TABLE OF CONTENTS

SECTION 4: PROVIDER CONTRACTING

Health Plan Provider Contracting Department is responsible for recruiting Providers and negotiating financially sound contracts with physicians, medical groups, hospitals, ancillary providers, and other health professionals to maintain a comprehensive provider network. Additionally, Health Plan will conduct California Integrated Care (CICM) functions via internal resources. For additional information about CICM populations, refer to the Care Coordination section of this manual.

BECOMING A PARTICIPATING PROVIDER

Health Plan Advantage D-SNP is an integrated program serving the unique needs of Enrollees who qualify for both Medicare and Med-Cal programs. As such, to become a D-SNP participating Provider must meet the requirements of Medicare as well as California's Medi-Cal program.

Medicare Program Requirements

The Centers for Medicare and Medicaid Services (CMS) requires all Medicare Advantage Providers, including facility and ancillary providers, to be enrolled in the Medicare program via a contractual agreement, either as 1) a participating Provider (accepting Medicare's approved amount as payment in full for services) or 2) as non-participating (not required to accept assignment on every claim and can charge up to 15% more than the Medicare-approved amount. To participate in Health Plan Advantage D-SNP, Providers may not opt out of Medicare.

Additionally, CMS mandates all Medicare Advantage Providers comply with the following but not limited to conditions:

1. Provider must allow HHS, the Comptroller General, or their designees access to audit, evaluate, and inspect any pertinent information for any particular contract period, including, but not limited to, any books, contracts, computer or other electronic systems (including medical records and documentation).

2. Provider will comply with the confidentiality and enrollee record accuracy requirements, including: (1) abiding by all federal and state laws regarding confidentiality and disclosure of medical records, or other health and enrollment information, (2) ensuring that medical information is released only in accordance with applicable federal or state law, or pursuant to court orders or subpoenas, (3) maintaining the records and information in an accurate and timely manner, and (4) ensuring timely access by enrollees to the records and information that pertain to them.

3. Provider will not hold Enrollees liable for payment of any fees that are the legal obligation of Health Plan.

4. Provider will not hold Enrollees eligible for both Medicare and Medi-Cal for Medicare cost sharing when the state is responsible for paying such amounts. Providers will be informed of Medicare and Medi-Cal benefits and rules for Enrollees eligible for Medicare and Medi-Cal. Providers may not impose cost-sharing that exceeds the amount of cost-sharing that would be

permitted with respect to the individual under title XIX if the individual were not enrolled in such a plan. Providers will: (1) accept Health Plan payment as payment in full, or (2) bill the appropriate state source.

5. Provider contract with Health Plan must contain a prompt payment provision, the terms of which are developed and agreed to by the contracting parties. Health Plan is obligated to pay contracted Providers under the terms of the contract.

6. Provider will comply with all applicable Medicare laws, regulations, and CMS instructions.

7. Provider credentials will be either reviewed by Health Plan or the credentialing process will be reviewed and approved by Health Plan and Health Plan must audit the credentialing process on an ongoing basis.

8. Health Plan retains the right to approve, suspend, or terminate any such arrangement.

CONFIRMATION OF ELIGIBILITY FOR PARTICIPATION IN MEDICARE

Excluded Providers

Federal requirements and industry practice prohibits Health Plan from employing or contracting with individuals or entities listed as debarred, excluded or otherwise ineligible to participate in the Medicare program. The Office of the Inspector General (OIG) maintains a sanction list that identifies those individuals found guilty of fraudulent billing, misrepresentation of credentials, etc. Health Plan is responsible for checking the sanction list with each new issuance of the list, as they are prohibited from hiring, continuing to employ, or contracting with individuals named on that list.

- For a list of Excluded Individuals and Entities, please visit **http://exclusions.oig.hhs.gov**.
- For a list of Parties Debarred from Federal Programs, please visit **http://epls.arnet.gov**.

The OIG has a limited exception that permits payment for emergency services provided by excluded providers under certain circumstances.

Opt-Out Providers

If a Provider opts out of Medicare, that Provider may not accept federal reimbursement for a period of two years. The only exception to the rule is for emergency and urgently needed services where a private contract had not been entered into with an Enrollee who receives such services.

Health Plan must pay for emergency or urgently needed services furnished by Provider to an Enrollee. Otherwise, Health Plan may not pay opt-out providers.

SECTION 4: PROVIDER CONTRACTING

Medi-Cal Program Requirements

The Department of Healthcare Services (DHCS) requires all Medi-Cal managed care plan providers, including facility and ancillary providers, to be enrolled in Medi-Cal Fee-For- Service (FFS), unless excluded.

Health Plan is required to ensure all contracted Providers are enrolled in Medi-Cal FFS. This requirement is consistent with state and federal regulations. Provider, or their affiliated medical groups, are responsible for their own enrollment process directly with DHCS and must provide evidence of current/active Medi-Cal enrollment. Please note while Providers are required to be enrolled in Medi-Cal, Providers are not required to accept Medi-Cal FFS beneficiaries in their practice.

Ordering, Referring or Prescribing (ORP) Providers must enroll either as a Medi-Cal billing Provider, rendering Provider, or as an ORP only (non-billing) Provider. Providers who are in a medical group and do not bill Health Plan directly for services can elect an ORP enrollment only. This means that if the Provider intends to bill Health Plan directly, he/she must enroll with Medi-Cal.

State requirements and industry practice prohibits Health Plan from employing or contracting with individuals or entities listed as debarred, excluded or otherwise ineligible to participate in Medi-Cal. Lists of debarred and excluded individuals and entities are maintained by DHCS. To ensure compliance, Health Plan verifies all contracted Providers are not excluded from participation at initial credentialing (prior to contracting) and monthly thereafter.

For a list of excluded or exempted provider types, please visit
www.dhcs.ca.gov/provgovpart/Pages/PAVE.aspx

Health Plan Advantage D-SNP Program Requirements

Health Plan continually monitors its network and is always looking to improve Enrollee access and availability. Providers interested in contracting directly with Health Plan, who are not under a delegated arrangement with Health Plan, should contact the Provider Contracting Department at 1-888-361-7526 or complete the Provider application available on Health Plan website at Provider Contract Request - HPSJ/MVHP. Upon receipt, Health Plan will review the application to assess eligibility. Qualified prospective Providers will be invited to submit additional information and supporting documentation for the credentialing process. Please review the Credentialing Section of the manual for details.

Upon successfully completing credentialing, the Contracting Department will contact the Provider to begin the contracting process. Providers cannot be contracted and, subsequently, accept Enrollees or referrals, until credentialing and Commission approval.

SECTION 4: PROVIDER CONTRACTING

TERMINATING A CONTRACT

Individual Providers and/or groups must provide Health Plan at least 90 calendar days advance written notice of any intent to leave the practice or medical group for any reason. Additionally, Providers or medical groups must comply with the specific termination provisions and notice periods outlined in their contracts.

CONTINUITY OF CARE OBLIGATIONS OF TERMINATING PROVIDERS

When Providers terminate from Health Plan network for reasons other than medical disciplinary cause, fraud, or other unethical activity, they must work with Health Plan to ensure continuation of medical care to the Enrollees assigned to their care.

Providers must continue to provide covered services to Enrollees who are hospitalized for medical or surgical conditions or who are under their care on the date of termination. Providers must also continue to provide covered services to Enrollees until the covered services are completed or until alternate care can be arranged.

Providers must ensure an orderly transition of care for case managed Enrollees including, but is not limited to, the transfer of Enrollee medical records.

SUSPENSION, TERMINATION OR NON-RENEWAL OF PHYSICIAN CONTRACTS

When Health Plan suspends, terminates, or elects to not-renew a Physician contract, Health Plan will:

1. Provide the affected physician written notice of the reason(s) for the action including, if relevant, the standards and profiling data used to evaluate the physician and the numbers and mix of physicians needed by Health Plan.
2. Allow the physician to appeal the action and give the physician written notice of his/her right to a hearing and timing for a request.
3. Ensure the majority of the hearing panel are peers of the affected physician.
4. Notify licensing and/or disciplinary bodies or other authorities when suspension or termination is due to a quality of care deficiency.
5. Provide at least 60 days written notice when termination of the contract is without cause.

FACILITY AND ANCILLARY CONTRACTING

Facility and Ancillary Providers seeking to contract with Health Plan should contact Health Plan's Contracting Department at (888) 361-7526 and speak with a contracting representative and or contact us at Provider Contract Request - HPSJ/MVHP

Facility and Ancillary Providers will be provided with the necessary applications and documents needed to move forward with credentialing.

SINGLE CASE AGREEMENTS

Health Plan offers a network of Providers designed to deliver health care services within the designated service area. These network Providers accept referrals and follow the guidelines set by Health Plan. They also comply with requirements for timely and geographic access for Enrollees.

In certain circumstances, covered services may be needed from out-of-network Providers. Examples include urgent care while traveling outside the service area or when specialty services are required and there is no available in-network Provider. In these cases, contact the UM Department at 1-209-942-6320 to request approval for the referral. If approved, Health Plan's Contracting Department may reach out to the Provider to discuss terms and payment specific to the situation.