Health Plan of San Joaquin

Mountain Valley Health Plan

Advantage D-SNP



# 2026

## D-SNP Provider Manual

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# SECTION 1: INTRODUCTION

## ABOUT HEALTH PLAN OF SAN JOAQUIN/MOUNTAIN VALLEY HEALTH PLAN ADVANTAGE DUAL SPECIAL NEEDS PLAN (D-SNP)

Health Plan of San Joaquin/Mountain Valley Health Plan and Advantage D-SNP (HMO) is pleased to have you as part of our Provider network. We recognize that the strength of our health care programs depends upon strong collaboration and communication with our Providers and their staff.

When we refer to Health Plan of San Joaquin/Mountain Valley Health Plan throughout this document, we will use the term "Health Plan".

Health Plan, a not-for-profit health plan initiative for San Joaquin County, has been serving Enrollees and the community since 1996. Health Plan is the leading Medi-Cal Managed Care Plan and as of January 1, 2026, Health Plan offers a Medicare Advantage Dual Special Needs Plan (D-SNP) program. The counties served includes Alpine, El Dorado, San Joaquin and Stanislaus counties. Our extensive referral network extends well beyond these local areas and includes facilities and Providers in other parts of the Central Valley, the Bay Area, and the Greater Sacramento Area.

We currently have three conveniently located offices to serve Enrollees and Providers. For more information, visit our website at www.hpsj-mvhp.org. Our friendly staff look forward to serving you!

| SAN JOAQUIN COUNTY | STANISLAUS COUNTY | EL DORADO COUNTY |
|---|---|---|
| 7751 S. Manthey Road<br>French Camp, CA 95231-9802<br>1-888-361-PLAN (7526) | 1025 J Street<br>Modesto, CA 95354-0803<br>1-888-361-PLAN (7526) | 4327 Golden Center Drive<br>Placerville, CA 95667<br>1-888-361-PLAN (7526) |

## DUAL SPECIAL NEEDS PLAN (D-SNP)

Health Plan Advantage D-SNP was awarded a contract with the Centers for Medicare and Medicaid Services (CMS) to deliver approved benefits to eligible Medicare beneficiaries under the D-SNP Plan. These benefits include coordination with Medi-Cal, ensuring Enrollees receive integrated care and services. CMS and the Commission are responsible for overseeing the program coordination, process approval and program compliance. For details regarding the D-SNP committees, please refer to Section 13.

Dual Eligible Special Needs Plans (D-SNPs) are Medicare Advantage (MA) plans that provide specialized care and wrap-around services for dual eligible beneficiaries (eligible for both Medicare and Medi-Cal). D-SNPs have a State Medicaid Agency Contract (SMAC) with the Department of Health Care Services (DHCS) in California and a contract with the Centers for Medicare and Medicaid Services (CMS). Beneficiaries enroll through an integrated Exclusively Aligned Enrollment (EAE) D-SNP model. This means that Medicare and Medi-Cal benefits are managed by the same organization. As a EAE D-SNP model plan, Health Plan Advantage D-SNP beneficiaries must be age 21 or older at the time of enrollment, have Medicare Part A and Part B,

have full Medi-Cal benefits and live in our service area which is San Joaquin, Stanislaus, Alpine and El Dorado counties.

A primary advantage for enrolling in an EAE D-SNP is improved care coordination and care experience for Health Plan Advantage D-SNP Enrollees through an integrated model. For Providers, a single claim is submitted for services rendered to Health Plan Advantage D-SNP Enrollees, offering more coordinated care for Enrollees and more efficient operations for Providers.

## MISSION, VISION, AND VALUES

### Our Vision

Healthy communities with equitable access to quality care.

### Our Mission

Provide high quality healthcare for our Enrollees through community partnerships.

### Our Values

| Accountability | Diversity, Equity, and Inclusion (DEI) | Partnerships | Stewardship | Excellence | Teamwork |
|---|---|---|---|---|---|
| We are accountable to Enrollees, Providers, our communities, and each other. | We believe in promoting a foundation of compassion and respect for diversity, equity, and inclusion strengthening our organization and community by embracing opportunities for growth and leveraging the uniqueness of individual ideas, thoughts, and cultures. | We actively engage in community partnerships to advance quality care and health equity. | We serve as a responsible steward of entrusted resources. | We act with integrity and aim for excellence in all we do. | We demonstrate teamwork in all our interactions. |

# SECTION 1: INTRODUCTION

## PROVIDER RIGHTS AND RESPONSIBILITIES

Health Plan Advantage D-SNP values its relationship with Providers and Providers have the right to know what they can expect from Advantage D-SNP. Providers' Rights include but are not limited to the following:

- The right to freely communicate with enrollees about their treatment, including medication treatment options, regardless of benefit coverage limitations.
- The right to review information Health Plan Advantage D-SNP has obtained to evaluate the Provider's individual credentialing application, including attestation, credentialing verification (CV), and information obtained from any outside source (e.g., malpractice insurance carriers, State licensing boards), with the exception of

  references, recommendations, or other peer-review protected information. Health Plan Advantage D-SNP is not required to reveal the source of information if the information is not obtained to meet credentialing verification requirements or if disclosure is prohibited by law.
- The right to correct erroneous information when credentialing information obtained from other sources varies substantially from information submitted by the Provider. The correction of erroneous information

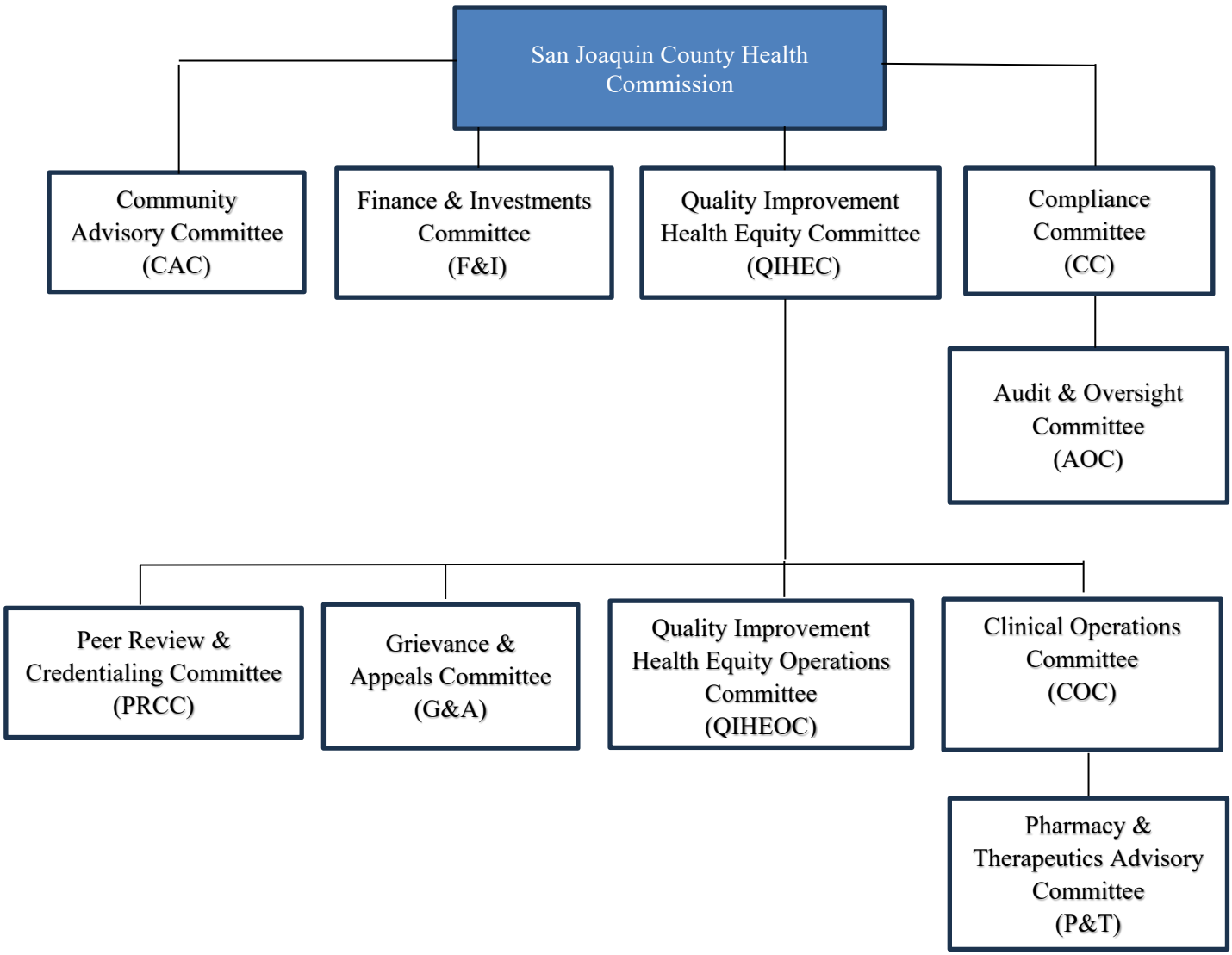
  submitted by another source is detailed in the Credentialing section of this Provider Manual.
- The right to be informed of a Provider's credentialing application status upon request.
- The right to receive information about Health Plan Advantage D-SNP, including but not limited to available programs and services, its staff and their respective titles, operational requirements, and contractual relationships.
- The right to information on how to coordinate interventions with treatment plans for individual enrollees.
- The right to receive support in making decisions interactively with enrollees regarding their health care.
- The right to expect and receive communication from Health Plan Advantage D-SNP staff regarding complaints, issues, or concerns relating to Provider rights and responsibilities and their staff.
- The right to receive policies and procedures about the grievance and appeals pro.

## GOVERNANCE AND COMMITTEES

Health Plan Advantage D-SNP is governed by the San Joaquin County Health Commission (Commission), a 13-member commission appointed by the San Joaquin County (SJC) Board of Supervisors.

Health Plan leadership is accountable to this governing entity. Within this structure is Health Plan's operations and administration:

**Health Plan Governance Committees**



# SECTION 1: INTRODUCTION

## INTENT OF THE PROVIDER MANUAL

The Provider Manual is an extension of the Agreement that Providers entered into with Health Plan Advantage D-SNP. Providers must abide by the conditions set forth in their Agreement and in the Provider Manual. Certain sections and provisions of this Manual may not apply to all Agreements and lines of business or products.

Health Plan may, from time to time, be required to make material changes to the Provider Manual to comply with:

- Federal and/or State laws
- Regulations of government agencies governing Benefit Plans covered by their Agreement
- Regulations of accreditation organizations
- Changes in policies and/or procedures

Should Health Plan determine that a change to the Provider Manual is required, Health Plan shall provide Providers with 45 business days prior written notice of said changes to Provider Manual unless a shorter time frame is required by a state or federal law, government regulations or an accreditation organization.

Changes shall become effective upon the expiration of the 45 business days. If a Provider believes the changes shall have a material impact on the arrangement with Health Plan Advantage D-SNP, the Provider must notify the Health Plan in writing prior to the effective date of the change and the Provider and Health Plan shall confer and/or negotiate in good faith regarding the change. If the Health Plan agrees that such changes shall have a material impact on Provider, and Provider and the Health Plan are unable to reach agreement regarding the change within 45 business days of Provider's notice to Health Plan Advantage D-SNP, the Provider may elect to terminate the Agreement pursuant to the "Termination without Cause" provision in the Agreement. The change to which the Provider objected shall not be in effect during the termination notice period.

If there are conflicts between this manual and current state and federal laws and regulations governing the provision of health care services, those laws and regulations will supersede this Manual.

The Provider Manual is intended to be used as a reference guide for Providers and their office staff. It includes:

- Operational Procedures
- Key Contacts
- Links to Resources
- Compliance Information

# SECTION 1: INTRODUCTION

## HOW TO USE THE PROVIDER MANUAL

The Provider Manual was designed to be easy to search and accessible through Health Plan's website. Providers can visit www.hpsj-mvhp.org and access the manual directly online. Providers can also download the manual by section or in its entirety. To obtain a copy in other formats, go to Health Plan Advantage D-SNP online portal Doctor's Referral Express (DRE) or call our Customer Service Department at 1 (888) 361-7526.

- **Updates to the Manual**

  Health Plan will update the Provider Manual and appendices periodically and make electronic versions available via www.hpsj-mvhp.org. Health Plan will share these updates and other important information via the website, Provider portal and electronic communications.

- **Provider Services**

  Providers have an assigned Health Plan Advantage D-SNP Provider Services Representative who serves as the liaison for Health Plan Advantage D-SNP. These representatives share information and respond to Provider inquiries.

  Health Plan Advantage D-SNP also maintains a dedicated Customer Service phone line available to assist Providers with questions regarding Health Plan Advantage D-SNP policies and procedures, Enrollee care, reimbursement, claim information and general information about Advantage D-SNP and its products. Providers may call the Customer Service Department at (888) 361-7526 8:00 am–8:00 pm seven days a week from October 1 through March 31; and 8:00 am–8:00 pm Monday to Friday from April 1 through September 30. After normal business hours, Providers may leave a message, and we will respond no later than the next business day.

- **Secure Provider Portal**

  Providers and their office staff can access information 24 hours a day, seven days a week through Health Plan Advantage D-SNP secure Provider portal. Quick and easy online registration includes access to tools that allow you to:

  - View claims status
  - Submit authorization requests and view the status
  - Download PCP panel report (Enrollee roster)
  - Submit Provider Dispute Resolutions (PDRs) and supporting documentation and files
  - Review the latest clinical guidelines, Provider alerts, and more
  - Eligibility Search
  - Messaging (Eligibility and benefits inquiry)
  - Authorization request status
  - Provider letters
  - Download Remittance Advice details
  - Required training modules

# SECTION 1: INTRODUCTION

## KEY FUNCTIONS AND CONTACT INFORMATION

The following table highlights key areas and outlines its functions. Health Plan Advantage D-SNP staff from these departments are available to assist Providers in delivering care to Enrollees.

| | |
|---|---|
| **Provider Contracting**<br>To assist with contracting, terms and conditions, fee schedule, suspensions, terminations, updates. | Phone: 1-888-361-7526<br>Email: ContractingDepartment@hpsj.com<br>Fax: 209-942-6384 |
| **Provider Credentialing**<br>To assist with onboarding credentialing and recredentialing process questions including online submissions | Email: Credentialing1@hpsj.com |
| **Provider Services/Customer Service**<br>To assist with routine issues related to training, payment, portal access, complaints, profile updates, etc. | Phone: 1-888-361-7526<br>Email: ProviderServices@hpsj.com<br>Fax: 1-209-461-2565 |
| **Member Services**<br>To assist Enrollees with a Health Plan-related services, including, but not limited to:<br>• Eligibility verification<br>• PCP selection<br>• Billing and claims<br>• Coordination of Benefits (COB)<br>• Demographic updates<br>• ID card replacement requests<br>• Member portal and app | 1-888-361-7526 (TTY: 711), 8:00 a.m. to 8:00 p.m., seven days a week from October 1 through March 31, and Monday to Friday from April 1 through September 30.<br><br>www.hpsj-mvhp.org. |
| **Medical Management Department**<br>To assist necessary approvals including:<br>• Prior authorization for initial and continuing care<br>• Transitional care<br>• Care management and disease management<br>• Assistance in finding appropriate specialists<br>• Utilization review<br>• Behavioral health services | Utilization Review: 1-888-361-7526<br>Care Coordination: 1-800-822-6226<br><br>Behavioral Health: 1-888-361-7526<br><br>Nurse Advise Line: 1-800-655-8294 |
| **Grievance and Appeals**<br>To assist a member in filing a grievance or appeal, you can visit our website at https://www.hpsj.com/dsnp-grievances-and-appeals/<br><br>**Part D Appeals** (MedImpact) | Phone: 1-888-361-7526<br>Email: grievances@hpsj.com<br><br>Phone: 1-833-546-0796 |
| **Confidential Compliance Contact**<br>To anonymously report compliance concerns in addition to suspected fraud, waste, and abuse | Phone: 1-855-400-6002 |

# SECTION 2: BENEFIT PROGRAMS

## OBTAINING COVERAGE AND EXCLUSIONS INFORMATION

Health Plan Advantage D-SNP covers, at a minimum, those medically necessary Medicare-covered benefits and services as approved by CMS and Medi-Cal benefits included in the State Medicaid Agency Contract (SMAC) with the DHCS. Excluded services will not be reimbursed by Health Plan Advantage D-SNP. To ensure the services provided to Enrollees are covered, please review the *Member Handbook/Evidence of Coverage* for the appropriate year. This document can be found on Health Plan Advantage D-SNP's website www.hpsj- mvhp.org.

If the Provider is not currently part of Health Plan Advantage D-SNP network, the provider can still access *Health Plan Advantage D-SNP's Member Handbook/Evidence of Coverage* on Health Plan Advantage D-SNP website.

## SERVICES COVERED BY HEALTH PLAN ADVANTAGE D-SNP

Covered Services refers to the health care services and items Health Plan Advantage D-SNP provides to its Enrollees through its health care programs. Health Plan Advantage D-SNP's health care programs currently include Medi-Cal and Medicare Advantage D-SNP but may also include other health care programs and/or products that Health Plan Advantage D-SNP may offer to individuals or other entities. This manual focuses on the health care services and items offered through the Medicare D-SNP program. In general, the Health Plan Advantage D-SNP includes all benefits covered by Original Medicare, any supplemental benefits and prescription drugs (Part D) that are submitted and approved by CMS plus Medi-Cal covered benefits as per contract with DHCS. For a complete list of covered services provided under the D-SNP for a particular year, please review the Member Handbook/Evidence of Coverage and for a summary of covered services for a particular year, please refer to the Summary of Benefits. Both documents can be found on Health Plan Advantage D-SNP's-website www.hpsj-mvhp.org.

## SERVICES NOT COVERED BY HEALTH PLAN ADVANTAGE D-SNP

Non-Covered Services typically refer to the following health care services and items:

- Health care services and items which are not covered by the Medicare or Medi-Cal programs.
- Health care services and items which are not "reasonable and medically necessary" according to Medicare and Medi-Cal.
- Excluded Services - Health care services and items which are not covered under any other Health Plan health care program.

For a complete list of excluded services for Health Plan's D-SNP program, please review the *Member Handbook/Evidence of Coverage,* which is available on the Health Plan Advantage D-SNP website at www.hpsj-mvhp.org.

## CALIFORNIA INTEGRATED CARE MANAGEMENT (CICM)

CICM is the California-specific requirements for integrated care coordination for specific vulnerable populations covered by D-SNPs as determined by the state. The goal of CICM program is to ensure delivery of extra medical and behavioral interventions, services and benefits that meet

the specialized needs of these most vulnerable beneficiaries as evidenced by measures from psychosocial, functional, and end-of-life domains. Health Plan Advantage D-SNP relies heavily on Provider partnerships to meet these complex needs. See Section 9: Care Coordination for additional details on the CICM program.

## COMMUNITY SUPPORTS

Community Supports are medically appropriate and cost-effective alternative services or settings to those covered under the Medi-Cal State Plan. These services are optional for Enrollees. These services may help Enrollees live more independently. They don't replace benefits that Enrollees already receive under Medi-Cal.

Community supports can help Enrollees with finding, securing and keeping housing if homeless, help with skill developments and assistance in the home, modifications to the home to improve safety, help remove asthma triggers that may be in the home, meals based on chronic or complex medical condition, help for caregivers to allow them to rest and help with transitions to assisted living or back to the community.

Health Plan Advantage D-SNP offers the following community supports:

- Housing Transition Navigation Services
- Housing Deposits
- Housing Tenancy and Sustaining Services
- Short-Term Post Hospitalization Housing
- Recuperative Care
- Meals/Medically Tailored Meals
- Sobering Center
- Asthma Remediation
- Environmental Accessibility Adaptations (Home Modifications)
- Day Habilitation Program
- Personal Care and Homemaker Services
- Respite Services
- Nursing Facility Transition/Diversion to Assisted Living Facilities
- Community Transition Services/Nursing Facility Transition to a Home

For additional information about Community Supports, please review the Member Handbook/Evidence of Coverage, which is available on the Health Plan Advantage D-SNP website at www.hpsj-mvhp.org.

# SECTION 3: PROVIDER CREDENTIALING

## CREDENTIALING

Credentialing is an important function of the Quality Improvement and Health Equity (QIHE) Department. Health Plan's credentialing program has been developed in accordance with applicable regulations from the Centers for Medicare and Medicaid Services (CMS), the California Department of Health Care Services (DHCS), California Department of Managed Health Care (DMHC) and the National Committee for Quality Assurance (NCQA). In selecting practitioners, Health Plan will not discriminate, in terms of participation, reimbursement, or indemnification, against any health care professional who is acting within the scope of his or her license or certification under state law, solely on the basis of the license or certification. Health Plan may, however:

- Refuse to grant participation to health care professionals in excess of the number necessary to meet the needs of the plan's Enrollees
- Use different reimbursement amounts for different specialties or for different practitioners in the same specialty.
- Implement measures designed to maintain quality and control costs consistent with its responsibilities.

Health Plan regularly obtains, and reviews reports and other documentation to enable ongoing monitoring health care professionals, including but not limited to:

- Providers who have been sanctioned, excluded, or precluded from participation from state and federally funded programs
- Providers who have opted out of accepting federal reimbursement from Medicare
- Resolution of beneficiary grievances
- Sanctions and limitations on licensure

Health Plan initially credentials all physicians who provide services to D-SNP Enrollees (including members of physician groups), and all other types of health care professionals who provide services to Enrollees and who are permitted to practice independently under state law. Health Plan recredentials them at least every three years. Credentialing information submitted to Health Plan is reviewed and primary source verified, as applicable using CMS and DHCS approved sources. To verify information, Health Plan uses the same sources and processes for initial credentialing and recredentialing.

To ensure the highest quality health care delivery system and to maintain compliance with regulatory and accreditation agencies, Health Plan credentials, or oversees the credentialing, of the following types of Providers:

- Physicians (MD)
- Osteopathic Practitioners (DO)
- Podiatrists (DPM)

- Nurse Practitioners (NP)
- Chiropractors (DC)
- Dentists (DMD)/Oral Surgeons
- Physician Assistants (PA)
- Nurse Midwives (NMW)
- Other practitioner types who serve Enrollees outside the inpatient hospital setting or outside ambulatory freestanding facilities and have an independent relationship with Health Plan
- Locum Tenens practitioners including physicians, dentists, chiropractors, optometrists, social workers, and psychologists after 90 calendar days of continuous service.
- Practitioners who are hospital-based but who see Enrollees as a result of their independent relationship with Health Plan including, but not limited to:
    - Anesthesiologists with pain management practices
    - Cardiologists
    - University faculty who are hospital-based and who also have private practices

In addition, Health Plan credentials the following allied health professional Providers:

- Psychologists
- Optometrists
- Physical Therapists
- Chiropractors
- Speech/Hearing Therapists
- Telemedicine Providers
- Audiologists
- Mental Health and Substance Use Disorder Provider
- Addiction Specialists
- Occupational Therapists
- Licensed Clinical Social Workers (LCSW)
- Licensed Marriage Family Therapists (LMFT)
- Clinical Nurse Specialists
- Other allied providers as deemed necessary
- Street Medicine Providers
- Clinical Nurse Specialists
- Board Certified Behavioral Analysts (BCBA)

# SECTION 3: PROVIDER CREDENTIALING

In accordance with Health Plan policies and procedures, the credentialing process typically takes between 60 and 90 days. Within 120 days of receipt of a provider application, Health Plan shall complete the enrollment process and provide the applicant with written determination. For Mental Health and Substance Use Disorder Providers, Health Plan will notify them within seven business days of receipt of a credentialing application to: 1) verify receipt; and 2) inform the Provider whether the application is complete. The information gathered during this process is confidential and disclosure is limited to parties who are legally permitted under state and federal law to have access to this information.

**In order to maintain health care quality standards, no Enrollees will be assigned or referred to Providers who have not completed the credentialing process and signed an Agreement with Health Plan to participate in the network.**

## REQUIREMENTS FOR CREDENTIALING/RECREDENTIALING

### Requirements for Physicians

Health Plan will ensure that, at a minimum, physicians considered for network participation and continued participation are in good standing (through primary source verification, as applicable), and meet the following criteria before being accepted in the network:

1) A written credentialing application and attestation of correctness and completeness signed and dated by the applicant no more than six months in advance of new contract or recredentialing, that includes the following:
    a) Work history of the preceding five years acceptable to Health Plan
    b) Any limitations in ability to perform the essential functions of the position, with or without accommodation
    c) Lack of present illegal drug use
    d) History of loss of license and/or felony convictions
    e) History of loss or limitation of privileges or disciplinary activity
    f) Request for practitioner race, ethnicity, and languages in which the practitioner is fluent when discussing medical care. The application includes a statement that providing this information is optional and that Health Plan does not discriminate or base credentialing decisions on an applicant's race, ethnicity and language
2) Valid, unrestricted, and current California state license
3) Medicare and Medi-Cal Fee for Service or Ordering, Prescribing, and Referring (ORP) Enrollment
4) Clinical privileges in good standing at a hospital or coverage arrangements with another physician for Enrollees who require hospitalization (if applicable)
5) Current and valid federal Drug Enforcement Agency (DEA) registration or Controlled Dangerous Substance (CDS) certificate for the state

6) Graduation from an approved medical school and completion of an appropriate residency or specialty program
7) Board certification (if required)
8) Current professional liability (malpractice) insurance in amounts acceptable to Health Plan
9) Professional liability claims history acceptable to Health Plan
10) Absence of Medicare and Medicaid sanctions and exclusions
11) Eligibility for participation in Medicare (i.e. not an opt-out provider)
12) Absence of state sanctions against licensure
13) National Practitioner Data Bank (NPDB) query results acceptable to Health Plan
14) Absence of Quality of Care and service issues
15) Facility Site Review (FSR) findings acceptable to Health Plan, if an office site visit is conducted

Health Plan has established a temporary, streamlined credentialing guideline for newly trained individuals. In the case of a newly trained health care professional who has completed all appropriate training and education within the last 12 months, Health Plan permits initial credentialing for a period of up to 60 days when the following conditions are met:

1) Health Plan verifies that the practitioner has a current, valid license from primary sources;
2) Health Plan verifies malpractice settlements from the last five years. (This may be performed by verifying with the malpractice carrier or the NPDB; attestation is not accepted);
3) Practitioner meets all standard credentialing requirements after 60 days; and
4) Health Plan Credentialing Committee has reviewed the case and makes the final determination about granting such an initial 60-day credentialing period.

For recredentialing, acceptable findings from quality reporting are required. This may include, but is not limited to, a review of:

1) Enrollee and Provider complaints
2) Results of access and satisfaction surveys
3) Grievance reports
4) Quality of care reporting

### Requirements for Institutional Provider and Supplier Certification

Health Plan will ensure, at a minimum, that each institutional provider or supplier has a signed contract or participation agreement and has met the following three requirements:

**1)** Medicare Approval for the following types of providers and suppliers:

**a)** Hospitals

**b)** Transplant Center

**c)** Critical Access Hospital

**d)** Skilled Nursing Facilities (SNFs)

**e)** Comprehensive Outpatient Rehabilitation Facilities (CORFs)

**f)** Home Health Agencies (HHA)

**g)** Hospices

**h)** Religious non-medical health care institution

**i)** Any clinic, rehabilitation agency or public health agency that has a Medicare participation agreement to furnish outpatient physical therapy or outpatient speech pathology services

**j)** An entity that has a Medicare participation agreement to furnish or opioid use disorder treatment services

**k)** Independent laboratory

**l)** Supplier of durable medical equipment prosthetics, orthotics, or supplies (DMEPOS)

**m)** Ambulance service provider

**n)** Independent diagnostic testing facility

**o)** Physician or other practitioner such as physician assistant

**p)** Physical therapist in private practice, an occupational therapist in private practice, or a speech-language pathologist

**q)** Supplier of portable X-ray services.

**r)** Rural health clinic (RHC).

**s)** Federally qualified health center (FQHC).

**t)** Ambulatory surgical center (ASC).

**u)** An entity approved by CMS to furnish outpatient diabetes self-management training

**v)** End-stage renal disease (ESRD) treatment facility that is approved by CMS as meeting the conditions for coverage of its services

**w)** A site approved by CMS to furnish intensive cardiac rehabilitation services

**2)** Current licensure to operate in California, and compliance with any applicable state or federal requirements

**3)** Review and approval by an accrediting body or meets standards established by Health Plan. Accrediting bodies include:

**a)** The Joint Commission (formerly JCAHO)

**b)** Accreditation Association for Ambulatory Health Care (AAAHC)

**c)** Commission on Accreditation of Rehabilitation Facilities (CARF)

**d)** Council on Accreditation (COA)

**e)** Community Health Accreditation Program (CHAP)

Health Plan also complies with CMS requirements related to the use of Medicare-Approved facilities for performing certain procedures, including but not limited to:

1) Carotid artery stenting
2) Ventricular Assist Device (VAD) destination therapy
3) Bariatric surgery
4) Certain oncologic Positron Emission Tomography (PET) scans in Medicare-specified studies
5) Lung volume reduction surgery
6) Organ transplants

### Requirements for Non-Physician Providers & Non-Physician Medical Practitioners

Health Plan shall ensure, at a minimum, that non-physician Providers and non-physician medical practitioners considered for network participation and continued participation are in good standing (through primary source verification, as applicable) and meet the following criteria before being accepted in or continue participation in the network:

**1)** A written application and attestation of correctness signed and dated by the applicant no more than six months before the date of appointment, including
   a) Work history of the preceding five years acceptable to Health Plan
   b) History of loss of license and/or felony convictions
   c) History of loss or limitation of privileges or disciplinary activity

**2)** Valid, unrestricted, and current California state license

**3)** For prescribing practitioners, current, valid federal DEA registration or CDS certificate for the state

**4)** Current professional liability (malpractice) insurance in amounts acceptable to Health Plan

**5)** Graduation from an approved professional school

**6)** Board certification, if applicable

**7)** Hospital clinical privileges, in good standing or coverage arrangements with other providers, if applicable

**8)** Professional liability claims history acceptable to Health Plan

**9)** Absence of OIG exclusions

**10)** Eligibility for participation in Medicare (i.e. not an opt-out provider) or Medi-Cal Fee for Service or Ordering, Prescribing, and Referring ORP Enrollment if a pathway exists.

**11)** Absence of state sanctions against licensure

**12)** NPDB query results acceptable to Health Plan

**13)** Absence of Quality of Care and service issues

## THE CREDENTIALING PROCESS

During the credentialing process, the information on the Provider's electronic credentialing application is reviewed and verified for correctness, and then reviewed through government verification sources which will include, but not be limited to:

1) NPDB
2) OIG
3) State licensing boards for California and other states if applicable

In addition to providing documentation, a FSR may be required for Primary Care Physicians (PCP). Providers will be contacted by Health Plan's FSR team to schedule and coordinate the FSR.

Completed electronic credentialing applications will then be presented to the Peer Review and Credentialing Committee (PR&CC) which currently meets every other month. The PR&CC reviews each credentialing application to determine if the Provider meets the initial credentialing or recredentialing criteria and then makes the decision to either accept or reject a Provider's application.

All credentialing applications approved by the PR&CC are submitted to the San Joaquin County Health Commission for review and final approval. The Commission meets monthly and once the Commission grants approval, Health Plan can offer or complete an agreement with the Provider.

## RECREDENTIALING

Health Plan re-credentials all Providers at least every three years but may re-credential Providers more often if deemed necessary. The same information reviewed during the initial credentialing process is reviewed and updated during the recredentialing process with the exception of the Provider's educational credentials and work history. Board certification will be reverified only if the provider was due to be recertified or states they have become board certified since the last time they were credentialed or recredentialed.

In addition, Health Plan will review Provider contact logs to consider any information collected through Health Plan activities, including but not limited to its quality and utilization management programs.

The recredentialing process requires a timely response from all Providers. Providers will receive an electronic recredentialing link five months in advance of the three-year anniversary of the last credentialing date. Providers are required to complete identified areas of the application and attest that the information provided on the current application is correct and complete.

The practitioner has 15 business days to send the recredentialing materials to Health Plan. If materials are not received within that timeframe, the Credentialing Specialist sends a second request on the 16th day. If the recredentialing materials are not received 15 business days after the second notice; on the 16th day, a THIRD AND FINAL notice is sent to the practitioner via email by the Contracting Department.

If the recredentialing materials are not received within 15 business days of the final notice; on the 16th day, the Credentialing Specialist notifies the Contracting Department. The Contracting Department attempts to obtain the materials. If unable to do so, the Contracting Department notifies the practitioner that he/she will receive an Administrative Termination via Certified Mail as the recredentialing appointment date has expired.

A practitioner may reapply for participation however the full initial credentialing process will be required.

## PROVIDER'S RIGHTS DURING THE CREDENTIALING PROCESS

### Review of Credentialing Files

Providers have the right to review the information in their credentialing files that have been obtained in order to evaluate their credentialing application. This includes the application, attestation, and Curriculum Vitae (CV), and information from outside sources. Credentialing information that is not available for review includes references, recommendations, or other peer review protected information as this information is used by the Chief Medical Officer and/or PR&CC to determine initial network participation and/or contract continuance.

Requests to review this file must be made in writing to the Chief Medical Officer, and the Chief Medical Officer will be present at the time of review.

### Notification of Errors in Credentialing Submissions

Providers have the right to be notified in the event that credentialing information obtained by Health Plan varies substantially from that provided by the Provider on the application materials, Health Plan Credentialing Specialists will notify the Provider by letter, telephone, or fax. If the notification is conducted by telephone, the date, time, and the person initiating the call and obtaining the information along with the response will be documented and the documentation retained in the credentialing file.

The notification to the Provider will include the following:

**1)** A description of the discrepancy
**2)** A request for a written explanation and/or correction of the discrepancy
**3)** The name and contact information of the Credentialing Specialist to whom the response should be submitted
**4)** Notification that a written response is due no later than 60 calendar days from the date of the letter

5) Notification that failure to respond within the 60 calendar days will result in, for initial application, closure of the file for lack of response
6) For recredentialing Providers, notification that the file will be presented to the PR&CC without benefit of explanation or correction of the discrepancy

The Credentialing Specialist will review the response, sign and date the response, and then notify the Provider that the response has been received. The Credentialing Specialist will also document the receipt and notification to the Provider of the receipt of the information in the credentialing file. Health Plan is not required to reveal to a Provider the source of the information if the information is not obtained to meet Health Plan's credentialing verification requirements, or if law prohibits disclosure.

### Correction of Erroneous Information

Providers have the right to correct erroneous information they may have provided within 14 business days or which has been submitted by another party in the course of the credentialing process. If information provided on the application is inconsistent with information obtained via primary source verification in the credentialing or recredentialing process, the Credentialing Specialist will send the Provider a written notification of the discrepancy and request formal written clarification.

This letter will include a summary of the information in question and a request to have the Provider's written response to the information returned within 14 business days. This letter will be sent electronically or via certified mail marked as "Confidential" with return receipt requested.

Providers do not have the right to correct an application already submitted and attested to be correct and complete. Providers have the right to correct erroneous information prior to the notification of decision and for applications that have not yet been attested to be correct and complete. However, they may submit an addendum to correct erroneous information they may have provided, or which is submitted by another party. This can be sent to the Credentialing Specialist via electronic or certified mail. If preferred, the Provider may add an explanation for the erroneous information on their application, include a signed and dated statement attesting to the accuracy of the information provided, and then return the information to the Credentialing Specialist who initiated the query.

### Application Status and Notification on Decision

Providers have the right to receive information about the status of their application or reapplication and may contact the Credentialing Department at any time to request this information. Upon request, the Credentialing Specialist will provide information regarding the current stage of the application process, such as in progress/pending or awaiting additional information or clarification. The Credentialing Department will respond to these requests in writing no later than 60 days after receipt of request.

Health Plan will notify Providers in writing of their approval no later than 30 calendar days from the PR&CC's approval date. Any Provider who is denied participation, approved with conditions, pended or terminated, will be notified in writing within 30 days of the PR&CC's action, given the reasons for the decision, and provided information about the process for appealing adverse participation decisions.

### Notification of Provider Rights

Health Plan notifies Providers of these rights through a number of methods, which includes notifications in the credentialing application or reapplication cover letter, written and web-based Provider Manual, and other publications distributed to Providers.

## CREDENTIALING A NEW GROUP PROVIDER

To ensure that there is no disruption in obtaining services requiring prior authorization and to avoid claims being denied, it is imperative that any new Provider who joins a group in Health Plan's Provider network is approved by the PR&CC prior to providing covered services to Enrollees.

Before a Provider can be added to a group contract, the new Provider must receive notification from the Credentialing Department that all credentialing requirements have been met. In addition, Providers must receive official notice from the Contracting Department as to the effective date upon which they can provide covered services to Enrollees. The Provider Services Department should be contacted as soon as possible when new Providers are joining a Group.

### Credentialing Provider Organization Certification

Health Plan may obtain Credentialing Provider Organization Certification (POC) from NCQA. HPSJ may accept evidence of NCQA POC certification in lieu of a monitoring visit at Network Provider's facilities.

#### SITE REVIEWS

When appropriate and at its sole discretion, Health Plan may elect:

1. **Facility Site Review (FSR):** a formal review of primary care sites that occurs prior to the practice accepting D-SNP Enrollees, and then every three years thereafter
2. **Medical Record Review (MRR):** A review of selected medical records to determine compliance in the documentation of clinical care
3. **Physical Accessibility Review Survey (PARS):** A review to determine physical accessibility for seniors and people with disabilities
4. **Focused Review:** A focused review is a targeted review of one or more specific areas of the FSR or MRR. The Plan must not substitute a focused review for a site review. The Plan may use focused reviews to monitor Providers between site reviews to investigate problems identified through monitoring activities or to follow up on corrective actions. Reviewers may utilize the appropriate sections of the FSR and MRR tools for the focused

review, or other methods to investigate identified deficiencies or situations. All deficiencies identified in a focused review must require the completion and verification of corrective actions according to the Corrective Action Plan (CAP) timelines.

## FACILITY AND ANCILLARY ASSESSMENT AND VERIFICATION

Facilities and Ancillary Providers seeking to contract with Health Plan must complete an application to verify it meets regulatory and Health Plan network criteria. Application submission is not a guarantee of acceptance. The criteria for participation and continued participation may vary depending upon the types of D-SNP covered services provided and network need/adequacy. The minimum criteria are as follows:

### Facility Providers

1. Valid California state license
2. Current general and professional liability (malpractice) insurance in amounts acceptable to Health Plan
3. Medicare/Medi-Cal Certification
4. Accreditation by Joint Commission or another accreditation body acceptable to Health Plan, if applicable
5. Absence of OIG exclusions

### Ancillary Providers

1. Valid business license
2. Current general and professional liability (malpractice) insurance in amounts acceptable to Health Plan
3. Medicare/Medi-Cal certified and/or participating, as appropriate
4. Clinical Laboratory Improvement Amendment (CLIA) certificate if applicable
5. Accreditation for Radiology/Imaging, if applicable
6. Absence of OIG exclusions

For more information regarding specific requirements for participation, please contact the Provider Contracting Department at 1-888-361-7526

## FACILITY SITE REVIEW

All new primary care sites must undergo an initial full scope site review and attain a minimum passing score of 80% on both the FSR and on MRR surveys. Initial full scope site reviews

will be performed at sites that have not previously had an FSR, PCP sites that have not had a FSR within the past three years, and PCP sites that are returning to D-SNP and have a passing score but were previously terminated for cause and non-compliance with their CAP.

There are additional scenarios that require Health Plan to conduct an FSR. Examples include, but are not limited to, instances when:

1. A new PCP site is added to the Plan's network.
2. A newly contracted Provider assumes a PCP site with a previous failing FSR and/or MRR score within the last three years.
3. A PCP site is returning to the D-SNP program and has not had a passing FSR in the last three years.
4. There is a change of ownership of an existing Provider site.
5. A PCP site relocates.

When a PCP site relocates, Health Plan must:

1. Complete an initial FSR within 60 days of notification or discovery of the completed move.
2. Allow assigned Enrollees to continue to see the Provider.
3. Not assign new Enrollees to Providers at the site until the PCP site receives passing FSR and MRR scores.

The reviewer will also complete a PARS during the FSR.

The FSR can be waived by Health Plan for a pre-contracted Provider site if the Provider has documented proof that a current FSR with a passing score was completed by another health plan within the past three years. Health Plan may review sites more frequently if it is determined necessary.

### Non-Compliance or Failure on FSR

*Pre-contractual Providers*

A pre-contractual Provider who scores below 80% on the full scope site review survey shall not be counted as a network Provider. Prior to being contracted with Health Plan, a non-passing Provider must be re-surveyed and pass the Full Scope Site Review Survey at 80% or higher. After achieving a score of 80% or higher, a CAP shall be completed as specified under CAP steps. If the Provider fails the site review after the second attempt, the Provider will need to reapply to the MCP after six months from the date of the second attempt. Health Plan reserves the right not to contract with any Provider who does not pass the pre-contractual Site Review Survey.

*Contracted Providers*

Contracted Providers must also pass the FSR every 3-years at a score of eighty (80%) or higher. Non-passing Providers shall be notified of the survey score, all cited deficiencies, and CAP requirements at the time of the non-passed survey. Health Plan shall have the right to remove any Provider with a non-passing score from the Provider network.

*Failed Audit Scores*

When a PCP site receives a failing score on an FSR or MRR, the Health Plan will notify the PCP site of the score, all cited deficiencies, and all CAP requirements. The Health Plan may choose to remove any PCP site with a failing FSR or MRR score from its Network. If the Health Plan allows a PCP site with a failing FSR or MRR score to remain in its Network, the Health Plan will require and verify that the PCP site has corrected the identified deficiencies within the CAP timelines established in this policy. The Health Plan will not assign new Members to Network PCP sites that receive a failing score on an FSR or MRR until the Health Plan has verified that the PCP site has corrected the deficiencies, and the CAP is closed.

If the PCP site fails the FSR or MRR on its third consecutive attempt, despite the Health Plan's ongoing monitoring and assistance, the PCP site will not have an opportunity to complete a CAP and must be removed from the Health Plan's Provider Network. Impacted Members must be reassigned to other Network Providers, as appropriate and as contractually required. If a PCP site is removed from one Health Plan's Network due to three consecutive failing scores, all other Health Plans must also remove the PCP site from their Networks.

*FSR/MRR CAP Noncompliance*

Any network Provider who does not come into compliance with survey criteria within the established timelines shall be removed from the network and Members shall be appropriately re-assigned to other network Providers. Health Plan shall provide affected Members with a 30-day notice that the non-compliant Provider is being removed from the network. In addition, Provider sites that score below 80 percent in either the FSR or MRR for two consecutive reviews must score a minimum of 80 percent in the next site review in both the FSR and MRR (including sites with open CAPs in place). Sites that do not score a minimum of 80 percent in both the FSR and MRR despite Health Plan's ongoing monitoring, must be removed from the network and Members must be appropriately reassigned to other network Providers. Health Plan must provide affected Members with 30-day notice that it will remove the noncompliant Provider from the network.

*Site Review and Medical Record Review Requirements for Street Medicine:*

Street medicine Providers who are serving in an assigned PCP capacity are required to undergo the appropriate level of site review process, which is either a full or a condensed review.

For street medicine Providers serving as an assigned PCP, and that are affiliated with a brick-and-mortar facility or that operate a mobile unit/RV, Health Plan must conduct the full review process of the street medicine Provider and affiliated facility in accordance with APL 22-017: Primary

Care Provider Site Reviews: Facility Site Review and Medical Record Review, as stated in APL-24-001

For street medicine Providers serving as an assigned PCP, and that are not affiliated with a brick-and mortar facility or mobile unit/RV, Health Plan must conduct a condensed Facility Site Review (FSR) and Medical Record Review (MRR) of the street medicine Provider to ensure Member safety as per the limited/condensed (as shared by DHCS) FSR and MRR requirements that would apply only to a street medicine Provider under this scenario. (APL-24-001)

**Scoring**

| | Exempted Pass | Conditional Pass | Fail |
|---|---|---|---|
| FSR | • Score of 90% and above with no deficiencies in critical elements, infection control, or pharmacy<br>• CAP not required | • Score of 90% and above with deficiencies in critical elements, infection control, or pharmacy<br>• Score of 80% and above<br>• CAP required | • Score below 80%<br>• CAP required |
| MRR | • Score of 90% and above, with all section scores at 80% and above<br>• CAP not required | • Score of 90% and above with one or more section scores below 80%<br>• Score of 80% and above<br>• CAP required | • Score of 79% or below<br>• CAP required |
| Health Plan may require a CAP regardless of score for other findings identified during the survey that require correction. | | | |

## Corrective Action Plans for Deficiencies

All sites that receive a conditional pass will require a CAP to address each of the noted deficiencies. Conditional pass is defined as a site score of 80% to 89%, or 90% and above with deficiencies in critical elements, pharmaceutical services, or infection control, will be required to establish a CAP that addresses each of the noted deficiencies.

CAP documentation must identify:

1. Specific deficiency
2. Corrective action(s) needed
3. Re-evaluation timelines/dates
4. Responsible person(s)

5. Problems in completing corrective actions
6. Education and/or technical assistance provided by Health Plan
7. Evidence of the correction(s)
8. Completion/closure dates
9. Name/title of reviewer

*Timelines for CAP*

Providers will be informed of non-passing survey scores, critical element deficiencies, other deficiencies that require immediate corrective action, and the CAP requirements for these deficiencies.

Below is the timeline for correction and reporting:

| CAP Timeline | CAP Action(s) |
|---|---|
| FSR and/or MRR Completion Day | Health Plan must provide the PCP site a report containing:<br>• The FSR and/or MRR scores.<br>• Any critical element findings, if applicable; and discussion of the CE CAP and this initiates the CAP timeline for CE<br>• A formal written request for CAPs for all critical elements, if applicable. |
| Within 10 business days of the FSR and/or MRR | • The PCP site must submit a CAP and evidence of corrections to the MCP for all deficient critical elements, if applicable.<br>• Health Plan must provide a report to the PCP site containing Non-FSR and/or MRR findings, along with a formal written request for CAPs for all non-critical element deficiencies. This starts the non- CE CAP timeline<br>• Health Plan must provide educational support and technical assistance to PCP sites as needed. |
| Within 30 calendar days from the date of the completed FSR and/or MRR (Audit date) | • Health Plan must conduct a focused review to verify that CAPs for critical elements are completed.<br>• Providers can request a definitive, time-specific extension period to correct CE deficiencies, and to be granted at the discretion of the MCP, not to exceed 60 calendar days from the date of the FSR. |

| | |
|---|---|
| Within 30 calendar days from the date of the FSR and/or MRR Report (10 days after the issuance of the CAP) | • The PCP site must submit a CAP for all non-CE (FSR/MRR) deficiencies to the MCP<br>• Health Plan must provide educational support and technical assistance to PCP sites as needed. |
| Within 60 calendar days from the date of the FSR | • For those sites that were granted an extension for CE CAPs, the MCP must verify that all CE CAPs are closed. |
| Within 60 calendar days from the date of the FSR and/or MRR report | • Health Plan must review, approve, or request additional information on the submitted CAP(s) for non-critical findings.<br>• Health Plan must continue to provide educational support and technical assistance to PCP sites as needed. |
| Within 90 calendar days from the date of the FSR and/or MRR report | All CAPs must be closed.<br>• Providers can request a definitive, time-specific extension period to complete the CAP(s), not to exceed 120 calendar days from the date of the initial report of FSR and/or MRR findings. |
| Beyond 120 calendar days from the date of the FSR and/or MRR Report | • Under extenuating circumstances, MCPs can request from DHCS/CMS a definitive, time-specific extension period to allow for 1) the PCP site to complete the CAP and/or 2) the MCP to verify CAPs have been completed.<br>• The MCP must conduct a focused FSR and/or MRR as applicable, within 12 months of the original FSR and/or MRR date(s). |

# 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.

# SECTION 5: PROVIDER SERVICES

## PROVIDER RIGHTS AND RESPONSIBILITIES

### Provider Rights

Health Plan Advantage D-SNP values its relationship with Providers, and Providers have the right to know what they can expect from Health Plan Advantage D-SNP. Health Plan Advantage D-SNP does not discriminate against healthcare professionals who act within the scope of their license or certification as defined by federal and state law in regard to network participation, reimbursement, or indemnification based solely on the practitioner's license or certification.

Additionally, Health Plan Advantage D-SNP does not discriminate against healthcare professionals who serve high-risk Enrollees or specialize in treating costly conditions. However, Health Plan Advantage D-SNP may make determinations about Provider participation status based on internal criteria considered necessary or appropriate for its Provider network.

Providers' Rights include but are not limited to the following:

- **Communication with Enrollees:** The right to freely communicate with Enrollees about their treatment, including medication treatment options, regardless of benefit coverage limitations. Health Plan Advantage D-SNP does not prohibit healthcare professionals, acting within the lawful scope of practice, from advising or advocating for an Enrollee regarding:
    - The Enrollee's health status, medical care, or treatment options, including alternative treatments that can be self-administered. This includes providing sufficient information so individuals can evaluate all relevant treatment options.
    - The risks, benefits and consequences of treatment or non-treatment.
    - The opportunity for Enrollees to refuse treatment and to express preferences concerning future treatment decisions.
    - The right to information on how Health Plan Advantage D-SNP coordinates its interventions with treatment plans for individual Enrollees.

- **Review of Credentialing Information:** The right to review information Health Plan Advantage D-SNP obtained to evaluate the Provider's individual credentialing application, including attestation, credentialing verification (CV) and information obtained from any outside source (e.g., malpractice insurance carriers, State licensing boards), with the exception of references, recommendations or other peer-review protected information. Health Plan Advantage D-SNP is not required to reveal the source of information if such is not obtained to meet Health Plan Advantage D-SNP credentialing verification requirements or if disclosure is prohibited by law.
- **Correction of Credentialing Information:** The right to correct erroneous information when credentialing information obtained from other sources varies substantially from information submitted by the Provider. The correction of erroneous information submitted by another source is detailed in the Credentialing section of this Provider Manual.
- **Credentialing Updates:** The right to be informed of a Provider's credentialing application status upon request to Health Plan Advantage D-SNP.

- **Staying Informed:** The right to receive information about Health Plan Advantage D-SNP, including but not limited to available programs and services, its staff and their respective titles, operational requirements and contractual relationships.
- **Health Plan Advantage D-SNP Support:** The right to receive support from Health Plan Advantage D-SNP in making decisions interactively with Enrollees regarding their health care.
- **Health Plan Advantage D-SNP Contact Information:** The right to receive contact information for staff responsible for managing and communicating with the Provider's Enrollees.
- **Health Plan Advantage D-SNP Communications:** The right to expect and receive communication from Health Plan Advantage D-SNP regarding complaints, issues, or concerns relating to Provider rights and responsibilities and their staff.
- **Grievance and Appeals**: The right to receive policies and procedures about the grievance and appeals process.

### Provider Responsibilities

Health Plan Advantage D-SNP maintains Provider agreements that incorporate both Provider and Health Plan Advantage D-SNP responsibilities consistent with industry standards in compliance with state and federal regulations and requirements. The following requirements apply to all Health Plan Advantage D-SNP participating Providers.

#### Telehealth

All Providers furnishing applicable Covered Services via audio-only synchronous interactions must also offer those same services via video synchronous interactions as to preserve Enrollees choice. To preserve an Enrollee's right to access covered services in-person, a Provider furnishing services through video synchronous interaction or audio-only synchronous interaction must offer those same services via in-person and/or face-to-face contact. Providers must arrange for a referral to, and a facilitation of, in-person care that does not require an Enrollee to independently contact a different Provider to arrange for that care.

## PROVIDER DIRECTORY MAINTENANCE

Health Plan Advantage D-SNP is responsible for directory maintenance; however, the Provider plays a key role. Federal guidelines encourage providers to promptly notify plans of changes such as new locations, changes in services offered, or updates to contact information.

Health Plan Advantage D-SNP adheres to provider directory accuracy and delivery, including:

- Update Frequency: Health Plan Advantage D-SNP will update the provider directory at least monthly. This ensures that newly contracted providers are added and terminated providers are promptly removed.

- Verification: Health Plan Advantage D-SNP contacts providers quarterly to verify the accuracy of directory data such as ability to accept new patients, street address, phone number, name(s), location(s), contact information, specialty and any other changes that affect availability to patients.
- Accessibility: Directory will be accessible both in print and online formats. They will be easy to navigate and searchable, with accommodations for individuals with disabilities.
- Required Information: Directory will include provider name, address, telephone number, specialty, whether they are accepting new patients and languages spoken.
- Complaints and Corrections: Health Plan Advantage D-SNP will have a process for receiving complaints regarding directory inaccuracies and correcting errors within a specified timeframe.

To ensure Enrollees obtain timely and accurate information on the Providers available in Health Plan Advantage D-SNP's network, Providers must comply with Health Plan Advantage D-SNP's policies and procedures regarding Provider Directory maintenance. Health Plan Advantage D-SNP has a regulatory responsibility to publish an accurate directory of all participating Providers. This directory is maintained and updated in accordance with state and federal law, including but not limited to 42 CFR § 422.112, and the Medicare Managed Care Manual, Chapter 4, Section 110.

Providers must notify Health Plan Advantage D-SNP when any of the following changes occur, so the Provider Directory remains current and accurate:

- Provider is no longer accepting new Enrollees.
- Provider was previously not accepting new Enrollees but is now open to new Enrollees.
- Provider is no longer contracted with Health Plan Advantage D-SNP (contract termination has occurred).
- Provider has moved to a different location.
- Provider has added a location.
- Provider has changed its office hours.
- A change in languages spoken in the office.
- As a result of an error identified through an Enrollee complaint.
- Any other information affecting the accuracy of the Provider Directory.

Health Plan Advantage D-SNP will update directory information any time a change is made. All updates to the online provider directories will be completed within 30 calendar days of receiving information requiring update. Updates to hardcopy provider directories will be completed within 30 calendar days; however, hardcopy directories that include separate updates via addenda are considered up-to-date.

# SECTION 5: PROVIDER SERVICES

**Provider Demographic Information**

This Provider Directory includes, but not be limited to, the following demographic information for each Provider as required by CMS:in 42 CFR 422.111(b)(3).

- Type of Provider (e.g., PCP, Specialists (types), Hospitals, Skilled Nursing Facilities, Outpatient Mental Health Providers, and Pharmacies, etc.)
- Medicare providers who accept Medi-Cal

In addition, there are specific requirements for information to be included in the Directory, based on provider type:

- For Primary Care Providers (PCP)s:
    - State, County, City, street address, Zip code, PCP Name, [If applicable: Accepting New Patients? Yes/No], Phone number, Cultural and linguistic capabilities (e.g., languages spoken, languages offered, interpreter/translation services offered, sensitivity to cultural health beliefs/practices, cultural competency training(s) completed)
- For Specialists:
    - Specialty Type, State, County, City, street address, Zip code, Specialist Name, [If applicable: Accepting New Patients? Yes/No], Phone number, Cultural and linguistic capabilities (e.g., languages spoken, languages offered, interpreter/translation services offered, sensitivity to cultural health beliefs/practices, cultural competency training(s) completed)
- For hospitals
    - State, County, City, street address, Zip code, hospital Name, Phone number, Cultural and linguistic capabilities (e.g., languages spoken, languages offered, interpreter/translation services offered, sensitivity to cultural health beliefs/practices, cultural competency training(s) completed)
- Skilled Nursing Facilities (SNFs)
    - State, County, City, street address, Zip code, SNF Name, Phone number, Cultural and linguistic capabilities (e.g., languages spoken, languages offered, interpreter/translation services offered, sensitivity to cultural health beliefs/practices, cultural competency training(s) completed)
- Outpatient Mental Health Providers
    - State, County, City, street address, Zip code, Provider Name, [If applicable: Accepting New Patients? Yes/No], Phone number, Cultural and linguistic capabilities (e.g., languages spoken, languages offered, interpreter/translation services offered, sensitivity to cultural health beliefs/practices, cultural competency training(s) completed)

- Pharmacies
  - Type of Pharmacy (e.g., retail, mail order, home infusion, long-term care, etc.), State, County, City, street address, Zip code, Pharmacy Name, Phone number

**Provider Directory Audits**

Health Plan Advantage D-SNP sends a written notification to all contracted Providers at least once a year, and as frequently as every six months, to verify the accuracy of the information on file. The following timelines and process points apply:

- Providers must respond to Health Plan Advantage D-SNP within 30 business days to confirm the information is correct or provide changes needed to update the directory.
- If no response is received from a Provider within 30 business days, Health Plan Advantage D-SNP will send a second written notice.
- Provider must respond to Health Plan Advantage D-SNP within 15 business days of the second notice to confirm the accuracy of the information or provide changes needed to update the directory.
- If Health Plan Advantage D-SNP does not receive a response from the Provider by the end of the 15 business days and Health Plan Advantage D-SNP cannot verify the Provider's information, Health Plan Advantage D-SNP sends a third notice to give the Provider ten business days prior notice of removal from the directory.
- Non-responsive Providers are removed from the directory on the next required update.

Accurate directories promote patient safety, reduce delays in accessing care and lower the risk of claims denials due to network confusion. Providers benefit from reduced administrative burden and improved patient retention

Failure to respond to the notices for directory confirmation or changes may result in delayed claims payment or capitation payments pursuant to HSC §1367.27. Please refer to the Provider Payment section in this manual for more information on payment delays.

# PROVIDER IDENTIFIED OVERPAYMENTS

If a Provider determines it has been overpaid by Health Plan, the Provider must send a refund check to Health Plan Advantage D-SNP at the address below within 60 calendar days of identification. In addition to the refund check, the Provider must include: a cover letter explaining the reason for the overpayment; identifying the specific Health Plan Advantage D-SNP claim number(s) (including Enrollee name, Enrollee ID and, dates of service) or invoices that were the source of the overpayment; Provider contact information for a person who can discuss the overpayment with Health Plan Advantage D-SNP if it has any questions regarding the repayment; and any supporting documentation or additional information explaining the overpayment.

Overpayment refund checks are mailed to:

Health Plan Advantage D-SNP
7751 S. Manthey Road
French Camp, Ca. 95231
Attn: Finance Department – Overpayment Recovery

## NON-DISCRIMINATION

Health Plan Advantage D-SNP follows federal civil rights laws and provides services without distinction based on race, color, national origin, age, disability, or sex. Providers must serve all Health Plan Advantage D-SNP Enrollees while complying with federal requirements such as 45 CFR § 92.101(a)(2), Title VI of the Civil Rights Act of 1975, the Age Discrimination Act of 1975, the Americans with Disabilities Act (ADA) and other relevant laws. This compliance covers areas including:

- Age
- National Origin
- Race
- Color
- Disability
- Religion
- Social Status
- Veteran Status
- Marital Status
- Sex, which includes sex characteristics, intersex traits, pregnancy or related conditions, sexual orientation, gender identity and sex stereotypes

## CULTURAL COMPETENCY

Providers are required to deliver services and treatment information in a manner that aligns with the Enrollee's capacity to comprehend the communication. Individuals from diverse racial, ethnic and religious backgrounds, as well as those with disabilities, must receive information in a comprehensive format tailored to their unique needs. If language barriers arise, Enrollees may elect to use a family member, friend, or healthcare professional proficient in their language as a translator.

Additionally, Health Plan Advantage D-SNP Customer Services and Medical Management departments offer support for non-English-speaking Enrollees through multilingual staff or by connecting Enrollees with a telephone-based language interpretation service. It is imperative that all reasonable measures are taken to ensure the Enrollee's understanding of diagnostic details and treatment choices, and that obstacles related to language, cultural differences, or disabilities do not hinder effective communication.

# PROVIDER COMMUNICATION

At Health Plan Advantage D-SNP, we value our relationship with our Provider network and believe that prompt and effective communication is critical to ensure that you are receiving the information and support you need from us. Throughout the year, Health Plan Advantage D-SNP is notified by regulators and accreditation agencies as to changes or clarifications that impact Enrollees, billing, or other administrative processes. In order to keep you up to date, we have several communications strategies that we employ:

**Provider Alerts**

The primary method of communication is a *Provider Alert*. Provider Alerts are typically condensed documents providing valuable updates, information and action requests. They are sent by fax and email to the contact information provided by the practice and they are provided during meetings, visits and programs. Provider Alerts often contain time sensitive information, so they should be a priority for review and response, if necessary. To ensure receipt of these important Provider Alerts on a timely basis, it is essential that Health Plan Advantage D-SNP is provided with accurate and current practice information including contact information for receipt of these notices. Current, as well as past, Provider Alerts are also available on Doctor's Referral Express (DRE*)* and on the website, www.hpsj-mvhp.org.

*Provider Alerts* generally address the following types of issues:

- Changes to Health Plan Advantage D-SNP policies, procedures and processes
- Important regulatory or legislative changes
- Upcoming meetings or events beneficial to Providers to support Enrollee
- Training opportunities and requirements
- Health Plan Advantage D-SNP company announcements
- Health Plan Advantage D-SNP initiatives requesting Provider input and/or feedback
- Changes in the Provider network that may impact the practice
- New programs and/or products in development where your input is requested
- New programs, products or Enrollee benefits

**Provider Webinars**

Health Plan Advantage D-SNP provides webinars to update Providers with important information. Providers will be notified in advance of upcoming webinars via Provider Alerts, through DRE and through updates on the website, www.hpsj-mvhp.org.

**Provider Newsletters**

On a quarterly basis, Health Plan Advantage D-SNP publishes a Provider newsletter called *PlanScan*. As deemed appropriate, Health Plan Advantage D-SNP will include content for D-SNP. PlanScan is made available electronically to all Providers including contracted Facilities. Both current and back issues of PlanScan are available on Health Plan Advantage D-SNP's website, www.hpsj-mvhp.org. This publication can be emailed to Providers by request.

**Provider Feedback**

Provider Satisfaction Surveys

Health Plan Advantage D-SNP performs satisfaction surveys on an annual basis in order to gain perspective on the level of service provided to Providers and office staff and to determine the overall satisfaction of Health Plan Advantage D-SNP from the Provider perspective. Providers are encouraged to complete these satisfaction surveys since the information gathered will be used to help improve services.

**Focus Groups**

Health Plan Advantage D-SNP may conduct focus groups with Providers in order to gain feedback on how services can be enhanced. Providers invited to participate in a focus group will be contacted by Health Plan Advantage D-SNP's Provider Services Department. Providers that agree to participate in the focus group may be compensated for their participation.

For more information or to provide feedback as to how Health Plan Advantage D-SNP can enhance our service to Providers and improve satisfaction, please contact Health Plan Advantage D-SNP at 1-888-361-7526 (TTY: 711).

# PROVIDER EDUCATION AND TRAINING

Health Plan Advantage D-SNP provides training opportunities to Providers based on operational relevance and regulatory requirements. Some training topics include:

**New Provider In-Service**

Providers and staff must start their initial training within ten (10) working days and complete the training within 30 working days of the effective date of the provider's agreement. This training is considered the onboarding (in-service) and may be conducted online or in-person. The training must include, but is not limited to, the following.

- Overview of Health Plan Advantage D-SNP
- Fraud, Waste & Abuse State-mandated training information and attestation
- Cultural Competency & Sensitivity State-mandated training information and attestations
    - Health Plan Advantage D-SNP

  - Cultural Competency & Diversity
  - Seniors and Persons with Disabilities (SPD) Awareness and Sensitivity
  - Non-Specialty Mental Health Services (NSMHS)
- Health Insurance Portability and Accountability Act (HIPAA) State-mandated training information and attestation
- Review of information contained in the Provider Manual, including timely access standards and after-hours requirements
- Explanation of Doctors Referral Express (DRE)
- Assistance in setting up DRE access
- Guidance on electronic claims submission and online authorization
- Guidance on coordinating preventive services (HEDIS) and standards, if applicable
- Enrollees' Rights and Responsibilities, including Advanced Directives, including the Enrollee Grievance and Appeals Process
- Provider Rights and Responsibilities, including the Provider Dispute Process
- Medicare D-SNP Model of Care Program (MOC)
- Risk Adjustment and Encounter Data
- Answers to any questions you may have regarding working with us

**Annual Mandatory Compliance Training**

- Fraud, Waste & Abuse State-mandated training information and attestation
- Cultural Competency & Sensitivity State-mandated training information and attestations
  - Health Plan Advantage D-SNP
    Cultural Competency & Diversity
  - Seniors and Persons with Disabilities (SPD) Awareness and Sensitivity
  - Non-Specialty Mental Health Services (NSMHS)
- Health Insurance Portability and Accountability Act (HIPAA) State-mandated training information and attestation
- Medicare D-SNP Model of Care Program (MOC)

Providers will need to complete and submit the Attestation applicable to the training found on Advantage D-SNP's website or furnish documentation to Health Plan Advantage D-SNP as proof that the training was completed annually. Provider Services will send out a courtesy reminder when annual trainings are due. It is the duty of the Provider to provide proof of training completed within 30 days of becoming a new provider, and annually thereafter.

The source of the training can be one of two options;

1. Download a pdf of Health Plan Advantage D-SNP trainings from our website at this link Provider Trainings - HPSJ/MVHP (www.hpsj-mvhp.org/provider-trainings).
2. Other: Take the training with another Medi-Medi Managed Care Plan. If the training source is Other, an outline of the content, or a copy of the training, or a URL link to the training source must be provided with the Training Date, List of Providers in the practice with NPIs.

For each training, providers must complete an attestation with completion dates for each training completed. The attestation links can be found here Provider Trainings - HPSJ/MVHP or (www.hpsj-mvhp.org/provider-trainings/).

**On-Going Provider Training and Education**

Advantage D-SNP Provider Services team conducts follow-up visits as necessary in order to assess the Provider's experience working with Advantage D-SNP and to address any additional questions or concerns. Advantage D-SNP staff is also available to conduct follow-up trainings to review or address any topic necessary to support Providers in performing their duties and functions. The goal is to ensure that working with Advantage D-SNP is a positive experience for Providers, their office staff and Enrollees.

**Other Training Opportunities**

Health Plan Advantage D-SNP also offers Providers and office staff the opportunity to attend trainings in either in- person setting during the day, as well as evening training on various operational and quality related topics. Topics could include, but not be limited to:

- How to Successfully Pass a Facility Audit (FSR)
- How to Successfully Pass a Chart Audit
- Improving HEDIS performance

**Valley Mountain Regional Center (VMRC)**

There is training available through VMRC, designed to assist Providers in identifying and managing Enrollees with disabilities and behavioral health issues. VMRC serves children and adults with developmental disabilities in Alpine, El Dorado, San Joaquin, and Stanislaus, counties.

## DOCTORS REFERRAL EXPRESS (DRE)

One of the most beneficial resources to help in providing efficient service to Enrollees is Doctors Referral Express (DRE). DRE is the HIPAA-compliant secure Provider portal that is available

24/7 to Providers. DRE also has a mobile application compatible with both iPhone and Android devices. This service is provided at no cost to the Provider and will assist in managing medical care for Enrollees. Throughout this Provider Manual, there are references to DRE that indicate the use of this tool to accomplish several administrative tasks such as:

- Enrollees' eligibility verification
- Obtaining PCP Enrollee rosters
- Sending emails to Health Plan Advantage D-SNP departments
- Checking claims status
- Submitting Provider Dispute Resolution (PDR) and checking status
- Reviewing *Milliman Care Guidelines*
- Accessing HEDIS "Gap Reports"
- Accessing the Patient Benefit Dossier
- Obtaining/Status checking Authorization and referrals
- Obtaining Enrollee coverage and benefits information
- Accessing Enrollee utilization history
- Billing Code Finder (CPT, HCPCS)
- Provider Lookup Tool
- Accessing Forms and Data
- Download Remittance Advice – RA

**Doctor's Referral Express (DRE) Portal Access**

To receive access to Doctor's Referral Express (DRE), Providers and their authorized users must have an active contract with Health Plan Advantage D-SNP. Each Provider office user (physician, medical assistant, office employee, biller, authorization clerk, etc.) is required to have its own unique access to DRE that is approved by the Provider office administration. Sharing log-in and password information is prohibited.

For security purposes, the user will be required to validate that an online account will be set up in his/her name and will be required to attest to the online Health Plan Advantage D-SNP Confidentiality Statement. Upon receiving the application and completing the online attestation, each user will receive a confirmation e-mail from Health Plan Advantage D-SNP providing him/her the resolution of the DRE access request. All fields must be completed in the online application before DRE Provider portal access will be activated. The Practice/Clinic NPI and Tax ID# will be required during the registration process.

Once the registration is completed, the user will be able to access DRE at Health Plan's website: www.hpsj-mvhp.org. A Provider Services Representative will contact all new Provider offices connecting to DRE to schedule training. To comply with Health Plan Advantage D-SNP security standards, all DRE users must validate their account on a quarterly basis. For questions regarding DRE access and training, please call the Provider Services department at 1-888-361-7526 (TTY: 711). DRE access can be obtained by linking to Health Plan Advantage D-SNP's on-line web page www.hpsj-mvhp.org/Providers.

# PROGRAM PARTICIPATION AND COMPLIANCE

Health Plan Advantage D-SNP establishes Quality Improvement, Medical Management and other initiatives to continually enhance the delivery and outcomes of health services. Health Plan Advantage D-SNP operates under agreements with federal, state and county agencies that define its participation in Medi-Cal managed care and Medicare programs. Regulatory bodies regularly review Health Plan Advantage D-SNP operations and data reporting, including complaints, enrollment and financial records. Under their Provider agreements, participating Providers must cooperate with Health Plan Advantage D-SNP to support its regulatory obligations and adhere to internal programs designed to ensure contractual compliance. This requirement pertains both to the policies contained within this Provider Manual and to any new programs developed by Health Plan.

Providers contracted with Health Plan Advantage D-SNP are expected to uphold the Enrollee care standards outlined in the Enrollee Rights and Responsibilities document found in Section 7 of this Provider Manual. These standards address Enrollee rights regarding access to care, comprehensive treatment information, privacy and confidentiality, non-discrimination, refusal of medical treatment and other key aspects of the Enrollee's relationship with Health Plan Advantage D-SNP.

Providers inform Enrollees about necessary follow-up care, educate Enrollees onpropriate self-care practices and recommend measures to support ongoing health and wellness. Additionally, providers are required to discuss available treatment options, potential side effects and symptom management, irrespective of plan coverage.

# RELEASE OF ENROLLEE INFORMATION

Medical information pertaining to Enrollees must be provided to Health Plan Advantage D-SNP upon request and in accordance with the Confidentiality Policy described in the Compliance section of this Provider Manual. Health Plan Advantage D-SNP will disclose medical information only to individuals authorized by Health Plan Advantage D-SNP for purposes related to medical management, claims processing, or quality and regulatory review. Providers are further required to comply with the appeals and expedited appeals procedures for Medicare Enrollees, which includes collecting and submitting appeal-related information to Health Plan Advantage D-SNP as needed.

Providers are also required to explain the following to Enrollees:

- The Enrollee's right to access covered services delivered via telehealth or in-person.
- That use of telehealth is voluntary and consent for the use of Telehealth can be withdrawn at any time by the Enrollees without affecting their ability to access covered services in the future.
- The availability of non-medical transportation to in-person visits.
- The potential limitations or risks related to receiving covered services through telehealth as compared to an in-person visit, if applicable.

# SECTION 6: ELIGIBILITY, ENROLLMENT AND DISENROLLMENT

## HEALTH PLAN ADVANTAGE D-SNP ELIGIBILITY

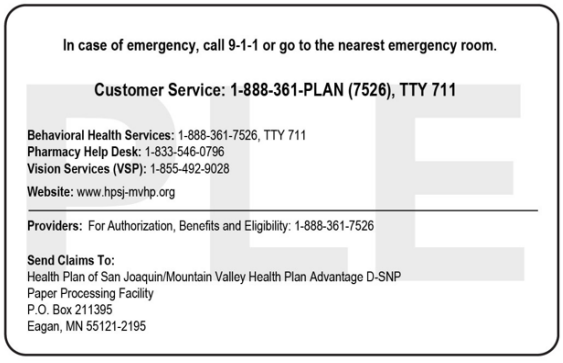
Health Plan Advantage D-SNP offers D-SNP (HMO) for individuals with Medicare Part A and Part B coverage and full benefits under the Medi-Cal program. Health Plan Advantage D-SNP is regulated by both federal and state agencies under Title 42, Chapter 4 of the Code of Federal Regulations and the provisions of Title 22 of the California Code of Regulations and the Department of Health Care Services (DHCS). Under this oversight, the D-SNP must comply with federal and state requirements. Health Plan Advantage D-SNP provides all benefits covered under Original Medicare Parts A, B and D and benefits under the Medi-Cal program.

The D-SNP permits enrollment during the annual election period (AEP) from October 15 through December 7 and when there is a change in an Enrollee's Medi-Cal entitlement which may occur outside of AEP. Enrollees may experience other changes which may permit an individual to enroll using a special election period (SEP). Contact Health Plan Advantage D-SNP's Member Services at 1-888-361-7526 (TTY: 711) for assistance to determine if a SEP is available to a prospective Enrollee.

Enrollees participating in this program must re- certify their Medi-Cal eligibility annually and. may lose Medi-Cal eligibility, regain it at a later date or become effective for services retroactively throughout the year. When an Enrollee in D-SNP loses Medi-Cal eligibility during the benefit year, Health Plan Advantage D-SNP will continue to provide Medicare and Medi-Cal benefits to the Enrollee for a period of five months from the date of loss of Medi-Cal eligibility, referred to as a deeming period.

## MEMBER IDENTIFICATION CARDS

Health Plan Advantage D-SNP issues all Enrollees an identification card that must be presented to Provider at the time covered services are requested. The Identification Card (ID Card) alone is not considered verification of Enrollee eligibility; the ID Card is issued for identification purposes only and does not guarantee eligibility. All Providers must verify eligibility on the date services are provided. A referral or authorization does not guarantee Enrollee is eligible on the date of service.

# SECTION 6: ELIGIBILITY, ENROLLMENT AND DISENROLLMENT

## VERIFICATION OF ELIGIBILITY

There are several ways to verify eligibility with Health Plan Advantage D-SNP. The methods listed below will provide various levels of detail about Enrollees including, but not limited to:

- Name
- Health Plan Advantage D-SNP identification number
- Birth date
- Gender (female or male)
- Language preference
- Eligibility status (eligible or termed) and effective dates
- PCP name and phone number
- PCP assignment effective date

### Interactive Voice Response System (IVR)

IVR is another tool that is available 24 hours a day, seven days a week to verify Enrollee eligibility. To use IVR, please call 1-209-942-6303 and provide the Enrollee's nine-digit Health Plan Advantage D-SNP identification number. A confirmation number will be provided which should be maintained to document the verification of eligibility.

### Member Service Department

Eligibility may be verified by calling the Member Services Department. representatives are available to assist with eligibility verification inquiries with live coverage Monday through Friday from 8:00 am to 8:00 pm April 1 – September 30 and seven days per week October 1 – March 31. Contact Member Services by phone at 1-888-361-7526 (TTY: 711)

### HealthReach Advice Nurse Line

Health Plan Advantage D-SNP's Advice Nurse Carenet is available 24 hours a day, seven days a week to assist with eligibility inquiries and to assist in triaging Enrollees in need of covered services. To access CareNet please call 1-800-655-8294.

### Edifecs

Health Plan leverages Edifecs for its X12N 270/271 Health Care Eligibility Request and Response, as mandated by the Health Insurance Portability and Accountability Act of 1996 (HIPAA).
Type 3 and Errata (also The X12N 270/271 version of the 5010 Standards for Electronic Data Interchange Technical Report referred to as Implementation Guides) for the Health Care Eligibility Request and Response Transaction has been established for eligibility status inquiry and response compliance. This document has been prepared to serve as a Health Plan specific companion guide to the 270/271 Transaction Sets. This document supplements but does not contradict any

requirements in the 270/271 Technical Report, Type 3. The primary focus of the document is to clarify specific segments and data elements that should be submitted to Health Plan on the 270/271 Health Care Eligibility Status Request and Response Transaction. This document will be subject to revisions as new versions of the 270/271 Transaction Set Technical Reports are released. This document has been designed to aid both the technical and business areas.

For more information on how to implement the X12 270/271, please refer to:
https://www.hpsj.com/wp-content/uploads/2024/07/HPSJ-MVHP_-270271-electronic-eligibility-verification-companion-guide-07232024E.pdf

## PRIMARY CARE PHYSICIAN (PCP) ASSIGNMENT AND CHANGE

PCPs are the primary Provider of covered services for Enrollees. They play a central role in coordinating care. For this reason, the selection or assignment of each Enrollee to a PCP is of critical importance. The PCP is the center of a multidisciplinary care team and coordinates all care for their assigned Enrollees while acting as their key contact and advocate.

The first and most important decision an Enrollee makes is the selection of a PCP. Health Plan Advantage D-SNP encourages individual PCP selection because it creates a better opportunity for an Enrollee to develop a one-on-one relationship with a physician who can personally engage with them in coordinating their care. This relationship creates continuity and improved quality and helps avoid confusion and duplication of services. Enrollees can find available PCPs on Health Plan Advantage D-SNP's website and are directed to choose PCPs for themselves and for each family member. If an Enrollee does not select a PCP, Member Services contacts the Enrollee to assist in selecting a PCP.

Enrollees can change PCPs by using the Member portal on Health Plan Advantage D-SNP's website or by calling the Member Services Department at 1-888-361-7526 (TTY: 711). Provider can also submit a PCP selection to Health Plan Advantage D-SNP by using the PCP Selection Form via secure Provider portal (DRE).

- PCP change requests made from the first through the 15th of the month will become effective the first day of the month of the request if the Enrollee has not accessed care with their current PCP during month of the request.
- PCP change requests made from 16th through the end of the month will become effective the first day of the following month.
- PCP changes requests made after the 15th can become effective the first day of the month of the request if:
    - The Enrollee has not seen their current PCP in the month of the request and the Enrollee is ill and need immediate medical attention
    - The Enrollee does not approve of a previous auto-assignment
    - The Enrollee previously requested a change and was not administratively processed

# SECTION 6: ELIGIBILITY, ENROLLMENT AND DISENROLLMENT

## GROUP/CLINIC ASSIGNMENT

Enrollees may select an individual PCP within a Group or clinic, a Federally Qualified Health Centers (FQHCs) or a Rural Health Centers (RHCs).

## PRIMARY CARE PHYSICIAN (PCP) AUTO-ASSIGNMENT

If an Enrollee does not select a PCP in the enrollment process, Member Services will contact the Enrollee to assist in PCP selection. If Health Plan Advantage D-SNP is unable to contact the Enrollee, a PCP Selection form will be mailed to the Enrollee. No response to the mailing will result in Health Plan Advantage D-SNP assigning Enrollee to a PCP considering:

- Language, age and gender of Enrollee
- Language, age and gender restrictions for potential PCPs
- Current report of PCPs accepting new Enrollees
- Panel capacity of current PCPs
- Geographic accessibility (travel time and distance) based on Enrollee's zip code
- Availability of traditional safety net PCPs
- Culture and ethnicity of Enrollee and PCPs
- PCPs with whom Enrollee has had a previous relationship

PCPs are notified of newly assigned Enrollees on the monthly roster, which is available through the secure Provider portal (DRE) on Health Plan Advantage D-SNP's website, www.hpsj-mvhp.org.

## MEMBER DISENROLLMENT

Health Plan Advantage D-SNP does not make Medicare or Medi-Cal eligibility determinations for Enrollees. The CMS retains responsibility for accurately determining Enrollee eligibility for, and enrollment in, Medicare.

The responsibility for the determination of Medi-Cal eligibility resides with the state and county Human Services Agency; it is subject to retroactive adjustment in accordance with the terms and conditions of coverage described in the *Evidence of Coverage and Disclosure Form*.

### Voluntary Disenrollment

Enrollees can elect to discontinue participation in the D-SNP during a valid election period and receive Medicare-covered services through Original Medicare or may enroll in another plan in the service area.

### Involuntary Disenrollment

CMS identifies circumstances when an Enrollee must be disenrolled from Health Plan Advantage D-SNP. Enrollees must be disenrolled if Enrollee:

- Moves outside of Health Plan Advantage D-SNP Service Area
- Loses Medicare entitlement to Part A, Part B or Part D
- Fails to pay Part D-IRMAA
- Is not lawfully present
- Fails to requalify for full Medi-Cal at the conclusion of the deeming period.
- No longer qualifies for full Medi-Cal benefits as determined by DHCS

Health Plan Advantage D-SNP may request to disenroll an Enrollee who engages in disruptive behavior which substantially impairs Health Plan Advantage D-SNP's ability to arrange or provide for services to the Enrollee or other Health Plan Advantage D-SNP Enrollees. Health Plan Advantage D-SNP must make a serious effort to resolve the problems presented by the Enrollee before requesting disenrollment from CMS which will be made at their sole discretion.

Circumstances which may constitute or provide evidence of disruptive behavior include:

- Contracted Providers refuse to see or treat Enrollee due to his/her behavior or actions
- Incidents of physical violence or threats of harm that significantly impair Health Plan Advantage D-SNP's ability to provide services to the Enrollee or another Enrollee
- Abusive, inappropriate, obscene language that is accompanied by an act of violence, by a threat of harm or perceived as a threat of harm by a Provider, other patient, or Health Plan Advantage D-SNP employee
- Inappropriate conduct

Contact Customer Service at **1-888-361-7526 (TTY: 711)** and ask to speak to a Provider Services Representative for additional information about procedures for handling disruptive Enrollee

# SECTION 7: PROVIDER–ENROLLEE RELATIONSHIP

An effective Provider-Enrollee relationship is fundamental to the delivery of high-quality health care. When established on trust, clear communication and mutual respect, this collaboration enables the Enrollee to feel acknowledged and understood, while Providers are able to respond attentively to each individual's needs. Joint participation fosters shared decision-making, empowers Enrollees to engage actively in their health management, and facilitates the provision of compassionate, tailored care by Providers. Strengthening these relationships not only enhances enrollee satisfaction but also promotes adherence to treatment recommendations and upholds the dignity and privacy of all parties.

## ENROLLEE RIGHTS AND RESPONSIBILITIES

Enrollees need to understand their rights and responsibilities as outlined in their Evidence of Coverage for the appropriate year. CMS regulation 42 CFR § 422.128 requires Health Plan Advantage D-SNP to give clear, accessible information about what Enrollees are entitled to and what is expected of them. This ensures Enrollees can make informed decisions about their healthcare.

The Enrollee's relationship with Health Plan Advantage D-SNP guarantees a number of basic rights, including entitlement to high-quality, accessible, responsive, and responsible health care; respectful and confidential treatment; and avenues to express dissatisfaction or receive assistance. In return, Enrollees are responsible for taking charge of their health care needs, using services appropriately, complying with Health Plan Advantage D-SNP Evidence of Coverage, and requesting assistance from Health Plan Advantage D-SNP to ensure they are utilizing and receiving services appropriately.

Health Plan Advantage D-SNP Enrollees' rights and responsibilities are outlined below. This information is provided to all new Enrollees as part of their welcome package. Providers participating with Health Plan Advantage D-SNP are expected to make every effort to support Enrollees' rights.

**Enrollee Rights**

- Obtain all services, both clinical and non-clinical, in a culturally competent manner and are accessible to all Enrollees, including those with limited English proficiency, limited reading skills, hearing incapacity or those with diverse cultural and ethnic backgrounds.
- Obtain free interpreter services to answer questions from non-English speaking Enrollees. See Interpreter section below.
- Obtain information in braille, large print or other alternate formats at no cost if Enrollees need it. Health Plan Advantage D-SNP is required to provide Enrollee information about Health Plan Advantage D-SNP benefits in a format that is accessible and appropriate. See Alternative Format below.
- Access to a women's health specialist within the network for routine and preventive health care services.

- Be treated with respect, giving due consideration to the Enrollee's right to privacy and the need to maintain confidentiality of Protected Health Information (PHI) and Private Information (PI).
- Receive information about Health Plan Advantage D-SNP, its practitioners and Providers, all services available to Enrollees, and Enrollee rights and responsibilities.
- Choose a Primary Care Provider (PCP) within Health Plan Advantage D-SNP's network unless the PCP is unavailable or not accepting new patients.
- Participate in decision-making with Providers regarding their own health care, including the right to refuse treatment.
- Discuss appropriate or medically necessary treatment options for their conditions, regardless of cost or benefit coverage.
- Submit grievances, verbally or in writing, about Health Plan Advantage D-SNP, Providers, care received or any other expression of dissatisfaction not related to an adverse benefit determination.
- Request reconsideration of a decision made by Health Plan Advantage D-SNP.
- Request all pertinent information regarding Advance Directives and confirm the validity of the Advance Directive with the Provider.
- Disenroll from Health Plan Advantage D-SNP and change to another health plan in the county, upon request, during a valid CMS enrollment period or special election.
- Remain free from any form or restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.
- Access and obtain copies of their medical records and request that they be amended or corrected, as specified in 45 CFR sections §164.524 and 164.526.
- Recommend changes regarding these Enrollee rights and responsibilities.
- Exercise these Enrollee rights freely without retaliation or any adverse conduct by Health Plan Advantage D-SNP, Providers, or the state.

**Enrollee Responsibilities:**

- Be familiar with covered services and the rules to follow to obtain covered services.
- Notify Health Plan Advantage D-SNP of other health coverage or prescription drug coverage in addition to the D-SNP plan.
- Inform Provider and other health care professionals of specific Health Plan Advantage D-SNP enrollment.
- Provide their Health Plan Advantage D-SNP membership card and any other insurance information when receiving medical care or Part D prescription drugs.
- Inform Providers by giving them information, asking questions, and following through on care.
    - Tell Providers about their health problems.
    - Follow the treatment plans and instructions agreed upon with Providers.

  - Ensure Providers are aware of all medications they take, including over-the-counter drugs, vitamins, and supplements.
- Follow the rules and procedures outlined in the Enrollee Handbook, Summary of Benefits, or Evidence of Coverage (EOC).
- Ask questions related to their medical needs and seek answers they can understand.
- Treat Health Plan Advantage D-SNP staff and Providers with courtesy and consideration. Enrollees are expected to respect the rights of other patients and to act in a way that supports the smooth operation of Provider offices, hospitals, and other facilities.
- Pay required costs, if applicable, including:
  - Medicare premiums, to remain enrolled.
  - Cost-sharing amounts (such as copayments or coinsurance) when receiving services or drugs.
  - Any additional Part D premium amounts required due to income, paid directly to the government.
- Notify Health Plan Advantage D-SNP if they move.
  - If they move within Health Plan Advantage D-SNP's service area, they must provide an updated address.
  - If they move outside the service area, they cannot remain enrolled in Health Plan Advantage D-SNP.
  - They must also notify Social Security (or the Railroad Retirement Board).
- Meet with their PCP and get a baseline physical exam.
- Receive all covered health care services through their PCP, except in emergencies, self-referral services (such as OB/GYN), or as otherwise described in their Health Plan Advantage D-SNP EOC.
- Enrollees are expected to follow recommended treatment. Comply with the care plan created by the Enrollee's Health Plan Advantage D-SNP Care Manager.
- Use the emergency room if the Enrollee has symptoms a prudent layperson would expect to indicate an emergency medical condition as defined in 42 CFR 438.114(a)
- Provide information, to the extent possible, that Health Plan Advantage D-SNP and its Providers need to deliver care.
- Understand their health problems and participate in developing mutually agreed-upon treatment goals and a care plan, to the degree possible.
- Keep scheduled appointments or cancel in advance if unable to attend.
- Contact Health Plan Advantage D-SNP's Customer Services Department for information or questions about the benefits, rules, or procedures described in the Member Handbook.

# SECTION 7: PROVIDER–ENROLLEE RELATIONSHIP

## ROLE OF PRIMARY CARE PROVIDERS (PCPs)

The PCP is the central relationship that all Enrollees are encouraged to develop to ensure personal attention, quality care and efficient services. When Health Plan Advantage D-SNP assigns an Enrollee to a selected PCP, it is with the expectation that the PCP provides most of the covered services. It is the PCP's responsibility to coordinate the services of specialists and ancillary Providers, or to coordinate with Health Plan Advantage D-SNP if out-of-network services are required.

Participating PCPs are contracted to either perform a number of key activities, including but not limited to:

- Provide appropriate medical care within their scope of practice for Enrollees, including preventive care, acute care and care for chronic conditions.
- Coordinate necessary health assessments as required by Health Plan Advantage D-SNP or other regulatory agencies.
- Provide referrals to other Providers for covered services outside of the PCP scope of practice and follow Health Plan Advantage D-SNP guidelines for out-of-network services.
- Maintain continuity of Enrollee's care through coordination and follow up with other Providers as well as Health Plan Advantage D-SNP when appropriate.
- Ensure care is provided in a safe, culturally responsive and timely manner.
- Provide Enrollees with educational information on maintaining healthy lifestyles and preventing serious illness.
- Provide screenings, health assessments and other activities in accordance with CMS, Health Plan Advantage D-SNP policies, DHCS requirements and other public health initiatives.
- Conduct behavioral health screenings based upon a Provider's assessment to determine whether an Enrollee requires behavioral health or substance abuse services and refer for services, if needed (for more information, please see Section 9: Care Coordination).
- Meet and maintain the access standards as outlined in this section under "Timely Access to Care".
- Cooperate with Health Plan Advantage D-SNP's case management and quality programs.
- Maintain complete and accurate medical records for Enrollees in a confidential manner, including documentation of all services and referrals provided to Enrollees by the PCP, specialists, and any ancillary Providers.
- Establish new patient relationships via telehealth visits.
  Note: Starting October 1, 2025, Enrollees must be in an office or medical facility located in a rural area (in the U.S.) for most telehealth services. If Enrollee is not in a rural health care setting, Enrollee can still get certain Medicare telehealth services on or after October 1, including:
  - Monthly End-Stage Renal Disease (ESRD) visits for home dialysis
  - Services for diagnosis, evaluation, or treatment of symptoms of an acute stroke wherever you are, including in a mobile stroke unit
  - Services for the diagnosis, evaluation, or treatment of a mental and/or behavioral health disorder (including a substance use disorder) in the home

# SECTION 7: PROVIDER–ENROLLEE RELATIONSHIP

## ROLE OF NON-PHYSICIAN MEDICAL PRACTITIONERS (NPMPs)

NPMPs provide a wide variety of medical care depending on their licensure, certification, and experience. This category includes physician assistants (PAs), nurse practitioners (NPs), and certified nurse midwives (CNMs). To provide covered services to Enrollees, these Providers must be credentialed by Health Plan Advantage D-SNP.

Consistent with Health Plan Advantage D-SNP and Medicare guidelines, NPMPs must perform services under the general supervision of a Provider. The supervising Providers must be available to the NPMP either in person or through electronic means to provide:

- Supervision as required by State professional licensing laws
- Necessary instruction in patient management
- Consultation
- Referral to specialists or other licensed professionals

### Supervision Limits of NPMPs

In accordance with state ~~regulations~~, an individual physician may not supervise more than four PAs (full-time equivalents). While there is no limit on the number of NPs or CNMs that a single physician may supervise, if the NPs or CNMs order drugs or devices, a single physician cannot supervise more than four. Supervising Providers are required to develop and document a system of collaboration and supervision with each NPMP they supervise. This document must be kept on file at the Provider's office and available for review by Health Plan Advantage D-SNP.

### Enrollee Awareness of Care from NPMPs

Providers who employ or use the services of NPMPs must ensure Enrollees are clearly informed that their services may be provided by NPMPs.

## ROLE OF SPECIALISTS

While the PCP provides the central relationship with the Enrollees, the role of the specialist is also important to ensure appropriate care is provided for any given medical need. For this reason, it is important that Health Plan Advantage D-SNP specialists communicate frequently with PCPs to coordinate care and maintain adequate documentation of services provided.

Specifically, specialists should:

- Provide all appropriate services within their scope of practice.
- Follow Health Plan Advantage D-SNP referral and authorization guidelines in coordinating services with other Providers.
- Provide the PCP with consultation reports and other appropriate records.
- Be available for, or provide, on-call coverage through another source 24 hours a day for the management of Enrollee care.
- Maintain the confidentiality of medical information
- Cooperate with Health Plan Advantage D-SNP's case management and quality programs.
- Meet and maintain the access standards as outlined in this section under "Timely Access to Care".

- Maintain complete and accurate medical records for Enrollees in a confidential manner, including documentation of all services and referrals provided to the Enrollee.

## NETWORK ADEQUACY

The Centers for Medicare & Medicaid Services (CMS) regulations at 42 C.F.R. 417.414, 42 C.F.R. 417.416, 42 C.F.R. 422.112(a)(1)(i), and 42 C.F.R. 422.114(a)(3)(ii) require that Health Plan Advantage D-SNP maintain a provider network that is adequate to offer access to covered services for Enrollees. Health Plan Advantage D-SNP will deliver health care services to enrollees through a contracted network of providers, consistent with the standard community practices of health care delivery in the network service area as reflected in 42 C.F.R. 422.112(a)(10)). This includes required number of providers and specialists within time and distance standards to provide access to care.

CMS requires Health Plans to comply with 42 C.F.R. 422.1162(3) by continuously monitoring their contracted networks during each contract year to ensure they meet current network adequacy standards. These standards specify provider and facility specialties that must be available according to CMS number, time, and distance requirements. CMS will routinely audit Health Plan Advantage D-SNP to validate compliance with requirements.

## TIME AND DISTANCE ACCESS TO CARE

As outlined in CMS regulations, specifically 42 C.F.R. 422.112(a)(1)(i), Health Plan Advantage D-SNP is required to ensure that timely access to covered services is available to all Enrollees. This regulation mandates that enrollees have reasonable access to appointments with both primary care and specialty providers, establishing clear expectations for prompt care delivery. Compliance with these standards is essential for maintaining network adequacy and safeguarding Enrollee health.

Contracted Providers or Enrollees can contact Health Plan Advantage D-SNP to obtain assistance if they are unable to obtain a timely referral to appropriate Providers by calling the Customer Services Department at 1-888-361-7526 (TTY: 711).

If Health Plan Advantage D-SNP is unable to help with a timely referral, the Provider or Enrollee may file a complaint. See additional information at www.hpsj-mvhp.org/grievances-appeals.

Timely access standards apply to all counties. Time and distance standards vary depending on county size and designation.

**CMS County Designation**

- Alpine County – CEAC (County with Extreme Access Considerations)
- El Dorado County – Metro
- San Joaquin County – Metro
- Stanislaus County – Metro

| Alpine County<br><br>PROVIDER TYPE | TIME or DISTANCE |
|---|---|
| Primary Care | 60 miles or 70 minutes |
| Obstetrics/Gynecology (OB/GYN) - acting as a PCP<br>Specialty | 125 miles or 110 minutes |
| Cardiology<br>General Surgery<br>Ophthalmology<br>Orthopedic Surgery | 95 miles or 85 minutes |
| Endocrinology<br>Infectious Disease | 145 miles or 130 minutes |
| Gastroenterology<br>Neurology<br>Psychology<br>Podiatry<br>Pulmonology | 110 miles or 100 minutes |
| Hospital | 110 miles or 100 minutes |

| El Dorado County<br><br>PROVIDER TYPE | TIME or DISTANCE |
|---|---|
| Primary Care | 25 miles or 15 minutes |
| Specialty<br>General Surgery<br>Orthopedic Surgery<br>Gastroenterology<br>Pulmonology | 55 miles or 35 minutes |
| Obstetrics/Gynecology (OB/GYN) - acting as a PCP | 45 miles or 30 minutes |
| Cardiology<br>Ophthalmology | 30 miles or 20 minutes |
| Endocrinology<br>Infectious Disease | 60 miles or 40 minutes |
| Neurology<br>Psychology<br>Podiatry | 45 miles or 30 minutes |
| Hospital | 45 miles or 30 minutes |

| San Joaquin County<br><br>PROVIDER TYPE | TIME or DISTANCE |
|---|---|
| Primary Care | 15 miles or 10 minutes |
| Obstetrics/Gynecology (OB/GYN) - acting as a PCP<br>Specialty | 45 miles or 30 minutes |
| Cardiology<br>General Surgery<br>Ophthalmology<br>Orthopedic Surgery | 30 miles or 20 minutes |
| Endocrinology<br>Infectious Disease | 60 miles or 40 minutes |
| Gastroenterology<br>Neurology<br>Psychology<br>Podiatry<br>Pulmonology | 45 miles or 30 minutes |
| Hospital | 45 miles or 30 minutes |

| Stanislaus County<br><br>PROVIDER TYPE | TIME or DISTANCE |
|---|---|
| Primary Care | 15 miles or 10 minutes |
| Obstetrics/Gynecology (OB/GYN) - acting as a PCP<br>Specialty | 45 miles or 30 minutes |
| Cardiology<br>General Surgery<br>Ophthalmology<br>Orthopedic Surgery | 30 miles or 20 minutes |
| Endocrinology<br>Infectious Disease | 60 miles or 40 minutes |
| Gastroenterology<br>Neurology<br>Psychology<br>Podiatry<br>Pulmonology | 45 miles or 30 minutes |
| Hospital | 45 miles or 30 minutes |

- **For provider types not listed, please contact Health Plan Advantage D-SNP Provider Services for more information.**

# SECTION 7: PROVIDER–ENROLLEE RELATIONSHIP

## WAIT TIMES FOR CARE AND SERVICES

According to (CMS) regulations, timely access to primary care appointments is required under 42 C.F.R. 422.112(a)(1)(i). This regulation states that Health Plan Advantage D-SNP must ensure that all Enrollees have reasonable access to appointments with both primary care, specialty providers and other services.

**Below are the required minimum standards for appointment wait times:**

| Type of Service | Minimum appointment wait standard |
|---|---|
| **Urgently needed services or emergency** | **Immediately** |
| **Services that are not an emergency or urgently needed, but the Enrollee requires medical attention** | **Within 7 business days** |
| **Routine and preventive care** | **Within 30 business day** |

## ASSESSING URGENCY OF NEED OF CARE

### Triage or Screen Enrollees to Assess Urgency of Need of Care

Appropriately licensed personnel for triaging the health concerns of a Health Plan Advantage D-SNP Enrollee includes:

1. Licensed Physician,
2. Registered Nurse (RN),
3. Certified Nurse Midwife (CNM),
4. Nurse Practitioner (NP),
5. Physician Assistant (PA), and
6. Other licensed personnel acting within their scope of practice to screen Enrollees.

### Unlicensed Personnel Are Not Eligible to Triage or Screen Medical Patients

Unlicensed personnel who process patient phone calls or unscheduled office visits may ask questions on behalf of appropriately licensed health care personnel for the purpose of determining a patient's condition. However, unlicensed personnel shall not use a patient's responses to assess, evaluate, or determine the urgency of the patient's need for care.

## PROVIDER PANEL CAPACITY

All Health Plan Advantage D-SNP Providers are considered open to serve new and established Enrollees unless written notice of panel capacity limitations is on file. Since the goal is to maintain maximum access for Enrollees, capacity limitations and restrictions are discouraged unless necessary.

# SECTION 7: PROVIDER–ENROLLEE RELATIONSHIP

Health Plan Advantage D-SNP monitors PCP availability and capacity annually as required by DHCS and State regulations. Availability ratio standards for PCPs and Non-Physician Medical Practitioners (Ns) are defined below:

- PCPs 1:2,000 Enrollees
- NPMP's 1:1,000 Enrollees

PCPs have an enrollment limit of 2,000 Enrollees. Health Plan Advantage D-SNP's policies follow these standards. All participating PCPs are encouraged to accept a minimum potential enrollment of 200 Enrollees.

If there is a change in panel capacity, Providers must notify the Provider Services Department in writing by fax at 1-209-461-2565 or by mail at 7751 S. Manthey Road, French Camp, CA 95231-9802.

## OPEN AND CLOSED PANEL STATUS

PCPs must maintain an "open" status for Health Plan Advantage D-SNP Enrollees consistent with their availability to patients of other health care plans and programs. PCPs must notify Health Plan Advantage D-SNP within five (5) business days of closing their practice(s) to new Enrollees. The five (5) business day notice also applies to reopening a practice that has been previously closed.

If a Provider is contacted by an Enrollee or potential Enrollee and the Provider is officially "closed" to new Enrollees, the Enrollee or potential Enrollee must be directed to contact Health Plan Advantage D-SNP for assistance in obtaining another Provider and, if necessary, to correct any errors in the Provider Directory.

## PROVIDER REQUEST FOR ENROLLEE REASSIGNMENT OR DISMISSAL

Providers may file a grievance regarding a Health Plan Advantage D-SNP Enrollee and request reassignment or dismissal. PCPs must submit reassignment requests in writing and include the reason(s). The Provider Services Department forwards all requests for PCP reassignment to Customer Services for Enrollee outreach.

Health Plan Advantage D-SNP Providers have the right to request an Enrollee reassignment or dismissal. To assist with this process, follow these best practices to ensure timely processing:

1. Mail a dismissal or reassignment letter to the Enrollee at least 30 days prior to the effective date via United States Postal Service. The letter must include the following:
    a. Date
    b. Dismissal/Reassignment effective date
    c. Enrollee Name
    d. Health Plan Advantage D-SNP ID Number

e. Reason for dismissal/reassignment such as:
    i. Disruptive behavior
    ii. Inability of the office to continue providing care due to breakdown in the Provider–Enrollee relationship
    iii. Non-compliance with office policies regarding multiple missed appointments
2. Ensure the letter is addressed directly to the Enrollee. If the Enrollee is a minor, address the letter to the parent/legal guardian
3. Send a copy of the dismissal letter to Health Plan Advantage D-SNP by fax or email at providerservices@hpsj.com
4. Submit a separate dismissal letter for each Enrollee.
5. Providers are required to continue seeing the Enrollee for up to 30 days, or until the effective date of dismissal (whichever is longer), after requesting reassignment or dismissal.

Note: A dismissal may be granted with less than 30 days' notice if the Enrollee poses a danger to the Provider or practice.

## OTHER ENROLLEE SUPPORTING SERVICES

### Self- Care

Providing quality health care to Enrollees includes supporting them not only in following their medication and treatment protocols, but also in making important changes in their health behaviors. This includes providing information and education to prevent disease and illness.

PCPs are expected to engage frequently with Enrollees to encourage preventive strategies such as improving diet, exercising, taking medications appropriately, and actively managing complex health conditions. Providers ensure that clinicians and staff communicate with Enrollees about health choices and preventive actions.

### Health Education Services

Health education services are covered at no cost to Enrollees. These services support Providers in promoting self-management and healthy behaviors for Enrollees.

The Health Education Department, part of Health Plan Advantage D-SNP's Medical Management Department, focuses on promoting and empowering healthy lifestyles. The goal is to help Enrollees stay engaged and informed so they can actively participate in their own care and in the care of their children.

Many of the services provided below are offered in English, Spanish and Chinese (the threshold languages for Health Plan Advantage D-SNP).

Health Plan Advantage D-SNP's Health Education Department:

1. Ensures that the health education services are provided directly by Health Plan Advantage D-SNP or through subcontracts or formal agreements with other Providers specializing in health education.
2. Conducts targeted outreach to promote program use and participation by Enrollees, ensuring these programs are available and accessible through self-referral or referral by contracted medical Providers. All programs are available to Enrollees at no charge.
3. Distributes health education information through, but not limited to:
    a. FOCUS YOUR HEALTH, the Enrollee newsletter (quarterly)
    b. Special mailings
    c. Provider offices
    d. Community outreach activities
4. Provides Enrollees access to an audio library through the Advice Nurse/Physician Line
5. Implements a multidisciplinary health education program that includes intervention such as:
    a. Self-care techniques publications
    b. Public service announcements (PSAs) reinforcing healthy behaviors
    c. Billboards (outdoor advertising) promoting awareness of health risks and healthy behaviors
    d. Development and distribution of health education materials
    e. Advice Nurse information and audio library promotions
    f. Participation in community organizations promoting healthy behaviors
    g. Community health education program development and referral
    h. Outreach to target populations using community-based organizations, faith communities, neighborhood groups, etc.
    i. Trainings and seminars for Provider staff to support their work with Enrollees
    j. Nutrition consultation when medical necessity
6. Promotes health through activities such as:
    a. Participating in community coalitions and meetings to understand the needs of Enrollees in community settings.
    b. Planning, facilitating, and participating in community events (e.g., health fairs, annual Black Family Day, Health Plan Advantage D-SNP Walks for Health, etc.)

### Health Education Materials

Health Plan Advantage D-SNP provides health education materials at no cost to Providers and Enrollees.

Topics include, but are not limited to:

- Asthma
- Chronic Obstructive Pulmonary Disease (COPD)
- Diabetes
- Parenting
- Colds & flu
- Chronic disease or health conditions
- Prevention of sexually transmitted diseases

- Alcohol and drug use
- Comprehensive tobacco cessation
- Nutrition
- Physical activity
- Congestive heart failure

New materials are developed as needed. Health Plan Advantage D-SNP welcomes suggestions for additional health education materials. Please contact the Provider Services Department at 1-209-942-6340.

### Other Educational Resources

Health education services are also provided to Enrollees through:

- **Carenet** – 24-Hour Advice Nurse/Physician Line. In addition to Advice Nurse services, the Advice Nurse can connect Enrollee with a physician.
- **Your Health Matters**, a quarterly newsletter that is mailed to Enrollees that includes health education and local resources.
- **Community Events & Health Fairs** – Health Plan Advantage D-SNP participates in health fairs and community events to promote health awareness and preventive health care to Enrollees and the community.

## SOCAL SERVICES SUPPORT FOR ENROLLEES

Health Plan Advantage D-SNP's Social Work Services team conducts Enrollee needs assessments to help Enrollees obtain necessary services that positively impact their overall health care. Based on the assessment findings, the team coordinates necessary services. These services include, but are not limited to:

- Payee Information
- Food Resources (i.e., food banks)
- Mental Health Resources
- Support Group Information
- Transportation (i.e., Dial-A-Ride)
- Housing and Shelter Resources
- In-Home Support Services (IHSS)
- Substance Abuse Resources

For questions or information about care management, disease management, social services, or community resources, please call 1-209-942-6320 or 1-800-822-6226.

## PARTICIPATING IN COMMUNITY INITIATIVES

Health Plan Advantage D-SNP participates in a variety of workgroups and coalitions that identify and develop health education interventions on important health issues.

## INTERPRETER SERVICES

Health Plan Advantage D-SNP offers qualified interpreter services 24/7 to assist Providers and staff in communicating with Enrollees. These services are available in person, over the phone, or via video remote interpreting. During regular business hours, bilingual Customer Service Representatives are available by phone, in person, or through a TTY/TDD line for the deaf and hard-of-hearing Enrollees.

### In-Person Interpreter Services

To schedule an in-person interpreter for medical appointments, contact the Customer Services Department at 1-888-361-7526(TTY: 711). This service must be scheduled at least five (5) business days prior to the scheduled appointment for spoken languages, and ten (10) business days prior for sign language or captioning services.

### Remote Interpreter Services

When an in-person interpreter is unavailable or not required, Remote Interpreting Services are available at no cost through over-the-phone interpretation (OPI) and video remote interpreting (VRI). Health Plan Advantage D-SNP's Cultural and Linguistic Services department assists Providers in establishing these services in their clinics or units as needed.

For Providers without dedicated remote interpreting service, over-the-phone interpreters may be accessed by calling 1-877-959-6462. For interpreter services after 5:00 p.m. and on weekends, Providers should contact Health Plan Advantage D-SNP's 24/7 Nurse Advice Line at 1-800-655-8294. The call will be handled in a three-way conversation through the over-the-phone service.

Video interpreting devices may also be available in your clinic or unit for 24/7, on-demand spoken and sign language interpreting. Providers interested in acquiring these services may contact Provider Relations, who will connect them with Health Plan Advantage D-SNP's Cultural and Linguistic Services department for consultation.

### Alternative Format Selection

Alternative format selection (AFS) is a way of communicating with Enrollees who are visually impaired. Health Plan Advantage D-SNP provides alternative formats such as Braille, audio CD, large print, and electronic format at no cost. Enrollees have the right to request informing materials in an alternative format.

If an Enrollee selects an electronic format, such as an audio or data CD, the information is provided encrypted (password protected). However, the Enrollee can request to receive the information unencrypted (not password protected). Unencrypted materials may increase the risk of loss or misuse. If the Enrollee chooses unencrypted materials, they must complete an informed consent before Health Plan Advantage D-SNP can mail the materials.

Providers can call the Customer Services Department at 1-888-361-7526 (TTY: 711) for alternative format requests or requests for auxiliary aids.

**Requirements for Providers**

Health Plan Advantage D-SNP Contracted Providers are required to determine the needs of their patients and enter AFS at the time of the Enrollee's request. AFS requirements can be reported online at https://afs.dhcs.ca.gov/, or by calling the AFS Helpline at 1-833-284-0040.

Health Plan Advantage D-SNP also maintains AFS preferences reported by Enrollees or received from DHCS. Health Plan Advantage D-SNP uses this data to provide the alternative format requested by the Enrollee. Additionally, Health Plan Advantage D-SNP shares AFS data with subcontractors and network Providers as appropriate.

## CARENET 24-HOUR NURSE/PHYSICIAN ADVICE LINE

Health Plan Advantage D-SNP provides a 24/7 advice nurse and physician consult service through Carenet.

This service is available to all Enrollees at no cost. Enrollees may call and speak to a registered nurse or access the audio health library for recorded messages on hundreds of health topics. If the advice nurse concludes a physician contact is needed, the nurse connects the Enrollees. Contact Carenet at 1-800-655-8294.

## TRANSPORTATION SERVICES

Health Plan Advantage D-SNP arranges medical transportation for Enrollees who qualify. Non-medical transportation (NMT) is available upon request for medically necessary visits.

Call the Customer Services Department at **1-888-361-7526 (TTY: 711)** to determine eligibility and schedule service.

# NEW ENROLLEE OUTREACH AND ORIENTATION

Upon enrollment, all new Enrollees are contacted by the Customer Services Department. They receive an outreach call and an introduction to their assigned Case Manager. These calls reinforce and supplement information provided during Health Plan Advantage D-SNP marketing presentations, with a focus on guiding new Enrollees through the enrollment process and explaining their benefits, rights, and responsibilities.

Outreach activities include presentations regarding covered benefits and services, clarification of the role of the Primary Care Provider (PCP).

Each Enrollee receives a quick-start guide. The guide informs Enrollees about materials that are available to them on Health Plan Advantage D-SNP's website, including the Member Handbook, Provider Directory and Formulary. Enrollees are also informed of how to request printed materials

and how to access information and materials in their preferred language. Enrollees also receive a

newsletter annually and health education materials on a regular basis based on the programs they are enrolled in.

As part of the D-SNP program, Health Plan Advantage D-SNP distributes a mandatory Health Risk Assessment questionnaire to new Enrollees, and annually to all existing D-SNP Enrollees. These self-reported tools enable Health Plan Advantage D-SNP to assess each Enrollee's health status, lifestyle, and potential needs for wellness or specialized services. Enrollees are encouraged to promptly schedule visits with their PCPs to access necessary services. Additionally, Care Coordinators reach out to Enrollees with complex medical conditions to ensure they receive appropriate and timely care.

### Enrollee Services and Education

The Customer Services Department offers a comprehensive range of customer service initiatives, outreach efforts, orientation sessions, and educational programs. Translation services are available free of charge to support speakers of all languages.

## ELIGIBILITY VERIFICATION

An Enrollee's eligibility and benefits must be verified prior to initiating non-emergent services. You may verify an Enrollee's eligibility as described below.

**Please note:** Eligibility verification at the time of service does not guarantee payment by Health Plan Advantage D-SNP. Enrollees may lose eligibility after services are provided and claims are submitted. In certain cases, the loss of eligibility may be retroactive to the date of service.

**View the Enrollee ID Card**
Each Enrollee is issued an identification card that includes the Enrollee's Name, assigned PCP, pharmacy benefit, and other identification and informational items.

**Verify Online**
The online search tool allows you to check Enrollee eligibility, coverage dates, and plan details in one central location. It also includes important information such as an Enrollee's recertification date, whether an Enrollee is eligible for another health plan, and additional benefits, as applicable.

**Call Customer Services**
Providers may call Customer Services to verify Enrollee eligibility and for other inquiries.

# SECTION 7: PROVIDER–ENROLLEE RELATIONSHIP

## ADVANCE DIRECTIVES

Health Plan Advantage D-SNP recognizes the Enrollee's rights to formulate Advance Directives, including the right to be informed of State law regarding Advance Directives and to receive information about any changes to that law.

Health Plan Advantage D-SNP notifies Enrollees of their right to formulate an Advance Directive at the time of initial enrollment and annually thereafter through the Combined Evidence of Coverage and Disclosure Form. PCPs and Specialists providing care should assist Enrollees in receiving additional information and understanding their right to execute Advance Directives.

Below are key actions that should be taken to assist Enrollees:

- At the Enrollee's first PCP visit, office staff should ask if an Advance Directive has been executed, and the Enrollee's response should be documented in the medical record.
- If the Enrollee has executed an Advance Directive, a copy should be included in the medical record.
- Providers should discuss the potential medical situations with the Enrollee and any designees named in the Advance Directive. This discussion should be documented in the medical record.
- If possible, a copy of the Advance Directive should be placed in the Enrollee's chart.

# SECTION 8: UTILIZATION MANAGEMENT

## UTILIZATION MANAGEMENT PROGRAM OVERVIEW

Health Plan Advantage D-SNP has Utilization Management (UM) policies and procedures that support the provision of quality and equitable health care services for Enrollees enrolled in D-SNP. The goal of UM is to provide Enrollees with the right care, in the right place, within the most appropriate timeframe across both Medicare Advantage and Medi-Cal benefits. The UM program staff provide guidance to Providers to support care in all settings and situations, including hospital admissions (both medical and psychiatric diagnoses), long term acute care, emergency situations, ancillary support, and long-term care.

The key objective of Health Plan Advantage D-SNP's UM Program is to improve access to care, maintain the highest quality, and create healthy outcomes, while providing the most cost-effective care possible considering the Enrollees needs.

UM processes are designed to be unified so the Enrollees experience a single, coordinated approach to requests, determinations, notices, and appeals across Medicare and Medi-Cal.

## COUNSELING ENROLLEES ON TREATMENT OPTIONS

Every Provider has the responsibility of counseling Enrollees on the course and options in medical treatment, regardless of whether the service is a covered benefit. The Care Management Department will assist and provide care coordination, case management, and disease management services for Enrollees at risk for substantial ongoing care. The Care Management Department will also assist in establishing whether the Enrollee is eligible for other medical programs available through federal or state agencies, as well as local community resources.

## AVAILABILITY OF MEDICAL REVIEW CRITERIA

The UM department conducts timely prospective, concurrent, and retrospective review of requested care and services. Licensed clinical staff evaluate treatment requests to ensure services are medically necessary and consistent with evidence-based, nationally recognized clinical guidelines.

Health Plan Advantage D-SNP's physicians and other licensed clinical staff apply Medicare coverage rules first, including National Coverage Determinations (NCDs), Local Coverage Determinations (LCDs), and Medicare statutes and manuals. If no Medicare criteria apply, nationally recognized evidence-based guidelines such as MCG may be used as a secondary reference. If the requested service is not addressed by Medicare or MCG, Medi-Cal State Plan criteria may be applied. If no applicable criteria exist, reviewers will consult Health Plan Advantage D-SNP's internal policies and peer-reviewed, published literature to support the decision.

If medical necessity criteria are not met, or if sufficient clinical information is not provided to make a determination, the request will be denied by the Medical Director.

# SECTION 8: UTILIZATION MANAGEMENT

At any time, a Provider may request a copy of criteria used to make medical necessity decisions during the utilization review process by calling Health Plan Advantage D-SNP at 1-888-361-7526 (TTY: 711). Appropriately licensed professionals supervise and monitor all authorization decisions. Only a physician with appropriate training, experience, and certification by the American Board of Medical Specialties, or a licensed pharmacist may deny a request for services based on medical necessity.

## INPATIENT CARE

Health Plan Advantage D-SNP reviews admissions, length of stay, and treatment options in accordance with Medicare coverage rules, including the Medicare Managed Care Manual, National Coverage Determinations (NCDs) and Local Coverage Determinations (LCDs). If no applicable Medicare criteria exist, the plan uses nationally recognized evidence-based guidelines such as MCG. If the service is not a Medicare-covered benefit but is covered under Medi-Cal, Medi-Cal State Plan criteria are applied.

It is imperative that the facility team and Health Plan Advantage D-SNP work together for the clinical benefit of the Enrollee, discharge planning and transitions of care coordination, and clarity in claims processing.

At any time, a Provider may request a copy of criteria used to make medical necessity decisions during the utilization review process by calling Health Plan Advantage D-SNP at **1-888-361-7526 (TTY:711)**. Appropriately licensed professionals supervise and monitor all authorization decisions. Only a physician with appropriate training, experience, and certification by the American Board of Medical Specialties, or a licensed pharmacist, may deny a request for services based on medical necessity.

## HOSPITAL CARE

### Planned (elective) admissions

The admitting Provider must obtain authorization from Health Plan Advantage D-SNP prior to the Enrollee's admission. Prior authorization requests are processed within seven calendar days of receipt of all necessary information, or within 72 hours for expedited requests. No extensions are permitted.

Procedures on Medicare's Inpatient-Only (IPO) list are applied only when performed in the inpatient hospital setting. These services will not be covered if performed in an outpatient setting and must be submitted as inpatient authorization requests.

Requests may be submitted online through the Provider Portal Doctor's Referral Express (DRE) at <www.hpsj-mvhp.org/Providers>, or by fax at 209-762-4702.

### Observation

If an Enrollee is seen in the emergency room (ER) and held for observation (not admitted), observation services are reimbursed per the contracted rate for up to 24 hours. Observation services

beyond 24 hours require notification and clinical documentation to support medical necessity, which should be submitted online through the DRE at www.hpsj-mvhp.org/Providers, or by fax at 1-209-762-4702. See section 8, page 6 of this manual for additional information.

### Emergency and Post-Stabilization Admissions

If an Enrollee is seen in the ER and admitted for stabilization and further treatment, no authorization is required for services necessary to stabilize the Enrollee. Once the Enrollee has been stabilized, the Provider must notify Health Plan Advantage D-SNP within one business day and submit clinical documentation to support medical necessity of ongoing inpatient services. This information should be submitted online through the DRE at www.hpsj-mvhp.org/Providers, or by fax at 1-209-762-4702.

Providers must notify Health Plan Advantage D-SNP once the treating physician determines the member is stabilized to request a post-stabilization authorization from Health Plan Advantage D-SNP. Health Plan Advantage D-SNP is responsible for responding to the request for post-stabilization care within 30 minutes of the request, or the care is deemed approved. Health Plan Advantage D-SNP provides 24-hour access for authorization or transfer coordination and complies with Medicare regulations and California Health & Safety Code §1262.8. Enrollees may not be balance-billed for post-stabilization services.

### Continued Stay (Concurrent) Review

If an Enrollee requires additional inpatient services beyond the approved length of stay, the hospital must provide updated clinical documentation to support the medical necessity of continued inpatient care. Requests may be submitted online through the DRE at www.hpsj-mvhp.org/Providers, or by fax at 1-209-762-4702.

Requests are processed within 72 hours of receipt. All continued stay reviews are conducted in accordance with Medicare coverage rules.

### Retrospective Authorizations

Health Plan Advantage D-SNP does not require retrospective authorization for Medicare-covered services. Coverage determinations are made prospectively (prior authorization) or concurrently (continued stay review). Services rendered without prior authorization, when required, will be reviewed through the claims process.

## UTILIZATION MANAGEMENT STAFF AVAILABILITY

Providers are encouraged to contact Health Plan Advantage D-SNP's UM Staff and/or Medical Directors to discuss referrals, case management services for specific Enrollees, or other areas of concern.

### UM Staff Availability during Normal Business Hours

Health Plan Advantage D-SNP's UM staff are available Monday through Friday from 8:00 am to

5:00 pm pacific time, to respond to utilization management inquiries from Enrollees and Providers. UM staff can be reached at 1-888-361-7526 (TTY:711). Providers may also use the Provider portal to connect with the Intake Processor of the Day (IPOD) for assistance with authorizations. A Medical Director may be reached for UM issues at 1-209-942-6431.

### UM Staff Availability After Hours

In accordance with CMS requirements, Health Plan Advantage D-SNP accepts prior authorization requests 24 hours a day, seven days a week, including holidays.

Providers may call 1-888-361-7526 (TTY: 711) after hours to submit any request, including urgent admissions, post-stabilization services or other coverage determinations. All requests received outside business hours are logged and time-stamped at the time submitted and processed within the applicable CMS timeframes.

Providers who need assistance with routine matters after normal business hours may also leave a secure voicemail at 1-888-361-7526 (TTY:711). Voicemail messages are retrieved each business day at 8:00 a.m. by a customer services representative, who responds to the call or routes the message to the appropriate UM staff. Responses are returned no later than the next business day.

## REFERRALS TO IN-NETWORK/OUT-OF-NETWORK PROVIDERS

Health Plan Advantage D-SNP maintains a comprehensive network of Providers to ensure most health care needs can be provided within the service area. These network Providers are best prepared to accept referrals and operate within the guidelines established by Health Plan Advantage D-SNP. These Providers also meet the standards for timely and geographic access for Enrollees. If Providers are experiencing difficulty in locating an in-network Provider that meet the Enrollees medical needs, they should contact the UM Department at 1-209-942-6431.

In some cases, Health Plan Advantage D-SNP may have exclusive contracts with specialty Providers. In these instances, referrals must be directed to these Providers. Currently all laboratory, and some vision and durable medical equipment services, are contracted through specific vendors. For more information on referrals to Providers, please contact the UM Department at 1-209-942-6431.

If covered services are needed from an out-of-network Provider, please contact the UM Department at 1-209-942-6431 to obtain approval for the referral. Health Plan Advantage D-SNP's Contracting Department will contact Providers that may be available to meet the clinical needs of the Enrollee.

## CONTINUITY OF CARE

Health Plan Advantage D-SNP provides continuity of care for Enrollees when their Provider is no longer part of the network or when the Enrollee is transitioning into Health Plan Advantage D-SNP coverage. Continuity of care is provided automatically when criteria are met, but may also be initiated by the Enrollee or Provider.

- **Primary Care Provider (PCP) and Specialist Providers:** Enrollees may continue to see a non-contracted PCP or specialist for up to 12 months when the Enrollee has an existing relationship with the Provider, the Provider agrees to work with Health Plan Advantage D-SNP at the applicable reimbursement rate and the Provider has no substantial quality-of-care concerns.
- **All Other Providers/Services:** For other providers and services, continuity of care is honored for up to 90 days if the Enrollee is actively receiving treatment. This includes services such as dialysis, home health, outpatient therapies, or other non-specialist care.

At the end of the continuity period, Enrollees must transition to in-network Providers to continue receiving covered services. Health Plan Advantage D-SNP will assist in coordinating this transition to ensure there is no disruption in care. If Health Plan Advantage D-SNP does not have an in-network Provider available to deliver the medically necessary service, the Enrollee may continue care with the non-contracted Provider for as long as medically necessary, at no additional cost to the Enrollee.

Although Health Plan Advantage D-SNP is responsible for initiating continuity of care when criteria are met, Providers may also request continuity of care on behalf of the Enrollee. If a non-contracted Provider is providing services to an Enrollee, he/she may initiate a request for continuity of care by submitting a Medical Authorization Form available on Health Plan Advantage D-SNP's website at www.hpsj-mvhp.org. or by contacting Health Plan Advantage D-SNP's Customer Service Department at **1-888-361-7526(TTY: 711).**

## OBTAINING A SECOND OPINION

Health Plan Advantage D-SNP honors the Enrollee's right to obtain a second opinion from another Provider when indicated. To coordinate this, the Enrollee should be directed to an in-network Provider. If an in- network Provider is unavailable, Authorization for an out-of-network second opinion should be requested. The UM Department will notify the requesting Provider in writing of the result of the authorization request and assist the Enrollee with making arrangements for the second opinion upon request.

Health Plan Advantage D-SNP will allow a second opinion to Enrollees by an appropriately qualified healthcare professional, if requested by an Enrollee or a participating Provider who is treating the Enrollee. An authorization is not needed for a second opinion with an in-network Provider. If the Provider is out of network, authorization is needed. Health Plan Advantage D-SNP will also arrange transportation if needed for the second opinion.

## COVERED SERVICES THAT DO NOT NEED PRIOR AUTHORIZATION

Health Plan Advantage D-SNP permits an Enrollee to obtain some covered services without prior authorization. A complete list of these covered services can be found on the Provider portal and should be regularly reviewed for changes.

However, the following covered services never require prior authorization. Enrollees may choose an in-network Provider or an out-of-network Provider for:

- Emergency Services
- Certain preventative services in-network (Access the Provider portal for more information)
- Basic prenatal care in-network
- HIV testing
- Family planning
- Treatment and diagnosis of sexually transmitted diseases (STDs)
- Well women health service in-network
- Initial mental health and SUD assessments

## ONGOING SPECIALTY CARE AUTHORIZATIONS

Enrollees with serious or ongoing health conditions may require extended access to a specialist. Health Plan Advantage D-SNP will authorize ongoing specialty care when medically necessary:

- **In-Network:** Enrollees will be directed to contracted specialists when available.
- **Out-of-Network:** If there is no qualified in-network specialist available, Health Plan Advantage D-SNP will authorize specialty care with an out-of-network Provider at no additional cost to the Enrollee.
- **Duration:** Authorizations for ongoing specialty care may be issued for up to 12 months, or longer if medically necessary, based on the Enrollee's treatment plan.

Ongoing specialty care authorizations are appropriate for conditions that require long-term specialized care. Examples include cancer, HIV/AIDS, lupus, renal failure, cystic fibrosis, severe neurological conditions, transplant candidacy, acute leukemia, and high-risk pregnancy. Authorizations may also be issued for other life-threatening, degenerative, or disabling conditions when medically necessary.

### Affirmative Statement on Incentives

Health Plan Advantage D-SNP's UM decision making is based solely on appropriateness of care, service, and existence of coverage. Health Plan Advantage D-SNP does not specifically provide incentives for the individual provider or entity to deny, limit, or discontinue medically necessary services to any member/enrollee.

## SUBMITTING REQUESTS FOR AUTHORIZATIONS

Providers must verify an Enrollee's eligibility before submitting a prior authorization for covered services. Eligibility may be verified through the Provider portal. Alternate methods to verify eligibility are detailed in this Manual under "Eligibility Verification, Enrollee Enrollment, and Customer Services." The list of services that require prior authorization, and the Authorization Request Form are located in the Provider portal, and on the Provider page of Health Plan Advantage D-SNP's website.

# SECTION 8: UTILIZATION MANAGEMENT

## ADVANTAGES OF SUBMITTING AUTHORIZATIONS ONLINE

Providers can submit prior authorizations online through the Provider portal or by fax at 1-209-762-4774. Online is the preferred mode of submission with the following advantages for Providers:

- Immediate access to the status of the prior authorization request (not available for faxed requests)
- Direct communication with Health Plan Advantage D-SNP staff via the Provider portal regarding any aspect of the authorization status

The following information is required for authorization requests:

- Enrollee's demographic information (name, date of birth, etc.)
- Request type (Office Based or Facility)
- Requester
- Requester affiliation or "Pay to Service"
- Provider's National Provider Identifier (NPI) (only required for paper submissions)
- Provider Group's NPI (if there is a Group NPI; only required for paper submissions)
- Provider's tax ID number (only required for paper submissions)
- Location where services will be provided
- Requested service/procedure, including specific CPT/HCPCS codes and quantity requested
- Enrollee diagnosis (ICD code and description)
- Signature of requesting provider modifiers, if applicable
- Fax back number
- Clinical indications necessitating service or referral
- Pertinent medical history and treatment
- Medical records and/or other documents supporting the request
- Supporting clinical documentation (Clinical information can be scanned and uploaded directly into the Provider portal along with the authorization request.)

## TURNAROUND TIME FOR PRIOR AUTHORIZATION[5]

The turnaround time for a prior authorization depends on the type of request:

- **Expedited Request:** Within 72 hours of receipt of the request.
- **Standard Request:** Within seven calendar days of receipt of the request.
- **Standard Part B Drug Request:** Within 72 hours of receipt of the request.
- **Expedited Part B Drug Request:** Within 24 hours of receipt of the request.

Authorization determinations are made in accordance with applicable Medicare guidelines. No extensions are permitted.

## DISMISSALS

In certain situations, Health Plan Advantage D-SNP may dismiss a request for an initial determination. A dismissal means the request cannot proceed as submitted. A dismissal notice will be issued to the Enrollee and Provider explaining the reason and outlining rights to request review of the dismissal.

A request may be dismissed when:

- The individual or entity submitting the request is not permitted under Medicare rules.
- The request does not meet the requirements to be considered valid (e.g., insufficient information to identify the Enrollee).
- The Enrollee passes away while the request is pending and no party with a financial interest wishes to continue.
- The request is withdrawn by the Enrollee or their representative.

Dismissals are binding unless modified, reversed, or vacated. A party may request review of a dismissal within 65 days of the dismissal notice. Health Plan Advantage D-SNP may also vacate a dismissal for good cause if evidence shows the dismissal was issued in error.

## EMERGENCY/URGENT CARE SERVICES

Emergency and urgent care services are available at any time, without prior authorization. Health Plan Advantage D-SNP covers emergency services, including screening and stabilization, wherever the Enrollee presents for care. Enrollees cannot be billed, charged, or held financially liable for emergency or urgent care services.

PCPs may help Enrollees understand appropriate use of the ER for non-emergency conditions and encourage use of contracted urgent care centers when clinically appropriate. Urgent care centers throughout the service area offer extended hours and shorter waiting times compared to emergency departments.

### Observation Stay

Observation services are covered as outpatient hospital services when ordered by a physician and when medical necessity criteria are met. No authorization is required for an observation stay of up to 24 hours. If an observation extends beyond 24 hours, clinical documentation must be submitted for continued review.

## INPATIENT ADMISSIONS

All non-emergency (elective) admissions to acute care, acute rehabilitation, long-term acute care, and long-term care facilities require prior authorization. Providers are also required to admit Enrollees only to hospitals contracted with Health Plan Advantage D-SNP. Elective admissions to out-of- network facilities will also require prior Authorization,

## Long-Term Care

Health Plan Advantage D-SNP covers long-term care services for Enrollees who require out-of-home placement due to their medical condition.

- **Medicare:** Skilled Nursing Facility (SNF) care is covered under Medicare Part A when criteria are met, including a qualifying inpatient stay and skilled nursing needs. Coverage is generally limited to 100 days per benefit period.
- **Medi-Cal:** When Medicare coverage ends or criteria are not met, Medi-Cal may cover long-term custodial care or placement in specialized facilities. This includes nursing facilities, subacute care, and intermediate care facilities for the developmentally disabled. Health Plan Advantage D-SNP coordinates placement at the appropriate level of care based on the Enrollee's medical needs.

## Criteria for Admission

Admission criteria are determined first using Medicare coverage rules. SNF admissions must meet Medicare Part A requirements, including medical necessity, qualifying inpatient stay, and need for skilled services.

When Medicare coverage does not apply or has been exhausted, Medi-Cal criteria are used to determine admission for long-term custodial or specialized facility care. Providers may access Medi-Cal facility-specific criteria at www.medi-cal.ca.gov.

## Referring an Enrollee to a Nursing Facility

Here are several important reminders for physicians who intend to refer a Health Plan Advantage D-SNP Enrollee to a nursing facility:

1. To refer Enrollees to a nursing home, the physician must order the admission and provide the following information:
    a. The Enrollees' medications, diet, activities, and medical treatments, such as wound care and labs.
    b. Current history and physical
    c. Diagnosis/diagnoses
    d. Indication of whether the physician will be following the Enrollee once admitted to the facility
2. In making prior authorization requests, the physician must identify the facility of admission. The Enrollee and/or the Enrollee's authorized representative may also seek the physician's counsel in determining an appropriate facility.
3. The admitting facility is responsible for obtaining authorization from Health Plan Advantage D-SNP. The admitting facility will present medical justification for the level of care requested. If the authorization request is not approved, the Enrollee, physician, or facility has an option to appeal the determination.

### Trauma Care

Health Plan Advantage D-SNP covers medically necessary trauma care when an Enrollee is treated at a designated trauma facility. Trauma care includes inpatient or outpatient services provided during one uninterrupted admission or emergency department episode of care.

- Trauma care is covered without prior authorization, consistent with the prudent layperson standard under Medicare.
- Enrollees cannot be billed or held financially liable for trauma services.
- Designated trauma facilities are required to follow trauma triage protocols established by the American College of Surgeons or the local county Emergency Medical Services (EMS) agency as part of their trauma center designation.
- Health Plan Advantage D-SNP reimburses contracted trauma facilities in accordance with their trauma care agreements.

## INPATIENT CONCURRENT REVIEW

To ensure quality and cost-effective inpatient care, Enrollees must receive the appropriate level of care while in the inpatient setting. Health Plan Advantage D-SNP's goal is a safe, efficient Enrollee discharge transition to the most appropriate and least restrictive setting that meets the Enrollee's needs.

Upon admission, a Concurrent Review Registered Nurse (CCRN) reviews the facility clinical documentation to ensure the Enrollee is receiving quality care at the appropriate intensity regardless of whether the care is delivered in an acute, rehabilitation, skilled, or other inpatient setting. Clinical information should be submitted within 24 hours.

Health Plan Advantage D-SNP's physicians and other licensed clinical staff initially apply Medicare coverage rules including NCDs, LCDs and Medicare manuals to determine the medical necessity of the inpatient stay and the appropriate level of care (e.g., acute medical-surgical, telemetry, intermediate, or intensive care). If no Medicare criteria apply, nationally recognized evidence-based guidelines such as MCG may be used as a secondary reference. If the requested service is not addressed by Medicare or MCG, Medi-Cal criteria may be applied. If no applicable criteria exist, reviewers will consult Health Plan Advantage D-SNP's internal policies and peer-reviewed, published literature to support the decision.

If medical necessity criteria are not met or if sufficient clinical information is not provided to determine the medical necessity for the inpatient stay or the level of care requested, the case will be reviewed by a Medical Director. When a request is denied, the facility and Provider are notified of the reason and the Enrollee's appeal rights.

Health Plan Advantage D-SNP's CCRN leverages a team approach with facility staff to successfully coordinate medical care and plan for post-discharge needs. Updated clinical information which includes facility Care Manager (CM) contact information should be submitted daily or as requested. The CCRN or Medical Director may need to contact the attending physician to address complex issues or problems that arise.

## REOPENINGS

Health Plan Advantage D-SNP may reopen or revise a coverage or authorization decision that has already been issued. Reopenings are not new requests or appeals, but a correction of the prior decision.

A reopening may occur:

- To correct a clerical error (such as a typographical error in dates or codes).
- When new or missing information is received that affects the outcome.
- When good cause exists, such as evidence showing the original decision was incorrect.

Requests for reopening must generally be made within six months of the original decision. If a reopening is granted, the timeframe for the new determination begins on the date Health Plan Advantage D-SNP decides to reopen the case.

## ADULT PREVENTIVE GUIDELINES

Health Plan of San Joaquin | Mountain Valley Health Plan

When it comes to patient care, HPSJ/MVHP is on your team. We understand that preventive health care is about improving quality of life. This quick reference guide is here to help you reach those goals with your patients.

| Screening Recommendations | 21 to 39 | 40 to 49 | 50 to 65 | 65 and Older |
|---|---|---|---|---|
| Initial Health Visit | Within 120 days of enrollment | | | |
| History and Physical Exam | Every Year | | | |
| Blood pressure, Weight, and Height Check | With Every History and Physical | | | |
| Alcohol misuse screening and counseling | Recommended | | | |
| Drug misuse screening and counseling | Recommended | | | |
| Depression and Anxiety Screening | Recommended | | | |
| Obesity | Recommended | | | |
| Tobacco Use Screening | Recommended | | | |
| HIV Infections | Recommended | | | If at risk |
| Syphilis | If at risk | | | |
| Tuberculosis | Screen all and test at risk | | | |
| BRCA Gene Screening | Talk to Doctor about risks (e.g. family history of breast or ovarian cancer) | | | |
| Chlamydia and Gonorrhea | Screening in all sexually active women 24 years or younger and in women 25 years or older who are at increased risk for infection | | | |
| Intimate Partner Violence | Childbearing-aged women | | | |
| Cervical Cancer | Pap smear every 3 years, or every 5 years with HPV co-testing starting at age 30 | | | |
| Abnormal Glucose/Diabetes | | Recommended | | |
| Hepatitis C Screening | If at risk | | | |
| Colorectal Cancer | | Recommended | | |
| Breast Cancer | | Biennial Screening | | |
| Lung Cancer Screening | | | If at risk | |
| Osteoporosis | | If at risk | | |
| Abdominal Aortic Aneurysm | | | | If an "ever smoker" |
| **Preventive Therapies** | | | | |
| Primary Prevention of Breast Cancer | If at risk | | | |
| Folic Acid Supplementation | If capable of conceiving | | | |
| Statins for Primary Prevention of CVD | If at risk | | | |
| Aspirin for Primary Prevention of CVD and Colorectal Cancer | | If at risk | | |
| Fall Prevention in Community-dwelling Older Adults | | | If at risk | |
| **Immunizations** | | | | |
| Influenza and COVID-19 | One dose annually | | | |
| Tetanus, diphtheria, pertussis (TDAP) | 1 dose Tdap, the Td booster every 10 years | | | |
| Shingles (Zoster) | | | 2 doses | |
| Pneumococcal Conjugate | | | 1 dose | |
| Meningococcal B | If at risk | | | |
| Meningococcal A, C, W, Y | If at risk | | | |
| Measles, mumps, rubella (MMR) | 1 or 2 doses depending on indication (if born in 1957 or later) | | | |
| HPV (Female) | 2 or 3 doses depending on age at initial vaccination 19-26 yrs | | | |
| HPV (Male) | 2 or 3 doses depending on age at initial vaccination 19 -21 yrs | | | |
| Chickenpox (Varicella) | 2 doses (if born in 1980 or later) | | | |
| Hepatitis A | If at risk | | | |
| Hepatitis B | If at risk | | | |
| Hepatitis C (HCV) | If at risk | | | |
| Haemophilus influenza type b (Hib) | If at risk | | | |
| RSV for pregnant people | If at risk | | | |
| **Counseling Recommendations** | | | | |
| Sexually Transmitted Infection | If at risk | | | |
| Diet/Activity for CVD* | If at risk | | | |
| Skin Cancer | If at risk | | | |
| Weight | | BMI 18.5 - 29.9 kg/m² | | |

Recommended for Women Only | Recommended for Men Only | Recommended for all Adults

* CVD=Cardiovascular Disease

For full guidelines visit www.uspreventiveservicestaskforce.org

Sources: USPSTF Recommended Adult Preventive Health Care Schedule Grade A and B 2024, CDC Recommended Adult Immunizations 2024

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### Behavioral Health Care Services

Prior authorization is not required for referral to an in-network mental health practitioner for most outpatient services. If out-of-network services are needed for continuity of care, Health Plan Advantage D-SNP will honor access in accordance with continuity of care requirements. For other medically necessary out-of-network services, a prior authorization request must be submitted. (see Forms & Documents for HPSJ/MVHP Providers).

For transcranial magnetic stimulation (TMS) and higher levels of care (such as intensive outpatient, partial hospitalization program, inpatient psychiatric hospitalization, and/or residential treatment), a prior authorization with supporting documentation is needed in order to be reviewed for medical necessity and referred to an in-network provider. (see Forms & Documents for HPSJ/MVHP Providers).

Physicians and other medical practitioner offices can refer Enrollees directly to in-network mental health practitioners listed in Health Plan Advantage D-SNP's Provider directory, Enrollees can call for appointments directly (they can self-refer), or call Health Plan Advantage D-SNP's Behavioral Health Customer Service Department at **1-888-361--7526 (TTY: 711)** for questions and assistance.

## DEVELOPMENTAL DISABILITY SERVICES (DDS) AND DISABLED ADULT CHILDREN (DAC)

Some Enrollees with developmental disabilities may qualify for Medicare coverage as Disabled Adult Children (DACs). A DAC is an individual aged 18 or older with a qualifying disability that began before age 22, who receives benefits based on a parent's Social Security record. Medicare eligibility generally begins after 24 months of Social Security Disability Insurance (SSDI) benefits, or sooner for individuals with Amyotrophic Lateral Sclerosis (ALS). Providers should be aware that many adult Enrollees with developmental disabilities may have Medicare through this pathway, even if they have never worked.

When Medicare does not cover a needed service, Medi-Cal benefits apply, including services available through California's Developmental Disability Services (DDS) and Regional Centers (RCs).

A developmental disability is a disability which originates before an individual reaches 21 years old, continues or can be expected to continue indefinitely, and constitutes a substantial disability for that individual. Conditions may include developmental delay, cerebral palsy, epilepsy, autism, or other disabling conditions, but exclude conditions that are solely physical in nature.

## REGIONAL CENTERS

Regional Centers (RC) are nonprofit agencies that have a contract with the Department of Developmental Services that provide or coordinate services for individuals with developmental disabilities. In the service area (Alpine, El Dorado, San Joaquin, and Stanislaus Counties), Regional Centers remain the lead entities for certain developmental services.

To be eligible for RC services, Enrollees must have a qualifying disability that begins before age 18, is expected to continue indefinitely, and present a substantial disability. Qualifying conditions include intellectual disability, cerebral palsy, epilepsy, autism, and other conditions as defined in Section 4512 of the California Welfare and Institutions Code.

Services offered by RCs include:

- Diagnosis and assessment of eligibility
- Access, coordinate and monitor services and supports
- Early Start Therapeutic services
- Adult day centers/program services
- Behavioral Management Services
- Client/Parent Support/Behavior Intervention Training
- Crisis Intervention Facility/Bed
- Crisis Team – Evaluation and Behavioral Intervention
- Day Care Services
- Durable Medical Equipment
- Employment Programs
- Family Home Agency
- Foster Grandparent/Senior Companion Programs
- Health Care Facilities
- Home Health Supports
- Housing Support Services
- Increase Community Access
- Independent Living Services
- Infant Development Services
- Medical Specialists and Professionals
- Mobility Training
- Out-of-home respite services
- Parent Coordinated Services
- Personal Emergency Response System
- Pharmaceutical Services
- Residential Care Homes
- Respite Services – In-home
- Social/Recreational Services and Non-Medical Therapies
- Self-Determination
- Specialized Transportation
- Speech Services
- Supplemental Program Supports
- Supported Living Services
- Therapies
- Translator/Interpreter Services

Resource: https://www.dds.ca.gov/wp-content/uploads/2019/03/RC_ServicesDescriptionsEnglish_20190304.pdf

Providers can refer Enrollees to RCs by contacting the corresponding office based on location:

| Regional Center | Office Location(s) | Counties Served |
|---|---|---|
| Alta California Regional Center<br><br>Website: www.altaregional.org | 2241 Harvard Street, Suite 100<br>Sacramento, CA 951815<br><br>Phone: 1-916-978-6400<br>TTY:1-916-489-4241<br>Early Start Intake: 1-916-978-6249 | Alpine and El Dorado |
| Valley Mountain Regional Center<br><br>Website: www.vmrc.net | San Joaquin Branch:<br>702 N Aurora St.<br>Stockton, CA 95269-2290<br><br>Phone: 1-209-473-0951<br>TTY: NA<br>Early Start Intake: 1-209-955-3281 (under age 3)<br>Lanterman Act Services: 1-209-955-3209 (over age 3) | San Joaquin and Stanislaus |
| | Stanislaus Branch:<br>1820 Blue Gum Ave.<br>Modesto, CA 95358<br><br>Phone: 1-209-529-2626<br>Early Start Services: 1-209-557-5619<br>Lanterman Act Services: 1-209-557-2197 | |

## TRANSGENDER SERVICES

Transgender services are a covered benefit available to D-SNP Members. Health Plan Advantage D-SNP continues to work with community partners to offer guidance, support and local resources to provide the best possible culturally sensitive care.

The basic elements available to support Providers caring for transgender Members are:

- Identification and criterion for transgender Members.
- PCP training to address the special needs of transgender candidates within Health Plan Advantage D-SNP's service area and adjoining areas.
- Training events for Provider~~'s~~ offices in transgender special needs and support.
- Specialists in the service area and surrounding areas for transgender care and support.

- Hospitals specializing in the surgical needs of transgender Members.
- Continuing dialogue with transgender advocates about support, programs, and initiatives.
- HIV testing and counseling
- Sexually transmitted diseases
- Elective abortions
- Behavioral health services

### AIDS Medi-Cal Waiver Program

Local agencies, under contract with the California Department of Public Health, Office of AIDS, provide home- and community-based services as an alternative to nursing facility care or hospitalization.

The Medi-Cal Waiver Program (MCWP) provides comprehensive case management and direct care services to persons living with HIV/AIDS as an alternative to nursing facility care or hospitalization. Case management is participant centered and provided using a team-based approach by a registered nurse and social work case manager. Case managers work with the participant, their PCP, family, caregivers, and other service Providers to determine and deliver needed services to participants who choose to live in a home setting rather than an institution.

The goals of the MCWP are to:

- Assist participants with disease management, preventing HIV transmission, stabilizing overall health, improving quality of life, and avoiding costly institutional care.
- Increase coordination among service Providers and eliminate duplication of services.
- Transition participants to more appropriate programs as their medical and psychosocial status improves, thus freeing MCWP resources for those in most need; and
- Enhance utilization of the program by underserved populations.

Enrollees eligible for the program must be Medi-Cal recipients: whose health status qualifies them for nursing facility care or hospitalization, in an "Aid Code" with full benefits and not enrolled in the Program of All-Inclusive Care for the Elderly (PACE); have a written diagnosis of HIV disease or AIDS with current signs, symptoms, or disabilities related to HIV disease or treatment; adults who are certified by the nurse case manager to be at the nursing facility level of care and score 60 or less using the Cognitive and Functional Ability Scale Assessment tool, children under 13 years of age who are certified by the nurse case manager as HIV/AIDS symptomatic; and individuals with a health status that is consistent with in-home services and who have a home setting that is safe for both the client and service Providers.

For further information refer to the Office of AIDS.

# AUTHORIZATIONS

## Hospital Authorizations

Facility referrals for elective inpatient service must be prior authorized by Health Plan Advantage D-SNP. After the Enrollee is admitted to the facility, the admitting Provider, including any hospitalists, will manage the Enrollee's treatment and care. Admissions to out-of-network facilities require prior authorization approval by Health Plan Advantage D-SNP's UM Department.

Health Plan Advantage D-SNP initially uses Medicare coverage rules, including NCDs, LCDs and Medicare manuals to determine the medical necessity for admission, length of stay and treatment options. For certain procedures included on Medicare's Inpatient-Only (IPO) list, Medicare coverage is limited to the inpatient hospital setting. If Medicare does not cover the procedure because of the setting, Medi-Cal coverage rules may apply.

It is imperative that the facility team Health Plan Advantage D-SNP work together to ensure that Enrollee receives appropriate care and that coverage determinations are accurate and consistent.

## Hospital Emergency Admissions

Emergency admissions do not require prior authorization and are covered under the prudent layperson standard, meaning Enrollees are covered when a reasonable person would believe the situation requires immediate medical attention. Facilities should notify Health Plan Advantage D-SNP within 24 hours of admission to support care coordination, concurrent review, and discharge planning.

Clinical information should be provided to Health Plan Advantage D-SNP to support continued stay review and transitions of care. Continued stay determinations are made in accordance with Medicare coverage rules, with Medi-Cal criteria applied only when Medicare does not cover the service.

## Outpatient and Ancillary Prior Authorization

Providers should consult the Provider portal for guidance on prior authorization for outpatient and ancillary services. For covered services requiring prior authorization, the requesting Provider will be notified of Health Plan Advantage D-SNP's decision to authorize or deny. Upon authorization, Health Plan Advantage D-SNP will coordinate with contracted outpatient and/or ancillary Providers.

Health Plan Advantage D-SNP's physicians and other licensed clinical staff initially applies Medicare coverage rules including NCDs, LCDs and Medicare manuals to determine the medical necessity for outpatient services. If no Medicare criteria apply, nationally recognized evidence-based guidelines such as MCG may be used as a secondary reference. If the requested service is not addressed by Medicare or MCG, Medi-Cal criteria may be applied. If no applicable criteria exist, reviewers will consult Health Plan Advantage D-SNP's internal policies and peer-reviewed, published literature to support the decision.

If medical necessity criteria are not met or if sufficient clinical information is not provided to determine the medical necessity for the requested outpatient service, the request will be denied by the Medical Director.

### Prior Authorization

Health Plan Advantage D-SNP requires all covered services for physical and behavioral health conditions that require authorization be submitted to Health Plan Advantage D-SNP's UM Department for medical necessity review.

Health Plan Advantage D-SNP's physicians and other licensed clinical staff initially applies Medicare coverage rules including NCDs, LCDs and Medicare manuals to determine the medical necessity for outpatient services. If no Medicare criteria apply, nationally recognized evidence-based guidelines such as MCG may be used as a secondary reference. If the requested service is not addressed by Medicare or MCG, Medi-Cal criteria may be applied. If no applicable criteria exist, reviewers will consult Health Plan Advantage D-SNP's internal policies and peer-reviewed, published literature to support the decision.

If medical necessity criteria are not met or if sufficient clinical information is not provided to determine the medical necessity for the requested outpatient service, the request will be denied by the Medical Director.

# SECTION 9: CARE COORDINATION

## PROVIDER RESPONSIBILITIES FOR CARE COORDINATION

Health Plan Care Coordination teams coordinate services and complex care for the best clinical and functional outcomes for our members. D-SNP Members select a Primary Care Provider (PCP) at the time of enrollment. The PCP is responsible for managing and coordinating healthcare services provided to Members, including the coordination of primary and specialty care, hospital care, diagnostic testing, and therapeutic care.

For the D-SNP population, PCPs play an integral role as members of the Interdisciplinary Care Team (ICT), collaborating with the Health Plan on all care planning and health education needs. Health Plan is responsible for managing the Member's care via the Individualized Care Plan (ICP), which is regularly updated to reflect current needs. Health Plan is required to share the ICP with the PCP and make it available to all members of the ICT, as needed. Health Plan relies on the collaboration of ICT members for the accuracy and effectiveness of the D-SNP care plan.

## INTEGRATED MEDICAL AND BEHAVIORAL CARE COORDINATION

D-SNP Members are automatically enrolled in Health Plan's case management program where care is managed via an ICP, customized to meet the specific needs of the Member, depending on their risk level, primary health driver and the complexity of their healthcare needs. Each Member is assigned a primary case manager, either a physical health clinician or behavioral health clinician, who interacts regularly with the Member throughout their D-SNP enrollment. The specific goals of the care coordination programs are to (1) facilitate efficient and effective communication between Members and Providers, (2) utilize appropriate resources enabling Members to improve their health status and self-management skills, and (3) fully integrate whole-person health solutions addressing all medical, psychosocial, cognitive, and mental/behavioral health and/or substance use disorder needs.

The primary goals of the Case Manager are:

- Complete initial and annual assessments, monitoring for increased risks and changes to health status.
- Determine benefits and resources available to the Member and remove health literacy barriers.
- Develop and implement an ICP in partnership with the Member, Provider(s), and family or caregiver, as appropriate to the Member's needs.
- Coordinate and communicate all needs amongst members of the Member's ICT to identify and mitigate barriers to care.
- Monitor, evaluate and follow up on progress toward collaborative care management goals.

Attention to behavioral and mental health, including substance use disorder and social determinants of health is integrated into the holistic care provided by the Case Management Department. Health Plan's Behavioral Health/Social Work (BH/SW) Department has a primary aim to enhance human well-being and help meet basic and complex needs of all people with a particular focus on those who are vulnerable, oppressed and living in poverty.

# SECTION 9: CARE COORDINATION

This part of the care management team includes behavioral health and social work coordinators/navigators, case managers and leadership to ensure:

- Timely access
- Coordination of care
- Quality of care
- Support linkages

Based on results from the initial and annual Health Risk Assessment (HRA), or any direct referral from the PCP or specialty Provider, Members may be referred directly to the BH/SW team for targeted assistance in a number of areas, including:

- Housing instability/insecure living situation
- Safety needs including signs or reports of domestic violence
- Cognitive changes, including thinking, remembering and decision-making
- Lack of caregiver support
- High-risk on behavioral health screening tools
- Social isolation
- Risks related to suicidal/homicidal ideation or activities
- High-risk behavioral or mental health diagnoses not currently treated
- Substance use disorder not currently treated
- Financial insecurity
- Food insecurity

Health Plan's BH/SW team regularly provides assistance with:

- Linkage to transportation via dial-a-ride or van services
- LTSS, CBAS and IHSS referrals
- Food and Utility resources
- Maternal child/adolescent health resources and education
- Mental health resources
- Substance Use Disorder resources

Providers needing assistance coordinating mental or behavioral health or social services can access the Behavioral Health Case Management Department, please call our Behavioral Health Customer Service line at 1-888-581-7526 and request to speak to a Behavioral Health Case Manager.

Risks related to the Members' health are stratified according to a risk stratification algorithm which aligns the Member with one of three case management categories:

- Complex case management (high-risk)
- Standard case management (moderate-risk)
- Community-well case management (low-risk)

Members are frequently evaluated for changes to health care needs and risk level and are linked to appropriate clinical, social or behavioral health services, as needed. Health Plan views care coordination as a collaboration between the Member, medical and behavioral care Providers, and Health Plan with a common goal of ensuring high-quality, cost-effective care.

# SECTION 9: CARE COORDINATION

## COMPLEX CASE MANAGEMENT (CCM)

Complex Case Management (CCM) Program focuses on coordinating care for the highest-risk Members. Members in this category have experienced a critical event or diagnosis requiring extensive use of resources and need help navigating the health care system to facilitate appropriate delivery of care and services.

CCM addresses the Member's social, physical, and behavioral health needs to maximize disease prevention and promote Member wellness in a high-quality, cost-effective manner.

Health Plan's CCM program is designed to improve communication between Members and Providers and to make efficient use of the available health care and community-based resources.

Members are identified for the CCM Program through analysis of assessment information including HRA information, authorization data, claims and encounter data, and pharmacy reporting.

Providers can refer Members with complex health care and coordination needs directly to the Case Management Department by calling 1-800-822-6226. The case management Department will take all available information and reach out to Members as quickly as possible. Members can also self-refer to this program by calling the case management number above.

## STANDARD CASE MANAGEMENT (SCM)

Standard case management program offers member centered approach. In this program, a case management staff member will be assigned to the member to assess member needs, develop plan of care, implement and coordinate case management services. Case Managers will monitor the progress of care plan to achieve optimal health outcomes. Case Managers will also collaborate among multiple providers and member/authorized representatives (AR) to deliver and evaluate member progress to achieve goals.

## COMMUNITY-WELL CASE MANAGEMENT (CWCM)

Community-well case management program will enroll members with a score of <15 on a 0-99 risk score. And are placed in the Community-Well (low) stratification bucket. Members will be assigned a primary Case Manager who is in the Patient Health Navigator role to conduct annual HRAs and will collaborate with the RN Case Manager who oversees the Care Plan.

All case management tiers of care focus on addressing all medical, psychosocial, cognitive, functional and mental health needs. Collaboration with the BH/SW Department occurs holistically as needs arise. Attention to the management of all medical and behavioral illness is a top priority, and all clinicians have the skills to address the needs related to these diagnoses.

# SECTION 9: CARE COORDINATION

## CARE TRANSITION SERVICES

Health Plan defines transition of care as the movement of Members between health care settings as their condition and care needs change during the course of a chronic or acute illness. Health Plan recognizes that older or disabled adults moving between different health care settings are particularly vulnerable to receiving fragmented and unsafe care when transitions are poorly coordinated. Health Plan case management clinicians are committed to working actively to coordinate care transitions for the best possible outcome. Health Plan delivers care through formal care transition protocols for every D-SNP Member. Case Managers provide seamless support and coordination of services during care transitions across healthcare settings for both medical and behavioral admissions.

Paramount to a successful transition is timely notification of transitions and engagement and collaboration with PCP and all care team members. Health Plan is committed to notifying the PCP office within Three (3) business days from the date of Health Plan notification of a care transition. A Case Manager will work in partnership with Providers and care team members to formulate a safe plan for transition, including the updating and sharing of the revised care plan.

A primary goal during care transition is to connect the Member with primary care services and facilitate a timely post-discharge follow-up visit to review care, medications and discharge instructions. Case managers work with all Providers to ensure care transition needs are reflected in the care plan and all Providers have input to care management.

Changes in healthcare status and needs, including those following a hospital discharge, may be escalated and addressed during the ICT meeting. Primary Care and Specialty Physicians, as well as community-based service providers, may periodically be invited to attend a virtual ICT meeting to provide input and guidance on the care needed.

## CALIFORNIA INTEGRATED CASE MANAGEMENT (CICM)

CICM is the California-specific requirements for integrated care coordination for specific vulnerable populations covered by D-SNPs as determined by the state. The goal of CICM program is to ensure delivery of extra medical and behavioral interventions, services and benefits that meet the specialized needs of these most vulnerable beneficiaries as evidenced by measures from psychosocial, functional, and end-of-life domains. Health Plan relies heavily on Provider partnerships to meet these complex needs.

Key features of this program are:

- Clearly identify the target populations
- Enhance care coordination between all Providers
- Integrate all services to help reduce fragmentation, improving overall quality of care
- Reduce health disparities by providing more comprehensive care to those who often face barriers
- Involve ICT to guide individuals to receive appropriate services

# SECTION 9: CARE COORDINATION

Health Plan is committed to strong collaboration with Providers to deliver the highest quality care possible for these eight most vulnerable subpopulations, as defined by the State of California:

- Adults experiencing homelessness
- Adults with serious mental health or substance use disorder needs
- Adults transitioning from incarceration
- Adults at risk for avoidable hospital or emergency room (ER) utilization
- Adults with documented dementia needs
- Adults pregnant or postpartum and subject to racial and ethnic disparities
- Adult nursing facility residents transitioning to the community
- Adults living in the community at-risk for long-term care institutionalization

CICM Members are specifically identified for the Case Management Department and stratified into the CCM program for intense intervention. Health Plan seeks to actively engage PCPs, specialists and community-based organizations in the development, implementation and evaluation of the ICP.

## CHRONIC CONDITIONS IMPROVEMENT PLAN (CCIP)

Health Plan is required to implement a CCIP for its D-SNP. The CCIP is a quality initiative which aims to improve the health for D-SNP Members diagnosed with diabetes mellitus, are of Hispanic/Latino ethnicity, and have a HbgA1c result >9.

Members identified for CCIP are stratified into the CCM or Standard level of case management based on their HRA score and receive the appropriate level of case management interventions. Care is focused on improving health outcomes, slowing disease progression, preventing health complications and decreasing inpatient stays.

Elements of the CCIP, additionally described in Section 13, Quality Improvement, include appropriate identification of Members meeting program criteria, mechanisms for monitoring the health and status of Members in the program, evaluating outcomes related to health disparity and HgbA1C results.

PCPs and endocrinologists helping to manage diabetes mellitus for Members are valuable partners to the case managers working to track bloodwork results and provide disease education to Members.

## REQUIREMENTS FOR FACE-TO-FACE ENCOUNTER

In compliance with CMS regulations, the D-SNP must provide for face-to-face encounters for the delivery of healthcare, case management or care coordination services. The minimum requirement for a qualified encounter is at least annually, beginning within the first 12 months of enrollment. The purpose of this visit is for an in-person or real-time visual/interactive encounter focused on coordination of services between the Member, his/her healthcare Providers and Health Plan.

As described in its SNP Model of Care (MOC), Health Plan utilizes the PCP to meet this requirement on an annual basis. Face-to-face encounters serve to deliver clinical and/or case management/care coordination services which focus on meeting the individualized needs of the member and are a mechanism to ensure the goals of the program are met.

A qualified face-to-face encounter can be conducted via either an in-network PCP, any member of the Member's ICT or Health Plan's case management and coordination staff. Health Plan case management staff actively engage with PCPs as part of regularly scheduled clinical case review process and coordinate with PCPs on visit goals and care planning. Case managers regularly provide education on the importance of at least an annual face-to-face PCP visit.

Health Plan's Case Management Department utilizes claims data and case management documentation to track completion of an annual face-to-face encounter with the appropriate party, annually. The Member may decline a face-to-face encounter at any time.

Face-to-face interactions between a Member and his/her ICT facilitate optimal outcomes through a person-centered approach, promotes advocacy, collaboration, communication, continuity of care and timely connection with programs and services. The expected outcome of the face-to-face visit includes:

- The sharing of critical health information
- Integration of needed services and referrals
- Monitoring health status including diagnoses
- Monitoring and assessment of home safety and social determinants of health
- Monitoring preventive health activities (i.e., blood pressure, HgbA1c, GYN/Mammogram, etc.)
- Assessment of gaps related to medication regimen adherence
- Assessment of specialist engagement and/or needs

The Case Management Department engages in robust collaboration with Providers to support Member health and comply with this federal regulation.

## LONG-TERM SERVICES AND SUPPORTS (LTSS)

All D-SNP Members are assessed via the initial and annual HRA for any needed LTSS needs including In-Home Supportive Services (IHSS) and Community-Based Adult Services (CBAS). California's Department of Health Care Services (DHCS) requires specific assessment questions in order to identify current services or those potentially needed by the Member questions used to assess for LTSS needs include:

- Evaluation of Activities of Daily Living (ADL), limitations and functional supports
- Evaluation of housing environment
- Evaluation of health literacy
- Caregiver stress
- Risk of abuse and neglect
- Evidence of cognitive impairment

- History of falls
- Evidence of financial insecurity
- Evidence of social isolation

PCPs may identify that Members requiring LTSS need referral to a participating LTSS Provider. Some ways to identify LTSS needs are:

- If the Member 1) already receives home care, adult day care, or other home care services.
- If the Member requests a home health aide, personal care assistant services, or other non-skilled assistance to support ADLs where assistance is needed but not available.
- If the Member meets criteria for Adult Day Health Care (ADHC) services.
- If the Member is receiving short-term rehab or nursing care and is qualified to return to the community with home care.
- If the Member is diagnosed with Alzheimer's disease or related dementia, and/or other cognitive deficits with a need for assistance with his/her ADL, or someone to direct his/her care in the community.
- If the Member requests a power wheelchair or a hospital bed and has an unmet need for assistance with his/her ADL.
- If the Member has a history of falling and a deficit in his/her ADL.

D-SNP care coordinators and managers supporting D-SNP Members are trained by the Health Plan to understand the full spectrum of Medicare and Medi-Cal LTSS programs.

## PROVIDER TRAINING

Health Plan offers a variety of training modules, including MOC training to contracted Providers and their staff via Health Plan's website. Non-contracted Providers may also visit Health Plan's website to obtain the MOC training. Because the trainings may be accessed at any time, it is easy for busy Providers and their staff to complete the training as their schedule permits.

Within 10 business days of a Provider becoming effective in the Health Plan network, a Provider Services Representative will reach out to the Provider's office staff to schedule Provider orientation (i.e., in-service), which is completed within 30 business days from becoming a contracted Provider. The orientation session may be held on-location at the provider office/clinic or through electronic methods including webinar; and includes, but is not limited to:

- Overview of Health Plan
- Fraud Waste & Abuse training
- Cultural Competency & Language training
- Seniors and Persons with Disability (SPD) Awareness and Sensitivity training
- Health Insurance Portability and Accountability Act (HIPAA) training
- Diversity and Equity and Inclusion training

- Explanation of and assistance setting up access to Doctors Referral Express (DRE). Health Plan's HIPAA-compliant secure provider portal is available 24/7 to contracted Providers
- Guidance on electronic claims submission and online authorization
- Guidance on coordinating preventive services (HEDIS) and standards, if applicable
- Members' rights and responsibilities, including advanced directives
- Member grievance and appeals process
- Provider rights and responsibilities, including the provider dispute resolution process

The Provider Relations Representative provides a brief introduction of Health Plan's benefits and program guidelines. The following topics are also discussed with the provider's office:

- D-SNP Overview
- SNP MOC training
- Coordination of services
- Covered and non-covered services

During the orientation, Providers are encouraged to access the Provider portal to view all Provider materials and the Health Plan's website for the current MOC. Providers accessing the training on the website are required to electronically sign a document attesting to the completion of the training. The Provider MOC training includes information on the various ways Providers are encouraged to participate in Health Plan's MOC.

For contracted Providers and their staff, MOC training content is updated when there is a significant change. Provider communications may include reminders that training is available. Provider Relations Representatives maintain lists of Providers still required to complete training and offer reminders during routine site visits or provider notices.

The Provider MOC training content reviews the four key elements of the Health Plan's D-SNP MOC:

- Description of the SNP population
- Care coordination
- Provider network
- Quality Measurement and Performance Improvement (QMPI)

In instances where the Member is authorized to routinely seek care from an out-of-network Provider, the care manager is responsible for educating the Provider regarding the MOC, as necessary. Out-of-network Providers and their staff may access the MOC training on Health Plan's web page specifically for non-contracted Providers:< https://www.hpsj-mvhp.org>.

# SECTION 10: CLAIMS AND BILLING GUIDELINES

## CLAIMS MANAGEMENT

A key component of quality health care is accurate, timely and efficient claims processing. Health Plan Advantage D-SNP utilizes industry standard billing codes and guidelines in the processing of paper and electronic claims set forth by the Center for Medicare and Medicaid Services (CMS), the Department of Health Care Services (DHCS) and the Department of Managed Health Care (DMHC).

## REQUIREMENTS FOR A COMPLETE CLAIM

A **Clean Claim**, as defined by CMS, is a claim or portion thereof, if separable, including attachments and supplemental information or documentation, which provides: "reasonably relevant information" and "information necessary to determine payer liability".

An **Unclean Claim**, or "other than clean" claim, as defined by CMS, is a claim requiring additional information to make a payment determination. Unclean claims are suspended and a written request identifying necessary information is sent to Provider. (See Claim Development in this section).

***Reasonably relevant information and/or Information necessary to determine payer liability:*** the minimum amount of itemized, accurate and material information generated by or in the possession of the Provider related to the billed services that enables a claims adjudicator to determine the nature, cost, if applicable, and extent of the plan's liability, if any, and to comply with any governmental information requirements in a timely and accurate manner.

**Emergency Services and Care Provider Claim as Defined by Section 1371.35©**

- The information specified in section 1371.35© of the Health and Safety Code; and
- Any state-designated data requirements included in statues or regulations

**Institutional Providers:**

- The completed **UB04** data set or its successor format adopted by the National Uniform Billing Committee (NUBC), submitted on the designated paper or electronic format as adopted by the NUBC
- Entries stated as mandatory by NUBC and required by federal statute and regulations; and
- Any state-designated data requirements included in statutes or regulations.

**Physicians and Other Professional Providers:**

- The **CMS Form 1500** or its successor adopted by the National Uniform Claim Committee (NUCC) submitted on the designated paper or electronic format
- Current Procedural Terminology (CPT) codes and modifiers and International Classification of Diseases (ICD-10 or its successors) codes
- Entries stated as mandatory by NUCC and required by federal statute and regulations; and
- Any state-designated data requirements included in statutes or regulations.

**Providers Not Otherwise Specified above:**

- A properly completed paper or electronic billing instrument submitted in accordance with the plan's reasonable specifications
- Any state-designated data requirements included in statutes or regulations; and
- Referring physician national provider identifier (NPI) for claims for durable medical equipment (DME)

## COMPLETE CLAIM SUBMISSION OPTIONS

Claims can be submitted on a paper form or electronically.

***Note:*** *Before submitting a claim, verify Enrollee eligibility (See Section 6 Eligibility).*

Paper claim submissions are mailed to address below:

Health Plan Advantage D-SNP
Paper Processing Facility
Box 211395 Eagan, MN 55121

To submit claims electronically, Providers must establish an account with a clearing house of choice.

Examples of clearing houses are Change Healthcare (Payer ID 68035), Office Ally (Payer ID HPSJ1) and ClaimsRemedi (68035). Please contact the clearinghouse vendor of choice to set up electronic claim submission. If Health Plan Advantage D-SNP does not already have the clearing house set up as a trading partner, it will be set up once Health Plan Advantage D-SNP is contacted by the clearing house. For any questions or assistance, contact the Provider Services Department at 1-888-361-7526 (TTY:711).

Health Plan Advantage D-SNP will acknowledge the receipt of electronic claims within two working days of receipt and acknowledge receipt of paper claims within 15 working days.

**Note:** *Working Days are defined as Monday through Friday, excluding recognized federal holidays.*

**Advantages of Electronic Claims Submission**

- **Expedited claims processing:** Electronic submission allows Health Plan Advantage D-SNP to begin adjudicating claims faster than if the claim is submitted by paper.
- **Cost effectiveness:** Electronic submission eliminates the cost of purchasing billing forms, envelopes and postage.
- Claims Submission Confirmation: Electronic submission provides fast electronic confirmation of a claim submission from the clearinghouse.

# SECTION 10: CLAIMS AND BILLING GUIDELINES

## CLAIM SUBMISSION TIMELINES

Health Plan Advantage D-SNP's timely filing guideline for claims submission is 365 calendar days from the date of service or date of discharge for acute inpatient claims. If a claim is not received within the appropriate time frame, the claim will be denied as untimely unless evidence of an exception (described below) accompanies claim submission. The determination of good cause is made by Health Plan Advantage D-SNP.

***Note:*** *Date of Service is the date which the Provider delivered separately billable health care services to the Enrollee.*

***Note:*** *Date of Receipt is the calendar day when a claim, by physical or electronic means, is first delivered to either the plan's specified claims payment office, post office box, designated claims processor, or Health Plan Advantage D-SNP delegate.*

Medicare regulations allow for the following exceptions to the 1 calendar year time limit for filing a claim:

- Administrative errors by Medicare contractor or Health Plan Advantage D-SNP
- Retroactive Medicare or Medi-Cal entitlement to or before the date the service was furnished.
- Retroactive disenrollment from a Medicare Advantage or PACE plan

See Section 12: Disputes for instructions on requesting adjustments, corrections, or reconsiderations of an adjudicated claim.

## CLAIMS DETERMINATION NOTIFICATION

Upon submission of a Clean Claim, payment or denial will be made within 30 calendar days. Health Plan Advantage D-SNP shall notify Providers in writing no later than 30 calendar days after receipt of a clean claim by Health Plan Advantage D-SNP. If a portion or whole claim is determined as unclean, one written attempt to obtain the necessary information is sent to Provider and the claim will remain suspended for no more than 60 calendar days to allow for the submission of requested information. Provider remittance advice notice will identify the specific reason Health Plan Advantage D-SNP is denying the claim. If the claim is denied because Health Plan Advantage D-SNP has not received the information necessary to determine Health Plan Advantage D-SNP liability for the claim, Provider will have 120 calendar days from the date of the notice to provide the information requested. Health Plan Advantage D-SNP will make a determination within 30 calendar days after receiving the requested information.

**Note:** *Date of denial or Date of notice: the date the notice is deposited with the United States Postal Service (USPS) or electronically sent to clearinghouses.*

Claims that cannot be auto adjudicated, fail an edit and/or audit check, may "pend" for review either by rule-based algorithms or by a claims analyst who has identified potential additional review is needed. All paper claim submissions are scanned, and images reviewed for completeness along with any attachments submitted with the claim.

### Claims Development

Health Plan Advantage D-SNP will reject a claim billed with invalid and/or missing required data elements including but not limited to industry-standard diagnosis and procedure codes. Health Plan Advantage D-SNP will develop a claim with incomplete information and/or additional information is needed to make a determination. Provider will receive written notice requesting a resubmission of a complete claim or the specific information needed to make a determination. The claim will be identified as an unclean claim and will remain open for not more than 60 calendar days from the date of receipt to allow for receipt and review of requested information. If the information is not received before the 60th day, the claim will be denied, in whole or in part, indicating requested records were not received. Provider is encouraged to submit the records as expeditiously as possible to the address indicated in the written request. *Reference Important Billing Tips and Claim Form Requirements* to avoid denials and ensure prompt payment.

## CLAIM REIMBURSEMENT

The reimbursement of a submitted claim is the payment for services rendered based upon either a contract term, letter of agreement (LOA) and/or in accordance with the Medicare fee schedules and guidelines. All Providers will receive remittance advice, indicating payment and/or the denied reason *(see Claims Determination Notification)*.

### Interest on Claims

Health Plan Advantage D-SNP will pay interest on clean claims paid after the 30th day from the date of receipt. Health Plan Advantage D-SNP will also pay interest on payment adjustments made if Health Plan Advantage D-SNP is responsible for the error resulting in an underpayment. Interest payments will apply to both contracted and non- contracted Providers.

The interest rate is updated bi-annually on first of January and July by the Bureau of the Fiscal Service. The applicable interest rate is selected based on the effective rate on the date the claim enters the mail stream or funds are released to Provider. Interest rates are available at Prompt Payment: Interest Rates.

The number of days for which interest is due is calculated as the date the payment is deposited with the USPS or funds released by the bank to Provider.

Interest is calculated as reimbursement amount multiplied by the interest rated divided by 365 and multiplied by the number of days interest is due.

Example:

Reimbursement amount: $100

Date received: March 1
Date payment deposited with USPS or funds released to Provider electronically: May 15
Number of days interest is due: 45 days (May 15 less March 1 less 30 days)
Applicable interest rate on May 15: 4.65%
Interest payable: $100 x (4.65%/365) x 45 days = $0.57

**Emergency Department (ED)/Trauma Admissions**
If an inpatient stay that was the result of an Emergency or Trauma is denied, Providers have the right to dispute (contracted Provider) or request reconsideration (non-contract Provider) of the denial. If Provider is requesting reimbursement for ED room charges only, please bill those services on a separate claim following the outpatient billing guidelines.

## RISK ADJUSTMENT

Risk adjustment is the process of considering Enrollees' health status and associated risk factors when determining Medicare payments to Health Plan Advantage D-SNP and/or Provider. This approach aims to provide compensation based on the diversity of Enrollee illness and complexity. Risk adjustment relies on patient diagnoses, mainly recorded via ICD-10 codes, to estimate anticipated healthcare expenses. Enrollees with more complex or severe conditions receive higher risk scores. Key Elements of Risk Adjustment include:

- Hierarchical Condition Categories (HCCs): HCCs group-related diagnoses that predict similar costs. Each diagnosis has a weight, and all weights contribute to the Enrollee's total risk score.
- Demographic Factors: Age, gender and Medicaid level are incorporated into risk adjustment calculations.
- Annual Reset: Risk scores generally reset each calendar year, underscoring the importance of documenting all relevant diagnoses annually.

**Provider Engagement**

For Providers, risk adjustment affects patient care approaches and the management of medical practices. Reasons include:

- Reimbursement Accuracy: Allows practices to receive compensation aligned with the complexity and needs of their patient population.
- Quality Reporting: Quality metrics and star ratings are based on risk-adjusted data; insufficient or inaccurate coding may affect these scores.
- Population Health Management: Evaluating patients' risk profiles supports targeted interventions, care coordination, and resource allocation.
- Regulatory Compliance: Proper documentation and coding meet requirements set by CMS.
-

**Patient Engagement**

Engaged patients are more likely to share complete information and participate in recommended care, leading to more accurate risk adjustment and better outcomes.

- Build trust to encourage open communication about symptoms and social challenges.
- Educate patients about the importance of chronic disease management and routine follow-up visits.
- Discuss the impact of accurate health information on care planning and resources.

**Accurate Coding and Documentation**

Accurate coding and documentation are essential for risk adjustment. Diagnoses need to be supported in the medical record and coded with the highest, detailed specificity.

- Document all chronic conditions, even if stable.
- Use precise ICD-10 codes—avoid generic or unspecified codes when possible.
- Ensure each diagnosis is assessed, monitored, or treated during the encounter
- Update diagnoses annually to maintain accurate risk scores.

**Best Practices**

Accurate risk adjustment depends on thorough clinical documentation and coding practices. Primary care providers may implement several steps:

- Annual Wellness Visits: Use these opportunities to review and document all existing conditions and screen for undiagnosed issues.
- Team-Based Care: Engage nurses, medical assistants, coders, and care managers to help capture and document patient complexity.
- Stay Up to Date on Coding Guidelines: Regularly review ICD-10 updates and payer guidance.
- Utilize Technology: Electronic health records (EHRs) often have tools and prompts to assist with documentation and coding; ensure your practice makes full use of these resources.
- Provide Ongoing Training: Offer staff and provider education on documentation, HCCs, and risk adjustment concepts.

Risk adjustment is an integral component of primary care, affecting payment structures, care quality and resource allocation. When primary care Providers apply risk adjustment principles, they contribute to the delivery of appropriate care and help maintain the financial stability of their practice.

By providing thorough documentation, accurate coding, and patient-focused care, primary care providers facilitate effective risk adjustment for both patient health outcomes and healthcare system sustainability.

## CLAIM OVERPAYMENT

If a Provider identifies an overpayment, the Provider is required to inform Health Plan Advantage D-SNP and return the overpayment to Health Plan within 60 days from the date the Provider identifies the overpayment as specified in the Social Security Act section 1128J(d).

In accordance with California Knox-Keene Health Care Service Plan Act and Regulations 2019 edition §1300.71 and DHCS, All Plan Letter (APL) 17-003, if Health Plan Advantage D-SNP determines that it has overpaid a claim(s) to a Provider, Health Plan Advantage D-SNP will notify the Provider in writing within 365 days of claim paid date and pursue collections of overpayments. ** The 365-day time limit shall not apply if the overpayment was caused in whole or in part by fraud or misrepresentation on the part of the Provider.*

Additionally, in accordance with DHCS, APL 20-010, all post-payment recoveries and identified overpayments related to Enrollee having Other Healthcare Coverage (OHC) at the time services are rendered will be reported no later than the 15th of each month to DHCS. All unrecovered monies after the 13th month of the date of payment will be reported and pursued by DHCS and/or assigned contractor. Any monies received by Health Plan Advantage D-SNP after the 13th month of the date of payment from the Provider will be paid to DHCS.

Health Plan Advantage D-SNP will notify Provider in writing, to the Provider's address of record with Health Plan Advantage D-SNP, which clearly identifies the claim, the name of the patient (Enrollee), the date of service and explanation of the basis upon which Health Plan Advantage D-SNP believes the amount paid on the claim was more than the amount due, including interest and penalties.

### Non-Contested Overpayment

If the Provider does not contest the notice of reimbursement of overpayment, the Provider must reimburse Health Plan Advantage D-SNP within 30 days of receipt of Health Plan Advantage D-SNP's notice of overpayment. Interest accrues on any uncontested overpayment amounts after the 30th day as described in the Medicare Financial Management Manual, Chapters 3 and 4.

### Offsetting Against Future Claims

Health Plan Advantage D-SNP may offset an uncontested notice of reimbursement of overpayment against a Provider's current claim submissions when:

- Provider fails to reimburse Health Plan Advantage D-SNP within 30 calendar days of the notice, and
- Provider's contract specifically authorizes Health Plan Advantage D-SNP to offset an uncontested notice of overpayment from the Provider's current claim submission.
- OR Provider submits Offset Request Form allowing Health Plan Advantage D-SNP to offset overpayment and/or future identified overpayments.

If the overpayment is offset against the Provider's current claim submission, Health Plan Advantage D-SNP will provide a detailed written explanation identifying the specific payments that have been offset against that specific current claim(s).

Offsets against current or future claims are available to Provider expected to have future claim submissions under the tax identification number associated with the overpayment.

### Contested Overpayment

If Provider contests the notice of reimbursement of overpayment, it must state in writing the basis upon which the Provider believes the claim was not overpaid within 30 working days of the date of notice [Knox-Keen Act §1300.71(4)].

**Note**: The written notice is considered a Provider Dispute Resolution and is tracked and acknowledged as such (See Section 12 - Disputes)

## ANCILLARY CLAIMS

Billing for ancillary covered services should be in accordance with D-SNP guidelines.

Below are the forms that should be used for billing the following ancillary services:

| PROVIDER TYPE | BILLING FORMS |
|---|---|
| Diagnostic Services | CMS-1500 Form |
| Skilled Nursing Facilities | UB04 Form |
| Ambulatory Surgery Center | UB04 Form, include correct type of bill |
| Ambulance Services | CMS-1500 Form |
| Durable Medical Equipment | CMS-1500 Form |
| Home Health | UB04 Form; use bill type 32X |

### Observation Stay Claims Submission and Payment Rules

Provider service agreements which contain a provision for reimbursement of an observation stay are reimbursed under the Outpatient Prospective Payment System (OPPS). No Authorization is required for an observation stay lasting 0-72 hours.

If the Enrollee is admitted to the hospital following or on the same day as an observation stay, charges from the observation stay will be included in the calculation of the inpatient stay. No separate reimbursement will be paid for the observation stay.

Submit observation stay (or portion of the stay if admitted) using revenue code 0762 with the corresponding CPT/HCPCS code. The unit(s) billed for the observation should reflect the number of observation hours beginning with the hour the admission order is written.

### Applicable Trauma Level of Care (Level 1-4)

When the Enrollee is downgraded to med/surg during the hospital stay the hospital will be paid the hospital's contracted rate for med/surg inpatient days.

1. Hospital admissions not authorized as trauma will be reimbursed at the hospital's contracted rate for inpatient med/surg admission.

## Inpatient and Outpatient Implant and Prosthetic Device Claims Submission and Payment Rules

Provider agreements which contain a provision for the reimbursement of implants and prosthetic devices may receive reimbursement for high-cost implants and prosthetic devices provided to an Enrollee or only receive reimbursement for high-cost implants and prosthetic devices when the unit cost exceeds a defined dollar amount threshold. Health Plan Advantage D-SNP will only reimburse Providers for covered services identified in Medicare fee schedules as "pass-through" items. When Provider identifies an implant or prosthetic device has been provided to an Enrollee and (if applicable) exceeds the unit cost dollar threshold as defined in their Provider agreement, the Provider may submit a claim for the implant or prosthetic device. The claim must be billed with revenue code 274, 275, 276 or 278.

If the Provider's agreement reimburses implants and prosthetic devices at the manufacturer's invoice cost plus an additional percentage, Provider must submit a manufacturer's invoice with the claim. Claims for implants and prosthetic devices will be paid according to their Provider agreement.

Claims missing the required revenue code 0274, 0275, 0276 or 0278 and manufacturer's invoice (if applicable) will be denied for lack of information.

Health Plan Advantage D-SNPmay perform periodic audits of the Provider's implant and prosthetics billing practices to ensure compliance with their Provider agreement and these rules.

## Inpatient and Outpatient High-Cost Drug Claim Submission and Payment Rules

Health Plan Advantage D-SNP has established a list of drugs, medications and biologics that are defined as high-cost drugs. (See High-Cost Drug List Below) Periodic updates will be made to this list as new drugs, medications and biologics are approved by the FDA. Claims must be billed with revenue code 0636, HCPCS code and NDC code. If the Provider's agreement reimburses high-cost drugs at manufacturer's invoice cost or manufacture's invoice cost plus an additional percentage, the Provider must submit a manufacturer's invoice with the claim.

Revenue code 0636 should only be used when the high-cost drug qualifies as separately payable as defined by their Provider agreement.

Claims for high-cost drugs will be paid according to Provider agreement.

Claims missing the required revenue code 0636, HCPCS, NDC code and manufacturer's invoice (if applicable) will be developed (See Claim Development).

Health Plan Advantage D-SNP may perform periodic audits of the Provider's high-cost drug billing practices to ensure compliance with their Provider agreement and these rules.

# REQUIRED FIELDS FOR CMS-1500 FORM (PROFESSIONAL)

| BOX # | FIELDNAME | INSTRUCTIONS | REQUIRED (Y, N) |
|---|---|---|---|
| 1 | MEDICAID/ MEDICARE/ OTHER ID | For D-SNP Enrollee, enter an "X" in the Medicare box. | Y |
| 1a | INSURED'S ID NUMBER | Enter the recipient's ID number from Health Plan Advantage D-SNP Identification Card. | Y |
| 2 | PATIENT'S NAME | Enter the recipient's last name, first name and middle initial (if known). A comma is required between recipient's last name, first name and middle initial (if known). | Y |
| 3 | PATIENT'S BIRTH DATE (MM/DD/CCYY) and SEX | Enter the recipient's date of birth in six-digit MMDDYY format (month, day, year). If the recipient is 100 years or older, enter the recipient's age and the full four-digit year of birth in Box 19. Enter an "X" in the M or F box. | Y |
| 4 | INSURED'S NAME | Not Required. | N |
| 5 | PATIENT'S ADDRESS | Enter the recipient's complete address and telephone number. | Y |
| 6 | PATIENT'S RELATIONSHIP TO INSURED | Not Required. | N |
| 9 | OTHER INSURED'S NAME | Enter when the policy holder's name differs from the patient's name and Enrollee has healthcare coverage other than Medicare and Medi-Cal | Y |
| 9a | OTHER INSURED'S POLICY OR GROUP NUMBER | Enter other policy or group number when Enrollee has healthcare coverage other than Medicare and Medi-Cal . | Y |
| 9d | INSURED PLAN NAME OR PROGRAM NAME | Complete this field if patient has other healthcare coverage (OHC). **Billing Tip: Do not populate with "Medicare" or "Medi-Cal".** Health Plan Advantage D-SNP will determine financial liability. | Y |
| 10a, b or c | PATIENT'S CONDITION | Complete this field if services were related to an accident or injury. Enter an "X" in the Yes box if accident/injury is employment related. Enter an "X" in the No box if accident/injury is not employment related. If either box is checked, the date of the accident must be entered in the Date of Current Illness, Injury or Pregnancy field (Box 14). | Y |

| BOX # | FIELDNAME | INSTRUCTIONS | REQUIRED (Y, N) |
|---|---|---|---|
| 11 | INSURED'S POLICY GROUP OR FECA NUMBER | Complete this field if patient has Other Health Coverage (OHC) which is not Medicare or Medi-Cal. | Y |
| 11a | INSURED'S DATE OF BIRTH | Complete this field if patient has Other Health Coverage (OHC) which is not Medicare or Medi-Cal. | Y |
| 11c | INSURANCE PLAN NAME OR PROGRAM NAME | Complete this field if patient has Other Health Coverage (OHC) which is not Medicare or Medi-Cal. | N |
| 11d | ANOTHER HEALTH PLAN ADVANTAGE D-SNP BENEFIT | Enter an "X" in the Yes box if the recipient has Other Health Coverage (OHC). Enter the amount paid (without the dollar or decimal point) by the other health insurance in the right side of Box 11d. | N |
| 14 | DATE OF CURRENT ILLNESS, INJURY OR PREGNANCY (LMP) | Enter the date of the onset of the recipient's illness, the date of accident/injury or the date of the Last Menstrual Period (LMP). | Y |
| 17 | NAME OF REFERRING PROVIDER OR OTHER SOURCE | Enter the name of the referring Provider in this box. When the referring Provider is a non-physician medical practitioner (NMP) working under the supervision of a physician, the name of the NMP must be entered. However, the NPI of the supervising physician needs to be entered in box 17b, below. | Y |
| 17b | NPI (OF REFERRING PHYSICIAN) | Enter the 10-digit NPI. The following Providers must complete Box 17 and Box 17b: Audiologist, Clinical laboratory (services billed by laboratory), Durable Medical Equipment (DME) and medical supply, Hearing aid dispenser, Nurse anesthetist, Occupational therapist, Orthotist, Pharmacy, Physical therapist, Podiatrist (services are rendered in a Skilled Nursing Facility [NF] Level A or B, Portable imaging services, Prosthetist, Radiologist, Speech pathologist. | Y |
| 18 | HOSPITALIZATION DATES RELATED TO CURRENT SERVICES | Enter the dates of hospital admission and discharge if the services are related to hospitalization. If the patient has not been discharged, leave the discharge date blank. | Y |
| 19 | ADDITIONAL CLAIM INFORMATION | Use this area for procedures that require additional information, justification, or an Emergency Certification Statement. **Billing Tip:** "By Report" codes, complicated procedures, modifier breakdown, unlisted services and anesthesia time require attachments. If the rendering Provider is an NP/PA or locum, their last name, first name and NPI should be documented in this field (for informational purposes only). Box 19 may be used if space permits. Please do not staple attachments. | Y |

| BOX # | FIELDNAME | INSTRUCTIONS | REQUIRED (Y, N) |
|---|---|---|---|
| 20 | OUTSIDE LAB | If this claim includes charges for laboratory work performed by a licensed laboratory, enter an "X." Outside laboratory refers to a lab not affiliated with the billing Provider. Indicate in Box 19 that a specimen was sent to an unaffiliated laboratory. Leave blank, if not applicable. | Y |
| 21a-l | DIAGNOSIS OR NATUREOF ILLNESS OR INJURY | Enter all letters and/or numbers of the ICD-10-CM (or latest version) diagnosis code, diagnosis code(s) should be in order of severity/illness presented, include fourth through seventh characters, if present. (Do not enter decimal point.) Relate A-L to service line(s) below (24e). | Y |
| 22 | RESUBMISSION CODE | Use to identify a corrected claim and add the original claim number when possible. In all other circumstances, these codes are optional. | Y |
| 23 | PRIOR AUTHORIZATION NUMBER | Use for Health Plan Advantage D-SNP authorization number. **Billing tip:** Only one authorization number can cover services billed on any one claim. | Y |
| 24a | DATE(S) OF SERVICE | Enter the date the service was rendered in the From and To boxes in the six-digit, MMDDYY (month, day, year) format in the unshaded area. When billing for a single date of service, enter the date in From box in Field 24A. | Y |
| 24b | PLACE OF SERVICE | Enter the two-digit national Place of Service code in the unshaded area, indicating where the service was rendered. **Billing Tip:** The national Place of Service codes are listed in the CMS-1500 Completion section (CMS COMP) of the Medi-Cal Provider Manual, Part 2. | Y |
| 24c | EMG | Emergency Code: Only one emergency indicator is allowed per claim and must be placed in the bottom-unshaded portion of Box 24C. Leave this box blank unless billing for emergency services. | Y |
| 24d | PROCEDURES, SERVICESOR SUPPLIES/MODIFIER(S ) | Enter the appropriate procedure code (CPT-4 or HCPCS) and modifier(s). **Billing Tip:** The descriptor for the procedure code must match the procedure performed, and the modifier(s) must be billed appropriately. Do not submit multiple National Correct Coding Initiative (NCCI)- associated modifiers on the same claim line. If necessary, the procedure description can be entered in the Additional Claim Information field (Box 19). **Billing Tip:** Do not submit a National Correct Coding Initiative (NCCI)-associated modifier in the first position (right next to the procedure code) on a claim, unless it is the only modifier being submitted. | Y |
| 24e | DIAGNOSIS POINTER | Use the diagnosis designations (A-L) listed in field 21, as the reference pointers in this field. The primary reason (primary diagnosis) for the service must be the first diagnosis pointer listed in the field. Use multiple pointers for secondary diagnoses related to the service line, if appropriate. | Y |
| 24f | $CHARGES | In the unshaded area of the form, enter the usual and customary fee for service(s) in full dollar amount. Do not enter a decimal point (.) or dollar sign ($). For example, $100 should be entered as "10000." | Y |

| BOX # | FIELDNAME | INSTRUCTIONS | REQUIRED (Y, N) |
|---|---|---|---|
| 24g | DAYS OR UNITS | Enter the number of medical "visits" (days) or procedures, surgical "lesions," units of anesthesia time, items, or units of service, etc. The field permits entries up to 999 in the unshaded area. **Billing Tip:** Providers billing for units of time should enter the time in 15-min increments. For example, one hour should be entered as "4." | Y |
| 24h | EDSDT FAMILY PLANNING | Enter code "1" or "2" if the services rendered are related to family planning (FP). Enter code "3" if the services rendered are Child Health and Disability Prevention (CHDP) screening related. Leave blank if not applicable. | Y |
| 24j | RENDERING PROVIDER ID# | Enter the NPI for a rendering Provider (unshaded area) if the Provider is billing under a group NPI. **Billing Tip:** If the rendering Provider is an NP/PA or locum, enter the supervising physicians NPI in this field. | Y |
| 25 | FEDERAL TAX ID# | Enter the Rendering/Supervising physicians Federal Tax ID in this field. | Y |
| 26 | PATIENT'S ACCOUNT NUMBER | Field use for Provider's unique patient account number. | N |
| 27 | ACCEPT ASSIGNMENT | "Yes" or "No" entry is required. | Y |
| 28 | TOTAL CHARGE | Enter the full dollar amount for all services without the decimal point (.) or dollar sign ($). For example, $100 should be entered as "10000." **Billing Tip:** If billing more than 1 claim form (or more than 6 lines) only enter total charge on the last claim form. | Y |
| 29 | DOLLAR AMOUNT | Enter the full dollar amount of payments(s) received from the Other Health Coverage (Box 11D) and/or patient's Share of Cost (Box 10D), without the decimal point (.) or dollar sign ($). **Billing Tip:** Do not enter Medicare payments in this box. The Medicare payment amount will be calculated from the Medicare EOMB/MRN/RA when submitted with the claim. | Y |
| 31 | SIGNATURE OF PHYSICIAN OR SUPPLIER | The claim must be signed and dated by the Provider, or a representative assigned by the Provider, in black ballpoint pen only. **Billing Tip:** If the rendering physician/Provider is PA/NP or locum, enter the supervising physicians' name in this field. Signatures must be written, not printed and should not extend outside the box. Stamps, initials, or facsimiles are not accepted. | Y |
| 32 | SERVICE FACILITY LOCATION INFORMATION | Enter the Provider's name. Enter the Provider's address, without a comma between the city and state, including the nine-digit ZIP Code, without a hyphen. **Billing Tip:** Use the name and address of the facility where the services were rendered if other than a home or office. | Y |
| 32a | SERVICE FACILITY NPI | Enter the NPI of the facility where the services were rendered. | Y |
| 33 | BILLING PROVIDER INFORMATION AND PHONE NUMBER | Enter the Provider's name. Enter the Provider address, without a comma between the city and state, including the nine-digit ZIP Code, without a hyphen. Enter the telephone number. | Y |
| 33a | BILLING PROVIDER NPI | Enter the billing Provider's NPI. | Y |

# REQUIRED FIELDS FOR UB-04 FORM (INSTITUTIONAL)

The following form outlines only the REQUIRED Field Information:

| UBREQUIREDFIELDINFORMATON | | | |
|---|---|---|---|
| **BOX #** | **FIELDNAME** | **INSTRUCTIONS** | **REQUIRED (Y, N)** |
| 1 | ADDRESS, ZIP CODE | Enter the Provider's name, hospital and clinic address, without a comma between the city and the state, and the nine-digit ZIP code without a hyphen. A telephone number is optional in this field. **NOTE:** The nine-digit ZIP code entered in this box must match the billing Provider's ZIP code on field for claims to be reimbursed correctly. | Y |
| 3a | PATIENT CONTROL NUMBER | Enter the patient's financial record number or account number in this field. | N |
| 3b | MEDICAL RECORD NUMBER | Use Box 3a to enter a patient control number. | N |
| 4 | INSURED'S NAME | Not Required. | Y |
| 6 | STATEMENT COVERS PERIOD (FROM-THROUGH) | **Outpatient Claims:** Not required. **Inpatient Claims:** Enter the dates of service for this claim in six-digit MMDDYY (month, day, year) format. The date of discharge should be entered in the THROUGH box, even though this date is not reimbursable (unless the day of discharge is the date of admission). **NOTE:** For "From- Through" billing instructions, refer to the UB-04 Special Billing Instructions for Inpatient Services section (U B SPEC IP) in the Part 2 portion of the Medi-Cal Provider manual. | Y |
| 8b | PATIENT NAME | Enter the patient's last name, first name and middle initial (if known). Avoid nicknames or aliases. **Newborn infant:** When submitting a claim for a newborn infant using the mother's eligibility, enter the infant's name in Box 8b. if the infant has not yet been named, use the mother's last name followed by "Baby Boy" or "Baby Girl" (for example, JONES, BABY GIRL). **Billing Tip:** If billing for newborn infants from a multiple birth, each newborn must also be designated by a number or a letter (for example, JONES, BABY GIRL TWIN A) on separate claims. Enter infant's date of birth/sex in boxes 10 and 11. **Organ Donors:** When submitting a claim for a patient donating an organ to an HPSJ/MVHP recipient, enter the donor's name, date of birth and sex in the appropriate boxes. Enter the Heath Plan recipient's name in the Insured's Name field (Box 58) and enter "11" (Donor) in the Patient's Relationship to Insured field. | Y |
| 10 | BIRTH DATE | Enter the patient's date of birth, using an eight-digit MMDDYYY (month, day, year) format (for example, September 16, 1967 = 09161967). **NOTE:** If the recipient's full date of birth is not available, enter the year preceded on 0101. For newborns and organ donors, see item 8b). | Y |
| 11 | SEX | Enter the capital letter "M" for male or "F" for female | Y |

| BOX # | FIELDNAME | INSTRUCTIONS | REQUIRED (Y, N) |
|---|---|---|---|
| 12 and 13 | ADMISSION DATE AND HOUR | **Outpatient Claims:** Not required. **Inpatient Claims:** Enter the date of hospital admission, in a six- digit format. Convert the hour of admission to the 24- hour (00-23) format. Do not include the minutes. **Billing Tip:** The admit time of 1:45p.m. will be entered on the claims as 13. | Y |
| 14 | ADMISSION TYPE | **Outpatient Claims:** Enter an admit type code of "1" when billing for emergency room-related services (in conjunction with the facility type "14" in Box 4). This field is not required by Health Plan Advantage D-SNP for any other use. **Inpatient Claims:** Enter the numeric code indicating the necessity for admission to the hospital. **NOTE:** If the delivery was outside the hospital, use admit type code "1" (emergency) in the Type of Admission and admission source code "4" (extramural birth) in the Source of Admission field (Box 15). | Y |
| 15 | ADMISSION SOURCE | **Outpatient Claims:** Not required. **Inpatient Claims:** If the patient was transferred from another facility, enter the numeric code indicating the source of transfer. Enter code "1" or "3" in Box 14 to indicate whether the transfer was an emergency or elective. When the type of admission code in Box 14 is "4" (newborn; baby born outside of hospital), submit claim with source of admission code "4" in Box 15 and appropriate revenue code in Box 42. | Y |
| 18-28 | CONDITION CODES | Required to indicate End-Stage Renal Disease (ESRD) and Dialysis and Skilled Nursing Facility (SNF) conditions. See Condition Codes - JE Part A - Noridian for a complete list of condition codes. | Y |
| 31 through 34a and b | OCCURRENCE CODES AND DATES | Occurrence codes and dates are used to identify significant events related to a claim that may affect payer processing. Occurrence codes and dates should be entered from the left to right, top to bottom in numeric-alpha order starting with the lowest value. Example: If billing for two occurrence codes "24" (accepted by another payer) and "05" (accident/no medical or liability coverage), enter "05" in Box 31a and "24" in Box 32a. Enter the accident/injury date in corresponding box (6-digit format MMDDYY). **NOTE:** Enter code "04" (accident/employment- related) in Boxes 31 through 34 if the accident or injury was employment related**. Outpatient Claims:** Discharge date in not applicable. **Inpatient Claims**: Discharge Date: Enter occurrence code "42" and the date of hospital discharge (in six-digit format) when the date of discharge is different from the "THROUGH" date in Box 6. | Y |

| | | | |
|---|---|---|---|
| 37a | UNLABELED (USE FOR DELAY REASONCODES) | If there is an exception to the billing limit, enter on the delay reason codes in Box 37a and include the required documentation. **NOTE:** Documentation justifying the delay reason must be attached to the claim for review. **For hospitals that are not reimbursed according to the diagnosis related groups (DRG) model:** Providers must use claim frequency code "5" in the Type of Bill field (Box 4) of the claim when adding a new ancillary code to a previous stay, if the original stay was already billed. | N |

| BOX # | FIELDNAME | INSTRUCTIONS | REQUIRED (Y, N) |
|---|---|---|---|
| 42 | REVENUE CODE | **Outpatient Claims:** Revenue codes are required (for instance, for organ procurement). **Inpatient Claims:** Enter the appropriate revenue or ancillary code. **Billing Tip:** For both outpatient and inpatient claims (single-page claims), enter code "001" in Box 42, line 23 to designate the total charge line. Enter the total amount in Box 47, line 23. | Y |
| 43 | DESCRIPTION | **Outpatient Claims:** Information entered this field will help separate and identify the descriptions of each service. The description must identify the service code indicated in the HCPCS/Rate/HIPPS Code field (Box 44). This field is optional, except when billing for physician-administered drugs. **Inpatient Claims:** Enter the description of the revenue or ancillary code listed in the Revenue Code field (Box 42). **NOTE:** If there are multiple pages of the claims, enter the page numbers on line 23 in this field. | Y |
| 44 | HCPCS/RATE | **Outpatient Claims:** Enter the applicable procedure code and modifier. Note that the descriptor for the code must match the procedure performed and that the modifier(s) must be billed appropriately. Attach reports to the claims for "By Report" codes, complicated procedures (modifier 22) and unlisted services.<br>Reports are not required for routine procedures. Up to four modifiers may be entered on the outpatient UB-04 claim form. **Inpatient Claims**: Not required. | Y |

| | | | |
|---|---|---|---|
| 45 | SERVICE DATES | Outpatient Claims: Enter the date the service was rendered in six- digit format. Inpatient Claims: Not required. Billing Tip: For "From- Through" billing instructions, see the UB-04 Special Billing Instructions for Outpatient Services section (UB SPEC OP). | Y |
| 46 | SERVICE UNITS | **Outpatient Claims:** Enter the actual number of times a single procedure or item was provided for the date of service. If billing for more than 99, divide the units on two or more lines**. Inpatient Claims:** Enter the number of days of care by revenue code. Units of service are not required for ancillary services. If billing for more than 99 units, divide the units between two or more lines. **Billing Tip:** Although Service Units is a seven-digit field, only two digits are allowed. | Y |

| BOX # | FIELDNAME | INSTRUCTIONS | REQUIRED (Y, N) |
|---|---|---|---|
| 47 | TOTAL CHARGES | In full dollar amount, enter the usual and customary fee for the service billed. Do not enter a decimal point (.) or dollar sign ($). Enter full dollar amount and cents, even if the amount is even (e.g., if billing for $100, enter "10000" not "100"). Enter the total charge for all services on the last line or on line 23. Enter "001" in Revenue Code field (Box 42, line 23) to indicate this is the total charge line. **Outpatient Claims:** If an item is a taxable medical supply, include the applicable state and county sales tax. To delete a line, mark with a thin line through the entire detail line (Box 42-49), using a black ballpoint pen. **NOTE:** Up to 22 lines of data (fields 42-49) can be entered. It is acceptable to skip lines. | Y |
| 50a through 50c | PAYER NAME | **Outpatient Claims:** Enter insurance plan name to indicate claim payer. **NOTE:** If the recipient has Other Health Coverage (OHC), the insurance carrier must be billed prior to billing Health Plan Advantage D-SNP. **Billing Tip:** When completing Boxes 50-65 (excluding Box 56) enter all information related to the payer on the same line (for example, Line A, B or C) in order of payment (Line A: other insurance, Line B: Medicare, Line C: HPSJ/MVHP). Do not enter information on Lines A and B for other insurance (or Medicare) if payment was denied by these carriers. If Health Plan Advantage D-SNP is the only payer billed, all information in Boxes 50-65 (excluding Box 56) should be entered online A. | Y |
| 51 | HEALTH PLAN ADVANTAGE D-SNP ID | Enter the 9-digit Health Plan Advantage D-SNP ID number. | Y |

| | | | |
|---|---|---|---|
| 54a through 54c | PRIOR PAYMENTS (OTHER COVERAGE) | Leave blank if not applicable. Enter the full dollar amount of the payment received from the OHC, online A or B that corresponds with OHC in the Payer field (Box 50). Do not enter a decimal point (.), dollar sign ($), plus (+) or minus (-) sign. | N |
| 55a through 55c | ESTIMATED AMOUNT DUE (NETAMOUNT BILLED) | In full dollar amount, enter the difference between "Total Charges" (Box 47, line23) and any deductions. Do not enter a decimal point (.) or dollar sign ($). **Example:** Patient's SOC Value Codes Amount and/or OHC Prior Payments. | N |
| 56 | NPI | Enter the appropriate 10-digit National Provider Identifier (NPI) number. | Y |
| 57a through 57c | OTHER PROVIDER ID | Not Required | N |

| BOX # | FIELDNAME | INSTRUCTIONS | REQUIRED (Y, N) |
|---|---|---|---|
| 58a through 58c | INSURED'S NAME | Enter the last name and first name of the policyholder, using a comma or space to separate the two. Do not leave a space between a prefix (e.g., MacBeth). Submit a space between hyphenated names rather than a hyphen (e.g., Smith Simmons). If the name has a suffix (e.g., Jr., III) enter the last name followed by a space and then the suffix (e.g., Miller Jr. Roger). **NOTE:** If billing for an organ donor, enter the recipient's name and the patient's relationship to the recipient in the Patient's relationship to Insured field. | N |
| 60a through 60c | INSURED's UNIQUE ID | Enter the recipient's Health Plan Advantage D-SNP 9-digit ID number as it appears on Health Plan Advantage D-SNP's Identification Card. **NOTE:** HealthPlan Advantage D-SNP does not accept the 14-digit ID number on the Benefits Identification Card (BIC). **Billing Tips:** When submitting a claim for a newborn infant for the month of birth or the following month, under the mother's eligibility, use the newborn infant Health Plan Advantage D-SNP 9-digit ID number. (This ID number is available 24- 48 hours after receipt of the newborn infant face sheet.) | Y |
| 63a through 63c | PRIOR AUTHORIZATION | For services requiring Prior Authorization, enter the alpha-numeric number in this field. It is not necessary to attach a copy of the Prior Authorization. Recipient information on the claim must match the Authorization. Multiple claims must be submitted for services that have more than one Authorization. Only one Authorization can cover services billed on any one claim. **Inpatient Claims:** Inpatient claims must be submitted with an Authorization. | Y |

| | | | |
|---|---|---|---|
| 66 | DIAGNOSIS CODE HEADER | Claims with a diagnosis code in Box 67 must include the ICD indicator "0" for ICD-10-CM diagnosis codes, effective October 1, 2015. | Y |
| 67 | UNLABELED (PRIMARY DIAGNOSISCOD E) | Include all letters and numbers of the ICD-10-CM diagnosis code to the highest level of specificity (when possible) including fourth through seventh digits if present for the primary diagnosis code. Do not include decimal point. Present on Admission (POA) indicator.<br>Each diagnosis code may require a POA indicator. Hospitals must enter a POA indicator (unless exempt) in the shaded portion of boxes 67 and 67a, to the right of the diagnosis field, to indicate when the condition occurred, if known. When the condition is present, use "Y" for yes. When the indicator is "N" for no, it means that the condition was acquired while the patient was in the hospital. | Y |
| 67a | UNLABELED (SECONDARY DIAGNOSIS CODE) | If applicable, enter all letters and/or numbers of the secondary ICD- 10-CM diagnosis code to the highest level of specificity (when possible). Do not include a decimal point. **NOTE:** Paper claims accommodate up to 18 diagnosis codes. | N |

| BOX # | FIELDNAME | INSTRUCTIONS | REQUIRED (Y, N) |
|---|---|---|---|
| 74 | OTHER PROCEDURE CODES AND DATES | **Outpatient Claims:** Not required. **Inpatient Claims:** Enter the appropriate ICD-10-PCS code, identifying the secondary medical or surgical procedure, without period or spaces between the numbers. In six-digit format, enter the date the surgery or delivery was performed. **Billing Tip:** Inpatient Providers must enter ICD- 10-PCS code in this field (not CPT- 4/HCPCS surgical procedure code). | Y |
| 74a through 74e | OTHER PROCEDURE CODES AND DATES | **Outpatient Claims:** Not required. **Inpatient Claims:** Enter the appropriate ICD-10-PCS code, identifying the secondary medical or surgical procedure, without period or spaces between the numbers. **NOTE:** For OB vaginal or cesarean delivery and transplants, enter a suitable ICD-10-PCS code in Box 74 or 74a-e. | Y |
| 76 | ATTENDING | **Outpatient Claims:** Enter the referring or prescribing physician's NPI in the first box. This field is mandatory for radiologists. Do not use a group Provider number. Referring or prescribing physician's first and last names are not required.<br>**Inpatient Claims:** Enter the attending physician's NPI in the first box. Do not enter a group number. The attending physician's first and last name is not required.<br>**Billing tip:** For inpatient claims, do not enter the operating physician NPI. | Y |

| | | | |
|---|---|---|---|
| 77 | OPERATING | **Outpatient Claims:** Enter the NPI of the facility in which the recipient resides or the physician providing services. Only one rendering Provider number may be entered on claim. Do not use a group number or state license number. **Inpatient Claims:** Enter the operating physician's NPI in the first box. Do not enter a group number. The operating physician's first and last name is not required.<br><br>Required for surgical services. | N |
| 78 | OTHER | **Outpatient Claims**: Not required. **Inpatient Claims**: Enter the admitting physician's NPI in the first box. Do not enter a group Provider number. | N |
| 80 | REMARKS | Use this area for procedures that require additional information, justification, or an Emergency Certification Statement. This statement must be signed and dated by the Provider and must be supported by a physician, podiatrist or dentist's statement describing the nature of the emergency, including relevant clinical information about the patient's condition. A mere statement that an emergency existed is not sufficient. If the Emergency Certification Statement will not fit in this area, attach the statement to the claim. Billing Tip: If additional information cannot be completely entered in this field, attach the additional information to the claim on single-sided 81/2 by 11-inch white paper. "By Report" claim submissions do not always require an attachment. For some procedures, entering information in the Remarks field (Box 80) | N |

## IMPORTANT BILLING TIPS

- Obtain prior authorization for any covered services that require authorizations.
- The Provider portal has a list of codes that require authorization.
- File complete claims within the required timely filing requirements.
- File complete claims electronically as recommended.
- Use the standard and most updated Current Procedural Terminology (CPT) codes, International Classification of Diseases (ICD) codes, Health care Procedure Coding System (HCPCS) codes, and Revenue Codes.
- Identify frequency limits for certain procedure codes using the National Correct Coding Initiative listing of medically unlikely services which are unlikely to be performed in quantities greater than one and/or in multiple/same locations.
- Use the National Provider Identifier Standard (NPI) correctly and appropriately.
- A valid 10-digit NPI must be entered in the billing Provider field on the paper claim form or electronic claim submission.
- The NPI must belong to the correct Provider. (A Provider rendering medical care cannot use the Group's NPI and vice versa. Providers who render medical care in a Facility cannot use the Facility's NPI, and vice versa. An individual Provider cannot use another individual Provider's NPI).
- A valid NPI is entered in the attending, admitting, or operating Provider ID field.
- A valid NPI is entered in the referring Provider field.
- The complete 9-digit ZIP code must be entered in the billing Provider address field.
- A valid NPI of the inpatient Facility where medical care is rendered is entered in the service facility NPI field.
- National Drug Code (NDC) numbers are required for physician administered drugs (PAD).
- Invoices are also required for certain HCPCS codes.
- Review National Correct Coding Initiative (NCCI) and bill appropriate modifiers
- Submit claims with all required documentation.
- When submitting paper claims:
    - Send the original claim form and retain a copy for your records.
    - Do not submit multiple claims stapled together. Stapling original forms together indicates the second form is an attachment, not an original form to be processed separately.
    - Carbon copies, photocopies, facsimiles, or forms created on laser printers are not acceptable for claims submission and processing.

# SECTION 10: CLAIMS SUBMISSION

## CLAIMS STATUS AND QUESTIONS

Claims status is available through the Provider Portal. The Provider Portal is available through Health Plan Advantage D-SNP website, www.hpsj-mvhp.org. If you are unable to obtain satisfactory answers regarding claims status or other claim questions, please contact Health Plan Advantage D-SNP's Member Services Department at 1-888-361-7526 (TTY:711).

## ENROLLEE BILLING

Balance billing D-SNP Enrollees is prohibited by federal and state laws. D-SNP Enrollees should not pay for covered services received from any Health Plan Advantage D-SNP Provider. This means Enrollees cannot be charged for co-pays, co-insurance, or deductibles. Health Plan Advantage D-SNPProviders cannot bill an Enrollee.

If the services provided are covered services in accordance with Health Plan Advantage D-SNP benefits, then Health Plan Advantage D-SNP's reimbursement to Provider constitutes full payment and the Enrollee cannot be balance billed for these services. If an Enrollee was invoiced or charged in error, all billing efforts must cease as soon as the error is identified. If the Enrollee paid for covered services, Provider must refund Enrollee within 15 calendar days.

Billing D-SNP enrollees violates federal and state laws. as outlined in section 1902(n)(3)(B) of the Social Security Act, as modified by section 4714 of the Balanced Budget Act of 1997; California Welfare and Institutions Code, section 14019.4; W&I Code section 14019.3; W&I Code section 14019.4; Title 28 CCR 1300.71; Title 22, §51002; Title 42 CFR, section 447.15.

If an Enrollee is willing to compensate Provider for a non-covered service and Provider is willing to accept a negotiated payment between the parties, that agreement is considered outside of D-SNP and thus outside the supervision of Health Plan Advantage D-SNP. However, the service must clearly be identified as not a covered benefit (NCB) in advance of providing the service.

Violation of federal, state, or Health INALPlan Advantage D-SNP payment rules could result in the immediate termination of the Provider agreement.

# SECTION 11: PROVIDER PAYMENT

## PROVIDER PAYMENT

To ensure timely and accurate reimbursement please note the following:

## FORMS

### W-9 Forms

To ensure the correct reporting of Provider income to the Internal Revenue Service and the California Franchise Tax Board Health Plan Advantage D-SNP must have an accurate and current W-9 form on file. The information on the W-9 provides Health Plan Advantage D-SNP with the following:

- The **entity** being paid.
- The full and complete **mailing address** where payments are to be directed.
- The **tax ID number** used to report income received from Health Plan Advantage D-SNP.

The critical sections of the W-9 are:

- **Legal Name**: The name of the individual and/or corporation that appear on the Provider's tax return.
- **Business Name**: The name under which the Provider does business (i.e., Doing Business As (DBA).

### Federal 1099 Forms

A 1099 form will be sent no later than January 31st of each year to Providers with payments of $600 or more in the previous calendar year. Please contact the Provider Services Department at 1-888-361-7526 (TTY:711) or via email to Providerservices@hpsj.com to report an error in the information on a 1099 form received from Health Plan Advantage D-SNP.

## FEE-FOR-SERVICE PAYMENT (FFS)

Providers interested in contracting with Health Plan Advantage D-SNP, are required to be enrolled in both the Medicare fee-for-service and the Medi-Cal fee-for-service (FFS) programs. Providers must also be credentialed by Health Plan Advantage D-SNP, meet all applicable screening and enrollment requirements and adhere to criteria outlined in regulatory Provider bulletins. FFS payments apply to any covered services provided by Providers. FFS payments are made when a claim is submitted and processed for payment in accordance with the Provider contract, national correct coding initiative (NCCI) edits, plan rules, and applicable Medicare and/or Medi-Cal guidelines. See Section 4: Provider Contracting – Becoming a participating provider for additional information.

# SECTION 11: PROVIDER PAYMENT

FFS payments are accompanied by a remittance advice identifying claims being paid and/or denied with an explanation reason.

**Note**: *Not all services are reimbursable. If services rendered require prior authorization and such authorization was not obtained, claims for contracted Providers will be denied. Claims from non-contracted Providers will be developed. See Section 10: Claims - Claim Development. No payment is made for non-covered benefits.*

## ELECTRONIC REMITTANCE ADVICE (835)

Health Plan leverages Smart Data Solutions (SDS) for its 835 file delivery. This process will ensure that you receive your 835 files faster and more efficiently.

The process operates as follows:

### Regular Check Run

After each check run, your 835 files are automatically generated and distributed to our clearinghouse partner, SDS.

To receive your 835 files, instructions are below:

- If you want to use SDS: Reach out to your existing clearinghouse vendor and ask them to add connection to SDS for Health Plan under Payer Enrollment using Payer ID: 68035 or visit https://sdata.us/ and select the Provider Portal link at the top of the webpage. Once there, you can log in if you have an account or you can register for a new account.
- For the SDS Provider Portal Companion Guide, you can access it here https://sdata.us/what-we-do/clearinghouse/smart-data-stream-provider-portal/.

We have also partnered with another clearinghouse, TriZetto/Cognizant, who can deliver 835 files to those who are already signed up or choose to sign up with them as their clearinghouse.

- If you want to use TriZetto: You must be signed up with TriZetto before Health Plan can deliver your 835 files. For new users and to sign up, visit: www.trizettoprovider.com/health-plan-of-san-joaquin-new-user-form.
- For existing users, please contact TriZetto to arrange delivery of 835 files from Health Plan.

## ELECTRONIC FUNDS TRANSFER (EFT)

Electronic Funds Transfer (EFT) is a great way to receive payments from Health Plan Advantage D-SNP faster. You may contact the Provider Services Department at 1-888-361-7526 (TTY:711) or via email to Providerservices@hpsj.com for more information.

# SECTION 11: PROVIDER PAYMENT

## CHECK TRACERS

If payment has not been received within 30 calendar days of the check issuance date, please contact the Provider Services Department at 1-888-361-7526 (TTY:711) or via email to Providerservices@hpsj.com to initiate a check tracer. The Provider Services staff will coordinate with Health Plan Advantage D-SNP's Finance Department to verify the check payment status.

If the check has been cashed or deposited, a copy of the canceled check will be provided. If the check has not been cashed or deposited, an affidavit form must be completed and returned to the Provider Services Department via email to <Providerservices@hpsj.com request payment to be reissued. Affidavits must be notarized for payments greater than $1,000.

Upon receipt of the completed affidavit, a stop payment order will be placed on the original check and Finance Department will process the reissued payment on the next scheduled payment date.

## COORDINATION OF BENEFITS (COB)

When Health Plan Advantage D-SNP is the secondary payer, all claims must be submitted within 365 days from the date of payment on the primary payer's Explanation of Benefits (EOB) form. A copy of the EOB must be attached to the claim if submitted via paper. COB data can also be submitted electronically if the claim is filed electronically. If the Enrollee's primary plan denies services and requests additional information, the information must be submitted to the primary insurance carrier before submitting to Health Plan Advantage D-SNP.

## PAYMENTS TO OUT-OF-NETWORK PROVIDERS

Payments to out-of-network providers are made with the applicable Medicare pricing methodology for the type and location of services provided, including but not limited to, the Medicare Physician Fee Schedule (MPFS), Clinical Laboratory, Durable Medical Equipment (DME), and Average Sale Price (ASP) for Part B drug fee schedules. Facility-based services are reimbursed using the Inpatient and Outpatient Prospective Payment System pricers.

Prior authorization is required for out-of-network services unless:

- Services are emergent or urgent
- Dialysis services when member is temporarily out of the service area
- Continuity of Care exists (See Section 8: Utilization Management – Continuity of Care)
- Ambulance services dispatched through 911 or local equivalent

Note: *See Medicare Managed Care Manual Chapter 4 – Benefits and Beneficiary Protections for additional information at:*

*https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/mc86c04.pdf*

# SECTION 11: PROVIDER PAYMENT

## FACILITY PAYMENTS

Health Plan Advantage D-SNP contracts with facilities within the service area and provides access to specialty facility services when needed outside of the service area. Each facility agreement/contract contains specific reimbursement information indicating payment methodologies.

Health Plan Advantage D-SNP will reimburse any Providers on staff within the facilities using the applicable Medicare fee schedule and/or contracted agreement.

**Note:** *Enrollees cannot be balance billed for services (See Section 10: Claims Submission – Enrollee Billing for details.)*

All facilities are expected to coordinate with Health Plan Advantage D-SNP's Utilization Management Inpatient Services for services that require prior authorization by providing the Enrollee information and medical documentation necessary to support high quality, timely, and cost-effective health care.

### No Payment for Never Events, Hospital Acquired Conditions (HAC), and Provider Preventable Conditions (PPC)

CMS defines Never Events as "serious and costly errors in the provision of health care services that should never happen." Never Events, HACs, and PPCs can be avoided through the application of evidence based clinical guidelines.

Institutional Providers are encouraged to take appropriate actions to reduce the likelihood of Never Events, HACs, and PPCs.

Facility Providers will not be reimbursed for covered services related to or resulting from Never Events, HAC, or PPC including reimbursement for additional inpatient days that would not have been incurred in the absence of such Never Event, HAC, or PPC. These events shall not be included in either APR-DRG calculations, per diems, or included in any stop loss calculations.

If a HAC or PPC event occurs, institutional Provider must submit a copy of the Enrollee's complete medical record with the claim and file the PPC with DHCS. PPC filing instructions are located at https://www.dhcs.ca.gov/individuals/Pages/PPC_Form_Instructions.aspx

# SECTION 12: DISPUTE RESOLUTION

## GRIEVANCES, APPEALS and PROVIDER DISPUTES

Enrollees may address concerns to the Health Plan Advantage D-SNP through a grievance or a request for reconsideration (appeal).

Providers may request a reconsideration or file a provider dispute resolution request depending on the type of concern.

**Enrollee Assistance**

The Enrollee can name a relative, friend, advocate, attorney, doctor, or someone else to act on his/her behalf; in some cases, others authorized under state law may act on behalf of the Enrollee. Representatives acting on behalf of the Enrollee must complete an Appointment of Representative (AOR), or equivalent, to file a grievance.

If the Enrollee needs help filing his/her grievance or appeal, Health Plan Advantage D-SNP can help and provide free language services.

Enrollees may file a grievance or appeal by contacting the Health Plan Advantage D-SNP using any of the methods below:

**In person:** Visit any of Health Plan Advantage D-SNP's locations in French Camp, Modesto, or Placerville

- **By Phone**: 1-888-361-7526 (TTY 711)
- **By Mail:**

  Health Plan Advantage D-SNP

  Attention: Grievance and Appeal Department

  7751 South Manthey Road French Camp, CA 95231
- **Online:** Visit Health Plan Advantage D-SNP's website at www.hpsj-mvhp.org/grievances-appeals
- **By Fax:** 1-209-942-6355
- **By email:** grievances@hpsj.com

Enrollees can also submit complaints externally to the following entities:

- Medicare: 1-800-MEDICARE (1-800-633-4227, TTY 1-877-486-2048)
- DHCS: Medi-Cal Managed Care Ombudsman: (1-888-452-8609, TTY 711)
- Department of Managed Health Care (DMHC): (1-888-466-2219, TTY 1-877-688-9891)
- OCR: (1-800-368-1019, TTY 1-800-537-7697)

# SECTION 12: DISPUTE RESOLUTION

**Enrollee Grievances**

A grievance (dispute or complaint) may occur when the Enrollee is not satisfied with Health Plan Advantage D-SNP or Providers. A grievance may include:

- Concerns about the operations of Provider Health Plan Advantage D-SNP
- Concerns about the health care or treatment received from a Provider or one of its network pharmacies
- Concerns about the quality of care provided by a Provider or at a pharmacy.

Health Plan Advantage D-SNP complies with all non-discrimination policies set forth by State and Federal Law as described in APL 21-004. Enrollees will not be required to file discrimination grievances with Health Plan Advantage D-SNP prior to filing directly with DHCS' Office of Civil Rights (OCR) or with the Department of Health and Human Services' (HHS) OCR.

All grievances alleging discrimination will be forwarded in a timely manner to the Department of Health Care Services (DHCS). This includes, and is not limited to, the following: language access grievances, failure to reasonably accommodate a Enrollee under the requirements of the American Disability Act (ADA), and discrimination based on sex, race, color, religion, ancestry, national origin, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity, sexual orientation, creed, health status, or identification with any other persons or groups (see CA Penal Code section 422.56).

Use the table below as a quick-reference to understand how the Centers for Medicare and Medicaid (CMS) expects Health Plans to classify and process standard and expedited grievances for Part C (medical services) and Part D (prescription drugs).

| **Description** | **Standard** | **Expedited:**<br>If member disagrees with health plan decision:<br>• NOT to expedite an organization determination (OD) or reconsideration (RD); or<br>• requesting an extension on an OD or RD |
|---|---|---|
| Filing deadline** | None – Grievances may be submitted any time | |
| Method of request? | Verbally or in writing | |
| Who may file? | • Enrollee | • Enrollee<br>• Assignee for Enrollee (Authorized |

| | | |
|---|---|---|
| | • Assignee for Enrollee (Authorized Representative;/good for one year)*<br>• Representative authorized by the Court (Surrogate; must provide documentation) | Representative;/good for one year)<br>• Representative authorized by the Court (Surrogate; must provide documentation) |
| How can I confirm receipt? | The Health Plan Advantage D-SNP will send written notification confirming receipt within 5 calendar days for standard grievances. See 'Timeframe for resolution' below for expedited grievance confirmation. | |
| Who can Review?** | Someone other than the person involved, or a subordinate of the person involved with the initial determination.<br>If medical necessity is involved, a physician with expertise in the field must review. | |
| Extension? | Yes. May extend 14 calendar days if appropriate | No |
| Timeframe for resolution | 30 calendar days | 24 hours<br>If oral notification is delivered initially, written confirmation must be sent within 3 calendar days of the verbal notification. |
| Timeframe for notification | Must send notification within the timeframe indicated above. | |
| Notification Requirements | When submitted in writing, response must be in writing | |

*Make effort obtain documentation. If not received, dismiss request. And ask to resubmit upon receipt of form.
**For Integrated Plans, requirements do not apply to Part D grievances

**Provider Role in Resolving a Grievance**

Providers may not dismiss, discriminate, or retaliate against the Enrollee for filing a grievance.

Provider may receive a letter outlining the grievance, requesting medical records and/or requesting a written response indicating a timeframe to respond and address to submit the requested documentation. Health Plan Advantage D-SNP resources may contact the Provider during the investigation to clarify information received or ask additional questions.

A corrective action plan (CAP) will be issued to the Provider and/or presented at Peer Review & Credentialing Committee (PRCC) when a Provider exceeds the thresholds for grievances related to access, quality of care and quality of service. The Medical Director may also issue a CAP at their discretion based on the severity of the case.

# SECTION 12: DISPUTE RESOLUTION

**Enrollee Appeals (Reconsiderations)**

An appeal is when there is disagreement with Health Plan Advantage D-SNP's decision to change services or not to cover them.

**The Enrollee has a right to appeal if the Enrollee believes that:**

- Health Plan Advantage D-SNP has not paid for emergency, post-stabilization, or urgently needed services
- Health Plan Advantage D-SNP has not paid a bill in full
- A non-contracted medical Provider or facility or supplier furnished health services that should have been provided by, arranged for, or reimbursed by Health Plan Advantage D-SNP.
- Health Plan Advantage D-SNP has not provided or paid for services for which the Health Plan Advantage D-SNP is responsible
- A previously authorized ongoing course of treatment has been reduced or prematurely discontinued and the services are still medically necessary.
- An organization determination has not been made within the appropriate time frames.
- A non-covered service should have been provided, arranged, or reimbursed.
- Health Plan Advantage D-SNP does not to cover a drug, vaccine, or other Part D benefit
- Health Plan Advantage D-SNP did not reimburse the Enrollee for a Part D drug
- Health Plan Advantage D-SNP made a payment for a Part D drug with which the Enrollee disagrees
- Health Plan Advantage D-SNP denied the Enrollee's exception request
- Health Plan Advantage D-SNP made a coverage determination with which the Enrollee disagrees

**Submitting a Part D reconsideration request**

Part D appeals for Health Plan Advantage D-SNP are handled through its Pharmacy Benefit Manager (PBM), MedImpact.

Enrollees, Enrollee representatives or Providers on behalf of Enrollees may submit a Part D appeal to PBM via the following:

- Phone: 1-833-546-0796
- Fax: 1- 858-790-6060
- Mail: MedImpact Healthcare Systems, Inc.

For a description of the Part D exception request process, please see the Pharmacy section of this manual.

The Enrollee or the Enrollee's representative may provide additional information to Health Plan Advantage D-SNP, either in person or in writing, including evidence and allegations of fact or law related to the issue in dispute.

If Enrollee or the Enrollee's Provider believes an expedited appeal is required because a delay would significantly increase risk to the Enrollee's health, the Enrollee or the Enrollee's appointed representative may request an expedited appeal. Health Plan Advantage D-SNP may reclassify Enrollee's expedited request for reconsideration and must notify Enrollee of its decision. If Provider requests or supports the Enrollee's request for an expedited appeal, Health Plan Advantage D-SNP will expedite the review.

The Enrollee's Provider can also request an expedited appeal if the denial was made during a concurrent review (request for extension of services beyond the time or quantity currently authorized).

Health Plan Advantage D-SNP will make reasonable efforts to request clinical documentation to substantiate services that are needed expeditiously if the information is not submitted with the initial request. Providers should understand that delays or failure to submit necessary clinical information may jeopardize the Enrollee's health.

**Provider Role in Resolving a Reconsideration**

Providers may not dismiss, discriminate, or retaliate against the Enrollee for filing a reconsideration.

Provider may receive a letter outlining the reconsideration, requesting clinical medical records and/or requesting a written response indicating a timeframe to respond and address to submit the requested documentation. Health Plan Advantage D-SNP resources may contact the Provider during the investigation to clarify information received or ask additional questions.

Any additional information requested can be faxed to the Appeals and Grievances Department at 1-209-942-6355.

Use the tables below as a quick reference to understand how the Centers for Medicare and Medicaid (CMS) expect Health Plans to classify and process standard and expedited grievances for Part C (medical services) and Part D (prescription drugs).

# SECTION 12: DISPUTE RESOLUTION

**PART C Reconsiderations**

| Description | Standard Payment/Claim Direct Member Reimbursement (DMR) | Expedited Payment/Claim (DMR) | Standard Pre-Service (Prior Authorization) | Expedited Pre-Service (Prior Authorization) | Standard Part B Drug | Expedited Part B Drug |
|---|---|---|---|---|---|---|
| Filing deadline | Reconsideration must be filed within 65 days of receipt of initial determination. If beyond the timeframe, good cause must be established. | | | | | |
| Method of request? | In writing | In writing | In writing or orally | | | |
| Who may file? | • Enrollee<br>• Assignee of the Enrollee (Authorized Representative (good for one year)<br>• Representative authorized by the Court (Surrogate; must provide documentation)<br>• Non-Contracted provider with appeal rights (Must execute waiver of liability) | • Enrollee<br>• Assignee of the Enrollee (Authorized Representative (good for one year)*<br>• Representative authorized by the Court (Surrogate; must provide documentation) | • Enrollee<br>• Assignee of the Enrollee (Authorized Representative (good for one year)*<br>• Representative authorized by the Court (Surrogate; must provide documentation)<br>• Provider treating the enrollee (Must notify Enrollee) | • Enrollee<br>• Assignee of the Enrollee (Authorized Representative (good for one year)*<br>• Representative authorized by the Court (Surrogate; must provide documentation)<br>• Physician, regardless of whether or not he/she is contracted with the Plan (Must notify Enrollee) | • Enrollee<br>• Assignee of the Enrollee (Authorized Representative (good for one year)*<br>• Representative authorized by the Court (Surrogate; must provide documentation)<br>• Provider treating the enrollee (Must notify Enrollee) | • Enrollee<br>• Assignee of the Enrollee (Authorized Representative (good for one year)*<br>• Representative authorized by the Court (Surrogate; must provide documentation)<br>• Provider treating the enrollee (Must notify Enrollee) |
| Who can Review? | Someone other than the person involved with the initial determination.<br>If medical necessity is involved, physician with expertise in the field must be appointed. | | | | | |
| Extension? | No | No | Yes. May extend 14 days if | Yes. May extend 14 days if | No | No |

| Description | Standard Payment/Claim Direct Member Reimbursement (DMR) | Expedited Payment/Claim (DMR) | Standard Pre-Service (Prior Authorization) | Expedited Pre-Service (Prior Authorization) | Standard Part B Drug | Expedited Part B Drug |
|---|---|---|---|---|---|---|
| | | | appropriate and with appropriate notice. | appropriate and with appropriate notice. | | |
| Timeframe for determination | Within 30 calendar days of receipt by the organization. | Within 72 hours of receipt in the A&G department. | Within 30 calendar days of receipt by the organization. | Within 72 hours of receipt in the A&G department. | Within 7 calendar days of receipt by the organization. | Within 72 hours of receipt in the A&G department. |
| Timeframe for notification | Within 30 calendar days of receipt by the organization. | Within 72 hours of receipt in the A&G department (orally). Must send written notification within 3 calendar days of oral notification. | Within 30 calendar days of receipt by the organization. | Within 72 hours of receipt in the A&G department (orally). Must send written notification within 3 calendar days of oral notification. | Within 7 calendar days of receipt by the organization. | Within 72 hours of receipt in the A&G department. |
| Timeframe to provide if overturned | Must effectuate no later than the earlier of 72 hours of making its decision (standard) or 72 hours of receipt of the request (expedited) or within the timeframes indicated above. | | | | | |
| Denial/ partial denials/untimely decisions | Forward to the IRE within the timeframe indicated on following page. | | | | | |

**PART D Table**

| Type | Timeframe |
|---|---|
| Standard Grievance | 30 calendar days |
| Expedited Grievance | 24 hours |
| Standard Appeal (Service) | 7 calendar days |
| Expedited Appeal | 72 hours |
| Standard Appeal (Payment) | 14 calendar days<br>(30 calendar days to issue payment) |

**Part C - Second Level Appeals**

If Health Plan Advantage D-SNP says no to all or part of the Enrollee's initial reconsideration/appeal, the case is automatically forwarded to the Independent Review Entity (IRE), not affiliated with Health Plan Advantage D-SNP, for the second level appeal process. If the appeal decision was untimely, the case is also automatically forwarded to the IRE. If the Enrollee is not satisfied with the decision at the Level 2 appeal, there may be additional levels of appeal available to him/her.

**PROVIDER GRIEVANCES AND APPEALS**

Provider grievances not related to the Enrollee are processed as an inquiry. Provider appeals related to payment are processed through the Provider Dispute Resolution process.

**Part C Non-Contract Provider Payment Appeals (Reconsiderations)**

Non-contract Providers may submit a written request to have Health Plan Advantage D-SNP review a claim denial or partial denial. Reconsideration requests for an amount paid which is different than what Provider would have been paid under Original Medicare will be handled as a provider dispute (See Provider Disputes below).

| Description | Standard Payment/Claim<br>Direct Member Reimbursement (DMR) |
|---|---|
| Filing deadline | Reconsideration must be filed within 65 calendar days of receipt of initial determination. If beyond the timeframe, good cause (must be established). |
| Method of request? | In writing - with all pertinent documentation, such as a copy of original claim, remit showing the denial, |

| Description | Standard Payment/Claim Direct Member Reimbursement (DMR) |
|---|---|
| | records, or any other documentation that would support the request for review |
| Required documentation | The Waiver of Liability (WOL) form must be completed and submitted with reconsideration request. The WOL is available online at https://www.cms.gov/medicare/appeals-grievances/managed-care/notices-forms |
| Who may file? | Non-Contract provider with appeal rights (Must execute waiver of liability) |
| Who can Review? | Someone other than the person involved with the initial determination.<br>If medical necessity is involved, physician with expertise in the field must be appointed. |
| Extension? | No |
| Timeframe for determination | Within 30 calendar days of receipt by the organization. |
| Timeframe for notification | Within 30 calendar days of receipt by the organization. |
| Timeframe to provide if overturned | Within 30 calendar days of receipt by the organization. |
| Denial/ partial denials/untimely decisions | Forward to the IRE within the timeframe indicated on following page. |

*Circumstances for good cause may include:

- Provider sent the request to an incorrect address, in good faith, within the time limit
- Provider did not receive the adverse initial determination, or it was received late, documentation was difficult to locate within the time limit.

## PROVIDER DISPUTE RESOLUTION (PDR)

Health Plan Advantage D-SNP maintains a dispute resolution process to support the review and resolution of Provider concerns including, but not limited to, disputes regarding claim payments and/or denials, utilization management decisions (authorizations) and recoupment requests.

Provider Dispute Resolution (PDR) request must be submitted as detailed below:

- **Contract Providers** must submit a Provider dispute online through the Provider Portal/Doctors Referral Express (DRE) <provider.hpsj.com/dre/default.aspx>
- **Non- Contract Providers** must mail Provider disputes to the attention of the Claims Department at: < Health Plan Advantage D-SNP, P.O. Box 30490, Stockton, CA 95213-30490> with the appropriate **Health Plan Provider Dispute Resolution** form, located at www.hpsj.com/provider-dispute-resolution.

# SECTION 12: DISPUTE RESOLUTION

***Note**: Failure to submit the Provider dispute through DRE or on Health Plan Advantage D-SNP's PDR form will result in return of form for completion and may result in a delay of processing and potentially falling outside of the dispute processing guidelines established by DMHC.*

## TYPES OF DISPUTES

A PDR request should only be submitted for the following reasons:

**Contract Providers**

- **Contract dispute**: Original claim did not pay per contracted rate.
- **Seeking resolution of a billing determination**: Do not agree with claim or claim line denial.
- **Recovery dispute**: A letter was received regarding an identified overpayment, and you do not agree with the determination.
- **Seeking resolution of a supplement payment**: Do not agree with the amount supplemental and/or denial of supplemental payment.

**Non-Contract Providers**

- **Amount different than Original Medicare**: Do not agree with the amount paid is the same as what would have been paid under Original Medicare.

**Note:** *Claim must be finalized before submitting a PDR*

## REQUIREMENTS FOR A COMPLETE PDR

A **Complete PDR** is a detailed request form. The required information depends on the dispute type (see list above).

All PDR's require the following:

### Provider Information

- Rendering Provider/facility Name
- NPI
- Pay To affiliate name
- Provider billing address
- Contact name & phone number

## SECTION 12: DISPUTE RESOLUTION

### Enrollee Information

- Enrollee name
- Health Plan Advantage D-SNP ID#
- Enrollee date of birth
- Enrollee account number

### Claim Information

- Health Plan Advantage D-SNP issued claim number

### Contract Dispute

- Expected payment amount per contract or fee schedule
- Claim/Claim line(s) amount disputing
- Expected amount
- Type of service (i.e. transportation)

### Seeking Resolution of a Billing Determination

- Denial description identifying line(s) denied with justification for payment

### Recovery Request Dispute

- Recovery request number (RU#)
- Detailed reason for dispute (i.e. check/recoupment already applied)
- Supporting documentation
- Copy of recovery request letter

### Amount different that Original Medicare

- Evidence of the amount calculated under Original Medicare including but not limited to, pricer software results showing all details, Medicare Physician Fee Schedule rate for the geographic locality, or other Medicare pricing tool results supporting the requested amount.

# SECTION 12: DISPUTE RESOLUTION

## PDR SUBMISSION TIMELINES

Health Plan Advantage D-SNP's timely filing guideline for PDR submissions is 120 calendar days from the paid date of the claim. PDRs submitted electronically (through the Provider portal) will be acknowledged within two working days of receipt. PDR's submitted by mail will be acknowledged within 15 working days of receipt.

**Note:** If the Provider wishes to contest (**Recovery Request Dispute**) the notice of reimbursement of overpayment request it must be within 30 calendar days.

If additional information is required and requested through the dispute process the additional information requested must be received within 30 calendar days of the receipt of the dispute request.

## PDR DETERMINATION NOTIFICATION

Upon submission of a complete PDR request and/or receipt of additional information requested, Health Plan Advantage D-SNP will resolve and issue a written determination within 30 calendar days.

**Note:** Failure to submit complete and accurate information may result in a delay of processing and potentially falling outside of the dispute processing guidelines set by DMHC.

## OTHER INFORMATION

If the Provider is trying to submit corrections on a claim, follow the **Corrected Claim** submission guidelines.

If a claim or claim line was denied for lack of supporting documentation, submit such documentation as **correspondence** with the requested information.

If a claim was denied as a duplicate and the Provider feels it was denied in error, make sure it was submitted with the appropriate documentation, modifiers, or correct claim submission indicator before submitting a dispute.

**Note:** Appeals filed by the Provider on behalf of the beneficiary (Enrollee) require written consent from the beneficiary. See additional information under Grievances & Appeals <www.hpsj-mvhp.org/grievances-appeals>

# SECTION 13: QUALITY IMPROVEMENT AND HEALTH EQUITY

## QUALITY IMPROVEMENT AND HEALTH EQUITY (QIHE) OVERVIEW

Health Plan offers a constellation of care, programs and services designed to meet quality and equity standards set forth in CMS, DMHC and DHCS contracts to improve quality, equity, access and availability, detection of under and over utilization of services, and policies and procedures that reflect current medical practice standards. In 2026, Health Plan's product portfolio will expand to include a D-SNP incorporating robust state and federal-specific quality and equity monitoring and reporting requirements.

Health Plan's Quality Improvement and Health Equity Transformation Program (QIHETP) supports its mission through the development and maintenance of a quality-driven Provider network. The QIHETP is a coordinated, comprehensive, equitable, and continuous effort to monitor and improve member safety and performance in all care and services provided.

## MEDICARE ADVANTAGE STAR RATINGS PROGRAM OVERVIEW

Health Plans participating in the Medicare Advantage Program require compliance with specific reporting standards and quality measures established by the CMS. All providers working with Health Plan are expected to adhere to the requirements set by Health Plan, CMS, and the designated Quality Improvement Organization (QIO), which reviews compliance on behalf of CMS.

The Medicare Advantage Star ratings evaluate the quality of Medicare Advantage plans which help CMS promote higher standards of care and accountability among providers and health plans. Each year, CMS publishes the Star ratings to guide members in selecting the best plan and to determine Medicare Advantage quality bonus payments. The Star Ratings Program is designed to focus on rewarding better care, fostering healthier communities, and reducing costs through care improvements.

### Domains of the Medicare Advantage Star Ratings System

Star rating measures are organized into the following categories:

- Staying Healthy: Screenings, Tests and Vaccines
- Managing Chronic (Long Term) Conditions
- Member Experience with Health Plan
- Member Complaints and Changes in the Health Plan's Performance
- Health Plan Customer Service
- Drug Plan Customer Service
- Member Complaints and Changes in the Drug Plan's Performance
- Drug Safety and Accuracy of Drug Pricing

### Member Surveys

Members in a D-SNP may be asked to participate in up to three surveys each year. Not all Members receive all three surveys annually.

1. Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey measures member satisfaction with their doctors and health plan. Sample questions include:

- "In the last six months, not counting times when you needed care right away, how often did you get an appointment as soon as you thought you needed one?"
- "In the last six months, how often did your personal doctor seem informed and up to date about the care you got from Specialists?"
- "How often did your health plan's customer service representative give you the information or help you needed?"

2. Health Outcomes Survey (HOS) evaluates both the physical and mental health of Members. Questions may include:
   - "In the past 12 months, did a doctor or other healthcare provider advise you to start, increase, or maintain your level of exercise or physical activity?"
   - "Has your doctor or other healthcare provider done anything to help prevent falls or treat problems with balance or walking?"
   - "Have you ever talked with a doctor, nurse or other healthcare provider about leaking of urine?"

3. Health Risk Assessment (HRA) is administered once a year to all Members. The HRA must be completed within 90 days of enrollment in the D-SNP and annually thereafter. This survey collects information about the Member's health status and any concerns or conditions he/she may have. Responses to the HRA are used to identify member needs, and as the foundation for development of an Individualized Care Plan for the Member.

### Other Performance Data Collected

CMS analyzes other performance data to determine a plan's Star rating. Data includes:

- Healthcare Effectiveness Data and Information Set (HEDIS) - used to measure performance on dimensions of care and services.
- CMS Part C Reporting Elements, including benefit utilization, adverse events, organizational determinations and procedure frequency.
- Medication therapy management measures.
- Clinical and administrative/service quality improvement projects.

### Provider Influence on Member Access and Care

Health Plan collaborates with providers to deliver care to Members. Several domains have been identified where providers influence the members' quality of care and access to services. Domains include:

- Adult and Pediatric Preventive Care (e.g., well-care visits, screenings, immunizations)
- Chronic Care Management (e.g., asthma, diabetes)
- Acute Care Management (e.g., pharyngitis, bronchitis)
- Behavioral Health Care (e.g., mental illness, substance use treatment)
- Efficiency of Care (e.g., hospital utilization rates, medication adherence)
- Member Experience and Satisfaction with Care (e.g., CAHPS, HOS)

# SECTION 13: QUALITY IMPROVEMENT AND HEALTH EQUITY

Through dedicated work in each domain, Providers meaningfully affect the outcomes of the Star Ratings Program. The Provider's commitment to delivering timely preventive and chronic care increases both clinical performance and member wellness, driving higher ratings in quality metrics. For example, encouraging members to have their annual wellness visits and ensuring medication adherence and following up on abnormal tests results.

Providers also play an essential role in enhancing care delivery and fostering positive Member experiences and in shaping a healthcare system where service quality is continually elevated and recognized through Star ratings.

### Provider benefits of Star Ratings Program

Star ratings provide significant benefits to participating providers:

- Clinical Performance: Clear guidelines in areas like preventive care and chronic management help enhance member outcomes and professional satisfaction.
- Quality Care: Providers' dedication to consistent, timely, and high-quality care is recognized and highlighted within the Star Ratings Program. High performance can enhance a provider's reputation within the health system and the broader community.
- Member Engagement and Satisfaction: The program places a strong emphasis on the experience and satisfaction of member, encouraging providers to foster stronger relationships with members, translating to higher member retention and better health outcomes.
- Performance Data and Support: Providers receive quality and performance data throughout the year, empowering them to identify areas for improvement and celebrate achievements.
- Stronger Healthcare Community: By actively participating in the Star Ratings Program, providers help shape a culture of excellence and improvement; creating a healthcare community where service quality is continually elevated and recognized.

Ultimately, through Star ratings, Providers are empowered to deliver better care, achieve higher ratings, and enjoy greater recognition for their commitment to members and the healthcare system as a whole.

Health Plan offers quality and performance data to Providers throughout the calendar year. For additional information, contact the Provider Services Department at 1-888-361-7526

## DEFINITION OF QUALITY

The definition of quality is an extension of Health Plan's vision that is "**STEEEP**" in Quality.

| | |
|---|---|
| **S - Safe:** | Avoiding injuries to members from the care that is intended to help them. |
| **T - Timely:** | Reducing waits and sometimes harmful delays for both those who receive and those who give care. |
| **E - Effective:** | Providing services based on scientific evidence to all who could benefit and refraining from providing services to those not likely to benefit (avoiding underuse and overuse respectively). |

| | |
|---|---|
| **E - Efficient:** | Avoiding waste, including waste of equipment, supplies, ideas, and energy. |
| **E - Equitable:** | Providing care that doesn't discriminate because of gender ethnicity, geographic location, socioeconomic status, or any other classifications prohibited by state or federal law. |
| **P - Patient Centered:** | Providing care that is respectful of and responsive to individual member preferences, needs, and values and ensuring that member values guide all clinical decisions. |

**Better Outcomes**
Improving the health of the overall population while creating an improved member experience will help Health Plan with more educated members that can manage their health more effectively. The premise of the Institute for Health Improvement Triple Aim is to assist organizations with creating a foundation for providing an environment that serves to improve quality and satisfaction while reducing costs. Improving the health of populations takes the first individual aspect of the Triple Aim and expands it towards the whole population. Society is facing an increase in chronic diseases, so improving the member experience for all individuals will ultimately lead to a decrease in prevalence and/or severity of chronic diseases and overall better chronic care management.

**Lower Costs**
The Triple Aim intends to drive down costs while improving the health of populations by improving quality of care. If members visit Providers less frequently because their needs are met using other modalities, their care will be much more affordable.

**Improve Clinical Experience**
As value-based care becomes more prevalent, the quality of care provided becomes more essential and the Provider is the key to ensuring successful value-based care. In order to ensure the success of the Triple Aim, the care delivered by the Provider is key. It all starts there.

The QIHETP is designed to monitor, evaluate, and take timely action to address necessary improvements in the quality of care delivered by all Providers in any setting and take action to improve equity. It is comprehensive and addresses both the quality and safety of medical and behavioral health care provided to members and participants of the D-SNP. In addition, it facilitates compliance with the CMS requirement that D-SNPs incorporate one or more activities in its quality improvement program to reduce disparities in health and healthcare.

Full service Behavioral Health care benefits are offered to all D-SNP members. Behavioral health services for members who meet criteria for specialty mental health services or substance use disorder services can access these services through the local county Behavioral Health department. The Behavioral Health Case Management team can coordinate care for any members seeking to access County Behavioral Health services.

Members are able to receive access to coordinated behavioral health services directly through Health Plan's contracted Behavioral Healthcare network or with the assistance of our Behavioral Health Case Management team.

# SECTION 13: QUALITY IMPROVEMENT AND HEALTH EQUITY

## SCOPE OF THE QIHETP

The QIHETP monitors and improves an array of indicators to measure critical clinical and service processes and outcomes while removing barriers to care and meeting the cultural, linguistic diverse preferences and needs of members.

The QIHETP outlines the delivery system programs and quality metrics that enable members to maintain or improve optimal health status and remediate or manage the debilitation caused by emerging or apparent chronic medical or behavioral illness or disability.

**QIHETP activities include but are not limited to:**

- Alignment between quality, equity and population health initiatives:
  - Ensuring Health Plan quality objectives align with CMS and DHCS whereby measures meet, at minimum, the Medicare Advantage three Star rating thresholds during its first year as a DSNP, with progressively higher Star ratings targets in subsequent years.
  - Alignment with Health Plan's NCQA-approved SNP Model of Care and measures its effectiveness in the following domains:
    - Access to care
    - Improvement in member health status
    - Continuity of care
    - Care coordination, including participation by an interdisciplinary care team (ICT)
    - Implementation of an individualized care plan that addresses the member's functional, psychosocial, and clinical needs
    - Medication management, disease management and behavioral health
    - End-of-life care
    - Integrated systems of communication
  - Ensuring preventive health programs, quality, and equity strategies address quality of care and access to include:
    - Ensure proper screening for women to ensure individuals at high risk are given appropriate follow up.
    - Identify and facilitate delivery of extra services and benefits that meet the specialized needs of the most vulnerable beneficiaries as evidenced by measures from the psychosocial, functional, and end-of-life domains.
    - Ensure network Providers and their staff routinely seen by D-SNP members receive training on the D-SNP Model of Care.
    - Monitor processes and outcomes with achieving compliance with preventive guidelines.

  - Engage in planned health equity-focused interventions to address gaps in the quality of and access to care for members, including preventive and screening services.
  - Engage with local entities when developing interventions and strategies to address deficiencies in performance measures related to health care services for members.
- Ensure quality and equity activities align with clinical practice guidelines
  - Ensure quality programs promote physical and behavioral health care through the design of programs which focus on medical and behavioral health conditions.
  - Quality and equity activities align with appropriate utilization.
- Behavioral health care programs that focus on the following:
  - Prevention and screening for evaluation of cognitive development, neurodivergent disabilities, functional and social impairment, substance use, and abuse.
  - Programs that support, recovery, resiliency, and rehabilitation.
  - Exchange of information.
  - Appropriate diagnosis, treatment, and referral of behavioral health disorders commonly seen in primary care.
  - Monitoring of psychotropic medications.
  - Primary and secondary behavioral health programs.
- Access to primary and specialty Providers and services:
  - Member disengagement with primary care.
  - Accessibility of Providers.
  - Availability of routine, regular, non-urgent and urgent and medical, ancillary, specialty, and behavioral health appointments.
  - Language accessibility at the time of appointment, when applicable.
- Continuity of care and coordination across settings and at all levels of care, including:
  - Referrals between members and Community Based Organizations (CBOs).
  - Transitions of care, with the goal of establishing consistent Provider-member relationships:
    - When members transition between Providers.
    - When members move across care settings.
- Improve member experience with respect to clinical quality, access, and availability, and culturally and linguistically competent health care and services, continuity, and care coordination.
- Population health activities that are designed to address:

  - Keeping members healthy by focusing on wellness and prevention programs.
  - Identifying and managing emerging risks for high and rising risk members:
    - Members with biometric indicators or high-risk behaviors that are known to increase risk for chronic conditions.
    - Members with increased risk of declining medical and/or behavioral health conditions.
  - Ensure effective transition planning across delivery systems or settings through care coordination and other means to minimize member risk and ensure appropriate clinical outcomes for members.
  - Delivery of extra services and benefits that meet the specialized needs of the most vulnerable beneficiaries.

- Access to a Chronic Care Improvement Program (CCIP). Program aims include:
  - Improving the health of D-SNP members diagnosed with Diabetes Mellitus (DM), are of Hispanic/Latino ethnicity, and have a HgbA1c result >9:
    - Slowing disease progression
    - Prevention of health complications
    - Decreasing inpatient stays

  Program elements include:
    - Methods for identifying members meeting program criteria
    - Mechanisms for monitoring members participating in the CCIP
    - Evaluating participant health outcomes
    - Systematic and ongoing follow-up on the effect of the program

**Goals of the Quality and Health Equity Transformation Program:**

- Promote an organization-wide commitment to equality of care and service through strong leadership involvement in improving quality.
- Address, prevent, and resolve health disparities within the network through monitoring quality data and implementation of targeted interventions.
- Enhance continuity and coordination of care among behavioral health and primary Providers.
- Respond actively to member expectations and feedback concerning the quality of member care delivered and services provided.
- Define, oversee, evaluate, and improve the care and service delivered by Health Plan staff, Providers, and delegated entities by:
  - Promoting member safety as a high-level priority through mechanisms designed to minimize member and organizational risk of adverse occurrences.

  - Improving and enhancing the quality of member care provided through ongoing, objective, and systematic measurement, analysis, and implementation of improvement actions.
  - Promoting processes to ensure the availability of safe, timely, effective, efficient, equitable, member-centered care and provide oversight within the network.
- Comply with legislative regulations, accreditation standards, and professional liability requirements.
- Ensure that medically necessary covered services are:
  - Available and accessible.
  - Provided in a culturally and linguistically appropriate manner.
  - Provided in an equitable manner.
  - Provided by qualified, competent Providers who are committed to Health Plan's mission and vision.
- Promote collaborative relationships between Health Plan, Providers and community partners.
- Promote and create condition specific health education and disease prevention materials that are age, culturally, and linguistically appropriate and encourages optimal behavioral health for members and staff.
- Maintain an appropriate number of credentialed network Providers to meet the access needs of members.
- Ensure Providers, delegated contractors and subcontractors participate in the QIHETP and Population Needs Assessment.
- Ensure members' protected health information (PHI) is protected, utilized, and released in accordance with state and federal law and regulation.
- Follow all accreditation, regulatory, and licensure survey recommendations within 90 days of identifying improvement opportunities.
- Continue implementing adequate information management systems to support complete data entry, aggregation, display, analysis, and the needs for all quality management activities.
- Incorporate responsibilities for quality management and improvement into management performance standards.

Other areas that have impact on the QIHETP include:

- Provider credentialing and recredentialing.
- Utilization management processes and outcomes.
- Inter-rater reliability.
- Provider performance.

- Pharmacy management.
- Facility site reviews (FSRs).
- Care coordination program performance.

## RESPONSIBILITIES OF NETWORK PROVIDERS IN QUALITY IMPROVEMENT

Network Providers (primary care physicians, specialists, facilities, etc.) are contractually required to participate in and cooperate with Health Plan's QIHETP.

Primary care physicians and specialty Providers participate with Health Plan's QIHETP through:

- Compliance with Health Plan policies, state and federal requirements by maintaining accurate and timely information and following all public health and regulatory guidelines related to the reporting of communicable diseases, the delivery of preventive care services, procedure consents, and any other required data sets.
- Providing all medical care with attention to confidentiality of care and professional standards of human dignity.
- Maintaining infection control, exposure control and safety policies and procedures.
- Cooperating with, and adhering to, Health Plan's QIHETP, utilization management plan and physician and provider credentialing policy.
- Identifying a staff physician/Chief Medical Officer (CMO) to serve as clinical liaison with Health Plan and who will be authorized to communicate directly with Health Plan's CMO regarding medical services and clinical issues.
- Cooperating with Health Plan's staff during facility and medical record reviews and initiating corrective action for areas identified as requiring improvement.
- Cooperating with Health Plan's staff during the investigation of member grievances and potential quality issues by (1) providing requested documentation of medical care and/or discussing the care with Health Plan's CMO; (2) assisting with the resolution of such grievances and (3) taking corrective action (if any) to prevent the recurrence of problem areas.
- Participating in committees and review panels within areas of expertise as requested and as feasible.
- Completing a credentialing application and requested documents at the time of initial credentialing and recredentialing.
- Cooperation with quality improvement activities to improve quality of care and member experience. Cooperation includes collection and evaluation of data and participation in Health Plan's clinical and service measure QI programs.
- Practitioners understand that Health Plan may use practitioner performance data for quality improvement activities.

**Hospitals, other facilities and other Providers participate with Health Plan's QIHETP through:**

- Permitting access to Health Plan's member's medical records for review when quality of care concerns or potential quality issues are identified.
- Investigating identified quality of care issues and reporting resolutions to Health Plan.
- Participating in the facility credentialing process by providing requested documents, allowing on-site visits, as necessary, and implementing corrective actions, as necessary.

## QUALITY IMPROVEMENT AND HEALTH EQUITY (QIHE) PROCESS

The QIHE process includes a comprehensive array of clinical and service indicators that provide information about the systems, processes, and outcomes of clinical care and service delivery. Clear, well-defined quality indicators represent what is most important to Health Plan in measuring and evaluating quality. The measures are developed using sound methodological principles and are rooted in best practice guidelines. Measured performance data is assessed to ensure reliability so that decisions can be made with confidence.

Quality indicators are reflective of areas that are high risk, high volume, problem prone specific populations, and specific conditions, as well as industry standard measures. Most indicators are rate-based outcome measures. Indicators are measurable and have a goal against which to measure performance. Indicators are developed with input from Health Plan's CMO, Chief Health Equity Officer (CHEO) and the Quality Improvement and Health Equity Committee (QIHEC).

To understand and properly implement QIHEC related practices and projects, there are approaches being utilized. Such models help collect and analyze data for test change, provide guidance for effort and improvement in efficiency, member safety, or quality outcomes. These models include:

- Plan Do Study Act (PDSA)
- Performance Improvement Projects (PIPs)

**Plan Do Study Act (PDSA)**
The PDSA methodology is a rapid cycle, continuous quality improvement process designed to perform small tests of change, which allows more flexibility throughout the improvement process. As part of this approach, Health Plan performs real-time tracking and evaluation of its interventions. PDSAs are the most common continuous quality improvement model utilized by Health Plan and have four major elements or stages:

A. **Plan**: The first step involves identifying preliminary opportunities for improvement. At this point the focus is to analyze data to identify concerns and ideas for improving process and to determine anticipated outcomes. Key stakeholders and/or people served are identified, data compiled, and solutions proposed.

B. **Do:** This step involves using the proposed solution, and if it proves successful, as determined through measuring and assessing, implementing the solution usually on a trial basis as a new part of the process.

C. **Study:** At this stage, data is again collected to compare the results of the new process with those of the previous one.

D. **Act, Adopt or Adapt:** This stage involves making the changes a routine part of the targeted activity. It also means "Acting" to involve others (other staff, program components or consumers) - those who will be affected by the changes, those whose cooperation is needed to implement the changes on a larger scale, and those who may benefit from what has been learned. Finally, it means documenting and reporting findings and follow-up.

**Health Equity Program**

The Health Equity Program description supports Health Plan's mission and vision through the development and maintenance of a quality driven, health equity focused, network of care for all lines of business. The CHEO works with various internal and external teams and stakeholders to continuously monitor and implement activities to improve health equity and reduce health disparities among Health Plan's members. This work aligns with corporate goals and CMS requirements for quality improvement programs. Health Plan has a matrix Health Equity Framework that has four key Pathways. The Pathways run concurrently and are specific to the key stakeholders for Health Plan:

1. Internal pathway focused on Health Plan employees, leadership and culture.
2. Member pathway focused on impacting members' health disparities.
3. Partner pathway focused on all key stakeholder partners.
4. Community pathway focused on system collaboration and overall community health equity efforts.

Reporting to the CHEO is the Quality, Grievance and Appeals, Health Equity and Cultural and Linguistics, Credentialing, FSR, Provider Partnership, HEDIS, Accreditation and Health Education Teams.

The QIHETP includes a comprehensive array of clinical and service indicators that provide information about the systems, processes, and outcomes of clinical care and service delivery. The quality indicators emphasize areas representing risk and need across the continuum of care. Indicators are developed with input from the CMO and the QIHEC which include key members of the Provider community. These indicators include, but are not limited to:

- All-cause hospital readmissions.
- Emergency room utilization.
- Ambulatory care utilization.
- Primary and urgent care utilization.
- D-SNP's ability to deliver high-quality healthcare services and benefits to members

## QUALITY IMPROVEMENT AND HEALTH EQUITY COMMITTEE (QIHEC) AND SUBCOMMITTEES

The key to Health Plan's quality management success is integration of information. Health Plan's committees may function separately, but it is an expectation that data and information be readily available to and from all who are actively involved in Health Plan's performance improvement processes. Committee information and data is validated, coordinated, aggregated, communicated, reported, and acted upon in a timely manner to ensure success with all performance improvement and quality initiatives. All committee members are required to note their attendance for each meeting and sign an annual "Conflict of Interest" statement. Committee members cannot vote on matters where they have an interest and must abstain until the issue has been resolved. Written minutes are maintained by each committee for each meeting. Many of Health Plan's QIHETP committees require the participation of Providers.

### Quality Improvement and Health Equity Committee (QIHEC) – Governing Board of Quality and Health Equity Transformation Program (QIHETP)

The QIHEC is responsible for collecting and analyzing out-of-network Provider use and referrals to assess Member use of services delivered by participating Providers with targeted clinical expertise and identifies any gaps in care or services relating to possible deficiencies in the network. Ensures a sufficient number of board-certified providers with expertise in such key areas as Geriatrics, Cardiology, Neurology, Endocrinology, Orthopedics, Nephrology, Pulmonology, and Behavioral Health specialties along with acute inpatient hospitals, rehabilitation and psychiatric facilities and subacute nursing facilities are participating in the network. An additional key consideration is to ensure the availability of qualified physicians and/or nurse practitioners willing and available to make home visits when a need arises. For ambulatory and community-based services, the provider contracting team insures the appropriate availability of ancillary service providers such as radiology, laboratory, licensed home health care agencies, transportation, and DME vendors.

The committee is chaired by the Chief Medical Officer and the Chief Health Equity Officer and provides additional input as needed and approves recommendations. QIHEC reports to the San Joaquin County Health Commission which is the highest Committee for quality oversight

The committee:

- Approves the annual QIHETP description, plan and evaluation.
- Recommends policy decisions or oversees recommendations and revisions to the QIHE activities.
- Reviews, analyzes, evaluates, and makes recommendations regarding the progress and outcome of quality improvement and health equity projects and activities.
- Ensures that quality performance standards are met and makes recommendations for improvements.
- Institutes actions to address performance deficiencies, identifies necessary actions and ensures follow-up according to plan.

- Assists in establishing the strategic direction for all quality and healthy equity initiatives.
- Receives subcommittee reports, identifies performance improvement opportunities and makes recommendations to be incorporated into the QIHETP work plan.
- Ensures Provider communication, education and follow-up related to quality of care issues.
- Ensures Provider participation in the QIHETP through planning, design, implementation, or review.
- Confirms and reports to the Commission that Health Plan activities comply with all state and federal regulations.
- Reports to the San Joaquin County Health Commission any variance from quality performance goals and the plan to correct.
- Submits to the Commission approved, signed minutes reflecting the committee decisions and actions of each meeting.
- Presents to the Commission an annual reviewed and approved QIHETP description and work plan and prior year evaluation.
- Annually reviews and approves medical review criteria and clinical practice guidelines.
- Oversees QI and health equity activities that validate quality management effectiveness through customer feedback reporting including:
    - Oversees Provider and Member satisfaction/experience surveys.
    - Reviews and approves the annual Healthcare Effectiveness Data and Information Set (HEDIS) rates and provides feedback about improvement initiatives.
    - Reviews and approves the annual Consumer Assessment of Health care Providers and Systems (CAHPS) survey results and provides feedback about improvement initiatives.
    - Reviews and approves the annual HOS results and provides feedback about improvement initiatives.
- Maintains compliance with standards for mandated reporting of diseases or conditions to the local health department.
- Review and provide feedback on quality and equity policies.

### Quality Improvement and Health Equity Operations Committee (QIHEOC)

The QIHEOC is responsible for improving the quality of health care and services by monitoring, evaluating and taking timely action on identified quality of care and service issues. The QIHEOC is responsible for reviewing and providing feedback on the processes, programs, and measurement activities undertaken by the organization and by making recommendations to the QIHEC Committee. The QIHEOC is co-chaired by the Director of HEDIS & Accreditation and Director of Health Equity.

The committee includes development and oversight of:

- HEDIS

- HOS
- CAHPS
- Quality Improvement Projects (QIP) and PDSA initiatives
- Customer Service Call Quality
- Review and approval of all quality improvement corrective action plans (CAPs)
- Wellness and preventive health programs
- Health Education standards/guidelines, and Health promotion actions
- Cultural and Linguistic Services
- Population Health Management
- Member and Provider experience survey results
- Provider access and availability
- Network adequacy
- Grievances and Appeals
- Performance Improvement Projects (PIP)
- Policy and procedures
- FSRs and Credentialing metrics
- Feedback and annual review process of Health Plan's Provider Manual and any new or revised policies and procedures.

### Peer Review and Credentialing Committee (PRCC)

The PRCC is responsible for reviewing the initial credentialing, recredentialing, recertification, and reappointment of physicians through a medical peer review committee. PRCC members are appointed by the Commission to which the committee also reports.

The committee is chaired by the Chief Medical Officer and is composed of Providers representing primary and specialty care, as well as other Providers.

The committee:

- Oversees and evaluates Health Plan's credentialing and recredentialing process for evaluating and selecting Providers.
- Reviews the qualifications of new and continuing Providers.
- Ensures a fair and effective peer review process to make recommendations regarding credential decisions.
- Reviews Provider quality service and performance data, including member complaints, FSRs, and identifies opportunities for improvement.

- Determines whether health care services were performed in compliance with standards of practice and directs corrective action measures when standards are not met.
- Evaluates and makes recommendations on all Provider adverse actions and takes appropriate disciplinary action against Providers who fail to meet established standards and/or legal requirements as appropriate.
- Ensures and oversees a formal and objective Provider appeal process.
- Reviews and recommends actions related to escalated Quality of Care issues.
- Submits to the Commission approved, signed minutes reflecting the committee's decisions and actions of each meeting.

### Grievance and Appeals (G&A) Committee

The Grievance and Appeals Committee ensures that the organization maintains adequate oversight of Member Grievance and Appeals. The G&A Committee provides oversight of the grievance and Appeal system to ensure the continuous and expedited review of grievances occurs and resolution is reached timely and that adverse benefits determinations are thoroughly evaluated. The G&A Committee ensures emergent and urgent trends in care and service are identified and timely action is taken when evidence of non-compliance exists. The G&A Committee meets at least quarterly and reports to the QIHE Committee.

The committee is chaired by the Executive Leadership of Quality Improvement and Health Equity and Manager of Quality.

The committee:

- Oversees and ensures the integrity of the grievance and appeal process, including tracking for timeliness and resolution.
- Evaluates grievances and potential quality of care issues.
- Reviews and evaluates G&A trend reports and identifies and makes recommendations for improvements.
- Ensures compliance with regulatory and contractual requirements.
- Submits to the QIHEOC and QIHEC approved, signed minutes reflecting the committee decisions and actions of each meeting.

### Clinical Operations Committee (COC)

The COC is responsible for conducting annual review and approval of medical and behavioral health clinical practice guidelines and medical necessity hierarchy and criteria. This process ensures the delivery of age-appropriate, evidence-based care aligned with industry standards for members. The COC also evaluates program performance, identifies findings and opportunities for improvement, and makes recommendations to the QIHEC. Clinical practice guidelines are reviewed by the COC and QIHEC at least annually.

The committee is chaired by the Executive Director of Clinical Operations and the Chief Medical Officer and reports to the QIHEC.

### Compliance Committee

The Compliance committee is responsible for assisting the Health Commission Board of Directors in overseeing Health Plan's Compliance Program.

The Committee is Chief Regulatory Affairs & Compliance Officer and reports to the CEO and Board of Directors.

The committee:

- Manages DHCS and CMS contracts, laws and regulations applicable to regulatory requirements.
- Ensures compliance with policies, as applicable to D-SNP; by employees, officers, directors, and other agents of the company.
- Establishes measures that prevent and detect, and correct fraud, waste and abuse or other incidents of non-compliance.

### Community Advisory Committee (CAC)

The CAC serves as Health Plan's Member Advisory Committee & is chaired by the Manager of Health Education. The CAC establishes and monitors Health Plan's relevant public policies:

- Transportation availability
- Language requirements
- Cultural issues
- Member health education needs
- The CAC also solicits, reviews and makes recommendations on ways to improve access to covered services, coordination of services, and health equity for underserved populations.

Through the Committee, Health Plan:

- Routinely engages with members and their families through focus groups, listening sessions, surveys and/or interviews and incorporate results into policies and decision-making when appropriate.
- Maintains the process for incorporating member, and their family's, input in policies and decision-making.
- Monitors and measure the impact of the above.
- Maintains processes to share with members and families on how their input impacts Health Plan policies and decision-making.

Committee members include, but are not limited to;

- Comprised of the population enrolled in D-SNP or other individuals representing those members. Factors such as racial ethnic representation, language, demography, occupation, and geography are considered in the selection of the committee's members.

### Pharmacy and Therapeutics (P&T) Committee

The P&T Committee is responsible for ensuring members receive high quality, safe and efficacious medication therapy. The Committee promotes the appropriate use of high quality and cost-effective pharmaceuticals for members and ensures compliance with state and federal regulations.

The committee is co-chaired by the Director of Pharmacy and the Medical Director and reports to the Clinical Operations Committee.

The committee:

- Is a multidisciplinary committee with a majority of physician and pharmacist members from the community.
- The committee meets at least quarterly.
- Members of the P&T Committee are: Chief Medical Officer, Director of Pharmacy, five practicing physicians in primary and specialty care, one pharmacist, and additional specialists.
- Reviews, oversees, and approves Health Plan's prescription drug formulary
- Identifies processes to evaluate pharmacy safety and effectiveness.
- Ensures the reliable function and maintenance of a notification system for drug alerts.
- Develops, approves, and maintains pharmacy criteria, policies and procedures that ensure safe and effective formulary management and authorization processes.
- Reviews pharmacy data and reports and makes recommendations for improvement.
- Establishes and oversees specialty advisory panels, as necessary, to provide expert opinion on clinical matters for P&T Committee consideration.
- Develops and approves member and Provider education to address member safety.
- Oversees the PBM to ensure practices meet Health Plan's quality standards.
- Submits to the Commission approved, signed minutes reflecting the committee decisions and actions of each meeting.

## NETWORK PROVIDER COMMITTEE PARTICIPATION

Contracted Providers are expected to cooperate with Health Plan's QIHE activities to improve the quality of care and service, to reduce health disparities and to improve member experience. Cooperation includes collection and evaluation of data and participation in Health Plan's QIHE programs. Providers understand that Health Plan may use Provider performance data for quality improvement activities.

All Providers who participate on our QIHECs or subcommittees receive a stipend for each meeting attendance. If you have an interest in being a participant on one of these committees, please email QIHE@hpsj.com.

## QUALITY OF CARE ISSUES

Potential quality of care issues are related to whether the quality of covered services provided by a plan or provider meets professionally recognized standards of health care (e.g., misdiagnosis, inappropriate treatment, care received or not received adversely impacted health).

### MONITORING QUALITY OF CARE ISSUES

Health Plan has a process for identifying and receiving reports of potential quality of care issues and responding to the Beneficiary and Family Centered Care Quality Improvement Organization (BFCC-QIO), designated as the review agent for CMS, within 14 calendar days when notified that it has received a quality-of-care grievance. Health Plan uses licensed personnel to perform case reviews, investigate potential quality of care issues, and determine the severity of the issue. Based upon these investigations, Health Plan will determine the appropriate follow-up action required for individual cases and comply with BFCC-QIO instructions. Health Plan will also aggregate potential quality of care issues data to help identify problems within the Provider network.

### REPORTING A POTENTIAL QUALITY OF CARE ISSUES

Members, Providers, and Health Plan staff may report quality of care issues. A quality-of-care issue may be reported to a Quality Management Nurse using the Clinical Potential Quality Issue Report Form. Providers and members can also report quality of care issues by contacting the Customer Service Department at 888-361-7526.

**Processing Quality of Care Issues**

Upon receipt of a Potential Quality Issue Report Form or notification by the BFCC-QIO that a member has filed a quality-of-care grievance, Health Plan's Quality Management staff will date stamp, log, and document/evaluate the reasons/screening criteria for quality-of-care issues and ensure that all supporting documentation is gathered and included.

- Quality of care issues are prioritized based on the urgency of review or due date of response to the BFCC-QIO.
- The Quality Improvement Nurse initiates an investigation of the quality-of-care issues by requesting and reviewing pertinent medical records and eliciting input from Member and Providers involved.

- All quality-of-care issues are reviewed by a Medical Director, or designee, to substantiate if the case can be closed or is determined to be a quality issue.
- Quality of care issues are assigned an action code directing the course for resolution and/or escalation to PRCC review.

**Communication to Provider or Party Filing the Complaint**

- Each quality-of-care issue is reviewed by a Medical Director who designates an action code that may indicate/ requirement to notify the Provider in writing.

**Medicare Stars Program – Overview for Primary Care Physicians**

The Medicare Star Ratings Program is a quality measurement system used by the Centers for Medicare & Medicaid Services (CMS) to evaluate Medicare Advantage (MA) and Part D prescription drug plans. Plans are rated from 1 to 5 stars, with 5 stars indicating excellent performance.

For primary care providers, performance in the Stars Program matters because clinical quality, patient experience, and care coordination metrics directly influence a plan's rating — and ultimately, bonus payments and enrollment for health plans.

Key Areas Affecting PCPs

- Clinical Outcomes:
  - Control of chronic conditions (e.g., diabetes A1c, blood pressure, cholesterol).
  - Preventive screenings (e.g., cancer screenings, annual wellness visits).
- Patient Experience:
  - Member satisfaction surveys (CAHPS).
  - Access to care, communication quality, and follow-up after visits.
- Medication Management:
  - Adherence to medications for chronic conditions.

Why It Matters

- High star ratings lead to bonus payments for health plans that can fund provider incentives, quality programs, and better resources for members.
- Providers who deliver high-quality, coordinated, patient-centered care directly contribute to better Star Ratings.

## HEALTH CARE EFFECTIVENESS DATA AND INFORMATION SET (HEDIS)

HEDIS consists of a set of performance measures utilized by Health Plan to compare how well a plan performs in the following areas:

- Effectiveness of care
- Effectiveness of care, prevention, screening, care coordination

- Access and availability of care
- Experience of care
- Utilization and risk-adjusted utilization
- Health Plan descriptive information

Improving a practice's HEDIS scores has benefits for Providers and Members. Consistently performing well in HEDIS measures can help save Providers time while also potentially reducing health care costs. By proactively managing members' care, Providers can effectively monitor members' health, prevent further complications and identify issues that may arise with Health Plan has tools that are available to PCPs to increase and improve HEDIS measures. HEDIS measures impact the Providers and Health Plan's compliance with DHCS, DMHC and CMS. Please contact the Provider Services Department at 1-888-361-7526 for information on HEDIS tools.

### TIPS FOR IMPROVING HEDIS SCORES

- Keep accurate, legible, and complete medical records for all members. Each document in the medical record must contain the member name and date of birth to be acceptable for HEDIS.
- If paper charts are used, document the member's full name and date of birth on the front and back of every page.
- Send out reminders and follow up with members for all U.S. Preventive Services Task Force (USPSTF) grade A and B preventive services guidelines.
- Encourage members to keep appointments for appropriate preventive services.
- Document in the members chart when preventive or other services are completed or are declined.
- Make sure that staff is familiar with HEDIS measures to understand which measures health plans are required to report.
- Report accurate claims and encounter data timely to the health plan.

## CLINICAL PRACTICE GUIDELINES

Providers can access *Clinical Practice Guidelines* on Health Plan's website at www.hpsj-mvhp.org. *Clinical Practice Guidelines* are guidelines about a defined task or function in preventive care and clinical practice, such as desirable diagnostic tests or the optimal treatment regimen for a specific diagnosis; generally based on the best available clinical evidence. The health plan adopts nationally recognized peer reviewed published guidelines.

## ENROLEE EXPERIENCE SURVEY

IN. The survey is called the Consumer Assessment of Health Plan Providers and Systems (CAHPS). The questions are designed to measure access, quality, and satisfaction with Health Plan. The results are then analyzed by Health Plan's HEDIS and Accreditation team and reported to the QIHEOC. Member results are trended and when patterns emerge, action plans are formalized into service expectations which are evaluated as often as quarterly when warranted, then progress against goals are monitored and activities are prioritized for the following year. The results are analyzed in relation to grievance trends, then measured each year to document Health Plan's commitment to serving our communities' health care needs.

## HEALTH OUTCOMES SURVEY (HOS)

Annually, NCQA administers an industry standard survey instrument utilizing a contracted certified survey vendor targeting a new cohort of members enrolled with Health Plan's D-SNP. The same cohort is reassessed two years later. The questions are carefully selected to measure member-reported health outcomes. The goal of HOS program is to gather valid and reliable clinically meaningful data that have many uses, such as monitoring health plan performance and rewarding top-performing health plans; helping people with Medicare make informed health care choices; and advancing the science of functional health outcomes measurement.

The results are analyzed by Health Plan's Quality Improvement and Medical Management teams and reported to the QIHEOC. Surveys are sent to a random sample of members. Results are trended and when patterns emerge, action plans are formalized into service expectations which are evaluated quarterly, progress against goals are monitored and activities are prioritized for the following year. The results are then measured each year to document Health Plan's commitment to serving our community's health care needs.

## PROVIDER SATISFACTION SURVEY

Each year, Health Plan Providers are surveyed by an independent survey company that surveys all PCPs, and a random selection of specialists and ancillary Providers. Results are reviewed by both Health Plan leadership and various departments within Health Plan. Action plans are incorporated into goals and objectives for the following year to address issues identified by the Provider community.

## MEMBER SAFETY

Health Plan is committed to a culture of member safety as a high-level priority. On an ongoing basis, Health Plan fosters a member safety culture that is communicated throughout the organization. Health Plan is committed to developing and implementing activities to improve member safety and clinical practice.

Health Plan defines member safety as "freedom from accidental injury caused by errors in medical care." Medical errors refer to unintentional, preventable mistakes in the provision of care that have actual or potential adverse impact on members.
Members, their families, Providers, and Health Plan staff, are able to report errors or close calls without fear of reprisal and where errors can be viewed as opportunities for improvement.

Health Plan's commitment to member safety is demonstrated through the identification and planning of appropriate member safety initiatives. The member safety initiatives promote safe health practices through education and dissemination of information for decision-making and collaboration between our Providers and members, and through:

- Evaluation of pharmacy data for Provider alerts about drug interactions, recall, and pharmacy over and under-utilization.

- Education of Providers regarding the availability and use of clinical practice guidelines. members are educated about the use of guidelines using member facing health education materials.
- Education of Providers regarding improved safety practices in their practice through the Provider newsletter, member profiles, and Health Plan website.
- Evaluation for safe clinic environments during office site reviews and dissemination of information regarding FSR findings and important safety concerns to members and providers.
- Education to members regarding safe practices at home through health education Intervention for safety issues identified through case management, and the grievance and clinical case review processes.
- Evaluation and analysis of data collected regarding hospital activities relating to member safety, including but not limited to the rate of hospital-acquired infections and all cause re-admissions within 30 calendar days of discharge.
- Collaboration and exchanges information between the hospital and PCP when members are admitted to and discharged from acute care facilities.
- Dissemination of information to Providers and members regarding activities in the network related to safety and quality improvement.
- Monitoring Hospital safety scores using publicly reported Leapfrog data: www.leapfroggroup.org/cp.

Health Plan receives information about actual and potential safety issues from multiple sources including, Member and Provider grievances, potential quality issues, pharmacy data, and through FSR CAPs.

# SECTION 14: PHARMACY

## PHARMACY SERVICES

Health Plan Advantage D-SNP's Pharmacy Department is dedicated to providing high quality, cost-effective pharmaceutical care to Enrollees and to working with Providers to achieve the best clinical outcomes.

## DEFINITION OF A PART D DRUG

Part D drug is defined under D-SNP as a prescription drug that meets the following criteria:

- A drug or biological that is dispensed only by prescription.
- Approved by the U.S. Food and Drug Administration (FDA) under the Federal Food, Drug, and Cosmetic Act (FFDCA)
- A biological licensed under the Public Health Service Act
- Insulin used for self-administration without a pump (including certain medical supplies associated with injection of insulin such as syringes, needles, and alcohol swabs)
- A vaccine not covered under Part B and is recommended by the Advisory Committee on Immunization Practices (ACIP) for routine use in adults

The drug must be used for a medically accepted indication that facilitates diagnosis or treatment of illness, injury, or to improve the functioning of a malformed body member (except for vaccines).

## EXCLUDED FROM PART D COVERAGE

Per the Centers for Medicare & Medicaid Services (CMS) regulations, the following categories are **excluded** from Part D coverage:

- Drugs for anorexia, weight loss or weight gain.
- Drugs to promote fertility
- Drugs for cosmetic purposes or hair growth
- Cough and cold preparations (unless specifically approved by CMS for certain clinical situations)
- Prescription vitamins and minerals (except prenatal vitamins and certain formulations of niacin, fluoride, or Vitamin D)
- Outpatient drugs for which payment is available under Medicare Part A or Part B
- Over the counter (OTC) products

## PART B COVERAGE

Medicare Part B covers drugs that are administered by a healthcare professional or through certain medical equipment. These medications cannot be self-administered and are provided in a clinical setting such as physician office, hospital outpatient department or infusion centers. Drugs used with durable medical equipment (DME) such as insulin pumps or nebulizers are also covered under Part B.

In addition, Part B also covers certain preventive vaccines such as influenza, pneumococcal, hepatitis B (for high or medium risk individuals) and COVID vaccines.

Certain drugs can be covered under Part D or Part B depending on the diagnosis, setting and route of administration. Examples include:

- Insulin is covered under Part B only if administered via insulin pump; otherwise, it's covered under Part D.
- Oral anti-cancer drugs may be covered under Part B if they are the oral equivalent of an IV medication.
- Immunosuppressive drugs are covered under Part B only for Enrollees who received a Medicare-covered organ transplant.

For additional information about Part B versus D coverage, Providers should refer to CMS Medicare Prescription Drug Benefit Manual, Chapter 6.
https://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/Downloads/Part-D-Benefits-Manual-Chapter-6.pdf

## PART D FORMULARY

Health Plan Advantage D-SNP maintains a CMS-approved Medicare Part D formulary that is reviewed and updated regularly to ensure safety, clinical effectiveness and cost-effectiveness.

The formulary is available online as a searchable site (https://client.formularynavigator.com/Search.aspx?siteCode=0143685768) as well as a pdf document under the "Formulary (Drug List)" tab (https://www.hpsj.com/d-snp-member-materials/#forms).

Some drugs on the formulary require a prior authorization (PA) or step therapy (ST) or quantity limit (QL) requirement to ensure appropriate use. The prior authorization and step therapy criteria are posted on Health Plan Advantage D-SNP's website, and can be accessed through the searchable site https://client.formularynavigator.com/Search.aspx?siteCode=0143685768 or through a pdf document under the "Other Drug Lists" tab (https://www.hpsj.com/d-snp-member-materials/#forms).

## COVERAGE DETERMINATION

A coverage determination is an initial decision by Health Plan Advantage D-SNP about whether a Part D drug can be covered. A coverage determination is required when the drug is:

- Covered in formulary with a(n) ST or PA or other utilization management restriction.
- Not on the formulary (exception request).

Providers can request a coverage determination via one of the following:

- Electronic PA: https://mp.medimpact.com/partdcoveragedetermination
- Fax: 858-790-7100
- Phone: 833-546-0796

Coverage determinations are either standard or expedited depending on the urgency of the request. Providers are encouraged to supply complete clinical documentation to support the medical necessity of the requested drug when submitting the coverage determination or formulary exception request.

Once all required supporting information is received, a coverage decision, based upon medical necessity, is provided within 24 hours for an expedited request and 72 hours for a standard request.

## APPEALS

A Part D appeal is the process by which an Enrollee, his/her appointed representative or prescribing physician can request a review of a denied drug coverage determination by Health Plan Advantage D-SNP.

Additional information about Part D appeals can be found in Section 12 of this provider manual.

## PHARMACY NETWORK

Health Plan Advantage D-SNP has a network of contracted pharmacies that meet requirements for access and service. Network pharmacies include retail, mail order, long-term care and home infusion pharmacies. A listing of all network pharmacies can be found on our website at www.hpsj-mvhp.org

Certain medications, particularly those used to treat complex, chronic or rare conditions, are dispensed through Health Plan Advantage D-SNP's specialty pharmacies. These pharmacies meet accreditation standards and offer enhanced services to ensure appropriate use of the specialty drugs. Providers will be notified if the prescribed drug requires fulfillment through a designated specialty pharmacy to ensure coordination and prompt initiation or continuation of therapy.

## MEDICATION THERAPY MANAGEMENT (MTM)

MTM is a clinical service offered free of charge to eligible Medicare Part D beneficiaries who meet certain criteria based on factors such as multiple chronic conditions, concurrent use of multiple Part D medications, and a high annual drug spend. The primary goals of MTM are to optimize therapeutic outcomes, improve medication adherence, reduce adverse drug events, prevent drug-disease problems, and identify cost-effective therapeutic alternatives. Detailed information about MTM can be found on Health Plan Advantage D-SNP's INwebsite https://www.hpsj.com/medication-therapy-management/.

MTM services include a Comprehensive Medication Review (CMR) delivered in person to the Enrollee and Targeted Medication Reviews (TMRs) focusing on specific issues such as duplication of therapy, drug-drug interactions and gaps in care.

Providers play a critical role in the MTM process and may be contacted to review clinical recommendations and make decisions regarding proposed medication changes. Providers are encouraged to review MTM communications and consider the recommendations in a timely manner. Active Provider engagement helps support care coordination, especially if more than one physician is involved in the patient care and helps improve health outcomes.

## DRUG MANAGEMENT PROGRAM (DMP)

Health Plan Advantage D-SNP has a DMP to help prevent misuse or abuse of opioids and frequently abused drugs (FADs). The DMP is designed to identify Enrollees who may be at risk for prescription drug misuse based on utilization patterns such as high opioid usage, multiple prescribers or pharmacies or history of drug overdose.

The DMP is not intended to hinder access to medically necessary drugs but rather to enhance patient safety and reduce the risk of adverse events associated with high-risk drugs; as such, conditions such as cancer pain, sickle cell disease and hospice patients are excluded from the program.

Once identified through a data-driven and case review process, potentially at-risk enrollees may be placed under drug management interventions, which can include limiting their access to specific prescribers and/or pharmacies for controlled substance prescriptions. Before any limitation is implemented, the patient, his/her prescribers and selected pharmacy are notified and given an opportunity to provide input.

Providers play a key role in the DMP process. They are contacted to provide clinical input regarding a patient's diagnosis, current opioid therapy, history of pain management, or risk of misuse. Providers may be asked to participate in a case review and assist in developing a care plan or determining whether prescriber/pharmacy limitations are clinically appropriate. This type of cooperation is essential to ensuring safe and coordinated care.

Additional information about the DMP program can be found at:
https://www.cms.gov/medicare/coverage/prescription-drug-coverage-contracting/improving-drug-utilization-review-controls-part-d.

# SECTION 15: REGULATORY COMPLIANCE

## REGULATORY COMPLIANCE

Providers are subject to a broad range of compliance regulatory requirements to ensure ethical operations and patient safety. These requirements are established by federal and state laws, accreditation bodies, and Health Plan Advantage D-SNP guidelines. Key responsibilities include:

- Adherence to Federal and State Laws: Providers must observe statutes such as the Health Insurance Portability and Accountability Act (HIPAA) for patient privacy, the False Claims Act to prevent fraudulent billing, the Anti-Kickback Statute, and other relevant healthcare regulations.
- Accurate Documentation and Billing: Medical records and billing should accurately reflect the services provided, supported by documentation that satisfies legal and Health Plan Advantage D-SNP requirements.
- Protecting Patient Information: Protocols are established to maintain the confidentiality and integrity of patient health information through secure storage, restricted access, and appropriate disposal of records.
- Staff Training and Education: Ongoing compliance training is necessary so that all staff understand applicable laws, policies, procedures, and reporting processes for potential violations.
- Internal Monitoring and Auditing: Regular audits and assessments help identify compliance issues and address them prior to regulatory action.
- Prompt Reporting and Corrective Action: Any suspected non-compliance or misconduct, including fraud, waste, and abuse (FWA), is to be reported through designated compliance channels. Corrective actions and documentation of any remediation are used to demonstrate compliance with regulations.

Following these regulatory requirements helps providers manage legal and financial risks, as well as support consistent standards of patient care. Routine review of compliance standards and attention to regulatory updates are part of ongoing compliance efforts in healthcare settings.

## COMPLIANCE POLICY

Health Plan Advantage D-SNP enforces a strict zero-tolerance policy regarding fraud, waste, abuse, and any inappropriate activities. Any individual found participating in such behaviors whether independently or in concert with an employee, Enrollee, or Provider will face legal action and immediate disciplinary measures, up to and including termination of employment or contract Health Plan Advantage D-SNP has implemented comprehensive fraud prevention and detection programs to safeguard our Enrollees, the government, and the organization from incurring undue costs for services.

# SECTION 15: REGULATORY COMPLIANCE

## FRAUD, WASTE, AND ABUSE (FWA)

Health Plan Advantage D-SNP is committed to full compliance with all applicable federal and state laws relating to fraud, waste, and abuse. The organization enforces policies and procedures designed to detect and prevent instances of fraud, waste, and abuse in claims submitted to federal and state healthcare programs and ensures protection for individuals who report actual or suspected violations in good faith.

Additionally, Health Plan Advantage D-SNP is obligated to refer any potential fraud or misconduct associated with Medicare Advantage and Prescription Drug programs to the Health and Human Services Office of Inspector General's Medicare Drug Integrity Contractor (MEDIC). Potential or suspected cases of fraud, waste, and abuse are forwarded to other sponsors, State Medicaid programs, Medicaid Fraud Control Units (MCFUs), commercial payers, and other organizations, as appropriate.

The Centers for Medicare & Medicaid Services (CMS) use strict protocols to detect and address FWA, with the Medicare Drug Integrity Contractor (MEDIC) playing a key role under the HHS Office of Inspector General. Organizations in Medicare Advantage and Prescription Drug programs are required to report suspected or confirmed FWA cases to CMS MEDIC.

MEDIC serves as the investigative arm for CMS, tasked with identifying, investigating, and referring cases of potential FWA in Medicare Advantage and Prescription Drug programs. Its goal is to protect program integrity, ensure compliance, and recover improperly paid funds.

### FWA Defined

**Fraud** refers to the deliberate act of deceiving, concealing, or misrepresenting information in order to unlawfully acquire money or property from any health care benefit program. Acts of fraud involving Medicare or Medicaid are classified as criminal offenses.

**Waste** is overusing services or other practices that directly or indirectly result in unnecessary costs to any health care benefit program.

**Abuse** is performing actions that directly or indirectly result in unnecessary costs to any health care benefit program. Abuse can also include any practice that doesn't provide patients with medically necessary services or meet professionally recognized standards.

The difference depends on circumstances, intent, and knowledge.

### FWA Case Handling

Health Plan Advantage D-SNP performs audits to monitor compliance with standards, including but not limited to, billing requirements, adherence to appropriate coding guidelines, NCCI (CMS National Correct Coding Initiative), and clinical policies. These audits can be used to identify the following examples of activities:

- Inappropriate "unbundling" of codes
- Inappropriate use of modifiers
- Claims for services not provided
- Up-Coding/Incorrect coding
- Potential overutilization
- Coding (diagnostic or procedural) not consistent with the Enrollee's age/gender
- Improper use of benefits
- Use of exclusion codes
- High number of units billed
- Provider exclusion and preclusion from Federally funded health care programs

Health Plan Advantage D-SNP maintains a confidential and anonymous 24/7 online reporting system available through both the external and internal website for employees, Enrollees, Commission Members, and FDRs. Syntrio is a vendor who collects the information electronically and forwards it to the Chief Regulatory Affairs and Compliance Officer or their designee. Every effort will be made to maintain confidentiality of the reporting to the extent permitted by law. Reporters wishing to remain anonymous are issued a PIN that enables them to follow up or get the status of an existing report through the Syntrio system. All reports made through this link http://www.lighthouse-services.com/hpsj can be anonymous.

Providers can also email piu@hpsj.com to report suspected FWA cases.

Health Plan Advantage D-SNP also maintains:

- A compliance hotline (855) 400-6002
- Or direct reporting to compliance offices for staff and external parties to submit FWA concerns.

Once a complaint is received, Health Plan Advantage D-SNP conducts a full investigation. Providers are expected to cooperate and respond to requests within 30 days. Requests may include but are not limited to:

- Medical records
- Electronic data
- Copies of claims, invoices and other supporting documents
- Allowing access to all involved office staff or subcontracted personnel for interviews, consultation, conferences, hearings, and for any other activities required in an investigation.
- Other requests associated with the FWA investigation

Health Plan Advantage D-SNP will refer the case and supporting documentation to the NBI MEDIC within 30 days of discovery, as appropriate unless the NBI MEDIC specifies otherwise.

In instances where the NBI MEDIC requires information in less than 30 days, all parties involved will be notified as soon as possible. Sponsors should provide updates to the NBI MEDIC when new information regarding the matter is identified. Health Plan Advantage D-SNP will also refer the subjects of FWA cases to state licensing boards through the California Department of Consumer Affairs when the evidence gathered warrants a referral.

## OTHER REGULATIONS THAT GOVERN FWA

**False Claims Act**

The False Claims Act is a federal law that makes it a crime for any person or organization to knowingly make a false record or file a false claim regarding any federal health care program, which includes any plan or program that provides health benefits, whether directly, through insurance or otherwise, which is funded directly, in whole or in part, by the United States Government or any state healthcare system.

"Knowingly" means:

- Actual knowledge of the information.
- Deliberate ignorance of the truth or falsity of the information.
- Reckless disregard of the truth or falsity of the information.
- Doesn't require proof of specific intent to defraud.

California False Claims Act (FCA) is more stringent than the Federal False Claims Act, because the FCA permits the Attorney General to bring a civil law enforcement action to recover treble damages and civil penalties against any person who knowingly makes or uses a false statement or document to either obtain money or property from the State or avoids paying or transmitting money or property to the State.

The California FCA also allows the "whistleblower" to receive a higher percentage of the recoveries and to participate even when prosecuted by the Department of Justice (DOJ) or Office of Attorney General (OAG).

Under the civil FCA, each instance of an item or a service billed to Medicare or Medi-Cal counts as a claim. California penalties start at $10,000 per claim.

There also is a criminal FCA. Criminal penalties for submitting false claims include imprisonment and criminal fines.

The federal False Claims Act protects employees who report violations under the False Claims Act from discrimination, harassment, suspension, or termination of employment as a result of reporting possible fraud. Employees who report fraud and consequently suffer discrimination may be awarded:

- Two (2) times their back pay plus interest.
- Reinstatement of their position without loss of seniority.
- Compensation for any costs or damage they incurred.

### Anti-Kickback Statutes 42 U.S. Code §1320a–7b

Federal and California State Anti-Kickback laws establish criminal penalties for individuals and entities that knowingly solicit or receive any remuneration in exchange for referring an individual to a Provider for services covered by Medicaid or Medicare programs. Remuneration may include money, goods, or services of value, and such exchanges are prohibited under these statutes.

### Stark Law and Physician Self-Referral Provisions 42 U.S. Code §1395nn

The Federal Physicians Self-Referral Law, commonly known as the "Stark Law," prohibits physicians from referring Medicare and Medicaid patients for health services to entities in which they have a financial interest such as ownership, investment, or structured compensation arrangements unless a specific exception applies.

Under the Stark Law, entities are also barred from submitting claims or bills for services rendered as a result of prohibited referrals.

Violations of the Stark Law may result in civil monetary penalties and exclusion from participation in Medicare and Medicaid programs.

Suspected violations must be reported to the Centers for Medicare and Medicaid Services (CMS) through the established self-disclosure protocol.

### FWA Compliance Requirements for First Tier, Downstream, Related Entities (FDRs), and Affiliates

Health Plan Advantage D-SNP is committed to ensuring that all contracted First Tier, Downstream, and Related Entities (FDRs), as well as Affiliates, comply with applicable state and federal regulations. These entities provide administrative and healthcare services to our enrollees, and Health Plan Advantage D-SNP remains ultimately responsible for meeting the terms of our contract with the Centers for Medicare and Medicaid Services (CMS), including all Medicare and Medicaid program requirements.

To uphold these standards, Health Plan Advantage D-SNP requires each FDR and Affiliate to adhere to compliance and fraud, waste, and abuse (FWA) expectations. Upon entering into a contract and annually thereafter, an authorized representative from each organization must complete an attestation confirming compliance with standards of conduct, compliance policies, exclusion and preclusion screenings (OIG, GSA/SAM, OMIG), and the publication of FWA and compliance reporting mechanisms.

Health Plan Advantage D-SNP must also report offshore subcontractor information to CMS and attest to the protection of beneficiary Protected Health Information (PHI). Therefore, FDRs and Affiliates must disclose the name, address, and delegated function of any offshore subcontractors used for Health Plan Advantage D-SNP business.

If an FDR or Affiliate is found to be non-compliant with any of these requirements, they must develop and submit a Corrective Action Plan (CAP Health Plan Advantage D-SNP will support the entity in resolving the identified issues.

Additionally, First Tier entities are responsible for ensuring that their downstream and related entities comply with Health Plan Advantage D-SNP policies and all applicable federal and state laws and regulations.

## Health Insurance Portability and Accountability Act (HIPAA)

The Health Insurance Portability and Accountability Act (HIPAA) is a federal law that requires Health Plan Advantage D-SNP and all network Providers to protect the security and maintain the confidentiality of Enrollee's Protected Health Information (PHI). PHI includes, but is not limited to, an Enrollee's name, address, phone number, medical information, social security number, ID Card number, date of birth, and other types of personal information. Additionally, Health Plan Advantage D-SNP considers Enrollee Personal Information (PI), such as, race/ethnicity, language, gender identity, and sexual orientation the same as PHI and applies the same safeguards.

In addition to Health Insurance Portability and Accountability Act (HIPAA) 45 CFR Parts 160 and 164, Health Plan Advantage D-SNP's contracted providers are also required to abide by the applicable laws and regulations imposed on the Health Plan Advantage D-SNP by both state and federal government agencies listed below:

1. Centers for Medicare and Medicaid Services (CMS) Contract
2. Health Information Technology for Economic and Clinical Health Act (HITECH Act)
3. Confidentiality of Medical Information Act (CMIA) section 56 et al
4. State Medicaid Agency Contract (SMAC)The Knox-Keene Health Care Service Plan Act of 1975, as amended
5. California Consumer Privacy Act of 2018 Section 1798.100
6. Information Practices Act (IPA) at California Civil Code section 1798.3(a)
7. The Privacy Act 5 U.S.C. 552a, as amended

When this Manual refers to "PHI/PI", it is collectively referring to PHI and PI including race/ethnicity, language, gender identity, and sexual orientation.

### Protecting PHI/PI at Provider Sites

Providers are additionally required by 45 CFR parts 160 and 164 to implement a comprehensive program to avoid unpermitted disclosure of PHI/PI. Providers are required to implement a training program, and to have detailed office policies and procedures in place in order to comply with HIPAA requirements. These policies and procedures should include, but are not limited to:

- Keeping medical records secure and inaccessible to unauthorized access

- Limiting the access of information to only authorized personnel, Health Plan Advantage D-SNP, and any regulatory agencies
- Ensuring that confidential information is not left unattended in a reception or patient care area
- Safeguarding discussions in front of other patients or unauthorized personnel
- Providing secure storage for medical records
- Using encryption procedures when transmitting patient information
- Maintaining computer security
- Securing fax machines, printers, and copiers
- Having published Privacy Practices

**Treatment, Payment and Operations**

Enrollee PHI/PI can be appropriately disclosed for treatment, payment and operations. Below are examples that apply. (This is not an all-inclusive list):

- Verifying eligibility and enrollment
- Authorization for covered services
- Claims processing activities
- Enrollee contact for appointments
- Investigating or prosecuting Medicare and Medi-Cal cases (i.e., fraud)
- Monitoring quality of care
- Medical treatment
- Case management/disease management
- Providing information to public health agencies permitted by law
- In response to court orders or other legal proceedings
- Appeals/grievances
- Requests from State or Federal agencies or accreditation agencies
- Providers must obtain specific written permission to use PHI/PI for any reason other than the ones listed above

**Member Rights to Confidential Communications 45 CFR Part 164.522**

Providers are required to take specified steps to protect the confidentiality of an Enrollee's medical information:

- An individual's reasonable request for communications to be sent to an alternative mailing address, email address, or telephone number should be accommodated by a Provider.

- If an individual clearly states that a disclosure of all or part of their PHI could endanger them, then the Provider must accommodate the reasonable request made by the individual to receive communications about his/her PHI by alternative means or at alternative locations.
- Providers are not allowed to require an explanation from an individual as to what the basis is for the request of confidential communications as a condition of honoring the confidential communications request.

**HIPAA Part 2 Final Rule Confidentiality of Substance Use Disorder Patient Records (SUD)**

HIPAA Part 2 Final Rule for Substance Use Disorder (SUD) has additional provisions that provide an added layer of protection with regard to services and treatment for SUD. These protections align the confidentiality requirements of SUD treatment records more closely with standard HIPAA regulations to improve patient care coordination, while maintaining specific, stricter privacy protections.

- A single consent from an Enrollee is sufficient for Providers to use for all future uses and disclosures for treatment, payment, and health care operations. Providers who receive records under this consent are allowed to redisclose records in accordance with HIPAA regulations.
- Providers are permitted to disclose records without Enrollee consent to public health authorities, if the records disclosed are de-identified according to the standards established in the HIPAA Privacy Rule.
- Providers are not allowed to use the records and testimony in civil, criminal, administrative, and legislative proceedings against Enrollees, absent the Enrollees' consent or a court order.
- Providers are not allowed to combine Enrollee consent for the use and disclosure of records for civil, criminal, administrative, legislative proceedings with Enrollee consent for any other use or disclosure.
- Providers are required to obtain a specific separate consent from Enrollees to disclose their SUD clinician notes analyzing the conversation in a SUD counseling session. SUD Clinician notes cannot be used or disclosed based on a broad TPO consent.

**Psychotherapy Notes Disclosure Requirements 45 CFR §164.508**

Under HIPAA, Psychotherapy notes receive heightened confidentiality. Psychotherapy notes are the private, separate records created by a mental health professional to document observations, thoughts, and feelings during a counseling session, distinct from an Enrollees general medical record. Therapy records for survivors of sexual violence are an example of psychotherapy notes. Psychotherapy notes require an Enrollees explicit written authorization for disclosure on a separate and independent document. However, in cases of legal requirements or serious threats to health or safety they can be disclosed without an Enrollees permission. They are also required to be kept separate from the rest of an Enrollees medical record.

In order to disclose an Enrollees psychotherapy notes, a Provider must obtain a separate written authorization from the Enrollee specific to the disclosure of psychotherapy notes, that includes the following requirements:

- A description of the information to be disclosed
- The identity of the person or class of persons who may disclose the information
- To whom the information may be disclosed
- A description of the purpose of the disclosure
- An expiration date for the authorization
- The signature of the person authorizing the disclosure as well as the date it was signed

**Access, Inspect, and Obtain Medical Records 45 CFR §164.524**

Providers must ensure that their medical records systems allow for prompt retrieval of medical records and that these records are available for review whenever the Enrollee seeks services. Enrollee medical records should be maintained in a way that facilitates an accurate system for follow-up treatment and permits effective medical review or audit processes.

Medical records should be provided to Enrollees upon reasonable request and should be organized, legible, signed, and dated.

**Minimum Necessary 45 CFR 164.502(b) and 164.514(d)**

The minimum necessary standard requires covered entities to evaluate their practices and enhance safeguards as needed to limit unnecessary or inappropriate access to and disclosure of protected health information (PHI). The Privacy Rule generally requires covered entities to take reasonable steps to limit the use or disclosure of, and requests for, PHI to the minimum necessary to accomplish the intended purpose.

## BREACHES OR UNAUTHORIZED DISCLOSURES OF PHI

**Reporting A Suspected or Confirmed Breach 45 CFR §164.400–164.414**

A breach is an unauthorized disclosure of PHI/PI that violates either Federal or State laws or PHI/PI that is reasonably believed to have been acquired by an unauthorized person. This could include, but is not limited to:

- Release of an Enrollee's PHI/PI to unauthorized persons.
- Misplacing or losing any electronic devices (e.g., thumb drive, or laptop) that contain PHI/PI.
- Unsecured PHI/PI, if the PHI/PI is reasonably believed to have been accessed or acquired by an unauthorized person.
- Any suspected privacy or security incident which risks unauthorized access to PHI/PI and/or other confidential information.

- Any intrusion or unauthorized access, use or disclosure of PHI/PI; or
- Potential loss of confidential information.

**Provider Reporting Obligations**

**Notify Health Plan Advantage D-SNP**

If a Provider becomes aware of a suspected breach, the Provider must notify Health Plan Advantage D-SNP within 24 hours of discovery of the incident/breach. Specifically, notify Health Plan Advantage D-SNP's PIU Department upon the discovery of the incident/breach by emailing or calling the Privacy Officer at the following email or phone number.

Privacy Officer
Email: piu@hpsj.com
Telephone: (855) 400-6002 (Compliance Hotline)

The Provider should complete the following actions upon discovery of a suspected or confirmed incident/breach, security breach, intrusion, unauthorized access, use, or disclosure of PHI/PI:

1. Immediately investigate such security incident or breach.
2. Take prompt action to mitigate any risks or damages involved with the security incident or breach, which should include attempting to retrieve the PHI/PI if possible.
3. Act as required by applicable Federal and State law.

**Notification to Health and Human Services, Office of Civil Rights (OCR)**

Providers must report breaches to OCR at the appropriate interval per the number of affected beneficiaries (<500 beneficiaries report within 60 days after the end of the calendar year, and >500 beneficiaries report within 60 days of discovery of the breach).

**Member Notifications**

Providers are responsible for notifying members of breaches, as well as for the cost to do so. The notifications must comply with applicable Federal and State law. If the cause of a breach of PHI/PI is attributable to the Provider or its subcontractors, the Provider is required to complete all required reporting of the breach as required by applicable Federal and State law, including any required notifications to media outlets, the Secretary, and other government agencies/regulators, including posting substitute notice where applicable.

**Office of Civil Rights**

Providers and beneficiaries can also report a suspected breach directly to OCR. Complaints must be filed **within 180 days** of your discovery of the violation occurring. OCR investigates complaints against health plans, healthcare Providers, healthcare clearinghouses, and business associates of these entities. You can submit a complaint in one of the following ways:

- Online
- Use the OCR Complaint Portal to file electronically.
- Mail or Email
- You can also send a written complaint to:

  U.S. Department of Health and Human Services Office for Civil Rights

  200 Independence Avenue

  S.W. Washington, D.C. 20201

- Email: OCRComplaint@hhs.gov

**Law Enforcement Hold on Notification of Breach**

If the Provider has received notification from law enforcement that requires a delay, the Provider should delay notification to individuals of the security incident, breach, or unauthorized use or disclosure of PHI or confidential data.

This direction will occur if or when such notification would impede a criminal investigation or damage national security and whether such notice is in writing, and whether Section 13402 of the HITECH Act (codified at 42 U.S.C. §17932), California Civil Code §1798.29 or §1798.82, or any other federal or state laws requiring individual notifications of breaches are triggered.

CMS, OCR and/or Health Plan Advantage D-SNP agree to not request the Provider to use or disclose PHI/PI in any manner that would not be permissible under HIPAA and/or other applicable Federal and/or State law.

If Providers have any questions, they should email piu@hpsj.com.

## MEDICARE MARKETING GUIDELINES

CMS (Centers for Medicare & Medicaid Services) has strict marketing guidelines that Health Plan Advantage D-SNP and Providers must follow, especially when promoting Medicare Advantage (MA), Medicare Part D, or other CMS regulated plans. These rules are designed to protect Enrollees from misleading or coercive marketing practices.

**Definitions**

- "**Providers**" include all entities (e.g., physicians or medical facilities including hospitals, clinics, diagnostic and treatment centers, and physician group practices) that contract with Health Plan Advantage D-SNP.
- "**Communications**" means activities and use of materials created or administered by the plans or any downstream entity to provide information to current and prospective Enrollees. All activities and materials aimed at prospective and current Enrollees, including

their caregivers, are "communications" within the scope of the regulations at 42 CFR Parts 417, 422, and 423. Note: where the term Enrollee is used, whether a current or prospective Enrollee, the term encompasses representatives of the Enrollee who are authorized to act on the Enrollee's behalf.

- "**Marketing**" is a subset of communications and must, unless otherwise noted, adhere to all communication requirements. To be considered marketing, communications materials must meet both intent and content standards. In evaluating the intent of an activity or material, CMS will consider objective information including, but not limited to, the audience, timing, and other context of the activity or material, as well as other information communicated by the activity or material. The organization's stated intent will be reviewed but not solely relied upon.

- **Advertising and Outreach Materials Approval** - All communication materials must be approved by Health Plan Advantage D-SNP before release or distribution. Providers must avoid any marketing practices or providing communication materials that may mislead, confuse, or defraud eligible individuals, the general public, or any government agency. Misrepresenting the Medicare program or any Health Plan Advantage D-SNP requirements is strictly forbidden.

Federal, state, or local government logos are not permitted on advertising or outreach materials, nor should Providers use similar designs or colors that could cause confusion about the source of the materials.

**Marketing and Outreach Activities**

- Outreach and advertising activities cannot discriminate based on health status, prior healthcare use, or expected service needs. Cold-call telephone solicitations are disallowed. Providers may not share patient mailing lists with Medicare Advantage Organizations (MAOs).
- Providers may permit marketing representatives to conduct outreach in their common areas. If a Provider works with multiple plans and allows marketing by one plan, or wishes to disclose affiliations, it must display a list of all contracted managed care plans operating in its area.
- Providers can discuss their affiliations with all contracted Health Plans and guide patients to select plans best suited to their health needs and those of their families, but this advice must be personal and not promotional for any specific plan.
- Neither Providers or Health Plan Advantage D-SNP representatives may market in emergency rooms, treatment areas or patient rooms.
- Providers who end their affiliation with a Health Plan but keep others, may inform patients about the change and its effects.
- All outreach and advertising must be professional, non-disruptive, and mindful of privacy and community norms.

**Inducements to Enroll**

Providers may not offer financial or material incentives to encourage Medicare beneficiaries to enroll. They may reference program benefits or services in outreach materials and offer "nominal gifts" (Currently, regulations limit a maximum annual limit of $15), which must be provided regardless of enrollment decision. CMS' interpretation of the terms "nominal gifts" and "cash equivalents," is intended to align with the Office of Inspector General's (OIG's) interpretation of the similar terms. The following rules apply to nominal gifts:

- Nominal gifts must be offered to similarly situated beneficiaries without discrimination and without regard to whether the Enrollee enrolls in a plan.
- Nominal gifts may not be in the form of cash, including cash-equivalents, or other monetary rebates.
- CMS is adopting OIG's interpretation of cash equivalents. OIG has interpreted the term "cash equivalents" to encompass items convertible to cash (such as a check) or items that can be used like cash (such as a general-purpose debit card, but not a gift card that can be redeemed only for certain categories of items or services, like a fuel-only gift card redeemable at gas stations).
- CMS's interpretation of "cash equivalents" for the purposes of this regulation mirrors OIG's interpretation subject to the following, additional guidance.
    - A general gift card that is not restricted to specific retail chains or to specific items and categories would fall under those types that would be considered a cash equivalent (e.g. Visa gift card).
    - Gift cards for retailers or online vendors that sell a wide variety of consumer products would also fall under this prohibition (e.g., Walmart and Amazon).
    - A gift card that can be used for a more limited selection of items or food would not be considered a cash equivalent (e.g. Starbucks or a Shell Gas gift card). CFR §422.2263(b)(3) and §423.2263(b)(3).
- Refreshments and light snacks are not considered "meals". Plans should ensure that items provided could not be reasonably considered a meal and/or that multiple items are not being "bundled" and provided as if a meal.
- Meals may be provided at educational events that meet CMS's regulations and other events that would fall under the definition of communications.
- Providers cannot accept, offer, or be paid any commission, bonus, or other payments linked to the number of Medicare Advantage Enrollees.

**Medicare Marketing Guidelines**

Health Plans are responsible for ensuring all comparative or descriptive materials produced and distributed by their contracted Providers, or their subcontractors, comply with CMS marketing requirements.