care to MeridianComplete members. Some critical ancillary provider responsibilities include:

- Confirming member eligibility and benefit level before rendering services
- Being aware of any limitations, exceptions, and/or benefit extensions applicable to MeridianComplete members
- Obtaining the required prior authorization from the plan before rendering services
- Communication of all pertinent patient information to Meridian and to the PCP

Confidentiality and Accuracy of Member Records
Medical records and other health and enrollment information of a member must be handled under established procedures that:

- Safeguard the privacy of any information that identifies a particular member
- Maintain such records and information in a manner that is accurate and timely
- Respect member rights to access, amend errors in, request confidentiality for, or an accounting of disclosures of the member's health information
- Identify when and to whom member information may be disclosed
- Safeguard the privacy of any information that identifies a particular member
- Secure information through robust controls designed to maintain the confidentiality, integrity, and availability of medical records and to protect against threats or hazards to the security or integrity of such information and any uses or disclosures of such information that could violate law
- Maintain such records and information in a manner that is accurate and timely, ensure timely access by enrollees to the records and information that pertain to them for what purpose the information will be used within the organization, and identify when and to whom member information may be disclosed

In addition to the obligation to safeguard the privacy and security of any information that identifies a particular member, the health plan and all participating providers are each obligated to abide by all federal and state laws regarding confidentiality and disclosure for mental health records, medical health records, and member information. First tier and downstream providers must comply with Medicare laws, regulations, and CMS instructions (422.504(i)(4)(v)), and agree to audits and inspection by CMS and/or its designees and to

cooperate, assist, and provide information as requested, within requested time frames ,and maintain records a minimum of 10 years.

Obligations of Recipients of Federal Funds

Providers participating in Meridian Medicare-Medicaid plans are paid for their services with federal funds and must comply with all requirements of laws applicable to recipients of federal funds, including but not limited to Title VI of the Civil Rights Act of 1964, the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, the Americans with Disabilities Act of 1990, the False Claims Act, the Anti-Kickback Statute, and HIPAA laws.

Meridian is prohibited from issuing payment to a provider or entity that appears in the List of Excluded Individuals/Entities as published by the Department of Health and Human Services Office of the Inspector General or in the List of Debarred Contractors as published by the General Services Administration (with the possible exception of payment for emergency services under certain circumstances).

- The Department of Health and Human Services Office of the Inspector General List of Excluded Individuals/Entities can be found at **exclusions.oig.hhs.gov/**
- The General Services Administration List of Debarred Contractors can be found at **www.sam.gov**
- The Preclusion List can be found at **https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/Preclusion-List**

Disclosures to CMS and Beneficiary

Meridian must disclose to CMS and Illinois Department of Human Services (IDHS) information on ownership and control, business transactions, and people convicted of crimes. Meridian must obtain federally required disclosures from all network providers and applicants, obtaining such information through providers' enrollment forms and credentialing and recredentialing packages. Meridian is required to obtain such disclosed information in a manner that can be periodically searched for exclusions and provided by IDHS and CMS.

Meridian is required to provide the necessary information to enable CMS to provide to current and potential beneficiaries the information they need to make informed decisions with respect to the available choices for Medicare coverage. This must happen annually and in a format using standard terminology that may be specified by CMS.

Meridian is required to provide to CMS all information that is necessary for CMS to administer and evaluate the program. Meridian is also required to provide information to CMS that would allow CMS to establish and facilitate a process for current and prospective enrollees to exercise choice in obtaining their Medicare services. This information includes, but is not limited to:

- Benefits covered under an Medicare Advantage (MA) plan
- MA monthly basic beneficiary premium and MA monthly supplemental beneficiary premium, if any, for Meridian
- Service area and continuation area, if any, of each plan and the enrollment capacity of each plan
- Information about beneficiary appeals and their disposition
- Information regarding all formal actions, reviews, findings, or other similar actions by states, other regulatory bodies, or any other certifying or accrediting organization
- Any other information deemed necessary by CMS for the administration or evaluation of the Medicare program

As a contracted provider with Meridian, you are required to comply with Meridian's request for information to meet disclosure obligations to CMS. Types of disclosures to CMS by Meridian include, but are not limited to: plan disenrollment rates for the previous two years, enrollee satisfaction results, health outcome information, recent compliance record of the plan, and any other information that may be necessary for CMS to assist beneficiaries in making an informed health plan choice.

In meeting these requirements, the provider must cooperate with Meridian and assist in complying when applicable.

Pay for Performance (P4P) Program
Meridian offers the Pay for Performance (P4P) program, a performance-based compensation program, to encourage providers to support our goal of providing accessible, high-quality care.

The goals of the P4P program are to improve health outcomes for members, thereby reducing costs associated with chronic conditions, and to link health quality and provider performance in a manner that is equitable for payers and providers.

The program's measurements are carefully considered. The metrics selected for inclusion are intended to meet HEDIS® specifications.

The measurements selected target health screening and prevention in all populations. Data used to determine compensation are gathered from a variety of sources, including administrative claims, laboratory results, and pharmacy use.

Clinical and Preventive Practice Guidelines (CPGs)
Meridian is accountable for adopting and disseminating practice guidelines for the provision of preventive, acute, and chronic care services that are relevant to its enrolled membership, and for monitoring provider adherence to clinical guidelines. Appropriately, board-certified providers are involved in the adoption of nationally or internally developed guidelines.

Meridian approves, adopts, distributes, and requires providers to use established evidence-based clinical and preventive health practice guidelines. Clinical practice guidelines (CPGs) provide a framework for evaluation and treatment of enrollees from diverse backgrounds and circumstances. CPGs reflect current scientific evidence, help reduce inappropriate variation in practice, promote efficient use of resources, are encouraged to providers as an educational resource, and are the clinical basis for Meridian's preventive medicine, disease management and behavioral health programs. The intention of these guidelines is not to replace a provider's judgment or serve as the singular driver for established protocol pertaining to all members with a particular condition.

Sources may be used as needed, and may include:

- National Cancer Institution (NCI)
- American Medical Association (AMA)
- American Diabetes Association (ADA)
- National Institute for Health and Care Excellence (NICE)
- American Psychiatric Association (APA)
- American Academy of Child & Adolescent Psychiatry (AACAP)

- American Heart Association (AHA)
- American Geriatrics Society (AGS)
- Centers for Disease Control and Prevention (CDC)
- Department of Veterans Affairs (DoVA)
- U.S. Preventive Services Task Force (USPSTF)

CPGs can be developed when existing guidelines do not meet the needs of the membership. Meridian uses information from recognized sources, and/or involves board-certified providers from appropriate specialties when developing internal guidelines.

Meridian ensures that decision-making in care management, utilization, enrollee education, interpretation of covered benefits, and other applicable areas are consistent with the CPGs. CPGs have been adopted to guide treatment of, but not limited to, the following:

- Adult preventive care
- Asthma
- Behavioral health (mental health and substance abuse) screening, assessment, and treatment, including medication management and primary care provider (PCP) follow-up
- Chronic kidney disease
- Chronic obstructive pulmonary disease
- Clinical pharmacy medication review
- Community reintegration and support
- Congestive heart failure
- Coordination of community support and services for enrollees
- Coronary artery disease
- Diabetes
- Hypertension
- Long-term care residential coordination of services
- Low back pain
- Osteoarthritis
- Osteoporosis
- Psychotropic medication management
- Prenatal, obstetrical, postpartum, reproductive health care, interconceptual care
- Smoking cessation
- Other conditions and services as deemed by Contractor and/or Department
- Advanced care planning
- Dental services
- Depression
- Hypercholesterolemia
- Pharmacy services
- Prevention of pregnancy and unintended pregnancy in adults
- Reproductive health care
- Care for older adults (advance care planning, pain assessment, functional assessment, and medication review)
- Fall prevention in older adults
- Medication reconciliation post-discharge

- Obesity
- Potentially harmful drug-disease interactions in the elderly
- Prenatal, postpartum, and interconceptual care
- Prescribing opioids for pain
- Pressure ulcers
- Reducing the risk of venous thromboembolism in adults
- Transition of care for adults with social care needs

The Plan, at a minimum, updates and/or reviews CPGs at least every two years, or more frequently as determined by state/line of business. CPGs are presented to the Physician Advisory Committee (PAC) and Quality Improvement Committee (QIC) for monitoring and approval. CPGs are made available for all providers through the provider portal, addressed in the Provider Manual, and hard copies are available upon request. Meridian's website allows public access for all providers (contracted and non-contracted) and members (enrolled and prospective).

Meridian monitors the usage of clinically appropriate care and guidelines through:

- Meridian's-Patient Centered Medical Home (PCMH) program
- Patient-safety audits
- Random medical record audits
- Quality of Care grievances
- Care Coordination services

Meridian recognizes that CPGs are targeted for average-risk patients. Providers are encouraged to use clinical judgment and consider individual circumstances when caring for patients. Should a provider not follow an identified treatment schedule, he or she is to follow an alternative schedule as provided by the United States Preventive Service Task Force.

Meridian promotes the use of CPGs through:

- Transparent utilization management policies
- Medical policies that follow evidence-based research
- E-prescribing
- Electronic Medical Records (EMR) that have prompts for appropriate care
- Peer-to-peer support and discussion

Patient-Centered Medical Home (PCMH) Program

MeridianComplete (Meridian) has a process to facilitate and incentivize medical homes in advancing towards National Committee for Quality Assurance (NCQA) Patient-Centered Medical Home (PCMH) recognition. Providers are educated about the PCMH model and the importance of using it to integrate all aspects of each member's care, as well as how to become a PCMH. PCMHs must demonstrate effective care coordination, family and caregiver involvement, health promotion and wellness programs, self-management strategies, and chronic health condition management.

Meridian recognizes the commitment required for PCMH recognition. PCMHs are patient-centered in approach and have the capacity to provide access to a personal clinician and care team that offers individualized, high quality comprehensive primary care and coordinates specialty and other needed services.

Meridian's PCMH model is an incentive program which supports Medical Homes based upon their stage of advancement towards recognition. Incentives are subject to change and are communicated via Meridian's Network Development (ND) department. Providers are educated about Meridian's PCMH Incentive Program during provider orientation, provider training, and via Meridian's provider facing website. Ongoing information is provided by Provider Relations Representatives (PRRs) during monthly office site visits to support and encourage provider participation.

PCMHs must provide high-quality, evidence-based primary care services; acute illness care; behavioral health care (as appropriate); chronic health condition management; and referrals for specialty care and long term services and supports (LTSS). PCMHs shall provide all PCP services and be supported by Integrated Care Teams and Health Information Technology.

Assessment and Support of Medical Homes
Meridian can assist facilities interested in advancing towards PCMH recognition by providing educational resources and self-assessment tools upon request. The tool allows primary care providers the ability to self-assess their organizational capacity; chronic health condition management approaches; coordination and continuity of care processes; community outreach knowledge and connections; data management; and quality improvement/change.

Care Coordination will support Medical Homes in their efforts to actively engage with patients in need of care management by including providers in Interdisciplinary Care Teams (ICT), which function to coordinate member care across the full spectrum of available services and manage transitions between levels of care. Meridian will embed Care Coordinators, as appropriate, onsite at FQHCs, CMHCs, and high-volume providers to support the integration of behavioral and physical health care, if providers request this service.

Education
Meridian's Provider Relations and Quality Improvement departments will educate Medical Homes on methods to improve care capacity and capabilities to provide wellness programs, preventive care, management of chronic health conditions and coordination and continuity of care through orientation, provider education, Quality provider Webinars, Provider Newsletters, provider mailings and fax blasts, and website updates.

- Meridian will provide general guidance or access to resources for practice utilization as part of the Medical Home's transformation and improvement efforts
- Health Information Technology (HIT) – Medical Homes will be supported by HIT, including, but not limited to, electronic transfer of data and the Meridian Provider Portal
    - PCMHs will have access to electronic medical record data collection to support quality improvement
    - PCMHs will have access to Meridian's Provider Portal, which allows for electronic features including, but not limited to,:
      i. Verification of eligibility;
      ii. Authorizations;
      iii. Claims status and submission/correction;
      iv. Member information and reports;

v. Enrollment lists;
vi. Healthcare Effectiveness Data and Information Set (HEDIS®) bonus information;

vii. HEDIS® self-reporting; and
viii. Requests for HEDIS® postcards.

Meridian offers two incentive tiers for practices either advancing or retaining their Medical Home status:

PCMH Basic Incentive
The Basic Incentive rewards a 20 percent discount on the initial application for the NCQA PCMH recognition program. This incentive will be available to any facility not currently NCQA PMCH recognized, has a fee for service contract with MeridianComplete, and is open to new MeridianComplete members.

PCMH Quality Incentive
The Quality Incentive pays out a $2.00 per member per month (PMPM) reward to qualifying facilities. This incentive will be available to any facility currently NCQA PCMH recognized, has a fee for service contract with MeridianComplete, is open to new MeridianComplete members, has granted remote access or an established Electronic Data Information (EDI) feed with MeridianComplete, and meets Meridian qualify national benchmarks for 10 or more PCMH HEDIS Performance Measures from the following list:

- Adults Access to Preventive/Ambulatory Services (AAP)
- Antidepressant Medication Management (AMA) – Acute and Continuation/Maintenance
- Breast Cancer Screening (BCS)
- Comprehensive Diabetic Care (CDC) – Eye Exam
- CDC – HBA1C<8%
- CDC – HBA1C Testing
- CDC – Neuropathy
- Follow-Up After Hospitalization for Mental Illness – 7 Day
- Initiation and Engagement of AOD Dependence Treatment (IET) – Engagement
- IET – Initiation
- Medication Management for People with Asthma – 75% Compliance
- Diabetes Screening for People with Schizophrenia or Bipolar Disorder
- Plan All – Cause Readmissions
- Controlling High Blood Pressure
- Care for Older Adults
- Annual Flu Vaccine

If a provider fails to retain the necessary qualifications of the PCMH Quality Incentive tier, the provider will no longer qualify for the incentive.

BILLING AND CLAIMS PAYMENTS

When billing for services rendered to MeridianComplete members, providers must use the most current Medicare-approved coding (ICD-10, CPT, HCPCS, etc.) available.

Claims must be submitted using the proper claim form/format, e.g., for paper claims, submit a CMS1500 or UB04 and for an electronically submitted claim, submit in approved ANSI/HIPAA format. It is recommended that claims be submitted as if they are being billed to Medicare fee-for-service. **Meridian will apply Medicare benefits and, when applicable, Medicaid benefits.**

Billing Requirements

- Providers must use a standard CMS 1500 Claim Form or UB-04 Claim Form for submission of claims to Meridian
- Specialty provider claims should include a PCP referral form and/or a corporate prior authorization number for payment
- Claim must be original, using national or state form types as applicable. Photo or scanned copies are not accepted. The claim information must be typed with no handwritten information other than applicable signatures
- Taxonomy code must be included on ALL claims
- Claims for MeridianComplete members must be submitted within **180 days** from the end of the date of service. Failure to submit claims data within the prescribed time period may result in payment delay or denial. This guidance is in accordance with CMS' expectations concerning timely submission of claims/encounter data by MMPs

Claims Mailing Requirements
Beginning January 1, 2021, Submit all initial claims for payment to:

Attn: MeridianComplete Claims Department
Meridian
P.O. Box 4020
Farmington, MO 63640

If you are resubmitting a claim for a status or a correction, please indicate *STATUS* or *CLAIMS CORRECTION* on the claim.

Billing Procedure Code Requirements
Meridian requires that providers use HCPCS, CPT, ICD-10, and revenue codes when billing Meridian.

Explanation of Payments (EOP)
Meridian sends its providers two remittance vouchers as a method of explanation of benefits.

Balance Billing Prohibited for Medicare Eligibles

You may not balance bill for services and supplies furnished to MeridianComplete members. Any difference between what you bill and what Meridian pays cannot be billed to the member.

Additionally, you may not bill for services and supplies furnished to Qualified Medicare Beneficiaries (QMBs); for them, Medicaid is responsible for premiums, deductibles, coinsurance and co-payment amounts for Medicare Part A and B covered services. Federal law prohibits Medicare providers from collecting Medicare Part A and Medicare Part B deductibles, coinsurance, or co-payments from those enrolled in the Qualified Medicare Beneficiaries (QMB) program, a dual eligible program that exempts individuals from Medicare cost-sharing liability. Billing prohibitions may also apply to other dual eligible beneficiaries in Medicare Advantage plans if the State Medicaid Program holds these individuals harmless for Part A and Part B cost sharing. Note that the prohibition on collecting Medicare cost-sharing is limited to services covered under Parts A and B. Low Income Subsidy co-payments still apply for Part D benefits. (Calendar Year (CY) 2018 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies and Final Call Letter; 42 C.F.R. §422.504(g)(1)(iii)). For more information, see **http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE1128.pdf**.

Note: QMBs are sometimes called "dual eligibles." They are entitled to Medicare Part A, eligible for Medicare Part B, have income below 100% of the Federal Poverty Level, and have been determined to be eligible for QMB status by the State Medicaid Office.

Electronic Claims Submission

Meridian is currently accepting electronic claims using the following payer ID information. Providers are responsible for ensuring that they receive a confirmation file for claims submitted via EDI.

Please refer to Member ID card for changes effective January 1, 2021, as the Payer IDs are not interchangeable.

Date of Service	Health Plan Name	Payer ID
On or before Dec. 31, 2020	MeridianTotal, MeridianComplete, Illinois Complete, YouthCare and Ambetter	13189
	MeridianHealth Illinois	13189
On or after Jan. 1, 2021	MeridianTotal, MeridianComplete, Illinois Complete, YouthCare and Ambetter	MHPIL
	MeridianHealth Illinois	13189

Payment to Non-Contracted Providers

Meridian will make timely and reasonable payment on behalf of or to the member for the following services if obtained by an out-of-network provider in accordance with 422.100(b):

- Ambulance services dispatched through 911 or its local equivalent
- Emergency and urgently needed services
- Maintenance and post-stabilization care services
- Renal dialysis services provided while the member was temporarily outside the plan's service area
- Services for which coverage has been denied by Meridian and found (upon appeal) to be services the member was entitled to have furnished, or paid for, by Meridian

Provider Grievance and Appeals Process for Denied Claims

Contracted providers can request an appeal from Meridian when acting strictly on their own behalf and the member is not at financial risk, such as for an unapproved inpatient admission.

Meridian offers a post-service claim appeal process for disputes related to denial of payment for services rendered to MeridianComplete members.

What Types of Issues Can Providers Appeal?

The appeals process is in place for two main types of issues:

1. The provider disagrees with a determination made by Meridian, such as combining two stays as a 15- or 30-day readmission. In this case, the provider should send additional information (such as medical records) that support the provider's position.
2. The provider is requesting an exception to a MeridianComplete policy, such as prior authorization requirements. In this case, the provider must give an explanation of the circumstances and why the provider feels an exception is warranted in that specific case.

A provider's lack of knowledge of a member's eligibility or insurance coverage is not a valid basis for an appeal. Providers cannot appeal denials due to member ineligibility on the date of service or non-covered benefits.

How to File a Post-Service Claim Appeal

1. Please send a letter explaining the nature of your appeal and any special circumstances that you would like Meridian to consider
2. Attach a copy of the claim and documentation to support your position, such as medical records
3. Send the appeal to the following address:

   Meridian
   ATTN: MeridianComplete Appeal Coordinator
   P.O. Box 4020
   Farmington, MO 63640-4402

Time Frame for Filing a Post-Service Appeal

Claims must be filed within 180 days from the date of service. The Claims Appeals department will allow 120 days from date of the last claim denial provided that the claim was submitted within one year of the date of service. Appeals submitted after the time frame has expired will not be reviewed.

Response to Post-Service Claims Appeals
The Claims Appeals department typically responds to a post-service claim appeal within 60 days from the date of receipt. Providers will receive a remittance with the Claims Appeals department decision and denial reason.

There is only one level of claims appeal available. All appeal determinations are final.

If you have questions about the post-service claim appeal process, please call Member Services at the numbers listed in the contact information section of this manual.

Meridian Incentive Program
Meridian has developed an incentive program for our contracted providers to align our goal of delivering the highest quality of care to your patients and our members. This is not done through any withhold program.

Effective January 1, 2021, our Healthcare Effectiveness Data and Information Set (HEDIS®) program is a pay-for-quality (P4Q) incentive that rewards providers for delivering quality preventive healthcare services. There are incentives for services such as behavioral visits and wellness visits.

2021 MeridianComplete Partnership for Quality (P4Q) Program

Access to Care							
Measure	**Service**	**Procedure**	**Performance Criteria**	**Target 1 Rate**	**Target 1 Incentive**	**Target 2 Rate**	**Target 2 Incentive**
AAP	Preventive/Ambulatory healthcare visit - ages 21 and older	Annual Wellness Visit	One incentive paid per member	43.00%	$15.00	86.00%	$30.00
Medicare HEDIS							
Measure	**Service**	**Procedure**	**Performance Criteria**	**Target 1 Rate**	**Target 1 Incentive**	**Target 2 Rate**	**Target 2 Incentive**
CBP	Controlling High Blood Pressure - ages 21-85		Members must have at least two visits with a diagnosis of hypertension on or between January 1 of the prior year and June 30 of the current year. Adequate blood pressure (BP) control includes both a representative systolic BP <140 mm Hg and a representative diastolic BP of <90 mm Hg. A representative BP reading is the most recent BP reading that occurs on or after the second diagnosis of hypertension according to HEDIS® guidelines. Once incentive paid per member.	9.50%	$15.00	19.00%	$30.00
Part D Medication Adherence for Oral Diabetes Medications^	Adherence to medication for individuals taking oral diabetes, hypertension or cholesterol medication - oral diabetes adherence (80% PDC)	Members with two or more fills of medication across any of the seven drug classes of oral diabetes drugs	Incentive paid for a PDC percentage of 80% or greater as of December 31. One incentive paid per member.	42.00%	$15.00	84.00%	$30.00

Mental Health							
Measure	**Service**	**Procedure**	**Performance Criteria**	**Target 1 Rate**	**Target 1 Incentive**	**Target 2 Rate**	**Target 2 Incentive**
FUH - 30 Day	Follow-up After Hospitalization for Mental Illness. (Paid to Servicing Provider)	One follow-up visit within 30 days after discharge	Incentive paid upon completion of follow-up with a mental health practitioner within 30 days after discharge from hospital, within the HEDIS® guidelines. One incentive paid per event.	N/A	$50.00	N/A	N/A
IET - Initiation	Initiation and Engagement of Treatment for Alcohol and other Drug (AOD) Dependence. (Paid to Servicing Provider)	One substance abuse treatment encounter within 14 days	Inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization, telehealth or medication-assisted treatment for the treatment of AOD must be within 14 days of the diagnosis for AOD. One incentive paid per event.	N/A	$50.00	N/A	N/A
IET - Engagement		Two additional substance abuse treatment encounters within 34 days	Two additional inpatient AOD admissions, outpatient visits, intensive outpatient encounters or partial hospitalizations, telehealth or medication-assisted treatment for the treatment of AOD must be within 34 days of the initiation of treatment. One incentive paid per event.	N/A	$50.00	N/A	N/A

Program Information:

^Adherence rates are adapted from the Pharmacy Quality Alliance (PQA) Proportion of Days Covered (PDC) measure and assess the extent to which members were adherent to the specific drug classes during the calendar year. Higher rates represent better performance. Results may be faxed to **1-312-508-7213**.

All procedures must be completed within strict HEDIS® guidelines. For a complete list of covered CPT codes for these measures or to view the Drug Formulary for a list of covered drugs, visit **mmp.ilmeridian.com**. Incentive is paid upon completion of all qualifying services in compliance with HEDIS® 2021 guidelines. Incentive is paid to Primary Care Provider unless otherwise noted. ***MeridianComplete maintains the right to modify or discontinue the P4Q Program at any time. MeridianComplete will notify providers of any changes or incentive program alterations.***

For more information, contact your local Network Management Representative or the Provider Services department at ***1*-866-606-3700** or ILProviderRelations@mhplan.com.

UTILIZATION MANAGEMENT

The objective of Meridian's Utilization Management (UM) department is to ensure that the medical services provided to members are medically necessary and/or appropriate, as well as in conformance with the plan benefits. To guide the decision-making process, UM applies systematic evaluations to appropriate medical necessity criteria and considers circumstances unique to the member.

Utilization decisions are based on appropriateness of care and service, as well as the member's eligibility. Meridian does not reward our providers, associates, consultants, or other individuals for any denials of coverage or care issued, nor do we use incentives to encourage denial of care or service.

Utilization management decisions determine the medical necessity of a service and are not a guarantee of payment. Claims payment is determined by the member's eligibility and covered benefits at the time the services are rendered.

Requesting Prior Authorization/Precertification For all authorization questions, please contact us at the numbers listed in the contact information section of this manual.

Meridian offers multiple methods to submit authorization requests. For the most efficient and timely service, **Meridian's Online Prior Authorization (PA) Form is the preferred method.**

1. **Online Electronic System —** The Meridian Online PA Form can be accessed in two ways:
   - Secure Provider Portal
   - Meridian website at **www.mhplan.com.** Click on "Prior Auth Form" at bottom of page

2. **Fax Submission -** Please include pertinent clinical documentation with the request.

Type of Request	Fax Number
Inpatient Admissions	**1-844-409-5557**
Post-Acute Admissions	**1-844-409-5557**
Pre-Service Standard Requests	**1-844-409-5557**
Concurrent Review(Clinical)	**1-855-581-2251**

   All Pre-Service Expedited Requests should call **1-855-580-1689.**

3. **Phone Submission**
   - Illinois MeridianComplete: **1-855-580-1689**

   *Please note: Many authorizations cannot be processed via phone, as clinical review and supporting documentation are required. Requests should only be submitted via the phone for services related to pending hospital discharges.

When submitting a Prior Authorization request, please include the following information:
- Member's name
- Member's identification number
- Member's date of birth

- Date(s) of service
- Facility where services are to be rendered
- Diagnosis/Procedure code(s), as applicable

UM Decision Clinical Review Criteria

Meridian must review and approve all services before they are provided. The primary reasons for clinical review are to determine whether the service is clinically appropriate, is performed in the appropriate setting and is a covered benefit. Clinical information is necessary for all services that require clinical review for medical necessity.

Utilization management clinical staff uses plan documents for benefit determination and Medical Necessity Coverage Guidelines to support Utilization Management decision-making. All utilization review decisions to deny coverage are made by MeridianComplete medical directors. In certain circumstances, external review of service requests are conducted by qualified, licensed providers with the appropriate clinical expertise.

Providers should refer directly to Medicare coverage policies for information on Medicare coverage policies and determinations. The two most common types of Medicare coverage policies are National Coverage Determinations (NCDs) and Local Coverage Determinations (LCDs).

As a Medicare Advantage plan, we must cover all services and benefits covered by Original Medicare.

National Coverage Determinations (NCDs)

The Centers for Medicare and Medicaid Services (CMS) explains NCDs through program manuals, which are located on the CMS website under Regulations & Guidance/Guidance/Manuals.

Local Coverage Determinations (LCDs)

LCDs provide guidance to the public and provider community within a specific geographical area. LCDs supplement an NCD or explain when an item or service will be considered covered if there is no NCD. An LCD cannot contradict an NCD.

In coverage situations where there are no NCDs, LCDs or guidance on coverage in the Medicare manuals, Meridian may use current literature review, along with consulting with practicing providers and medical experts in their particular fields. Meridian also uses government agency policies and relies on standards adopted by a national accreditation organization and Meridian Medical Management policies for clinical decision making. Meridian may also adopt the coverage policies of other Medicare Advantage Organizations in its service area.

It is the responsibility of the attending provider to make all clinical decisions regarding medical treatment. These decisions should be made consistent with generally accepted principles of professional medical practice and in consultation with the member.

To ensure timely decisions are rendered, Meridian requires completed and legible clinical information with each request. The preferred method of clinical review submission is via Meridian's Online Prior Authorization (PA) Form. If clinical information is not received with the request, the MeridianComplete Utilization Management staff will send a fax request for the information and/or contact the provider or specialist verbally to collect the necessary documentation.

Clinical information includes relevant information regarding the member's:

- History of presenting problem
- Physical assessment
- Diagnostic results
- Photographs
- Consultations
- Previous and current treatment
- Response to treatment
- Discharge disposition

Clinical information should be provided at least 14 days prior to the service, unless services are urgent. Meridian provides a request ID on all authorizations.

Inpatient Review

Our nurse reviewers are assigned to members at specific acute care facilities to promote collaboration with the facility's review staff and management of the member across their continuum of care. MeridianComplete nurse reviewers assess the care and services provided in an inpatient setting and the member's response to the care by applying InterQual® criteria. Together with the facility's staff and care management's clinical staff, we are able to coordinate the member's discharge needs.

All elective hospital admissions initiated by the PCP or specialist require a Prior Authorization. A provider may initiate a prior authorization request by calling Member Services, entering the authorization request via the Meridian online PA form or by submitting the request via fax. Be sure to include clear and concise clinical documentation to support medical necessity, which will facilitate a quick determination.

Turnaround Time for Referral Processing

Review type	Makes decision	Written/verbal notification	Written notification (denials)
Pre-service nonurgent	Within 14 days of receipt of the request	Within 14 days of receipt of the request	Within 14 days of receipt of the request
Pre-service urgent	Within 72 hours of receipt of the request	Within 72 hours of the request	Within 72 hours of the request
Urgent concurrent	Within 24 hours of receipt of the request, 72 hours if clinical is not included with initial request	Within 24 hours of receipt of the request, 72 hours if clinical not included with initial request	Within 72 hours of the decision

Required Notification to Members for Observation Services

In compliance with the Federal Notice of Observation Treatment and Implication for Care Eligibility Act (NOTICE Act), contracted hospitals and Critical Access Hospitals (CAHs) must deliver the Medicare Outpatient Observation Notice (MOON) to any beneficiary (including an MA enrollee) who receives observation services as

an outpatient for more than 24 hours. See the final at:
https://www.cms.gov/Medicare/Medicare-General-Information/BNI/MOON#:~:text=Hospitals%20and%20CAHs%20are%20required,critical%20access%20hospital%20(CAH).

Case Management

The MeridianComplete Case Management Program provides patient-focused, individualized case management for members who meet program criteria. The following case management programs are available to personally support the healthcare needs of members: asthma, diabetes, congestive heart failure, cardiovascular disease, complex/catastrophic illness, and high emergency room use.

Our case managers will send you a Member-Centric Care Plan identifying the member's health status and short- and long-term goals for case management.

Our case managers may contact you for other reasons:

- To coordinate a plan of care
- To confirm a diagnosis
- To verify appropriate follow-up such as cholesterol/LDL-C screening or HbA1c testing
- To identify compliance issues
- To invite you to an Interdisciplinary Care Conference
- To discuss other problems and issues that may affect outcomes of care
- To inform you of a member's potential need for behavioral health follow-up

MEMBER APPEALS AND GRIEVANCES

Members, or their representatives, have the right to make a complaint if they have concerns or problems related to their coverage or care. "Appeals" and "grievances" are the two types of complaints members can make. All contracted providers must cooperate with the Medicare Advantage appeals and grievances process.

Definitions

Appeal: Any of the procedures that deal with the review of adverse organization determinations on the healthcare services a member believes he or she is entitled to receive, including delay in providing, arranging for, or approving the healthcare services (such that a delay would adversely affect the health of the member), or on any amounts the member must pay for a service as defined in 42 CFR 422.566(b). These procedures include reconsideration by the Medicare health plan and, if necessary, an independent review entity, hearings before Administrative Law Judges (ALJs), review by the Medicare Appeals Council (MAC), and judicial review.

Grievance: Any complaint or dispute, other than one involving an organization determination, expressing dissatisfaction with the manner in which a Medicare health plan or delegated entity provides healthcare services, regardless of whether any remedial action can be taken. A member or their representative may make a complaint or dispute, either orally or in writing, to a Medicare health plan, provider, or facility. An expedited grievance may also include a complaint that a Medicare health plan refused to expedite an organization determination or reconsideration, or invoked an extension to an organization determination or reconsideration time frame.

Appeals

Expedited Appeal

An expedited appeal is a request to change a denial decision for urgent care. Urgent care is any request for medical care or treatment with respect to which the application of the time period for making nonurgent care determinations could seriously jeopardize the life or health of the member or the member's ability to regain maximum function, based on a prudent layperson's judgment.

Inpatient services that are denied while a member is in the process of receiving the services are considered an urgent concurrent request and is therefore eligible for an expedited appeal.

Pre-Service Nonurgent Appeal

Members, their representatives, or providers, acting on behalf of a member, may request an appeal of denial in advance of the member obtaining care or services. Meridian will provide acknowledgement of the appeal within three days of receipt of the request. No provider will be involved in an appeal for which he or she made the original Adverse Determination. No provider will render an appeal decision who is a subordinate of the provider making the original decision to deny.

Refer to the Billing and Payment section for directions on Post-Service Appeals.

Levels of the Appeals Process

The levels of the appeals process are listed below. If an appeal is not resolved at one level, it can proceed to the next.

1. Meridian standard or expedited appeals process
2. Review by an Independent Review Entity (IRE)
3. Review by an Administrative Law Judge (ALJ)
4. Review by a Medicare Appeals Council (MAC)
5. Review by a Federal District Court Judge

If your problem is about a **Medicaid** service or item, you can file a Level 2 Appeal yourself with the State Hearings office. The denial letter will tell you how to do this. If your problem is about a service or item that could be covered by **both Medicare and Medicaid**, you will automatically get a Level 2 Appeal with the IRE. If they also deny your appeal, you can ask for another Level 2 Appeal with the State Hearings office.

Members can appeal a medical decision within 60 calendar days of receiving Meridian's letter denying the initial request for services or payment on their own behalf. They can also designate a representative, including a relative, friend, advocate, provider or other person, to act for them. The member and the representative must sign and date a statement giving the representative legal permission to act on the member's behalf ("Appointment of Representative" Form CMS-1696 may be used, or a similar statement). The Member can also call the Member Services department at the number listed in the contact information section of this manual to learn how to name an authorized representative.

Expedited or Non-urgent Pre-service appeals, and/or the representative statement may be sent to Meridian at:

Appeals for Part D (Drugs):
MeridianComplete (Medicare-Medicaid Plan)
Part D Appeals
1 Campus Martius, Suite 750
Detroit, MI 48226

Fax: **1-844-328-1906**
Phone: **1-855-898-1480 (TTY: 711)**

Appeals for Part C (Medical and Part B Drugs):
MeridianComplete (Medicare-Medicaid Plan)
Appeals & Grievances
Medicare Operations
7700 Forsyth Blvd
St. Louis, MO 63105

Fax Number: **1-844-273-2671**
Phone (Member Services): **1-855-580-1689**

Appeals and Grievances
A member may appeal an adverse initial decision by Meridian or a participating provider concerning authorization for or termination of coverage of a healthcare service. A member may also appeal an adverse initial decision by Meridian concerning payment for a healthcare service. A member's appeal of a decision about authorizing health care or terminating coverage of a service must generally be resolved by Meridian within 15 calendar days if the member's health condition requires. An appeal concerning payment must generally be resolved within 60 calendar days.

Participating providers must also cooperate with Meridian and members in providing necessary information to resolve the appeals within the required time frames. Participating providers must provide the pertinent medical records and any other relevant information to Meridian. In some instances, participating providers must provide the records and information very quickly in order to allow Meridian to make an expedited decision.

If the normal time period for an appeal could result in serious harm to the member's health or ability to function, the member or the member's provider can request an expedited appeal. Such an appeal is generally resolved within 24 hours unless it is in the member's interest to extend this time period. If a provider requests the expedited appeal and indicates that the normal time period for an appeal could result in serious harm to the member's health or ability to function, we will automatically expedite the appeal.

A special type of appeal applies only to hospital discharges. Hospitals are required to notify all MeridianComplete members who are admitted to the hospital of their hospital discharge appeal rights. Hospitals must issue *Important Message from Medicare About Your Rights (IM),* a statutorily required notice, up to seven days before admission or within two calendar days of admission, obtain the signature of the member or of his or her representative, and provide a copy at that time. Hospitals will also deliver a copy of the

signed notice as far in advance of the discharge as possible, but not less than two calendar days before discharge.

If the member thinks their hospital stay is ending too soon, the member can appeal directly and immediately to the Quality Improvement Organization that is contracted with CMS. However, such an appeal must be requested no later than noon on the first working day after the day the member gets notice that Meridian's coverage of the stay is ending. If the member misses this deadline, the member can request an expedited appeal from Meridian.

Another special type of appeal applies only to a member dispute regarding when coverage will end for skilled nursing facility (SNF), home health agency (HHA) or comprehensive outpatient rehabilitation facility services (CORF). Medicare regulations require the provider to deliver the standard *Notice of Medicare Non-Coverage* (*NOMNC)* to all members when covered services are ending, whether the member agrees with the plan to end services or not. Providers must distribute the NOMNC at least two days prior to enrollee's CORF or HHA services ending and two days prior to termination of SNF services. If the member thinks his or her coverage is ending too soon, the member can appeal directly and immediately to the Quality Improvement Organization. If the member gets the notice two days before coverage ends, the member must request an appeal to the Quality Improvement Organization no later than noon of the day after the member gets the notice. If the member gets the notice more than two days before coverage ends, then the member must make the request no later than noon the day before the date that coverage ends. If the member misses the deadline for appealing to a quality improvement organization, the member can request an expedited appeal from Meridian.

If a member has a grievance about his or her plan, a provider or any other issue, the member can call Member Services or submit a complaint in writing by mail or fax.

We will resolve the grievance as quickly as the case requires based on the member's health status, but no later than 30 calendar days after receiving the complaint. We may extend the time frame by up to 14 days if the member requests the extension, or if we justify a need for additional information and the delay is in the member's best interest.

Further Appeal Rights

If Meridian denies the member's appeal in whole or in part, it will forward the appeal to an Independent Review Entity (IRE) that has a contract with the federal government and is not part of Meridian. This organization will review the appeal and, if the appeal involves authorization for healthcare services, make a decision within 30 days. If the appeal involves payment for care, the IRE will make the decision within 60 days. If the IRE issues an adverse decision and the amount at issue meets a specified dollar threshold, the member may appeal to an Administrative Law Judge (ALJ). If the member is not satisfied with the ALJ's decision, the member may request review by the Medicare Appeals Council (MAC). If the MAC refuses to hear the case or issues an adverse decision, the member may be able to appeal to a Federal District Court of the United States.

Critical Incidents Reporting

Meridian requires participating program providers to report all Critical Incidents that occur in a home, community-based, or long-term services and supports delivery setting. This includes assisted living facilities, community-based residential alternatives, adult day care centers, other HCBS provider sites, and a member's home, if the incident is related to the provision of HCBS. Providers will be provided with Critical Incident education materials and have access to additional information via our website (**www.mhplan.com**). Providers

must participate in trainings offered by Meridian to ensure accurate and timely reporting of all critical incidents. Trainings may be offered as webinars, online learning, and regional meetings.

Critical incidents include, but are not limited to:

- Unexpected death of a program member
- Any abuse, such as physical, sexual, mental, or emotional, of a program member
- Theft or financial exploitation of a program member
- Severe injury sustained by a program member
- Medication error involving a program member
- Abuse and neglect and/or suspected abuse and neglect of a program member
- Provider no-shows, particularly when the enrollee is bedbound all day or there is a critical need

Providers must contact Meridian's Provider Relations, Members Services, or the member's care manager for a report of the incident within 48 hours. The report, at a minimum, must include:

- Member name
- Date of birth
- Date and time of incident
- A brief description of the incident
- Member's current condition
- Actions taken to mitigate risk to the member

A summary of the critical incident must be submitted to Meridian via secure email at HCBS@Centene.com, no later than 48 hours following the discovery of the incident. Providers must cooperate fully in the investigation of reported critical incidents, including submitting all requested documentation. If the incident involves an employee or an HCBS provider, the provider must also submit a written report of the incident, including actions taken within 20 calendar days of the incident. To protect the safety of the member, actions that can be taken immediately include, but are not limited to:

- Providers must contact 911 if the incident can cause immediate/severe harm to the member
- Remove the accused worker from the member's case (if incident includes an allegation of improper behavior by that worker)
- Remove the accused worker from servicing all plan members until the investigation is complete. This may take up to 30 calendar days
- Order an immediate drug screen or appropriate testing if an allegation includes theft of drugs or use of substances including alcohol while on the job
- Interview any involved employee(s) as soon as possible following the incident. Have the employee(s) submit a written account of events. Fax these written accounts to Meridian along with documentation to support completion of pre-employment screenings, including background checks, drug screening, and a statement that the employee did not begin to perform services for plan members until all required pre-employment screenings were completed and verified. Fax numbers can be obtained by calling Meridian.

Depending upon the severity of the incident, any identified trend, or the failure on the part of the provider to cooperate with any part of the investigation, the provider may be required to submit a written plan of correction to address and correct any problem or deficiency surrounding the critical incident.

When a provider has reasonable cause to believe that an individual known to them in their professional or official capacity may be abused, neglected, or exploited, the provider must also report the incident to the appropriate State agency. The following phone numbers should be used to report suspicion of abuse, neglect, or exploitation.

Illinois Reporting Table

Illinois State Government website:
www.illinois.gov/dcfs/safekids/reporting/Pages/index.aspx
https://www.dhs.state.il.us/page.aspx?item=32675

If there is immediate risk of serious injury or death, call the local dispatch office.
Providers must notify HFS immediately if there is a member death related to alleged abuse, neglect, or exploitation.

If you perceive an immediate threat to the member's life or safety, contact 911.

Incident Involves	Contact	Time frame
All Adults **(including disabled)**, ages 18-59; All adults living in an **institutional setting**	Illinois Department of Human Services Office of the Inspector General Hotline **1-800-368-1463** (voice and TTY)	*Immediately*
Disabled Adults ages 18-59, living in a **community setting;** Older adults (60 years of age and older) regardless of residence	Adult Protective Services Hotline **1-866-800-1409** **1-800-206-1327** TTY	*Immediately*
All Adults ages 18-59 living in a **community setting**	Adult Protective Services **1-866-800-1409** AND Department of Human Services' Office of Inspector General (DHS OIG) **1-800-368-1463**	*Immediately*
Nursing Facilities Residents	Department of Public Health Registry Hotline **1-800-252-4343**	*Immediately*
Supportive Living Facilities Residents	Department of Healthcare and Family Services SLF Complaint Hotline **1-844-528-8444**	*Immediately*

FRAUD, WASTE, AND ABUSE

Healthcare fraud, waste and abuse affects every one of us. It is estimated to account for between 3% and 10% of the annual expenditures for health care in the U.S. Healthcare fraud is both a state and federal offense.

The following are the official definitions of Fraud, Waste, and Abuse: 42 CFR §455.2 Definitions.

Fraud: An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to him or some other person. It includes any act that constitutes fraud under applicable Federal or State law.

Waste: Involves the taxpayers not receiving reasonable value for money in connection with any government funded activities due to an inappropriate act or omission by players with control over or access to government resources (e.g., executive, judicial or legislative branch employees, grantees or other recipients). Waste goes beyond fraud and abuse and most waste does not involve a violation of law. Waste relates primarily to mismanagement, inappropriate actions and inadequate oversight.

Abuse: Provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicare program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes recipient practices that result in unnecessary cost to the Medicare program.

Here are some examples of Fraud, Waste, and Abuse:

Fraud and Waste

- Providers billing for services not provided
- Providers billing for the same service more than once (i.e., double billing)
- Providers performing inappropriate or unnecessary services
- The misuse of a Medicare card to receive medical or pharmacy services
- Altering a prescription written by a provider
- Providers performing inappropriate or unnecessary services
- The misuse of a Medicare card to receive medical or pharmacy services
- Altering a prescription written by a provider
- Making false statements to receive medical or pharmacy services

Abuse

- Going to the emergency department for non-emergent medical services
- Threatening or abusive behavior in a provider's office, hospital, or pharmacy

Overpayment and Recovery

Meridian handles recovery of overpayments (take-backs) according to the situation that created the overpayment and the time frame between when the payment was made and when the overpayment was identified. Below are examples of overpayment and recovery situations:

- Inaccurate payment: This includes duplicate payment, system setup error, claim processing error and claims paid to wrong provider. Adjustment/notification date for recovery will be limited to 12 months from date of payment
- Identified through a medical record audit: Adjustment/notification date for recovery will be limited to 12 months from date of payment. In the event that the audit reveals fraud, waste, or abuse, the 12-month look-back period will no longer apply
- Fraud and abuse: Adjustment/notification date for recovery time period will be the statute of limitations or the time limit stated in the Provider Agreement

In the event it is determined that an inaccurate payment was made, Meridian will not provide prior written notice of a recovery. In that case, Meridian will recover the overpayment by issuing an invoice or performing a take-back. Full details of this recovery will be provided in either the invoice or the remittance advice.

No time limit applies to the initiation of overpayment recovery efforts required by a state or federal program or where there is suspected fraud or intentional misconduct involved.

To report possible Fraud, Waste, or Abuse (FWA):
Contact Meridian through the Fraud, Waste & Abuse Hotline at 1-866-685-8664. All reporting of possible FWA may be done anonymously through this hotline. The Special Investigations Unit (SIU) can be contacted by email at: **Special_Investigations_Unit@CENTENE.COM**, or by mail at:

Special Investigations Unit
1 Campus Martius, Suite 700
Detroit, MI 48226