Provider Manual

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Medicare Advantage

About

CCA Health Michigan, Inc. (CCA Health)

CCA Health was formed by primary care doctors in Southeast Michigan. CCA Health prides itself on being made by doctors to meet the needs of their patients. We strive to break down administrative barriers that prevent the primary care physician from delivering the care they know their member needs.

We trust you, our providers, to partner with us on our goal to deliver high quality care to your patients. We are not like other insurance company we are physicians that want to build true partnerships.

Quick Information

Provider and Member Line: 855-959-5855
Website: ccahealthmi.org
PAYER ID: RHP01
Claimsnet clearinghouse

Paper Claims

CCA Health (RHP)- Claims

P.O. Box 94370

Lubbock, TX 79493

Pharmacy Information:

OptumRX

Pharmacy Line: 844-705-7498

https://professionals.optumrx.com/

Payment:

CCA Health has partnered with VPay® to provide a faster, more efficient way to reimburse your business for services rendered. Payments are distributed via secure fax and settled through your in-office terminal processing functionality, allowing for faster access to each payment. EFT registration is available along with 835/Electronic Remittance Advice election for EOP details and there is an additional option to opt-out of electronic payment methods entirely to receive a standard paper check from the Plan. Note that card processing fees will be assessed at the rate outlined in your merchant agreement with your acquiring bank for any VCard transactions. For EFT, limited transaction fees may apply per the VPay registration agreement.

Important Items to Remember:

There is no immediate action required in order to receive VCard payments from the Plan; however, to receive faster payments in the future a secure fax number will need to be on file at VPay.

On or after 1/1/2020 please contact our Customer Service Department who will connect you directly with VPay for any of the following actions:

- Add a secure fax number on file
- Enroll in EFT payments
- Opt-out of electronic delivery and receive paper check payments
- Enroll to receive 835/Electronic Remittance Advice transmissions through VPay

https://www.vpayusa.com/healthcare/

Prior Authorizations (Medical) and Cover Determinations (Pharmacy) Contact info

	Prior Authorization for Medical Care – Contact Information
CALL	(855) 959-5855
FAX	813-775-2609
WRITE	CCA Health PO BOX 25677 TAMPA, FL 33622
Web	Reliancemedicareadvantage.org- provider portal

Method	**Coverage Decisions for Part D Prescription Drugs – Contact Information**
CALL	844-705-7498
FAX	877-239-4565
WRITE	Optum RX P.O. Box 25184 Santa Ana, California 92799

Provider Services and Tools

Please call, email, fax, talk to your provider concierges or use our comprehensive provider portal to reach us.

This Manual

The provider manual is intended to help you effectively deliver covered services to CCA Health beneficiaries. We will modify it over time or CMS will make us, if and when policies change and as we incorporate feedback from you on what would make it more useful.

When to Call

If you have any questions, concerns, or comments, we want to hear from you. Our Provider Services team is here to help you resolve any issues you have.

Provider Portal

The CCA Health portal is available to you for quick and easy access for any of the following:

- Look up member eligibility and benefits
- Submit claims and view remittances
- Determine need for an authorization/referral
- Submit and check the status of an authorization/referral

If you have not used the CCA Health provider portal before, go to **ccahealthmi.org** to register.

Provider Information

Notification of Important Changes

CCA Health is committed to providing our members with accurate provider information. Please let us know as soon as possible (and within 30 days) of any changes to your information (e.g., new providers in your group, name changes of providers, address changes, whether a provider is no longer accepting new patients, etc). We also ask that you let us know if you have changes to your office staff, so that we can maintain accurate contact information. You may access the most current provider information we have by searching our online provider directory.

Please send any changes in provider information, including roster updates, to **ccahealthmi.org**

Access to Care

CMS requires that the hours of operation of its practitioners are convenient for and do not discriminate against members.

Practitioners must provide coverage for their practice 24 hours a day, seven days a week with a published after-hours telephone number (to a practitioner's home or other relevant location), pager or answering service, or a recorded message directing members to a physician for after-hours care instruction. Note: Recorded messages instructing members to obtain treatment via emergency room for conditions that are not life threatening is not acceptable.

In addition, primary care physicians must provide appropriate backup for absences.

See the table below for CCA Health standards regarding appointment availability.

SERVICE TYPE	APPOINTMENT STANDARD
Emergency care	Immediately (available 24/7)
Urgent primary care appointments (non-life threatening)	Within 48 hours
Urgent specialty care	Within 3 days
Referrals to specialists	Within 3 business days
Non-urgent symptoms or concerns	Within 7 days
Annual exams	Within 60 days

We also ask our providers to develop and follow telephone protocols, including:

- Answer member telephone inquiries on a timely basis
- Prioritize appointments by scheduling and rescheduling promptly and by respecting appointment times and minimizing waiting time
- Schedule a series of appointments and follow-up appointments as needed by a member
- Identify and reschedule no-show appointments
- Identify special member needs while scheduling an appointment — e.g. the need for a wheelchair, appropriate medical interpretation for Limited English Speaking patients, and transportation to and from appointments
- Adhere to the following guidelines for telephone call-back response times:
  - For non-emergent, symptomatic issues: after-hours telephone care within 45 minutes
  - Non-symptomatic concerns: same-day response
  - Crisis situations: response within 15 minutes
- Schedule continuous availability and accessibility of professional, allied, and supportive medical/dental personnel to provide covered services within normal working hours. Protocols shall be in place to provide coverage in the event of a provider's absence
- Document after-hours calls in writing in the member's medical record within 24 hours of receipt of the call
- Contact urgent care or the emergency room, and inform them of the member's condition if after-hours urgent care or emergent care is needed. CCA Health, Inc. will monitor appointments and after-hours availability on an ongoing basis.

Confidentiality

All providers must respect the confidentiality of member information in accordance with state and federal laws and regulations. This includes HIPAA privacy and security regulations. Providers must also respect the confidentiality of Protected Health Information (PHI) by following internal policies and by limiting PHI access to the minimum necessary required to accomplish the intended purpose.

Please report any member confidentiality issues, questions, or concerns immediately to CCA Health

Access to Medical Records

CCA Health may request member medical records from you for a variety of purposes. You must provide requested medical records within the time frame they are requested. You must maintain medical records for a minimum of ten years, and it is possible that CCA Health will have to request medical records after the term of our agreement is over.

Non-Discrimination

CCA Health will not tolerate discrimination against our members. Providers and their staff must not discriminate against any member on the basis of:

- Race, ethnicity, or national origin
- Religion
- Sex/gender or age
- Sexual orientation
- Mental or physical disabilities
- Medical condition, medical history, or genetic information
- Source of payment
- Evidence of insurability or claims history

Responsibilities of All Providers

In addition to everything listed in this manual and in your provider agreement, CCA Health also has the following expectations of all providers:

Respect members

- Observe the rights of members
- Engage members in their treatment options and planning
- Communicate clearly with members and take measures to confirm shared understanding

Cooperate and coordinate with CCA Health

- Respond in a timely fashion to any requests or outreach from CCA Health Michigan, Inc or any of our partners
- Proactively communicate with CCA Health Michigan, Inc about members' health and treatment

Adhere to plan policies

Follow documented policies and procedures for referrals, prior authorizations, admissions, discharges, and other events as indicated in your provider agreement and this provider manual

Maintain a safe practice

- Maintain an office that complies with all environmental safety and hygiene regulations
- Inform CCA Health immediately of changes to your practice such as licensure status or loss of liability insurance
- Train your staff on proper safety and emergency procedures

Hospice services

Federal regulations require that Medicare fee-for-service contractors (Medicare fiscal intermediary, administrative contractor, DME regional carrier, Part D or prescription drug plan, or another carrier) maintain payment responsibility for Medicare Advantage members who elect hospice care. Claims for services provided to a Medicare Advantage member who has elected hospice care should be billed to the appropriate Medicare contractor.

If the member elects hospice care and the service is related to the member's terminal condition, submit the claim to the regional home health intermediary.

If the member elects hospice care and the service is not related to the member's terminal condition, submit the claim to the Medicare fiscal intermediary, administrative contractor, DME regional carrier, Part D or prescription drug plan, or another carrier as appropriate.

If the service is provided during a lapse in hospice coverage,

Note: Original Medicare is responsible for the entire month that the member is discharged from hospice.

If the service is not covered under Original Medicare but offered as an enhanced benefit under the member's Medicare Advantage (for example, vision)

Medicare Advantage member cost-share for hospice services

As provided in 42 CFR § 422.320, an MA organization must inform each enrollee eligible to select hospice care about the availability of hospice care if: (1) a Medicare hospice program is located within the plan's service area; or

It is common practice to refer patients to hospice programs outside the MAO's service area.

An MA enrollee who elects hospice care but chooses not to disenroll from the plan is entitled to continue to receive (through the MA plan) any MA benefits other than those that are the responsibility of the Medicare hospice. Through the Original Medicare program, subject to the usual rules of payment, CMS pays the hospice program for hospice care furnished to the enrollee and the MAO, providers, and suppliers for other Medicare–covered services furnished to the enrollee.

The table below summarizes the cost-sharing and provider payments for services furnished to an MA plan enrollee who elects hospice.

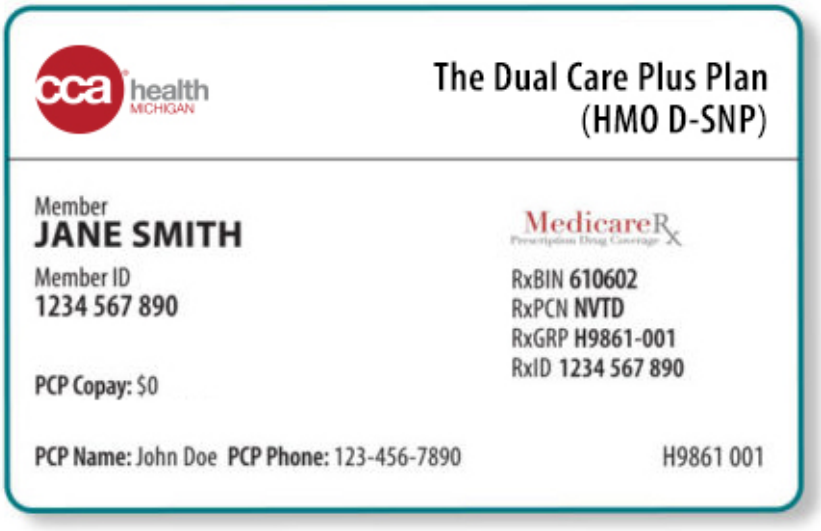
Type of Services	Enrollee Coverage Choice	Enrollee Cost-sharing	Payments to Providers
Hospice program	Hospice program	Original Medicare cost-sharing	Original Medicare
Non-hospice[1], Parts A & B	MA plan or Original Medicare	MA plan cost-sharing, if enrollee follows MA plan rules[3]	Original Medicare[2]
		Original Medicare cost-sharing, if enrollee does not follow MA plan rules[3]	Original Medicare
Non-hospice[1], Part D	MA plan (if applicable)	MA plan cost-sharing	MAO
Supplemental	MA plan	MA plan cost-sharing	MAO

Notes:

The term "hospice care" refers to Original Medicare items and services related to the terminal illness for which the enrollee entered the hospice. The term "non-hospice care" refers either to services not covered by Original Medicare or to services not related to the terminal condition for which the enrollee entered the hospice.

If the enrollee chooses to go to Original Medicare for non-hospice, Original Medicare services, and also follows plan requirements, then, as indicated, the enrollee pays plan cost–sharing and Original Medicare pays the provider. The MA plan must pay the provider the difference between Original Medicare cost–sharing and plan cost–sharing, if applicable.

Note: Out-of-network coverage is not available to members unless it is emergent or urgent or a Prior Authorization has been received.



Facility Responsibilities

Hospitals must notify Medicare Beneficiaries who are hospital in-patients about their discharge rights by complying with the requirements for providing the Important Message from Medicare, including the time frames for delivery. For copies of the notice and additional information regarding this requirement, see CMS' "Hospital Discharge Appeal Notices".

Skilled nursing facilities, home health agencies, and comprehensive outpatient rehabilitation facilities must notify Medicare beneficiaries about their right to appeal a termination of benefits decision by complying with the requirements for providing a Notice of Medicare Non-Coverage (NOMNC), including the time frames for delivery. Providers may be required to furnish a copy of any NOMNC to CCA Health upon request. For copies of the notice and the notice instructions, see CMS "MAED Notices".

CCA Health members may appeal a decision regarding a hospital discharge or termination of home health agency, comprehensive rehabilitation facility or skilled nursing facility benefits within the time frames specified by law.

Identification of Members and Eligibility

Our member identification cards contain basic information you will need when providing covered services to our members. The Medicare Advantage ID card indicates the member is enrolled in which HMO plan. Our Medicare Advantage members only need to show our ID card to receive services. A member doesn't need to show his/her Original Medicare ID card to obtain services.

Below is a sample of the members' ID card.

Important Notes

Billing members
Collect coinsurance and or copayments at time of service
Providers should collect the applicable coinsurance and/or copayments, also known as the members cost-share, from the member at the time of the service when possible.

Balance billing is not allowed
You may only collect applicable cost–sharing from CCA Health members for covered services and may not otherwise charge or bill them.

Refund over–billed members
If you collect more from a member than the applicable cost–sharing, you must refund the difference. Medicare Advantage members are to be reimbursed within 30 days of recognizing the error.

Coordination of benefits
If a member has primary coverage with another plan, submit a claim for payment to that plan first. The amount we will pay depends on the amount paid by the primary plan. We follow all Medicare secondary–payer laws.
Non–covered services and referrals for non–covered services - provider responsibilities
Sometimes you and your patient may decide that a service, treatment or item is the best course of care, even though it isn't covered by Medicare Advantage Plans or may be supplied by another provider or practitioner.

You are responsible for determining which items, services or treatments are covered. If you believe that a service, item or treatment won't be covered, you must tell the member before the service or treatment is performed or item obtained. If the member acknowledges that the item, service or treatment won't be covered by CCAHealth,and agrees that he or she will be solely responsible for paying you, you may perform and bill the member for the non–covered service, treatment or item. When the member covers an expense for an item, service or treatment, the rendering provider will submit a claim to the plan for a post service organization determination, using the appropriate modifier when applicable.

If you provide an item, treatment or service that is not covered and have not provided the patient with prior notice that the item, treatment or service is not (or may not be) covered by the plan, you may not bill the patient for such non–covered items, treatments or services.

If you believe that an item, service or treatment won't be covered and the provider supplying the service, treatment or item is not contracted with CCA Health you must tell the member before you refer them. If the member acknowledges that the item, service and/or treatment won't be covered and understands that you're referring them to a non–contracted provider and agrees that he or she will be solely responsible for paying for the service, then you may refer the member to the non–contracted provider for the non–covered service.

CCA Health Plans

CCA Health offers only Medicare Advantage plans. We provide our members with comprehensive benefit packages that include all the benefits offered by Traditional Medicare as well as a number of additional benefits and covered services. Additional services may include:

- Preventive care at $0 copayments
- Dental, hearing, and vision benefits
- Acupuncture and massage
- Transportation and meal services for members who meet certain requirements

Covered services must be medically necessary and appropriate as defined in the provider's contract with CCA Health.

A member may elect to receive medical care for services not included in their benefit plan or services that are determined by us to be not medically necessary. In such cases, the provider should let the member know that the service is not covered by CCA Health and that the member will be responsible for payment. In those instances, a provider should direct the member to the EOC plan document. Before treating the member for a non-covered service, the provider must obtain written signed documentation from the member by which the member acknowledges and agrees to responsibility for all such out-of-pocket expenses of the service. Such notice must meet Medicare program requirements.

CCA Health Plans Other Programs

Dental
Dental coverage services are administered by Delta. When members obtain covered services from an Delta network provider, they receive the maximum level of coverage available under their plan. Information about delta, is available at 800-330-2732and on their website at www.deltadentalmi.com

Fitness Program
CCA Medicare Advantage Plan plans offer a fitness benefit known as the Silver and Fit Fitness Program. CCA Health supports physical fitness at any age, and hopes that you will encourage your CCA Medicare Advantage Plan patients to enroll in the program, which offers a complimentary membership to any participating location. Silver and Fit also includes a self-directed program for members who are unable to leave the home. More information about this fitness benefit is available at **877.427.4788** and online at https://www.silverandfit.com/.

NationsHearing
CCA Medicare Advantage Plan plans offer hearing aid benefits through Nationshearing. Please review with them all rules associated with dispensing hearing aids. Call at 800-921-4559 https://www.nationshearing.com/

American Specialty Health (ASH)
CCA Medicare Advantage Plan plans offer chiropractic and other benefits such as massage and acupuncture. All benefits are administered through ASH.

Member Complaints and Grievances

If a member is dissatisfied with the health plan and/or a provider, including quality of care concerns, disputes, or requests for reconsideration or appeal, they can file a grievance or complaint. Grievances can also be filed by an authorized representative and/or a provider on the member's behalf. Providers who have seen or who are treating a member may file a grievance on the member's behalf without written consent of the member. If the member wishes to use an authorized representative, then they must complete a Medicare Appointment of Representative (AOR) statement. The member and the person who will be representing the member must sign the AOR statement. CCA Health will never disenroll or penalize in any way for making a complaint.

Examples of issues that may result in a grievance include, but are not limited to:

Provider Service including, but not limited to:

- Rudeness by provider or office staff
- Refusal to see member (other than in the case of patient discharge from office)
- Office conditions

Services provided by CCA Health including, but not limited to:

- Hold time on telephone
- Rudeness of CCA Health staff
- Involuntary disenrollment from CCA Health
- Unfulfilled requests

Access availability including, but not limited to:

- Difficulty getting an appointment
- Wait time in excess of one hour
- Handicap accessibility

Filing a MemberGrievance

CCA Health members or their representatives with the member's consent can file a standard grievance within 60 calendar days of the date of the incident or when the member was made aware of the incident.

Phone	Call our Member Service at 1-855-959-5855 8am to 8pm EST, Monday to Friday (from October 1 to March 31, 8am to 8pm EST, 7 days a week). TTY users should call 711.

Fax	888-918-2993
Mail	Medicare Advantage AP/GR PO Box 94770 Lubbock, TX 79493 – 4770

Expedited Grievances

A member may request an expedited grievance if CCA Health makes the decision not to expedite an organizational determination, expedite an appeal, or invoke an extension to a review. CCA Health will respond to an expedited grievance within 24 hours of receipt. The grievance will be conducted to ensure that the decision to not apply an expedited review time frame or extend a review time frame does not jeopardize the member's health. See contact information above or the Evidence of Coverage (EOC) for information on how to file an Expedited Grievance.

Member Responsibilities

CCA Health members are responsible for following the rules of their EOC, including their financial responsibilities in the form of copayments, deductibles, or coinsurance associated with their plan.

Members are also responsible for:

- Providing their health care providers accurate information about any ongoing treatments, any medications they are taking, or changes in their health
- Keeping appointments or notifying the provider if unable (when appropriate)
- Following provider rules and being respectful to providers and their teams

Primary Care Providers

The primary care provider (PCP) is the foundation of CCA Medicare Advantage Plan. The PCP has a long-term relationship and is the primary factor in determining their members care. We believe that a Primary Care doctor is not just a traffic cop routing the member to and from doctor to doctor. They are the primary custodian of their patients care.

CCA Health Promise

CCA Health realizes how important your members are to your practice and will do everything possible to make sure your member is assigned to your practice after enrollment into CCA Health. If your member does not have your name on their ID card or they have the wrong PCP listed please have the member call CCA Health to make sure you are assigned correctly.

PCP Responsibilities

The PCP is responsible for providing all primary care services for CCA Health members, including but not limited to:

- Supervising, coordinating, and providing care (routine care, wellness and preventive care, chronic disease management, and urgent care)
- Screening for behavioral health needs at each visit and when appropriate, initiating a behavioral health referral
- Maintaining continuity of care for each assigned member
- Initiating referrals for medically necessary specialty care, as relevant
- Ensuring smooth transitions between acute or post-acute stays and ambulatory care
- Maintaining the member's medical record, including documentation for all services provided to the member by the PCP, as well as consult notes for any specialists, behavioral health, or other referral services to the best of the provider's ability
- Engaging and coordinating with CCA Health when care navigation can help improve outcomes, quality performance, and experience

PCP Coverage

CCA Health believes it's incredibly important for members to have access to their PCP. In cases where the PCP is on leave or unavailable, the PCP should arrange to have a substitute provider who is also a credentialed, in-network provider provide care for their members.

After-Hours, Weekend, and Holiday Coverage

A provider must be available by telephone 24 hours a day, 7 days a week in accordance with their provider agreement. Members must be able to call the practice's daytime telephone number and reach the after-hours coverage. If a healthcare professional does not answer the phone, there must be an option for a qualified provider to call back within a stated time frame. Members with emergencies should be directed to hang up and call 911 or go to the nearest emergency room.

Panel Changes

Medicare Advantage Plan

All PCPs may reserve the right to state the number of patients they are willing to accept into their practice from CCA Health. Since PCP assignment for CCA Health members is based on member choice, CCA Health does not guarantee any given PCP a certain number of patients.

PCPs who wish to make changes to their panel must contact Provider Services. This is true for:

- PCPs interested in changing their maximum number of assigned CCA Health members
- PCPs interested in closing their practice to new patients
- PCPs interested in re-opening a closed panel

Medical Management

CCA Health plays an active role in managing the care of our members. We partner with each member's PCP and work closely with their other providers and facilities. Prior Authorizations are a way for us to help you identify what is going on with the members health and make sure everyone is informed about the members status.

Referrals

Referrals are not required for in network Specialist visits.

Prior Authorizations

CCA Health is dedicated to making sure our members get the right care at the right time in the right place. Our Utilization Management team works to ensure that members, their providers, and CCA Health are all aligned on treatment decisions. "Prior authorization" is defined as approval in advance by CCA Health in order for a member to receive certain services or drugs. Providers are responsible for obtaining a prior authorization for all qualifying, non-emergent services prior to the service being scheduled or delivered. Please see CCA Health Prior Authorization List for a complete list of these services.

Clinical Decision Making

Our prior authorization criteria are based on Medicare requirements defined in CMS National Coverage Determinations (NCDs) and relevant Local Coverage Determinations (LCDs) and generally accepted criteria such as InterQual®.

We use InterQual® criteria to review certain services (e.g. inpatient hospital care); we make these criteria available, upon request, to members and providers impacted by a denial decision. Please note: Failure to obtain the required prior authorization may result in a claim being denied or in a reduction in payment. CCA Health members cannot be billed for services that require prior authorization and are delivered without a prior authorization.

Submitting a Prior Authorization Request

The preferred method for submitting prior authorization requests is through the CCA Health web portal or calling 855-959-5855.

Prior Authorization Time Frames

CCA Health expects that prior authorization requests will be received from providers in a timely manner. Delivery expectations vary by service type, as shown in the table below.

SERVICE TYPE	PRIOR AUTHORIZATION DECISION TIME FRAME
Elective or scheduled admissions, procedures, services	Required 10 business days prior to the scheduled admission date
Emergent inpatient admissions	Notification required within one business day of admission
Emergency room and post stabilization, urgent care, crisis intervention, observation	Notification requested within one business day of admission

The requesting or rendering provider must provide the following information as part of a request for a prior authorization (regardless of the method utilized):

- Member's name, date of birth, and CCA Health ID number
- Provider's National Provider Identifier (NPI) number, taxonomy code, name, and telephone number
- Facility name, if the request is for an inpatient admission or outpatient facility services
- Provider location if the request is for an ambulatory or office procedure
- Valid, specific ICD-10 diagnosis code, and relevant CPT procedure code(s)
- Relevant clinical information (e.g., past/proposed treatment plan, surgical procedure, and diagnostic procedures to support the appropriateness and level of service proposed)
- Admission date and/or proposed surgery date, if the request is for a surgical procedure
- Expected discharge plans

Utilization Determination Time Frames

CCA Health will review and make utilization management decisions in keeping with the time frames referenced in the table below. To meet these time frames, we ask that providers provide all relevant information and documentation in a timely manner. In the event that CCA Health needs to request an extension, we will communicate clearly why we need additional time and adhere to Medicare Advantage rules.

Expedited organization determinations are made when the member or their physician believes

that waiting for a decision under the standard time frame could place the member's life, health, or ability to regain maximum function in serious jeopardy. Expedited organization determinations may not be requested for cases in which the only issue involves a claim for payment for services that the member has already received. Expedited requests must be called into CCA Health by telephone.

CATEGORY OF UTILIZATION MANAGEMENT DECISION	REVIEW AND DETERMINATION TIME FRAME
Standard	Determination and notification within 14 calendar days after receipt of request, and as quickly as needed based on the member's health condition
Standard Extension	Up to 14 additional calendar days (not to exceed 28 calendar days) after receipt of the original request
Expedited	Determination and notification as quickly as the member's health condition requires, but no later than 72 hours after receipt of request
Expedited Extension	Up to 14 additional calendar days (not to exceed 17 calendar days) after receipt of the original request
Concurrent	Determination and notification as soon as medically indicated; usually within one business day of request

Prior Authorization Denials

CCA Health may deny a request for prior authorization for the following reasons:

- Your patient is not an eligible CCA Health member
- The service requested is not a covered benefit
- The service requested is determined not to be medically necessary
- The member's benefit has run out for the service requested

We will let you know in writing if we deny your request (either entirely or partially), and this written notice will include an explanation for why the request was denied. These denials are also called an "adverse determination."

Notifications

In certain situations, such as emergency room visits or emergent admissions, providers are required to notify CCA Health about our members as soon as possible, and within a specified time frame. This notification is important as it allows us to follow up with the member to help with managing the care and appropriate follow up.

A few notes on notifications:

- If a member is admitted through the emergency room, notification is required no later than 24 hours from the time the member is admitted for purposes of concurrent review and follow-up care.
- If a member receives emergent or urgent care services, the provider must notify us within 48 hours of the services being rendered.

Discharge Planning

We believe it is critical that the member or member's authorized representative, CCA Health the facility, the admitting provider, and the PCP are all in agreement about the treatment plan and next steps by the time the member is to be discharged from a facility.

The facility or admitting physician is required to contact CCA Health and provide clinical information to support discharge decisions for:

- Requests for facility stay extensions (Note: Contact must be made prior to the expiration of the approved days)
- Requests to move members to a different level of care
- Discharge plans that include any of the following:
  - Home health services or specialized durable medical equipment
  - Multiple medications
  - Programs for lifestyle changes like weight management, nutrition, smoking cessation, exercise, diabetes education, or stress management

Appealing a Decision

Appeals are different than grievances and are processed by CCA Health differently. An appeal (or a request for reconsideration) is a written or oral request to change or reconsider a service decision made by CCA Health. Examples of appeals include a request to overturn a denial of a prior authorization, or a denial of coverage for health care services or prescription drugs. Appeals can be received prospectively or after services have been rendered or supplies procured.

Appeals can be submitted by either:

- A member (or their legal guardian, authorized representative, or power of attorney)
- A non-participating provider (who has signed a waiver indicating they will not seek payment from the member for the item or service in question).

A physician who is providing treatment to a member, upon providing notice to the member, may request an expedited or standard reconsideration on the member's behalf without having been appointed as the member's authorized representative. CCA Health will follow applicable Medicare Advantage regulations and requirements concerning member appeals.

CCA Health will identify and remove any communication barriers that may impede members or their representatives from effectively making appeals. CCA Health will facilitate the request to file an appeal for a member or treating provider who has a communication challenge affecting their ability to communicate or read, through the following means:

- TTY line is available for the hearing impaired
- Translation service for members with limited English communication capabilities or comfort

Additional accommodations will be made for any member with special needs who is unable to follow the standard process.

Appealing a Hospital Discharge

Members have the statutory right to appeal their hospital discharge to a Beneficiary Family Centered Care Quality Improvement Organization (BFCC-QIO) for immediate review. The BFCC-QIO for Michigan is Livanta. The BFCC-QIO notifies the facility and CCA Health of an appeal.

A primary care provider (PCP) or a provider who is actively treating a member may file an appeal on behalf of the member without having been appointed as the member's authorized representative.

Care Management Programs

CCA Health will engage some members in either case or disease management programs. While CCA Health will be using multiple approaches and resources to identify members, we also encourage our network providers to alert us to members who would benefit from participating in a case or disease management program. We expect providers will cooperate with CCA Health in regards to these programs.

Quality Management

Quality is not just a noun it’s a belief that together we can achieve 5 Stars.

Program Goals

The primary goal of CCA Health quality management program is to significantly and sustainably improve the health and well-being of members.

- Continuously improve the quality of clinical care and services that members receive
- Optimize members' satisfaction with their clinical care and CCA Health
- Continuously improve the quality of service that providers receive from CCA Health
- Increase provider satisfaction with CCA Health
- Improve the health of the communities that CCA Health serves

Program Activities

As part of our commitment to continuous quality management, CCA Health will engage in the following activities:

- Medical records review: CCA Health will undertake periodic medical records reviews. For example, CCA Health may conduct an annual review of a sample of clinical records from one or more provider practices. Please see the Medical Records chapter of this manual for more information.
- Healthcare Effectiveness Data and Information Set (HEDIS®): CCA Health will monitor and collect data needed to assess performance on HEDIS® quality measures for all members throughout the course of the year and will report these measures to CMS annually.
- Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey: CAHPS is a survey that includes questions designed to evaluate member satisfaction with their care, their clinicians, and their health plan.
- Health Outcomes Survey (HOS): The Medicare HOS measures the physical and mental health of the Medicare population at the beginning (baseline measure) and after two years (follow-up measure) to provide an indication of how a Medicare Advantage plan is managing the health of its membership.
- Risk management occurrences and adverse events: Unexpected occurrences, adverse clinical events, medical errors, and "near misses" will be reviewed in accordance with CCA Health Quality Management Process, and as required by law and accrediting agencies.
- Analysis of member complaints: Review of all member complaints and grievances related to concerns about care quality.

In addition to the programs described above, CCA Health also works on several other quality initiatives specific to preventable hospital admissions, discharge planning, appropriate nursing facility institutionalization, fall prevention, and identification of abuse or neglect. The reporting requirements of such events are described in the Reporting Responsibilities section of this manual.

Star Rating

As a Medicare Advantage plan, CCA Health will be evaluated by the Centers for Medicare and Medicaid Services (CMS) and assigned a Star Rating. The Star Rating is an indicator of a plan's ability provide high quality care and service to its members. Ratings range from 1 to 5 stars with 5 stars representing the highest possible grade for quality. The Star Rating is informed by many sources of information:

- Preventive health and other clinical indicators from Healthcare Effectiveness and Information Set (HEDIS®)
- Member satisfaction and experience from the annual Consumer Assessment of Healthcare Providers & Systems (CAHPS®)
- Member-reported health outcomes from the Health Outcomes Survey (HOS)
- Health plan performance from CMS data

Over the course of the year, CCA Health will use a number of programs to ensure our members receive the highest possible quality care. In many cases, this involves direct member engagement campaigns (for example, call and letter campaigns for certain clinical programs) and provider engagement (for example, alerting PCPs to members with gaps in care).

The
- re are a few things you can do to help Reliance Health's Star rating efforts:
  Regularly update your provider roster and contact information so that we can contact you with important star rating information in a timely manner
- Comprehensively and accurately capture diagnosis information when submitting claims and encounters so that we can identify members eligible for potential disease management programs
- Maintain appointment availability to minimize potential access to care issues
- Coordinate with the member's PCP and provide follow-up notes promptly
- Cooperate with requests for medical records

Credentialing

Credentialing is the review of qualifications and other relevant information pertaining to a health care professional who seeks to participate with CCA Health and provide care for our members. The credentialing process exists to verify that participating providers meet the criteria established by CCA Health as well as applicable government regulations and accreditation agency standards. Credentialing is important to ensure a high quality network. We try to make this process as rapid and smooth as possible for each provider. If you have any questions about credentialing, please email our credentialing department at providerinquiry@Relianceaco.org.

Initial Credentialing

Provider must complete a credentialing application, including all supporting documentation as identified in the application. To initiate the credentialing process, CCA Health must receive a complete application, inclusive of signature, date, and an attestation by the applicant of the correctness and completeness of the application. CCA Health requests that providers use the Council for Affordable Quality Health (CAQH) credentialing application.

Once we have received a complete and compliant application, CCA Health will review it and verify the information contained therein. Some information may be verified from a primary source and some information may be verified from a secondary source.

After the application has been reviewed, the Credentialing Committee will render a decision on acceptance, or ask for more information as necessary. CCA Health Credentialing Committee, including the Medical Director or a physician designee, has the responsibility to establish and adopt necessary criteria for participation, termination, and direction of the credentialing procedures, including approval and denial guidelines.

Failure of an applicant to submit a complete and compliant credentialing application, or to respond to requests for more information may result in the denial of a provider. Providers have the right to appeal credentialing decisions, as explained further in this section of the provider manual.

Following the Credentialing Committee's decision of approval or denial, a notification will be sent to the provider. These notifications are generally sent by email from providerinquiry@Relianceaco.org

Providers must be credentialed prior to submitting claims to CCA Health for treating members. Primary care providers (PCPs) cannot accept member assignments until they are credentialed.

Site Visits

Site visits are performed at provider offices and other facilities at the discretion of CCA Health and in accordance with our policy for conducting site visits. At a minimum, each site visit will evaluate:

- Physical accessibility
- Physical appearance
- Adequacy of equipment
- Conformity to CCA Health standards for medical record keeping practices and confidentiality requirements including management of Protected Health Information (PHI)

Site visits will be conducted by appropriately qualified staff who are trained in the evaluation of provider sites.

Recredentialing & Monitoring

CCA Health conducts provider recredentialing at least every 36 months from the date of the initial credentialing decision and/or most recent recredentialing decision. The purpose of this process is to identify any changes in the provider's areas of clinical expertise and capabilities, licensure, sanctions, certification, competence, health status, or other status which may affect the provider's ability to perform services under the contract. This process applies to all providers, facilities, and ancillary providers previously credentialed and currently participating in the network.

In between credentialing cycles, CCA Health conducts ongoing provider performance monitoring activities on all network providers. This includes monitoring any new adverse actions taken by regulatory bodies, including the Medicare program (for sanctions and opt-outs) and state licensure against providers. Additionally, CCA Health reviews reports released by the Office of the Inspector General (OIG) to identify any network providers who have been newly sanctioned or excluded from participation in Medicare.

A provider's participation agreement may be suspended or terminated at any time, or not renewed, if it is determined by the CCA Health Credentialing Committee that credentialing requirements or standards are no longer being met. Any suspension, termination or renewal will follow the process, if any, required by the Centers for Medicare and Medicaid Services (CMS) in its Medicare Managed Care Manual.

Institutional Provider Certification

CCA Health will also determine that each institutional provider or supplier in our network has met the following requirements:

- Approval by CMS for participation in Medicare
- Licensed to operate in the state
- Approval by an appropriate accrediting body (or meets CCA Health standards)

CCA Health will obtain documentation and attestation at least every three years.

Provider Right to Review and Correct Information

All providers participating within the network have the right to review and improve the quality and accuracy of information obtained by CCA Health to evaluate their credentialing or recredentialing application. This includes information obtained from any outside primary source such as the National Practitioner Data Bank (NPDB) Healthcare Integrity and Protection Data Bank, CAQH, malpractice insurance carriers and state licensing agencies. This does not allow a provider to review references, personal recommendations, or other information that is peer review protected.

Providers have the right to correct any erroneous information submitted by another party (other than references, personal recommendations, or other information that is peer review protected) in the event the provider believes any of the information used in the credentialing or recredentialing process to be erroneous, or should any information gathered as part of the primary or secondary source verification process differ from that submitted by the provider.

A request to review credentialing information must be submitted to the Credentialing Department by email at providerinquiry@Relianceaco.org. If a provider chooses to provide a written explanation to the Credentialing Committee, they must submit their information within 30 days of receiving the credentialing information from CCA Health Michigan, Inc.. The Credentialing Committee will then include this information as part of the credentialing or recredentialing process.

Provider Right to be Informed of Application Status

At any time, all providers who have submitted an application to join the network have the right to be informed of the current status of their application upon request. To obtain application status, the provider should contact the Credentialing Department by email at providerinquiry@Relianceaco.org

Provider Right to Appeal Credentialing Decisions

New applicants who are declined participation may request a reconsideration by contacting providerinquiry@Relianceaco.org within 60 days from the date of the notice and by following the instructions in their official denials notification. Reconsiderations will be reviewed by the Credentialing Committee at the next regularly scheduled meeting and/or no later than six months from the receipt of the additional documentation.

Applicants who are existing providers and who are declined continued participation due to adverse recredentialing determinations have the right to request an appeal of the decision. Requests for an appeal must be made by email at providerinquiry@Relianceaco.org within 60 days of the date of the notice.

CCA Health does not discriminate, in terms of participation, reimbursement, or indemnification, against any health care professional who is acting within the scope of their license or certification under state law, solely on the basis of the license or certification.

Pharmacy

All of Medicare Advantage (MA) plans offer Part D prescription drug coverage (MA-PD). We understand the importance of having a holistic view of a member's health care needs, including prescriptions. CCA Health has worked with OptumRX our Medicare Part D prescription drug benefit manger to create a formulary that is easy to use and has common sense Step Therapy and Authorization rules.

Formulary Overview

CCA Health contracts with CMS to provide drug coverage for Medicare Part D members using the Medicare Part D Drug Formulary, utilization management programs, and pricing structure. The Part D pharmacy benefit does not cover all medications. Some medications require prior authorization or have limitations on age, dosage, and/or maximum quantities. CCA Health will work with its PBM to administer and oversee all pharmacy benefits, including the prior authorization process.

CCA Health Drug Formulary is organized into five sections, or tiers. Each section is divided by therapeutic drug class primarily defined by mechanism of action. Products are listed by generic or by brand name, depending on formulary coverage. Unless exceptions are noted, generally all applicable dosage forms and strengths of the drug cited are included in the CCA Health Formulary.

The PBM's pharmacy and therapeutics committee (P&T) reviews all medications selected for inclusion in the CCA Health Formulary. The P&T meets regularly to ensure that the formulary remains current, and that it provides members with optimal access to effective and cost-effective pharmacotherapies.

Formulary documents, including a comprehensive list of medications included on the CCA Health Formulary, can be found on CCA Health website.

Formulary Tiers

CCA Health covers both brand name drugs and generic drugs. The branded version of the drug is the first version to be discovered and the patented version. Generic drugs contain the same active chemical substance as the branded version, but can only be sold once the patent(s) on the original, branded drug have expired. Generally, generic drugs are less expensive than brand name drugs.

Drugs included in the CCA Health Formulary may have varying costs to members. For members, these costs will take one of two possible forms:

- Copays: a fixed dollar amount paid per prescription
- Cost-shares: a payment equal to a fixed percentage of a drug's price

Prescription drugs are grouped into one of five tiers:

Tier 1 Preferred Generic Drugs	Generic or brand drugs that are available at the lowest cost share for the plan
Tier 2 Generic Drugs	Generic or brand drugs that the plan offers at a cost to members that is equal to or higher than the cost share for Tier 1 drugs
Tier 3 Preferred Brand Drugs	Generic or brand drugs that the plan offers at a lower cost to members than Tier 4 drugs
Tier 4 Non-Preferred Drugs	Generic or brand drugs that the plan offers at a higher cost to members than Tier 3 drugs
Tier 5 Specialty Tier	A select subset of high cost drugs, including injectables, infusions, and monoclonal antibodies. These drugs are the most expensive drugs on the formulary. The copay or cost share for these drugs will be higher than for Tier 4 drugs.

Part D Utilization Management

Certain prescription drugs on the CCA Health Formulary have additional requirements or limits on coverage. These requirements and limits ensure that members can use these drugs in the most effective way and help to control drug costs.

CCA Health uses prior authorization (PA) criteria and requirements, quantity limits (QL), and step therapy (ST) to ensure members receive safe, cost-effective, and efficacious medicines. These terms are defined as follows:

Prior Authorization (PA)	CCA Health requires that members or their physicians obtain PA for certain drugs. For these drugs, a member will need to get approval from CCA Health before filling a prescription. If this approval is not obtained, CCA Health may not cover the drug.
Quantity Limits (QL)	For certain drugs, CCA Health limits the amount of the drug that CCA Health will cover.
Step Therapy (ST)	In some cases, CCA Health requires that a member try one or more drugs to treat a medical condition before agreeing to cover another drug for this same condition. For example, if Drug A and Drug B both treat a medical condition, CCA Health may not cover Drug B unless a member first tries Drug A. If Drug A does not work for the member, or the member experiences side effects when taking Drug A, then CCA Health will cover Drug B. Additional information about step therapy is available on CCA Health website at **www.ccahealthmi.org**

Generic Substitution: When generic versions of a brand-name drug are availableCCA Healths network pharmacies will automatically dispense the generic version unless the brand-name drug was requested. If the brand-name drug is not on the CCA Health Formulary, the member and/ or their physician will need to file a formulary exception request with CCA Health seeking approval for coverage of the non-formulary medication. If the formulary exception request is approved, then CCA Health pharmacy benefit manager (PBM) will cover the drug. However, the member may be asked to pay a higher copay for this brand-name version.

CCA Health may occasionally make an exception to its formulary coverage rules. When requesting a utilization restriction exception, the provider should submit a supporting statement along with a completed "Request for a Medicare Prescription Drug Coverage Determination form,"

found on CCA Health website to OptumRx.

In general, CCA Health will make a decision about all exception requests within 72 hours. Providers can request that an exception request be expedited if the member's health could be seriously harmed by waiting the full 72 hours for a decision. If the request to expedite the decision is granted, CCA Health must provide a decision within 24 hours of receiving the prescriber's supporting statement.

Medicare Advantage Formulary Coverage Exclusions

CCA Health Part D Prescription Drug Benefit does not cover the following drugs and drug categories:

- Agents used to treat weight loss (even if used for a non-cosmetic purpose, such as for morbid obesity)
- Agents used to promote fertility
- Agents used for cosmetic purposes or hair growth
- Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations
- Covered outpatient drugs that the manufacturer seeks to require as a condition of sale that associated tests or monitoring services be purchased exclusively from the manufacturer or its designee

Transition Policy

Under certain circumstances, CCA Health will approve a temporary supply of a non-formulary Part D drug, which is defined as meeting one of the following criteria:

- Part D drugs that are not on CCA Health formulary
- Part D drugs previously approved for coverage under an exception once the exception expires
- Part D drugs that are on a CCA Health formulary but require prior authorization (PA), quantity limits (QL), and step therapy (ST) lower than the member's current dose under CCA Health utilization management rules

Members with at least one of the following characteristics may be eligible for a transition fill:

- New beneficiaries enrolled into the plan following the annual coordinated election period
- Newly eligible Medicare beneficiaries from other coverage
- The transition of beneficiaries who switch from one plan to another after the start of a contract year
- Current beneficiaries affected by negative formulary changes across contract year
- Beneficiaries residing in long-term care (LTC) facilities, including beneficiaries being admitted to or discharged from an LTC facility

For those members who are new to CCA Health and are not in a LTC, CCA Health will cover a temporary supply of the drug one time only during the first 90 days of the member's enrollment in CCA Health Michigan, Inc.. This temporary coverage will supply a maximum of 30 days, or fewer if the prescription is written for fewer days. The prescription must be filled at a network pharmacy.

For new CCA Health members who are residents in LTC facilities, CCA Health will cover a temporary supply of the drug during the first 90 days of the member's enrollment in CCA Health Michigan, Inc.. This temporary coverage will supply a maximum of 31 days, or fewer if the prescription is written for fewer days. The prescription must be filled at a network pharmacy.

For members who have been a member of CCA Health for more than 90 days, reside in LTC facilities, and need a drug refilled immediately, CCA Health will cover up to a 31 day
supply of the medication, or less if the prescription is written for fewer days. This coverage is in addition to the above LTC transition supply. An exception or PA must be requested at the time the prescription is filled.

For all transition fills, members will be required to pay for the requisite copay or coinsurance. Non-formulary brand-name drugs approved for a transition fill will be assigned copays equal to those for drugs on Tier 4 of CCA Health Formulary, while generic drugs approved for a transition fill will be assigned copays equal to those for Tier 2 drugs.

Additional information about the CCA Health Transition Policy is on CCA Healths website.

Pharmacy Network

CCA Health and OptumRX have developed and will maintain a network of pharmacies where members can fill prescriptions. With a few exceptions, members must go to a network pharmacy to receive covered drugs. Refer to the CCA Health Provider & Pharmacy Directory, available online at **ccahealthmi.org** for a list of participating retail, chain, long-term care, home infusion, and mail-order pharmacies, and other relevant information.
Members may obtain the Mail Order form at **ccahealthmi.org** or may call Member Services at 844-705-7498 TTY 711.

Drug Utilization Review

CCA Health and OptumRX will conduct drug utilization reviews (DURs) to make sure members are getting safe and appropriate care. These reviews are especially important for members who are receiving prescription medications from more than one physician. CCA Health and OptumRX perform DURs every time a prescription is filled, and when CCA Health reviews the member's medical records.

DURs focus on identification of one or more of the following medication-related problems:

- Prescriptions which could lead to medication errors, including prescribing of drugs to which a member has a listed allergy, or incorrect dosing
- Duplicate drugs that are unnecessary because the member is taking another drug to treat the same medical condition
- Drugs with prohibitively dangerous side effects, and/or which pose undue risk when used by older people or by people of a particular gender
- Combinations of drugs which should not be taken together due to the risk of drug-drug interactions

If CCA Health identifies any medication-related problems that could warrant a modification to a member's prescription, CCA Health will share these findings with the prescriber and help the prescriber to address the issue if and as needed. Accordingly, prescribers may receive calls or faxes from CCA Health Health's pharmacy department following up on any findings. Prescribers should contact 844-705-7498 TTY 711 with any questions about this or other policies.

Medication Therapy Management

The Medication Therapy Management (MTM) program is offered at no additional cost to CCA Health members. The MTM program will focus on members who meet all of the following criteria for chronic conditions:

- Are taking at least a defined number of unique Part D Drugs
- Incur an annual cost of a defined amount for all covered Part D drugs

CCA Health will use the MTM program to help make sure that members are using appropriate drugs to treat their medical conditions, and to identify potential medication errors. We attempt to educate members as to drugs currently on the market, and recommend lower-cost, generic drugs where applicable.

CCA Health may also relay MTM information to the prescribing clinician and provide them with the opportunity to change the member's treatment if and as appropriate.
Providers may receive calls or faxes from CCA Health Pharmacy department as part of our efforts to follow up on the outcomes of any interventions discussed with a member.

New Medicare Part D prescriber prerequisite

As an update to the new CMS mandate, health care professionals who write prescriptions for Medicare Part D members should enroll in Medicare for an approved prescriber status or submit a valid-opt-out affidavit no later than July 31, 2016, to allow CMS time to process your application before the implementation date. This is required of health care professionals who write prescriptions to ensure continued prescription coverage under Medicare Part D. Those who have previously applied to meet this requirement and have received confirmation of their registration from CMS are not required to take additional action to fulfill this requirement. CMS has also issued an interim final rule that exempts pharmacists from the enrollment requirement; however, other prescribers remain subject to the final rule. Additionally, the new rule deems the new requirements, will be enforced beginning January 1, 2019. Providers should have submitted their completed Medicare enrollment applications or opt-out affidavits to their Medicare Administrative Contractors no later than July 31, 2016, to prevent their patients' prescription drug claims from being denied by their Part D plans beginning February 1, 2017.

Beginning January 1, 2019, Medicare Part D prescription drug benefit plans may not cover drugs prescribed by providers who are not enrolled in (or validly opted out of) Medicare, except in very limited circumstances. Unless you enroll (or validly opt out), Medicare Part D plans will be required to notify your Medicare patients that you are not able to prescribe covered Part D drugs. Part D plans will only cover up to one 3–month provisional supply of a drug, if prescribed by a provider who has not enrolled in or validly opted out of Medicare. If you opt out, you cannot receive reimbursement from traditional Medicare or a Medicare Advantage plan, either directly or indirectly (except for emergency and urgent care services).

In addition, in order for Part D claims to adjudicate appropriately, eligible prescribers must ensure their taxonomy information is accurate in the CMS National Plan and Provider

Enumeration System (NPPES) National Provider Identifier (NPI) registry. You can search https://npiregistry.cms.hhs.gov/registry/* to verify the taxonomy code(s) associated with your NPI. The taxonomy code is an element Prime Therapeutics uses to determine whether or not a claim may be paid based on eligibility to prescribe.
For more information on the Part D enrollment requirements, visit http://www.cms.gov/Medicare/Provider- Enrollment-and-Certification/MedicareProviderSupEnroll/index.html*
If you have any questions, please contact your MAC at its toll-free number. That number is available at http://www. cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/index.html*

Enrolling in Medicare Part D

You may submit your enrollment application electronically using the Internet-based Provider Enrollment, Chain, and Ownership System located at https://pecos.cms.hhs.gov/pecos/login.do* or by completing the paper CMS-855I or CMS-855O application, which is available at http://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/CMS-Forms- List.html*. Note that an application fee is not required as part of your application submission.

Pharmacy treatment improvement opportunities

In addition to our formularies, prescribing limits and restrictions, we promote quality of care by monitoring claims to improve outcomes and patient safety. CMS requires us to identify certain treatment opportunities and proactively address them with providers and members. Some of these medication issues factor into our Star rating scores.

High risk medications

Certain medications pose a high-risk of serious side effects in older patients, as described in the Beers Criteria for Potentially Inappropriate Medication Use in Older Adults. CCA Health and CMS endorse the Beers Criteria and, when a routine claim review identifies an instance when a high risk medication (HRM) is prescribed, we alert the prescriber of the risk and offer safer alternatives.

Medication adherence

We pay close attention to medication adherence for disease states such as diabetes, hypertension and hypercholesterolemia. We monitor medication adherence rates by reviewing pharmacy claims data, and if a member is non-adherent to their medications, we will address this with the member to see why the member is not taking his/ her medication as prescribed.

Statin use in diabetes

The guidelines of several medical societies state that diabetics should be on a statin, regardless of whether they have high cholesterol or not, in order to prevent cardiac events such as heart attacks. We will alert prescribers when they have members with diabetes that are not on a statin.

Opioid overutilization

Because of the risks involved with opioid and acetaminophen use, both CCA Health and CMS urge physicians to prescribe opioids with caution and carefully monitor patients using these medications. CMS requires CCA Health to actively monitor claims data for potential opioid and/or

acetaminophen overuse. If our analysis suggests
potential overuse, we send a letter to the prescriber detailing our concerns and ask them to complete and return a questionnaire about the patient's condition and treatments. If the physicians verify that the current opioid therapy is medically necessary, safe, and appropriate for their patient, we'll follow up with a letter of confirmation and report our findings to CMS. If the physicians fail to respond to our request for information or agree that the current opioid therapy is not appropriate, CCA Health may stop or limit coverage for the patient's opioid medication and notify the member, prescribers, and report our findings to CMS.

Our analysis looks at:
Safety risks, such as instances when a patient receives a daily dosage of opioids — either from a single prescription, or multiple prescriptions – that's higher than established safety levels.
High utilization patterns, where a patient may have opioid prescriptions from multiple physicians within the same time period.
Potential fraud, waste or abuse, when a patient visits multiple physicians to expand their access to these painkillers, a practice known as "doctor shopping."
Immunization
Medicare Part B and Part D both cover certain immunizations. Although the delineation of coverage is fairly clear, there are some exceptions where a vaccine could be covered under either plan.
When billing for prophylactic immunizations, the following always applies:
Influenza and pneumonia immunizations are always paid under Part B.
(These are never covered under Part D.)
Shingles immunizations are always paid under Part D.
(These are never covered under Part B.)
Part B covers two categories of immunizations (prophylactic and injury/disease-related) and the benefit pays everything associated with the vaccination in a single claim, including ingredient cost, dispensing fee, and injection or administration fee. Medicare will pay for immunizations in various venues: at a pharmacy, a clinic or a physician's office.

Activity associated with administering Part D vaccinations are also bundled into a single claim. However, incidental activity, such as an office visit, may involve additional cost-share to the patient.

Type of immunization	Part A covers	Part B covers	Part D covers
Prophylactic immunizations associated with a senior population: · Seasonal influenza · Pneumococcal pneumonia · Hepatitis B		Covers influenza, pneumonia and hepatitis B for patients at high- or intermediate risk of contracting the disease.	Hepatitis B vaccine may be covered if the patient does not meet Medicare's Part B criteria.
Vaccines administered by a health care provider for treatment of an injury, or as a result of direct exposure to a disease or condition.	Covers vaccines administered during an inpatient stay.	Covers limited vaccines administered on an outpatient basis. Some vaccines subject to review of clinical criteria to determine Part B or Part D coverage.	Covers shingles vaccination, and other Part D vaccines. Some vaccines (other than shingles) subject to review of clinical criteria to determine Part B or Part D coverage.

Medicare Part B covers influenza immunizations in full and some organizations provide the influenza immunizations free of charge while others may charge for a influenza immunizations. Because not all venues will file the Part B claim on the patient's behalf, the patient may have to pay cash for the influenza immunizations, and then seek reimbursement from Medicare Part B. It's important to remind these patients that Medicare Part B covers annual influenza immunizations at 100 percent (no copay or deductible) and that they must submit a completed claim form and receipt to their Medicare Part B insurance plan to obtain reimbursement. The claim must be submitted under Part B because influenza immunizations and pneumonia vaccinations are never paid under Part D.

Although shingles vaccinations are a prophylactic measure, these vaccinations are always covered under Part D. There is no coverage for this vaccination under Part B.

Billing guidelines for roster bills

Providers who are mass immunizers, and/or providers who chose to bill using the roster billing method, must submit immunization claims on a roster bill and accept assignment under Original Medicare on both the administration
and vaccine. Physicians and other health care providers enrolled in the Medicare program should follow the billing guidelines below when submitting roster bills to CCA Health:

At this time, CCA Health can only accommodate roster billing on paper claims. Providers may submit up to three rosters on a single CMS-1500 claim form for each type of vaccination. Rosters may include information regarding multiple patients.

Typed rosters are preferred. If it is not typed, the roster information must be in blue or black ink and legible.

Do not fold your claim or roster forms.

Mail your CMS-1500 claims and attached roster bills to the following address:

CCA Health Plan (RHP)- Claims
P.O. Box 94370
Lubbock, TX 79493

Claims

CCA Health is committed to paying claims accurately and on time so that you can focus on patient care. This chapter describes how to submit claims, our payment integrity programs, dispute resolution process and coordination of benefits.

Electronic Claims Submission

To expedite the claims process, please submit claims electronically. Submitting claims electronically (rather than through the mail) is faster, more reliable, and less prone to front-end process rejections. CCA Health supports electronic submission via the Health Insurance Portability and Accountability Act (HIPAA) transaction set (837P & 837I) and follows Medicare guidance requiring electronic claim submission as defined by the American Simplification Compliance Act.

You may submit electronic claims to CCA Health via Claimsnet clearinghouses. If you use a clearinghouse other than Claimsnet for your electronic transactions, please contact your clearinghouse to establish an electronic claim submission process to CCA Health via Claimsnet.

CCA Health Payer ID:

RHP01

Paper Claims Submission

CCA Health encourages direct electronic claim submission, but also accepts CMS-1500 and CMS-1450 (UB-04) paper claim form submissions. Please refer to our on-line Provider resources at www.ccahealthmi.org for more details on the data to include in each of the fields.

Paper claims must be submitted to:

CCA Health Plan (RHP)- Claims

P.O. Box P.O. Box 94370

Lubbock, TX 79493

If you have not registered for EFT as outlined below, CCA Health requires providers to indicate where paper checks should be send on the applicable claim for.

CMS-1500: Checks will be sent to the address submitted in box 33
UB-04: Checks will be sent to the address submitted in box 1 or box 2 (if different than box 1)

Electronic Funds Transfer (EFT)

In partnership with Vpay, CCA Health has implemented an enhanced online provider registration process for electronic funds transfer (EFT). Once registered, this no-cost secure service offers providers a number of options for viewing and receiving remittance details. CCA Health Plan has partnered with VPay® to provide a faster, more efficient way to reimburse your business for services rendered. Payments are distributed via secure fax and settled through your in-office terminal processing functionality, allowing for faster access to each payment. EFT registration is available along with 835/ Electronic Remittance Advice election for EOP details and there is an additional option to opt-out of electronic payment methods entirely to receive a standard paper check from the Plan. Note that card processing fees will be assessed at the rate outlined in your merchant agreement with your acquiring bank for any VCard transactions. For EFT, limited transaction fees may apply per the VPay registration agreement.

Electronic Remittance Advice (ERA)

ERA, or 835, is the electronic transaction that provides claim payment information. These files provide an ability to auto-post claim payments into your systems.

Timely Filing of Claims

Each provider should refer to their Provider Agreement for filing guidelines and documentation requirements, though CCA Health encourages its providers to submit claims as quickly and accurately as possible.

Unless otherwise specified in the Provider Agreement, CCA Health timely filing limit is 365 days from the claim's date of service. Claims not submitted by the claims' filing deadline are not eligible for reimbursement and a provider may not bill a member for claims submitted after the timely filing limit.

Claims Processing

CCA Health uses a combination of guidelines established by the Centers for Medicare and Medicaid Services (CMS) and internal claims processing policies to assist in determining proper coding. These guidelines and policies dictate claims edits, specifying adjustments to payment, and/or require review of medical records that relate to the claim.

Clean Claims

CCA Health uses the Centers for Medicare and Medicaid Services (CMS) Medicare Advantage (MA) definition for a clean claim (available in Chapter 11 of the Medicare Managed Care Manual), which consists of a properly completed claim that can be processed as soon as it is received. Clean claims include:

- Member name, date of birth, sex, and their CCA Health unique member identification number
- Date(s) of service, place of service(s), and number of days or units, if applicable
- Provider tax identification (TIN) and National Provider Identifier (NPI) number
- ICD-10 diagnosis codes by specific service to the highest level of specificity
- Current CPT, revenue, and HCPCS procedure code(s) with modifiers, if appropriate
- Billed charges per service(s) provided and total charges
- Provider name and address, signature, and phone number
- Information about other insurance coverage, workers' compensation, accident or auto information, if available
- Detailed description of the service or procedure for the claim submitted with unlisted medical or surgical codes
- For resubmissions and corrections of a claim, please submit a new CMS 1500 or UB-04 indicating the correction (see below)

Failure to submit a clean claim may result in a delay of payment and/or rejection of a claim. Common types of errors include incomplete fields, invalid codes, lack of supporting medical records, and provider data mismatches.

Timely Processing of Claims

CCA Health will adhere to standard Centers for Medicare and Medicaid Services (CMS)-compliant claims timeline guidelines, which are stipulated in the Provider Agreement.

Claims Payment

A network provider will be reimbursed according to the reimbursement addendum of the provider agreement.

Claims Corrections

CCA Health will deny a claim if it is determined to be incorrect or incomplete due to missing or invalid information. In this event, the provider may re-submit a corrected claim within the timely period as indicated in the Timely Filing of Claims section above.

As set forth in your Provider Agreement, providers cannot bill members for services submitted beyond the timely filing limit.

Correcting or Voiding Electronic Claims

Professional claims (837p)	• Enter Frequency Code 7 for corrections, or Frequency 8 to void, in Loop 2300 Segment CLM05-3 • Enter the original claim number on the 2300 loop in the REF*F8*
Institutional claims (837i)	Submit with the last character of the Type of Bill as 7, to indicate Frequency Code 7 for corrections, or Type of Bill as 8, to indicate Frequency Code 8 to void

Correcting or Voiding Paper Claims

Professional claims CMS-1500	• Stamp "Corrected Billing" on the CMS 1500 form • Complete box 22 when re-submitting a claim • Enter the appropriate bill frequency code left justified in the left-hand side of the field: 6 - Corrected Claim 7 - Replacement of prior claim 8 - Void/Cancel prior claim • Enter the original CCA Health claim number as the Original Ref. Num
Institutional claims UB-04	Submit with the last digit of 7 in the Type of Bill for corrections, or last digit of 8 for void claims

Corrected claims should be submitted with all line items completed for that specific claim, and should not be filed with just the line items that need to be corrected.

Pass-through Billing/CLIA

If you are a health care provider, you must only bill for services that you or your staff perform. For laboratory services, you will only be reimbursed for the services you are certified to perform through the Federal Clinical Laboratory Improvement Amendments (CLIA). You must not bill our members for any laboratory services for which you lack the applicable CLIA certification.

Sequestration

CCA Health will use the same sequestration reductions as those imposed by the Centers for Medicare and Medicaid Services (CMS). All providers are reimbursed using a fee schedule based on the Medicare payment system, percentage of Medicare Advantage (MA) premium or Medicare-allowed amount (resource-based relative value scale [RBRVS], diagnosis-related group [DRG], etc.) and will have the sequestration reduction applied the same way it would be applied by CMS. This reduction applies to all MA plans.

Overpayment Recovery

We abide by Centers for Medicare and Medicaid Services (CMS) guidelines for overpayment recoupments, which include:

- provider notification
- opportunity for dispute
- possibility of auto-recoupments from future claims payments

CCA Health may reopen and revise its initial determination or redetermination on a claim on its own motion, including any of the following:

- Within one year from the date of the initial determination or redetermination for any reason
- Within four years from the date of the initial determination or redetermination for good cause as defined in 42 CFR 405.986
- At any time if there exists reliable evidence that the initial determination was procured by fraud or similar fault as defined in 42 CFR 405.902

CCA Health will provide written documentation that identifies affected claims and justifies the reimbursement request. CCA Health will make three attempts at recoupment before offset occurs unless otherwise specified in provider contract. Overpayments can stem from coding edits, improper coordination of benefits, technical denials, and medical necessity review, among other reasoning outlined by applicable law. CCA Health will not, however, base a reimbursement request for a particular claim on extrapolation of other claims, except where applicable law permits, including any of the following circumstances:

- In judicial or quasi-judicial proceedings, including arbitration

- In administrative proceedings
- Where relevant records a provider was required to maintain have been improperly altered or reconstructed, or a material number of the relevant records are otherwise unavailable
- Where CCA Health has investigated the claim in accordance with its fraud prevention plan and there is clear evidence of fraud by the provider.

In seeking reimbursement from a provider for any overpayment the provider may have received, except as expressly otherwise stated in the Provider Agreement, CCA Health attempts to collect the funds for reimbursement according to the following guidelines:

- Provider agrees to repay such amounts within 60 days of receiving notice from CCA Health Repayment can be made via check or deducted from future payment.
- If the provider disputes the request and initiates a review after CCA Health has sent the reimbursement request, CCA Health will not collect the amount until the dispute is resolved.
- CCA Health may assess the amount against payments of any future claims the provider submits. CCA Health will collect the funds after sending a written explanation to the provider that has sufficient detail to allow the provider to reconcile each member's bill. Additionally, CCA Health may also collect a monetary penalty in addition to outstanding value of the reimbursement request.

Overpayment refund checks can be sent to:

CCA Health
ATTN: Program Integrity
PO BOX 25677
TAMPA, FL 33622

Payment Disputes and Reconsiderations

Payments that are made to in-network providers are based on the terms of the Provider Agreement with CCA Health. If you feel that the claim was not processed correctly, you may file a payment dispute. Our dispute resolution process allows for disputes to be filed for either of the following:

- A dispute of medical necessity or administrative determinations resulting in no payment
- A dispute of the amount CCA Health paid on a claim and a request to obtain a higher level of payment

You can submit your dispute within the contractually agreed-upon time frame, or within 90 days of receipt of your remittance notice, if not specified otherwise in your Provider Agreement.

Disputes should be submitted in writing and must include supporting documentation, including a copy of the Explanation Of Payment (EOP) and full explanation of why the payment should be adjusted. Submit payment disputes to:

CCA Health
ATTN: Provider Disputes
PO BOX 94370
Lubbock, TX 79493

A resolution to the Claims Payment Dispute will be rendered and communicated to the provider within 60 calendar days.

Payment Integrity (Pre- and Post-payment Review)

In our relationship with the Centers for Medicare and Medicaid Services (CMS), we are obligated to monitor for signs of fraud, waste, and abuse, ensuring well-managed care through a payment integrity review, including both pre- and post-payments. CCA Health uses software tools designed to identify providers and facilities whose billing practices indicate suspect conduct.

If a claim, provider, or facility is identified as a behavioral outlier, further investigation is conducted by CCA Health to determine the reason(s) for the outlier behavior or appropriate explanation for an unusual claim, billing, or coding practice. If the investigation results in a determination that the provider's or facility's actions may involve fraud, waste, or abuse, the provider or facility will be notified and given an opportunity to respond, and CCA Health may institute an overpayment recovery process as described above.

Providers may also then be placed under prepayment review and may be subject to one or more clinical utilization management guidelines. The impacted providers and/or facilities are notified of a request for additional clinical information in support of the medical necessity of services billed for/coded on the identified claims in prepayment review.

Access to Medical Records

Access to medical records is essential to CCA Health efforts to assess payment integrity and evaluate whether or not services delivered were medically necessary.

If we determine that we need more clinical data or documentation to process a claim, our team (or a trusted third party) may request medical records and stipulate that the processing of the claim is dependent upon receiving and evaluating the records.

CCA Health will also request medical records to substantiate risk-adjustment, verify diagnoses and corresponding treatment plans, extract quality data required by the Centers for Medicare and Medicaid Services (CMS), and identify gaps in care and opportunities to improve quality of care. Having access to medical records will also enable us to:

- better ascertain a member's overall level of health
- predict future health services needs
- leverage our predictive analytics expertise to furnish providers with targeted information about patients' risks for different outcomes
- support provider's efforts to use this information to improve patients' health and wellbeing

Ultimately, having access to these data and documentation will help CCA Health make it easier for a provider to deliver outstanding care to your patients.

Unless stated otherwise in the Provider Agreement, we would request that the provider will provide to CCA Health or its designee, medical records or access to electronic records within 7 business days of CCA Health request.

Member Cost-Sharing

Each provider plays a critical role in CCA Health network and in the delivery of high quality health care services to our members. In accordance with the Centers for Medicare and Medicaid Services (CMS) regulations, and as included in the Provider Agreement, no provider may bill or collect payment for services rendered to our members, except for applicable copayments, coinsurance, or deductibles.

Members are only responsible for applicable copayments, deductibles, and coinsurance associated with their benefit plans.

If a provider collects an amount from a member that exceeds the payment responsibility, the provider must reimburse the excess amount to the member. To determine the member's responsibility, please refer to the Evidence of Coverage or the Remittance Advice. If a correction to a claim or a payment must be made, the result of which indicates that the original amount collected in member cost-share exceeds the member's actual responsibility, it is the provider's responsibility to reimburse the excess amount to the member.

Furthermore, the provider must advise members of any charges they will accrue that are not covered services in CCA Health plan and obtain prior approval signed by a member from the member before requesting payment for any out-of-pocket expenses.

Balance Billing and Inappropriate Billing of Members

Inappropriate billing of members includes billing members for services where payment from CCA Health has not been obtained due to claim cleanliness issues or other billing issues.

It is a violation of the Provider Agreement and applicable law for CCA Health contracted providers to balance bill or inappropriately bill members.

Coordination of Benefits (COB)

Coordination of Benefits (COB) is intended to avoid duplication of benefits and at the same time preserve certain rights to coverage under all plans in which the member is covered. COB is an important part of CCA Health overall objective of providing healthcare to members on a cost-effective basis. CCA Health members may not be billed for covered services rendered except for any copayments for which the member may be responsible. CCA Health members who have coverage under the Medicaid Qualified Medicaid Beneficiary (QMB) Program are not responsible for copayment. A provider's contract with CCA Health requires the provider to accept CCA Health payment as payment in full.

Primary Plan	Determines a member's health benefits without taking into consideration the existence of any other plan
Secondary Plan	Pays the remaining costs after the primary plan has paid

All CCA Health members must follow these procedures:

- All CCA Health members, excluding those on Medicaid, will pay or be billed copayments at the time of their office visit
- Under no circumstances may members be directly billed beyond the amount due for their cost-share (e.g., deductibles, copayments and coinsurance)

Coordination of Benefits for Medicare Advantage Members with Medicaid

CCA Health members who have limited income and resources may receive help paying out-of-pocket medical expenses from Medicaid. If a member is identified as having secondary insurance coverage through Medicaid, the provider should obtain a copy of the member's Medicaid card to bill Medicaid after receiving the Remittance Advice from CCA Health. No copayment should be collected or billed at the time of the visit from a member with Medicaid coverage. For further

information, the provider's office can contact Provider Services (see Quick Reference Guide).

Coordination of Benefits for Medicare Advantage Members with Multiple Payer Sources

If a member has coverage from more than one payer or source, we coordinate benefits with the other payer(s) in accordance with the provisions of the member's benefits. If a provider has knowledge of alternative payer(s) who are primary, the provider must bill the other payer(s) with the primary liability based on such information prior to submitting claims for the same services to CCA Health.

Providers are also expected to provide CCA Health with relevant information regarding coordination of benefits and to bill payer(s) with the primary liability based on such information prior to submitting bills for the same services to CCA Health. To the extent permitted by law, if CCA Health is not the primary payer, a provider's compensation from CCA Health will be no more than the difference between the amount paid by the primary payer(s) and the provider's applicable rate with CCA Health, less any applicable copayments or coinsurance.

Because members accept CCA Health benefits by their participation in the COB program, they are legally responsible to adhere to the rules and regulations required of all CCA Health members, such as use of the primary care provider (PCP) and/or prior approval for out-of-plan services.

CCA Health cannot deny a claim in whole or in part, on the basis of COB unless we have a reasonable basis to believe that the member has other insurance coverage that is primary for the claimed benefit. In addition, if we request information from the member regarding other coverage and do not receive the information within 45 days, we must adjudicate the claim. However, the claim cannot be denied on the basis of non-receipt of information about other coverage.

Risk Adjustment

Well-coordinated and high quality healthcare depends on a shared understanding of each member's complete health profile, which relies on comprehensive and specific diagnosis capture. Diagnosis codes also serve as the basis for the Centers for Medicare and Medicaid Services (CMS)'s Hierarchical Condition Category (HCC) risk adjustment model. Medicare Risk Adjustment refers to the methodology CMS uses to adjust payments to Medicare Advantage (MA) plans based on the diagnosis information the plan submits to CMS.

Medicare Risk Adjustment

The Medicare Risk Adjustment model relies on the ICD-10-CM diagnosis codes accurately documented in one year to prospectively pay MA organizations based on the health status of their enrolled beneficiaries in the next year. In order to be compliant with CMS guidance, complete and accurate diagnosis reporting according to the official ICD-10-CM coding is required along with reporting the ICD-10-CM diagnosis codes to the highest level of specificity and report these codes accurately.

Reporting the ICD-10-CM coding and diagnosis requires accurate and complete medical record documentation. Providers are encouraged to notify CCA Health of any erroneous data submitted and to follow CCA Health procedures for correcting erroneous data. Finally, providers should report claims and encounter information in a timely manner, generally within 30 days of the date of service (or discharge for hospital inpatient facilities).

Provider Responsibilities

CCA Health has a number of programs to ensure the complete and compliant collection, transmission, and curation of diagnosis codes. As a CCA Health network provider, it is important that you provide complete and accurate diagnosis information when submitting claims or responding to a CCA Health request for medical records.

In addition, providers should:

- Consistently follow general principles of medical record documentation
- Respond quickly to requests for medical records and other related queries
- Send all records in an organized, secure and confidential manner
- Ensure all documentation to support a reported diagnosis on a given date or range of dates is provided to CCA Health upon request
- Include supporting documents referred to in the encounter notes, such as test results or problem lists
- Notify CCA Health of any diagnoses that are erroneously associated with a CCA Health member

Medical Records

Medical records are an important component of delivering high quality care to members. Providers are required to maintain accurate and complete paper or electronic medical records for each of the CCA Health members for whom they provide care.

Requirements

Medical records should include all information as required by applicable state and federal laws. CCA Health records medical data for HEDIS at certain times of the year for quality improvement initiatives. Medical record reviews may require data collection on services obtained over multiple years. Archived medical records/data may be required to complete data collection.

For the HEDIS reviews, we look for details that may not have been captured in claims data such as blood pressure readings, HbA1c lab results, colorectal cancer screenings and body mass index. This information helps us enhance our member quality improvement initiatives.

A CCA Health employee or designated vendor(s) will perform the HEDIS reviews. Provider offices are responsible for responding to the medical record request and providing the documentation requested in a timely manner. CCA Health or its designated vendor(s) will contact your office to establish a date for an onsite visit or the option to fax or mail the data requested. A patient list will be sent including the name and information being requested. If your office is selected for an onsite visit, please have the medical records available ahead of time. If a chart for a patient is being requested and not available at your practice location, you should notify the CCA Health employee or the designated vendor immediately.

We request that providers allow CCA Health employees or its designated vendor(s) to scan the medical records during an onsite visit. HEDIS requires proof of service for any data that is collected from a medical record. CCA Health will not reimburse for copy house services. If a provider or an accountable care organization contracts with a copy house vendor they will be responsible for reimbursing that vendor.

Documentation

All medical record documentation must be legible, detailed, organized in a consistent and logical matter, and in adherence with each provider's internal practice protocols. All entries into the medical record should be dated and signed or initialed by the author and must include the author's credentials (e.g., medical doctor (MD) or advanced registered nurse practitioner (ARNP)). Providers are also responsible for maintaining the confidentiality of medical records and the information contained within them.

Reviews

CCA Health performs medical record reviews for multiple purposes, including but not limited to our quality management program and our credentialing and recredentialing program. If a provider's medical records are found to contain significant deficiencies during the review process, the provider will be notified by CCA Health of the deficiency as well as implications and next steps.

Medicare Compliance, Fraud, Waste, and Abuse

As a Medicare Advantage (MA) plan, CCA Health has a responsibility to make sure that the guidelines set by the Centers for Medicare and Medicaid Services (CMS) are followed, and that beneficiaries as well as the ethical integrity of the MA program are protected. We take this responsibility seriously and it is a significant part of our compliance program. The purpose of this section is to provide you with an overview of relevant parts of our compliance program related to marketing MA plans to beneficiaries and Fraud, Waste, and Abuse programs.

Provider Promotional Activities

Please refer to the Medicare Marketing Guidelines, applicable to Medicare Advantage (MA) and Medicare Advantage Part D (MA-PD) plans for more detailed information about provider promotional activities.

As used in specific guidance about provider activities, the term "provider" refers to all providers contracted with CCA Health Plan and their subcontractors, including but not limited to: pharmacists, pharmacies, physicians, hospitals, and long term care facilities (LTCs). CCA Health shall ensure that any provider contracted with CCA Health (and its subcontractors) performing functions on CCA Health behalf related to the administration of the plan benefit, including all activities related to assisting in enrollment and education) agrees to the same restrictions and conditions that apply to CCA Health, and shall prohibit any provider from steering, or attempting to steer an undecided potential enrollee toward a plan, or limited number of providers, offered either by CCA Health or another plan sponsor, based on the financial interest of the provider or agent (or their subcontractors or agents) or otherwise. While conducting a health screening, providers may not distribute plan information to patients.

The Centers for Medicare and Medicaid Services (CMS) is concerned with the provider activities for the following reasons:

- Providers may not be fully aware of all plan benefits and costs
- Providers may confuse the individual if the provider is perceived as acting as an agent of the plan versus acting as the individuals' provider

Providers may face conflicting incentives when acting as a plan representative. For example, some providers may gain financially from a beneficiary's selection of one plan over another plan. Additionally, providers generally know their patients' health status. The potential for financial gain by the provider steering a patient's selection of a plan could result in recommendations that do not address all of the concerns or needs of an individual or potential member. These provider marketing guidelines are designed to guide CCA Health and providers in assisting individuals with plan selection, while at the same time striking a balance to ensure that provider assistance results in plan selection that is always in the best interests of the beneficiary.

Providers should remain neutral parties in assisting plan sponsors with marketing to members or potential members or assisting with enrollment decisions. Providers not being fully aware of plan benefits and costs could result in members or potential members not receiving information needed to make an informed decision about their health care options.

The subsections below provide information about the requirements associated with provider activities. CCA Health requires that any provider contracted with CCA Health (and its subcontractors) comply with these requirements.

Provider Activities and Materials in the Healthcare Setting

Members and potential members often look to their health care professionals to provide them with complete information regarding their health care choices (e.g., providing objective information regarding specific plans, such as covered benefits, cost sharing, drugs on formularies, utilization management tools, eligibility requirements for Special Needs Plans). To the extent that a provider can assist a member or potential member in an objective assessment of the individual's needs and potential plan options that may meet those needs, providers are encouraged to do so. To this end, providers may certainly engage in discussions with members or potential members when patients seek information or advice from their provider regarding their Medicare options. Providers are permitted to make available and/or distribute plan marketing materials for all plans with which the provider participates and display posters or other materials announcing plan contractual relationships (including PDP enrollment applications, but not MA or MA-PD enrollment applications).

Providers cannot:

- Offer scope of appointment forms
- Accept enrollment applications
- Make phone calls or direct, urge, or attempt to persuade members or potential members to enroll in a specific plan based on financial or any other interests of the provider
- Mail mandatory materials on behalf of CCA Health
- Offer anything of value to induce individuals to select them as their provider
- Offer inducements to personal individuals to enroll in a particular plan or organization
- Conduct health screenings as a mandatory activity

Providers may inform prospective individuals where they may obtain information on the full range of plan options. Because providers are usually not fully aware of all Medicare plan benefits and costs, they are advised to additionally refer their patients to other sources of information, such as the State Health Insurance Assistance Programs, plan marketing representatives, their State Medicaid Office, local Social Security Administration Office, www.medicare.gov, or 1-800-MEDICARE. The "Medicare and You" Handbook or "Medicare Compare Options" (from www.medicare.gov), may be distributed by providers without additional approvals. Keep in mind, CCA Health determination(if any) to deny payments for services which CCA Health determines are not Covered Services or which were not provided in accordance with the provider contract or agreement, the attachments or the Provider Manual, are administrative decisions only. Notwithstanding any language in the contract agreement, any attachment, or the Provider Manual to the contrary, such administrative decisions by CCA Health

Health in no way limit, restrict, or absolve providers or groups of their responsibility to exercise independent judgment in the provision of care and treatment of Covered Persons.

Plan Activities and Materials in the Health Care Setting

Plans/Part D sponsors may conduct sales activities, including sales presentations, the distribution of marketing materials, and the distribution and collection of enrollment forms in common areas of a healthcare setting. Common areas in a healthcare setting include, but are not limited to common entryways, vestibules, waiting rooms, hospital or nursing home cafeterias, and community, recreational, or conference rooms. Plans/Part D sponsors may not market in restricted areas. Restricted areas generally include, but are not limited to: exam rooms, hospital patient rooms, treatment areas where patients interact with a provider and his/her clinical team and receive treatment (including dialysis treatment facilities), and pharmacy counter areas (where patients interact with pharmacy providers and obtain medications). Communication materials may be distributed and displayed in all areas of the healthcare setting.

Provider Affiliation Information

Providers may announce new affiliations and repeat affiliation announcements for specific plans through general advertising (e.g., radio, television). New affiliation announcements are permitted, for example, by providers who have entered into a new contractual relationship with CCA Health. Providers may make new affiliation announcements within the first 30 days of the new contract agreement. An announcement to patients of a new affiliation which names only one plan may occur only once when such announcement is conveyed through direct mail, email, or phone. Additional direct mail and/or email communications from providers to their patients regarding affiliations must include all plans with which the provider contracts. Any affiliation communication materials that describe plans in any way (e.g., benefits, formularies) must be approved by CMS. Materials that indicate the provider has an affiliation with certain plan sponsors and that only list plan names and/or contact information does not require CMS approval. CMS does not expect providers to proactively contact all participating plans; rather, if a provider agrees to make available and/or distribute plan marketing materials for some of its contracted plans, it should do so knowing it must accept all future requests from other plan sponsors with which it participates.

Fraud, Waste, and Abuse

Fraud Policy Notice

The corporate policy of CCA Health is to report cases of fraud or suspected fraud to CCA Health Compliance hotline.

All employees of CCA Health, members, vendors, and providers who suspect fraud are encouraged to report any possible fraudulent activities, over-billing by providers and/or other matters which they deem suspicious. No adverse action will be taken against any person for reporting possible corrupt, criminal or fraudulent activities, over-billing or other suspicious matters in good faith.

CCA Health Compliance Hotline

866-457-4953

CCA Health and its employees are committed to working closely with state and federal authorities in their investigation of such fraud cases. Providers are required to adopt and enforce a zero-tolerance policy for retaliation or intimidation against anyone who reports suspected misconduct.

Compliance Fraud and Abuse Training for First Tier, Downstream, and Related Entities (FDRs)

Your applicable employees and Downstream Entities assigned to provide administrative health care services for CCA Health can access the training at the CMS Medicare Learning Network (MLN) website. https://learner.mlnlms.com/Default.aspx. FWA training is called "Combating Medicare Parts C and D Fraud, Waste, and Abuse Training." Once completed, download and retain the certificate of completion. The certificates must be made available to CCA Health and/or CMS upon request. Your organization can also download the materials and incorporate them into your internal training; however, you cannot change the content of the MLN training. If your organization decides to incorporate into your internal training, you must have a tracking mechanism that the training was completed.

Not every employee needs to take training. Below are examples of critical roles within First Tier, Downstream, and Related Entities (FDRs) that clearly should be required to fulfill the training requirements:

- Senior administrators or managers directly responsible for the FDR's contract with CCA Health
- Individuals involved with decision-making authority on behalf of CCA Health
- Reviewers of beneficiary claims and services submitted for payment
- Individuals with job functions that place the FDR in a position to commit significant noncompliance with CMS program requirements or healthcare FWA

Reach out to CCA Health Medicare Compliance Officer with any questions regarding required trainings.

- The only exception to this training requirement is if you/your organization is deemed to have met the FWA certification requirements through enrollment into Medicare Part A or B of the Medicare program or though accreditation as a supplier of durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS). You can find the training requirements and information about deemed status in: 42 CFR § 422.503(b)(4)(vi)(C) for MA
- 42 CFR § 423.504(b)(4)(vi)(C) for Part D
- Medicare Managed Care Manual, Chapter 21 § 50.3

Regardless of the method used, the training must be completed:

- Within 90 days of initial hire or the effective date of contracting
- At least annually during each calendar year (January 1 – December 31) thereafter

If you have any questions regarding these instructions, concerns about what and who to report information to regarding what is required in this document, please reach out to the CCA Health Compliance Hotline at 1-855-292-7485.

Health Insurance Portability and Accountability Act (HIPAA)

We anticipate that providers may have questions about whether the Health Insurance Portability

and Accountability Act of 1996 (HIPAA) Privacy Rule permits a provider to disclose any patient's (our member's) medical information to CCA Health for these activities without written authorization from the member.

Section 164.506(c)(4) of the Privacy Rule explicitly permits a provider to make this type of disclosure to CCA Health without a written authorization from the member. The Office of Civil Rights (the federal agency tasked with enforcing the Privacy Rule) agrees; as written in its December 3, 2002, "Guidance on the Privacy Rule": "A covered entity may disclose protected health information to another covered entity for certain health care operation activities of the entity that receives the information if each entity either has or had a relationship with the individual who is the subject of the information and the protected health information pertains to the relationship, and the disclosure is for a quality-related health care operations activity."

As the Privacy Rule and the Office of Civil Rights have made clear, a provider does not need a written authorization from the provider's patients, who are or have been members of CCA Health Michigan, Inc., to disclose their medical information to us for Healthcare Effectiveness Data and Information Set (HEDIS) and other quality improvement, accreditation, or regulatory purposes.

In addition, providers must comply with the provisions of HIPAA, including the effective dates of regulations adopted to implement HIPAA and HITECH or other such amendment. CCA Health requires that providers protect the privacy, integrity, security, confidentiality, and availability of the protected health information disclosed to, used by, or exchanged by the parties by implementing appropriate privacy and security policies, procedures, and practices and physical and technological safeguards and security mechanisms, all as required by, and set forth more specifically in, the HIPAA Privacy Regulations and the HIPAA Security Regulations, codified at 45 C.F.R. Part 164. Providers will provide written verification of compliance with all applicable laws and confirm its full licensure and certification to the extent appropriate to its then current operations.

- 45 CFR §164.506(c)(4). The full text of the Privacy Rule is available at **www.hhs.gov/policies/index.html** Section 164.506(c) is on page 13 of this document.
- The full text of the Office of Civil Rights December 3, 2003 Guidance is available at: **www.hhs.gov/ocr/privacy/hipaa/understanding/index**.

Providers must notify CCA Health (and CCA Health will notify providers) via the compliance hotline of any modifications they believe necessary to bring CCA Health into compliance with any new HIPAA regulations and/or HIPAA.

Glossary & Acronyms

Advance Directives

A written statement of a person's wishes regarding medical treatment, often including a living will, made to ensure those wishes are carried out should the person be unable to communicate them to a doctor

Adverse Event

An unintended physical injury resulting from or contributed to by medical care (including the absence of indicated medical treatment), that requires additional monitoring, treatment, or hospitalization, or that results in death."

Appeal

Something a member does if they disagree with our decision to deny a request for coverage of health care services or prescription drugs or payment for services or drugs they already received. They may also make an appeal if they disagree with our decision to stop services that they are receiving. For example, they may ask for an appeal if we don't pay for a drug, item, or service they think they should be able to receive.

Balance Billing

When a provider (such as a doctor or hospital) bills a patient more than the plan's allowed cost-sharing amount. CCA Health members only have to pay our plan's cost- sharing amounts when they get services covered by our plan. We do not allow providers to "balance bill" or otherwise charge members more than the amount of cost-sharing their plan says they must pay.

Brand Name Drug

A prescription drug that is manufactured and sold by the pharmaceutical company that originally researched and developed the drug. Brand name drugs have the same active-ingredient formula as the generic version of the drug. However, generic drugs are manufactured and sold by other drug manufacturers and are generally not available until after the patent on the brand name drug has expired.

Centers for Medicare and Medicaid Services (CMS)

Government agency responsible for overseeing the Medicare and Medicaid Programs.

Complaint

The formal name for "making a complaint" is "filing a grievance." The complaint process is used for certain types of problems only. This includes problems related to quality of care, waiting times, and the customer service members receive.

Comprehensive Outpatient Rehabilitation Facility (CORF)

A facility that mainly provides rehabilitation services after an illness or injury, and provides a variety of services including physical therapy, social or psychological services, respiratory therapy, occupational therapy and speech-language pathology services, and home environment evaluation services.

Copayment (or"Copay")

An amount a member may be required to pay as their share of the cost for a medical service or supply, like a doctor's visit, hospital outpatient visit, or a prescription drug. A copayment is a set amount, rather than a percentage. For example, a member might pay $10 or $20 for a doctor's visit or prescription drug.

Cost-sharing

Cost-sharing refers to amounts that a member has to pay when services or drugs are received. Cost-sharing includes any combination of the following three types of payments: (1) any deductible amount a plan may impose before services or drugs are covered; (2) any fixed "copayment" amount that a plan requires when a specific service or drug is received; or (3) any "coinsurance" amount, a percentage of the total amount paid for a service or drug, that a plan requires when a specific service or drug is received. A "daily cost-sharing rate" may apply when a doctor prescribes less than a full month's supply of certain drugs for a member and the member is required to pay a copayment.

Coverage Determination

A decision about whether a drug prescribed for a member is covered by the plan and the amount, if any, the member is required to pay for the prescription. In general, if a member brings a prescription to a pharmacy and the pharmacy says the prescription isn't covered under their plan, that isn't a coverage determination. The member will need to call or write to their plan to ask for a formal decision about the coverage.

Covered Drugs

The term we use to mean all of the prescription drugs covered by our plan.

Covered Services

The general term we use to mean all of the health care services and supplies that are covered by our plan.

Deductible

The amount a member must pay for health care or prescriptions before our plan begins to pay.

Disenroll or Disenrollment

The process of ending a membership in our plan. Disenrollment may be voluntary (the member's choice) or involuntary (not the member's choice).

Durable Medical Equipment (DME)

Certain medical equipment that is ordered by a member's doctor for medical reasons. Examples include walkers, wheelchairs, crutches, powered mattress systems, diabetic supplies, IV infusion pumps, speech generating devices, oxygen equipment, nebulizers, or hospital beds ordered by a provider for use in the home.

Emergency

A medical emergency is when a member, or any other prudent layperson with an average knowledge of health and medicine, believes that they have medical symptoms that require immediate medical attention to prevent loss of life, loss of a limb, or loss of function of a limb. The medical symptoms may be an illness, injury, severe pain, or a medical condition that is quickly getting worse.

Emergency Care

Covered services that are: 1) rendered by a provider qualified to furnish emergency services; and 2) needed to treat, evaluate, or stabilize an emergency medical condition.

Evidence of Coverage (EOC) and Disclosure Information

Documents that explain the member's coverage, what we must do, the member's rights, and what each member has to do as a member of our plan. Documents include the EOC, the member's enrollment form and any other attachments, riders, or other optional coverage selected.

Exception

A type of coverage determination that, if approved, allows the member to get a drug that is not on the plan sponsor's formulary (a formulary exception), or get a non-preferred drug at a lower cost-sharing level (a tiering exception). Each member may also request an exception if their plan sponsor requires the member to try another drug before receiving the drug being requested, or the plan limits the quantity or dosage of the drug being requested (a formulary exception).

Florida Agency for Health Care Administration (AHCA)

State agency responsible for the administration of the Florida Medicaid program, licensure, and regulation of Florida's health facilities and for providing information to Floridians about the quality of care they receive

Generic Drug

A prescription drug that is approved by the Food and Drug Administration (FDA) as having the same active ingredient(s) as the brand name drug. Generally, a "generic" drug works the same as a brand name drug and usually costs less.

Grievance

A type of complaint a member makes about CCA Health or pharmacies, including a complaint concerning the quality of their care. This type of complaint does not involve coverage or payment disputes.

Health Insurance Portability and Accountability Act (HIPAA)

A US law designed to provide privacy standards to protect patients' medical records and other health information provided to health plans, doctors, hospitals and other health care providers

Medicaid (or Medical Assistance)

A joint federal and state program that helps with medical costs for some people with low incomes and limited resources. Medicaid programs vary from state to state, but most health care costs are covered if the member qualifies for both Medicare and Medicaid.

Medicare

The federal health insurance program for people 65 years of age or older, some people under age 65 with certain disabilities, and people with End-Stage Renal Disease (generally those with permanent kidney failure who need dialysis or a kidney transplant).

Medicare Advantage(MA)

Medicare Beneficiaries can receive their Medicare benefits through Original Medicare,

or a Medicare Advantage Plan (like an HMO or PPO). Medicare Advantage Plans, sometimes called "Part C" or "MA Plans," are offered by private companies approved by Medicare. Medicare pays these companies to cover all Part A and B Medicare benefits.

Medical Error

An act of commission (doing something wrong) or omission (failing to do the right thing) leading to an undesirable outcome or significant potential for such an outcome.

Medically Necessary

Services, supplies, or drugs that are needed for the prevention, diagnosis, or treatment of a member's medical condition and meet accepted standards of medical practice.

Medicare Prescription Drug Coverage (Medicare Part D)

Insurance to help pay for outpatient prescription drugs, vaccines, biologicals, and some supplies not covered by Medicare Part A or Part B.

Member (Member of our Plan, or "Plan Member" or "Covered Person")

A person with Medicare who is eligible to get covered services, who has enrolled in our plan, and whose enrollment has been confirmed by the Centers for Medicare & Medicaid Services (CMS).

Member Services

A department within our plan responsible for answering member questions about membership, benefits, grievances, and appeals.

Network Pharmacy

A pharmacy where members of our plan can get their prescription drug benefits. We call them "network pharmacies" because they contract with our plan. In most cases, member prescriptions are covered only if they are filled at one of our network pharmacies.

Network Provider

"Provider" is the general term we use for doctors, other health care professionals, hospitals, and other health care facilities that are licensed or certified by Medicare and by the State to provide health care services. We call them "network providers" when they accept our payment as payment in full, and in some cases to coordinate as well as provide covered services to members of our plan. Our plan pays network providers based on the agreements it has with the providers or if the providers agree to provide the member with plan-covered services. Network providers may also be referred to as "plan providers."

Never Events

Errors in medical care that are of concern to both the public and health care professionals and providers, clearly identifiable and measurable, and of nature such that the risk of occurrence is significantly influenced by the policies and procedures of the health care organization.

Organization Determination

The Medicare Advantage plan has made an organization determination when it makes a decision about whether items or services are covered or how much the member has to pay for covered items or services.

Original Medicare

The traditional fee-for-service program offered directly through the federal government. It is sometimes called Traditional Medicare or Fee-for-Service Medicare. Under Original Medicare, the government pays directly for the health care services the member receives.

Out-of-Network Provider or Out-of-Network Facility

A provider or facility with which we have not arranged to coordinate or provide covered services to members of our plan. Out-of-network providers are providers that are not employed, owned, or operated by our plan or are not under contract to deliver covered services to the member.

Part D

The voluntary Medicare Prescription Drug Benefit Program.

Part D Drugs

Drugs that can be covered under Part D. We may or may not offer all Part D drugs. Certain categories of drugs were specifically excluded by Congress from being covered as Part D drugs.

Preferred Cost-sharing

Preferred cost-sharing means lower cost-sharing for certain covered Part D drugs at certain network pharmacies.

Primary Care Provider (PCP)

The doctor or other provider a member sees first for most health problems. A PCP makes sure the member gets the care they need to stay healthy. The PCP may talk about the member's care with other doctors and health care providers, referring the member to the other providers as needed. In many Medicare health plans, the member must see a PCP before they can see any other health care provider.

Prior Authorization

Approval in advance to get services or certain drugs that may or may not be on our formulary. Some in-network medical services are covered only if the member's doctor or other network provider gets "prior authorization" from our plan.

Prosthetics and Orthotics

These are medical devices ordered by the member's doctor or other health care provider. Covered items include, but are not limited to, arm, back and neck braces; artificial limbs; artificial eyes; and devices needed to replace an internal body part or function, including ostomy supplies and enteral and parenteral nutrition therapy.

Protected Health Information (PHI)

Any information about health status, provision of health care, or payment for health care that is created or collected by a Covered Entity (or a Business Associate of a Covered Entity), and can be linked to a specific individual.

Provider Preventable Conditions (PPC)

PPCs are Conditions that meet the definition of a "health care acquired condition (HCAC)" or "other provider preventable condition (PPC)" as defined by CMS in Federal Regulations as 42 CFR 447.26 (b).

Quality Improvement Organization (QIO)

A group of practicing doctors and other health care experts paid by the Federal government to check and improve the care given to Medicare patients.

Serious Reportable Events (SRE) and Serious Reportable Adverse Events (SRAE)

Unambiguous, serious, preventable adverse incidents involving death or serious harm to a member resulting from a lapse or error in a healthcare facility.

Skilled Nursing Facility (SNF) Care

Skilled nursing care and rehabilitation services provided on a continuous, daily basis, in a skilled nursing facility. Examples of skilled nursing facility care include physical therapy or intravenous injections that can only be given by a registered nurse or doctor.

Special Needs Plan

A special type of Medicare Advantage Plan that provides more focused health care for specific groups of people, such as those who have both Medicare and Medicaid, who reside in a nursing home, or who have certain chronic medical conditions.

Step Therapy

A utilization tool that requires a member to first try another drug to treat a medical condition before CCA Health will cover the drug the physician may have initially prescribed.