



CENTERS PLAN
FOR HEALTHY
LIVING



Provider Manual

Heart. Health. Home.

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I. Introduction

Welcome and thank you for becoming 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/Participants.

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 a 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/Participants to specific services. To carry out critical functions and provide or refer Members/Participants 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
- How to request and get more information

This manual applies to all Centers Plan for Health Living (CPHL) plans. It includes detailed information about your administrative responsibilities, contractual and regulatory obligations, and best practices for interacting with our plans, and helping our Members/Participants navigate CPHL delivery systems.

Please keep your e-mail address with us current so that you can receive electronic communications with new and updated operational information. To update your e-mail address and your directory information log on to your secure account at www.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
- Postings to our Policy updates, Claims and Clinical sections of our provider pages 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: This Provider Manual links to Web sites 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 therein are not necessarily CPHL. Centers Plan for Healthy Living does not guarantee or warrant that the links referenced in this manual, or any information therein contained, are complete, accurate, or up-to-date since the date of this manual's publication or last update.

About Us

Centers Plan for Healthy Living is a New York Managed Care Organization (MCO) operating in the following counties: Bronx, Kings (Brooklyn), Queens, Richmond (Staten Island), Manhattan, Rockland, Erie and Niagara. Plans offered include the following:

Name of Plan	Eligibility Criteria	New York Service Area
Centers Plan for Medicare Advantage Care (HMO) or MAPD	<ul style="list-style-type: none">Has Medicare Part A and enrolled in Part BDoes not have end-stage renal disease (ESRD) at time of enrollmentResides in the Plan's service areaAgrees to continue to pay Medicare Part B premiums if not paid by Medicaid or another third party	Bronx, Kings, New York, Queens, Richmond, Rockland, Niagara, and Erie counties

Name of Plan	Eligibility Criteria	New York Service Area
Centers Plan for Duals Coverage Care (HMO SNP) or DSNP	<ul style="list-style-type: none"> • Has Medicare Part A and enrolled in Part B • Does not have end-stage renal disease (ESRD) at time of enrollment • Resides in the Plan's service area • Has Active Medicaid or another New York State medical assistance program (Medicare Savings Program) 	Bronx, Kings, New York, Queens, Richmond
Centers Plan for Nursing Home Care (HMO SNP) or ISNP	<ul style="list-style-type: none"> • Has Medicare Part A and enrolled in Part B • Does not have end-stage renal disease (ESRD) at time of enrollment • Resides in a CPHL SNP-contracted skilled nursing facility and requires nursing home level of care for at least 90 days 	Bronx, Kings, New York, Queens, Richmond, Rockland, Niagara, and Erie counties
Centers Plan for Healthy Living Medicaid Managed Long Term Care Plan or MLTCP	<ul style="list-style-type: none"> • 21 years of age or older • Resides in the Plan's service area • Determined eligible for Medicaid by the Local Department of Social Services/NY Human Resources Administration • Requires long term care services for more than 120 days 	Bronx, Kings, New York, Queens, Richmond, Rockland, Niagara and Erie counties

Name of Plan	Eligibility Criteria	New York Service Area
Centers Plan for FIDA Care Complete or FIDA	<ul style="list-style-type: none"> • 21 years of age or older • Resides in the Plan's service area • Entitled to benefits under Medicare Part A and enrolled under Medicare Parts B and D, and receiving full Medicaid benefits; <p>Individuals must also meet <i>one of</i> the <i>three</i> following criteria:</p> <ul style="list-style-type: none"> • Nursing facility clinically eligible and receiving facility- based long-term services and supports (LTSS), • Eligible for the Nursing Home Transition & Diversion (NHTD) 1915(c) waiver <ul style="list-style-type: none"> ○ Requires community-based long-term care services for more than 120 days, as determined by a State approved clinical assessment. 	Bronx, Kings, Queens, New York and Richmond counties

Contact Information

Contact	Information
General Information	Centers Plan for Healthy Living 75 Vanderbilt Ave. Staten Island, NY 10304 1-718-215-7000
CPHL website	www.centersplan.com
CPHL Provider Services Department	1-844-292-4211 Fax: 1-718-581-5562 Email: Providerservices@Centersplan.com
Member/Participant Services Department	1-844-274-5227 Medicare Advantage Plans (MAPD, DSNP, ISNP): Option #1 MLTC: Option #2 FIDA : Option #3
Relay Health Claims Resolution	1-866-775-8860
Eligibility Verification	1-844-274-5227 Medicare Advantage Plans (MAPD, DSNP, ISNP): Option #1 MLTC: Option #2 FIDA : Option #3
Grievance and Appeals Department	1-844-274-5227 Medicare Advantage Plans (MAPD, DSNP, ISNP): Option #1 MLTC: Option #2 FIDA : Option #3
Prior Authorization	1-844-274-5227 Medicare Advantage Plans (MAPD, DSNP, ISNP): Option #1 MLTC: Option #2 FIDA : Option #3
Fraud, Waste and Abuse Hotline	1-855-699-5046 or www.centersplan.ethicspoint.com

II. Participating Provider Roles and Responsibilities

All 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, provider 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**
 - Provider ensures Members/Participants of various racial, ethnic and religious backgrounds; as well as disabled individuals are communicated with in an understandable manner, accounting for different needs. Best possible efforts should be made to speak with the member in their 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.
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. Credentialing and Re-credentialing

- 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 business days if his/her medical license, DEA certification (if applicable), and/or hospital privileges (if applicable) are revoked or restricted. Notification within two 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.

6. Provider Directory Requirements

- CPHL will conduct quarterly notifications to contracted provider network to ensure that the required directory information is accurate.
- Providers agrees to notify CPHL immediately, and or at least quarterly 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
- Providers must complete a Demographic Change Request Form whenever you change or update your information. Please complete the [Demographic Change Form](#) and submit to CPHL Provider Services Department at:

Centers Plan for Healthy Living
Provider Relations Department
Vanderbilt Avenue
Staten Island, NY 10304 or

Or by Email: Providerservices@centerplan.com

7. Billing Requirements

- Provider may NOT balance bill Members/Participants for authorized and/or covered services.
- Provider agrees that CPHL reimbursement for services constitute payment in full.
- Provider agrees to follow CMS and CPHL billing guidelines.
- A provider may bill a Member/Participant only when the service is performed with the expressed written acknowledgment that payment is the responsibility of the Members/Participants and that CPHL does not cover the service.

8. Medical Records and On-site Auditing

Centers Plan for Healthy Living participating provider offices must maintain medical records in accordance with good professional medical documentation standards. The provider and office staff must provide CPHL staff with Members/Participants medical records upon request, at no additional cost to CPHL. CPHL staff must also have access to Members/Participants medical records for on- site chart reviews. The 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 Members/Participants 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, and the Centers for Medicare and Medicaid Services.
- Keeping medical records for ten years after the death or disenrollment of a Members/Participants from CPHL. The record shall be kept in a place and form that is acceptable to the New York State Department of Health.

9. Medical Record Documentation Criteria:

The medical record must be written in ink or computer generated and contain at 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 time of visit/service/admission
- Diagnosis
- Significant chronic illnesses and medical conditions
- Allergies
- Treatment plan consistent with the patient's diagnosis.
- Return visit date and follow up plan documented for each encounter.
- Medical status of previous complaints exhibited in previous visits.
- Diagnostics performed or planned
- Documentation of coordination and continuity of care with consultants where applicable.
- Documentation 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. Transition of Care

Provider agrees to provide transition of care to Members/Participants according to the guidelines below:

- **New Members/Participants:** When a new Member/Participant is currently undergoing a course of treatment with a non-participating provider upon or prior to enrollment, CPHL will review the member's treatment plan, and the member will have the option of continuing care for up to 90 days after their enrollment date to allow for consultations, medical record transfer, and stabilization of their medical condition. After the 90-day period, the transition must be complete and care must be received from participating providers. The Care Management Department will assist with and coordinate the transition of care plan.
- **Participating Provider Leaves the Plan:** When a provider leaves the plan for reasons other than fraud, loss of license, or other final disciplinary action impairing the ability to practice, CPHL will authorize the Member/Participant to continue an ongoing course of treatment for a specific period of time, depending on the type of benefit plan and the Members/Participants' need for ongoing treatment. The request for continuation of care will be authorized provided that the request is agreed to or made by the Member/Participant, and the provider agrees to accept CPHL reimbursement rates as payment in full. The provider must also agree to adhere to quality assurance requirements, abide by CPHL policies and procedures, and supply all necessary medical information and encounter data related to the

Members/Participants' care. The Care Management Department will assist with and coordinate the transition of care plan.

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

Providers will remain compliant with ADA standards, including but not limited to:

- Utilizing waiting room and exam room furniture that meet needs of all enrollees, including those with physical and non-physical disabilities
- Accessibility along public transportation routes, and/or provide enough parking
- Utilizing clear signage and way finding (e.g., color and symbol signage) throughout facilities
- Providing secure access for staff-only areas

15. Provider Training

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

Role of the PCP

PCPs are responsible for the provision of initial and routine health care to Members/Participants, as well as for the supervision of a Members/Participants' overall care. PCPs coordinate specialty care and ancillary services, and maintain continuity of care for their Members/Participants. 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/Participants are hospitalized.
- Reaching out to Members/Participants who have not had an annual primary care appointment.
- Referring Members/Participants for at least one dental visit a year, and encouraging dental appointment attendance.
- Complying with standards for 24-hour coverage.
- Ensuring coverage by a Participating Provider for short and long term leaves of absence.
- Counseling adult Members/Participants regarding advance directives. CPHL recognizes the following practitioners as PCPs:

General Practitioners

Family Practice

Nurse Practitioners

Internal Medicine

Geriatricians

Specialist as PCP

CPHL's Centers Plan for FIDA Care Complete allows Participants to choose a contracted specialist as a PCP. In these instances the participating specialists are responsible for providing and coordinating all of the member's primary and specialty care (including the ordering of tests, arrangement of procedures, provision of referrals and medical services) in the same capacity as a PCP.

For all other CPHL plans, Members may request to select a participating specialist as PCP when the member has a life-threatening or degenerative/disabling condition and the following conditions are met:

- The Members' condition or disease requires specialized medical care over a prolonged period.
- The desired participating specialist must have the necessary qualifications and expertise to treat the member's condition or disease.
- The selection will be permitted only if CPHL's Medical Director, after consulting with the PCP and participating specialist (if applicable), agrees that the member's care would most appropriately be coordinated in this manner.

The Member/Participant, their caregivers, their current PCP, or the participating specialist, can initiate requests for specialists as a PCP.

Role of the Specialist

Specialist physicians have advanced training in a medical specialty and provide consultation and treatment to Members/Participants in a designated specialty area.

Specialists deliver specialty services to Members/Participants 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.

III. Member Eligibility

Centers Plan for Healthy Living provides every Member/Participant with an identification (ID) card. The card provides both Members/Participants and Providers with important health plan information. We issue unique non-Social Security Number (SSN)-based member ID numbers to our Members/Participants to protect their confidentiality. This practice also protects our Members/Participants from potential identity theft and fraud. All CPHL Members/Participants receive their own personal ID card with unique Client Identification Number (CIN)-based alphanumeric ID numbers.

You and your staff should familiarize yourself with Members/Participants ID cards. The Members/Participants ID card provides you with information on co-pay requirements, care management authorization requirements, and other information to help care for the Members/Participants 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. CPHL does not require a Provider to verify a Members/Participants eligibility prior to rendering emergency services. Verifying the Members/Participants eligibility is critical to determine whether a member's enrollment status has changed and to help ensure payment. A Member identification card does not guarantee eligibility.

NOTE: Enrollment and eligibility is distinctly different for MLTC / Medicare Members and FIDA Participants. Therefore, the information below has been divided in to 3 different sections describing each plan type.

A. Medicare Advantage Plans (MAPD, DSNP, ISNP)

Eligibility

Medicare beneficiaries that live in a CPHL Service Area and show evidence of Medicare Part A and Part B coverage may be eligible to enroll in one of the following plans Medicare Advantage Plans: MAPD, DSNP, ISNP.

Medicare Member ID Cards

An ID card is issued when a Member joins CPHL. 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 ID card only when the information on the card changes, or if a Member loses a card, or if a Member requests an additional card. Because ID cards do not guarantee eligibility, Providers must verify a Member's eligibility on each date of service.



Providers may use our secure Provider Portal on our website to check Member eligibility, or call the Centers Plan for Medicare Advantage Care Member Services at 1-877-940-9330.

B. Managed Long Term Care (MLTC) Plan

Eligibility

Individuals 21 years or older, who live in CPHL Service Area, are eligible for New York State Medicaid, and upon enrollment, require long-term care services from CPHL for 120 days or more are eligible to enroll in CPHL's Managed Long Term Care Plan.

MLTC Member ID Cards

All new CPHL MLTC Members receive a Membership ID card, which replaces the State Medicaid card. A new card is issued only when the information on the card changes, or the Member loses a card, or if a Member requests an additional card.

The Member ID card is used to identify a CPHL MLTC Member; it does not guarantee eligibility or benefits coverage. Members may disenroll from CPHL and still have their member card. Likewise, Members may lose Medicaid eligibility at any time, which affects their CPHL membership. Therefore, it is important to verify Member eligibility prior to each service rendered.



Providers may use our secure Provider Portal on our website to check Member eligibility, or call the MLTCP Member Services at 1-855-270-1600.

C. Fully Integrated Duals Advantage (FIDA) Plan – Centers Plan for FIDA Care Complete

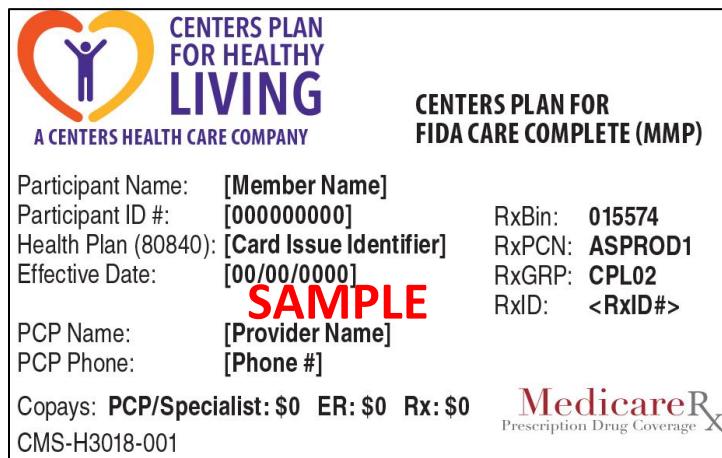
Eligibility

Medicare beneficiaries are eligible to enroll in CPHL's FIDA Plan if they live in a CPHL Service Area, show evidence of Medicare Part A and Part B coverage, and are eligible for New York State Medicaid. Individuals must also meet *one* of the *three* following criteria:

- Nursing Facility Clinically Eligible and receiving facility-based long-term services and supports (LTSS),
- Eligible for the Nursing Home Transition & Diversion (NHTD) 1915(c) waiver
- Require community-based long-term care services for more than 120 days.

A Centers Plan for FIDA Care Complete ID card is issued when a Participant joins CPHL. New Participants are effective on the first day of the month. Participants can continuously use the same ID card as long as they maintain eligibility. CPHL will issue a new ID card only when the information on the card changes, or if a Participant loses a card, or if a Participant requests an additional card. Because ID cards do not guarantee eligibility, Providers must verify a Participants eligibility on each date of service.

Centers Plan for FIDA Care Complete Participant ID Cards



Providers may call the FIDA Participant Services at 1-800-466-2745 to check Participant eligibility.

Important Tips about the Participant ID card

The ID card contains the following information:

- I. Participant's name and ID number
- II. Participant's effective date
- III. Participant's co-payment information, if applicable
- IV. Participant's PCP name and the PCP's phone number, if applicable

IV. Covered Services

Please visit the CPHL website at www.centersplan.com for information on covered services for each line of business. Please refer to our website and the “Referrals and Prior Authorizations” section of this manual for more information about referral and prior authorization procedures.

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 Member/Participant Services at:

Medicare Advantage Plans (MAPD, DSNP, ISNP): 1-877-940-9330

MLTC: 1-855-270-1600

FIDA: 1-800-466-2745

This section describes the services and exclusions to benefits that are provided to our CPHL Members/Participants. 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/Participants 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. Please see the “Appeal Procedures” section of this manual for information on how to file an appeal. Covered services and exclusions for CPHL Members/Participants can be found at www.centersplan.com.

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 or, in the case of a pregnant woman, the health of the woman or her unborn child
- Serious impairment to bodily functions
- Serious dysfunction of any bodily organ or part

CPHL covers emergency services if they are:

- Furnished by a provider qualified to provide emergency services
- Needed to evaluate or stabilize an emergent medical condition in accordance with the prudent layperson standard

Members/Participants 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

Managed Long Term Care Plan (MLTC)

MLTC Members can receive services at home, in the community or in an institution. CPHL provides each Member with a Care Manager who consults with the Member, their family and/or caregivers and their physicians to coordinate services. A list of covered and non-covered services is available on the CPHL website.

Centers Plan for Medicare Advantage Care (MAPD)

Covered services and exclusions for Centers Plan for Medicare Advantage Care Members are listed in the Centers Plan for Medicare Advantage Care Evidence of Coverage (EOC), located on our website at [MAPD marketing materials](#).

Centers Plan for Dual Coverage Care (D-SNP)

Covered services and exclusions for Dual Coverage Care Members are listed in the Center's Plan for Dual Coverage Care Evidence of Coverage (EOC), located on our website at [DSNP marketing materials](#).

Centers Plan for Nursing Home Care (I-SNP)

Covered services and exclusions for Nursing Home Care Members are listed in the Centers Plan for Nursing Home Care Evidence of Coverage (EOC), located on our website at [I-SNP marketing materials](#).

Centers Plan for FIDA Care Complete (FIDA)

FIDA Participants can receive services at home, in the community or in an institution. CPHL provides each Participant with a Care Manager who consults with the participant, their family and/or caregivers and the physicians to coordinate services. Covered services and exclusions for FIDA Participants are listed in the CPHL FIDA Care Complete Participant Handbook, located on our website at [FIDA marketing materials](#).

V. Member/Participant Support Services

Member /Participant Information

Medicare Advantage Plans (MAPD, DSNP, ISNP): 1-877-940-9330, TTY 1-800-421-1220

MLTC: 1-855-270-1600, TTY 1-800-421-1220

FIDA: 1-800-466-2745, TTY 1-800-421-1220

Hours of Operation

Medicare Advantage Plans (MAPD, DSNP, ISNP): Monday – Sunday 8:00am – 8:00pm

MLTC: Monday – Sunday 8:00am – 8:00pm

FIDA: Monday – Sunday 8:00am – 8:00pm

Member Welcome Kits

Each new CPHL Member/Participant receives a Welcome Kit, a Welcome Letter and an ID Card. The new member kits contain the following:

Medicare Advantage Plans (MAPD, DSNP, ISNP)

- A Cover Letter
- An Evidence of Coverage booklet detailing the Medicare health care and prescription drug coverage, and how to access benefits (includes multi-language insert)
- A Provider and Pharmacy Directory
- An Abridged Formulary
- A Health Risk Assessment survey with a self-addressed pre-stamped envelope
- If applicable, a Low Income Subsidy (LIS) rider
- A HIPAA Privacy Policy

MLTC

- 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.

Centers Plan for FIDA Care Complete

- A Cover Letter
- A Participant Handbook
- A Summary of Benefits
- A comprehensive Formulary
- A combined Provider and Pharmacy Directory

Assistance with Cultural and Linguistic Services

Centers Plan for Healthy Living (CPHL) provides access to health care services for a diverse population of Members/Participants 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 all Members/Participants.

Interpreter Services — Non Hospital Providers

Providers are expected to identify the need for interpreter services for your CPHL patients and offer assistance to them appropriately. CPHL offers language and sign interpreters for Members/Participants who speak languages other than English, and those with hearing impairments or speech limitations. Certain printed materials are offered in various languages or formats such as large print, 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 arrange services, please contact Member Services at 1-855-270-1600 for MLTC, and 1-877-940-9330 for Medicare Advantage Plans (MAPD, DSNP, ISNP), and Participant Services at 1-800-466-2745 for FIDA (TTY for the hearing impaired: 1-800-421-1220). We ask that you let us know of any Members/Participants in need of interpreter services, as well as any Members/Participants who may be receiving interpreter services through another resource. The following translations services are available:

Afrikaans	Flemish	Latvian	Shanghainese
Akan	French	Lingala	Sinhala
Albanian	Fukienese	Lithuanian	Slovak
Amharic	Georgian	Macedonian	Slovene
Arabic	German	Malagasy	Somali
Armenian	Greek	Malay	Sotho
Azerbaijani	Gujarati	Maltese	Spanish
Belarusian	Haitian Creole	Mandarin	Swahili
Bengali	Hebrew	Marathi	Swedish
Bosnian	Hindi	Marshallese	Tagalog
Bulgarian	Hmong	Nepali	Tajik
Burmese	Hungarian	Norwegian	Tamil
Cantonese	Icelandic	Nuer	Telugu
Catalan	Indonesian	Nyanja	Thai
Chinese, Simplified	Italian	Pashto	Tibetan
Chinese, Traditional	Japanese	Polish	Tigrinya
Chuukese	Javanese	Portuguese	Tswana
Croatian	Kannada	Punjabi	Turkish
Czech	Kazakh	Quechua	Turkmen
Danish	Khalkha	Romani	Ukrainian
Dutch	Mongolian	Romanian	Urdu
Dzongkha	Khmer	Romansch	Uzbek
English	Korean	Rundi	Vietnamese
Estonian Farsi	Kurdish	Russian	Welsh
Finnish	Lao	Samoan	Yao
	Latin	Serbian	Yiddish
			Zulu

Interpreter Services — Hospital Providers

CPHL requires hospitals, at their own expense, to offer sign and language interpreters for Members/Participants who are hearing impaired, do not speak English, or have limited English-speaking ability. 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 will be available at no cost to the member. You are also required to identify the need for interpreter services for your CPHL patients and offer assistance to them appropriately. If you do not have access to interpreter services, contact Member/Participant Services:

Medicare Advantage Plans (MAPD, DSNP, ISNP): 1-877-940-9330

MLTC: 1-855-270-1600

FIDA: 1-800-466-2745

TTY for the hearing impaired: 1-800-421-1220

We ask that you let us know of any Members/Participants who need interpreter services, as well as any Members/Participants who may be receiving interpreter services through another resource.

VI. Member Rights and Responsibilities

As a CPHL Provider, you are required to respect the rights of our Members/Participants. CPHL Members/Participants are informed of their rights and responsibilities via their Member Handbook and/or their Evidence of Coverage (EOC). The list of our Members/Participants' rights and responsibilities are listed below.

All Members/Participants are encouraged to take an active and participatory role in their own health. Member rights, as stated in the Member Handbook, are as follows:

Member Rights

- 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.

Member 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 in the following ways including, but not limited to: expressing their opinions or concerns to their Care Management Team, or through CPHL's Grievance and Appeals Process.
- 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

HIPAA Notice of Privacy Practices

Members/Participants 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/Participants 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/Participants.

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/Participants 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 member's 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 Member's have completed an Advance Directive, the primary care physician's office should have the existence of the form conspicuously noted in the Member's medical record.

VII. Model of Care

CPHL's Models of Care (MOC) provides structure for care management processes and systems that will enable coordinated care for Members/Participants. Our Models of Care outline goals and objectives for a targeted population, a specialized provider network, uses nationally recognized clinical practice guidelines, conducts health risk assessments to identify the special needs of our Members/Participants, and adds services for the most vulnerable Members.

Elements outlined in our Models of Care include:

- (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 Portal to view our benefit specific Models of Care at
www.centersplan.com.

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/Participants

If you wish to speak with a CPHL Care Team member, please call CPHL's Member/Participant Services Department at 1-844-274-5227.

VIII. Provider Credentialing and Recredentialing

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), NYSDOH, and 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.

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

Practitioner Information Reviewed During Credentialing Process

- New York licensure
- Current professional liability insurance or self-insurance
- Exclusions, suspensions or ineligibility to participate in any state or federal health care program
- Eligibility for payment under Medicare
- 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 clinical privileges
- History of professional liability claims
- Licenses of any mid-level practitioners 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 Practitioners who have opted out of Medicare using the OIG/Medicare Website, both during primary source verification and on a quarterly basis.

The following 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/Participants only as a result of the Members/Participants being directed to the hospital or other inpatient setting.
- Practitioners who practice exclusively within free-standing facilities and who provide care for organization Members/Participants only as a result of Members/Participants 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/Participants in a treatment setting (e.g. consultants).

Organizational Credentialing and Recredentialing

The following organizational Providers are credentialed and recredentialed:

- Hospitals
- Home Health Agencies (HHAs);
- Hospices;
- Clinical laboratories (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; and
- 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
- Every three years is still in good standing with state and federal regulatory bodies and is 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

The Office of the Inspector General (OIG) maintains a sanction list that identifies those individuals found guilty of fraudulent billing, misrepresentation of credentials, etc. CPHL checks the sanction list with each new issuance of the list, as we are prohibited from hiring, continuing to employ, or contracting with individuals named on that list. CPHL checks the Office of the Inspector General (OIG) website at

http://www.oig.hhs.gov/fraud/exclusions/list_of_excluded.html for the listing of excluded providers and entities. The OIG has a limited exception that permits payment for emergency services provided by excluded providers under certain circumstances.

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.

Practitioner 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 Credentialing Department prior to presenting to the 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 the credentialing committee.
- Practitioners have the right to be informed of the status of their credentialing or recredentialing application upon written request to the Credentialing Department.

Provider 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 years through a process that updates 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, enrollee satisfaction surveys, and other CPHL's activities, and that includes an attestation of the correctness and completeness of the new information.

IX. Referral and Prior Authorization

This section describes the referral and prior authorization processes and requirements for services provided to CPHL Members/Participants. Please visit our website at **www.centersplan.com** for the most current information on prior authorization (PA) and referral requirements.

Access to Staff

- Staff is available from 8 a.m. to 8 p.m. during normal business hours for inbound calls regarding Utilization Management (UM) issues.
- Staff can send outbound communication regarding UM inquiries during normal business hours.
- Staff is identified by name, and title when initiating or returning calls regarding UM issues.
- Staff is accessible to callers who have questions about the UM process.

If you have questions about referrals and prior authorizations, please call Member/Participant Services at:

Medicare Advantage Plans (MAPD, DSNP, ISNP): 1-877-940-9330

MLTC: 1-855-270-1600

FIDA: 1-800-466-2745

Timeframes for Processing Prior Authorization Requests

Plan	Standard	Expedited	Extension
Medicare Advantage Plans (MAPD, DSNP, ISNP)	Within 3 business days of receipt of all necessary information, but no more than 14 days of receipt of the request	72 hours	14 day extension permitted
MLTC	Within 3 business days of receipt of all necessary information, but no more than 14 days of receipt of the request	Within 3 business days of receipt of request	14 day extension permitted

Plan	Standard	Expedited	Extension
Centers Plan for FIDA Care Complete (FIDA)	<p>3 business days for most requests</p> <p>Exceptions:</p> <ul style="list-style-type: none"> ● Decisions about continuing or adding to current health care services, 1 business day ● Decisions about home health care services after an inpatient hospital stay, 1 business day or 72 hours if request is received on a weekend or holiday. ● Decisions on services or items already received, within 14 days. 	24 hours	3 day extension permitted

Timeframe Extensions —CPHL can, within regulatory guidelines, extend the timeframe 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.

Expedited Authorizations — A member, a member's authorized representative, or physician may request an expedited review of an authorization request if he or she believes that the standard time frame may seriously jeopardize the life or health of the member and his or her ability to regain maximum function.

A. Medicare Advantage Prescription Drug (MAPD) Plan - MAPD, DSNP, ISNP

MAPD, DSNP, ISNP Referral Procedures

Member that participate in one of CPHL Medicare plans are not required to obtain referrals from their PCP prior to obtaining services from specialists. However, PCPs are asked to assist Members/Participants in obtaining specialty services. If you have difficulty finding a specialist for your CPHL Member, please call Member Services at 1-877-940-9330.

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

- Emergency care
- Out of area dialysis care
- Out of area urgently needed care

Out-of-Plan Providers

A Member may be sent to out-of-plan Providers or Pharmacies if the Member needs health care that can only be received from a doctor, pharmacy or other health care Provider who is not participating with our health plan. Members/Participants may also receive out of network care if a participating provider is not within a reasonable distance from the member's residence. **PCPs must get prior authorization from our health plan before sending a Member to an out-of-plan Provider.** You (or the Member/Participant) can request prior authorization by calling our Member Services at 1-877-940-9330.

Second Opinions

While a second opinion may not be required for surgery or other medical service, health care Providers, or Members/Participants 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 Provider. If not, prior authorization must be obtained to send the patient to a non-participating Provider (see the "Prior Authorization" section below).
- 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.

MAPD, DSNP, ISNP Services requiring Prior Authorization:

- Inpatient admissions (elective and post-stabilization)
 - Acute inpatient rehabilitative care
 - Skilled nursing facilities
 - Behavioral health facilities
 - Elective admissions
- Ambulatory Surgery Center (ASC) services
- Durable Medical Equipment
- Prosthetics and Orthotics
- Outpatient Rehabilitation Services-Physical, Occupational and Speech therapies
- Cardiac and Pulmonary Rehabilitation
- Certified Home Health Agency (CHHA) services

- Radiology (CT, MRA, MRI, PET and SPECT)
- Therapeutic radiology
- Transplant evaluation and Services
- Non-emergency ambulance services
- Partial hospitalization
- Outpatient Substance Abuse treatment
- Out of Network and Out-of-Area Services
- Investigational/experimental treatment

Note: Some formulary medications may require prior authorization. The prescribing provider should contact CPHL's Pharmacy Benefit Manager for clinical information and coverage determination.

The following services for MAPD, DSNP, ISNP Members do not require Prior Authorization:

- Emergency/Urgent Services
- Emergency Ambulance Services dispatched through 911 or its local equivalent, where other means of transportation would endanger the member's health
- Routine OB/GYN care by in-plan providers: Care including but not limited to mammography screening, pap smears, pelvic and breast exams
- Yearly routine physicals by in-plan providers:
- Colorectal and prostate screening exams.
- Influenza vaccine (annual), Pneumococcal vaccines and Hepatitis B vaccines by in- plan providers
- Renal Dialysis Services for those temporarily out of the service area
- Basic Lab tests (i.e. CBC, SMA-7, UA)
- Skeletal x-rays/chest x-rays
- Clinical trials: Original Medicare covers routine costs of qualifying clinical trials. A member does not need to obtain a referral to join a clinical trial. However, it is recommended that the member inform CPHL before they start a clinical trial so the plan can keep track of the member's health care services. Further information regarding clinical trials is included in these publications:
 - Medicare Managed Care Manual, Chapter 7 – Payment to Medicare Advantage Organizations, section 55, "Coverage of Clinical Trials"
 - Medicare Coverage Issues Manual, Clinical Trials, section "30-1 Routine Costs in Clinical Trials"
 - CPHL Evidence of Coverage (EOC)

B. Managed Long Term Care (MLTC) Plan

MLTC Covered Services Requiring Prior Authorization

- Adult Day Health Care
- Dental Care (Restorative Services, Endodontics, Periodontics, Removable prosthetics)
- Dietary Counseling
- Enteral and Parenteral Nutritional Supplements
- Home Delivered Meals
- Home Health Care
- Prosthetics and Orthotics
- Durable Medical Equipment and Medical Supplies
- Non-Emergency Ambulance Transportation
- Nursing Home Care
- Physical, occupational and speech therapies in a setting other than the home
- Personal Care
- Personal Emergency Response System
- Podiatry (for surgical or orthotic services)
- Private Duty Nursing
- Respiratory Therapy
- Social Day Care
- Social and Environmental Supports
- Social Services

MLTC Services that do not Require Prior Authorization

- Nutritionist
- Non-emergent transportation to and from medical appointments.
- Routine podiatry care when such services are performed as a necessary and integral part of medical care such as the diagnosis and treatment of diabetic ulcers and infections.
- Routine dental care
- Optometrist

MLTC Non-Covered Services*

- Inpatient Hospital Services/Outpatient Hospital Services
- Physician Services
- Laboratory Services
- Radiology and Radioisotope Services
- Emergency Transportation

- Rural Health Clinic Services
- Chronic Renal Dialysis
- Mental Health Services
- Alcohol and Substance Abuse Services
- OPWDD Services (Developmental Disabilities)
- Family Planning
- Prescription Drugs, Non Prescription Drugs and compounded Prescriptions

*Services covered by Medicaid

C. Fully Integrated Duals Advantage (FIDA) Plan – Centers Plan for FIDA Care Complete

Centers Plan for FIDA Care Complete referral procedures:

The Centers Plan for FIDA Care Complete Interdisciplinary Team (IDT) is, within the scope of its expertise, responsible for authorizing all services and items that can be anticipated during the development of a Participant's Person-Centered Service Plan (PCSP). Centers Plan for FIDA Care Complete and certain delegated providers are responsible for authorizing most of the health care services and items a Participant might need in between IDT service planning meetings and PCSP updates. These are services and items that could not have been planned or predicted and therefore were not included in the PCSP.

The following items and services must be authorized by the indicated specialist:

- Preventive Dental X-Rays – These require Dentist authorization.
- Comprehensive Dental – These services require Dentist authorization.
- Eye Wear – These require Optometrist or ophthalmologist authorization.
- Hearing Aids – These require Audiologist authorization.

FIDA services not requiring prior authorization

- a) Emergency services from network providers or out-of-network providers.
- b) Urgently needed care from network providers.
- c) Urgently needed care from out-of-network providers when the Participant is out of the service area.
- d) Kidney dialysis services at a Medicare-certified dialysis facility when the Participant is outside the plan's service area, before you leave the service area.
- e) Immunizations, including flu shots, hepatitis B vaccinations, and pneumonia vaccinations obtained from a network provider

- f) Routine women's health care and family planning services. This includes breast exams, screening mammograms (x-rays of the breast), Pap tests, and pelvic exams obtained from network providers.
- g) Primary Care Provider (PCP) visits
- h) Palliative care.
- i) Other preventive services.
- j) Services from public health agency facilities for tuberculosis screening, diagnosis and treatment, including Directly Observed Therapy (TB/DOT).
- k) Vision services through Article 28 clinics that provide optometry services and are affiliated with the College of Optometry of the State University of New York to obtain covered optometry services.
- l) Dental services through Article 28 clinics operated by Academic Dental Centers.
- m) Cardiac rehabilitation for the first course of treatment (a Physician or RN authorization is required for courses of treatment following the first course).
- n) Supplemental education, wellness, and health management services.
- o) Additionally, if the Participant is eligible to receive services from Indian health providers, they may see these providers without approval from Centers Plan FIDA Care Complete or the IDT.

Prior Authorization Procedures

Prior authorizations for health care services can be obtained by contacting the Utilization Management Department by email, phone, or mail:

Phone: 1-855-270-1600

Fax: 1-718-581-5522

Mail: Centers Plan for Healthy Living
75 Vanderbilt Ave.
Staten Island, NY 10304
ATTN: UM Department

When requesting an authorization, please provide the following information:

- Member/patient name and CPHL Member ID number
- Provider name and NPI
- Anticipated date of service
- Diagnosis code and narrative
- Procedure, treatment or service requested
- Number of visits requested, if applicable
- Reason for referring to an out-of-plan Provider, if applicable

- 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 **inpatient surgery** is planned, please include the date of surgery, surgeon, and facility, admit date, admitting diagnosis and presenting symptoms, plan of treatment, any appropriate clinical and anticipated discharge needs.

If the request is for **outpatient surgery**, please include the date of surgery, surgeon, and facility, diagnosis and 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/Participants. 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 mailed 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
- Appeal rights and process

X. 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/Participants 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/Participants 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:

XI. Member Grievances & Appeals Process

Centers Plan for Healthy Living (CPHL) serves various types of Members/Participants 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.

A. Medicare Advantage Plans (MAPD, DSNP, ISNP)

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/Participants, the claims regarding 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	72 hours*
Standard Appeal (Payment Related)	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).

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

Email: GandA@Centersplan.com

Phone: 1-877-940-9330

(TTY 1-800-421-1220)

Mail: Centers Plan for Healthy Living

75 Vanderbilt Avenue

Staten Island, NY 10304

Attention: Grievances and Appeals Department

If we say no to all or part of the member's first Reconsideration/Appeal the member can move on to a Level 2 Appeal through the Independent Review Entity, not affiliated with CPHL. If the member is not satisfied with the decision at the Level 2 Appeal, there are 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 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.

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

Phone: 1-888-807-5717

(TTY 1-800-421-1220)

Fax: 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)	7 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.*

B. Managed Long Term Care (MLTC) Plan

MLTC Members have the right to complain about any aspect of their coverage of care.

A **Grievance** is an expression of dissatisfaction that a member may have regarding a matter that is not an appeal. Some examples of grievances 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 grievance and provide a written decision to the member. If the member does not agree with the grievance decision, they can appeal. All decision timeframes are listed in the table below.

An **Action Appeal** is 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 grievance or action appeal:

Email: GandA@Centersplan.com

Phone: 1-855-270-1600

(TTY 1-800-421-1220)

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 Grievance	45 days after the necessary information has been received but no later than 60 days
Expedited Grievance	48 hours after the necessary information has been received but no later than 7 days
Grievance Appeal	30 business days
Expedited Grievance Appeal	2 business days
Expedited Action Appeal	2 business days but no more than 3 business days of receipt of appeal request
Standard Action Appeal	30 calendar days

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

C. Fully Integrated Duals Advantage (FIDA) Plan - Centers Plan for FIDA Care Complete (MMP)

The Grievance and Appeals process for FIDA incorporates the most consumer-favorable elements of the Medicare and Medicaid grievance and appeals systems into a consolidated, integrated system for Participants.

FIDA also provides a Participant Ombudsman, an independent, conflict-free entity that will provide FIDA participants and their caregivers with free assistance in accessing care, understanding and exercising rights and responsibilities and appealing adverse decisions. The Participant Ombudsman provides advice, information, referral, direct assistance, and representation in dealing with Plans, Providers, or the New York State Department of Health. CPHL is required to notify Centers Plan for FIDA Care Complete Participant's of the availability of the Participant Ombudsman in enrollment materials, annual notice of Grievance and Appeal procedures, and all written notices of denial, reduction, or termination of service. Below is the contact information for the New York State Participant Ombudsman:

Independent Consumer Advocacy Network (ICAN)

Call: 1-844-614-8800

A free interpreter: 1-844-614-8800

TTY: 711

Monday-Friday, 8:00 am – 8:00 pm

Online: icannys.org

Centers Plan for FIDA Care Complete Grievances about Services and Items

Centers Plan for FIDA Care Complete Participants can file a grievance about CPHL or any provider (including a non-network or network provider). Examples of the kinds of problems handled through the grievance 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 grievances about the timeliness of CPHL's actions related to coverage decisions or appeals.

Participants have the option of filing an internal grievance or an external grievance. An internal grievance is filed with and reviewed by Centers Plan for FIDA Care Complete. An external grievance is filed with and reviewed by an organization that is not affiliated with Centers Plan for FIDA Care Complete.

Centers Plan for FIDA Care Complete Part D 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.

Centers Plan for FIDA Care Complete is required to process appeals as expeditiously as the member's health status requires, but no later than indicated in the following chart.

Centers Plan for FIDA Care Complete determinations for services and items are made in accordance with the following timeframes:

Type	Timeframe
Standard Grievance	30 days*
Expedited Grievance	Within 24 hours, in certain circumstances. For all other expedited circumstances, within 48 hours after receipt of all necessary information but no more than seven (7) days from receipt of the grievance
Standard Appeal (Service Related)	30 days
Expedited Appeal	72 hours
Standard Appeal (Payment Related)	60 calendar days

(*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).

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

Email: GandA@Centersplan.com

Phone: 1-877-940-9330

(TTY 1-800-421-1220)

Mail: Centers Plan for Healthy Living

75 Vanderbilt Avenue

Staten Island, NY 10304

Attention: Grievances and Appeals Department

Centers Plan for FIDA Care Complete Grievances 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.

Centers Plan for FIDA Care Complete 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 Centers Plan for FIDA Care Complete Participant 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 Participant does not agree with the Centers Plan for FIDA Care Complete 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 1-800-421-1220)

Fax: 858-790-7100

Mail: MedImpact Healthcare Systems, Inc.
Scripps Corporate Plaza
10680 Treena Street, Stop 5
San Diego, CA 92131

Centers Plan for FIDA Care Complete Part D grievance and appeal resolution 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)	7 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.*

XII. 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.

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:

CPHL
Attn: Grievance and Appeals Department
75 Vanderbilt Ave
Staten Island, NY 10304

Providers must submit a written request with supporting documentation, such as an Explanation of Payment (EOP) and a copy of the claims 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 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.

XIII. 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 can accept a Provider's electronic claim transaction through one of three delivery methods.

Direct-Please contact us at 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 1.

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 with an EDI submission.

Paper Claim Submissions

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

Paper claims are mailed to:

Centers Plan for 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:

The minimum data required for all CMS-1500 claims includes:

- Member name
- Payer specific Member ID number. The number will be a total of 11 digits. The number is a combination of 9 digits followed by two digits (typically 00).
- Date of Birth
- Provider Name, Tax ID number, NPI number and Service Location that matches your provider record.
- Date of Service that falls within the effective and expiration date printed on the authorization
- Valid Place of Service code
- Service Code such as HCPCS/CPT (billed Service Code MUST match the code that is listed in the authorization).
- Number of Units
- Valid Diagnosis Code(s)
- Co-insurance claims must include a copy of the primary insurer EOB

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

- Member name
- Payer specific Member ID number. The number will be a total of 11 digits. The number is a combination of 9 digits followed by two digits (typically 00).
- Date of Birth
- Provider Name, Tax ID Number and NPI number

- Date of Service that falls within the effective and expiration date printed on the authorization.
- Service Code such as HCPCS/CPT (billed Service Code MUST match the code that is listed in the authorization).
- Number of Units
- Valid Bill Type
- Valid Diagnosis Code(s)
- Valid Revenue Code
- Valid Value Code(s) and Occurrence Code(s)
- Applicable Admit Dates
- Valid Patient Status
- Valid Admission Source
- Valid Admit Date
- Co-insurance claims must include a copy of the primary insurer EOB

Encounter Data Submissions

For providers that are contracted under a capitation agreement, CPHL is required to report services provided on behalf of its Members/Participants to Medicare and/or Medicaid. As such, a provider is 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/Participants 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/Participants 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/Participants. 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 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 Relations department at 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 <u>written</u> request within 90 days from the date of the Explanation of Payment (EOP)
Required Documents	<ul style="list-style-type: none"> • Copy of the Explanation of Payment (EOP) • Completed <u>Provider Claim Dispute Request</u> form² 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 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.

¹Time frames in the provider contract will supersede time frames in this manual.

²The Provider Claim Reconsideration Request Form can be found on the Provider page at www.centersplan.com

XIV. Quality Assurance/Improvement Program

CPHL is committed to providing comprehensive, patient-centered, quality health care and to establishing a coordinated, cost effective health delivery system, which is timely and appropriate for Member needs. CPHL has developed a Quality Improvement Program to help fulfill this commitment. The Quality Improvement Program is designed to continuously monitor, evaluate, and improve CPHL administrative services and the health care services delivered by Participating Providers.

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

- Develop and implement standards of operations based on federal and state regulatory guidelines that include 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 the fulfillment of the compliance plan in meeting all regulatory, contractual, and internal standards of care.
- Review all monthly or quarterly metrics to evaluate whether or not the benchmark was met.
- Create and implement a corrective action plan for any metric that fell below the benchmark and submit to 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.
- Review member/provider complaints of call center staff/operations.
- Track and trend issues looking for opportunities for improvement.
- Review data and reports in relation to enrollment. Track and trend issues looking for opportunities for improvement
- Review data and reports in relation to care coordination services. Track and trend issues looking for opportunities for improvement.

Scope of the Program

The program emphasizes evaluation of processes, performance, and monitoring results that are identified as opportunities for improvement of services and member care. These may include, but is 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 Assurance Reporting Requirements (QARR)
- CMS Reporting Requirements (HEDIS, CAHPS, HOS)

Provider Participation

As a component of the quality program CPHL participates in data collection that addresses 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 quality program by providing input in to the plan's clinical studies or conducting their own quality improvement projects. On an annual basis, CPHL makes information available to Providers about its Quality Improvement (QI) Program via the website.

XV. Pharmacy Services

CPHL provides pharmacy benefits to our Medicare Advantage members and Centers Plan for FIDA Care Complete participants 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.

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. Any changes to the formulary will be communicated to providers through our website at www.centersplan.com.

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 when used for the treatment of sexual or erectile dysfunction, such as Viagra, Cialis, Levitra, and Caverject
- Drugs when 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/Participants to order **up to a 90-day supply** on some select drugs.

Members/Participants 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 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, Centers Plan for FIDA Care Complete covers some OTC drugs when they are written as prescriptions by the provider. Please see Centers Plan for FIDA Care Complete's List of Covered Drugs (Drug List) for more information.

Please refer to the member's Summary of Benefits for additional information about coverage for over-the-counter items. The Summary of Benefits can be found on our website at www.centersplan.com.

Member Co-Payments

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 for the exact co-pay/coinsurance that can be found on CPHL's website at www.centersplan.com.

Centers Plan for FIDA Care Complete Participants 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 Provider Relations 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.

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 1-800-421-1220

By fax: 1-858-790-7100
By mail: MediImpact Healthcare Systems, Inc.
Scripps Corporate Plaza
10680 Treena Street, Stop 5
San Diego, CA 92131

Medication Appeals

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

By phone: 1-888-807-5717, TTY 800-421-1220
By fax: 1-858-790-7100
By mail: MediImpact Healthcare Systems, Inc.
Scripps Corporate Plaza
10680 Treena Street, Stop 5
San Diego, CA 92131

Once the appeal of the initial coverage determination has been properly submitted and obtained by CPHL/MediImpact, 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/Pharmacy_Policy_Guidelines.pdf

XVI. Compliance

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. The CPHL Compliance Program reflects our commitment to integrity, accountability, and quality services. A copy of the CPHL Code of Conduct & Compliance Program is available on the Provider page of our website, www.centersplan.com.

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 care, services or supplies for or on behalf of another person provider for which the Medicaid program is or should be reasonably expected by a provider to be a substantial portion of their business operations.

CPHL must ensure that our 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 contract with the Centers for Medicare and Medicaid Services (CMS), and meeting the Medicare and Medicaid program requirements, we require each FDR and Affiliate comply with requirements such as general compliance training and fraud, waste, and abuse training as outlined by the Centers of Medicare and Medicaid Services (CMS). The training is mandatory, and must occur within 90 days of hire/contracting and annually thereafter. Training materials may be found at: <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/ProviderCompliance.html>.

First Tier entities are responsible for ensuring that their downstream and related entities comply with this policy and applicable Federal and State statutes and regulations. FDRs and Affiliates must maintain supporting documentation of compliance with the 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.

OIG/GSA Exclusion Screening

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 are not are excluded from participation in federally funded healthcare programs prior to hire and monthly thereafter. The following websites may 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.com_physiciandirectory
- System for Award Management (SAM):
<https://www.sam.gov/portal/SAM/#1>

If you identify an employee or contractor on an exclusion list, the 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.

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. FDRs and Affiliates must either establish a comparable Code of Conduct that meet 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 to all employees and contractors CPHL's Code of Conduct.

Health Care Fraud, Waste, and Abuse

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 Medicare or Medicaid fraud laws. As a provider, if you have any knowledge or information that any such activity may be taking, or has taken, place please contact the Chief Compliance Officer immediately.

Fraud: Making false statements or representations of material facts to obtain some benefit or payment for which no entitlement would otherwise exist. These acts may be committed either for the person's own benefit or for the benefit of some other party. In other words, fraud includes the obtaining of something of value through misrepresentation or concealment of material facts.

Waste: The extravagant, careless, or needless expenditure of funds resulting from deficient practices, systems, controls, or decisions.

Abuse: Practices that, either directly or indirectly, result in unnecessary costs. Abuse includes any practice that is not consistent with the goals of providing patients with services that are medically necessary, meet professionally recognized standards, and are fairly priced.

Common Methods 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 s/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: Provider submits a claim with all the incidental codes or itemizes the components of the procedures/services (e.g. Antepartum care, Vaginal delivery and Obstetric care) which includes the three components. Some providers may submit the unbundled procedures on multiple claims in an attempt to bypass 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: There has been fraud where perpetrators obtain current membership information from operatives working in the billing offices of legitimate providers (usually hospitals) and submit claims.

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,
- 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 which 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 it is effective for claims filed or presented on or after April 1, 2007.

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 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 Statute may 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/Participants, 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).

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 be or has taken place, please contact our Compliance Department. Reporting fraud, waste, or abuse 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
75 Vanderbilt Avenue
Staten Island, NY 10304
- E-mail: Compliance@centersplan.com

Medicare Reporting

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

NY 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 a 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 investigations 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 NY state-funded programs are reported to the New York State Office of the Medicaid Inspector General (OMIG).

XVII. 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/Participants' Protected Health Information (PHI) and to provide its Members/Participants 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, 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/Participants 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/Participants on how they may obtain a statement of disclosures or request their personal 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/Participants.

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.

Safeguarding PHI

Both CPHL and its providers are required by law to protect Members/Participants' 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. PHI must not be left unattended in baggage at any time during traveling.
When disposing	PHI must be shredded or destroyed.

PHI in Electronic Form:

Email	<p>Internal Email: Email must be limited to the use and disclosure of the minimum necessary data to complete the required task.</p> <p>External Email: Email sent or received from an external entity through the internet through the open Internet should not contain PHI unless the email and attachment are encrypted to prevent anyone, other than the intended receiver, from reading the contents.</p> <p>Do not include PHI in the subject line of the email.</p> <p>Email signatures should contain a confidentiality disclaimer.</p>
Electronic devices	Portable data storage devices (CDs, DVDs, USB drives, portable hard drives, 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 855-270-1600 for MLTC and 877-940-9330 for MAPD/FIDA (TTY for the hearing impaired: 800-421-9330). If a provider becomes aware of any breach of a CPHL Members/Participants' PHI, 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/bristruction.html>

