Provider Manual

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I. Introduction

Welcome and thank you for being a participating Provider with Centers Plan for Healthy Living (CPHL). We strive to work with our Providers as partners to ensure that we make it easy to do business with us. This strong partnership helps facilitate a high quality of care and respectful experience for our members.

Intent of this Manual

We are pleased to be able to offer this manual to CPHL's providers. This Provider Manual is intended to be used as a communication tool and reference guide for providers and their office staff. It contains basic information about how to work with CPHL as well as how to refer Members to specific services. We wrote this manual in a way that emphasizes: essential information that providers need to know; steps that providers should take to complete any CPHL related transaction; and; the process for requesting and obtaining additional information.

This manual applies to all CPHL plans. It includes detailed information about your administrative responsibilities, contractual and regulatory obligations, best practices for interacting with our staff, and helping our members navigate CPHL's delivery systems.

In order to ensure you receive electronic communications regarding new and updated operational information, please keep your current email address on file. To update your email address or any other directory information, please email the CPHL Provider Services Department at ProviderServices@centersplan.com.
This manual is an extension of your Provider Agreement and is amended accordingly as our operational policies change. We regularly communicate these updates and other important information through available communication channels, including, but not limited to:

- Targeted mailings to directly-impacted providers;
- Updates to our Provider page on www.centersplan.com
- Provider newsletters

Updates to the Provider Manual occur as policies are reviewed and updated, new programs are introduced, and as contractual and regulatory obligations change. Please visit www.centersplan.com/providers for the most current information.

Note: The links to web sites found in this manual are provided as a convenience as well as an educational and informational service to our providers. These links are not intended to provide medical or professional advice. All medical information, whether from these links or from any other source, needs to be reviewed carefully by the practitioner. The opinions and information expressed therin are not necessarily those of CPHL. CPHL does not guarantee the accuracy or completeness of the information containied in these link.

About Us and Our Plans

CPHL is a New York State licensed Managed Care Organization (MCO). The plans' service areas vary depending on the plan.

The plans offered, their eligibiligy criteria, and the counties they serve, are as follows:

Name of Plan	Eligibility Criteria	New York Service Area Counties
Centers Plan for Medicare Advantage Care (HMO) or MA-PD	• Enrolled in Medicare Part A • Enrolled in Medicare Part B • Resides in the Plan's service area • Continues to pay Medicare Part B premiums if not paid by Medicaid or another third party	Bronx, Kings, New York, Queens, Richmond, Nassau, Niagara, Erie, Rockland.
Centers Plan for Nursing Home Care (HMO I-SNP) or I-SNP	• Enrolled in Medicare Part A • Enrolled in Medicare Part B • Resides in one of CPHL's in-network skilling nursing facilities (for at least 90 days)	Bronx, Kings, New York, Queens, and, Richmond, Rockland, Erie, Niagra, Nassau, Suffolk, Westchester.

Name of Plan	Eligibility Criteria	New York Service Area Counties
Centers Plan for Dual Coverage Care (HMO D-SNP) or D-SNP	• Enrolled in Medicare Part A • Enrolled in Medicare Part B • Enrolled in New York State Medicaid program or another New York State medical assistance program (Medicare Savings Program) • Resides in the Plan's service area	Bronx, Kings, New York, Queens, and, Richmond.
Centers Plan for Medicaid Advantage Plus (HMO D-SNP) or MAP	• Enrolled in Medicare Part A • Enrolled in Medicare Part B • Enrolled in New York State Medicaid program, receiving full benefit Medicaid • Resides in the Plan's service area • Aged 21 years or older • Capable of returning to, or remaining in, your home and the community safely • Eligible for nursing home level of care at time of enrollment • In need of care management and expected to need at least one Community Based Long-Term Care services for more than 120 days • Are determined eligible for long-term care services by the plan or an entity designated by the Department using the current NYS eligibility tool	Bronx, Kings, New York, Queens, Richmond, Rockland, Nassau.
Centers Plan for Healthy Living Medicaid Managed Long Term Care Plan or MLTC	• Eligible for New York State Medicaid program • Resides in the Plan's service area • Aged 21 years or older • In need of more than 120 days of Community Based Long Term Care services	Bronx, Kings, New York, Queens, and, Richmond, Rockland, Erie, Niagra, Nassau, Suffolk, Westchester.

Contact Information

Contact	Information
General Information	Centers Plan for Healthy Living 75 Vanderbilt Avenue Staten Island, NY 10304 1-844-274-5227
CPHL Website	www.centersplan.com
CPHL Provider Hotline Authorizations Claims Member Eligibility Provider Services and all other concerns (including Grievances and Appeals) Grievances and Appeals	1-844-292-4211 1-844-292-4211; Option #1 Email: UM@centersplan.com 1-844-292-4211; Option #2 1-844-292-4211; Option #3 1-844-292-4211; Option #4 Fax: 1-718-581-5562 Email: ProviderServices@centersplan.com Email: GandA@centersplan.com
Member Services Department:	1-844-274-5227 Medicare Advantage Plans (MA-PD, D-SNP, I-SNP): Option #1 MLTC: Option #2 MAP: Option #3
Relay Health Claims Resolution	1-866-775-8860
Fraud, Waste, and Abuse Ethics and Compliance Hotline	1-855-699-5046 or www.centersplan.ethicspoint.com

II. Participating Provider Roles and Responsibilities

All Centers Plan for Healthy Living (CPHL) participating professionals, facilities, agencies and ancillary providers agree to:

1. **Compliance with contractual requirements**
    - Provider must comply with all contractual, administrative, medical management, quality management, and reimbursement policies as outlined in the CPHL provider contract, manual and updates.

2. **Non-Discrimination**
    - Provider must not differentiate or discriminate in accepting and treating patients on the basis of race, color, creed, national origin, ancestry, disability, type of illness or condition, sex, age, religion, sexual orientation, marital status, place of residence, actual or perceived health status or source of payment.
    - CPHL and its contracted providers shall ensure compliance with Title VI of the Civil Rights Act, the Age Discrimination Act of 1975, the Americans with Disabilities Act, and other laws applicable to recipients of Federal Funds.

3. **Cultural Sensitivity**
    - CPHL maintains an inclusive and culturally competent provider network. Providers must ensure that members of various racial, ethnic and religious backgrounds, as well as disabled individuals, are communicated within an understandable manner, accounting for different needs. Best possible efforts should be made to speak with the member in his/her primary language.
    - Translation services through a family member, friend, or other health care professional that speaks the same language is encouraged. It is the provider's responsibility to ensure the member clearly understands the diagnosis and treatment options that are presented, and that language, cultural differences, or disabilities are not posing a barrier to communication.
    - CPHL may require certain participating providers to certify, on an annual basis, completion of a New York State-approved cultural competence training curriculum as well as a community needs assessment to identify threshold populations in each service area in which the provider operates.
    - Native Americans Access to services from Tribal or Urban Indian Health Facility. CPHL shall not prohibit, restrict, or discourage enrolled Native Americans from receiving care from or accessing Medicaid reimbursed health services from or through a tribal health or urban Indian health facility or center.

4. **Ethical Medical Practice**
    - Provider agrees to provide services within the scope of the provider's license and/or specialty.
    - Provider agrees to adhere to established standards of medical practice and the customary rules of ethics and conduct of the American Medical Association and all other medical and specialty governing bodies.
    - Provider agrees to report to CPHL any reports or sanctions against them for failure to provide quality care, negligence determinations or licensing terminations imposed upon them.

5. **Minimum Wage Clause**
   The provider shall comply with all applicable provisions of State Labor Labor Law 652.1(a) and (b) and of the State Minimum Wage Law. The provider shall develop protocols for compliance, and such protocols shall include adequate record keeping methodologies and identify rate reimbursement as appropriate.

6. **Provider Notification Requirement**
    - Provider must notify CPHL within two (2) business days if his/her medical license, DEA certification (if applicable), and/or hospital privileges (if applicable) are revoked or restricted. Notification within two (2) business days is also required when any reportable action is taken by a City, State or Federal agency.
    - Should any lapse in malpractice coverage, change in malpractice carrier or coverage amounts occur as a result of item above, the provider must notify CPHL immediately.

7. **Provider Directory Requirements**
    - Providers agree to notify CPHL immediately of any changes in their demographic information, including, but not limited to:
        - Office address changes and/or additions
        - Office telephone, email or fax phone number changes
        - Office hours
        - Languages spoken
    - Providers must complete a Demographic Update Form whenever they change or update their information. by completing the Demographic Update Form and submitting it to CPHL Provider Services Department at:

      Centers Plan for Healthy Living
      Provider Services Department
      75 Vanderbilt Avenue
      Staten Island, NY 10304
      OR by emailing it to Providerservices@centerplan.com.

8. Billing Requirements

- Provider may NOT balance bill members for authorized and/or covered services.
- Provider agrees that CPHL reimbursement for services constitute payment in full.
- Provider agrees to follow Centers for Medicare and Medicaid Services (CMS) and CPHL billing guidelines.
- A provider may bill a member only when the service is performed with the expressed written acknowledgment that payment is the responsibility of the Members and that CPHL does not cover the service.
- Please refer to your provider agreement for more information.
- Any provider with Value Based Payment (VBP) arrangement shall comply with the requirements outlined in their provider contract.

9. Medical Records and On-Site Auditing

CPHL participating provider offices must maintain medical records in accordance with professional medical documentation standards. The provider must provide CPHL staff with member medical records at no additional cost to CPHL upon request. CPHL staff must also have access to member medical records for on-site chart reviews. The provider office is responsible for:

- Maintaining medical records in a manner that is current, detailed, and organized to facilitate quality care and chart reviews.
- Maintaining medical records in a safe and secure manner that ensures member confidentiality and medical record confidentiality in accordance with all State and Federal confidentiality and privacy laws, including HIPAA.
- Making the medical record available when requested by the Plan and regulatory agencies. Providers are required to allow medical information to be accessed by CPHL, the New York State Department of Health ("NYSDOH"), and CMS.

The medical record must be computer generated and contain at a minimum:

- Patient's name and/or ID number
- Author (professional(s)) identification and professional title
- Date of visit/service/admission
- Pertinent history and physical
- Assessment at the time of visit/service/admission
- Diagnosis/Diagnoses
- All medical conditions
- Allergies
- Medications
- Treatment plan consistent with the patient's diagnosis
- Return visit date and follow up plan documented for each encounter
- Medical status of previously documented conditions
- Diagnostics performed or planned

- Documentation of coordination and continuity of care with referral to specialists where applicable
- Documentation of evidence of advanced medical directives where completed.

10. Confidentiality

- Provider and staff must maintain complete confidentiality of all medical records and patient visits/admissions. Medical record release, other than to the plan or noted government agencies, may only occur with the patient's written consent or if required by law.

11. Conflict of Interest

- No practitioner in Medical Management may review any case in which he or she has had professional involvement.
- CPHL does not reward practitioners or other individual professional consultants performing utilization review for issuing denials of coverage or service.

12. Reporting Elder Abuse

If a provider suspects elder abuse, he/she should immediately notify Adult Protective Services at 1-844-697-3505, or contact the local County Department of Social Services Adult Protective Services. The provider must initiate the proper notifications to any agency or authority that are required by the law in effect at the time. For more information, please see:
http://www.health.ny.gov/facilities/long term care/waiver/nhtd manual/section 10/

13. Continuity of Care

Continuity of care refers to the cooperative process between the member and his/her physician-led care team to manage the member's health with the shared goal of high quality, cost-effective medical care. CPHL providers must comply with all Federal, State, and Local Continuty of Care laws, rules, and regulations.

14. Compliance with Americans with Disabilities Act (ADA) Standards

Participating providers should use every method reasonable to comply with the Americans with Disabilities Act. CPHL will assess whether a provider is compliant and, if so, indicate ADA compliance on the Provider Directory. More information on standards for ADA compliance could be found at www.ada.gov. Further resources and technical assistance are available through the NYS Office of Advocate for Persons with Disabilities at (800) 522-4369.

15. Provider Training

Providers, including medical, behavioral, community-based and facility-based LTSS services, should review all training modules located on the Provider tab of the CPHL website: www.centersplan.com/providers. Providers will be notified via newsletters, emails, or updates to the CPHL website on the availability of new and/or updated training modules as they become available.

16. Communication with Patients (MLTC ONLY)

Participating Providers who wish to communicate with their patients about managed care options must direct patients to the State's Enrollment Broker for education on all plan options. Participating Providers shall not advise patients in any manner that could be construed as steering towards any Managed Care product type including displaying only 'preffered plans' outreach material.

17. Record Access

Participating providers are responsible for ensuring that pertinent contracts, books, documents, papers and records of their operations are available to DOH, OMIG, DHHS, the Comptroller of the State of New York and the Comptroller General of the United States and the New York State Office of the Attorney General and/or their respective designated representatives, for inspection, evaluation and audit. In the case where a provider is no longer participating with CPHL, the aforementioned requirement shall be applicable through ten (10) years from the final date of the Provider Contract or from the date of completion of any audit, whichever is later.

18. Government Audits

Participating providers shall provide the New York State Office of the Attorney General, DOH, OMIG, the Office of the State Comptroller, DHHS, the Comptroller General of the United States, DHHS, CMS, and/or their respective authorized representatives with access to all the provider's and/or subcontractor's premises, physical facilities, equipment, books, records, contracts, computer or other electronic systems relating to CPHL performance for the purposes of audit, inspection, evaluation and copying. The provider shall give access to such records on two (2) business days prior notice, during normal business hours, unless immediate access is required pursuant to an investigation, or otherwise provided or permitted by applicable laws, rules, or regulations. When records are sought in connection with an audit, inspection, evaluation or investigation, all costs associated with production and reproduction shall be the responsibility of the provider.

19. Notification and Recovery of Overpayments

- Participating providers must notify CPHL of any overpayment, and the reason of such overpayment, and return the overpayment within 60 days of the date of the identification of the overpayment.
- Where CPHL has identified an overpayment and the overpayment is subject to investigation, audit, or action by the New York State Office of Attorney General, OMIG, OSC, or NYSDOH, CPHL will not attempt to recover said overpayment directly from the participating provider.

20. Role of the Primary Care Provider (PCP)

PCPs are responsible for the provision of initial and routine health care to members, as well as for the supervision of a member's overall care. PCPs coordinate specialty care and ancillary services, and maintain continuity of care for their members. In addition, PCP duties include, but are not limited to:

Conducting baseline and periodic health examinations.

- Delivering medically necessary primary care services, in accordance with Clinical Practice Guidelines (see Section X).
- Diagnosing and treating conditions not requiring the services of a specialist.
- Arranging for inpatient care, specialist consultations, and laboratory and radiological services when necessary and coordinating follow-up care.
- Consulting with the admitting physician and participating in inpatient discharge planning and follow-up care when members are hospitalized.
- Reaching out to members who have not had an annual primary care appointment.
- Referring members for at least one dental and vision visit a year, and encouraging appointment attendance.
    - CPHL is contracted with Healthplex for dental services. Members should be directed to call 1-888-468-5175 to schedule an appointment.
    - CPHL is contracted with VSP for Vision services. Members should be directed to call call 1-800-877-7195 to schedule an appointment.
- Complying with standards for 24-hour coverage.
- Ensuring coverage by a participating provider for short- and long-term leaves of absence.
- Counseling adult members regarding advance directives.

PCP Examples (CPHL recognizes the following practitioners as PCPs):

- General Practitioners
- Family Practice
- Nurse Practitioners
- Internal Medicine
- Geriatricians

21. Role of the Specialist

Specialist physicians have advanced training in a medical specialty and provide consultation and treatment to members in a designated specialty area. Specialists deliver specialty services to members when referred by a PCP or under other circumstances. In addition, specialist duties include, but are not limited to:

- Ensuring continuity of care by communicating all testing and treatment to the member's PCP.
- Arranging for laboratory and radiological services when necessary and coordinating follow-up care.
- Participating in inpatient treatment, discharge planning, and follow-up care, as appropriate.

22. Standard of Performance for Physicians

Physicians are expected to accommodate the following types of appointments within the indicated time frames:

Type of Appointment	Scheduling Requirement
Urgent (Non-Emergency)	within 24 hours
Non-urgent	within one week
Routine and preventive care	within 28 days

Physicans must maintain 24 Hour/ 7 Day patient telephone access and office coverage to respond to emergencies. Primary care physicians must have appropriate back-up for absences.

24-hour access includes:

- An answering service or recording with a message explaining:
    - that if a patient believes that his/her health is in distress then the patient should go to an emergency room for immediate attention; and,
    - how to access medical care if the condition is not life threatening.
- Coverage by another practitioner if existing practitioner is unavailable.
- A system to convey issues and advice between covering practitioners, primary care physicians and the member's file.

23. Panel Closure

A provider wishing to implement a panel closures affecting CPHL members must send an explicit written notification to CPHL 60 days prior to the intnended panel closure date. Universal panel closures for reasons such as provider retirement may only apply to all patients regardless of insurance coverage and cannot discriminate based on the members insurance coverage.

III. Member Identification (ID) Cards

Centers Plan for Healthy Living (CPHL) provides every member with an identification (ID) card. The card provides both members and providers with important health plan information. We issue unique non-Social Security Number (SSN)-based member ID numbers to our members to protect their confidentiality. This practice also protects our members from potential identity theft and fraud. Each CPHL member receives his/her own personal ID card with his/her unique member ID number.

You and your staff should familiarize yourself with member ID cards. The member ID card provides you with information on co-pay requirements, care management authorization requirements, and other information to help care for CPHL members and ensure you pre-authorize services. Except for emergency services, providers rendering covered services to **any CPHL member** should first verify eligibility prior to rendering the service. Verifying the member's eligibility is critical to determine whether a member's enrollment status has changed and to help ensure payment. A Member ID card does not guarantee eligibility.

An ID card is issued upon enrolling in a CPHL plan. New members are effective on the first day of the month. Members can continuously use the same ID card as long as they maintain eligibility. CPHL will issue a new Member ID card only when the information on the card changes, a member loses a card, or a member requests an additional card. Since ID cards do not guarantee eligibility, providers must verify a member's eligibility on each date of service. Providers should call the CPHL Provider Hotline at 1-844-292-4211; Option #3 to verify member eligibility.

Medicare Plan Member ID Cards

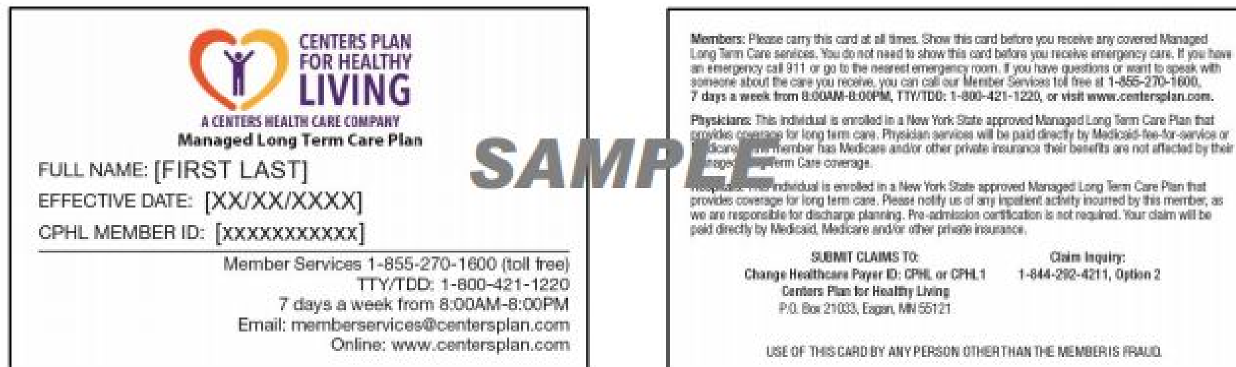
CPHL offers four Medicare Plans:

1. Centers Plan for Medicare Advantage Care (HMO) or MAPD
2. Centers Plan for Nursing Home Care (HMO I-SNP) or I-SNP
3. Centers Plan for Dual Coverage Care (HMO D-SNP) or D-SNP
4. Centers Plan for Medicaid Advantage Plus (HMO D-SNP) or MAP

Below is a sample of the MAPD Member ID card. All Medicare Plan Member ID cards will look similar except for plan name and benefit information.[1]

Medicaid Managed Long Term Care Plan (MLTCP) Member ID Cards

Below is a sample of the CPHL MLTCP Member ID Card.



[1] Please note that the copay and other benefit information on this sample card may not be accurate. Please refer to each member's ID card for his/her specific copay structure and benefit information.

IV. Covered Services

Please visit the Centers Plan for Healthy Living (CPHL) website at www.centersplan.com for information on covered services for each line of business. Information prior authorization procedures is on our website and in Section IX, “Prior Authorizations” of this manual.

Benefit Limits
In general, most benefit limits for services and procedures follow state and federal guidelines. Benefits limited to a certain number of visits per year are based on a calendar year (January through December). Please check to be sure the member has not already exhausted benefit limits before providing services by calling the CPHL Provider Hotline at 1-844-292-4211; Option #3 to verify benefit limits and member eligibility.

This section describes the services and exclusions to benefits that are provided to our CPHL members. Covered services may require prior authorization. Please visit our website at www.centersplan.com for the most up-to-date list of services that require prior authorization.

Medical Necessity Determinations
Some services require prior authorization. If a request for authorization is submitted, CPHL will notify the provider and member in writing of the determination. If a service cannot be covered, Providers and members may have the right to appeal the decision. The letter will include the reason that the service cannot be covered and how to request an appeal if applicable.

Emergency Care
An emergency medical condition is a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson with an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in:

- Serious jeopardy to the health of the individual
- Serious impairment to bodily functions
- Serious dysfunction of any bodily organ or part

Members with an emergency medical condition should be instructed to call 911 and/or go to the nearest emergency room. Precertification for an emergency medical condition is not required.

Covered Benefits

Covered services for each line of business can be found at our website at www.centersplan.com/plans. For the Medicare plans, they can be found under each plan's Summary of Benefit section. For MLTC, they can be found in the "Benefits and Coverage/Coordination of Other Medical Services" section of the Member Handbook at https://www.centersplan.com/plans/mltc.

V. Member Services

Member Services Contact Information

Plan	Phone Numbers	Hours of Operation
MA-PD, I-SNP, and D-SNP	1-877-940-9330, TTY 711	7 days a week, 8:00 am – 8:00 pm
MAP	1-855-270-5627, TTY 711	7 days a week, 8:00 am – 8:00 pm
MLTC	1-833-274-1600, TTY 711	7 days a week, 8:00 am – 8:00 pm

Member Welcome Packet

The Member Services Department focuses on ensuring new members are familiar with their benefits and rights by performing welcome calls. The purpose of these calls is to: confirm enrollment; make sure that the member has all necessary information; and, address the member's questions.

Each new Centers Plan for Healthy Living (CPHL) member receives a New Member Welcome Packet, which contains the following:

<u>Medicare Advantage Plans (MA-PD, D-SNP, I-SNP, MAP)</u>

- A Welcome Letter with ID Card
- Summary of Benefits
- Member Handbook (MAP)
- Directory, Formulary, EOC Electronic Notification
- A letter telling the member where they can find the following documents on the plan's website and how they can request hard copies:
  - (EOC), Summary of Benefits, Provider Directory
  - Comprehensive Formulary; and HIPAA Privacy Policy
- A Health Risk Assessment survey
- If applicable, a Low Income Subsidy (LIS) rider
- Fraud Awareness Insert
- Language Assistance Service Notice
- Notice of Non-Discrimination
- Star Rating
- Opiod Letter
- MedImpact Direct Member Flyer
- MedImpact Direct Order Form

<u>MLTC</u>

- A current Provider Directory that lists health care providers and facilities participating with CPHL.
- Member Handbook that explains plan services and benefits and how to access them.

Assistance with Cultural and Linguistic Services

CPHL provides access to health care services for a diverse population of members enrolled in all lines of business. Our services are provided in multiple languages, utilizing multi-lingual staff, language lines and sign language interpreters as needed to meet the needs of our members. The CPHL website, the new member welcome kits, and, other plan communications advise members of their right to receive free language interpretation services upon request.

Interpreter Services — Offered by Providers

Providers are expected to identify the need for interpreter services for their CPHL patients and offer assistance to them appropriately. Language interpreter services must be provided at no cost to the member by a third-party interpreter who is either employed by or contracted with the provider. Language interpreter services must be provided during a scheduled appointments and scheduled encounters. These services may be provided face-to-face, by telephone, and/or by video remote interpreter technology. The interpreter must demonstrate competency and skills in medical interpretation techniques, ethics, and terminology. It is recommended, but not required, that such individuals be certified by the National Board of Certification for Medical Interpreters (NBCMI) or be qualified by New York State wherever possible.

Certain printed materials are offered in various languages or formats such as large print or braille, and if needed, benefits and materials can be explained orally. These services are available at no cost to the member or health care provider. To request materials in another format or have them explained verbally, please contact the Provider Hotline at 1-844-292-4211; Option #3. We ask that you let us know of any members in need of interpreter services and of any members who may be receiving interpreter services through another resource.

Interpreter Services — Offered by Hospitals

CPHL requires hospitals, at their own expense, to offer sign and language interpreters for members who are hearing impaired, and translation services for members who do not speak English, or have limited English proficiency. CPHL can provide, at no charge, certain printed materials in other languages or formats, such as large print, or, if needed, materials can be explained orally. These services are available at no cost to the member. Hospitals are also required to identify the need for interpreter services for CPHL patients and offer assistance to them accordingly. If you do not have access to interpreter services, contact the Provider Hotline at 1-844-292-4211; Option #3.

VI. Members' Rights and Responsibilities

As a Centers Plan for Healthy Living (CPHL) provider, you are required to respect the rights of our members. CPHL Members are informed of their rights and responsibilities via their Member Handbook and/or their Evidence of Coverage (EOC). The list of our Members' rights and responsibilities are listed below.
All Members are encouraged to take an active and participatory role in their own health. Members' rights, as stated in the Member Handbook and/the EOC, are as follows:

Members' Rights (MLTC & MAP)

- To receive medically necessary care.
- To receive timely access to care and services.
- To privacy about their medical record and when they get treatment.
- To get information on available treatment options and alternatives presented in a manner and language they understand.
- To get information in a language they understand.
- To get information necessary to give informed consent before the start of treatment.
- To be treated with respect and dignity.
- To get a copy of their medical records and ask that the records be amended or corrected.
- To take part in decisions about their health care, including the right to refuse treatment.
- To be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation.
- To get care without regard to sex, race, health status, color, age, national origin, sexual orientation, marital status or religion.
- To be told where, when and how to get the services they need from CPHL, including how they can get covered benefits from out-of-network providers if they are not available in the plan network.
- To complain to the New York State Department of Health.
- To complain to HRA or their LDSS and the right to use the New York State Fair Hearing system.
- To appoint someone to speak for them about their care and treatment.
- To make advance directives and plans about their care.
- To appeal any restriction, reduction, suspension or termination of authorized CDPAS (including CDPAS itself) or denial of a request to change CDPAS, pursuant to 42 CFR Part 438.

Member Rights (MAPD, D-SNP, I-SNP, MAP)
All Members are encouraged to take an active and participatory role in their own health. Members' rights, as stated in the Evidence of Coverage, are as follows:

- To receive medically necessary care.
- To receive timely access to care and services.
- To privacy about their medical record and when they get treatment.
- To get information on available treatment options and alternatives presented in a manner and language they understand.
- To get information in a language they understand.
- To get information necessary to give informed consent before the start of treatment.
- To be treated with respect and dignity.
- To get a copy of their medical records and ask that the records be amended or corrected.
- To take part in decisions about their health care, including the right to refuse treatment.
- To be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation.
- To get care without regard to sex, race, health status, color, age, national origin, sexual orientation, marital status or religion.
- To be told where, when and how to get the services they need from CPHL, including how they can get covered benefits from out-of-network providers if they are not available in the plan network.
- To complain to HRA or their LDSS and the right to use the New York State Fair Hearing system.
- To appoint someone to speak for them about their care and treatment.
- To make advance directives and plans about their care.
- To take part in decisions about their health care, including the right to refuse treatment
- To choose a primary care provider (PCP) in the plan's network to provide and arrange for your covered services.
- To receive information from Medicare about your health information including information about your Part D prescription drugs.
- To get a copy of their medical records and ask that the records be amended or corrected.
- To receive information about why something is not covered and their options.
- To make complaints and to ask us to reconsider decisions we have made.
- To receive written explanation if a medical service or Part D is not covered even if they received the medical service or drug from an out-of-network provider or pharmacy.

Members' Responsibilities

- Be familiar with the covered services and rules that they must follow to obtain these services.
- Disclose other health insurance or prescription drug coverage.
- Participate actively in their care and care decisions
- Inform providers that they are enrolled in the plan.
- Provide information to doctors and other providers, ask questions, and follow through on care.
- Appropriately express opinions, concerns, and suggestions to their Care Management Team, through CPHL's Grievance and Appeals process, or through applicable City, State, and Federal channels.
- Be considerate.
- Pay amounts owed, if any.
- Inform the plan and provider if they have moved.
- Call Member Services if they have questions or concerns.
- If you have any other health insurance coverage or prescription drug coverage in addition to our plan, you are required to tell us.

Member Disenrollment

When CPHL is instructed to disenroll or retroactively disenroll a member by a regulatory agency (e.g., DOH, CMS DHHS, etc…), CPHL will terminate coverage as directed.

HIPAA Notice of Privacy Practices

Members are notified of CPHL's privacy practices as required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). CPHL's Notice of Privacy Practices includes a description of how and when Member information is used and disclosed within and outside of the CPHL organization. The notice also informs Members on how they may obtain a statement of disclosures or request their medical information. CPHL takes measures across our organization internally to protect oral, written and electronic personally identifiable health information, specifically, protected health information (PHI) of Members.

As a Provider, please remember to follow the same HIPAA regulations as a covered entity and only make reasonable and appropriate uses and disclosures of protected health information for treatment, payment and health care operations.

Advance Directives

The Patient Self-Determination Act of 1990 and state law provides every adult Member the right to make certain decisions concerning medical treatment. Members have the right, under certain conditions, to decide whether to accept or reject medical treatment, including whether to continue medical treatment that would prolong life artificially. These rights may be communicated by the Member through an Advance Directive. New York State recognizes three types of advance directives:

- New York State Health Care Proxy
- Living Will
- Do Not Resuscitate (DNR) Order

The Member's primary care office is not required to make blank Advance Directive forms available. However, the office should be able to direct members to resources where they can obtain advance directive forms. Below are some resources for additional information:

- http://www.health.ny.gov/forms/doh-1430.pdf
- http://www.nyc.gov/html/doh/downloads/pdf/public/dohmhnews7-12.pdf

If a member has completed an Advance Directive, the primary care physician's office should have the existence of the form prominently noted in the member's medical record/EHR.

If the member has signed an advance directive, and the member believes that a doctor or hospital did not follow the advance directive, the member may file a complaint with the New York State Department of Health.

Mail: New York State Department of Health
Office of Professional Medical Conduct Riverview Center
150 Broadway Suite 355
Albany, New York 12204-2719.

Phone: 1-800-663-6114 - Complaints/Inquiries
(Monday-Friday 9:00 AM - 5:00 PM) or
1-518-402-0836 - Main Number.

Email: opmc@health.ny.gov

Online: www.health.ny.gov/professionals/doctors/conduct/

VII. Model of Care

Center Plan for Healthy Living's (CPHL's) Models of Care (MOC) provide structure for care management processes and systems that will enable coordinated care for our Special Needs Plan(SNP) members, including those in our D-SNP, I-SNP, and, MAP plans. Our Models of Care outline goals and objectives for a targeted population, identifies specialized provider network to address the needs of the targeted population, use nationally recognized clinical practice guidelines, includes the completion of health risk assessments to identify the special needs of our members, and the development of an individualized care plan that add services for the most vulnerable Members.

Elements outlined in our Models of Care include, but are not limited to:

1) Description of Target Population;
2) Measurable goals;
3) Staff structure and Care Management Roles;
4) Interdisciplinary Team;
5) Provider Network having Specialized Expertise and Use of Clinical Practice Guidelines and Protocols;
6) MOC Training for Personnel and Provider Network;
7) Health Risk Assessment;
8) Individualized Care Plan;
9) Communication Network;
10) Care Management for the Most Vulnerable Subpopulations;
11) Performance and Health Outcome Measurement; and
12) Member access to the New York Consumer Directed Personal Assistance Program (CDPAP)

Please visit our provider page to view our specific Model Of Care (MOC) documents and review annually. CPHL encourages provider involvement in the implementation of our Models of Care through participation and communication with CPHL's Care Teams to ensure optimal coordination of care and transition for the members.

Please note that D-SNP, I-SNP, and, MAP plan providers are required to complete a MOC training upon contracting and an annually thereafter. The training materials are available at: [https://www.centersplan.com/providers.](https://www.centersplan.com/providers)

VIII. Provider Credentialing and Recredentialing

Centers Plan for Healthy Living (CPHL) requires all licensed independent practitioners including physicians, facilities and non-physicians with whom it contracts and who fall within its scope of authority and action to be credentialed and recredentialed. Credentialing and recredentialing activities are conducted utilizing the Centers for Medicare and Medicaid Services (CMS), New York State Department of Healthy (NYSDOH), and National Committee for Quality Assurance (NCQA) guidelines. Through credentialing, CPHL checks the qualifications and performance of physicians and other health care practitioners. The CPHL Chief Medical Officer has overall responsibility for the plan's credentialing and recredentialing program.

CPHL has a formal process for credentialing providers on a periodic basis (initially and not less than once every three (3) years) and for monitoring provider performance. This shall include, but not be limited to, requesting and reviewing any certifications required by contract or 18 NYCRR § 521.3 completed by the Participating Provider since the last time CPHL credentialed the Provider. For providers that are not subject to licensure or certification requirements (other than Social Day Care), CPHL shall establish alternative mechanisms to ensure the health and safety of members which could include such activities as criminal background checks or review of abuse registries. CPHL enters into contracts only with providers who are in compliance with all applicable state and federal licensing, certification, and other requirements; and are generally regarded as having a good reputation; and have demonstrated capacity to perform the needed contracted services. All provider contracts must meet the requirements of MLTC Partial Capitated Contract, MAP Model Contract and applicable state and federal laws and regulations.

In general, CPHL delegates credentialing and recredentialing activities to contracted health systems. As a result, practitioners working within those health systems wishing to participate with CPHL must complete the specific health system's credentialing process. Providers must be in good standing with Medicaid and CMS.

- CPHL credentials providers upon acceptance of application and signed participation contract.
- CPHL ensures all participating providers are recredentialed on a three (3)-year cycle from date of initial credentialing.
- Provider must notify CPHL within two (2) business days if his/her medical license, DEA certification (if applicable), and/or hospital privileges (if applicable) are revoked or restricted. Notification within two (2) business days is also required when any reportable action is taken by a City, State or Federal agency.
- Should any lapse in malpractice coverage, change in malpractice carrier or coverage amounts occur as a result of item above, the provider must notify CPHL immediately

Practitioner Credentialing and Recredentialing

Practitioner information reviewed during the credentialing and recredentialing process includes, but is not limited to the following:

- New York licensure
- Current professional liability insurance or self-insurance
- Permanent exclusions, suspensions or ineligibility to participate in any state or federal health care program
- No exclusion from participation at any time in federal or state health programs based upon conduct within the last five years that supports mandatory exclusion under the Medicare program
- Valid Drug Enforcement Agency (DEA) or Controlled Dangerous Substance (CDS) certificate
- Education and training, including board certification if the practitioner states on the application that he/she is board certified
- Work history
- Status of hospital privileges
- History of professional liability claims
- Licenses of any mid-level practitioners (e.g., NP, PA) employed under the practitioner, as well as verification of liability insurance coverage for the mid-level practitioner.

CPHL will also verify practitioners who are excluded from participation in Medicare and Medicaid and Practitioners who have opted out of Medicare using the OIG/Medicare Website, both during primary source verification and on a monthly basis.

Exclusions to Credentialing

The following participating providers do not need to be credentialed by CPHL**:**

- Practitioners who practice exclusively within the inpatient setting and who provide care for an organization's Members only as a result of the Members being directed to the hospital or other inpatient setting
- Practitioners who practice exclusively within free-standing facilities and who provide care for organization Members only as a result of Members being directed to the facility and who are not listed separately in the CPHL Provider Directory
- Pharmacists who work for a Pharmacy Benefit Management (PBM) organization
- Practitioners who do not provide clinical care for Members in a treatment setting (e.g. consultants)

All participaing CPHL providers are subject to exclusion checks as outlined in the "Practitioner Credentialing and Recredentialing" section above.

Organizational Credentialing and Recredentialing
The following organizational Providers are credentialed and recredentialed by the credentialing department:

- Hospitals
- Home Health Agencies (HHAs)
- Hospices
- Clinical laboratories (with a CMS-issued CLIA certificate or a hospital-based exemption from CLIA)
- Skilled Nursing Facilities (SNFs)
- Comprehensive Outpatient Rehabilitation Facilities (CORFs)
- Outpatient Physical Therapy and Speech Pathology Providers
- Ambulatory Surgery Centers (ASCs)
- Providers of end-stage renal disease services
- Providers of outpatient diabetes self-management training
- Portable x-ray Suppliers
- Rural Health Clinic (RHCs) and Federally Qualified Health Center

The following elements are assessed for the credentialing of organizational Providers:

- Provider is in good standing with state and federal regulatory bodies
- Provider has been reviewed and approved by an accrediting body
- Liability insurance coverage is maintained
- CLIA certificates are current
- Completion of a signed and dated application

Excluded Providers
Various federal and state organizations maintain sanction lists that identify individuals found guilty of fraudulent billing, misrepresentation of credentials, etc. At a minimum, CPHL checks the exclusion lists that are mandated within its state and federal contracts to ensure that none of its network providers have been excluded. These checks are done prior to a provider being added to our network and on monthly thereafter. Any provider that is found to be a confirmed match on an exclusion list will be immediately terminated from CPHL's provider network and any payments made to the provider during the exclusion period will be recouped.

Opt-Out Providers
If a physician or other practitioner opts out of Medicare, that physician or other practitioner may not accept Federal reimbursement for a period of two years. The only exception to that rule is for emergency and urgently needed services where a private contract had not been entered into with a beneficiary who receives such services. CPHL pays for emergency or urgently needed services furnished by a physician or practitioner to an enrollee in our CPHL plans that has not signed a private contract with a beneficiary, but does not otherwise pay opt-out providers. Information on providers who opt-out of Medicare may be obtained from the local Medicare Part B carrier. CPHL checks this list on a regular basis.

Practitioners' Rights

- Practitioners have the right to review information submitted to support their credentialing application upon request to the CPHL Credentialing Department. CPHL keeps all submitted information locked and confidential.
- Practitioners have the right to correct incomplete, inaccurate, or conflicting information by supplying corrections in writing to the CPHL Credentialing Department prior to presenting to our Credentialing Committee. If any information obtained during the credentialing or recredentialing process varies substantially from the application, the practitioner will be notified and given the opportunity to correct this information prior to presenting to our Credentialing Committee.
- Practitioners have the right to be informed of the status of their credentialing or recredentialing application upon written request to the CPHL Credentialing Department.

Providers' Responsibilities

Providers are monitored on an ongoing basis to ensure continuing compliance with participation criteria. CPHL will initiate immediate action in the event that the participation criteria are no longer met. Providers are required to inform CPHL of changes in status, such as being named in a medical malpractice suit, involuntary changes in hospital privileges, licensure, or board certification, or any event reportable to the National Practitioner Data Bank (NPDB).

Recredentialing

Providers are recredentialed a minimum of every three (3) years through a process that:

- Reviews updated versions of information obtained in initial credentialing;
- Considers performance indicators such as those collected through the plan's Quality Improvement Program, the utilization management system, the grievance system, member satisfaction surveys, and other CPHL activities; and
- Includes an attestation of the correctness and completeness of the new information.

IX. Social Adult Day Care, LHCSA and CDPAP Annual Review

CPHL conducts an initial and annual review of its participating Social Adult Day Care, LHCSA and CDPAP providers to ensure compliance of standards from federal, state and local agencies as well as CPHL's standards of care. During the review process, CPHL assists the provider by educating them on recent updated rules, regulations and trends as well as guides the provider to ensure they reach full compliance.

Examples of documentation reviewed annually

LHCSA	CDPAP	SADC
- Staff Certifications - W-4, I-9 forms - Proof of Wage Parity - References - Trainings and In-services - Staff Medical Files - Time Sheets - NY State Licensure - Proof of Accreditation If Applicable - Liability Insurance - Worker's Compensation - QI/QA Binder - P&Ps/Workflows - EVV Compliance attestation to DOH	- Liability Insurance - Worker's Compensation - EVV Compliance attestation to DOH - Member Memorandum/ agreement - Initial Member Authorization - PA Staff Agreement/Memorandum - W-4, I-9 forms - Proof of Wage Parity - Staff Medical Files - Time sheets	- Food Menu Calendar - Registered Dietician Registry Card or certificate form - Nutritional Analysis - DFTA FSE Permit - Food Safety Certification - OMIG Certification (Current) - DFTA Registration - Program Director's Resume - Certificate of Occupancy - Place of Assembly (if applicable) - Workers Compensation - Professional Liability - Activity Calendar - Member Files - Staff Files - Policy & Procedure Manual - Bill of Rights - Emergency Instructions/ Evacuation Plan

*Documentation requested may not be limited to the above list and could be subject to change.

X. Prior Authorization

Please visit our website at www.centersplan.com for the most current information on prior authorization (PA) requirements and procedures

Please contact the CPHL Utilization Management (UM) Department with any questions or concerns regarding prior authorizations by calling 1-844-292-4211; Option 1 or emailing UM@centersplan.com. CPHL UM staff are available Monday through Friday, 9 am – 5 pm. When initiating or returning communications, CPHL UM staff will identify themselves by name and title.

Prior Authorization Procedures

PCPs must obtain prior service authorization from CPHL before referring a member to an out-of-network provider. The Service Authorization Request Form and all required supporting documentation can be emailed, faxed or mailed to the CPHL UM Department.

Email: UM@centersplan.com
Fax: 1-718-581-5522
Mail: Centers Plan for Healthy Living
ATTN: UM Department
75 Vanderbilt Avenue
Staten Island, NY 10304

When requesting an authorization, please provide the following information:

- Request type (standard or expedited)
- Provider Information
  - Name
  - CPHL Provider ID number
  - Contact information
- Member/patient information
  - Name
  - CPHL Member ID number
  - Address and Phone
  - Date of Birth
  - ICD Diagnosis Code(s)
- Service/Procedure information
  - Service location
  - CPT/HCPCS Codes(s) and Units
  - Anticipated date of service if known
- Clinical information to support the medical necessity for the service

If the request is for **inpatient admission**, submitted documentation should include admitting diagnosis, presenting symptoms, plan of treatment, clinical review and anticipated discharge needs.

If the request is for a planned **inpatient surgery**, submitted documentation should include the date of surgery, surgeon, facility, date of admission, admitting diagnosis, presenting symptoms, procedure planned, plan of treatment, and anticipated discharge needs.

If the request is for **outpatient surgery**, submitted documentation should include the date of surgery, surgeon, facility, diagnosis, procedure planned, and anticipated discharge needs.

Prior authorization is not based solely on medical necessity, but on a combination of member eligibility, medical necessity, medical appropriateness, and benefit limitations. When prior authorization is requested for a service rendered in the same month, member eligibility is verified at the time the request is received. When the service is to be rendered in a subsequent month, authorization is given contingent upon member eligibility on the date of service. Providers must verify eligibility on the date of service. CPHL is not able to pay claims for services provided to ineligible members. It is important to request prior authorization as soon as it is known that the service is needed.

All services that require prior authorization from CPHL should be authorized before the service is delivered. CPHL is not able to pay claims for services in which prior authorization is required but not obtained by the provider. CPHL will notify you of prior authorization determinations by a letter faxed to the provider's address on file.

Denials and Notifications

All denial determinations related to medical necessity are made by the Medical Director using nationally recognized criteria. Providers will have the opportunity to discuss denial decisions with the CPHL Medical Director. Denial notification letters will be mailed to the member and the provider, and include:

- The specific reason for the denial;
- A reference to the criterion on which the decision was based; and
- Appeal rights and process.

Timeframes for Processing Prior Authorization Requests

Once a provider or member submits a service authorization request and all necessary documentation, CPHL works diligently to process that request in a timely manner. A member, member's authorized representative, or physician may request an **expedited** review of an authorization request if he/she believes that the standard time frame may seriously jeopardize the life or health of the member or his/her ability to attain or regain maximum function. CPHL can, within regulatory guidelines, employ an **extension** for making a determination by the timeframes permitted if the plan determines that such a delay would be in the best interests of the member. The following chart outlines CPHL's timeframes for processing service authorization requests.

Plan	Standard	Expedited	Extension
MA-PD, I-SNP, and D-SNP	Within 14 calendar days from receipt of request	Within 72 hours of receipt of request	Up to 14 days
MAP	Within 3 business days of receipt of all necessary information, but no more than 14 calendar days from receipt of request	Within 1 business day but no more than 72 hours.	Up to 14 days
MLTC	Within 14 calendar days from receipt of request	Within 72 hours of receipt of request	Up to 14 days

Prior Authorization List

A Prior Authorization list is available on www.centersplan.com for each plan. The timeframes for the approval process differ by plan and are outlined in the chart above. The list below outlines some of the services for the MLTC and MAP plans that require prior authorization. Please refer to the Evidence of Coverage and Member Handbooks on the website for updated plan specific requirements.

Durable Medical Equipment
Custom Shoes/Orthotics
C-PAP Machines
Hospital Bed
Hoyer Lift
Insulin Pumps
Prosthetics – Major Limbs
Specialty Mattresses
Wheelchairs (motorized, customized & scooters)
Wound Pumps

Inpatient Admission
Acute Care Facilities, Skilled Nursing Facilities
Psychiatric Health Care Facilities

- Elective Admissions
- Urgent/Emergent Admissions*

Comprehensive Rehabilitation Facilities
**Does not require prior authorization but notify health plan within 24-48 hours of admission*

Rehabiliation Services Outpatient
Physical Therapy
Occupational Therapy
Speech Therapy
Pulmonary & Cardiac Rehabilitative Therapy

Radiology
CT, MRA, MRI, PET & SPECT

Transplant Evaluation & Services
Out-of-Network and Out-of-Area Service
Surgery/ Admissions/Testing at Non-participating facility
Visits to non-participating Providers

Investigational/Experimental Treatment

All cosmetic procedures (if medically necessary-listed below)

- Abdominoplasty
- Blepharoplasty
- Keloid & Scar Revisions
- Mammoplasty, Reduction or Augmentation
- Surgical Treatment of GynecomastiaENT Procedures
- *(Rhinoplasty, Septoplasty, Uvuloplasty & LAUP)*
- Mastopexy
- Otoplasty
- Varicose Veins Treatment and Ventral Hernias

Outpatient Services
Acupuncture
Ambulatory Surgeries
Chiropractic Services
Outpatient Behavioral Health
Outpatient Alcohol & Substance abuse
Transportation (for CCM Direct members only)
Podiatry (see chart below)

Benefit	MLTC	MAPD	DSNP	ISNP	MAP
Medically Necessary Podiatry	No Auth Code billed must be in Medicaid Podiatry Fee Schedule	Auth Required -------------- No Auth: First 4 visits per year	Auth Required -------------- No Auth: First 4 visits per year	No Auth	Auth Required -------------- No Auth: First 4 visits per year
Not Medically Necessary Podiatry (Routine)	Not Covered	Not Covered	No Auth: 4 visits per year	No Auth: 1 visit every 3 months	Not Covered

Other Services
Audiology Equipment
Hyperbaric O2 Therapy
Skilled Home Care Services including Home Infusions (CCM Direct only)

MA-PD, I-SNP, D-SNP Referral Procedures

Members that participate in one of CPHL's Medicare Advantage plans are not required to obtain referrals from their PCPs prior to obtaining services from specialists. However, PCPs are asked to assist members in obtaining specialty services from in-network providers. If you have difficulty finding a specialist for your CPHL member, please contact Provider Services by calling 1-844-292-4211; Option #4 or emailing ProviderService@centersplan.com.

Please note that Members may go to non-participating Providers for:

- Emergency care
  - Worldwide emergency services outside the United States are provided under certain circumstances.
- Out of area dialysis care in certain circumstances
- Out of area urgently needed care

Second Opinions

While a second opinion may not be required for surgery or other medical service, health care providers or members may request a second opinion at no cost to the member. The following criteria should be used when selecting a provider for a second opinion:

- The provider must be a participating in-network provider OR prior service authorization must be obtained for the out-of-network second option visit/consultation.
- The provider *must be* in an appropriate specialty area.
- Results of laboratory tests and other diagnostic procedures must be made available to the provider giving the second opinion.

CPHL likes to create an alliance with our network practitioners, clinicians, hospitals, facilities and ancillary services in order to meet a CPHL member's health care needs.

CPHL provides prior approval, discharge planning and case management services. These processes are reviewed by our Quality Assurance and Utilization Management teams.

CPHL strives to facilitate our network practitioner's role through careful structuring of our network of specialty providers and facilities. Our authorization processes focus on member eligibility, identification of participating providers and review of member benefits. Some services might require prior approval to help the member select appropriate care, in the appropriate setting with the appropriate provider.

Certain variations in authorization requirements and coverage exist depending on the plan and benefit package. For more information please contact Utilization Management or visit the CPHL website at www.centersplan.com for a service authorization reference list.

Phone: 844-292-4211; Option #1
Email: UM@centersplan.com

XI. Clinical Practice Guidelines

Centers Plan for Healthy Living (CPHL) embraces nationally recognized clinical practice guidelines (CPGs), guidelines promulgated by the New York State Department of Health and standards proposed by specialty organizations relevant to preventive care and chronic healthcare conditions for the provision of appropriate evidence based protocols and education. The purpose of guidelines is to help clinicians and Members make appropriate decisions about health care. CPGs attempt to do this by:

- Describing a range of generally accepted approaches for the diagnosis, management, or prevention of specific diseases or conditions.
- Defining practices that meet the needs of most patients in most circumstances.

Clinicians and members should utilize CPG to develop individual treatment plans that are tailored to the specific needs and circumstances of the member. CPHL will periodically update its website (www.centersplan.com) to reflect new clinical recommendations or standards relevant to prevent health or emerging healthcare concerns.

XII. Member Grievances & Appeals Process

Centers Plan for Healthy Living (CPHL) serves various types of members who are covered under different governmental contracts; therefore, the requirements for appeals and grievances may differ among the various products offered. The information in this section is provided for the program(s) for which the information applies.

MA-PD, I-SNP, and D-SNP

Part C Grievances
A standard Part C grievance is defined as any complaint or dispute a member has regarding CPHL or CPHL providers, which does not involve a coverage decision. This can include concerns about the operations of providers or CPHL, such as: waiting times; the demeanor of health care personnel; the adequacy of facilities and respect paid to Members; and, claims of dissatisfaction related to the right of the enrollee to receive services or receive payment for services previously rendered. CPHL shall provide notice specifying what information must be provided to CPHL in order to render a decision on the grievance.

If a member complains because CPHL denied their request for an expedited coverage decision or an expedited appeal, we will automatically treat the grievance as an "expedited grievance."

Part C Appeals (Reconsiderations)
When CPHL receives a request for payment or to provide services to a member, it must make an organization determination to decide whether coverage is necessary and appropriate. If the determination is not made in a timely manner or is not favorable, the member has the right to request a reconsideration or appeal.

CPHL is required to process appeals as expeditiously as the member's health status requires, but no later than indicated in the following chart.

Part C determinations are made in accordance with the following timeframes:

Type	Timeframe
Standard Grievance	30 calendar days*
Expedited Grievance	24 hours
Standard Appeal (Service Related)	30 calendar days*
Expedited Appeal (Service Related)	72 hours
Standard Appeal Part B Drugs	7 calendar days**
Expedited Appeal Part B Drugs	7 calendar days
Expedited Appeal	72 hours
Standard Appeal (Payment Related -Part C)	60 calendar days

**Please note CPHL may extend the determination period noted above by up to 14 calendar days if additional information or documents are needed and it's in the best interest of the member.*

***Extensions are not granted for Part B appeals.*

There are several ways a grievance or appeal request can be submitted:

- **Email:** GandA@centersplan.com
- **Phone:** 1-877-940-9330 (TTY: 711)
- **Fax:** 1-347-505-7089
- **Mail:** Centers Plan for Healthy Living
  Attn: Grievances and Appeals Department
  75 Vanderbilt Avenue
  Staten Island, NY 10304

If we say no to all or part of the member's first Reconsideration/Appeal, the case is automatically forwarded to the Independent Review Entity, not affiliated with CPHL, for the second Level Appeal process. If the member is not satisfied with the decision at the Level 2 Appeal, there may be additional levels of appeal available.

Part D Grievances

A Part D Grievance is a complaint about CPHL or one of our network pharmacies, including a complaint about the quality of care provided at a pharmacy. This type of complaint does not involve coverage of prescription drugs or payment disputes.

Part D Appeals (Redeterminations)
A member has a right to appeal if he/she believes that CPHL did any of the following:

- Decided not to cover a drug, vaccine, or other Part D benefit
- Decided not to reimburse a member for a part D drug that he/she paid for
- Asked for payment or provided reimbursement with which a member disagrees
- Denied the member's exception request
- Made a coverage determination with which the member disagrees

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

There are several ways a Part D grievance or appeal request can be submitted: 711

- **Phone:** 1-888-807-5717 (TTY: 711)
- **Fax:** 1-858-790-7100
- **Mail:** MedImpact Healthcare Systems, Inc.
  Scripps Corporate Plaza
  10680 Treena Street, Stop 5
  San Diego, CA 92131

Part D determinations are made in accordance with the following timeframes:

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 (30 calendar days to issue payment)

**Please note CPHL may extend the determination period noted above by up to 14 calendar days. if additional information or documents are needed and it's in the best interest of the member.*

Managed Long Term Care (MLTC) Plan

MLTC Members have the right to complain about any aspect of their coverage of care.
Complaint: is an expression of dissatisfaction that a member may have regarding a matter that is not an appeal. Some examples of complaints include, but are not limited to, the following:

- Quality of care of services provided
- Rudeness of the provider or staff
- Failure to respect member's rights

CPHL will review the complaint and provide a written decision to the member. If the member does not agree with the complaint decision, they can appeal. All decision timeframes are listed in the table below.

Action Appeal: takes place when the member does not agree with an action that CPHL has taken. The following scenarios are all actions that are subject to appeal:

- Denial or limited authorization of a requested service
- Reduction, suspension or termination of a previously authorized service
- Denial, in whole or in part, of payment for a service

When a member submits an appeal, it means that CPHL must look again at the reason for our action to decide if we were correct. Appeals must be filed within 60 business days of receipt of the denial action notice.

There are several methods of submitting a complaint or action appeal:

Email: GandA@Centersplan.com
Phone: 1-855-270-1600 (TTY: 711)
Fax: 1-347-505-7089
Mail: Centers Plan for Healthy Living
75 Vanderbilt Avenue
Staten Island, NY 10304
Attention: Grievances and Appeals Department

MLTC determinations are made in accordance with the following timeframes:

Type	Timeframe
Standard Complaint	45 days after the necessary information has been received but no later than 60 days from receipt of the complaint
Expedited Complaint	48 hours after the necessary information has been received but no later than 7 days
Standard Complaint Appeal	30 business days
Expedited Complaint Appeal	2 business days
Standard Action Appeal	30 calendar days after receipt of appeal.*
Expedited Action Appeal	72 hours after receipt of appeal request*

*The review period can be increased up to 14 days if the member requests an extension or we need more information and the delay is in the member's interest.

If the member is not satisfied with CPHL's Initial Adverse Determination, they may request a State Fair Hearing or an External Appeal through the appropriate New York State agency.

Centers Plan for Medicaid Advantage Plus (MAP)
The Compliant and Appeals process for MAP incorporates the most consumer-favorable elements of the Medicare and Medicaid grievance and appeals systems into a consolidated, integrated system for Members.

MAP Complaints about Services and Items
MAP members can file a complaint about CPHL or any provider (including a non-network or network provider). Examples of the kinds of problems handled through the complaint process include: quality of care, privacy concerns, poor customer service, lack of physical accessibility, waiting times, facility cleanliness, access to interpreter services, plan communications and complaints about the timeliness of CPHL's actions related to coverage decisions or appeals.

Members have the option of filing an internal complaint or an external complaint. An internal complaint is filed with and reviewed by CPHL. An external complaint is filed with and reviewed by the New York State Department of Health.

MAP Appeals for Services or Items

When CPHL receives a request for payment or to provide services or items to a member, it must make an organization determination to decide whether coverage is necessary and appropriate. If the determination is not made in a timely manner or is not favorable, the member has the right to request a reconsideration or appeal.

CPHL is required to process appeals as expeditiously as the member's health status requires, but no later than the time frames outlined in the chart below.

There are several ways a complaint or appeal request can be submitted via:

Email: GandA@Centersplan.com
Phone: 1-877-940-9330 (TTY 711)
Fax: 1-347-505-7089
Mail: Centers Plan for Healthy Living
75 Vanderbilt Avenue
Staten Island, NY 10304
Attn. Grievances and Appeals Department

MAP Complaints about Drugs

A Part D Grievance is a complaint about CPHL or one of our network pharmacies, including a complaint about the quality of care provided at a pharmacy. This type of complaint does not involve coverage of prescription drugs or payment disputes.

MAP Part D Appeals related to Drugs

A member has a right to appeal if he or she believes that CPHL did any of the following:

Decided not to cover a drug, vaccine, or other Part D benefit
Decided not to reimburse a member for a part D drug that he/she paid for Asked for payment or provided reimbursement with which a member disagrees
Denied the member's exception request
Made a coverage determination with which the member disagrees.

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

If the MAP member is not satisfied with the decision on an internal appeal, they may request an External Appeal and/or a State Fair Hearing, depending on the circumstances. If the member is not satisfied with the decision at the State Fair Hearing, there are additional levels of appeal available. Additionally, if a Member does not agree with the MAP grievance decision they can file a grievance appeal. Grievance appeals may also be expedited.

CPHL will accept a Part D-related grievance or appeal in any of the following ways:

Phone: 1-888-807-5717 (TTY 711)
Fax: 1-858-790-7100
Mail: MedImpact Healthcare Systems, Inc.
Scripps Corporate Plaza
10181 Scripps Gateway Ct.
San Diego, CA 92131

MAP complaints and appeals are made in accordance with the following timeframes:

Type	**Timeframe**
Standard Complaint*	30 calendar days
Expedited Complaint	24 hours
Standard Complaint Appeal	30 business days from receipt of all necessary information
Expedited Complaint Appeal	2 business days from receipt of necessary information
Standard Appeal *	30 calendar days after receipt of appeal
Expedited Appeal*	72 hours after receipt of appeal

*Please note that CPHL may extend the determination periods noted above by up to 14 calendar days if additional information or documents are needed and it’s in the best interest of the member.

XIII. Provider Grievance & Appeal Process

Provider Grievances/Complaints

CPHL has a formal process for the handling of provider administrative complaints or non-payment related issues. Provider grievances will be resolved fairly and consistent with CPHL policies and covered benefits.

CPHL shall, upon contracting with a provider, provide the following information about the grievance and appeal system to participating providers:

- The right of the member to file grievances and appeals, or, with the member's written consent, the right of a provider or an authorized representative to file grievances and appeals on the member's behalf;
- The requirements and timeframes for filing a grievance or appeal;
- The availability of assistance in the filing process;
- The right to request a fair hearing after CPHL has made a determination on the member's appeal which is adverse to the member; and
- The fact that, when requested by the member, benefits that CPHL seeks to reduce or terminate will continue if the member files an appeal or a request for a New York State fair hearing within the timeframes specified for filing, and that the member may, consistent with New York State policy, be required to pay the cost of services furnished while the appeal or New York State fair hearing is pending if the final decision is adverse to the member.

CPHL must ensure that punitive action is not taken against a provider who requests an expedited resolution or supports a member's service authorization request, appeal, or grievance.

Payment Appeals/Disputes

If you believe CPHL has not paid for your services according to the terms of your provider agreement, submit a request to CPHL at the following address:

Centers Plan for Healthy Living
Attention: Claims Department
75 Vanderbilt Avenue
Staten Island, NY 10304

Please use the Claim Reconsideration Request form which may be found in the Claims and Payment section on the provider page of our website at www.centersplan.com. Providers must submit a written request with supporting documentation, such as an Explanation of Payment (EOP) and a copy of the claim(s) or denial letter received along with other written documentation. A full explanation of the dispute/appeal is required and must be submitted within 90 days of when the CPHL notice of initial determination was generated or we will not accept the request. The provider is responsible to submit all necessary documentation at the time of the request. CPHL's Claims department conducts the review and/or the health plan Medical Director reviews the second level dispute if medical information is involved.

XIV. Claims Submissions

Overview

This section provides information about the manner in which a provider may submit a clean claim to Centers Plan for Healthy Living (CPHL). You will also find information on how to submit a claim, required data elements, advantages of submitting electronic claims, important information regarding coordination of benefits, member balance billing, and our adjudication/remittance process.

When to Submit Claims

CPHL encourages providers to submit all claims as soon as possible after the date of service. In no event should a claim be submitted beyond the time allotted in your provider agreement. Timely submission will facilitate prompt payment and avoid delays that may result from expiration of timely filing requirements. Exceptions may be made to the timely filing requirements of a claim when situations arise concerning other payer primary liability such as Original Medicare, Medicaid or third-party insurers.

Electronic Claim Submissions

CPHL processes electronic claims in accordance with the requirements for standard transactions set forth at 45 CFR Part 162. CPHL is able to accept a provider's electronic claim transaction through one of three delivery methods:

- Direct - Please contact us at 1-844-299-4211; Option #2 if you are interested in setting up access for direct submission.
- Through the Relay Health Clearinghouse
- Through a Clearinghouse of your choice

Our Payer ID is CPHL or CPHL1

If you are submitting a file through the RelayHealth Clearinghouse or another clearinghouse that connects to the RelayHealth Clearinghouse you must use the following CPIDs:

- Professional claims 6777
- Institutional claims 8660

To ensure adherence to timely filing requirements, paper claims should be submitted until the Provider has been completed successfully testing an EDI submission.

Paper Claim Submissions

In the event you are unsure which form to use please contact our Provider Services department.

Please mail paper claims to:

Centers Plan or Healthy Living
P.O. Box 21033
Eagan, MN 55121

Paper claims should be completed in their entirety including but not limited to the following elements:

<u>The minimum data required for all CMS-1500 claims includes:</u>

- 1a Insured's ID Number
- 2 Patient Name
- 3 Date of birth
- 4 Insured's Name
- 6 Patient Relationship to Insured (always Self)
- 7 Insured's Address
- 11c Insurance Plan Name or Program Name
- 17 Name of Referring Provider or Other Source
- 17b NPI of Referring Provider
- 18 Hospitalization Dates Related to Current Services (for Place of Service 21, 51, 61)
- 21 A thru L Diagnosis or Nature of Illness or Injury
- 22 Resubmission Code for Corrected claims only
- 7 Replacement of prior claim or 8 Void/cancel of prior claim
- 22 Original Reference Number for Corrected claims only (submit Health Plans Claim ID Number)
- 23 Prior Authorization Number
  - Ambulance claims for Medicare Advantage members must contain a Point of Pick-up (POP) ZIP code in box 23
- 24a Date of Service
- 24b Place of Service
- 24d CPT/HCPCS codes and Modifiers as applicable
- 24e Diagnosis Pointer
- 24f Charges (must be greater than $0.00)
- 24g Days or Units
- 24j Rendering Provider NPI
  - Report the Identification Number in Items 24I and 24J only when different from data recorded in items 33a and 33b
- 25 Federal Tax ID Number
- 26 Patients Account Number
- 28 Total Charge
  - If using multiple pages only last page should include the total charges
- 29 Amount Paid
- 31 Signature of Physician or Supplier Including Degrees or Credentials
- 32 Service Facility Location Information (name, address, city, state, and ZIP code)
  - Transportation claims should include the full address of the pick-up & destination
- 32a NPI Number
- 33 Billing Provider Info & Phone Number
- 33a Billing Provider NPI Number
  - Co-insurance claims must include a copy of the primary insurer EOB

The minimum data required for all UB-04 Claims includes:

- 1 Provider Name and address
- 2 Pay-to name **(only if different than field 1)**
- 3a Patient Control Number (**enter your invoice number**)
- 4 Bill type (last digit of 7 is Replacement of prior claim and 8 Void/cancel of prior claim)
- 5 Tax ID Number
- 6 Statement Covers Period From and Through dates (**mmddyy**)
- 8a Member ID number (**Centers Plan ID**)
- 8b Member name
- 9a-d Member address
- 10 Date of Birth (**mmddccyy**)
- 11 Sex (**M or F**)
- 12 Admission Date (**mmddyy**)
- 14 Admission Type
- 15 Admission Source
- 17 Patient status
- 42 Revenue code (4 digits)
- 44 HCPCS or CPT code
- 45 Service Date (**mmddyy**)
- 46 Service Units (must be greater than zero)
- 47 Total Charges (for that service date; include cents)
- 56 NPI number (**10 digits**)
- 58 Insured's name
- 59 Patient's Relationship to Insured (Always 18-Self)
- 60 Insured's unique id (**Centers Plan ID**)
- 64 Document Control Number (Centers Plan claim ID) (Required when bill type [Fl 4] ends in 7 or 8
- 66 Diagnosis Code Qualifier (0 for ICD-10 codes)
- 67 Valid Diagnosis Code
- 69 Admitting Diagnosis
    - Totalssum of all the values in Fl 47

Submitting a Corrected Claim

Corrected claims should be submitted when data has changed from the original submission of the claim. As an example, a corrected claim should be submitted if any of the following data changes: service dates, procedure codes, units, charges, diagnosis codes. Corrected claims should not be submitted if a claim was denied for lack of authorization or if there was a retroactive rate change, rather a claim dispute should be filed.

When submitting a corrected claim to CPHL please ensure that the following data elements are present:

- CMS 1500 form use Item Number 22
    - Resubmission code
        - 7 Replacement of prior claim (used to correct a previously submitted bill)
        - 8 Void/cancel of prior claim (used to indicate this bill is an exact duplicate of an incorrect bill previously submitted)
    - Original Ref. No.
        - CPHL Claim ID of the claim that is being coded or corrected
- UB04 form
    - Field 4 Bill Type
        - 4th Digit requirement
            - 7 Replacement of Prior Claim (used to correct a previously submitted bill)
            - 8 Void/Cancel of a Prior (used to indicate this bill is an exact duplicate of an incorrect bill previously submitted)
    - Field 64 Document Control Number
        - CPHL claim ID of the claim that is being coded or corrected

Please keep in mind that CPHL will adjust the original claim in its entirety based on the claim ID presented on the claim form.

Common errors to avoid:

- Error: Underpayment of corrected claims
    - Original claim ID is processed for 5 lines, 4 are paid, line 5 unpaid due to invalid charges.
    - New corrected claim submitted only for line 5.
    - CPHL will reverse the entire original claim and process the new claim.
    - CPHL processes new claim and pays line 5.
    - Provider is now underpaid as lines 1-4 were reversed and replaced by line 5.
- Solution: submit the corrected claim with all 5 lines, with line 5 now having charges.
- Error: Claim denied for lack of authorization
    - Original claim denied
    - New corrected claim has no data elements changes but is submitted
    - CPHL may reverse the entire original claim and deny for the same reason
    - Deny for invalid corrected claim as no data has been changed
- Solution: Submit a claim dispute (refer to Claim Dispute Resolution Section)

Encounter Data Submissions

For providers that are contracted under a capitation agreement, CPHL is required to report services provided on behalf of its Members to Medicare and/or Medicaid. As such, applicable providers are obligated to submit encounters to CPHL in a manner consistent with the submission of an electronic or paper claim and within the timeframes indicated in their provider agreement.

Coordination of Benefits

If a member has coverage with another plan that is primary to CPHL, please submit a claim for payment to the other plan first. When you have received a determination from the primary plan you may then submit a copy of the primary carrier's Explanation of Payment (EOP) with your claim to CPHL. The amount payable by CPHL will be determined by the amount paid by the primary plan.

Please note that our Managed Long Term Care Plan is a partially capitated plan and may not cover all services covered by other insurers (i.e. inpatient admissions, radiology services, medical visits, lab work, etc.). The cost sharing applied for these types of services should be billed to NYS Medicaid.

Balance Billing

Reimbursement by CPHL constitutes payment in full except for applicable cost sharing (copays, deductibles and coinsurance); these amounts will be indicated on the EOP.

Members of certain CPHL Medicare products may also have Medicaid as a secondary insurance. In those cases the Provider must bill any cost sharing applied by CPHL directly to NYS Medicaid.

If a Member is enrolled in a CPHL Medicare plan that has cost sharing and that Member does not have Medicaid insurance a Provider may collect the cost sharing applied by CPHL directly from the Member.

You agree NOT to balance bill Members for balances that are not their responsibility or that are the responsibility of another carrier.

You may not bill a member for a non-covered service unless:

1) You have informed the member in advance that the service is not a covered service; and
2) The member has agreed in writing to pay for the non-covered service.

Claim Adjudication

CPHL is dedicated to providing timely adjudication of provider claims for services rendered on behalf of their Members. All provider claims submitted for adjudication are processed according to generally accepted claims coding and payment guidelines. Providers must use the most current and specific codes when billing CPHL. When industry codes are updated, the provider is required to update their billing software to meet the current standards. CPHL will not pay any claims submitted using noncompliant codes.

CPHL reserves the rights to use code editing software to determine which services are considered part of, incidental to or inclusive of the primary procedure. The automated claims auditing system verifies the coding accuracy of claims for CPT and Healthcare Common Procedure Coding System (HCPCS) procedures. This system ensures the same auditing criteria are applied across all claims. Editing decisions are supported by online medical coding policy statements published by CMS as a part of the National Correct Coding Initiative (NCCI, also known as CCI).

In order for your claim to be adjudicated in the most efficient manner and for you to receive reimbursement as quickly as possible you must submit a clean claim. Clean claims are typically adjudicated within 30 calendar days of receipt.

Examples of a clean claim are claims that:

- Are submitted in a timely manner
- Pass all edits
- Have all basic information necessary to adjudicate the claim
- Are accurate in services rendered and coding used to request for payment
- Are submitted on a HIPAA-compliant standard claim form, including a CMS-1500 or CMS-1450 or the electronic equivalent of such claim form
- Require no further information, adjustment or alteration by the provider or by a third party in order to be processed

Claim Payment

CPHL finalizes claims and issues EOP statements on a weekly basis.
CPHL has partnered with PaySpan® Health - a solution that delivers Electronic Funds Transfers (EFTs), Electronic Remittance Advice (ERAs), and much more. This service is free to all CPHL Providers.

PaySpan Health gives you the option to your receive payment electronically direct to your bank account. You are also able to choose the method in which you receive EOP:

- EOP presented online and printed at your location
- HIPAA 835 electronic remittance file for download directly to a HIPAA-compliant Practice Management or Patient Accounting System
- Mailbox capability to establish a mailbox for automated delivery of 835s and/or PDFs

If you sign up to receive payments and remittances electronically, you will no longer receive paper checks or Explanations of Payment in the mail.

As a Provider, you can gain immediate benefits by signing up for PaySpan Health:

- **Improve cash flow** – Electronic payments can mean faster payments, leading to improvements in cash flow.
- **Maintain control over bank accounts** – You keep TOTAL control over the destination of claim payment funds. Multiple practices and accounts are supported.
- **Match payments to EOP** – You can associate electronic payments quickly and easily to an advice/voucher.
- **Multiple Payers** – Reuse enrollment information to connect with multiple Payers. Assign different Payers to different bank accounts, as desired.

Registering your Practice

Signing up for PaySpan Health is simple, secure, and will only take 5-10 minutes to complete. To enroll, you must register as a user on the PaySpan Health website. Using your web browser, go to http://www.payspanhealth.com. Enter your unique registration code and PIN, provided **in a separate correspondence that will be sent via USPS mail to each provider**. Have your bank routing and account information found on a check, not a deposit slip, available. A step-by-step guide for registration is available online. For additional assistance, please call our Provider Hotline at 1-877-331-7154, Option 1.

Claim Status

After filing a claim with CPHL, please review the EOP for accuracy. If the claim does not appear on an EOP within 30 business days from when it was mailed or you have no other written indication the claim has been received, check the status of your claim by calling our Provider Services department. If the claim is not on file with CPHL, please resubmit your claim within 90 days from the date of service. If filing electronically, check the confirmation reports for acceptance of the claim you receive from your EDI or practice management vendor

Claim Dispute Resolution

CPHL and its contracted providers are responsible for the timely resolution of any disputes between both parties.

CPHL informs providers about the dispute resolution process through the Provider Manual, provider orientation, or the Plan's website. Providers may also obtain information about the provider dispute process by calling the CPHL Provider Hotline at 1-844-292-4211. Providers in disagreement with a non-clinical/administrative decision, related to a claim, may access the Claim Dispute Resolution process. This process allows a contracted provider on his/her own behalf to receive a review of an administrative claim denial, including, but not limited to computational errors, clerical errors, interpretation of contract reimbursement terms, timely filing denials, failure to obtain prior approval for any services, authorization limits exceeded, and failure to follow a plan policy or procedure.

Requests by non-contracted providers, providers on behalf of a Member, and requests to reverse pre-service denials, are excluded from this process and are addressed elsewhere in this manual.

If a Claim Dispute Resolution request fails to include all required elements or is not received at the Plan’s address listed in the chart below, the claim will not be reviewed.
The only written notice of a Claim Dispute Resolution decision will be either an updated Explanation of Payment (EOP) or a letter upholding the original claim decision. Such notice constitutes CPHL’s final decision related to the claim and no further review is available. Should a contracted provider wish to challenge the plan’s Claim Dispute Resolution decision, further rights, if any, are as documented in the provider agreement.

For New York State Medicaid products only
Pursuant to Section 3224-a(h)(1) of New York Insurance Law, should CPHL receive an Administrative Appeal from a contracted provider regarding a claim that was denied exclusively because it was submitted untimely, the denial will be reversed, subject to a potential twenty-five (25%) reduction, if the provider is able to demonstrate that: a) his/her non-compliance with the applicable claim submission timeframe was the result of an unusual occurrence; and b) he/she has a pattern/practice of timely submitting claims. The foregoing will apply only if the claim had been submitted within 365 days of the date of service.

Contracted Provider Claim Dispute Resolution Procedures and Timeframes

Filing Timeframe	Provider must submit a written request within 90 days from the date of the Explanation of Payment (EOP) unless otherwise specified in the contractual agreement[1].
Required Documents	Copy of the Explanation of Payment (EOP) Completed Provider Claim Dispute Request form[2] documenting the nature of the request (factual basis for dispute) Any records or documentation supporting the dispute.
Send written request	By mail: Centers Plan for Healthy Living Attn.: Claims Department 75 Vanderbilt Ave Staten Island, NY 10304 or via secure fax: (347)-802-4308
Plan's Determination Notification	Within 45 days of receipt of required documents in the form of a letter or a new EOP. All decisions are final.

Note: The right to a dispute review shall not apply to a claim submitted 365 days after the service date.

[1]Timeframes in the provider contract supersede timeframes in this manual.
[2]The Provider Claim Reconsideration Request Form can be found on the Provider page at www.centersplan.com.

XV. Quality Assurance/Improvement Program

Centers Plan for Healthy Living (CPHL) is committed to providing quality, comprehensive, patient-centered health care. The Quality Assurance and Performance Improvement (QAPI) Program plays a vital role in maintaining a coordinated, cost-effective health delivery system that appropriately and expeditiously meets members' needs. The QAPI Program is designed to continuously monitor, evaluate, and improve CPHL administrative services as well as the services delivered by network providers.

The QAPI Program is governed and executed by the QAPI Committee, which is supervised by the Chief Medical Officer (CMO). The role of the QAPI Program is to:

- Develop and implement standards of operations based on federal and state regulatory guidelines, including ADA requirements;
- Develop and implement an annual work plan;
- Complete an annual review of the work plan and department performance evaluation;
- Develop, review/adjust, and implement policies and procedures to ensure compliance with all regulatory, contractual, and internal standards of care;
- Review metrics quarterly to evaluate whether or not benchmarks are met;
- Create and implement a Corrective Action Plan (CAP) for any metric that falls below the benchmark, and submit the CAP to the QAPI Committee on a quarterly basis;
- Review and analyze data from internal/external audits to ensure regulatory, contractual, and internal compliance;
- Make recommendations for change based on results from internal/external audits;
- Measure member satisfaction and identify areas of dissatisfaction through the analysis of complaints and grievances and focused surveys
- Promote member safety and prevent undesirable occurrences through systematic monitoring of care/services.
- Track and trend issues to find opportunities for improvement.

Scope of the Program

The QAPI Program emphasizes evaluation of processes and performance, as well as identification of opportunities for improving services and member care. These may include, but are not limited to the following:

- Utilization Management
- Case Management
- Member Grievances and Appeals
- Compliance with Preventive Health and Clinical Practice Guidelines
- Provider Network
- Credentialing and Recredentialing
- Member/Provider Satisfaction
- NYDOH Quality Reporting Requirements
- CMS Reporting Requirements (HEDIS, CAHPS, HOS)

Provider Participation

As a component of the QAPI program, CPHL collects data regarding provider adherence to clinical treatment or preventive health guidelines. The results of this data collection are used to establish baseline measurements for future quality initiatives. CPHL encourages contracted providers to participate in the QAPI Program by providing input on the plan's clinical studies or conducting their own quality improvement projects.

Notice of Medicare Non-Coverage (NOMNC)

Per CMS guidelines, providers are required to deliver notice to members at least two days before termination of skilled nursing care, home health care or comprehensive rehabilitation facility services. If a member's service is expected to be fewer than two days in duration, the notice should be delivered at the time of admission, or beginning of services in a non-institutional setting. If the span of time between services exceeds two days, the notice should be given no later than the next to last time services are furnished.

Delivery of notice is valid only upon signature and date of member or their authorized representative, if the member is not competent. The standard CMS approved notice entitled, ***"Notice of Medicare Non-Coverage" (NOMNC***) must be used.
The NOMNC form and instructions can be accessed on the CMS website at:
cms.gov > Medicare > Beneficiary Notices Initiative (BNI) > MA ED Notices
(*www.cms.gov/Medicare/Medicare-General-Information/BNI/MAEDNotices*)*.
There can be no modification of this text and all required elements must be present, including instructions on how to contact the QIO and the member's Medicare Advantage benefit plan.

Appeals of the service terminations are called ***fast track*** appeals and are reviewed by the QIO. You must provide requested records and documentation to us or the QIO, as requested, no later than the close of calendar day of the day that you are notified by us or the QIO if the member has requested a ***fast track*** appeal. This includes weekends and holidays.

*Note: The URL is managed by CMS and is subject to change.

Required Notification to Members for Observation Services

In compliance with the Federal Notice of Observation Treatment and Implication for Care Eligibility Act (NOTICE ACT) effective August 6, 2015, contracted hospitals and critical access hospitals must deliver the Medicare Outpatient Observation Notice (MOON) to any Member who receives observation services as an outpatient for more than 24 hours. The MOON is a standardized notice to a Member informing that the Member is an outpatient receiving observation services and not an inpatient of the hospital or critical access hospital and the implications of such status. The MOON must be delivered no later than 36 hours after observation services are initiated or, if the Member is released from observation less than 36 hours after observation was initiated, then upon the Member's release from observation.
The OMB approved Medicare Outpatient Observation Notice and accompanying form instructions can be found at www.cms.gov/Medicare/Medicare-General-Information/BNI/MOON.

XVI. Pharmacy Services

CPHL provides pharmacy benefits to our Medicare Advantage members via the plan's Pharmacy Benefit Manager (PBM), MedImpact. Pharmaceutical management procedures are an integral part of the CPHL pharmacy program that promotes the utilization of the most clinically appropriate agent(s) to improve the health and well-being of our members. The utilization management tools used to optimize the pharmacy program includes:

- Formulary;
- Prior Authorization;
- Step Therapy;
- Quantity Limits; and
- Mail Order Service

These processes are described in detail below. In addition, prescriber and member involvement is critical to the success of the pharmacy program. To help your patients get the most out of their pharmacy benefit, please consider the following guidelines when prescribing:

- Follow national standards of care guidelines for treating conditions;
- Prescribe drugs listed on the formulary;
- Prescribe generic drugs when therapeutic equivalent drugs are available within a therapeutic class; and
- Evaluate medication profiles for appropriateness and duplication of therapy.

For more information on CPHL's benefits, visit CPHL's website at www.centersplan.com.

All medication prescriptions need to be processed through the pharmacy. Prescriptions for medications to be administered in the provider's office need to be sent to the pharmacy. CPHL does not accept the "buy and bill" method of processing prescriptions. Prior authorization requests for all medications should be sent to MedImpact, and should follow their protocol. This applies to both Part B and Part D medications.*

*An exception is Avastin (bevacizumab) for ophthalmic indication/intravitreal injection.

Formulary

The formulary is a reference tool and clinical guide of prescription drugs selected by the Pharmacy and Therapeutics (P&T) Committee. The formulary identifies any of the pharmacy utilization management tools that apply to a particular drug. The medications on the formulary are organized by therapeutic class, product name, strength, form and coverage details (quantity limit, prior authorization and step therapy).
The formulary is located on CPHL's website www.centersplan.com. The formulary file gets updated every month to reflect any additions or changes.

Coverage Limitations

- Non-prescription (OTC) drugs
- Drugs when used to promote fertility
- Drugs when used for the relief of cough or cold symptoms
- Drugs when used for cosmetic purposes or to promote hair growth
- Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations
- Drugs which are used for the treatment of sexual or erectile dysfunction, such as Viagra, Cialis, Levitra, and Caverject
- Drugs which are used for treatment of anorexia, weight loss, or weight gain
- Outpatient drugs for which the manufacturer seeks to require that associated tests or monitoring services be purchased exclusively from the manufacturer as a condition of sale
- Barbiturates, except when used to treat epilepsy, cancer, or a chronic mental health disorder

Prior Authorization

Prior authorization protocols are developed and reviewed annually by the P&T Committee. Prior authorization protocols indicate the criteria that must be met in order for the drug to be authorized. Part D drugs requiring prior authorization are designated by the letters "PA" on CPHL's formulary.

Quantity Limits

Quantity limits are used to encourage that drugs are supplied in a quantity consistent with FDA-approved dosing guidelines. Quantity limits are used to help prevent billing errors.

Part D drugs that have quantity limits are designated by the letters "QL," and the quantity permitted, on CPHL's formulary.

Mail Order Service

Drugs available through mail order are maintenance medications.

CPHL's mail-order service allows Members to order **up to a 90-day supply** on some select drugs.

Members who utilize CPHL's mail order service may be eligible for reduced co-payment amounts. More information on the Mail Order Service can be found on our website at www.centersplan.com.

Over-the-Counter (OTC) Medications

Medications available to Medicare Advantage Plan members without a prescription are not eligible for coverage under the member's Medicare Part D benefit. However, some of CPHL's plans (e.g., MAP, MA-PD, D-SNP, I-SNP) include a supplemental OTC debit card benefit. The amount loaded to the OTC debit card varies by plan, as does the frequency with which the funds are loaded. Please direct members to their EOC or member services for additional

information. The amounts loaded to the OTC debit card does not roll over from month to month or quarter to quarter. Please direct members to their OTC card carrier or the plan's website for the list of covered items.

Please refer to the member's Summary of Benefits/Evidence of Coverage (EOC) for additional information about their supplemental over-the-counter benefit. The Summary of Benefits and

EOC can be found on our website at www.centersplan.com .

Member Part D Cost Sharing

Medicare Advantage Plans - The co-payment and/or coinsurance amounts are based on the drug's formulary status, including tier location, and the member's subsidy level. Refer to the member's Summary of Benefits/EOC for the exact co-pay/coinsurance. These documents are available on CPHL's website at www.centersplan.com.

Our real time benefit tool (RTBT) is integrated with most electronic health record (EHR) systems to provide patient-specific cost-sharing information, clinically appropriate formulary alternatives, when available, and the formulary status of each drug including any utilization management requirements. This information is available to the prescriber (using one of the integrated EHRs) in real time during e-prescribing for helping to decide on the most clinically relevant and cost-effective option.

Centers Plan for Medicaid Advantage Plus members have zero co-pay for covered drugs obtained from in-network providers.

Prescription Drug Coverage Determinations

CPHL/Medimpact will make decisions as to whether to provide or pay for a Part D drug including determinations on medical necessity, drugs not on the formulary, drugs provided by an out-of-network pharmacy, drugs that are benefit exclusions, drugs requested as exceptions, and decisions on cost-sharing amounts. You may contact the CPHL Provider Hotline 1-844-292-4211 with questions concerning member prescriptions or any other questions you may have or you can use the Prescription Drug Coverage Determination form to request information that is available on our website at https://www.centersplan.com/providers under "Prescription Drug Coverage Information."

Exceptions to the Formulary

When requesting a formulary, tiering or utilization restriction exception, a prescriber or physician supporting statement must be submitted to the PBM. Generally, a decision will be made within 72 hours of getting the supporting statement. If waiting up to 72 hours for a decision, could be seriously affect the member's health, an expedited exception request can be submitted. If the request to expedite is granted, a decision will be rendered no later than 24 hours after the supporting statement is received.

To request a prescription drug coverage determination or an exception to the formulary, contact MedImpact in one of the following ways:

By phone: 1-888-807-5717, TTY 711
By fax: 1-858-790-7100
By mail: MedImpact Healthcare Systems, Inc.
Scripps Corporate Plaza
10181 Scripps Gateway Ct.
San Diego, CA 92131

Medication Appeals

To request an appeal of an initial coverage determination, contact MedImpact at:

By phone: 1-888-807-5717, TTY 800-421-1220
By fax: 1-858-790-7100
By mail: MedImpact Healthcare Systems, Inc.
Scripps Corporate Plaza
10181 Scripps Gateway Ct.
San Diego, CA 92131

Once the appeal of the initial coverage determination has been properly submitted and obtained by CPHL/MedImpact, the request will follow the appeals process described in *Section XI: Member Grievance and Appeals Process.*

Pharmacy – Managed Long-Term Care Product

MLTC members get their prescription drugs covered through the New York State Medicaid Program using their Medicaid card. The New York State Medicaid Pharmacy program covers medically necessary FDA approved prescription and non-prescription drugs (OTC). Prescription drugs require a prescription order with appropriate required information. Non-prescription drugs, often referred to as Over-the-Counter or OTC drugs, require a fiscal order (a fiscal order contains all the same information contained on a prescription). Certain drugs/drug categories require the prescribers to obtain prior authorization.

The list of Medicaid covered prescription drugs can be found at:
https://www.emedny.org/info/fullform.pdf

Pharmacy program and billing policy and other pharmacy related information can be found in the Pharmacy Provider Manual, which can be found at:
https://www.emedny.org/ProviderManuals/Pharmacy/PDFS/PharmacyPolicyGuidelin es.pdf

XVII. Compliance

Centers Plan for Healthly Living's (CPHL's) Board of Directors, management staff, and employees are committed to conducting its business operations in compliance with ethical standards, contractual obligations, and all applicable statutes, regulations, and rules. CPHL's Compliance Program reflects our commitment to integrity, accountability, and quality services. A copy of CPHL's Code of Conduct & Compliance Program is available on the Provider page of our website, www.centersplan.com/providers.

CPHL's commitment to compliance extends to its own internal business operations and to our contracted entities, referred to as First Tier, Downstream, and Related Entities (FDRs) or Affiliates, all of which are defined below.

First Tier Entity

Any party that enters into a written arrangement, acceptable to CMS, with a Medicare Advantage Organization or Part D plan sponsor or applicant to provide administrative services or healthcare services to a Medicare eligible individual under the Medicare Advantage program or Part D program. (See 42 C.F.R. § 423.501)

Downstream Entity

Any party that enters into a written arrangement, acceptable to CMS, with persons or entities involved with the Medicare Advantage benefit or Part D benefit, below the level of the arrangement between a Medicare Advantage Organization or applicant or a Part D plan sponsor or applicant and a First Tier entity. These written arrangements continue down to the level of the ultimate provider of both health and administrative services. (See 42 C.F.R. §, 423.501)

Related Entity

Any entity that is related to a Medicare Advantage Organization or Part D sponsor by common ownership or control and:

1) Performs some of the Medicare Advantage Organization or Part D plan Sponsor's management functions under contract or delegation;
2) Furnishes services to Medicare enrollees under an oral or written agreement; or
3) Leases real property or sells materials to the Medicare Advantage Organization or Part D plan Sponsor at a cost of more than $2,500 during a contract period. (See, 42 C.F.R. §423.501).

Affiliate

A person, provider, or entity who provides care, services, or supplies under the Medicaid program, or a person who submits claims for such health care services for, or on behalf of, another Medicaid provider.

CPHL's Responsibilities

CPHL must ensure that its First Tier, Downstream and Related Entities (FDRs) and Affiliates comply with applicable State and Federal regulations. As ultimately, CPHL is responsible for fulfilling the terms and conditions of our contracts with the Centers for Medicare and Medicaid Services (CMS) and New York State Medicaid, and for meeting the Medicare and Medicaid program requirements, we require each FDR and Affiliate to comply with requirements such as general compliance training and Fraud, Waste, and Abuse training as outlined by CMS. An FDR or Affiliate must provide its organization and Downstream Entities, who may be in a position to commit significant noncompliance or health care FWA (Fraud, Waste and Abuse), with CMS's General Compliance Training and Fraud, Waste, and Abuse Training (or comparable training modules) within 90 days of initial hire/contracting and annually thereafter. Training materials may be found at: https://www.centersplan.com/share/pdfs/CPHL_Uploads/fwa_compliance_training_revised_08292016.pdf.

Providers' Responsbilities

First Tier entities are responsible for ensuring that their downstream and related entities comply with this policy and all applicable Federal and State statutes and regulations. FDRs and Affiliates must maintain supporting documentation of compliance with these requirements below for a period of ten (10) years and must furnish evidence of said compliance to CPHL upon request. Failure to meet the requirements may lead to a Corrective Action Plan, retraining, or the termination of a contract and relationship with CPHL.

Exclusion Screenings and Conflicts of Interest

Federal law prohibits the payment by Medicare, Medicaid or any other Federal or State healthcare program for any item or service furnished by a person or entity excluded from participation in these Federal programs. Each FDR and Affiliate must perform a check to confirm that employees and contractors (including temporary employees) are not are excluded from participation in federally funded healthcare programs prior to hire and monthly thereafter.

The following websites must be used to perform the required screening:

- OIG List of Excluded Individuals/Entities (LEIE):
- http://exclusions.oig.hhs.gov
- General Services Administration (GSA) database of excluded individuals/entities: http://www.gsa.gov
- NYS Office of Medicaid Inspector General Exclusion Listing: http://www.omig.state.ny.us/data/content/view/72/52 and http://www.omig.state.ny.us/data/component/option.comphysiciandirectory
- System for Award Management (SAM):
- https://www.sam.gov/portal/SAM/#1

If an FDR or Affiliate is contracted to service CPHL's Managed Long Term Care Plan (MLTC), FDR or Affiliate must also screen its organization prior to hire/contracting and monthly thereafter using the exclusion screening resources of the Office of the Medicaid Inspector General (OMIG), National Plan and Provider Enumeration System (NPPES), List of Excluded Individuals and Entities (LEIE) or the Medicare Excluded Database (MED), the United States Department of the Treasury's Office of Foreign Assets Control Sanctions List, and any other databases the NYS Secretary prescribes.

If the FDR or Affiliate identifies an employee or contractor on an exclusion list, the excluded individual or entity (FDR or Affiliate) must be prohibited from performing any work directly or indirectly related to Federal or State healthcare programs, and appropriate corrective action must be taken. Evidence of exclusion checks must be maintained (i.e., logs or other records) to document that each employee and contractor has been screened in accordance with current regulations and requirements.

FDRs and Affiliates must effectively screen its organization's governing bodies and senior leadership for conflicts of interest upon hire and annually thereafter.

Provider Access and Availability

CPHL will conduct a service area review of provider access and availability annually. CPHL shall take appropriate action with providers who fail to meet reasonable standards as defined by New York State Department of Health ("NYSDOH"). The results of these surveys will be kept on file and made readily available for review by the NYSDOH upon request.

Code of Conduct

CPHL publishes its Code of Conduct which articulates broad principles that guide its Board of Directors, employees, FDRs and Affiliates in conducting their business activities in a professional, ethical, and legal manner. A copy of the Code of Conduct may be found on the Provider page of our website, www.centersplan.com/providers. FDRs and Affiliates must either establish a comparable Code of Conduct that meets applicable laws and regulations, including the CMS requirements set forth in 42 CFR § 422.503(b)(4)(vi)(A) and 42 CFR § 423.504(b)(4)(vi)(A), or adopt and distribute CPHL's Code of Conduct to all employees and contractors.

Health Care Fraud, Waste, and Abuse (FWA)

CPHL's policy is to detect and prevent any activity that may constitute fraud, waste, or abuse, as defined below, **including** violations of the Federal False Claims Act or any Federal or State, and/or Medicare or Medicaid fraud laws.

Fraud:

Any type of intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person in a managed care setting, including any act that constitutes fraud under applicable federal or state law, committed by an MCO, contractor, subcontractor, provider, beneficiary or enrollee or other person(s). Fraud also includes knowingly and willfully executing, or attempting to execute, a scheme or artifice to defraud any healthcare benefit program or to obtain (by means of false or fraudulent pretenses, representations, or promises) any of the money or property owned by, or under the custody or control of, any healthcare benefit program.

Waste:

The overutilization of services, or other practices that, directly or indirectly, result in unnecessary costs to the Medicare program, Medicaid program, or CPHL. Waste is generally the misuse of resources.

Abuse:

Provider practices that are inconsistent with sound fiscal, business or medical practices and result in unnecessary costs to the state or federal government programs or Managed Care Organization (MCO), or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for healthcare in a managed care setting, committed by an MCO, contractor, subcontractor, provider, beneficiary or enrollee. Abuse also includes enrollee practices that result in unnecessary costs to the state or federal government, MCO, contractor, subcontractor, or provider.

Common Examples of Fraud, Waste, and Abuse include the following:

Fabrication of Claims:

In the outright fabrication of claims or portions of claims, a fraud perpetrator uses legitimate patient names and insurance information either to concoct fictitious claims, or to add to otherwise legitimate claims fictitious charges for treatments or services that were never provided or performed.

Falsification of Claims:

In the falsification of claims, the perpetrator makes a material and intentional misrepresentation of one or more elements of information in the claim, for obtaining a payment to which she/he is not entitled.

Unbundling:

Provider submits a claim reporting comprehensive procedure code (e.g. Resection of small intestine) along with multiple incidental procedure codes (e.g. Exploration of abdominal and Exploration of the abdomen) that are an inherent part of performing the comprehensive procedure. Some providers may submit the unbundled procedures on multiple claims in an attempt to bypass bundling edits in the claims processing system.

Fragmentation:

The provider bills multiple procedure codes for a group of procedures normally covered by a single, comprehensive CPT code. An example of fragmentation is billing parts of a single, whole procedure separately in an attempt to bypass the fragmentation edits in the claims processing system.

Duplicate claim submissions:

Submitting claims under two Tax Identification Numbers to bypass duplicate claim edits in the claims processing system.

Fictitious Providers:

Fraud where perpetrators obtain current membership information from operatives working in the billing offices of legitimate providers (usually hospitals) and submit claims.

As a provider, if you have any knowledge or information that any such activity (i.e., known or suspected noncompliance and/or FWA) may be taking, or has, taken place you must report it to CPHL either by calling CPHL's anonymous Reporting Hotline at **1-855-699-5046** or reporting it online at www.centersplan.ethicspoint.com.

Regulations Related to Fraud, Waste and Abuse

The Affordable Care Act (ACA)

The ACA requires providers, suppliers, Medicare Advantage plans, and Part D plans to report and return Medicare and Medicaid overpayments within 60 days of notification.

The Deficit Reduction Act of 2005

The Deficit Reduction Act of 2005 (DRA) contains many provisions reforming Medicare and Medicaid that are designed to reduce program spending. As an entity that offers Medicaid and Medicare coverage, CPHL is required to disseminate information to employees and FDRs about our mutual roles and responsibilities to detect and prevent fraud, waste, and abuse in the healthcare system. This includes providing you with information about the Federal False Claims Act, the New York State False Claims Act, and other State laws regarding Medicare and Medicaid fraud. Any organization that does not comply with the requirements may be denied Medicare or Medicaid reimbursement.

The Federal False Claims Act

The False Claims Act is a Federal law that is intended to prevent fraud in federally funded programs such as Medicare and Medicaid. The act allows everyday people to bring suits against groups or other individuals that are defrauding the government through programs, agencies, or contracts (but the act does not cover tax fraud).

Both Federal and State False Claims Acts (FCA) applies when a company or person:

- Knowingly presents (or causes to be presented) to the Federal Government a false or fraudulent claim for payment;
- Knowingly uses (or causes to be used) a false record or statement to get a claim paid by the Federal Government;
- Conspires with others to get a false or fraudulent claim paid by the Federal Government; or
- Knowingly uses (or causes to be used) a false record or statement to conceal, avoid, or decrease an obligation to pay or transmit money or property to the Federal Government.

The False Claims Act defines "knowing" and "knowingly" to mean that a person with respect to the information:

1) has actual knowledge of the information,
2) acts in deliberate ignorance of the truth or falsity of the information, or
3) acts in reckless disregard of the truth or falsity of the information, and
4) no proof of specific intent to defraud is required.

Criminal penalties for submitting false claims may include fines, imprisonment, or both. For more information on fraud, visit https://oig.hhs.gov/fraud on the Internet.

New York State False Claims Act

The NYS False Claims Act was enacted by NY State and enhances the State's ability to recover and impose penalties upon the "knowing" submission of false claims to state or local government programs, including Medicaid and Child Health Plus. It is modeled after the Federal False Claims Act and is effective for claims filed or presented on or after April 1, 2007.

Fiscal Intermediaries (FI)

Pursuant to SSL 365-f, and in accordance with guidance issued by the ,New York State Department of Health (DOH), CPHL will be required to solely contract with FIs that have either initiated or received DOH approval of Fiscal Intermediary authorization.

Anti-Kickback Statute

The Anti-Kickback Statute (42 U.S.C. Section 1320a-7b(b)) makes it a criminal offense to knowingly and willfully offer, pay, solicit, or receive any remuneration to induce or reward referrals of items or services reimbursable by a Federal health care program. Where remuneration is paid, received, offered, or solicited purposefully to induce or reward referrals of items or services payable by a Federal health care program, the Anti- Kickback Statute is violated. If an arrangement satisfies certain regulatory safe harbors, it is not treated as an offense under the statute. The safe harbor regulations are set forth at 42 Code of Federal Regulations (CFR) Section 1001.952. Criminal penalties for violating the Anti-Kickback Statute may include fines, imprisonment, or both. For more information, visit https://oig.hhs.gov/compliance/safe-harbor-regulations/ on the Internet.

Physician Self-Referral Law (Stark Law)
The Physician Self-Referral Law (Stark Law) prohibits a physician from making a referral of designated health services to an entity in which the physician (or an immediate member of his or her family) has an ownership/investment interest or with which he or she has a compensation arrangement, unless an exception applies. Penalties for physicians who violate the Physician Self-Referral Law (Stark Law) include fines as well as exclusion from participation in all Federal health care programs. For more information, visit http://www.cms.gov/Medicare/Fraud-and-Abuse/PhysicianSelfReferral on the Centers for Medicare & Medicaid Services (CMS) website.

Criminal Health Care Fraud Statute
The Criminal Health Care Fraud Statute (18 U.S.C. Section 1347) prohibits knowingly and willfully executing, or attempting to execute, a scheme or artifice:

- To defraud any health care benefit program; or
- To obtain (by means of false or fraudulent pretenses, representations, or promises) any of the money or property owned by, or under the custody or control of, any health care benefit program; in connection with the delivery of or payment for health care benefits, items, or services. Proof of actual knowledge or specific intent to violate the law is not required. Penalties for violating the Criminal Health Care Fraud Statutemay include fines, imprisonment, or both.

Health Insurance Portability and Accountability Act (HIPAA)
HIPAA established the national Health Care Fraud and Abuse Control Program ("HCFAC") which coordinates federal, state, and local law enforcement activities with respect to healthcare fraud and abuse. HIPAA also enacted an additional prohibition of healthcare fraud, forbidding knowing and willful acts to defraud a healthcare benefit program by false or fraudulent pretenses. (Note: HIPAA also protects and safeguards the information health plans, and other covered entities, maintain and transmit about Members, whether in paper, electronic or any other form. Member information must be kept confidential and its use and disclosure is only permitted, as required, by state and federal laws and regulations. See Section XVII below.)

Health Information Technology for Economic and Clinical Health (HITECH) Act
HITECH enacted as part of the American Recovery and Reinvestment Act of 2009, imposes notification requirements on covered entities, business associates, vendors of personal health records, and related entities in the event of certain security breaches relating to protected health information (PHI).

Audit and Payment Recovery

- New York State Office of the Attorney General (OAG), DOH, OMIG and the Office of the State Comptroller (OSC) have the right to audit, investigate or review the provider or subcontractor and recover overpayments and damages. The OAG also has the right to recover penalties, and other damages as a result of any investigation, audit or action, including, but not limited to any litigation brought pursuant to State Finance Law § 187 et seq. or 31 U.S.C. § 3729 et seq. and to bring criminal prosecutions.

- OMIG or NYSDOH has the right to request that CPHL recover an overpayment, penalty or other damages owed to the Medicaid program, including any interest, from its Participating Providers. In such cases OMIG or DOH may charge the Participating Provider a collection fee, in an amount to be determined by OMIG or DOH at their sole discretion. CPHL remits, on a monthly basis, to DOH all amounts collected from the Participating Providers. CPHL reports the amounts recovered in its Quarterly Provider Investigative Report. OMIG will only request that CPHL recover an overpayment, payment or other damage, where there has been a final determination. For purposes of this section, a final determination is defined as: i) a Notice of Agency Action issues by OMIG pursuant to 18 NYCRR Part 515; ii.) a Notice of Agency Action issued by OMIG pursuant to 18 NYCRR Part 516; iii.) a Final Audit Report issued by OMIG pursuant to 18 NYCRR Part 517; iv.) a stipulation of settlement or repayment agreement resolving any outstanding audit, investigation, or review; or v.) an Administrative Hearing Decision issued by the Department pursuant to 18 NYCRR Part 519: however, only a timely request for an administrative hearing, as defined in 18 NYCRR 519.7, shall delay OMIG's request pending a decision.
- New York State Office of the Attorney General (OAG), DOH, OMIG and the Office of the State Comptroller (OSC) have the right to audit, investigate or review the provider or subcontractor and recover overpayments and damages. The OAG also has the right to recover penalties, and other damages as a result of any investigation, audit or action, including, but not limited to any litigation brought pursuant to State Finance Law § 187 et seq. or 31 U.S.C. § 3729 et seq. and to bring criminal prosecutions.

How to Report Fraud, Waste, Abuse, and Compliance Issues

CPHL's policy is to detect and prevent any activity that may constitute fraud, waste, or abuse, including violations of the Federal False Claims Act or any State Medicaid fraud laws. If you have knowledge or information that any such activity may have or has taken place, please contact our Compliance Department. Reporting fraud, waste, or abuse to CPHL can be anonymous through the Hotline below:

CPHL Reporting

- **Phone:** CPHL's 24/7, confidential & anonymous hotline 1-855-699-5046
- **Web:** www.centersplan.ethics.com
- **Mail:** Centers Plan for Healthy Living
Attn: Compliance Department
Vanderbilt Avenue
Staten Island, NY 10304
- **Email:** compliance@centersplan.com

In addition to report suspected or real FWA to CPHL, you may also report FWA to Medicare and/or New York State Medicaid:

Medicare Reporting

- **Office of Inspector General:**
  1-800-HHS-TIPS (1-800-447-8477), TTY 1-800-377-4950
- **Centers for Medicare and Medicaid (CMS):**
  1-800-Medicare (1-800-633-4227), TTY 1-877-486-2048; or
- **By mail to:** Medicare
  Attention: Beneficiary Contact Center
  P.O. Box 39
  Lawrence, KS 66044

New York State Medicaid Reporting

- **Fraud Hotline:** 1-877-873-7283; or
- **Online at:** http://www.omig.ny.gov/data/content/view/50/224/

If a CPHL FDR or Affiliate does not maintain their own confidential reporting mechanism, the CPHL Confidential Hotline and website information must be distributed to encourage employees and contractors to report potential compliance issues, fraud, waste, abuse, conflict of interests, violations of compliance policies and/or any applicable regulation.

Non-Retaliation

Federal and State law and CPHL's policy prohibit any retaliation or retribution against employees, FDRs and Affiliates who report known or suspected Misconduct, Fraud, Waste, and/or Abuse. Each FDR and Affiliate must adopt a policy of non-retaliation and publicize the policy to all employees and contractors.

Investigations

CPHL investigates all allegations of misconduct, fraud, or abuse involving CPHL employees or operations. Investigations are conducted in a manner that protects the rights of the reporting party as well as the subject of the allegations. CPHL requires the cooperation of FDRs and Affiliates during any investigation that may involve their organization or individuals associated with their organization.

CPHL reports, as required, potential fraud or misconduct related to the Medicare program to the HHS-OIG and the Medicare Drug Integrity Contractor (MEDIC) for fraud and misconduct related to the Medicare Prescription Drug Program. Potential fraud, waste, and abuse related to the New York State-funded programs are reported to the New York State Office of the Medicaid Inspector General (OMIG).

XVIII. Risk Adjustment

Overview

Risk Adjustment is the payment model for Medicare Advantage health plans which is designed to ensure that all members are enrolled in plans that are appropriately reimbursed by CMS and meet their individual health needs. By risk adjusting plan payments, CMS is able to make appropriate and accurate payments for enrollees with differences in expected costs. Risk adjustment is used to adjust bidding and payment based on the health status and demographic characteristics of an enrollee. The model uses Hierarchical Condition Category (HCCs) which is comprised of ICD-10 CM diagnosis codes that are grouped together with similar conditions and have similar clinical characteristics, severity and cost implications. These diagnoses contribute to the calculation of the risk score which is used to predict individual and beneficiary needs. Centers Plan for Healthy Living is required to submit diagnosis data to CMS relating to inpatient, outpatient or physician encounters.

Providers play a critical role in helping to ensure the integrity of the data used in calculating the overall health risk of members. The providers are the primary source of diagnostic data for the Plan. The providers' role in this process is to submit encounter records resulting from a face to face visit, documented according to the requirements listed below, and reported to the highest level of specificity. The risk score is calculated annually, and therefore, all diagnosis existing at the time of a visit need to be documented and reported. It is the provider's responsibility to ensure that every diagnosis applied to a claim is supported by documentation within the medical record as noted in the medical record section below.

Medical record requirements

- Patient name and date of birth should appear on all pages of the record.
- Every note must be authenticated with the provider's signature, credentials and the date.
- Documentation must be clear, concise, consistent and complete.
- All conditions affecting the treatment and management of the patient's care should be documented.
- Documentation must meet the MEAT requirement- Monitored, Evaluated, Assessed, Treated
- Documentation must contain the components of a visit; problem list, history and physical, exam, treatment, medications, plan (refer to the medical record guidance).
- The treatment and management for each condition should be documented.
- Abbreviations must be standard and appropriate abbreviations, preferably from a pre-approved abbreviation list.
- Documentation must support the code selection.

Coding

- Utilize guidelines set forth for ICD-10-CM coding by the Centers for Medicare and Medicaid Services (CMS), the American Hospital Association (AHA) and the National Center for Health Statistics (NCHS).
- Codes should be reported to the highest degree of specificity.
- All conditions affecting the treatment and management of the patient's care should be coded.
- The code selection must be supported by documentation.
- Only code conditions previously treated that affect the patient's care.
- Report status conditions such as amputation or transplant.
- Report definitive diagnosis only, not probable, suspected or unconfirmed diagnosis.
- Link the casual relationship between a condition and its' manifestation.
- Ensure claims accuracy.

RADV- Risk adjustment data validation

Risk Adjustment Data validation is the process of verifying diagnosis codes submitted for payment with the support of medical record documentation. Risk adjustment regulations indicate that "MA organizations and their providers and practitioners will be required to submit a sample of medical records for the validation of risk adjustment data, as required by CMS. There may be penalties for submission of false data."

It is important for providers and office staff to be aware of the RADV activities because medical record documentation may be requested for review and audit purposes. As noted in the medical record section. medical records must be available for utilization, risk management, peer review, studies, customer service inquiries, grievance and appeals processing, HEDIS, validation of risk adjustment data and other initiatives.

XIX. HIPAA The Health Insurance Portability and Accountability Act (HIPAA)

Overview

The Health Insurance Portability and Accountability Act (HIPAA) is a federal law that requires CPHL and its providers to protect the security and privacy of its members' Protected Health Information (PHI) and to provide its members with certain privacy rights, including filing a privacy complaint. PHI is any individually identifiable health information. PHI includes a member's name, address, phone number, medical information, social security number, CIN number, Medicare Beneficiary Identification number, date of birth, financial information, etc.

CPHL supports the efforts of its providers to comply with HIPAA requirements. Because patient information is critical to carrying out health care operations and payment, CPHL and its providers need to work together to comply with HIPAA requirements, in terms of protecting patient privacy rights, safeguarding PHI and providing patients with access to their own PHI upon request.

Members are notified of CPHL's privacy practices upon enrollment, at least once every three years and upon any change to the practices, as required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). CPHL's Notice of Privacy Practices includes a description of how and when Member information is used and disclosed within and outside of the CPHL organization. The notice also informs Members on how they may obtain a statement of disclosures or request their personal medical information. CPHL takes measures across our organization to protect oral, written and electronic personally identifiable health information, specifically, protected health information (PHI) of Members.

As a Provider, you must follow the same HIPAA regulations as a covered entity and only make reasonable and appropriate uses and disclosures of protected health information for treatment, payment and health care operations.

Safeguarding Protected Health Information (PHI)

CPHL **and** its providers are required by law to protect member/patient PHI. Providers must take a few basic steps that will significantly minimize the risk of a breach of PHI. The table below contains a few important reminders on how to protect and secure PHI.

PHI in Paper Form

In the office	PHI should be locked away during non-business hours.
Mail	Quality checks of mailings should be conducted prior to sending. Envelopes or packages must be properly sealed and secured prior to sending.
Handling PHI offsite	PHI must be protected during transport to and from the office through the use of binders, folders, or protective covers, or locked in the trunk of the vehicle. PHI must not be left unattended in vehicles, or in baggage at any time.
When disposing	PHI must be shredded or destroyed in a secure manner.

PHI in Electronic Form

Email	**Internal Email:** Email must be limited to the use and disclosure of the minimum necessary data to complete the required task. **External Email:** Email sent or received from an external entity through the internet should not contain PHI unless the email and attachment are encrypted to prevent anyone, other than the intended receiver, from reading the contents. Do not include PHI in the subject line of the email. Email signatures should contain a confidentiality disclaimer.
Electronic devices	Portable data storage devices (CDs, DVDs, USB drives, portable hard drives, tablets, laptops, smartphones, iPhones, etc.) must be encrypted.
Disposal	PHI in electronic form must be destroyed or disposed of in a secure manner.

Reporting a Breach of PHI

If a provider becomes aware that a breach of PHI has occurred, the provider should notify CPHL immediately. To report a breach to CPHL, call CPHL's Member Services at 1-855-270-1600 for MLTC and 1-877-940-9330 for Medicare Advantage products (TTY users should call 711). If a provider becomes aware of any breach of a CPHL member's PHI, in addition to reporting the breach to CPHL, it is critical that the provider report the breach to the Federal Department of Health and Human Services (DHHS) Agency. To report a breach, click on the link below to DHHS' Health Information Privacy web page: http://www.hhs.gov/ocr/privacy/hipaa/administrative/breachnotificationrule/brinstruction.html