

2024



Provider Manual

For physicians, hospitals, and healthcare providers

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INTRODUCTION

CarePlus Health Plans Inc., (“CarePlus”) is a Florida-based health maintenance organization (HMO) with a Medicare Advantage (MA) contract committed to serving our members, our community and our providers through:

- TEAMWORK
- QUALITY OF CARE
- COMMUNITY SERVICES
- PROVIDER SATISFACTION

Purpose of this manual: CarePlus’ Provider Manual furnishes providers and their staffs with the policies, procedures and guidelines used to administer CarePlus’ healthcare benefits/services. In accordance with the Compliance with Plan Rules clause of the provider agreement, it is important that all contracted providers and administrators review this manual and abide by all provisions contained herein, as applicable. Any requirements under applicable law, regulation or guidance that are not expressly set forth in the content of this manual or in the provider agreement shall be incorporated herein by this reference and shall apply to providers and/or CarePlus where applicable. Such laws and regulations, if more stringent, take precedence over the content in this manual. Providers are responsible for complying with all laws and regulations that are applicable.

Responsibility for Provision of Medical Services: Providers make all independent healthcare treatment decisions. Additionally, providers are responsible for the costs, damages, claims and liabilities that result from their own actions. CarePlus does not endorse or control the clinical judgment or treatment recommendations made by providers.

CarePlus Service Areas: Brevard, Broward, Clay, Duval, Flagler, Hernando, Hillsborough, Indian River, Lake, Marion, Miami-Dade, Orange, Osceola, Palm Beach, Pasco, Pinellas, Polk, Seminole, St. Johns, Sumter and Volusia counties.

Provider Operations inquiry line: 1-866-220-5448, Monday - Friday, 8 a.m. - 5 p.m., Eastern time.

CarePlus Provider Services Executive: Upon initial contracting with CarePlus, a provider is assigned a provider services executive who serves as the liaison between the provider and CarePlus. Questions regarding membership, reports and/or issues relating to agreements should be directed to your provider services executive.

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KEY CONTACTS LIST

<u>Department/Area</u>	<u>Contact Information</u>
CarePlus member eligibility and benefits *PWS sunsetting July 2024	Log in to your Availity account: Availity (Availity.com) OR *Log in to your PWS account: CarePlus-HP.com/PWS.htm OR Call us at: 1-866-313-7587
Provider emergency hotline	1-877-210-5318
Authorizations <u>Pre-service telephonic requests</u> For dates of service occurring within three days <u>Pre-service electronic requests</u> For dates of service greater than three days please utilize the Availity or Provider Web System (PWS)* *PWS sunsetting July 2024 <u>Pre-service fax requests</u> Must use Health Services Preauthorization Form <u>Inpatient Hospital and Post-Acute Facility Requests</u> This includes inpatient/observation notifications, census reports (if applicable), Post-Acute Pre-Service requests, and supportive clinical documents. *Note: Authorizations for services that are covered under a capitated provider/network/delegate should be submitted directly to the provider/network/delegate. Please refer to the pages below included in the Additional Services Contact List.	Phone: 1-800-201-4305 Availity: (Availity.com/) *PWS: (CarePlus-HP.com/PWS.htm) Dade: 1-888-790-9999 Broward and Palm Beach: 1-866 832-2678 All other counties: 1-888-634-3521 Inpatient: 1-866-229-1538
Transplant Services/Inquiries	CPHP_HSD_Transplant_Team@humana.com
Pharmacy Utilization Management Authorizations Prior Authorizations and Exceptions	CarePlusHealthPlans.com/CarePlus-Providers/Pharmacy-Resources Phone: 1-866-315-7587 Fax: 1-800-310-9071

KEY CONTACTS LIST

<u>Department/Area</u>	<u>Contact Information</u>
Pharmacy Technical Help Desk Call Center	DST Pharmacy Solutions 1-800-522-7487
CarePlus website – Information for providers webpage	https://www.careplushealthplans.com/careplus-providers/ This webpage provides you with access to useful provider publications and trainings.
Claim status/inquiries	Availity (Availity.com) OR Phone: 1-866-313-7587 Fax: 855-811-0408
Claims address	Availity (Availity.com) CarePlus Payer ID No. 95092 OR P.O. Box 14697 Lexington, KY, 40512-4697
Request copies of remits and checks	Provider.requests@careplus-hp.com or Fax: 813-463-7809* *Please include claim number and check number within request.
Laboratory services	Labcorp (All counties) 1-800-877-5227 Labcorp.com
Pharmacy mail order	CenterWell Pharmacy® (All counties) Phone: 1-800-526-1490 (TTY: 711) Fax: 1-800-526-1491
Ethics Help Line	1-877-584-3539 EthicsHelpline.com
Fraud, Waste & Abuse (FWA) Hotline	1-800-614-4126

Provider Operations inquiry line: 1-866-220-5448
Our hours of operation are Monday – Friday, 8 a.m. – 5 p.m., Eastern time.

ADDITIONAL SERVICES (CONTACT INFORMATION)

Service	Telephone and Addresses	Authorization – Referrals
Glucometer and diabetic supplies	CenterWell Pharmacy™ (All counties) Phone: 1-800-526-1490 Fax: 1-800-526-1491	Refer to CarePlus' PAL at CarePlusHealthPlans.com/PAL for items and services that require authorization. Copayment may vary based on the preferred/ nonpreferred manufacturer and place of service received. Participating providers must call to obtain authorization.
Vision services (Optometry)	Premier Eye Care Network (All counties) 855-765-6759	Members may self-refer to a participating provider for their yearly exam. Primary care physician (PCP) or optometrist must refer to an ophthalmologist when specialty services are required. Refer to CarePlus' PAL at CarePlusHealthPlans.com/PAL for items and services that require authorization.
Vision services (Ophthalmology)	Premier Eye Care Network (All counties) 855-765-6759	PCP must request authorizations from Premier Eye Care Network directly. Refer to CarePlus' PAL at CarePlusHealthPlans.com/PAL for items and services that require authorization.
Dental services	Humana Dental (All counties) 1-800-833-2223	Members may self-refer to a participating dentist for covered dental services. Coverage may include preventive and comprehensive dental services. Refer to CarePlus' PAL at CarePlusHealthPlans.com/PAL for items and services that require authorization.
Hearing services	HearUSA Inc. (All counties) 1-800-333-3389 Option 2	Authorizations are required for all Medicare covered services received from a participating Ear, Nose and Throat (ENT) physician.

ADDITIONAL SERVICES (CONTACT INFORMATION)

Service	Telephone and Addresses	Authorization – Referrals
		<p>Participating ENTs can be utilized for diagnostic hearing services only.</p> <p>Authorizations are not required for supplemental/routine hearing testing and hearing aids through HearUSA.</p> <p>Members may self-refer for a Medicare-covered hearing exam once every 12 months.</p> <p>Refer to CarePlus' PAL at CarePlusHealthPlans.com/PAL for items and services that require authorization.</p>
Chiropractic services	<p>Quality Managed Health Care (Broward, Clay, Duval, Hillsborough, Miami-Dade, Palm Beach, and Pinellas counties) 786-441-8500 Option 3</p>	<p>Members may self-refer to network provider up to 12 times per calendar year for manual manipulation of the spine.</p> <p>Refer to CarePlus' PAL at CarePlusHealthPlans.com/PAL for items and services that require authorization.</p>
Podiatry services	<p>PodAmerica (Broward, Miami-Dade and Palm Beach) Please refer to the Provider Directory for list of providers</p> <p>Health Network One (Hillsborough, Lake, Marion, Orange, Osceola, Pasco, Pinellas, Polk, Seminole, and Sumter) 1-800-595-9631</p> <p>Foot & Ankle Network (Brevard, Clay, Duval, Indian River, and Volusia) 786-441-8500 Option 3</p>	<p>Members may self-refer to a participating provider and do not require an authorization for routine foot care.</p> <p>Refer to CarePlus' PAL at CarePlusHealthPlans.com/PAL for items and services that require authorization.</p>
Wound care Tracheotomy/ Mastectomy Supplies	<p>Advance Care Solutions (All counties) Phone: 1-877-748-1977 Fax: 1-877-748-1985</p>	<p>For all ostomy, urological, tracheotomy, and mastectomy supplies. Refer to CarePlus' PAL at CarePlusHealthPlans.com/PAL for items and services that require authorization.</p>

ADDITIONAL SERVICES (CONTACT INFORMATION)

Service	Telephone and Addresses	Authorization – Referrals
Transportation*	<p>Alivi NEMT Network (All counties) 1-888-998-4640</p>	<p>Contact Alivi NEMT Network to schedule transportation.</p> <p>*Rules/exclusions may apply. Please refer to the “CarePlus Covered Benefits” section within this manual for rules/exclusions.</p>
Acupuncture*	<p>Quality Managed Health Care (All counties) 786-441-8500, Option 3</p>	<p>Routine Acupuncture is limited to 25 visits per calendar year.</p> <p>Members with a documented history of chronic low back pain lasting 12 weeks or longer may be referred to a network acupuncturist for up to 20 acupuncture treatments annually.</p> <p>*Exclusions may apply depending on the plan and county. Refer to CarePlus’ PAL at CarePlusHealthPlans.com/PAL for items and services that require authorization.</p>
<p>Integrative Services and Well Being *</p> <p>(Massage therapy)</p>	<p>Wholehealth Networks Inc. (Tivity Health) (All counties) fapsnet.wholehealthmd.com/CarePlusSearchPractitioner.aspx</p>	<p>Refer to CarePlus’ PAL at CarePlusHealthPlans.com/PAL for items and services that require authorization.</p> <p>*Exclusions may apply depending on the plan and county. Contact your provider services executive or the Provider Operations inquiry line for details.</p>
Health and wellness education	<p>Tivity Health SilverSneakers® Fitness program 1-888-423-4632 SilverSneakers.com</p>	<p>Members must visit participating fitness centers and enroll in person. Members must have their membership card present at the time of enrollment. A SilverSneakers sticker will be placed on the ID card upon enrollment. Refer members to the CarePlus Provider Directory or the CarePlus Member Services department for participating locations.</p>

ADDITIONAL SERVICES (CONTACT INFORMATION)

Service	Telephone and Addresses	Authorization – Referrals
CarePlus Spending Account Card*	<p style="text-align: center;">Solutran 1-855-391-0942 (TTY:711)</p>	<p>A preloaded card including one or more benefit allowance wallets.</p> <p>Members of plans with a Flex card have an annual allowance to help members pay for any out-of-pocket costs for covered dental, hearing, and vision items/services received from any participating network dental, optometry, or hearing aid providers until member has used the entire allowance. Any Flex Allowance balance expires at end of plan/calendar year or upon member's disenrollment.</p> <p>Allowance should only be applied once supplemental benefit is exhausted. Dental, vision, and hearing providers may process the transaction through a Practice Management Systems (PMS), from office computer and/or mobile device that can scan/read QR code/bar code, by visiting the Solutran Provider Portal site to key-in/manually process the transaction or by contacting Solutran directly.</p> <p>Members of plans with a CareEssentials card have an allowance that can be used only in the issued month to purchase healthy foods/beverages and other necessities from participating retailers in-store or online. Members can also use this allowance to pay for eligible items and services (e.g., Over-the counter (OTC) and personal care products, pet care supplies, bills like utilities, rent, and mortgage, and more)</p> <p>*Exclusions may apply depending on the plan and county. Contact your provider services executive or</p>

ADDITIONAL SERVICES (CONTACT INFORMATION)

Service	Telephone and Addresses	Authorization – Referrals
		the Provider Operations inquiry line for details.
Dermatology services	Health Network One (Broward, Duval, Hillsborough, Lake, Marion, Miami-Dade, Orange, Osceola, Palm Beach, Pinellas, and Seminole) 305-614-0100 1-800-595-9631	Members may self-refer to a network provider and do not require an authorization for routine office services. Refer to CarePlus' PAL at CarePlusHealthPlans.com/PAL for items and services that require authorization.
Gastroenterology services	Health Network One (Broward, Miami-Dade and Palm Beach) 1-800-595-9631	Refer to CarePlus' PAL at CarePlusHealthPlans.com/PAL for items and services that require authorization.
Durable Medical Equipment	One Homecare Solutions (Broward, Miami-Dade and Palm Beach) Phone: 855-441-6900 Fax: 844-862-5486 Integrated Home Care Services (Brevard, Clay, Duval, Flagler, Hernando, Hillsborough, Indian River Lake, Marion, Orange, Osceola, Pasco, Pinellas, Polk, Seminole, St. Johns, Sumter, and Volusia) Phone: 844-215-4264 Fax: 844-215-4265	Refer to CarePlus' PAL at CarePlusHealthPlans.com/PAL for items and services that require authorization. A physician order and medical records validating medical necessity must be submitted to process all requests.
Home Health	One Homecare Solutions (Broward, Miami-Dade and Palm Beach) Phone: 855-441-6900 Fax: 844-862-5486 Integrated Home Care Services (Brevard, Clay, Duval, Flagler, Hernando, Hillsborough, Indian River Lake, Marion, Orange, Osceola, Pasco, Pinellas, Polk, Seminole, St. Johns, Sumter and Volusia) Phone: 844-215-4264 Fax: 844-215-4265	Refer to CarePlus' PAL at CarePlusHealthPlans.com/PAL for items and services that require authorization. .
Home infusion	One Homecare Solutions (All counties) Phone: 855-441-6900 Fax: 844-862-5486	Refer to CarePlus' PAL at CarePlusHealthPlans.com/PAL for items and services that require authorization.

ADDITIONAL SERVICES (CONTACT INFORMATION)

Service	Telephone and Addresses	Authorization – Referrals
Mental health	<p>Carelon Behavioral Health, Inc. (All counties) Phone: 1-833-227-3757</p>	<p>Members should contact Carelon directly for appointments.</p> <p>Providers should contact Carelon directly for details regarding mental health referrals and authorizations. Refer to CarePlus' PAL at CarePlusHealthPlans.com/PAL for items and services that require authorization.</p>
Admitting Panel	<p>H2 Hospitalist Group LLC (Broward, Miami-Dade and Palm Beach) 833-542-2273</p> <p>TBIM Hospitalists (TBIM) (Hillsborough) 813-681-0340</p> <p>Mid Florida Hospital Specialist (Orange, Seminole) 321- 207-0174</p> <p>Greater Orlando Hospitalist Group (Orange and Seminole) 407-767-0727</p> <p>Dr. William Muñoz (Osceola) 407-248-8862</p>	<p>The hospital is responsible for contacting the appropriate hospitalist company for admitting assignment.</p> <p>Contact your provider services executive or the Provider Operations inquiry line for details.</p>

***For questions or inquiries relating to these services or services not listed above, please contact the
Provider Operations inquiry line at: 1-866-220-5448 ***

Our hours of operation are Monday – Friday, 8 a.m. – 5 p.m., Eastern time.

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DEFINITIONS

For the purposes of this manual, the following words and phrases shall have the meaning specified below:

- A. **CarePlus (CarePlus Health Plans Inc.)** – a health maintenance organization (HMO) with a Medicare Advantage (MA) contract.
- B. **Administrative Fee** – the amount subtracted from total monthly premiums received by CarePlus or on behalf of enrollees in each line of business (e.g., Medicare) and retained by CarePlus for administration. The amount of the administrative fee is set forth in your PCP agreement.
- C. **Beneficiary and Family-centered Care Quality Improvement Organization (BFCC-QIO)** – an organization comprised of practicing doctors and other healthcare experts under contract to the federal government to monitor and improve the care given to Medicare enrollees. BFCC-QIOs review complaints raised by enrollees about the quality of care provided by physicians, inpatient hospitals, hospital outpatient departments, hospital emergency rooms, skilled nursing facilities, home health agencies, Medicare health plans, and ambulatory surgical centers. BFCC-QIOs also review continued stay denials in acute inpatient hospital facilities as well as coverage terminations in skilled nursing facilities (SNFs), home health agencies (HHAs), and/or comprehensive outpatient rehabilitation facilities (CORFs).
- D. **Calendar Quarter** – any of the three-month periods from Jan. 1 through March 31, April 1 through June 30, July 1 through Sept. 30, and Oct. 1 through Dec. 31.
- E. **Capitation Fee** – the monthly payment made by CarePlus to the provider for each enrollee assigned to provider. The amount of the capitation fee is set forth in the provider agreement.
- F. **Clean Claim** – a claim that has no defect or impropriety, including lack of required substantiating documentation for non-contracted providers and suppliers, or particular circumstances requiring special treatment that prevents timely payment from being made on the claim, passes all edits (contractor and Common Working File [CWF]), and is processed electronically. A claim is “clean” even if CarePlus refers it to a medical specialist for examination. If additional documentation in the medical record involves a source outside CarePlus, the claim will not be considered “clean.”
- G. **Coinsurance** – the percentage of the total cost of certain medical services. Members may be required to pay providers a coinsurance at the time of service.
- H. **Copayment** – the fixed amount required to be paid by a member to a provider as additional payments for covered services as are medically necessary pursuant to section 1.23 of your agreement and shall include fixed payments to be paid as well as percentage amounts based on the cost of a service (i.e., coinsurance). Copayments will vary in amount for members, depending on benefit structure.
- I. **Covered Services** – all medical services and other benefits required to be provided to members by CarePlus under its agreement(s) with the Centers for Medicare & Medicaid Services (CMS), the Agency for Healthcare Administration and members, including, without limitation, primary care,

specialist medical services, hospital services, ancillary and diagnostic services, and emergency medical services. Covered services are subject to change any time as required by applicable law or under CarePlus' Medicare agreement(s).

- J. **Covering Provider** – a physician who will continue to render covered services to members during those times when a provider cannot provide these services as set forth in this agreement, but is doing so under the same terms of this agreement.
- K. **Emergency Medical Condition** – (a) a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, pursuant to Section 4704 of the 1997 Balanced Budget Act, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in any of the following:
 - (1) Serious jeopardy to the health of the individual or, in the case of a pregnant woman, the health of the woman or her unborn child
 - (2) Serious impairment to bodily functions
 - (3) Serious dysfunction of any bodily organ or part
- L. **Emergency Services** – covered inpatient and outpatient services that are:
 - (1) Furnished by a provider qualified to furnish emergency services
 - (2) Needed to evaluate or stabilize an emergency medical condition
- M. **Grievance** – expression of dissatisfaction with any aspect of the operations, activities or behavior of a plan or its delegated entity in the provision of health care items, services, or prescription drugs, regardless of whether remedial action is requested or can be taken. A grievance does not include, and is distinct from, a dispute of an appeal of an organization determination or coverage determination or an Late Enrollment Penalty (LEP) determination.
- N. **Interdisciplinary Care Team or ICT** refers to interdisciplinary services provided by a treatment team in which all its members participate in a coordinated effort to benefit the patient and the patient's significant others and caregivers. Interdisciplinary services, by definition, cannot be provided by only one discipline. Though individual members of the interdisciplinary team work within their own scopes of practice, each professional also is expected to coordinate his or her efforts with team members of other specialties, as well as with the patient and the patient's significant others and caregivers. The purpose of the interdisciplinary team is to foster frequent, structured, and documented communication among disciplines to establish, prioritize, and achieve treatment goals.
- O. **MAO (Medicare Advantage Organization)** – a public or private entity organized and licensed by a state as a risk-bearing entity (with the exception of a provider-sponsored organization receiving waivers) that is certified by CMS as meeting the MA contract.
- P. **MA (Medicare Advantage) Plan** – medical benefits coverage offered under a policy or contract by an MA organization that includes specific set of health benefits offered at a uniform premium and uniform level cost-sharing to all Medicare beneficiaries residing in the service areas (or segment of the service area) of the MA plan.

- Q. **MA (Medicare Advantage) Plan Enrollee** means an MA eligible individual who has elected an MA plan offered by an MA organization.
- R. **MAPD (Medicare Advantage Prescription Drug) Plan** – an MA plan that provides qualified prescription drug coverage and Part A and Part B benefits in one plan.
- S. **Medicaid** – a joint federal and state program that provides health coverage for selected categories of people with low incomes. Its purpose is to improve the health of people who might otherwise go without medical care for themselves. Medicaid is different in every state. In Florida, the Agency for Healthcare Administration (AHCA) develops and carries out policies related to the Medicaid program.
- T. **Medicaid Fiscal Agent** refers to the state Medicaid program’s vendor contracted to serve as the state’s fiscal agent. Some of the fiscal agent functions include enrolling non-institutional providers, processing Medicaid claims, serving as the enrollment broker for Medicaid recipients, and distributing Medicaid forms and publications.
- U. **Medical Director** – a physician designated by CarePlus to monitor and review covered services provided by a healthcare provider to members or requested by a healthcare provider for members.
- V. **Medical Group** – a group of primary care physicians (PCPs) and/or specialist physicians who:
 - (1) Are formally organized as a partnership or professional corporation;
 - (2) Provide for the diagnosis or direct care and treatment of a medical condition
 - (3) Divide their income based on a specified, fixed formula.
- W. **Medically Necessary** – determined by CarePlus’ medical director and includes consideration of whether services:
 - (1) Are appropriate and necessary for the symptoms, diagnosis or treatment of a medical condition
 - (2) Provide for the diagnosis or direct care and treatment of a medical condition
 - (3) Are not primarily for the convenience of the enrollee, the enrollee’s attending or consulting physician, or another healthcare provider
- X. **Member (Member of our Plan, or Plan Member)** – a person with Medicare who is eligible to receive covered services who has enrolled in CarePlus and whose enrollment has been confirmed by CMS.
- Y. **Model of Care (MOC)** – an approved CMS document where MA plans outline their basic framework to support a special needs plan (SNP) in meeting the needs of each of its members. The MOC provides the needed infrastructure to promote quality, care management, and care coordination processes for SNPs.

- Z. **Open Access** – a type of health plan in which its enrollees do not need to get a referral to receive covered services from in-network providers.
- AA. **Participating Hospital** – a hospital that has entered into a contractual agreement with CarePlus to serve enrollees.
- BB. **Participating Physician** – any physician licensed to practice in the state of Florida who satisfies the participation criteria established by CarePlus and who has entered into a contractual arrangement with, or is otherwise engaged by, CarePlus to provide physician services to enrollees.
- CC. **Participating Provider** – a participating physician, a participating hospital, or other healthcare professional or provider that has entered into a contractual agreement with CarePlus to serve enrollees.
- DD. **Primary Care Physician (PCP)** – a participating physician who supervises, coordinates, and provides primary care services to enrollees, including the initiation of their referral for specialist services and other non-PCP services, and who meets all the other requirements for PCP contained in CarePlus’ rules and regulations and in the primary care physician agreement.
- EE. **Primary Care Services** – covered services customarily provided by a PCP in his or her office as well as services customarily provided by an attending PCP to institutionalized patients. This includes, by way of example and not limitation, the primary care services as set forth in Attachment “A” of the PCP agreement.
- FF. **Point-of-service (POS)** – an additional, mandatory supplemental, or optional supplemental benefit that allows the enrollee the option of receiving specified services outside of the plan’s provider network.
- GG. **Preauthorization list (PAL)** – a list of services, items, and medications delivered in a physician’s office, clinic, outpatient, or home setting that require advance approval from the plan as to whether the service, item, or medication will be covered. Services must be provided according to Medicare coverage guidelines established by the Centers for Medicare & Medicaid Services (CMS). According to the guidelines, all medical care, services, supplies, and equipment must be medically necessary. View the CarePlus Health Plans PAL at CarePlusHealthPlans.com/PAL.
- HH. **Reserve** – an amount segregated within the claims fund estimated by CarePlus to be sufficient to satisfy claims that have been incurred but not reported, based upon historical experience for CarePlus enrollees. The reserve amount shall be determined by CarePlus.
- II. **Service Area for Medicare** – a geographic area approved by CMS within which an MA-eligible individual may enroll in a particular plan offered by CarePlus.
- JJ. **Special Needs Plans or SNPs** were created via the Medicare Modernization Act (MMA) of 2003 as a new type of Medicare managed-care plan focused on certain vulnerable groups of Medicare beneficiaries: the institutionalized, Medicare/Medicaid dual-eligibles and beneficiaries with severe or disabling chronic conditions. SNPs offer the opportunity to improve care for Medicare

beneficiaries with special needs through improved coordination and continuity of care and by combining benefits available through Medicare and Medicaid.

- KK. **Specialist Physician** – a participating physician who is board certified or has met the academic requirements to sit for the board in a certain medical specialty; who provides services to enrollees within the range of such specialty; who elects to be designated as a specialist physician by CarePlus; and who meets all other requirements for specialist physicians contained in CarePlus’ rules and regulations and in the agreement between CarePlus and the specialist physician.
- LL. **Specialist Services** – the services of a specialist physician, within the scope of his/her board-certified or board-eligible specialty, that are:
- (1) Provided upon the referral of a PCP pursuant to CarePlus’ rules and regulations
 - (2) Covered services, but not PCP services
- MM. **Urgently Needed Services** – covered services provided when a member is temporarily absent from the plan’s service (or, if applicable, continuation) area (or, under unusual and extraordinary circumstances, provided when the member is in the service or continuation area but a participating provider is temporarily unavailable or inaccessible) when such covered services are medically necessary and immediately required:
- (1) As a result of an unforeseen illness, injury, or condition
 - (2) It was not reasonable given the circumstances to obtain the covered services through a participating provider.
- NN. **Urgent Care** – care provided for those problems which, though not life-threatening, could result in serious injury or disability unless medical attention is received or substantially restrict a member’s activity (e.g., infectious illnesses, flu, respiratory ailments, etc.).

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RESPONSIBILITIES OF CAREPLUS

CarePlus, under its agreement with its contracted providers, is responsible for the following:

- A. Assist contracted providers in meeting the expectations of the health plan;
- B. Maintain a record of eligibility for all enrolled members;
- C. Process all enrollment and disenrollment applications;
- D. Educate and encourage enrolled members to be seen for appropriate preventive services;
- E. Keep contracted providers informed of any changes set forth by the CMS;
- F. Prepare necessary reports required for maintenance of the health plan;
- G. Make member service representatives available to handle all concerns and issues members may have;
- H. Support contracted providers by having provider services executives handle issues regarding agreement and general concerns;
- I. Provide training and support in the application of utilization review programs and the development of a network of contracted providers;
- J. Serve as a referral support center, to assist in the provision of any service by a specialty provider, as requested by the affiliated provider;
- K. Perform periodic site visits to PCP offices and high-volume specialists to ensure compliance with CarePlus' established procedures, access to information, and response to inquiries concerning issues that may relate to quality of care;
- L. Maintain and monitor a panel of PCP from which the member may select a PCP;
- M. Consult and communicate with physicians regarding CarePlus' medical policy, quality assurance/improvement programs, and medical management procedures;
- N. Agree to comply with federal laws and regulations designed to prevent or ameliorate fraud, waste and abuse, including, but not limited to, applicable provisions of federal criminal law, the False Claims Act (31 USC 3729 et. Seq.), and the anti-kickback statute (section 1128B (b)) of the ACT);
- O. Disclose to CMS all information necessary to (1) administer and evaluate the program; and (2) establish and facilitate a process for current and prospective members to exercise choice in obtaining Medicare services;

- P. Maintain ultimate responsibility for adhering to and otherwise fully complying with all terms and conditions with its contract with CMS. Require its related entities, contractors and subcontractors to grant the U.S. Department of Health and Human Services (HHS), the comptroller general or its designee the right to inspect, evaluate and audit any pertinent information for any particular contract period and maintain this information for 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later;
- Q. Communicate and certify the truthfulness and completeness of encounter data and medical records submitted by the plan and its affiliated physicians, contractors, and subcontractors;
- R. Agrees to arrange through its contracted physicians continuation of members' healthcare benefits for the duration of the contract period with CMS; and, provide continuation of care for members who are hospitalized on the date should the contract terminate, or, in the event of insolvency, through discharge;
- S. Notify prospective and participating providers in writing the reason for denial, suspension, and termination from the plan;
- T. Shall not discriminate against provider with respect to participation, reimbursement, or indemnification as long as provider is acting within the scope of his/her licensure or certification under applicable state law, solely on the basis of such license or certification. This provision shall not be construed as an "any willing provider law," as it does not prohibit CarePlus from limiting provider participation to the extent necessary to meet the needs of its members;
- U. Shall not discriminate against provider when serving high-risk populations or when provider specializes in conditions requiring costly treatments.

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CONTRACT REQUIREMENTS THROUGH POLICIES, STANDARDS AND MANUALS

In addition to the provisions mentioned above, CarePlus must include certain MA-related provisions in the policies and procedures that are distributed to providers and suppliers that constitute the organization's health services delivery network. The following table summarizes these provisions, which may be accessed online by viewing the Code of Federal Regulations (CFR) which is available on the U.S. Government Publishing Office website (www.gpo.gov).

Summary of CMS Requirements	Title 42 > Chapter IV > Subchapter B > Part 422 >
Safeguard privacy and maintain records accurately and timely	422.118
Permanent "out of area" members to receive benefits in continuation area	422.54(b)
Prohibition against discrimination based on health status	422.110(a)
Pay for emergency and urgently needed services	422.100(b)
Pay for renal dialysis for those temporarily out of a service area	422.100(b)(1)(iv)
Direct access to mammography and influenza vaccinations	422.100(g)(1)
No copay for influenza and pneumococcal vaccines	422.100(g)(2)
Agreements with providers to demonstrate "adequate" access	422.112(a)(1)
Direct access to women's specialists for routine and preventive services	422.112(a)(3)
Services available 24 hours a day, seven days a week	422.112(a)(7)
Adhere to CMS marketing provisions	422.80(a), (b), (c)
Ensure services are provided in a culturally competent manner	422.112(a)(8)
Maintain procedures to inform members of follow-up care or provide training in self-care as necessary	422.112(b)(5)
Document in a prominent place in medical record if individual has executed advance directive	422.128(b)(1)(ii)(E)
Provide services in a manner consistent with professionally recognized standards of care	422.504(a)(3)(iii)
Continuation of benefits provisions (may be met in several ways, including contract provision)	422.504(g)(2)(i); 422.504(g)(2)(ii); 422.504(g)(3)
Payment and incentive arrangements specified	422.208
Subject to applicable federal laws	422.504(h)
Disclose to CMS all information necessary to (1.) administer and evaluate the program (2.) establish and facilitate a process for current and prospective beneficiaries to exercise choice in obtaining Medicare services	422.64(a): 422.504(a)(4) 422.504(f)(2)

CONTRACT REQUIREMENTS THROUGH POLICIES, STANDARDS AND MANUALS

Summary of CMS Requirements	Title 42 > Chapter IV > Subchapter B > Part 422 >
Must make good faith effort to notify all affected members of the termination of a provider contract 30 calendar days before the termination by plan or provider	422.111(e)
Submission of data, medical records and certify completeness and truthfulness	422.310(d)(3)-(4), 422.310(e), 422.504(d)-(e), 422.504(i)(3)-(4), 422.504(l)(3)
Comply with medical policy, QI and MM	422.202(b); 422.504(a)(5)
Disclose to CMS quality and performance indicators for plan benefits regarding disenrollment rates for beneficiaries enrolled in the plan for the previous two years	422.504(f)(2)(iv)(A)
Disclose to CMS quality and performance indicators for the benefits under the plan regarding enrollee satisfaction	422.504(f)(2)(iv)(B)
Disclose to CMS quality and performance indicators for the benefits under the plan regarding health outcomes	422.504(f)(2)(iv)(C)
Notify providers, in writing, of reason for denial, suspension and termination	422.202(c)(1)
Provide 60 days' notice when terminating contract without cause	422.202(c)(4)
Comply with federal laws and regulations including, but not limited to, federal criminal law, the False Claims Act (31 U.S.C. 3729 et. Seq.) and the anti-kickback statute (section 1128B(b) of the Act)	422.504(h)(1)
Prohibition of use of excluded practitioners	422.752(a)(8)
Adhere to appeals/grievance procedures	422.562(a)

Source: Medicare Managed Care Manual, Chapter 11, “Medicare Advantage Application Procedures and Contract Requirements,” § 100.4 – Provider and Supplier Contract Requirements. (Revised 04/25/07)

The Code of Federal Regulations (CFR) is the codification of the general and permanent rules published in the Federal Register by the executive departments and agencies of the federal government. It is divided into 50 titles that represent broad areas subject to federal regulation. Each title is divided into chapters, which usually bear the name of the issuing agency. Each chapter is further subdivided into parts that cover specific regulatory areas. Large parts may be subdivided into subparts. All parts are organized in sections, and most citations in the CFR are provided at the section level.

The MA-related provision can be found under title 42. Example: 42 CFR 422.111.

CFRs can be retrieved on the following website: www.govinfo.gov/app/collection/cfr/

GENERAL COMPLIANCE AND FRAUD, WASTE AND ABUSE REQUIREMENTS

CarePlus is committed to maintaining high ethical standards and conducting business with integrity and in compliance with applicable laws, regulations and requirements. This strong commitment to ethics is the foundation of CarePlus' business relationships. CMS mandates that all CarePlus-contracted entities complete compliance requirements annually. As a wholly owned subsidiary of Humana, CarePlus is providing two Humana documents: Compliance Policy for Contracted Healthcare Providers and Third Parties and Ethics Every Day for Contracted Healthcare Providers and Third Parties. You will see references to Humana throughout these documents. In addition, CMS requires your organization to provide education about combating fraud, waste and abuse (FWA) to all who support a (CarePlus-administered) Medicare plan. This includes your organization's employees, administrative and healthcare professionals, and, if applicable, any other individuals and entities supporting your organization in meeting contractual obligations to CarePlus.

The Humana documents are available on the CarePlus website:

[CarePlusHealthPlans.com/Careplus-Providers/Compliance](https://www.CarePlusHealthPlans.com/Careplus-Providers/Compliance). If you are unable to access the internet, please contact our Provider Operations inquiry line at 1-866-220-5448, Monday – Friday, 8 a.m. – 5 p.m., Eastern time.

CarePlus suggests the requirements outlined above occur within 30 days of contract/employment and annually thereafter. Review of these two documents, or materially similar documents, and FWA training is required of healthcare providers and those supporting their contract with CarePlus so sufficient awareness is gained of the compliance requirements. CarePlus reserves the right to request that contracted healthcare providers and those in their organizations supporting a CarePlus contract provide evidence of distribution of the above documents or materially similar content, as well as tracking logs and documentation related to any other requirements the documents outline.

If you have any questions about this compliance program and training requirement, please contact your assigned provider services executive or call the Provider Operations inquiry line at 1-866-220-5448, Monday – Friday, 8 a.m. – 5 p.m., Eastern time.

We appreciate your assistance with this requirement!

Thank you for your care of our members.

Contracted providers are responsible for complying with all applicable laws, regulations and CarePlus' policies and procedures, including, but not limited to the Compliance Policy for Contracted Healthcare Providers and Third Parties ("Compliance Policy"), Ethics Every Day for Contracted Healthcare Providers and Third Parties ("Ethics Every Day,") and FWA Training. These Humana documents are available on the CarePlus website at [CarePlusHealthPlans.com/Careplus-Providers/Compliance](https://www.CarePlusHealthPlans.com/Careplus-Providers/Compliance).

These Humana documents incorporate requirements outlined by CMS for all MA or prescription drug plans (PDP) sponsors, as well as any individuals and entities that provide administrative support, related materials/supplies and/or render services for or on behalf of the sponsors, as detailed in Chapter 21 of the Medicare Managed Care Manual and Chapter 9 of the Prescription Drug Benefit Manual.

CarePlus' general compliance and FWA requirements for contracted providers, include, but are not limited to:

1. Having designated resource(s) to fulfill compliance obligations.
2. Being familiar with CarePlus' expectations and requirements relating to compliance program requirements and FWA prevention, detection and correction, which have been outlined in the Compliance Policy and Ethics Every Day.
3. Monitoring the compliance of employees.
4. Monitoring and auditing the compliance of subcontractors that provide services or support related to administrative or healthcare services provided to a member of CarePlus ("downstream entities").
5. Obtaining approval from CarePlus for any relationships with downstream entities. In addition, note that CarePlus must notify CMS of any location outside of the United States or a U.S. territory that receives, processes, transfers, stores, or accesses a Medicare member's protected health information in oral, written, or electronic form.
6. Reporting instances of suspected and/or detected FWA and noncompliance with the Compliance Policy and Ethics Every Day.
7. Having policies and procedures in place for preventing, detecting, correcting and reporting noncompliance and FWA, including, but not limited to:
 - a. Requiring employees and downstream entities to report suspected and/or detected FWA and noncompliance;
 - b. Safeguarding CarePlus' confidential and proprietary information;
 - c. Providing accurate and timely information/data in the regular course of business; and,
 - d. Screening all employees and downstream entities against federal government exclusion lists, including the Office of Inspector General (OIG) list of Excluded Individuals and Entities (oig.hhs.gov/exclusions/) and the General Services Administration (GSA) Excluded Parties Lists System (www.sam.gov). Anyone listed on one or both lists who is not eligible to support CarePlus' MA and PDPs, must be removed immediately from providing services or support to CarePlus, and CarePlus must be notified upon such identification.
8. Cooperating fully with any investigation of alleged, suspected, or detected violation of the manual, CarePlus policies and procedures, or applicable state or federal laws or regulations, and/or remedial actions.
9. Administering compliance and FWA training to employees and downstream entities including, but not limited to:
 - a. Documenting that training requirements have been met; and
 - b. Having a system in place to collect and maintain records of compliance and FWA training for a period of at least 11 years.
10. Publicizing disciplinary standards to employees and downstream entities.

11. Instituting disciplinary standards and taking appropriate action upon discovery of noncompliance, FWA or actions likely to lead to either one.
12. Avoiding conflicts of interest, having an internal policy in place to identify and disclose and address conflicts of interest and, upon request, providing CarePlus with conflict of interest statements covering the provider, employees and downstream entities.

Additional information can be found online in the Compliance Policy and Ethics Every Day at CarePlusHealthPlans.com/Careplus-Providers/Compliance.

REPORTING METHODS FOR SUSPECTED OR DETECTED NONCOMPLIANCE

Contracted providers, their employees, and downstream entities are required to notify our parent organization, Humana's Special Investigations Unit (SIU), of suspected or detected FWA. Information about SIU and CarePlus'/Humana's efforts to prevent, detect and correct FWA can be found on the CarePlus website (CarePlusHealthPlans.com/Careplus-Providers/Compliance) and in Ethics Every Day, the compliance policy, and FWA training. Providers, their employees, and downstream entities also may report concerns and information related to FWA and noncompliance with this manual, Ethics Every Day, and/or compliance policy to our parent organization, Humana, via one of the following anonymous options:

Phone: 1-800-614-4126

Fax: 920-339-3613

Email: siureferrals@humana.com

Mail: Humana, Special Investigation Unit, 1100 Employers Blvd., Green Bay, WI 54344

Ethics Help Line: 1-877-5-THE-KEY (584-3539)

Ethics Help Line Reporting website: EthicsHelpline.com

Another option is to complete and submit the Special Investigations Referral Form online at Humana.com/Legal/si-referral-form

Individuals and entities that report suspected or detected false claims violations are protected from retaliation under 31 U.S.C. 3730(h) for False Claims Act complaints. CarePlus prohibits intimidation of and retaliation against those who, in good faith, report suspected or detected violations of CarePlus' policies and has zero tolerance for retaliation or retribution against any person who reports suspected misconduct.

Once SIU performs its initial investigation, SIU may refer the case to the appropriate law enforcement and/or regulatory agencies, including, but not limited to, the appropriate CMS regional office, as SIU deems appropriate.

DISCIPLINARY STANDARDS

Confirmed noncompliance and/or FWA violations by healthcare providers, their employees and/or downstream entities could result in any or all of the following:

- Oral or written warnings or reprimands
- Suspensions or termination(s) of employment or agreement
- Other measures which may be outlined in the agreement
- Mandatory retraining
- Written corrective action plan(s) that must be completed to closure
- Reporting of the conduct to the appropriate external entities, such as CMS, a CMS designee, and/or law enforcement agencies

REPORTING OCCURRENCES TO CAREPLUS

Pursuant to Florida Statute 641.55 and, Florida Administrative Code Rule 59A-10, The Agency for Health Care Administration (AHCA) mandates that an HMO maintain an internal risk management program. As part of the CarePlus Risk Management Program, physicians and other healthcare providers are expected to report any occurrences and/or adverse incidents involving a CarePlus member, whether it happens in their office or in any other facility.

An **occurrence** is defined as any unforeseen complication or unusual event in which a plan member is involved. Examples of occurrences are:

- Complication of drug, treatment, or service prescribed
- Dissatisfaction angrily expressed with threats
- Delay in care, diagnosis, or referral
- Breach of confidentiality
- Receipt of a notice of intent to initiate litigation against a contracted physician or facility

An **adverse incident** is defined as an event over which healthcare personnel could exercise control, and which is associated in whole or in part with medical intervention, rather than the condition for which such intervention occurred, and which results in one of the following:

- Unexpected death of a patient
- Brain or spinal damage
- Performance of surgical procedure on the wrong patient
- Performance of a wrong site surgical procedure
- Performance of a surgical procedure that is medically unnecessary or otherwise unrelated to the patient's diagnosis or medical condition
- Surgical repair of damage to a patient resulting from a planned procedure, where the damage was not a recognized specific risk, as disclosed to the patient and documented through the informed-consent process
- Performance of procedure to remove unplanned foreign objects remaining from a surgical procedure
- Never Events – per CMS guidelines

As per Florida Administrative Code R. 59A-12.012, occurrences and adverse incidents must be reported to the CarePlus risk manager within three calendar days. The information submitted to CarePlus is used for state-mandated risk management review.

Independent physicians or private practice physicians and their health plan medical director should report occurrences and adverse incidents using one of the following methods:

- Telephonically between the independent physician and the health plan medical director
- Telephonically between the office staff and the health plan risk manager or provider representative
- In writing by completing a Member Occurrence Report, filled out by the independent physician or office staff. For your convenience, we have included a copy of the Member Occurrence Report under the "Forms" section of this manual. The report should be mailed to the risk manager, medical director, or the designated provider services executive. Facsimiles should be avoided because of lack of confidentiality.

Group physicians and their staffs should use the following methods:

- Telephonically between the group medical director/group leader and the health plan medical director. The group physician, who becomes aware of an occurrence, should report the occurrence to the group medical director/group physician leader.
- Telephonically between the office staff and the health plan risk manager or provider representative.
- In writing by completing a Member Occurrence Report filled out by the group medical director/group physician leader or office staff. For your convenience, we have included a copy of the Member Occurrence Report under the "Forms" section of this manual. The report should be mailed to the risk manager, medical director, or the designated provider services executive. Facsimiles should be avoided because of lack of confidentiality.

Note: Allied healthcare professionals should report to their supervising physician. **All other healthcare providers** should report as independent physicians.

The information submitted to the plan is used to investigate potential quality issues and for risk management review. All information reported to the plan will remain strictly confidential in accordance with the policy and procedure on confidentiality.

If you have any questions regarding the above-mentioned information or would like to obtain guidance on how to establish a risk management program within your practice or facility, please contact CarePlus' Risk Management department via email at riskmanagementadministration@humana.com.

RESPONSIBILITIES OF THE PRIMARY CARE PHYSICIAN (PCP)

To comply with the requirements of accrediting agencies, CarePlus has adopted certain rules that are summarized below for participating physicians. This is not a comprehensive, all-inclusive list. Additional responsibilities are represented elsewhere in this manual and within the provider agreement.

1. All PCPs must have 24-hour-a-day, seven-days-a-week coverage; regular hours of operation should be clearly defined and communicated to members.
2. The PCP is the coordinator of all care. Therefore, the PCP agrees to ensure continuity of care to CarePlus members when the PCP's office is closed by arranging for the provision of on-call and after-hours coverage by a participating and credentialed CarePlus physician.
3. The PCP agrees to treat all CarePlus members with respect, consideration, and dignity.
4. The PCP agrees to practice his/her profession ethically and legally and provide all services in a culturally competent manner consistent with professionally recognized standards of care, accommodate those with disabilities, and not to discriminate against anyone based on race, ethnicity, national origin, religion, sex, age, marital status, mental or physical disability or medical condition, sexual orientation, claims experience, medical history, evidence of insurability (including conditions arising out of acts of domestic violence), genetic information, or source of payment.
5. The PCP agrees to refer and/or admit CarePlus members only to participating physicians and providers (including hospitals, skilled nursing facilities [SNFs] and other facilities) except when participating physicians and providers are not available in network or for urgent/emergent covered services.
6. The PCP shall attempt to conduct a health risk assessment of all new enrollees within 90 days of the effective date of enrollment if the plan is unable to obtain it from the enrollee upon initial enrollment.
7. When clinically indicated, the PCP agrees to contact CarePlus members as quickly as possible regarding identified significant problems and/or abnormal laboratory, radiological, or other diagnostic findings.
8. The PCP agrees to conduct assessments of the members' needs and will make appropriate and timely specialty and care management referrals.
9. The PCP will establish office procedures to facilitate the follow-up of member referrals and office visits to specialty care providers by entering the referral in Availity or *PWS (*sunsetting July 2024) . Note that referrals may not be required for certain services or benefits. Please contact CarePlus for details.
10. The PCP will consult with specialty care providers, including providing necessary history and clinical data to assist the specialty care provider in his/her examination of the member, and retrieve consultation and diagnostic reports from specialty care provider.

11. The PCP shall participate in any system established by CarePlus to facilitate the sharing of medical records, subject to applicable confidentiality requirements in accordance with 42 CFR, Part 431, Subpart F, including a minor's consultation, examination and drugs for sexually transmitted infections (STIs) in accordance with Section 384.30 (2), F.S.
12. The PCP agrees to provide services in a culturally competent manner, e.g., removing all language barriers. Care and services should accommodate the special needs of ethnic, cultural, and social circumstances of the patient.
13. All referrals must be submitted via Availity or *PWS (*sunsetting July 2024), as applicable.
14. The PCP's office is responsible for notifying CarePlus of changes in staff. If a new physician is added to a group, CarePlus must approve and credential the physician before he/she treats CarePlus members.
15. The PCP agrees to participate and cooperate with CarePlus in internal and external quality improvement/management, utilization review, continuing education, and other similar programs established by CarePlus.
16. The PCP agrees to cooperate with an independent review organization's activities pertaining to the provision of services for CarePlus members. The PCP also agrees to respond expeditiously to CarePlus' requests for medical records or any other documents to comply with regulatory requirements and to provide additional information when necessary to resolve/respond to a member's grievance or appeal.
17. The PCP agrees to participate in, and cooperate with, CarePlus' grievance/appeal procedures when CarePlus notifies the PCP of any member grievances/appeals.
18. All PCPs are required to provide 45-day written notice to CarePlus if they are closing their panel to new and/or transferring CarePlus members.
19. The PCP agrees not to bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any resources against CarePlus members other than for copayments, fees from non-covered services furnished on a fee-for-service basis. Non-covered services are services not covered by Medicare or services excluded in the member's Evidence of Coverage (EOC). Notification that a service is not a covered benefit must be provided to the member prior to the service and be consistent with CarePlus policy for the member to be held financially responsible. CarePlus policy requires that the notification include the date and description of the service, an estimate of the cost to the member for such services, name and signature of the member agreeing in writing to receive such services, name and signature of the provider, and be in at least 12-point font. Documentation of that preservice notification must be included in the member's medical record and shall be provided to CarePlus or its designee upon request, and in a timely manner to substantiate member appeals. For additional guidance, please refer to the section titled **Limitations on Member Liability Related to Plan-directed Care** under **Role of the Primary Care Physician (PCP)**.

20. The PCP agrees that in the event CarePlus denies payment for a health service(s) rendered to CarePlus members determined not to be medically necessary, the PCP will not bill, charge, seek payment, or have any recourse against said member for such service(s), unless the member has been advised in advance that the service(s) is/are not medically necessary and has agreed in writing to be financially responsible for those services pursuant to CarePlus policy (see No.19 for details).
21. In no event, including, but not limited to, nonpayment by the plan, insolvency of the plan, or breach of the provider agreement by either party, shall the PCP bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against any dual-eligible SNP member or a person acting on their behalf for fees that are the responsibility of the plan or state Medicaid agency.
22. The PCP must continue care in progress for members through the effective date of termination.
23. The PCP agrees to maintain malpractice insurance acceptable to CarePlus, which shall protect the PCP and its employees. If the PCP elects not to carry malpractice insurance, appropriate documentation must be submitted to CarePlus, and members must be notified via a written statement or a posting in the PCP's office.
24. The PCP agrees to retain all agreements, books, documents, papers, and medical records related to the provision of services to CarePlus members, as required by state and federal laws.
25. The PCP agrees to treat all member records and information confidentially, accurately, and timely, and agrees not to release such information without the written consent of the member, except as indicated herein, or as needed for compliance with state and federal laws, including Health Insurance Portability and Accountability Act (HIPAA) regulations.
26. The PCP agrees to establish procedures to obtain, identify, store, and transport laboratory specimens or biological products, when applicable.
27. The PCP shall comply with applicable state and federal laws and regulations including, but not limited to, the False Claims Act (31 USC 3729 et. Seq.) and the anti-kickback statute (Section 1128B[b] of the Act), Title VI of the Civil rights Act of 1964, Rehabilitation Act of 1973, Age Discrimination Act of 1975, and the Americans with Disabilities Act.
28. The PCP agrees to support and cooperate with CarePlus' Quality Management and Risk Management programs to provide quality care in a cost-effective and responsible manner.
29. The PCP agrees to inform CarePlus if he/she objects to the provision of any counseling, treatments or referral services on religious grounds.
30. The PCP agrees to provide CarePlus members complete information concerning their diagnosis, evaluation, treatment, prognosis, and the use of the healthcare system. The PCP will give members the opportunity to participate in decisions involving their healthcare regardless of

whether he/she has completed an advance directive, except when contraindicated for medical reasons.

31. The PCP agrees to adequate and timely communication among providers and the transfer of information when members are transferred to other healthcare providers to ensure continuity of care. The PCP agrees to obtain a signed and dated release allowing for the release of information to CarePlus and other providers involved in the member's care.
32. Food snacks or services provided to patients should meet their clinical needs and should be prepared, stored, secured, and disposed of in compliance with local health department requirements.
33. The PCP agrees to make provisions to minimize sources and transmission of infection within his/her office.
34. The PCP agrees to establish office procedures to notify public health authorities of reportable or communicable conditions.
35. The PCP agrees to maintain communication with the appropriate agencies such as local police, social services, and poison control centers to provide high-quality patient care.
36. The PCP agrees that any notation in a member's clinical record indicating diagnostic or therapeutic intervention as part of clinical research shall be clearly contrasted with entries regarding the provision of non-research related care.
37. The PCP agrees to document in a member's medical record whether the member has executed an advance directive.
38. The PCP agrees to provide CarePlus with 60 days' notice when he/she intends to terminate an agreement to allow CarePlus to make a good faith effort to contact affected member(s) within 45 days of receipt of termination notice.
39. The PCP agrees not to charge a copayment for influenza and pneumococcal vaccines.
40. The PCP agrees to follow the Medicare Communications and Marketing Guidelines found in the CMS Medicare Managed Care Manual.
41. The PCP agrees to receive approval from CarePlus prior to sending any communication(s) to CarePlus members.
42. The PCP agrees to submit a report of an encounter for each visit when the member is seen by the provider and the member receives a Healthcare Effectiveness Data and Information Set (HEDIS®) service. Encounters should be submitted electronically or recorded on a CMS-1500 Claim Form, or its respective successor forms, as may be required by CMS, or such other forms as may be required by law when submitting encounters or claims in an electronic format and submitted according to the time frame listed in the participation agreement.

43. The PCP shall inform CarePlus immediately upon exclusion from participation in the Medicare program and acknowledges that CarePlus is prohibited by federal law from contracting with a physician excluded from participation in the Medicare program.
44. The PCP shall have on-site written policies and procedures that are reviewed and updated annually, to include an evaluation for the availability of safer medical services and devices, as well as changes in technology. Office policies and procedures should include, but not be limited to, the following:
 - Appointment scheduling and telephone guidelines
 - Recordkeeping and general documentation requirements
 - Medical records and confidentiality (e.g., HIPAA)
 - Medication administration (e.g., refill policies, controlled substances, etc.)
 - Infection control (e.g., blood-borne pathogens, housekeeping, sharps safety, hand hygiene, written exposure-control plan)
 - Safety program
 - Hazard communications
 - Hazardous drugs plan
 - Fire safety
 - Emergency action plans and preparedness (i.e., fire, tornado, and workplace violence)

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ROLE OF THE PRIMARY CARE PHYSICIAN (PCP)

Each CarePlus member will select a PCP at the time of enrollment. The PCP coordinates the member's healthcare needs through a comprehensive network of specialty, ancillary, and hospital providers.

An initial health risk assessment (HRA) is completed within 90 days of enrollment, for the purpose of engaging members in care management, providing continuity of care and appropriate coordination of clinical services. HRAs also are performed annually, within one year (365 days) of the previous HRA. Telephonic attempts are made by CarePlus to reach members and ask for member's agreement to complete the HRA. PCPs also are expected to contact each new member to schedule a first visit. PCPs must work actively in the development, implementation, and management of each member's individualized care plan.

The PCP is responsible 24 hours a day, seven days a week for providing and arranging for all covered services including prescribing, directing and authorizing all care to members who have been assigned to the PCP. The only exception to this rule is when a member is enrolled in an Open Access plan (CareAccess (HMO)). In this case, although members are encouraged to keep the PCP updated, members are not required to obtain a PCP referral before seeking covered services from in-network providers. The PCP is responsible for arranging coverage by a CarePlus credentialed physician in the event of the PCP's absence. All financial arrangements must be made between the PCP and covering physician. The PCP also is responsible for notifying CarePlus in writing (two weeks prior to their absence) of the duration of the absence and the physician who will be providing the coverage. The covering physician must be credentialed by CarePlus.

All PCPs must be credentialed by CarePlus. All personnel assisting in the provision of healthcare services to CarePlus members are to be appropriately trained, qualified, and supervised in the care provided. Any time a new physician joins a practice, that individual must be credentialed with CarePlus and cannot see CarePlus members until the credentialing process is completed. Services must never be provided by a non-credentialed physician, and if provided, will not be covered by CarePlus. PCPs must notify his/her provider services executive when a new physician requires credentialing. The PCP is responsible for the direct training and supervision of all employed physician extenders in the provision of care and directed according to Medicare regulations and applicable state licensure requirements.

Payments: The PCP shall collect copayments or cost-sharing percentage due from members only when applicable.

PCPs are required to provide care in a culturally competent manner which includes, but is not limited to, the following:

- Providing free oral interpretation services
- Establishing standards and mechanisms to confirm the timeliness, quality, and accuracy of oral interpretations
- Establishing standards and criteria to promote the efficiency of interpreter services
- Identifying points of contact when the need for interpretation is reasonably anticipated and establishing how the provider will provide timely access to interpretation services at all points of contact

- Establishing a range of interpreting services and types of resources needed to provide effective interpreting
- Creating mechanisms for promoting sensitivity to the culture of those with limited English-speaking proficiency
- Establishing a policy regarding a patient's request in a nonemergency to use a family member or friend as the interpreter
- Establishing a policy regarding use of a minor as an interpreter in an emergency

Limitations on Member Liability Related to Plan-directed Care

If a participating provider furnishes a service or directs a CarePlus member to another provider to receive a plan-covered service without following CarePlus' internal procedures (such as obtaining the appropriate plan pre-authorization), then the member must not be penalized to the extent the provider did not follow plan rules.

- Consequently, when a participating provider furnishes a service or refers a member for a service that a member reasonably believes is a plan-covered service, the member cannot be financially liable for more than the applicable cost-sharing for that service. If an item or service is not explicitly excluded within the EOC, or if a participating provider believes an item or service may not be covered for a member or could be covered only under specific conditions, the appropriate process is for the member or provider to request a preservice organization determination from CarePlus.
- If a participating provider refers a member to an out-of-network provider for a service that is covered by CarePlus, the member is financially liable only for the applicable in-network cost-sharing for that service. Participating providers are expected to work with CarePlus to coordinate care prior to referring a member to an out-of-network provider to ensure, to the extent possible, that members are receiving medically necessary services covered by their plan.

Provider Responsibilities under Title VI of the Civil Rights Act of 1964 and the Americans with Disabilities Act (ADA) of 1990

Title VI of the Civil Rights Act of 1964

Title VI of the Civil Rights Act of 1964 prohibits national origin discrimination, which protects individuals with limited English proficiency (LEP). It applies to all entities that receive federal financial assistance, either directly or indirectly (e.g., through a grant, cooperative agreement, contract/subcontract, Medicaid and Medicare payments, etc.). Virtually all healthcare providers must ensure that LEP patients have meaningful access to healthcare services at no cost to the patient. "Meaningful access" means that the LEP patient can communicate effectively.

In 2003, the U.S. Department of Health and Human Services (HHS) issued guidance to assist healthcare providers in complying with Title VI. The HHS points out that a thorough assessment of the language needs of the population served is to be conducted to develop appropriate and reasonable language assistance measures. The guidance details four factors PCPs should consider when determining the extent and types of language assistance that may be pursued:

1. The number or proportion of LEP individuals eligible to be served or likely to be encountered.
2. The frequency with which the LEP individuals come into contact with the provider.
3. The nature and importance of the program, activity, or service provided by the provider to people's lives.
4. The resources available to the provider and costs.

A PCP must have an appropriate response for the LEP patients they serve, such as use of translated documents, bilingual office staff, and/or use of family members or an interpreter, when necessary. In the event a PCP is unable to arrange for **language translation services for non-English speaking or LEP CarePlus members**, he/she may contact our member services department at 1-800-794-5907, and a representative will assist in locating a qualified interpreter who communicates in the member's primary language via telephone while the member is in the office. To avoid having the member experience delayed during the scheduled appointment, it is recommended that this be coordinated with the member services department prior to the date of the visit.

For additional information regarding improving cultural competency when providing care, please refer to the section titled **Cultural Gaps in Care** within this manual.

Furthermore, Section 1557 of the Patient Protection and Affordable Care Act strengthened requirements for language resources providing that individuals cannot be denied access to health care or health care coverage or otherwise be subject to discrimination because of race, color, national origin, sex, age, or disability. Under a new requirement, covered entities are required to post information telling consumers about their rights and telling consumers with disabilities and consumers with LEP about the right to receive communication assistance. To reduce burden and costs, the HHS Office for Civil Rights (OCR) has translated a sample notice and taglines for use by covered entities into 64 languages. For translated materials, visit hhs.gov/civil-rights/for-individuals/section-1557/translated-resources/index.html.

Additional Resources to Assist You in Serving LEP Patients

U.S. HHS – Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons:
hhs.gov/civil-rights/for-individuals/special-topics/limited-english-proficiency/guidance-federal-financial-assistance-recipients-title-VI/index.html

U.S. HHS Office of Minority Health – Cultural and Linguistic Competency:
minorityhealth.hhs.gov/omh/browse.aspx?lvl=1&lvlID=6

U.S. HHS Office of Civil Rights – Section 1557 of the Patient Protection and Affordable Care Act
hhs.gov/civil-rights/for-individuals/section-1557/index.html

U.S. HHS Office of Civil Rights – Section 1557: Frequently Asked Questions
hhs.gov/civil-rights/for-individuals/section-1557/1557faqs/index.html

The Americans with Disabilities Act of 1990

Under the ADA, physicians' offices are considered places of public accommodation. PCPs are required to comply with basic non-discrimination requirements that prohibit exclusion, segregation, and unequal treatment of any person with a disability. All PCP facilities must have in operation: (i) handicapped accessibility, including an accessible exam table and adequate space and supplies; (ii) good sanitation; (iii) fire safety procedures. To provide medical services in an accessible manner, PCPs and their staff may need training in operating accessible equipment, helping with transfers and positioning, and not discriminating against individuals with disabilities.

PCPs must furnish appropriate auxiliary aids and services where necessary to ensure effective communication. For deaf or hard-of-hearing patients, this may include written notes, readers, and telecommunication devices or an interpreter. In situations where information is more complex, such as discussing medical history or providing complex instructions about medications, an interpreter should be present. If the information is simple and direct, such as prescribing an X-ray, the PCP may be able to communicate in writing. For the visually impaired, this may include providing materials in large print or Braille text.

In addition, the ADA requires that service dogs be admitted to healthcare provider offices unless it would result in a fundamental alteration or jeopardize safe operation.

The cost of an auxiliary aid or service must be absorbed by the provider and cannot be charged to the member either directly or through CarePlus. PCPs are required to modify policies and procedures when necessary to serve a person with disability. However, the ADA does not require providers to make changes that would fundamentally alter the nature of their service. PCPs are responsible for making reasonable efforts to accommodate members with sensory impairments. Without these, the PCP and staff might not understand the patient's symptoms and misdiagnose medical problems or prescribe inappropriate treatment.

Additional Resources Concerning ADA Requirements

U.S. Department of Justice: ADA home page, www.ada.gov.

Language Assistance and Interpretation Services

Providers of medical services are contractually and federally required to ensure "equality of opportunity for meaningful access" to healthcare services and activities. This includes ensuring that non-English/limited English and disabled members are provided effective communication of "vital information" during doctor visits/appointments/follow-ups to avoid consequences or adverse risk to the patient/member (i.e., over-the-phone interpretation, video interpretation, in-person interpretation including American Sign Language.) Oral interpretation services must be provided, at no cost, in the language of the member, including American Sign Language.

More than 300 languages are spoken in the United States. To ensure "equality of opportunity for meaningful access to healthcare services and activities," (Executive Order 13166, Section 504/508 of Rehabilitation Act and Title III of ADA, Section 1557 of Patient Protection and Affordable Care Act);

providers must ensure patients/members are not discriminated against by not receiving effective communication.

When creating appointments with current and future members, providers must provide:

- Notification of availability of oral interpretation (over the phone, video or in-person) for non-English/limited English appointments
- Notification of availability of video or in-person sign language interpretation for hearing impaired members

CyraCom, an over-the-phone and video interpreter vendor, offers interpretation services in 200 languages and video interpretation in 24 languages, including American Sign Language, to meet providers' contractual and federal requirements. Please click the link below:

<https://start.cyacom.com/humana>

Deaf Interpreters Service has an in-person sign language service available across the United States to make it easy for providers to meet ADA requirements regarding hearing impaired patients.

www.deaf-interpreter.com

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RESPONSIBILITIES OF THE SPECIALTY CARE PHYSICIAN

Listed below are highlights from the specialty care agreement. For more comprehensive, specific details, please refer to your executed specialty care agreement.

1. Specialist must have coverage 24 hours a day, seven days a week.
2. Specialist will participate in any system established by CarePlus to facilitate the sharing of records (subject to applicable confidentiality requirements in accordance with 42CFR, Part 431, Subpart F, including a minor's consultation, examination and drugs for STIs in accordance with Section 384.30 [2], F.S.).
3. Specialist agrees to practice his/her profession ethically and legally and provide all services in a culturally competent manner consistent with professionally recognized standards of care, accommodate those with disabilities, and not to discriminate against anyone based on race, ethnicity, national origin, religion, sex, age, mental or physical disability or medical condition, sexual orientation, claims experience, medical history, evidence of insurability (including conditions arising out of acts of domestic violence), genetic information, or source of payment.
4. Specialist agrees to treat all CarePlus members with respect, consideration, and dignity.
5. Specialist agrees to refer and/or admit CarePlus members only to participating physicians and providers (including hospitals, SNFs, and other facilities) except when participating physicians and providers are not available in network or in an emergency.
6. If a new physician is added to a group, CarePlus must approve and credential the physician before the physician treats enrollees.
7. Specialist agrees to participate and cooperate with CarePlus in any internal and external quality improvement/management, risk management review, utilization review, continuing education, and other similar programs established by CarePlus.
8. Specialist agrees to cooperate with an independent review organization's activities pertaining to the provision of services for CarePlus members. Specialist also agrees to respond expeditiously to CarePlus' requests for medical records or any other documents to comply with regulatory requirements and to provide additional information when necessary to resolve or respond a member's grievance or appeal.
9. Specialist agrees to participate in, and cooperate with, CarePlus' grievance/appeal procedures when CarePlus notifies specialist of any member grievances/appeals.
10. Specialist agrees to follow all utilization and referral guidelines established by CarePlus, including, but not limited to, prior authorization requirements.
11. Specialist is required to provide 45-day written notice to CarePlus if closing his or her practice and moving to a new location and/or transferring CarePlus members.

12. Specialist agrees not to bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any resources against a CarePlus member other than for copayments or fees from non-covered services furnished on a fee-for-service basis. Non-covered services are services not covered by Medicare or services excluded in the member's Evidence of Coverage. Notification that a service is not a covered benefit must be provided to the member prior to provision of the service and be consistent with CarePlus policy for the member to be held financially responsible. CarePlus policy requires that the notification include the date and description of the service, an estimate of the cost to the member for such services, name and signature of the member agreeing in writing of receiving such services, name and signature of the provider, and be in at least 12-point font. Documentation of the pre-service notification must be included in the member's medical record and shall be provided to CarePlus or its designee upon request, and in a timely manner to substantiate member appeals. For additional guidance, please refer to the section titled **Limitations on Member Liability Related to Plan-directed Care** under **Role of the Specialty Care Physician**.
13. Specialist agrees that in the event CarePlus denies payment for a service(s) rendered to a CarePlus member and determined by the plan not to be medically necessary, the specialist will not bill, charge, seek payment, or have any recourse against the member for such service(s), unless the member has been advised in advance that the service(s) is/are not medically necessary and has agreed, in writing, to be financially responsible for those services, pursuant to CarePlus policy (see No. 12 for details).
14. In no event, including, but not limited to, nonpayment by the plan, insolvency of the plan, or breach of the provider agreement by either party, shall the specialist bill, charge, collect a deposit from, seek compensation, remuneration, or reimbursement from, or have any recourse against any Qualified Medicare Beneficiary (QMB), Qualified Medicare Beneficiary (QMB+), Specified Low-Income Medicare Beneficiary (SLMB+) and Full Benefit Dual Eligible (FBDE) individual or a person acting on their behalf for fees that are the responsibility of the plan or state Medicaid agency.
15. Specialist must continue care in progress during and after the termination period until CarePlus has made arrangements for substitute care for the member.
16. Specialist agrees to maintain malpractice insurance acceptable to CarePlus, which shall protect the specialist and the specialist's employees. If the specialist elects not to carry malpractice insurance, appropriate documentation must be submitted to CarePlus, and members must be notified via written statement or a posting in specialist's office.
17. Specialist shall comply with all applicable federal and state laws regarding the confidentiality of patient records.
18. Specialist agrees to establish procedures to obtain, identify, store and transport laboratory specimens or biological products, when applicable.

19. Specialist agrees to establish an appropriate mechanism to fulfill obligations under the Americans with Disabilities Act.
20. Specialist agrees to support and cooperate with CarePlus' Quality Improvement and Risk Management programs.
21. Specialist agrees to inform CarePlus if he/she objects to provisions of any counseling, treatments, or referral services on religious grounds.
22. Specialist agrees to treat all member records and information confidentially, accurately and timely, and not release such information without the written consent of the member, except as indicated herein, or as needed for compliance with state and federal laws, including HIPAA regulations.
23. Specialist agrees to provide services in a culturally competent manner, i.e., removing all language barriers. Care and services should accommodate the special needs of ethnic, cultural, and social circumstances of the patient.
24. Specialist agrees to provide to CarePlus members complete information concerning their diagnosis, evaluation, treatment, prognosis, and use of the healthcare system. Specialist will give members the opportunity to participate in decisions involving their healthcare regardless of whether he/she has completed an advance directive, except when contraindicated for medical reasons.
25. When the need arises, patients will be transferred to another provider. Specialist agrees to obtain a signed and dated release for each CarePlus member so records may be released to CarePlus, other providers involved in their care, and external agencies such as peer review organizations.
26. Specialist will provide reports of consultations and diagnostic reports to the member's PCP to promote continuity of care.
27. When clinically indicated, specialist agrees to contact CarePlus members as quickly as possible for follow-up regarding significant problems and/or abnormal laboratory or radiological findings. In the event the member cannot be located, specialist will contact the member's PCP for assistance in contacting the member.
28. Food snacks or services provided to patients will meet their clinical needs and be prepared, stored, secured, and disposed of in compliance with local health department requirements.
29. Specialist agrees to make provisions to minimize sources and transmission of infection within his/her office.
30. Specialist agrees to establish office procedures to notify public health authorities of reportable or communicable conditions.
31. Specialist agrees to maintain communication with the appropriate agencies such as local police, social services, and poison control centers to provide high quality patient care.

32. Specialist agrees to retain all agreements, books, documents, papers, and medical records related to the provision of services to CarePlus members as required by state and federal laws.
33. Specialist agrees that any notation in a patient's clinical record indicating diagnostic or therapeutic intervention as part of clinical research shall be clearly contrasted with entries regarding the provision of non-research related care.
34. Specialist agrees to provide CarePlus with a 60 day notice when he/she intends to terminate an agreement to allow CarePlus to make a good faith effort to contact affected member(s) within CMS required timeframes (30 or 45 days of receipt of the termination notice depending on the provider type).
35. Specialist agrees to not charge a copayment for influenza and pneumococcal vaccines.
36. Specialist agrees to document in a member's medical record whether the member has executed an advance directive.
37. Specialist agrees to follow the Medicare Communications and Marketing Guidelines found in the CMS Medicare Managed Care Manual.
38. Specialist agrees to receive approval from CarePlus prior to sending any communication(s) to CarePlus members.
39. Specialist agrees to submit a report of an encounter for each visit when the member is seen by the provider if the member receives a HEDIS service. Encounters should be submitted electronically, or recorded on a CMS-1500 Claim Form, or its respective successor forms, as may be required by CMS, or such other forms as may be required by law when submitting encounters or claims in an electronic format, and submitted according to the time frame listed in the participation agreement.
40. Specialist shall inform CarePlus immediately upon exclusion from participation in the Medicare program and acknowledges that CarePlus is prohibited by federal law from contracting with a physician excluded from participation in the Medicare program.
41. Specialist shall comply with applicable state and federal laws and regulations including, but not limited to, the False Claims Act (31 USC 3729 et. Seq.) and the anti-kickback statute (Section 1128B(b) of the Act), Title VI of the Civil Rights Act of 1964, Rehabilitation Act of 1973, Age Discrimination Act of 1975, and the Americans with Disabilities Act.
42. Specialist shall have on-site written policies and procedures that are reviewed and updated annually, including an evaluation for the availability of safer medical services and devices and changes in technology. Office policies and procedures should include, but not be limited to, addressing following:
 - Appointment scheduling and telephone guidelines
 - Recordkeeping and general documentation requirements

- Medical records and confidentiality (e.g., HIPAA)
- Medication administration (e.g., refill policies, controlled substances, etc.)
- Infection control (e.g., blood-borne pathogens, housekeeping, sharps safety, hand hygiene, written exposure control plan)
- Safety program
- Hazard communications
- Hazardous drugs plan
- Fire safety
- Emergency action plans and preparedness (i.e., fire, tornado, and workplace violence)

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ROLE OF THE SPECIALTY CARE PHYSICIAN

Each CarePlus member will select a PCP at the time of enrollment. The PCP coordinates the member's healthcare needs through a comprehensive network of specialty, ancillary, and hospital providers. Upon examining a member, should the PCP determine that specialty referral services are medically indicated, he/she will arrange for the appointment with the specialist by generating a referral or submitting a preauthorization request. The same process is followed for members who are hospitalized, even in cases when the PCP is not the admitting physician.

It is important to note that timely communication with the PCP is fundamental to ensure effective management of members' care. Specialty care providers are expected to establish a consistent process for distributing copies of consultation reports and medical records to PCPs.

Limitations on Member Liability Related to Plan-directed Care

CMS considers a participating provider to be an agent of CarePlus. Thus, if a participating provider furnishes a service or directs a CarePlus member to another provider to receive a plan-covered service without following CarePlus' internal procedures (such as obtaining the appropriate plan preauthorization), the member should not be penalized to the extent the provider did not follow plan rules.

- Consequently, when a participating provider furnishes a service or refers a member for a service that a member reasonably believes is a plan-covered service, the member cannot be financially liable for more than the applicable cost-sharing for that service. If an item or service is not explicitly excluded within the EOC or if a participating provider believes an item or service may not be covered for a member, or could be covered only under specific conditions, the appropriate process is for the member or provider to request a pre-service organization determination from CarePlus.
- If a participating provider refers a member to an out-of-network provider for a service that is covered by CarePlus, the member is financially liable only for the applicable in-network cost-sharing for that service. Participating providers are expected to work with CarePlus or the member's assigned PCP to coordinate care prior to referring a member to an out-of-network provider to ensure, to the extent possible, that members are receiving medically necessary services covered by their plan.

Specialty care providers are required to provide care in a culturally competent manner which includes, but is not limited to, the following:

- Providing free oral interpretation services
- Establishing standards and mechanisms to confirm the timeliness, quality, and accuracy of oral interpretations
- Establishing standards and criteria to promote the efficiency of interpreter services
- Identifying points of contact when the need for interpretation is reasonably anticipated and establishing how the provider will provide timely access to interpretation services at all points of contact
- Establishing a range of interpreting services and types of resources needed to provide effective interpreting

- Creating mechanisms for promoting sensitivity to the culture of those with limited English-speaking proficiency
- Establishing a policy regarding a patient's request, in a nonemergency, to use a family member or friend as the interpreter
- Establishing a policy regarding use of a minor as an interpreter in an emergency

Provider Responsibilities under Title VI of the Civil Rights Act of 1964 and the Americans with Disabilities Act (ADA) of 1990

Title VI of the Civil Rights Act of 1964

Title VI of the Civil Rights Act of 1964 prohibits against national origin discrimination which protects individuals with limited English proficiency (LEP). It applies to all entities that receive federal financial assistance, either directly or indirectly (e.g., through a grant, cooperative agreement, contract/subcontract, Medicaid and Medicare payments, etc.). Virtually all healthcare providers must ensure that LEP patients have meaningful access to healthcare services at no cost to the patient. "Meaningful access" means that the LEP patient can communicate effectively.

In 2003, the U.S. Department of Health and Human Services (HHS) issued guidance to assist healthcare providers in complying with Title VI. The HHS points out that a thorough assessment of the language needs of the population served is to be conducted to develop appropriate and reasonable language assistance measures. The guidance details four factors specialists should consider when determining the extent and types of language assistance that may be pursued:

1. The number or proportion of LEP individuals eligible to be served or likely to be encountered.
2. The frequency with which LEP individuals come into contact with the provider.
3. The nature and importance of the program, activity or service provided by the provider to people's lives.
4. The resources available to the provider and costs.

A specialist must have an appropriate response for the LEP patients they serve, such as use of translated documents, bilingual office staff, use of a family member or an interpreter, when necessary. In the event a specialist is unable to arrange for **language translation services for non-English speaking or LEP CarePlus members**, he/she may contact our member services department at 1-800-794-5907, and a representative will assist in locating a qualified interpreter who communicates in the member's primary language via telephone while the member is in the office. To avoid having the member experience a delay during the scheduled appointment, it is recommended that this be coordinated with member services prior to the date of the visit.

For additional information regarding improving cultural competency when providing care, please refer to the section titled **Cultural Gaps in Care** within this manual.

Furthermore, Section 1557 of the Patient Protection and Affordable Care Act strengthened requirements for language resources providing that individuals cannot be denied access to health care or health care coverage or otherwise be subject to discrimination because of race, color, national origin, sex, age, or disability. Under a new requirement, covered entities are required to post information telling consumers

about their rights and telling consumers with disabilities and consumers with LEP about the right to receive communication assistance. To reduce burden and costs, the HHS Office for Civil Rights (OCR) has translated a sample notice and taglines for use by covered entities into 64 languages. For translated materials, visit www.hhs.gov/civil-rights/for-individuals/section-1557/translated-resources/index.html.

Additional Resources to Assist You in Serving LEP Patients

U.S. HHS – Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons:

www.hhs.gov/civil-rights/for-individuals/special-topics/limited-english-proficiency/guidance-federal-financial-assistance-recipients-title-VI/index.html

U.S. HHS Office of Minority Health – Cultural and Linguistic Competency:

www.minorityhealth.hhs.gov/omh/browse.aspx?lvl=1&lvlID=6

U.S. HHS Office of Civil Rights – Section 1557 of the Patient Protection and Affordable Care Act

www.hhs.gov/civil-rights/for-individuals/section-1557/index.html

U.S. HHS Office of Civil Rights – Section 1557: Frequently Asked Questions

www.hhs.gov/civil-rights/for-individuals/section-1557/1557faqs/index.html

The Americans with Disabilities Act of 1990

Under the ADA, physicians' offices are considered places of public accommodation. Specialists are required to comply with basic non-discrimination requirements that prohibit exclusion, segregation, and unequal treatment of any person with a disability. All specialist facilities must have in operation: (i) handicapped accessibility, including an accessible exam table and adequate space and supplies; (ii) good sanitation; (iii) fire safety procedures. To provide medical services in an accessible manner, specialists and their staff may need training in operating accessible equipment, helping with transfers and positioning, and not discriminating against individuals with disabilities.

Specialists must furnish appropriate auxiliary aids and services where necessary to ensure effective communication. For deaf or hard-of-hearing patients, this may include written notes, readers, telecommunication devices or an interpreter. In situations where information is more complex, such as discussing medical history or providing complex instructions about medications, an interpreter should be present. If the information is simple and direct, such as prescribing an X-ray, the specialist may be able to communicate in writing. For the visually impaired, this may include providing materials in large print or Braille text. In addition, the ADA requires that service dogs be admitted to healthcare provider offices unless it would result in a fundamental alteration or jeopardize safe operation.

The cost of an auxiliary aid or service must be absorbed by the provider and cannot be charged to the member either directly or through CarePlus. Specialists are required to modify policies and procedures when necessary to serve a person with disability. However, the ADA does not require providers to make changes that would fundamentally alter the nature of their service. Specialists are responsible for making reasonable efforts to accommodate members with sensory impairments. Without these, the specialist

and staff might not understand the patient's symptoms and misdiagnose medical problems or prescribe inappropriate treatment.

Additional Resources Concerning ADA Requirements

U.S. Department of Justice – ADA home page: www.ada.gov.

Language Assistance and Interpretation Services

Providers of medical services are contractually and federally required to ensure “equality of opportunity for meaningful access” to healthcare services and activities. This includes during the doctor visits/appointments/follow-up ensuring that non-English/limited English and disabled members are provided effective communication of “vital information” that could create a consequence or an adverse risk to the patient/member (i.e., over-the-phone interpretation, video interpretation, in-person interpretation, including American Sign Language). Oral interpretation services must be provided, at no cost, in the language of the member, including American Sign Language.

There are more than 300 languages spoken in the United States. To ensure “equality of opportunity for meaningful access to healthcare services and activities” (Executive Order 13166, Section 504/508 of Rehabilitation Act and Title III of ADA, Section 1557 of Patient Protection and Affordable Care Act); providers need to ensure patients/members are not discriminated against by not providing effective communication.

When creating appointments with current and future members, providers must provide:

- Notification of availability of oral interpretation (over the phone, video or in-person) for non-English/limited-English appointments.
- Notification of availability of video or in-person sign language interpretation for hearing impaired members.

CyraCom, an over-the-phone and video-interpreter vendor, offers interpretation services in 200 languages and video interpretation in 24 languages (including American Sign Language) to meet providers contractual and federal requirements, please click the link below:

<https://start.cyacom.com/humana>

Deaf-interpreters has an in-person sign language service available across the United States to make it easy for providers to meet ADA requirements regarding hearing impaired patients.

www.deaf-interpreter.com

RESPONSIBILITIES OF THE FACILITY

1. Facility must have 24 hours, seven days a week coverage and regular hours of operation should be clearly defined and communicated to the members.
2. Facility agrees to provide services ethically and legally and provide all services in a culturally competent manner consistent with professionally recognized standards of care, accommodate those with disabilities, and not discriminate against anyone based on race, ethnicity, national origin, religion, sex, age, marital status, mental or physical disability or medical condition, sexual orientation, claims experience, medical history, evidence of insurability (including conditions arising out of acts of domestic violence), genetic information, or source of payment.
3. Facility shall participate in any system established by CarePlus to facilitate the sharing of records (subject to applicable confidentiality requirements in accordance with 42 CFR, Part 431, Subpart F, including a minor's consultation, examination and drugs for sexually transmitted infections in accordance with Section 384.30(2), FS).
4. Facility agrees to provide services in a culturally competent manner, e.g., removing all language barriers. Care and services should accommodate the special needs of ethnic, cultural, and social circumstances of the patient.
5. Facility agrees to refer and/or admit CarePlus members only to participating hospitals, skilled nursing facilities (SNFs), and other facilities except when participating hospitals, SNFs, and other facilities are not available in network or in an emergency.
6. Facility agrees to participate and cooperate with CarePlus in any reasonable internal and external quality assurance/quality improvement, utilization review, continuing education, and other similar programs established by CarePlus if it is customarily provided by facility.
7. Facility agrees to participate in, and cooperate with, CarePlus' grievance/appeal procedures when CarePlus notifies facility of any member grievances/appeals.
8. Facility agrees not to bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any resources against CarePlus member other than for copayments, or fees from non-covered services furnished on a fee-for-service basis. Non-covered services are services not covered by Medicare or services excluded in the member's Evidence of Coverage. Notification that a service is not a covered benefit must be provided to the member prior to the service and be consistent with CarePlus policy, in order for the member to be held financially responsible. CarePlus policy requires that the notification include the date and description of the service, an estimate of the cost to the member for such services, name and signature of the member agreeing in writing of receiving such services, name and signature of the provider, and be in at least 12-point font. Documentation of that pre-service notification must be included in the member's medical record and shall be provided to CarePlus or its designee upon request, and in a timely manner to substantiate member appeals.
9. All facilities must continue care in progress during and after the termination period.

10. Facility agrees to treat all member records and information confidentially, accurately, timely, and not release such information without the written consent of the member, except as indicted herein, or as needed for compliance with state and federal laws, including HIPAA regulations.
11. Facility agrees to have onsite written policies and procedures that are reviewed and updated annually, to include an evaluation for the availability of safer medical services and devices, as well as, changes in technology. Office policies and procedures should include, but not be limited to, the following:
 - Appointment scheduling and telephone guidelines
 - Recordkeeping and general documentation requirements
 - Medical records and confidentiality (e.g., HIPAA)
 - Medication administration (e.g., refill policies, controlled substances, etc.)
 - Infection control (e.g., blood-borne pathogens, housekeeping, sharps safety, hand hygiene, written exposure control plan)
 - Safety program
 - Hazard communications
 - Hazardous drugs plan
 - Fire safety
 - Emergency action plans and preparedness (e.g., fire, tornado and workplace violence)
12. Facility agrees to establish an appropriate mechanism to fulfill obligations under the Americans with Disabilities Act.
13. Facility agrees to support and cooperate with CarePlus' Quality Improvement Program to provide quality care in a cost-effective and reasonable manner if consistent with facility's operations.
14. Facility agrees to inform CarePlus if member objects to provision of any counseling, treatments, or referral services on religious grounds.
15. Facility agrees to treat all members with respect and dignity, to provide them with appropriate privacy and treat member disclosures and records confidentially giving the members the opportunity to approve or refuse their release.
16. Facility agrees to provide to the members complete information concerning their diagnosis, evaluation, treatment and prognosis and the use of the healthcare system. Facility will give the members the opportunity to participate in decisions involving their healthcare except when contraindicated for medical reasons.
17. When clinically indicated, facility agrees to contact CarePlus members as quickly as possible for follow-up regarding significant problems and/or abnormal laboratory or radiological findings.
18. When the need arises, patients will be transferred to another provider. Facility agrees to an adequate transfer of information when members are transferred to other healthcare providers with a completed signed release from the member.

19. Food snacks or services provided to patients should meet their clinical needs and should be prepared, stored, secured, and disposed of in compliance with local health department requirements.
20. Facility agrees to have a policy and procedure to ensure proper identification, handling, transport, treatment, and disposal of hazardous and contaminated materials and wastes to minimize sources and transmission of infection in the facility.
21. Facility agrees to establish procedures to obtain, identify, store, and transport laboratory specimens or biological products, when applicable.
22. Facility agrees to establish procedures to notify public health authorities of reportable or communicable conditions.
23. Facility agrees to maintain communication with the appropriate agencies such as local police, social services agencies, and poison control centers to provide high quality patient care.
24. Facility agrees that any notation in a patient's clinical record indicating diagnostic or therapeutic intervention as part of clinical research shall be clearly contrasted with entries regarding the provision of non-research related care.
25. Facility agrees to provide to plan a copy of any changes to the facility's charge master.
26. Facility agrees to notify plan within 24 hours after facility becomes aware of the admission and identification of the member as inpatient.
27. Facility agrees to cooperate with an independent quality improvement organization's activities pertaining to the provision of services for CarePlus members. The facility also agrees to respond expeditiously to CarePlus' request for medical records or any other documents to comply with regulatory requirements, and to provide any additional information when necessary to resolve/respond to a member's grievance or appeal.
28. Facility agrees to retain all agreements, books, documents, papers, and medical records related to the provision of services to plan members as required by state and federal laws.
29. Facility agrees to comply with applicable state and federal laws and regulations to include, but not limited to: federal criminal law, the False Claims Act (31 USC 3729 et. Seq.) and the anti-kickback statute (section 1128B(b) of the Act), Title VI of the Civil rights Act of 1964, the Age Discrimination Act of 1975, the Americans with Disabilities Act, and the Rehabilitation Act of 1973.
30. Facility agrees that in the event CarePlus denies payment of health service(s) rendered to CarePlus members determined not to be medically necessary, the facility will not bill, charge, seek payment or have any recourse against said member for such service(s), unless the member has been advised in advance that the service(s) is/are not medically necessary and has agreed in

writing to be financially responsible for those services pursuant to CarePlus policy (see No.7 for details).

Facility Responsibilities under Title VI of the Civil Rights Act of 1964 and the Americans with Disabilities Act (ADA) of 1990

Title VI of the Civil Rights Act of 1964

Title VI of the Civil Rights Act of 1964 prohibits against national origin discrimination, which protects individuals with limited English proficiency (LEP). It applies to all entities that receive Federal financial assistance, either directly or indirectly (e.g., through a grant, cooperative agreement, contract/subcontract, Medicaid and Medicare payments, etc.). Virtually all healthcare providers must ensure that LEP patients have meaningful access to healthcare services at no cost to the patient. “Meaningful access” means that the LEP patient can communicate effectively.

In 2003, the U.S. Department of Health and Human Services (HHS) issued guidance to assist healthcare providers in complying with Title VI. The DHHS points out that a thorough assessment of the language needs of the population served is to be conducted in order to develop appropriate and reasonable language assistance measures. The guidance details four factors providers should consider when determining the extent and types of language assistance that may be pursued:

5. The number or proportion of LEP individuals eligible to be served or likely to be encountered.
6. The frequency with which the LEP individuals come into contact with the provider.
7. The nature and importance of the program, activity, or service provided by the provider to people’s lives.
8. The resources available to the provider and costs.

A facility must have an appropriate response for the LEP patients they serve, such as, use of translated documents, bilingual office staff, and/or use of family members or an interpreter, when necessary. In the event a facility is unable to arrange for **language translation services for non-English speaking or LEP CarePlus members**, he/she may contact our member services department at 1-800-794-5907, and a representative will assist in locating a qualified interpreter via telephone who communicates in the member’s primary language while the member is in the office. To avoid having the member experience delayed during the scheduled appointment, it is recommended that this be coordinated with the member services department prior to the date of the visit.

For additional information regarding improving cultural competency when providing care, please refer to the section titled **Cultural Gaps in Care** within this manual.

Furthermore, **Section 1557 of the Patient Protection and Affordable Care Act** strengthened requirements for language resources providing that individuals cannot be denied access to health care or health care coverage or otherwise be subject to discrimination because of race, color, national origin, sex, age, or disability. Under a new requirement, covered entities are required to post information telling consumers about their rights and telling consumers with disabilities and consumers with LEP about the right to receive communication assistance. To reduce burden and costs, the HHS Office for Civil Rights (OCR) has translated a sample notice and taglines for use by covered entities into 64 languages. For translated materials, visit <https://hhs.gov/civil-rights/for-individuals/section-1557/translated-resources/index.html>.

Additional Resources to Assist You in Serving LEP Patients

U.S. HHS – Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons:

www.hhs.gov/civil-rights/for-individuals/special-topics/limited-english-proficiency/guidance-federal-financial-assistance-recipients-title-VI/index.html

U.S. HHS Office of Minority Health – Cultural and Linguistic Competency:

www.minorityhealth.hhs.gov/omh/browse.aspx?lvl=1&lvlID=6

U.S. HHS Office of Civil Rights – Section 1557 of the Patient Protection and Affordable Care Act

www.hhs.gov/civil-rights/for-individuals/section-1557/index.html

U.S. HHS Office of Civil Rights – Section 1557: Frequently Asked Questions

www.hhs.gov/civil-rights/for-individuals/section-1557/1557faqs/index.html

The Americans with Disabilities Act of 1990

Under the ADA, facilities are considered places of public accommodation. Providers of medical services are required to comply with basic non-discrimination requirements that prohibit exclusion, segregation, and unequal treatment of any person with a disability. All facilities must have in operation: (i) handicapped accessibility, including an accessible exam table and adequate space and supplies; (ii) good sanitation; (iii) fire safety procedures. To provide medical services in an accessible manner, facilities and their staff may need training in operating accessible equipment, helping with transfers and positioning, and not discriminating against individuals with disabilities.

Facilities must furnish appropriate auxiliary aids and services where necessary to ensure effective communication. For deaf or hard-of-hearing patients, this may include written notes, readers, and telecommunication devices or an interpreter. In situations where information is more complex, such as discussing medical history or providing complex instructions about medications an interpreter should be present. If the information is simple and direct, such as prescribing an X-ray, providers may be able to communicate in writing. For the visually impaired, this may include providing materials in large print or Braille text.

In addition, the ADA requires that service dogs be admitted to healthcare provider offices unless it would result in a fundamental alteration or jeopardize safe operation.

The cost of an auxiliary aid or service must be absorbed by the provider and cannot be charged to the member either directly or through CarePlus. Facilities are required to modify policies and procedures when necessary to serve a person with disability. However, the ADA does not require providers to make changes that would fundamentally alter the nature of their service. Facilities are responsible for making reasonable efforts to accommodate members with sensory impairments. Without these, facilities and their office staff might not understand the patient's symptoms and misdiagnose medical problems or prescribe inappropriate treatment.

Additional Resources Concerning ADA Requirements:

U.S. Department of Justice ADA home page: www.ada.gov.

Language Assistance and Interpretation Services

Providers of medical services are contractually and federally required to ensure “equality of opportunity for meaningful access” to healthcare services and activities. This includes ensuring that non-English/limited English and disabled members are provided effective communication of “vital information” during doctor visits/appointments/follow-ups to avoid consequences or adverse risk to the patient/member (i.e., over the phone interpretation, video interpretation, in-person interpretation (including American Sign Language)). Oral interpretation services must be provided, at no cost, in the language of the member (this includes American Sign Language).

More than 300 languages are spoken in the United States. To ensure “equality of opportunity for meaningful access to healthcare services and activities” (Executive Order 13166, Section 504/508 of Rehabilitation Act and Title III of ADA, Section 1557 of Patient Protection and Affordable Care Act) ; providers must ensure patients/members are not discriminated against by not receiving effective communication.

When creating appointments with current and future members), facilities must provide:

- Notification of availability of oral interpretation (over the phone, video or in-person) for non-English/limited English appointments.
- Notification of availability of video or in-person sign language interpretation for hearing impaired members.

Cyracom, an over-the-phone and video interpreter vendor, offers interpretation services in 200 languages and video interpretation in 24 languages, including American Sign Language, to meet providers’ contractual and federal requirements. Please click the link below:

<https://start.cyracom.com/humana>

Deaf Interpreters Service has an in-person sign language service available across the United States to make it easy for providers to meet ADA requirements regarding hearing impaired patients.

www.deaf-interpreter.com

PHYSICIAN EXTENDERS

All physician extenders are required to provide care under the direct supervision of a physician, which means that a physician must always be present on the premises when the physician extender is seeing patients. When utilizing a physician extender (for example, a physician assistant [PA]), the patient must be notified of their credentials and the possibility of not being seen by a medical doctor. Notwithstanding the foregoing, a patient's request to be seen by a physician, rather than a physician extender, should always be honored. All progress notes made by the physician extenders must be signed by a physician. Physician extenders will provide services as defined by protocol developed and signed off by the sponsoring physician. All signatures must include identification of professional title (e.g., M.D., D.O., APRN, PA, DC, OD, etc.).

CarePlus does not contract directly with physician extenders, nor are they included in the provider directory.

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ENCOUNTER PROCESS

Prior to providing care to CarePlus members, providers must verify eligibility by requesting a CarePlus membership card or calling the provider services queue listed below to confirm. **All co-payments should be collected according to the member's EOC or per the information provided when checking eligibility.**

What is an encounter?

- An encounter is a unique type of claim.
- Encounter data is used to determine a member's health status.
- Encounter data is submitted by CarePlus' provider groups.

What is the difference between a claim and an encounter?

- Encounter data contains the same provider, member, service, and diagnosis information that a claim does.
- A claim generates a payment or a denial; an encounter does not.
- Encounters are the responsibility of the provider under the capitation agreement.

Why is an encounter so critical?

- Encounters are used for Healthcare Effectiveness Data and Information Set (HEDIS) reporting and are primary drivers for risk-adjustment scoring.
- Encounters must contain **all diagnosis codes** for which a member was treated and/or monitored during his or her visit.
- Encounters enable accurate and complete reporting of risk-adjustment data to CMS for reimbursement.

Upon request by CarePlus, CMS or any other governmental agency, providers shall certify the accuracy, completeness and truthfulness of encounter data submitted.

All encounters must be recorded and submitted to CarePlus within 30 days of the date of service or sooner. Electronic format is preferred and should be submitted on a HIPAA-accepted 837P file format and filed electronically in **Availity** ([Availity.com](https://www.availity.com)) using the **CarePlus Payer ID No. 95092**.

If you are not submitting encounters electronically and would like to, please contact your assigned provider services executive or the provider services queue at 1-866-313-7587, Monday – Friday, 8 a.m. – 5 p.m., Eastern time.

Paper encounters should be submitted on CMS-1500 forms and sent to the following address:

CarePlus Health Plans Inc.
P.O. Box 14697
Lexington, KY, 40512-4697

SUMMARY OF THE FLORIDA PATIENT'S BILL OF RIGHTS AND RESPONSIBILITIES

NOTE: All providers are required to post this summary in their offices.

Florida Law requires that your health care provider or health care facility recognize your rights while you are receiving medical care and that you respect the health care provider's or health care facility's right to expect certain behavior on the part of patients. You may request a copy of the full text of this law from your health care provider or health care facility. A summary of your rights and responsibilities follows:

- A patient has the right to be treated with courtesy and respect, with appreciation of his or her individual dignity, and with protection of his or her need for privacy.
- A patient has the right to a prompt and reasonable response to questions and requests.
- A patient has the right to know who is providing medical services and who is responsible for his or her care.
- A patient has the right to know what patient support services are available, including whether an interpreter is available if he or she does not speak English.
- A patient has the right to bring any person of his or her choosing to the patient-accessible areas of the healthcare facility or provider's office to accompany the patient while the patient is receiving inpatient or outpatient treatment or is consulting with his or her healthcare provider, unless doing so would risk the safety or health of the patient, other patients, or staff of the facility, or office or cannot be reasonably accommodated by the facility or provider.
- A patient has the right to know what rules and regulations apply to his or her conduct.
- A patient has the right to be given by the healthcare provider information concerning diagnosis, planned course of treatment, alternatives, risks, and prognosis.
- A patient has the right to refuse any treatment, except as otherwise provided by law.
- A patient has the right to be given, upon request, full information and necessary counseling on the availability of known financial resources for his or her care.
- A patient who is eligible for Medicare has the right to know, upon request and in advance of treatment, whether the healthcare provider or healthcare facility accepts the Medicare assignment rate.
- A patient has the right to receive, upon request, prior to treatment, a reasonable estimate of charges for medical care.
- A patient has the right to receive a copy of a reasonably clear and understandable itemized bill and, upon request, to have the charges explained.
- A patient has the right to impartial access to medical treatment or accommodations, regardless of race, national origin, religion, handicap, or source of payment.
- A patient has the right to treatment for any emergency medical condition that will deteriorate from failure to provide treatment.
- A patient has the right to know if medical treatment is for purposes of experimental research and to give his or her consent or refusal to participate in such experimental research.
- A patient has the right to express grievances regarding any violation of his or her rights, as stated in Florida law, through the grievance procedure of the healthcare provider or healthcare facility which served him or her and to the appropriate state licensing agency.

- A patient is responsible for providing to the healthcare provider, to the best of his or her knowledge, accurate and complete information about present complaints, past illnesses, hospitalizations, medications, and other matters relating to his or her health.
- A patient is responsible for reporting unexpected changes in his or her condition to the healthcare provider.
- A patient is responsible for reporting to the healthcare provider whether he or she comprehends a contemplated course of action and what is expected of him or her.
- A patient is responsible for following the treatment plan recommended by the healthcare provider.
- A patient is responsible for keeping appointments, and when he or she is unable to do so for any reason, for notifying the healthcare provider or healthcare facility.
- A patient is responsible for his or her actions if he or she refuses treatment or does not follow the healthcare provider's instructions.
- A patient is responsible for assuring that the financial obligations of his or her healthcare are fulfilled as promptly as possible.
- A patient is responsible for following healthcare facility rules and regulations affecting patient care and conduct.

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PLAN MEMBERSHIP AND ELIGIBILITY INFORMATION

CarePlus operations focus on service to members and quality of care. It is essential to comply with policies and procedures to ensure complete member satisfaction and the successful delivery of services. This section of the manual explains the responsibility of the affiliated provider pertaining to enrollment, member identification card, eligibility, transfers and disenrollment.

MEMBER ELIGIBILITY

Medicare beneficiaries are eligible to enroll in an HMO if they are entitled to Medicare Part A and enrolled in Part B (Prior to Dec. 31, 1998, beneficiaries enrolled in Part B-only were eligible to enroll in HMOs).

CarePlus eligibility verification does not guarantee payment. If CarePlus subsequently learns that the member was ineligible on the date of verification, no payment will be made. Therefore, it is important that physicians/providers always ask the patient for his/her most recent insurance status.

MY CAREPLUS MEMBER PORTAL

CarePlus members can access information via “MyCarePlus,” a secure online member portal. Members can register for MyCarePlus at CarePlusHealthPlans.com, or go directly to CarePlus.HealthTrioConnect.com/app/index.page. After creating a member portal account and logging into it, members can access their health benefits and coverage information, plan forms, and other valuable resources instantly. MyCarePlus will continue to evolve, based on member feedback and requests.



INELIGIBLE FOR CAREPLUS MEMBERSHIP

The following categories of individuals are ineligible for membership:

- Individuals enrolled in a prescription drug plan (PDP) cannot be simultaneously enrolled in an MAPD plan
- Individuals residing outside of CarePlus’ service areas
- Individuals who do not agree to abide by the rules of the plan
- Individuals not enrolled with both Medicare Part A and Part B
- Individuals who are not legal United States residents

ASSIGNMENT OF PRIMARY CARE PHYSICIAN

Each member selects a PCP upon enrollment. The PCP functions as a “gatekeeper” arranging for all of the member’s healthcare needs for primary, specialty and ancillary services by promoting quality and continuity of care.

ENROLLMENT OPTIONS AND PERIODS

Enrollment Options

- Enroll in a MA plan with or without prescription drug coverage

There are six types of election periods during which individuals may make enrollment changes for MA plans:

- The Annual Election Period (AEP)
- The Initial Coverage Election Period (ICEP)
- Initial Enrollment Period for Part D (IEP for Part D). Allows enrollment requests for MA-PD plans only.
- The Open Enrollment Period for Institutionalized Individuals (OEPI)
- All Special Election Periods (SEP)
- The Medicare Advantage Open Enrollment Period (MA OEP)

Patients who are new to Medicare have an Initial Coverage Election Period (ICEP) that is similar to the Initial Enrollment Period for Part B. This period begins three months immediately before the individual's first entitlement to both Medicare Part A and Part B and ends on the later of:

- 1) The last day of the month preceding entitlement to both Part A and Part B, or
- 2) The last day of the individual's Part B initial enrollment period.

Once an ICEP enrollment request is made and enrollment takes effect, the ICEP election has been used.

The AEP is from Oct. 15 through Dec. 7 of every year. During the AEP, MA eligible individuals may enroll in or disenroll from an MA plan. All plan changes take effect Jan. 1 of the following year, unless otherwise indicated on the enrollment application.

The MA OEP is Jan. 1 through March 31 of every year for individuals enrolled in an MA plan as of Jan. 1. During the MA OEP, MA plan enrollees may switch to a different MA plan (with or without Medicare prescription drug coverage) or return to Original Medicare (with or without Medicare prescription drug coverage). For new Medicare beneficiaries enrolled in an MA plan during their ICEP, the MA OEP is from the month of entitlement to Part A and Part B through the last day of the third month of entitlement.

Special Election Periods (SEPs)

Special election periods (SEPs) constitute periods outside of the usual ICEP, AEP or MA OEP when an individual may elect a plan or change his or her current plan election. Below is a listing of the various types of SEPs a member may be eligible for:

- Changes in residence
- Contract violation
- Non-renewals or terminations
- SEPs for exceptional conditions

- Employer/union group health plan
- Individuals who disenroll in connection with a CMS sanction
- Individuals enrolled in cost plans that are non-renewing their contracts
- Individuals in the Program of All-inclusive Care for the Elderly (PACE)
- Dual-eligible individuals and other Low Income Subsidy (LIS) eligible individuals
- Individuals who terminated a Medigap policy when they enrolled for the first time in an MA plan, and who are still in a “trial period”
- Individuals whose Medicare entitlement determination is made retroactively
- MA SEPs to coordinate with Part D enrollment periods
- Individuals who lose special needs status
- Individuals who gain, lose, or have a change in their dual or LIS-eligible status
- Enrollment into a Chronic Care Special Needs Plan (SNP) and for individuals found ineligible for a Chronic Care SNP
- Disenrollment from Part D to enroll in or maintain other creditable coverage
- Non-U.S. citizens who become lawfully present
- Providing individuals who requested materials in accessible formats equal time to make enrollment decisions
- Government entity-declared disaster or other emergency
- Individuals enrolled in a plan placed in receivership
- Individuals enrolled in a plan that has been identified by CMS as a Consistent Poor Performer
- Other exceptional circumstances
- Significant change in provider network

Note: Without evidence of other creditable coverage, individuals who become eligible for Medicare and choose not to enroll in a prescription drug plan at that time will likely pay a penalty if they choose to enroll later. This is known as a late enrollment penalty.

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PHYSICIAN OFFICE/FACILITY PROCEDURES AND RESPONSIBILITIES

PCP ACTIVE MEMBER LIST

Each PCP office will receive an active-member list by the end of the first week of each month. The list consists of those CarePlus members who have chosen or have been assigned to the PCP office. Please verify that all CarePlus members receiving treatment in your office are on your membership listing. If you do not receive your list by the date described above, please contact your assigned provider services executive. If there are questions regarding a patient's eligibility, please call CarePlus' provider services queue at 1-866-313-7587.

IDENTIFYING/VERIFYING CAREPLUS MEMBERS

Upon receipt of an enrollment application, CarePlus sends members a member identification (ID) card and a Verification of Enrollment letter. Once CMS accepts the enrollment, CarePlus then sends members the Notice to Acknowledge Receipt of Completed Enrollment Request and to Confirm Enrollment letter with an Evidence of Coverage (EOC) document. The EOC educates members about:

- How to schedule an appointment with his/her PCP
- What to do in case of an emergency
- How to contact his/her PCP during and after business hours
- How to access out-of-area services

Each CarePlus member is identified by a CarePlus member ID number, which indicates assignment to a specific PCP and copayment guidelines. All CarePlus members are sent an ID card that must be presented at each visit. When membership eligibility cannot be determined, you can verify eligibility online via Availity ([Availity.com](https://www.availity.com)) or *PWS (*sunsetting July 2024) at CarePlus-HP.com/PWS.htm ; or call the provider services queue for eligibility verification at 1-866-313-7587, Monday – Friday, 8 a.m. – 5 p.m., Eastern time.

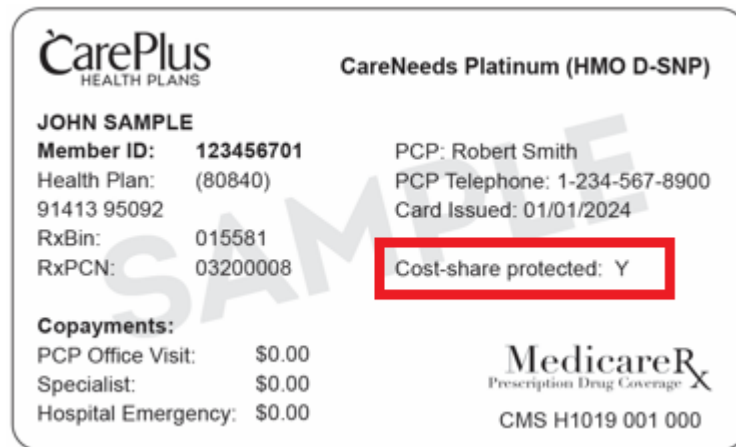
Please note that possession of a member ID card does not constitute eligibility for coverage. Therefore, it is important that physicians/providers verify a member's eligibility each time the member presents at the office for services. If a CarePlus member is unable to present his/her membership card, please call the provider services queue to determine eligibility. Members cannot be denied medical services.

Verifying eligibility does not guarantee that the member is, in fact, eligible at the time the services are rendered or that payment will be issued. Payments will be made for the specific covered services provided to eligible CarePlus members after satisfaction of applicable premiums and cost-shares.

IDENTIFYING/VERIFYING CAREPLUS MEMBERS' MEDICAID ELIGIBILITY

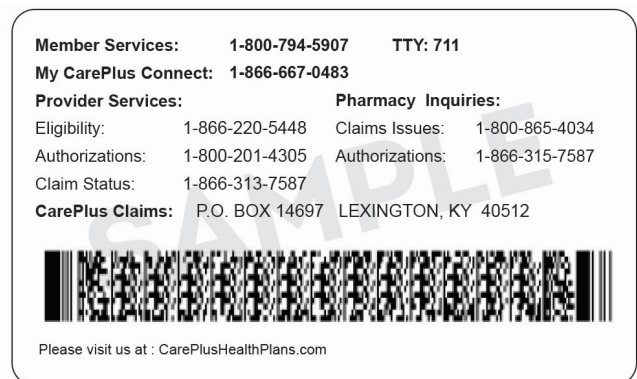
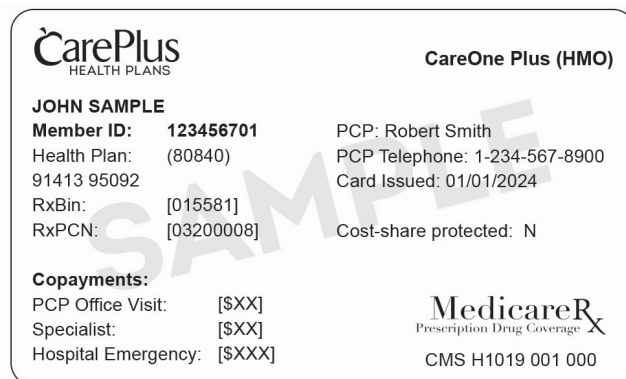
The state of Florida recognizes QMB, QMB+, SLMB+ and FBDEs as cost-share protected individuals. Providers must not bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against any of these individuals. Providers may verify a member's Medicaid eligibility using Availity ([Availity.com](https://www.availity.com)) or *PWS (*sunsetting July 2024) ([CarePlus-](https://CarePlus-HP.com/PWS.htm)

HP.com/PWS.htm). In addition, a cost-share protected indicator can be found on a member's ID card (example follows).



For additional information regarding the QMB program and billing practices as it relates to cost-share protected individuals, please refer to the following CMS Medicare Learning Network (MLN) Matters® article: www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1128.pdf

Sample Member Identification (ID) Card (enlarged for better visibility)



APPOINTMENT SCHEDULING CRITERIA

To ensure accessibility and availability of health services to CarePlus members, providers must adhere to the following standards set forth by CMS:

- Urgently needed services or emergency – immediately
- Services that are not an emergency or urgently needed, but in need of attention – within one (1) week
- Routine and preventive care – within 30 days

In addition, providers must maintain hours that are convenient to, and do not discriminate against, members.

AFTER HOURS ACCESS

Providers must ensure that, when medically necessary, services are available 24 hours a day, seven days a week.

- Availability of 24-hour answering service
- Answering system with option to page the physician
- On-call schedule. Physicians will provide advice and assess care as appropriate for each patient's medical condition. Life-threatening conditions will be referred to the nearest emergency room.

In addition, CarePlus recommends the following standards for all physicians:

- Respond to urgent calls within 15 minutes; respond to routine calls within 24 hours.
- After hours, respond to urgent calls within 15 minutes; respond to non-urgent calls in 30 minutes.
- The average wait time should not exceed 60 minutes from the scheduled appointment time. This includes time spent both in the waiting and examination room prior to being seen by the physician. In the case of an unexpected emergency, the member should be promptly notified and given the option of waiting or rescheduling.

CarePlus may monitor compliance with the above-mentioned access standards through a variety of methods, including, but not limited to, site visits, telephone audits, member surveys, and complaints. By monitoring compliance using the aforementioned methods, CarePlus can take action to improve member service availability and access to medical services when necessary.

MISSED APPOINTMENTS

Providers must follow up with members who have missed appointments. If the member does not go to a previously scheduled appointment without prior cancellation, provider must document within the member's medical record. Providers may charge a fee for missed appointments, provided such fee is applied uniformly for all Medicare and non-Medicare patients. However, providers may not require members to create a fund or "escrow account" to ensure payment of missed appointment fees. This violates CMS' anti-discrimination regulations and creates a barrier for members in accessing care.

Note: Providers may not charge a fee for missed appointments to cost-share protected dual eligible members including QMB, QMB+, SLMB+ and FBDE.

OPEN/CLOSED PCP PANELS

A PCP may close his/her panel to new and/or transferring CarePlus members with at least 45 days prior written notice to the provider operations department. The closing of a PCP's practice to new members must be applicable to all third-party payers with whom the PCP contracts. Signed attestations regarding the size and adequacy of the physician panel may be required. An asterisk (*) indicating a closed panel will be placed beside a PCP's name in hard copies of the Provider Directory and the phrase "Not accepting new patients" will be placed beside a PCP's name within the online physician finder tool. A PCP

must provide verbal or written notification to the plan if the PCP wishes to accept a new member into a closed panel or would like to reopen his/her panel to new members.

Written requests for opening and closing a panel should be submitted on the PCP's letterhead to the following:

Via direct mail

CarePlus Health Plans, Inc.
Attention: Provider Operations department
PO Box 277810
Miramar, FL 33027

By fax

1-866-449-5668

ADDRESS CHANGE OR OTHER PRACTICE INFORMATION

For CarePlus to maintain accurate provider directories, all changes to address or practice information should be submitted to CarePlus as soon as possible. Notices of any changes must adhere to time frames outlined in the participation agreement. Changes that require notice to CarePlus include, but are not limited to, the following:

- Provider information (e.g., practice name, legal entity, etc.)
- Tax Identification Number
- Address
- Phone number
- Adding a physician – physician joining practice/group. (Please note that the new physician must be credentialed prior to rendering treatment to any CarePlus member)
- Provider deletions – provider no longer participating with the practice/group.

If you have changes to your practice information, please provide CarePlus with the updated information immediately using one of the following options:

- Contact your assigned provider services executive.
- Fax the information to 1-866-449-5668.
- Call the CarePlus Provider Operations inquiry line at 1-866-220-5448, Monday – Friday, 8 a.m. – 5 p.m., Eastern time.

When submitting updates, please provide your contact information should questions about the correspondence arise.

Note: If your practice is managed by a health system, independent physician association (IPA) or other practice association, please report changes to the administrative office of that organization, which will then update your information with CarePlus. Changes to the practice name, legal entity or Tax ID Number(s) may require an amendment, assignment, or new agreement, depending on the reason for the change. Please check with your assigned provider services executive if you have questions.

MEDICAL RECORDS

Well-documented medical records are fundamental to maintaining and enhancing coordination and continuity of care, facilitating communication and promoting quality care. CarePlus requires all participating providers to maintain individual, appropriate, accurate, complete, and timely medical records for all CarePlus members receiving medical services. Medical records must be in a format required by Medicare laws, regulations, reporting requirements, CMS and CarePlus instructions and maintained for a minimum of 11 years. Medical records **must be available** for utilization, risk management, peer review, studies, customer service inquiries, grievance and appeals processing, validation of risk adjustment data, and other initiatives CarePlus may be required to conduct. To comply with accreditation and regulatory requirements, periodically CarePlus may perform a medical record documentation audit of some provider medical records. Please refer to section **Medical Record Documentation Standards** for additional details pertaining to medical record documentation.

To be compliant with HIPAA, providers should make reasonable efforts to restrict access and limit routine disclosure of protected health information (PHI) to the minimum necessary to accomplish the intended purpose of the disclosure of member information.

Providers also are expected to establish office policies that are consistent with the following:

- Maintain a system for the collection, processing, maintenance, storage, retrieval, and distribution of members' medical records. Designate a person in the office to be responsible for the system. That person is responsible for the overall maintenance of the provider's medical records and specifically for:
 - Maintaining confidentiality, security, and physical safety of the records
 - The timely retrieval of individual records upon request
 - The unique identification of each member's record
 - The supervision of the collection, processing, maintenance, storage, and appropriate access to (e.g., retrieval) and usage of records (e.g., distribution)
 - The maintenance of a predetermined, organized and secured record format
 - The release of information contained in records in compliance with state and federal requirements governing the release of medical information
- Policies that address retention of active records, inactive records and timely entry of data in records
- Ensure medical records are filed away from public access

If a member changes his/her PCP for any reason, providers must transfer the member's medical records to the member's new PCP at the request of CarePlus or the member. Providers who terminate their CarePlus agreements are responsible for transferring members' medical records.

ADVANCE DIRECTIVES

CarePlus acknowledges a member's right to make an advance directive. Advance directives are written instructions, such as living wills or durable power of attorney for healthcare, recognized under state law

and signed by a member, that explain the member's wishes concerning the provisions of healthcare should the member become incapacitated and is unable to make those wishes known.

Providers are expected to advise all CarePlus members regarding his or her future healthcare needs and available options. Providers may give advance directive information to the member's family or surrogate should the member be incapacitated at the time of enrollment.

Providers should:

- On the first visit, as well as during routine office visits when appropriate, discuss the member's wishes regarding advance directives for care and treatment.
- If asked, provide the member with information about advance directives.
- Document in a prominent part of the member's current medical records whether the individual has executed or refused an advance directive.
- Do not discriminate against the member based on whether he or she has executed an advance directive.

CarePlus is pleased to have available printed versions of **Five Wishes®** booklets with permission from *Aging with Dignity*. This document was designed by the Commission on Aging with Dignity and it meets Florida legal requirements for advance directives. Five Wishes is easy to understand and will allow your patients to express how they want to be treated if they are seriously ill and unable to speak for themselves. If you would like to receive hard copies of this document, please contact your assigned provider services executive or call the Provider Operations inquiry line at 1-866-220-5448, Monday – Friday, 8 a.m. – 5 p.m., Eastern time.

Advance directive forms also are available at the National Hospice and Palliative Care Organization' (NHPCO) Caring Connections website: www.caringinfo.org/planning/advance-directives/by-state/florida/.

EMERGENCY AND DISASTER PREPAREDNESS PLAN

Providers are expected to have a comprehensive, written emergency and disaster preparedness plan to address internal and external emergencies, including participating in community health emergency or disaster preparedness, when applicable. The written plan must include a provision for the safe evacuation of individuals during an emergency, especially individuals who may be unable to self-evacuate. For your convenience, we have included a sample of an emergency evacuation plan at the end of this manual.

In the event a disaster or other crisis requires evacuation from your geographic area and/or relocation of your provider office(s), you must complete the Provider Crisis Contact/Location Information Form located in the **Forms** section of this manual. This form also is available on the CarePlus website at CarePlusHealthPlans.com/CarePlus-Providers/Updates under **Provider Crisis Contact/Location Information**. This form is needed so that the CarePlus Member Services department will have the most current information to provide to our members who may call for assistance in locating their providers during emergency situations. The Provider Crisis Contact/Location Information form may be submitted to CarePlus' Provider Operations department in any of the following ways:

Mail	Fax	Provider Services Executive
CarePlus Health Plans, Inc. Attention: Provider Operations Dept. PO Box 277810 Miramar, FL 33027	1-866-449-5668	Please scan the form and email it directly to your assigned provider services executive

In addition, you may call CarePlus' Provider Emergency Hotline at 1-877-210-5318. The hotline gives our provider community instructions and information regarding CarePlus and its members in the event that CarePlus is forced to close as a result of natural disaster.

INFECTION CONTROL, PREVENTION AND SAFETY

Today, the bulk of healthcare is delivered in physician practice settings. Practices of all sizes are expected to have in place the policies and tools necessary to ensure their sites are operated in a safe, sanitary, and secure manner. Your office must be in compliance with federal and state regulations concerning infection control (e.g., prevention, control, identification, reporting), exposure to blood-borne pathogens, and the use of universal precautions. It is strongly recommended that you implement measures and processes in accordance with nationally recognized standards and organizations.

• INFECTION CONTROL AND PREVENTION IN THE PHYSICIAN'S OFFICE

Wherever patient care is provided, application and adherence to infection control and prevention guidelines are needed to ensure that all care is safe and provided in a functional and sanitary environment. With each encounter (e.g., patient-to-patient, patient-to-physician, or patient-to-staff member) there is an opportunity for infection or transmission prevention. It is your responsibility to minimize the risk of acquiring an infection in your office setting.

All contracted providers are expected to have written policies for infection control and prevention that are readily available, updated annually and enforced. All patients and personnel should be educated regarding the various modes infections may be transmitted (e.g., directly or indirectly) and the techniques that can prevent or minimize the risk of transmission. The Centers for Disease Control and Prevention (CDC) provide standards and guidelines that are appropriate for most patient encounters. Furthermore, the Occupational Safety and Health Administration (OSHA) requires physicians as employers to have processes in place to reduce the risk of their employees from being exposed to blood-borne pathogens or other potentially infectious materials.

Key principles of infection control include, but are not limited to:

- Hand hygiene consistent with nationally recognized guidelines (i.e., WHO, CDC, etc.)
- Written blood-borne pathogen exposure control plan
- Personal protective equipment (PPE) such as gloves, eyewear, facial masks, or gowns
- Immunization of personnel (e.g., hepatitis B, tuberculosis, etc.)
- Monitoring of employee illnesses
- Safe handling and disposal of needles and sharp containers

- General housekeeping policies – cleaning, disinfection, antisepsis, and sterilization of medical equipment and patient areas (e.g., examination rooms should be cleaned before and after each patient and, along with patient waiting areas, should be thoroughly cleaned at the end of each day)
- Appropriate hazardous waste disposal policies
- Isolation or immediate transfer of individuals (patients and staff members) with an infectious or communicable disease
- Processes to communicate with local and state health authorities (e.g., reporting of communicable or infectious diseases)
- Processes that address the recall of items including drugs and vaccines, blood and blood products, and medical devices or equipment
- Recordkeeping
- Employee orientation and annual staff training regarding office procedures, plans and programs (e.g., OSHA, infection control/prevention, sharps injury prevention, blood-borne pathogens)

Below are resources to assist you or your staff in locating guidelines or best practices to reduce the day-to-day risks of transmission in your office setting. Please note that additional resources are available on the CarePlus website at CarePlusHealthPlans.com/CarePlus-Providers/Updates.

Regulatory Agency	Web Link to Guideline/Best Practice
CDC	Healthcare-associated Infections (HAIs) Guidelines, www.cdc.gov/infectioncontrol/guidelines/index.html
CDC	Guideline for Infection Control in Healthcare Personnel, www.cdc.gov/infectioncontrol/guidelines/healthcare-personnel/index.html
CDC	Healthcare-associated Infections (HAIs) Guide to Infection Prevention for Outpatient Settings – Minimum Expectations for Safe Care, www.cdc.gov/HAI/settings/outpatient/outpatient-care-guidelines.html
CDC	2007 Guidelines for Isolation Precautions: Preventing Transmissions of Infectious Agents in Healthcare Settings, www.cdc.gov/hicpac/pdf/isolation/Isolation2007.pdf
CDC	Hand Hygiene in Healthcare Settings, www.cdc.gov/handhygiene
CDC	Injection Safety, www.cdc.gov/injectionsafety
OSHA	Medical and Dental Offices – A Guide to Compliance with OSHA Standards, www.osha.gov/sites/default/files/publications/osha3187.pdf
OSHA	Safety and Health Topics: Healthcare, www.osha.gov/SLTC/healthcarefacilities/index.html
OSHA	Safety and Health Topics: Healthcare – Standards/Enforcement, www.osha.gov/healthcare/standards
OSHA	Safety and Health Topics: Healthcare – Other Hazards, www.osha.gov/healthcare/hazards/

OSHA	Safety and Health Topics: Blood-borne Pathogens and Needlestick Prevention Standards, www.osha.gov/SLTC/bloodbornepathogens/index.html
OSHA Publication	Model Plans and Programs for the OSHA Blood-borne Pathogens and Hazard Communications Standards (OSHA 3186-06R 2033), www.osha.gov/Publications/osha3186.pdf
CDC	Guideline for Disinfection and Sterilization in Healthcare Facilities, www.cdc.gov/infectioncontrol/guidelines/disinfection/index.html
U.S. Food and Drug Administration (FDA)	Guidance for Industry and FDA Staff - Medical Device User Fee and Modernization Act of 2002, Validation Data in Premarket Notification Submissions (510(k)s) for Reprocessed Single-Use Medical Devices, www.fda.gov/regulatory-information/search-fda-guidance-documents/medical-device-user-fee-and-modernization-act-2002-validation-data-premarket-notification

- SAFETY

A comprehensive safety program should be established to address the office's environment of care and the safety of all your patients. The elements of the safety program should include, but not be limited to, the following:

- Processes for the management of identified hazards, potential threats, near misses, and other safety concerns
- Processes for reporting known adverse incidents to appropriate local, state, and/or federal agencies when required by law to do so
- Unique patient identifiers used throughout care
- Processes to reduce and avoid medication errors. Examples of such are:
 - Write legible prescriptions which include dosage and indication.
 - Utilize an electronic prescribing system and submit electronic requests directly to pharmacies.
 - Encourage and educate members to be actively involved in their healthcare and serve as safety checkers. Members should review their medications prior to taking them and when picking up medications from pharmacies.
- Policies addressing manufacturer or regulatory agency recalls related to medications, medical equipment and supplies and which include: (i) sources of recall information (e.g., FDA, CDC); (ii) methods to notify staff that need to know; (iii) methods to determine if a recalled product is present at the office or has been given or administered to a member; (iv) documentation of response to recalled products; (v) disposition or return of recalled items (including samples) and (vi) member notification*, as appropriate.

***Note:** When notified of a drug recall, CarePlus uses pharmacy claims data to identify members who have received the recalled medication. CarePlus provides prompt notification to the impacted members and their prescribing physicians.

- Policies regarding food and drink, if made available

- Establish a process to ensure that all tests ordered are received and prompt member notification occurs to advise of the results
- Environmental hazards associated with safety are identified (i.e., fall prevention, physical safety, ergonomic exposures, violence in the workplace and external physical threats) and safe practices are established

It is important always to remember that safety policies and procedures help achieve a safer work environment and improve the quality and effectiveness of the care you provide to your patients.

SITE VISITS – FACILITIES AND ENVIRONMENT

CarePlus conducts site visits to assess the office environment as it relates to physical accessibility, physical appearance, adequacy of patient care areas and medical equipment, medical record policies, and practice management. A site visit may be conducted upon initial credentialing and on other occasions as determined by CarePlus (e.g., quality review).

CarePlus' site visit standards are based on state and federal guidelines and accreditation standards established by the Accreditation Association for Ambulatory Health Care, Inc. (AAAHC).

The standards reviewed during site visits include, but may not be limited to, the following:

A. Accessibility/Physical Appearance

1. Site is operated in a safe and secure manner.
2. Reception areas, toilets, and telephones are provided in accordance with patient/visitor volume.
3. There is adequately marked patient/visitor parking, when appropriate.
4. Examination rooms, dressing rooms, and reception areas are constructed and maintained in a manner that ensures patient privacy.
5. Provisions are made to reasonably accommodate disabled individuals.
6. Adequate lighting and ventilation are provided in all areas.
7. Office/facility is clean and properly maintained.
8. Space allocated for a particular function or service is adequate for the activities performed there.
9. Smoking is prohibited in the office/facility.
10. Office/facility must be in compliance with applicable state and local building codes and regulations, state and local fire prevention regulations, and applicable federal regulations. Site must receive periodic inspection by local or state fire control agency if this service is available in the community.

Note: In the event an office/facility undergoes demolition, construction, or renovation projects, providers are expected to conduct a proactive and ongoing risk assessment for existing or potential environmental hazards.

B. Medical Records and Confidentiality

1. Medical recordkeeping (e.g., unique identification of each member's records, timely retrieval of requested medical records, secured and filed away from public access)
2. Documentation in medical records, including advance directives
3. Policies addressing retention, maintenance, storage, retrieval, and distribution of medical records

C. Fire Safety

1. Appropriately maintained and placed firefighting equipment to control a limited fire for each potential type of fire (e.g., ABC fire extinguisher)
2. Prominently displayed illuminated signs with emergency power capability at all exits, including exits from each floor or hall
3. Emergency lighting, as appropriate, to provide adequate illumination for evacuation of patients and staff in case of an emergency
4. Testing of fire alarm and inspection of fire suppression systems, if applicable
5. Stairwells are protected by fire doors, if applicable

D. Emergency and Disaster Preparedness

1. Necessary personnel, equipment, and procedures to deliver safe care, and to handle medical and other emergencies that may arise
2. Documented periodic instruction of all personnel in the proper use of safety, emergency, and fire-extinguishing equipment
3. At least one drill a year of the internal emergency and disaster preparedness plan as appropriate to the office/facility. A written evaluation of the drill must be completed to promptly implement any needed corrections or modifications to the plan.
4. Personnel trained in CPR and the use of cardiac and all other emergency equipment in the office/facility to provide patient care during hours of operation
5. Alternate power, adequate for the protection of the life and safety of patients and staff, available in all patient care areas
6. Appropriate emergency equipment and supplies are maintained and readily accessible to all areas of patient care

E. Safety

1. Hazards that might lead to slipping, falling, electrical shock, burns, poisoning, or other trauma are eliminated
2. Food services and refreshments provided to patients meet their clinical needs and are prepared, stored, served, and disposed of in compliance with local, state, and federal health department requirements, if applicable.
3. A system for the proper identification, management, storage, handling, transport, treatment, and disposal of hazardous materials and wastes, whether solid, liquid, or gas. The system includes, but is not limited to: (i) infectious, radioactive, chemical, and

- physical hazards; and (ii) provides for the protection of patients, staff and the environment.
4. Policies and procedures regarding medical equipment include its standardized use and documented evidence of periodic testing and scheduled preventive maintenance according to manufacturer's specifications
 5. Ongoing monitoring of expiration dates for medications (including samples)
 6. Ongoing temperature monitoring of refrigerated medications (including samples)
 7. Medications (including samples) are stored in a secured location

MEMBER-INITIATED PCP TRANSFER

To maintain continuity of care, CarePlus encourages its members to remain with their PCP. However, a member or power of attorney/guardian may request to change the PCP by contacting CarePlus' Member Services department or submitting a written request.

- Change requests received by the 21st day of the month usually are effective the first day of the following month.
- The PCP office must send his/her medical records to the newly selected PCP office.

PHYSICIAN-INITIATED MEMBER TRANSFER

As part of his or her provider agreement with CarePlus, a PCP agrees to provide primary care services to all assigned CarePlus members, as long as the practice is open to new patients, in an ethical and legal manner, in accordance with professional standards of care in the medical community. CarePlus expects that PCPs will not discriminate against members because of race, color, religion, age, sex, national origin, marital status, health status, or disability. A request for transfer to another provider of care cannot be based on a member's refusal to follow treatment plan such as preventive care services or routine condition-specific care (except as otherwise provided by law), the member's medical condition, amount or variety of care required, the cost of covered services required by the member, or missed appointments.

The relationship between a physician and his or her patient is an extremely important one. During the relationship, there may be times when the physician and patient do not agree. These disagreements usually can be discussed with a favorable resolution for both parties. Ending a physician-patient relationship is a rare event and needs to be conducted with careful consideration. Like any relationship, open discussions need to take place long before the physician requests that a member be transferred out of the panel. Reasonable efforts always should be made to establish a satisfactory provider and patient relationship.

In general, healthcare professional organizations recommend that a physician may discharge a patient from the practice only after attempts to resolve the matter have failed. Patients should be informed of the consequences of their actions, both for their own health and for their relationship with the physician. The provider must provide adequate documentation in the member's medical records or evidence to support his or her efforts to develop and maintain a satisfactory provider— and— patient relationship, as well as proof of disclosure to members of the rules and regulations that apply to their conduct. The documentation must include attempts to bring the member into compliance. For example,

the use of warning letters that document the date, time, behavior, and recommendation for cooperation. A member's failure to comply with a written corrective action plan must be documented, as well as warnings to the member regarding the implications of his or her conduct.

Two sample warning letters have been included in this manual under the **Forms** section as a tool to assist PCPs in documenting disruptive behavior. These letters are meant as an aid for documentation and do not constitute legal or medical advice on handling a disruptive patient. Physicians need to evaluate the most appropriate methods for handling a disruptive patient on a case-by-case basis and in accordance with legal and professional standards. Physicians must seek guidance from their own independent legal counsel and their professional boards and associations if they have questions or concerns about a patient's conduct or related issues.

Following the process outlined below, CarePlus will help reassign members to new PCPs:

- **First occurrence/patient warning letter** – The member or Power of Attorney (POA) must be informed of the consequences of his/her actions verbally and in writing. Document what has been done to address the member's problems and attempts to resolve the matter. Include the date of the occurrence, time, behavior, recommendation for cooperation with time frames, and a telephone number where the member can call the practice for assistance. The member should be given adequate time to change the behavior. The letter must be sent via certified mail.
- **Second occurrence/warning letter, including notification to CarePlus** – Document continued noncompliance, date, time, and additional behavior(s) displayed. Note how attempts to solve the matter have failed. Complete the **Physician Initiated Transfer Request Form** and forward to the provider operations department or your designated provider services executive with all required information and documentation. The form is included as part of this manual under the **Forms** section.

In situations involving a need for **immediate action**, the requirement to issue member warning letters is waived and PCPs may complete the **Physician Initiated Transfer Request Form** and forward to the provider operations department for review. Immediate action is defined as behavior that endangers the safety of staff or other patients. Examples include, but are not limited to:

- a) Threats of violence, stalking, harassment, or acts of violence or aggression
- b) Lawsuit or claim filed against physician
- c) Fraud or criminal activity (e.g., forged prescriptions, altered medical records, identity theft, or theft in office)
- d) Inappropriate physical contact with staff
- e) Failed drug screen, in violation of practice policy/pain management contract
- f) Police intervention, behavior resulting in member's arrest, or involuntary removal from premises

CarePlus will notify the PCP of its decision. If CarePlus approves the request, the member's care remains the responsibility of the PCP requesting the transfer until the change is effective. **PCPs may not, in any way, coerce a member to transfer.** Furthermore, any PCP office that violates guidelines for transferring

members to another office is given a 30-day noncompliance written notification requiring immediate corrective action. No further written notice is necessary to terminate the participation agreement if the PCP office is found in violation of established policies and procedures and is, therefore, considered to be noncompliant. Members or their POAs/guardians have the right to file a formal grievance if they do not agree with the transfer.

In addition, CarePlus has developed a training presentation detailing the process a PCP needs to follow to request that CarePlus transfer a member from the PCP's panel. To request a copy of the presentation, please contact your assigned provider services executive or call the Provider Operations inquiry line at 1-866-220-5448.

MEMBER DISENROLLMENT PROCEDURE

A member may disenroll from CarePlus only during a valid election period. Some members may have special circumstances. For disenrollment procedures, please refer members to the Member Services department for assistance at 1-800-794-5907.

INVOLUNTARY DISENROLLMENT

Disenrollment may be involuntary under the following conditions:

- Death of member
- Loss of Medicare entitlement to Part A and/or Part B
- Disruptive behavior to the extent that a member's continued enrollment in CarePlus substantially impairs CarePlus' ability to arrange for or provide services to either that member or other members of the plan. Disruptive behavior must be substantiated by strong evidence.
- CarePlus' contract is terminated or CarePlus reduces its service area, excluding the member.
- Member permanently moves outside the service area, is away from the service area for more than six consecutive months, or is incarcerated and, therefore, out of the area
- Member is not lawfully present in the United States
- Member provides fraudulent information on an enrollment request or if the member permits abuse of a member identification (ID) card
- The SNP enrollee loses special needs status and does not reestablish SNP eligibility prior to the expiration of the period of deemed continued eligibility.
- Member fails to pay Part D Income Related Monthly Adjustment Amount (IRMAA) to the government and CMS notifies the plan to effectuate the disenrollment

If a member's behavior is so disruptive that it substantially impairs CarePlus' ability to arrange for the care of that member or other members of the plan, CarePlus may submit a request to CMS to have the member involuntarily disenrolled from the plan.

Requests cannot be made because of a member exercising the option to make treatment decisions with which the plan disagrees, including the option of no treatment and/or no diagnostic testing. CarePlus cannot disenroll a member because he/she chooses not to comply with any treatment regimen (CFR 42 §422.74).

Serious effort to resolve the problems presented by the member must be made. Such efforts must include providing reasonable accommodations, as determined by CMS, for individuals with mental or cognitive conditions, including mental illness and developmental disabilities.

A PCP may request an involuntary disenrollment of a CarePlus member for cause. The required information includes, but is not limited to, the following:

- Details of disruptive behavior, including a thorough explanation detailing how the member's behavior has impacted the PCP's or CarePlus' ability to arrange for or provide services to the member
- Member information, including age, diagnosis, mental status, functional status, description of their social support systems, and any other relevant information
- Statement(s) from the PCP describing his/her experience with the member
- Efforts to resolve the problem
- Efforts to provide reasonable accommodations for members with disabilities, in accordance with the Americans with Disabilities Act
- Evidence indicating that the member's behavior is not related to the use/lack of use of medical services
- Evidence of appropriate written notices addressed to the member and/or information provided by the member

The disenrollment for disruptive behavior process requires three written notices:

1. Advance notice to inform the member that the consequence of continued disruptive behavior will be disenrollment
2. Notice of intent to request CMS' permission to disenroll the member
3. A planned-action notice advising that CMS has approved the MA organization's request

In situations where CarePlus disenrolls the member involuntarily for any of the reasons addressed above, CarePlus must send the member or his/her authorized representative notice of the upcoming disenrollment that meets the following requirements:

- Advises the member that CarePlus intends to disenroll the member and why such action is occurring
- Provides the effective date of termination
- Includes an explanation of the member's grievance rights

Unless otherwise indicated, all notices must be mailed to the member before submission of the disenrollment transaction to CMS.

PHYSICIAN TERMINATION BY PLAN

Before terminating a contract with a physician or provider, a written explanation of the reason(s) must be provided. Notice is given to the physician/provider at least 60 days before the termination date, without cause, as stipulated in the physician agreement. Nonetheless, CarePlus may immediately suspend or terminate a provider under circumstances including, but not limited to, the following:

- Termination, suspension, limitation, voluntary surrender, or restriction of professional license or other government certification/licensure
- Conviction of a felony or any other criminal charge
- Any disciplinary action taken by the U.S. Drug Enforcement Agency (DEA)
- Any other legal, government, or other action or event which may materially impair the ability to perform any duties or obligations under the provider's agreement with CarePlus

Individual physicians whose agreements are terminated by CarePlus are entitled to an advisory panel hearing. However, the right to request a review is not applicable when a provider fails to maintain professional licensure, or any governmental authorization required to provide services under the terms and provisions set forth in the provider agreement.

Please note the following:

- Denials of initial participation in CarePlus are not subject to an advisory hearing review.
- The hearing review applies only to terminations initiated by CarePlus.
- The physician must submit his/her request in writing to CarePlus when opting for an advisory hearing review.
- The request and supporting written documents must be dated and postmarked not more than 5 calendar days following the date of the termination notice. If the request is not received within the 5 calendar-day time frame, the physician's right to review is waived.
- Supporting written documentation must specifically address the termination reason noted on the termination letter.
- An advisory panel review will consist of three physicians who are peers of the physician; however, at least two members of the advisory panel must be present at the review to constitute a quorum.
- The advisory panel will base its recommendation on the written information presented by the physician and CarePlus, along with any additional information requested by the panel.
- The review will occur prior to the effective date of the termination, and in most cases, within 15 business days of CarePlus' receipt of the physician's request for the review.
- A provider operations representative shall send a notification letter via certified or registered mail to the physician(s) within two weeks of receipt of the advisory panel's decision.

Should a provider elect to terminate his or her provider agreement with CarePlus, a notice of the pending termination must be forwarded to CarePlus in accordance with the terms of the agreement and applicable federal regulations. Please refer to your provider agreement for more details.

Members will be given reasonable advance notice of the impending termination of any provider. Members currently under treatment with a specialty care physician may be able to continue to receive care for a limited time. Continuity-of-care determinations will be made on a case-by-case basis by CarePlus. However, please note that continuity of care will not be offered to members if a provider is terminated for violations of medical competence or professional behavior, decredentialed, relocated outside of the CarePlus' service area, or retires. **IMPORTANT: In the event of a provider termination, the terminated provider is responsible for transferring the members' medical records.**

CarePlus reviews the Department of Health and Human Services' (HHS) and the Office of the Inspector General's (OIG) exclusion lists as often as required by federal regulations. If your name appears in the

current OIG's excluded/sanctioned provider listing, your contract with CarePlus will be immediately terminated and not subject to a hearing. If you have been reinstated into a federal healthcare program(s), contact CarePlus immediately.

Note: Physician/provider will provide or arrange for continued treatment until the member: (i) has been evaluated by a new participating provider who has had a reasonable opportunity to review or modify the member's course of treatment, or until plan has made arrangements for substitute care for the member; and (ii) until the date of discharge for members hospitalized on the effective date of termination of the agreement. Members will be given reasonable advance notice of the impending termination of any provider. Continuity of care determinations will be made on a case-by-case basis by the plan.

CENTERS FOR MEDICARE & MEDICAID SERVICES (CMS) UPDATES AND EDUCATIONAL RESOURCES

CMS issues program transmittals to communicate new or changed policies and/or procedures that are being incorporated into a specific CMS program manual. The cover page (or transmittal) summarizes the new material, specifying the changes made. Furthermore, CMS has developed MLN Matters®, which provides Medicare coverage and reimbursement rules in a brief, accurate and easy-to-understand format. It's important that you remain current on all regulatory changes as you are responsible for implementing any applicable changes. To find specific CMS transmittals or MLN Matters® articles, please visit the CMS website at the following addresses:

CMS Transmittals Overview: www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals

MLN Matters Articles Overview: www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles

CMS NATIONAL COVERAGE DETERMINATIONS (NCD) & LOCAL COVERAGE DETERMINATIONS (LCDs):

Medicare coverage is limited to items and services that are reasonable and necessary for the diagnosis or treatment of an illness or injury (and within the scope of a Medicare benefit category). National coverage determinations (NCDs) describe whether specific medical items, services, treatment procedures, or technologies can be paid under Medicare. It is important that you remain up-to-date on these changes to coverage. Several helpful resources include:

Medicare Coverage Database: www.cms.gov/medicare-coverage-database/

CMS Medicare Coverage Center: www.cms.gov/Center/Special-Topic/Medicare-Coverage-Center

Note: CarePlus provides direct access to the above-mentioned CMS websites on our CarePlus website at: CarePlusHealthPlans.com/CarePlus-Providers/Updates under the section of "CMS Transmittals and National Coverage Determinations."

MEDICAL AND PHARMACY COVERAGE POLICIES

CarePlus follows Humana's medical and pharmacy coverage policies. Humana has an established process for developing medical and pharmacy coverage policies, utilizing a variety of clinical resources, including but not limited to, the latest scientific evidence, prevailing medical practice standards, and professional clinical guidelines for specific services. These medical coverage policies may be used in the absence of an

applicable National Coverage Determination (NCD), Local Coverage Determination (LCD), or other CMS published directive or to supplement existing NCD, LCD, or other published criteria.

You can access the medical and pharmacy coverage policies by visiting: [CarePlusHealthPlans.com/PAL](https://www.CarePlusHealthPlans.com/PAL)

MILLIMAN CARE GUIDELINES (MCG)

MCG is an evidence-based clinical guidance tool that gives healthcare organizations support in clinical decisions that ensure patients facing hospitalization or surgery receive the right level of care and the appropriate care activities for the right amount of time. CarePlus clinicians focus their medical reviews on hospital stays of any length to ensure compliance with the CMS Two-Midnight Rule. To determine medical necessity, the CarePlus clinician considers complex medical factors found in the medical record, as well as time spent receiving outpatient services within the hospital prior to the inpatient admission. MCG Inpatient & Surgical Care (ISC) guidelines may be used by the medical reviewer to assist in evaluating the complex medical factors that support the inpatient hospital stay.

You can access the MCG criteria by visiting: [CarePlusHealthPlans.com/PAL](https://www.CarePlusHealthPlans.com/PAL)

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MEDICARE COMMUNICATIONS AND MARKETING GUIDELINES

These guidelines are intended to serve as a general summary of applicable laws, rules and regulations, CMS guidance, and CarePlus policies. If any aspects of these guidelines may be construed to be less strict than applicable laws, rules, regulations, CMS guidance, or CarePlus policies, the laws, rules, regulations, CMS guidance, and CarePlus policies control. **For specific guidance on provider activities related to Medicare plans, please refer to the CMS Medicare Managed Care Manual, Medicare Communications and Marketing Guidelines for more detailed information. Providers must receive plan approval prior to sending any communications that reference CarePlus to patients or prospective patients. Furthermore, providers may not engage in any activities with respect to CarePlus or use trademarks and/or trade names employed by CarePlus without prior written approval.**

CMS and your CarePlus Provider Agreement require that all activities related to Medicare plans must be consistent with Medicare regulations. The term “provider” refers to all providers contracted with CarePlus and their subcontractors, including, but not limited to, pharmacists, pharmacies, physicians, hospitals, and long-term care facilities.

CMS is concerned with providers engaging in plan marketing activities because:

- Providers may not be fully aware of all plan benefits and costs.
- Providers may face conflicting incentives if they act as agents of a plan instead of in the best interest of their patients.

CMS’ communication and marketing guidelines are designed to guide plans and providers in assisting beneficiaries with plan selection, while at the same time striking a balance to ensure that **provider assistance results in plan selection that always is in the best interests of the beneficiary.**

Any provider (and/or subcontractors) contracted with CarePlus must comply with the following:

1. Provider Activities and Materials in the Healthcare Setting – Upon the beneficiary’s request, providers may assist a beneficiary in an objective assessment of the beneficiary’s needs and potential plan options that may meet those needs. To this end, providers may engage in discussions with beneficiaries when patients seek information or advice from their provider regarding their Medicare options. Providers must remain neutral in assisting beneficiaries with enrollment decisions.

Providers are permitted to make available and/or distribute plan marketing materials, as long as the provider and/or facilities distributes or makes available plan marketing materials for all plans with which the provider participates. CMS does not expect providers to proactively contact all participating plans; rather, if providers agree to make available and/or distribute plan marketing materials, they should do so knowing they must accept future requests from other plans with which they participate. Providers also are permitted to display plan posters or other plan marketing materials in common areas such as the provider’s or a long-term care facility’s waiting room. Additionally, a long-term-care facility may provide materials in admission packets announcing all plan contractual relationships.

2. Plan Activities and Materials in the Healthcare Setting – CarePlus or CarePlus sales agents may conduct sales activities, including sales presentations, distribution of marketing materials, and collection of enrollment forms in common areas of healthcare settings. Common areas where marketing activities are allowed include, but are not limited to, common entryways, vestibules, waiting

rooms, hospital or nursing home cafeterias, community or recreational rooms, and conference rooms. If a pharmacy counter is located within a retail store, common areas would include where patients interact with pharmacy providers and obtain medications. Communication materials, as defined the MCMG, may be distributed and displayed in all areas of the healthcare setting.

CarePlus or CarePlus sales agents 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). These restrictions also apply to activities planned in these settings outside of normal business hours.

Plans are permitted to schedule appointments only with beneficiaries residing in a long-term care facility upon request by the beneficiary.

3. Provider Affiliation Information – Providers may announce new or continuing affiliations with specific plans once a contractual agreement between the Plan/Part D sponsor and provider has been agreed upon by both parties. Affiliation announcements may be made through direct mail, email, phone, or advertisement. Providers must submit affiliation announcements to CarePlus for review and approval prior to distribution, or use pre-approved templates provided by CarePlus without any alterations. Affiliation announcements must clearly state that the provider also may contract with other health plans. These announcements are considered communication materials. **Any provider affiliation announcement materials that include additional information, such as plan benefits, premiums or cost sharing, are considered marketing materials and cannot be mailed by providers on behalf of the plan.**

4. Privacy, Anti-discrimination and Other Laws, Rules and Regulations – Plans and providers must follow all federal and state laws regarding confidentiality and disclosure of beneficiary information. This obligation includes compliance with the provisions of the HIPAA Privacy Rule and its specific rules regarding uses and disclosures of beneficiary information.

Plans are subject to sanction for engaging in any practice that may reasonably be expected to have the effect of denying or discouraging enrollment of individuals whose medical condition or history indicates a need for substantial future medical services (i.e., health screening or “cherry picking”).

A provider should not attempt to switch or steer plan enrollees or potential plan enrollees to a specific plan or group of plans to further the financial or other interests of the provider. All payments that plans make to providers for services must be fair market value, consistent for necessary services, and otherwise comply with all relevant laws and regulations, including the federal and any state anti-kickback statutes. Providers must not accept compensation directly or indirectly from a plan for enrollment activities.

For enrollment and disenrollment issues related to beneficiaries residing in long-term care facilities (e.g., enrollment period for beneficiaries residing in long-term care facilities and use of personal representatives in completing an enrollment application), please refer to Chapter 2 of the CMS Medicare Managed Care Manual and Chapter 3 of the CMS Medicare Prescription Drug Benefit Manual.

5. Provider and Plan Joint Events – Providers may invite contracted plans to conduct educational seminars or marketing events. All CMS guidance around health plan sales and marketing events, as well as health plan educational events hosted within provider settings, and CarePlus policies, standards and procedures, must be followed. All contracted plans must be permitted to participate upon request. In addition:

- There must be a clear separation between the plan’s activities and the provider’s activities. It must be clear to an attendee whether the provider or the plan is the host of the provider-plan event. Some relevant factors in determining which party is hosting the event include which party moderates the event, organizes the event, welcomes attendees ,and produces the majority of the agenda.
- Funding for the event should be proportionate to the level of participation by each party and in all cases must be commensurate with the fair market value of that participation.
- Providers must not market the plan and the plan must not market providers, and there cannot be an understanding that such activity will occur in the future.
- If the plan conducts any marketing activities at the seminar, all CMS regulations around plan sales events and plan marketing in provider settings must be followed.
- Plans may conduct marketing activities only in common areas where patients do not primarily receive healthcare services or are waiting to receive healthcare services.
- Meals cannot be served at a plan marketing or sales event.
- Health screenings cannot take place at a plan marketing or sales event.
- Attendees cannot be required to provide any contact information as a prerequisite for attending.
- If a raffle or drawing is conducted, contact information obtained from attendees cannot be used for any other purpose than to notify the winner of the raffle or drawing.
- Any gifts, giveaways, prizes, refreshments, food ,or promotional activities must meet CMS and OIG requirements.

Outlined below are general **dos** and **don’ts** to assist you in achieving and maintaining compliance with CMS requirements. The Medicare Communications and Marketing Guidelines can be found in the Medicare Managed Care Manual located on the CMS website at www.cms.gov/Medicare/Health-Plans/ManagedCareMarketing/FinalPartCMarketingGuidelines.html. Providers also must comply with Anti-inducement Provisions of the Civil Monetary Penalties Law. Please refer to the Office of Inspector General (OIG) special advisory bulletin “Offering Gifts and Other Inducements to Beneficiaries” at: oig.hhs.gov/fraud/docs/alertsandbulletins/SABGiftsandInducements.pdf; and the “Office of Inspector General Policy Statement Regarding Gifts of Nominal Value To Medicare and Medicaid Beneficiaries” at: oig.hhs.gov/fraud/docs/alertsandbulletins/OIG-Policy-Statement-Gifts-of-Nominal-Value.pdf.

DON'Ts:

- **DO NOT** make phone calls or direct, urge, or attempt to persuade beneficiaries to enroll in or select a specific plan.
- **DO NOT** offer anything of value to induce anyone to select you as their physician or to enroll in a particular plan or organization.
- **DO NOT** mail marketing materials on behalf of CarePlus or any other health plan at any time.

DOs:

- **DO** provide the names of health plans with which you contract.
- **DO** provide information and assistance in applying for the low-income subsidy (LIS).
- **DO** answer your patients’ questions and, when requested, discuss the merits of a health plan or health plans, including cost-sharing and benefits

<ul style="list-style-type: none"> • DO NOT conduct health screenings during a health plan marketing/sales event. • DO NOT accept or collect health plan scope-of-appointment or health plan enrollment forms. • DO NOT assist beneficiaries with the completion of health plan enrollment applications. • DO NOT distribute health plan marketing materials or enrollment applications in areas where healthcare services are provided. • DO NOT advertise non-health items or services as health plan benefits (e.g., computer classes, citizenship classes, English classes). • DO NOT accept compensation directly or indirectly from a health plan for beneficiary enrollment or marketing activities or offer/accept financial incentives to/from sales agents. • DO NOT advertise or market the ability to make a plan change or reference the open enrollment period (OEP) in advertising or marketing materials during OEP (Jan. 1 – March 31). • DO NOT provide any patient information or lists of patients to health plan sales representatives. 	<p>information. These discussions may occur in areas where care is delivered.</p> <ul style="list-style-type: none"> • DO refer your patients to other sources of information, such as state health insurance assistance programs (SHIPs), plan marketing representatives, state Medicaid offices, the local Social Security office, the CMS website or 1-800-MEDICARE (1-800-633-4227). • DO distribute unaltered, printed materials created by CMS, such as reports from Medicare Plan Finder, the “Medicare and You” handbook or “Medicare Options Compare” (from www.medicare.gov), including in areas where care is delivered. • DO announce via mail, email, phone, or other media new or continuing affiliations with CarePlus to inform patients about your network participation and the CarePlus health plans you accept. Communications of this type are allowable at any time. • DO make available CarePlus health-plan marketing materials and enrollment forms outside of the areas where care is delivered (such as common entryways; waiting rooms; vestibules; hospital or nursing home cafeterias; community, recreational or conference rooms), as long as you do so for any contracted health plans, upon their request. • DO make available, distribute and display CarePlus health plan communications, including permission-to-contact forms, in areas where care is delivered, as long as you do so for any contracted health plans, upon their request.
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For additional information and applicable policies and procedures, please call your assigned provider services executive or call the CarePlus Provider Operations inquiry line at 1-866-220-5448.

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PHYSICIAN INCENTIVE PLAN

Any physician incentive plan operated by CarePlus must meet the following requirements (42 CFR 422.208).

1. CarePlus makes no specific payment, directly or indirectly, to a physician or physician group including subcontracts as an inducement to reduce or limit medically necessary services furnished to any particular member. Indirect payments may include offerings of monetary value (such as stock options or waivers of debt) measured in the present or future.
2. If the physician plan places a physician, physician group, or subcontract at substantial financial risk for services that the physician, physician group, or subcontract does not furnish itself, CarePlus must assure that all physicians, physician groups, and subcontracts at substantial financial risk have either aggregate or per-patient stop-loss protection.
 - Financial risk occurs when risk is based on the use or costs of referral services, and that risk exceeds the risk threshold. Payments based on other factors, such as quality of care furnished, are not considered in this determination.
3. For all physician incentive plans, CarePlus will provide assurances satisfactory to the secretary of that physician incentive plan so that requirements are met. CarePlus must provide to CMS information concerning physician incentive plans as requested.

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QUALITY IMPROVEMENT PROGRAM OVERVIEW

Scope and Purpose

CarePlus' quality improvement (QI) program guides activities to improve care and treatment of CarePlus-covered patients. In doing so, the program aligns with our corporate purpose of helping patients achieve their best health, which supports continuous quality improvement companywide and the Centers for Medicare & Medicaid Services' (CMS) National Quality Strategy (NQS), who has raised the bar for a resilient, high-value health system that promotes quality outcomes, safety, equity, and access to care for all individuals. To accomplish this, CarePlus supports physicians and other health care professionals as they work to deliver integrated care for their CarePlus-covered patients.

The purpose of the QI program is to monitor, evaluate, and facilitate improvement in the quality of health care services provided to CarePlus-covered patients. The program is based on contractual, governmental, accreditation and organizational requirements and guidelines. Data is tracked and analyzed for trends monthly, quarterly, and annually. Opportunities for improvement are identified and root-cause analysis is performed as needed.

Data Collection/Monitoring

As part of the company-wide quality improvement program, the CarePlus QI and Accreditation department systematically monitors and collects data to be used for evaluation of care and services.

Data collection may include, but not be limited to, the following:

- Retrospective clinical quality of care/grievance investigations
- Healthcare Effectiveness Data and Information Set (HEDIS)
- Consumer Assessment of Healthcare Providers and Systems (CAHPS)
- Health Outcomes Survey (HOS)
- Provider satisfaction survey
- Medicare quality improvement/chronic care improvement projects
- Clinical practice guidelines adherence
- Medical record documentation reviews

Data is derived from multiple sources, including medical records, claims and encounter data, member and provider surveys, complaint/grievance reports, clinical operations staff, peer review, risk management, vendors/delegates, and provider site visits.

Monitoring activities are designed for a broader range of healthcare issues with a focus on identifying areas of vulnerability, risks, and the tracking and trending-related data. This is performed through, but is not limited to:

- Provider site visits
- Review of the provider practice patterns and provider experience
- Medical record documentation reviews
- Review of population health outcomes, e.g., HEDIS, chronic care management, cost effectiveness of care

- Evaluation of patient safety, clinical care and other areas of concern, e.g., readmission, medical errors, pharmacy management
 - Evaluation and trending of member and provider grievances
 - Evaluation of CAHPS and HOS survey results (member experience)
 - Evaluation of vendor/delegate performance
 - Evaluation of transition/continuity of care and medical-behavioral health coordination of care
 - Evaluation of access to care or Social Determinants of Health (SDOH) barriers and health equity trends
- Evaluation of efficacy of emerging healthcare technology, e.g., telehealth, wearables, AI (augmented intelligence)

Quality of Care Issues

CarePlus associates and outside entities, e.g., Florida's Beneficiary and Family Centered Care Quality Improvement Organization (BFCC-QIO) and CMS, communicate potential quality of care issues, which are investigated through the QI and Accreditation department. QI and Accreditation associates identify, investigate, analyze, monitor, and evaluate individual issues or trends for specific providers. Referrals are generated by calls from members/providers, grievances, CMS reports, clinical/pharmacy operations, risk management, outlier trends from clinical practice guidelines adherence reports, medical record documentation audits, and delegated networks, as well as other sources. Issues with implications for risk management are referred to the risk and/or law department.

Resolution may include notification of the provider, corrective action plans, referral to the chief medical officer, or referral to the credentialing and quality peer review committees, and reporting to the National Practitioner Data Bank as appropriate.

Beneficiary Complaints

- As required by the Medicare statute and regulations, CarePlus participates with the Florida BFCC-QIO, The Keystone Peer Review Organization Inc. (KEPRO). CarePlus collaborates with the BFCC-QIO in the following broad activities: Mandatory case review activities – medical record reviews, which determine whether the medical services provided to the Medicare beneficiaries are medically necessary, furnished at the appropriate level of care and of a quality that meets professionally recognized standards of care.
- Beneficiary complaints – medical record reviews which determine quality of care provided to beneficiaries.
- Cooperative project activities – collaborative efforts with healthcare providers and other groups, which result in measurable improvement of processes and outcomes, related to healthcare.

Clinical Practice Guidelines

CarePlus' clinical practice guidelines are adopted from clinically sound and well-respected national sources.

These guidelines may have some differences in recommendations. Information contained in the guidelines is not a substitute for a healthcare professional's clinical judgment and is not always applicable to an individual. Therefore, the healthcare professional and patient should work in partnership in the decision-making process regarding the patient's treatment. Furthermore, using this information will not

guarantee a specific outcome for each patient. None of the information in the guidelines is intended to interfere with or prohibit clinical decisions made by a treating healthcare professional regarding medically available treatment options for patients.

Links to other websites are provided only for your convenience and do not constitute or imply endorsement by CarePlus of these sites, products, or services described on these sites, or of any other material contained therein. CarePlus disclaims responsibility for their content and accuracy.

A copy of CarePlus' Clinical Practice Guidelines is available online at [CarePlusHealthPlans.com/CarePlus-Providers/Updates](https://www.CarePlusHealthPlans.com/CarePlus-Providers/Updates).

Clinical practice guidelines are resources for CarePlus-contracted physicians and other CarePlus-contracted healthcare professionals. CarePlus has adopted the following guidelines:

Adult Immunizations

Centers for Disease Control (CDC) [Recommended Adult Immunization Schedule - United States, 2022](https://www.cdc.gov/vaccines/imz/downloads/pdf/2022-05-16-adult-immunization-schedule.pdf)

Asthma Care

Global Initiative for Asthma (GINA)

[2022 GINA Report: Global Strategy for Asthma Management and Prevention Updated](https://ginasthma.org/2022-report/)

Atrial Fibrillation

American College of Cardiology (ACC)/American Heart Association (AHA)/Heart Rhythm Society (HRS)

[2019 Focused Update of the 2014 Guideline for Management of Patients with Atrial Fibrillation](https://www.acc.org/clinical/guidelines/2019/05/01/atrial-fibrillation)

Back Pain

Institute for Clinical Systems Improvement (ICIS)

[Health Care Guideline: Adult Acute and Subacute Low Back Pain 16th Edition \(March 2018\)](https://www.icsi.org/clinical-guidelines/health-care-guideline-adult-acute-and-subacute-low-back-pain-16th-edition-march-2018)

Cholesterol Management

American Academy of Physician Assistants (AAPA) /American Association of Cardiovascular and Pulmonary Rehabilitation (AACVPR) /American Pharmacists Association (AphA) /American Society for Preventive Cardiology (ASPC) /Association of Black Cardiologists (ABC) /Preventive Cardiovascular Nurses Association (PCNA) / Women Heart: The National Coalition for Women with Heart Disease

[Cholesterol Clinical Practice Guidelines: 2018 Guideline on the Management of Blood Cholesterol](https://www.cholesterolclinicalpracticeguidelines.org/2018-guideline-on-the-management-of-blood-cholesterol)

COVID-19

National Institute of Health (NIH)

[Guideline for the Management of COVID -19](https://www.cdc.gov/media/releases/2020/s0508-covid-19-guidelines.html)

Depression Adults (for PCPs)

Institute for Clinical Systems Improvement (ICSI)

[Depression, Adult in Primary Care, 17th edition \(March 2016\)](https://www.icsi.org/clinical-guidelines/depression-adult-in-primary-care-17th-edition-march-2016)

Diabetes Care

American Diabetes Association (ADA)

[Standards of Medical Care in Diabetes - 2021 ADA](#)

Heart Failure

American College of Cardiology (ACC) /American Heart Association (AHA) Task Force [2020 ACC/AHA Clinical Performance and Quality Measures for Adults with Heart Failure](#)

Heart Risk Calculator

American College of Cardiology (ACC)

[ASCVD Risk Estimator + \(acc.org\)](#)

Home Oxygen

American Thoracic Society

[Home Oxygen Therapy for Adults with Chronic Lung Disease. An Official American Thoracic Society Clinical Practice Guideline. Nov 15th, 2020](#)

Hypertension

International Society of Hypertension [2020 International Society of Hypertension Global Hypertension Practice Guidelines](#)

Kidney Disease

National Kidney Foundation [Evidence-Based Clinical Practice Guidelines for All Stages of Chronic Kidney Disease](#)

Medical Record Documentation Guidelines

CarePlus has adopted guidelines based on accreditation and state medical record documentation requirements. Refer to the CarePlus Resources Library webpage for providers at:

<https://www.careplushealthplans.com/careplus-providers/forms>

Opioids 1 Institute for Clinical Systems Improvement (ICIS)

[Pain: Assessment, Non-Opioid Treatment Approaches and Opioid Management 8th Edition, August 2017: Version 2 \(ICIS\)](#)

Opioids 2

Health and Human Services (HHS)

[Opioid Facts and Statistics | HHS.gov](#)

Preventive Care

United States Task Force on Preventive Services (USTFPS)[Preventive Services Selector](#)

Primary Prevention of Cardiovascular Disease and Stroke

American College of Cardiology (ACC) /American Heart Association (AHA) Task Force [2019 Guideline on the Primary Prevention of Cardiovascular Disease](#)

Sleep Apnea

American Society of Anesthesiologists Task Force on Perioperative Management of Patients with Obstructive Sleep Apnea [Practice Guidelines for the Perioperative Management of Patients with Obstructive Sleep](#)

Valvular Heart Disease

American College of Cardiology (ACC) /American Heart Association (AHA) Task Force
[2020 ACC/AHA Guideline for the Management of Patients with Valvular Heart Disease: A Report of the American College of Cardiology/American Heart Association Joint Committee on Clinical Practice Guidelines](#)

Well-woman routine care

The American College of Obstetricians and Gynecologists (ACOG)
[Recommendations for Well-Woman Care 2021](#)

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MEDICAL RECORD DOCUMENTATION STANDARDS

CarePlus conducts annual reviews of medical records using a standardized medical record review tool for a sample of providers providing primary care services to CarePlus members. This record review is part of the annual compliance guidelines stipulated by AAAHC, state regulatory agencies, and CMS.

Medical record elements for review include compliance with the following:

Working diagnosis/clinical impression

The diagnosis is appropriate for the findings in the current history and physical examination.

Medication profile is maintained

The record reflects a current review and update at each visit of all individual patient medications, including over-the-counter products and dietary supplements when information is available to provider.

Plan of care documented

Treatment, diagnostic, and therapeutic procedures are consistent with clinical impression or working diagnosis.

Follow-up of acute or chronic problems

The record documents appropriate and timely consultation and follow-up of referrals, tests, and findings.

Member identification on each page

The record includes appropriate patient identifiers including, at a minimum, name, identification number (if appropriate), date of birth, gender, and responsible party (if applicable).

Record is legible

Clinical record entries are legible and easily accessible within the record by the organization's personnel.

Record is organized

Content and format of the record are uniform and consistent with the organization's clinical records policies.

Health history documented

Reports, histories and physicals, progress notes, and other patient information (such as laboratory reports, X-ray readings, operative reports, and consultations) were reviewed and incorporated into the record in a timely manner.

Previous records

For records with multiple visits/admissions or complex and lengthy records, diagnostic summaries are used in accordance with organization policies and procedures. If applicable, records of patients treated elsewhere or transferred to another healthcare provider are present.

Allergies/untoward drug reactions

Presence or absence of allergies and untoward reactions to drugs or materials are recorded in a prominent and consistent location, verified at each patient encounter and updated when new allergies or sensitivities are identified.

Entries dated

All entries must be dated and include department, if departmentalized.

Chief/subjective complaint recorded

Chief complaint or purpose of visit as told by the member, or family member, must be recorded.

Clinical/objective findings

Clinical findings, to include the physical findings related to the subjective complaint, should be recorded.

Diagnosis/objective findings

Diagnosis or clinical impressions must be in the record.

Consults/lab/diagnostic reports

Documentation is present of consultations, lab, X-ray, imaging, or other studies ordered. Results should be filed in the medical record and initialed by the primary care physician, thereby signifying review. Abnormal X-ray, lab, and imaging study results should have an explicit notation in the medical record regarding follow-up plans and notification to patient of all results (positive and negative).

Member education/participation

Disposition, recommendations, and instructions given to the patient should be clearly documented within the record.

Entries authenticated

Authentication and verification of contents by healthcare professionals should be present.

Follow-up of missed and canceled appointments

Documentation regarding missed and canceled appointments should be recorded in the record.

Entries signed

Signature of physician or other author of the clinical record entry is recorded in the record.

Communication of abnormal labs/diagnostic findings

Significant patient advice given by telephone, online, or after hours is entered in the clinical record and appropriately signed or initialed.

Clinical research

Any notation in the clinical record indicating diagnostic or therapeutic intervention as part of clinical research is clearly contrasted with entries regarding the provision of non-research-related care.

Advance directives

If applicable, the record reflects discussions with the patient concerning the necessity, appropriateness, and risks of proposed care, surgery, or procedure, as well as discussions of treatment alternatives and advance directives. If response is yes to an advance directive, a copy of the directive must be included in the medical record.

For any comments or questions you might have regarding CarePlus' QI Program, you can call 305-626-5195.

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Health Insurance Portability and Accountability Act (HIPAA)

Per the U.S. Department of Labor, HIPAA was initially passed in 1996 to “improve portability and continuity of health insurance coverage.” As a result, there are more consumer protections regarding options for coverage (aspe.hhs.gov/admsimp/pl104191.htm). Later “rules,” or provisions, were passed in 2001 and 2003 to protect privacy, confidentiality and security of individually identifiable health information. This includes the establishment of security standards for electronic protected health information.

Providers and CarePlus are required to have sufficient safeguards regarding this type of information, including who may access it, how much of it may be accessed by any individual, and how it is retained and transmitted.

<https://www.hhs.gov/hipaa/for-professionals/index.html>

We anticipate that you may have questions about whether the HIPAA Privacy Rule permits you to disclose your patients’ (our members) medical information to us for these activities without written authorization from your patients.

Section 164.506(c)(4) of the HIPAA Privacy Rule explicitly permits you to make this type of disclosure to CarePlus without a written authorization. Additionally, the Office of Civil Rights (the federal agency tasked with enforcing the Privacy Rule) has also made this point clear. It wrote in its Dec. 3, 2002, Guidance on the Privacy Rule that: “A covered entity may disclose protected health information to another covered entity for certain healthcare 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 healthcare operations activity.”

As the Privacy Rule and the Office of Civil Rights have made clear, you do not need a written authorization from your patients who are or have been members of CarePlus to disclose their medical information to us for HEDIS and other quality improvement, accreditation or regulatory activities.

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DOMESTIC VIOLENCE – ELDERLY ABUSE

- The number of elder abuse and neglect cases are expected to grow as increased longevity is occurring. Most reported cases of abuse are physical abuse, neglect, and fiduciary or financial abuse. Abuse can occur at an elder's home, in a skilled nursing facility (SNF), or other residential care setting. As a healthcare provider, it is imperative that you understand that abuse can occur anywhere, at any time, and to anyone.
- According to statistics from the Administration on Aging, female elders are abused at a higher rate than males, due to their larger proportion in the aging population. The nation's oldest (85 years and older) are abused and neglected at two to three times their proportion of the elderly population. In a national study, the vast majority of abusers were family members (approximately 90 percent), most often adult children, spouses, partners, and others.
- There tends to be a typical profile of both the abused and the abuser in cases of elder abuse; the victim typically is a white female, widowed, and either living alone or with her adult child who is cited as the perpetrator of the abuse. Research also has identified some of the more common reasons for abuse, on which several theories have been based: caregiver stress, domestic and family violence issues, and social isolation.

The National Center on Elder Abuse (NCEA) defines seven major types of elder abuse:

SIGNS AND SYMPTOMS

PHYSICAL ABUSE

Bruises, black eyes, welts, lacerations and rope marks
 Bone fractures, broken bones, and skull fractures
 Open wounds, cuts, punctures, or untreated injuries in various stages of healing
 Sprains, dislocations, or internal injuries/bleeding
 Broken eyeglasses or frames, physical signs of being subjected to punishment, or signs of being restrained
 Laboratory findings of medication overdose or under-utilization of prescribed drugs
 Elder's report of being hit, slapped, kicked, or mistreated
 Elder's sudden change in behavior
 Caregiver's refusal to allow visitors to see an elder alone

SEXUAL ABUSE

Bruises around the breasts or genital area
 Unexplained venereal disease or genital infections
 Unexplained vaginal or anal bleeding
 Torn, stained, or bloody underclothing
 Elder's report of being sexually assaulted or raped

EMOTIONAL OR PSYCHOLOGICAL ABUSE

Being emotionally upset or agitated
 Being extremely withdrawn and non-communicative or nonresponsive
 Unusual behavior usually attributed to dementia

SIGNS AND SYMPTOMS

Elder's report of being verbally or emotionally mistreated

NEGLECT

Dehydration, malnutrition, untreated bed sores, or poor personal hygiene
 Unattended or untreated health problems
 Hazardous or unsafe living condition/arrangements
 Unsanitary and unclean living conditions
 Elder's report of being mistreated

ABANDONMENT

Desertion of an elder at a hospital, nursing facility, or other similar institution
 Desertion of an elder at a shopping center or other public location.
 Elder's report of being abandoned

FINANCIAL OR MATERIAL EXPLOITATION

Sudden changes in bank account or banking practice including an unexplained withdrawal of large sums of money by a person accompanying the elder
 Inclusion of additional names on an elder's bank signature card
 Unauthorized withdrawal of the elder's funds using the elder's ATM card
 Abrupt changes in a will or other financial documents
 Unexplained disappearance of funds or valuable possessions
 Substandard care being provided or bills unpaid despite the availability of adequate financial resources
 Discovery of an elder's signature being forged for financial transactions or for the titles of his/her possessions
 Sudden appearance of previously uninvolved relatives claiming their rights to an elder's affairs and possessions
 Unexplained sudden transfer of assets to a family member or someone outside the family
 Provision of services that are not necessary
 Elder's report of financial exploitation

A controversial category in relation to elder abuse is self-neglect. According to the National Center on Elder Abuse (NCEA), self-neglect is characterized as an adult's inability, due to physical or mental impairment or diminished capacity, to perform essential self-care tasks. The definition of self-neglect excludes a situation in which a mentally competent older person, who understands the consequences of decisions, makes a conscious and voluntary decision to engage in acts that threaten health or safety as a matter of personal choice.

Signs and symptoms of self-neglect include, but are not limited to:

- Dehydration, malnutrition, untreated, or improperly attended medical conditions, and poor personal hygiene

- Hazardous or unsafe living conditions/arrangements
- Unsanitary or unclean living quarters
- Inappropriate and/or inadequate clothing, lack of the necessary medical aids, and grossly inadequate housing or homelessness

Florida Statute 415.1034 mandates reporting of abuse, neglect, or exploitation of vulnerable adults and mandatory reports of death. All persons are required to report abuse of the elderly or disabled adults. This includes any person, not just treating professionals, including, but not limited to: physicians, nurses, other healthcare professionals, mental health professionals, nursing home staff, assisted living facility staff, social workers, and law enforcement officers. Reporting is confidential and includes immunity for good faith reporting. Any abuse, neglect or exploitation should be reported to the Florida Abuse toll-free hot line 1-800-96-ABUSE (962-2873).

References:

National Protective Services Association

www.napsa-now.org/

National Clearinghouse on Abuse in Later Life.

www.ncall.us/

Online Sunshine (2012). The Florida Statute 415.1034 (Mandatory reporting of abuse, neglect, or exploitation of vulnerable adults; mandatory reports of death). Official Site of the Florida Legislature.

www.flsenate.gov/laws/statutes/2012/415.1034

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CULTURAL GAPS IN CARE

CULTURAL GAPS IN CARE

A report by the Institute of Medicine, “Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care,”¹ released in 2003, found racial and ethnic differences in the quality of care delivered across a wide range of settings and disease conditions, even when controlling for socioeconomic factors such as income and insurance coverage. Annual National Healthcare Disparities reports from the Agency for Healthcare Research and Quality (AHRQ) have confirmed that these gaps persist in the American healthcare system².

Communication is paramount in delivering effective care. Mutual understanding may be difficult when doctors and patients come from different cultures. Language barriers, cultural norms, beliefs and attitudes that determine health-care-seeking behaviors can contribute to miscommunication. By becoming more aware of their patients’ cultural needs and by improving communication with their growing numbers of diverse patients, doctors can address racial and ethnic gaps in healthcare.

CarePlus offers several initiatives intended to deliver healthcare services to all members regardless of race, ethnicity, national origin, religion, gender, age, mental or physical disability, sexual orientation, genetic information, or socioeconomic status. Some of these initiatives include member services representatives who are fluent in English and Spanish, translation services provided by a CarePlus-certified vendor, a Spanish-language website, and education of CarePlus associates in cultural competency. While making strides in addressing diversity and disparities in healthcare, CarePlus continues to work to improve its current processes.

Resources for Continuing Medical Education

Cultural competence refers to the knowledge, skills, attitudes, and behaviors required of a healthcare professional to provide optimal care and services to patients from a wide range of cultural and ethnic backgrounds. CarePlus offers physicians and other healthcare providers resources and materials, including the following tools, to improve awareness of gaps in care and to promote culturally competent care.

Web-based module for continuing education credit

- **A Physician’s Practical Guide to Culturally Competent Care**, a guide from the U.S. Department of Health & Human Services’ Office of Minority Health (9.0 CMEs), [Physician's Site \(hhs.gov\)](https://www.hhs.gov/physician-practical-guide-to-culturally-competent-care/)

Learn more about the cultures you serve

- **Cultural Competence**, through its focus on health literacy, **Agency for Healthcare Research and Quality (AHRQ)** provides information for providers and patients related to cultural competence, www.ahrq.gov/topics/cultural-competence.html
- **Culture, Language and Health Literacy**, a website run by the Health Resources and Services Administration of the U.S. Department of Health and Human Services, www.hrsa.gov/about/organization/bureaus/ohe/health-literacy/culture-language-and-health-literacy

Toolkits for clear health communication and language services

- **Ask Me 3**, a quick and effective tool from the Institute for Healthcare Improvement that encourages patients and families to ask specific question of their providers to better understand their health conditions and what they need to do to stay healthy, www.ihl.org/resources/Pages/Tools/Ask-Me-3-Good-Questions-for-Your-Good-Health.aspx
- **The Guide to Providing Effective Communication and Language Assistance Services**, a document from the Office of Minority Health that can help physicians better serve patients with limited English proficiency, hclsig.thinkculturalhealth.hhs.gov/

Frameworks and guidelines for culturally appropriate care

- **National Standards for Culturally and Linguistically Appropriate Services in Health Care**, a report published by the U.S. Department of Health & Human Services, <https://thinkculturalhealth.hhs.gov/clas>
- **One Size Does Not Fit All: Meeting the Health Care Needs of Diverse Populations**, a guide from The Joint Commission (TJC) www.researchgate.net/publication/255616396_One_Size_Does_Not_Fit_All_Meeting_the_Health_Care_Needs_of_Diverse_Populations

Additional sources that address healthcare disparities

- **National Healthcare Quality & Disparities Reports**, a collection of the annual reports that track disparities related to the quality of and access to healthcare, published by the Agency for Healthcare Research and Quality, www.ahrq.gov/research/findings/nhqrdr/index.html
Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care, the landmark report that raised awareness of clinical disparities among diverse populations, published by the Institute of Medicine (IOM), www.ncbi.nlm.nih.gov/pubmed/25032386

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QUALITY AND PERFORMANCE RATINGS

1. CMS STAR RATINGS

CMS uses a five-star quality rating system to measure Medicare patients' experiences with their health plans and the healthcare system. This rating system applies to MA and MA Prescription Drug plans (MAPD). CMS uses Stars ratings to determine whether CarePlus receives quality bonus payments, which CarePlus shares with physicians through its Physician Star Rewards program and other value-based relationships.

The program is a key component in financing healthcare benefits for MA plan participants. In addition, the ratings are posted on the CMS consumer website, www.medicare.gov, to help Medicare participants choose from among the MA plans offered in different areas.

It is important to understand the metrics included in the CMS Star Rating system, as some of them are part of CarePlus' Physician Star Rewards program, in which you may be eligible to participate. The Physician Star Rewards program is designed to promote quality improvement and recognize PCPs for improved performance on stipulated measures over defined periods of time.

For more information on the Physician Star Rewards program, please contact your assigned quality improvement nurse or provider services executive.

How Are Star Ratings Derived?

An MA health plan's Star rating is based on measures that fall into five categories:

- Staying healthy: screening tests and vaccines
- Managing chronic (long-term) conditions
- Tracking member experiences with the health plan
- Monitoring member complaints and changes in the health plan's performance
- Evaluating the health plan's customer service

Ratings for Medicare Prescription Drug Plan (PDP) are based on measures in four categories:

- Drug plan customer service
- Monitoring members' complaints and changes in the drug plan's performance
- Members' experience with the drug plan
- Drug safety and accuracy of drug pricing

Measures in both categories are used to rate MAPD health plans. CMS sets the thresholds for each measure on an annual basis.

Benefits to Physicians and Healthcare Clinicians

- Improved communications with patients and health plans
- Stronger benefits to support chronic condition management
- Greater focus on preventive medicine and early disease detection
- Increased awareness of patient safety issues

- Opportunities to improve patient health outcomes
- Additional compensation for physicians in value-based relationships who meet Stars goals

Benefits to Patients

- Improved relations with their doctors
- Greater health plan focus on access to care
- Increased levels of customer service
- Greater focus on preventive services for peace of mind, early detection, and healthcare that matches their individual needs
- Improved health and lower care costs

CarePlus' Commitment

CarePlus is committed to providing high-quality Medicare health plans that meet or exceed all CMS quality benchmarks. The CMS Star Rating system is structured so that pay-for-performance funding is used to protect, or, in some cases, to increase benefits and to keep member premiums low.

CarePlus encourages patients to become engaged in their preventive and chronic care management through outreach, screening opportunities, and member rewards.

Tips for Physicians and Healthcare Clinicians:

- Encourage patients to obtain preventive screenings annually or when recommended
- Create office practices to identify noncompliant patients at the time of their appointments
- Remember to have key conversations with your senior population about recommended immunizations, ways to reduce the risk of falling, physical activity and urinary incontinence
- Leverage access to the Health Information Exchange (HIE) or ensure your practice's electronic health record (EHR) has the interoperability to obtain vital inpatient notifications as well as other pertinent patient health information.
- Secure spots for patients who have been discharged from ED/Hospital for appropriate transition of care
- Submit complete and correct encounters/claims with appropriate codes
- Submit clinical data, such as lab results, to CarePlus
- Establish trusting relationships with your patients by listening and communicating clearly and thoroughly
- A primary care setting that delivers patient-centered care is linked to better health outcomes, increased patient satisfaction and treatment adherence¹
- Create office practices to follow up with referrals to specialist to ensure timely referral processing and knowledge of visit outcomes/careplan
- Review CMS-administered annual surveys, which have been developed to evaluate population health outcomes and patient satisfaction with the healthcare system

1. <https://www.ahrq.gov/sites/default/files/wysiwyg/ncepcr/tools/PCMH/creating-patient-centered-team-based-primary-care-white-paper.pdf>

For More Information

To learn more about the CMS Five-star Quality Rating System, visit

www.cms.gov/medicare/provider-enrollment-and-certification/certificationandcompliance/fsgrs

To learn more about the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) survey, visit ma-pdpcahps.org/en/survey-instruments-and-specifications/

To learn more about the Health Outcomes Survey (HOS), visit www.hosonline.org/en/survey-instrument/

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2024 Centers for Medicare & Medicaid Services (CMS) Star Ratings Measures

Healthcare Effectiveness Data and Information Set (HEDIS®)	
BCS	Breast cancer screening
COL	Colorectal cancer screening
OMW	Osteoporosis management in women who had a fracture
EED	Diabetes care – eye exam
KED	Diabetes care – kidney health evaluation
HBD	Diabetes care – blood sugar controlled
CBP	Controlling blood pressure
PCR	Plan all-cause readmissions
SNP	Health risk assessment within 90 days of enrollment (CMS requirement, not HEDIS)
COA - MDR	Care for older adults – medication review
COA - PNS	Care for older adults – pain screening
FMC	Follow-up after emergency department visit for people with multiple high-risk chronic conditions
KED	Kidney health evaluation for patients with diabetes
SPC	Statin therapy for patients with cardiovascular disease
TRC	*Transitions of care: Notification of Inpatient Admission (NIA), Receipt of Discharge Information (RDI), Patient Engagement After Inpatient Admission (PED) and Medication Reconciliation Post-Discharge (PED)

*TRC is a composite score of 4 measures listed.

Consumer Assessment of Healthcare Providers and Systems (CAHPS®)	
GNC	Getting needed care
GACQ	Getting appointments and care quickly
CS	Customer service
RHCQ	Overall rating of healthcare quality
RHP	Overall rating of health plan
CC	Care coordination
GNRx	Getting needed prescription drugs (Part D)
RDP	Overall rating of drug plan (Part D)

Health Outcomes Survey (HOS)	
IBC	Improving bladder control
ROF	Reducing the risk of falling
MPA	Monitoring physical activity
IMPH	Improving or maintaining physical health
IMMH	Improving or maintaining mental health

Independent review entities (IRE)	
PTD	Plan making timely decisions about appeals (Part C)
RAD	Reviewing appeals decisions (Part C)

CMS (Part C)	
CHP	Complaints about the health plan
FLIC	Call center – foreign language interpreter and TTY/TDD availability
MLPC	Members choosing to leave the plan
HPQI	Health plan quality improvement
SNP	Special needs plan care management

CMS (Part D)	
FLID	Call center – foreign language interpreter and TTY/TDD availability
CHPD	Complaints about the drug plan
MLPD	Members choosing to leave the plan
DPQI	Drug plan quality improvement
MPF	Medicare Plan Finder accuracy
CMR	Medication therapy management (MTM) program: completion rate for comprehensive medication review (CMR)

Patient safety	
SUPD	Statin use in persons with diabetes
MAD	Medication adherence for diabetes medications
MAH	Medication adherence for hypertension (renin-angiotensin system [RAS] antagonists)
MAC	Medication adherence for cholesterol (statins)

2. Healthcare Effectiveness Data and Information Set (HEDIS®)

HEDIS is a set of performance measures established by the National Committee for Quality Assurance (NCQA) for the managed care industry. Each year, CarePlus collects data from a randomly selected sample of members for HEDIS reporting purposes. MA plans are required to report their results annually to CMS, NCQA, and the Agency for Health Care Administration (AHCA), who use this information to monitor the performance of health plans.

Altogether, HEDIS is published across a number of volumes and includes 95 measures across six domains:

- Effectiveness of care
- Access/availability of care
- Experience of care
- Utilization and risk adjusted utilization
- Health plan descriptive information
- Measures collected using electronic clinical data systems

As a PCP, certain measures are indicative of your practice for preventive care and chronic condition management. Below are the Effectiveness of Care HEDIS measures applicable to the Medicare line of business. CarePlus is required to report the measures to governing partners.

Prevention Screening Measures

- **Breast cancer screening** – Percentage of female members 50-74 who had a mammogram any time on or between Oct. 1 two years prior to the measurement year and Dec. 31 of the measurement year.
- **Colorectal cancer screening** – Percentage of members 45-75 years old who had an appropriate screening for colorectal cancer. Documentation must include one of the following:
 - Fecal occult blood testing (either guaiac or immunochemical) testing during measurement year
 - DNA with FIT test during the measurement year or the two years prior to the measurement year
 - CT colonography during the measurement year or the four years prior to the measurement year
 - Flexible sigmoidoscopy during the measurement year or four years prior to the measurement year
 - Colonoscopy during the measurement year or nine years prior to the measurement year
- **Influenza Vaccination** – Percentage of members who are up to date with their influenza vaccination

Respiratory Condition Measures

- **Appropriate Testing for Pharyngitis** – The percentage of episodes for members 3 and older where the member was diagnosed with pharyngitis, dispensed an antibiotic, and received a group A streptococcus (strep) test for the episode.
- **Use of Spirometry Testing in the Assessment and Diagnosis of Chronic Obstructive Pulmonary Disease (COPD)** – The percentage of members 40 and older with a new diagnosis or newly active COPD who received appropriate spirometry testing to confirm the diagnosis.
- **Pharmacotherapy Management of COPD Exacerbation** – The percentage of COPD exacerbations for members 40 and older who had an acute inpatient discharge or ED encounter on or between Jan. 1 – Nov. 30 of the measurement year and were dispensed appropriate medications (systemic corticosteroid within 14 days of event and bronchodilator within 30 days of event). Two rates are reported:
 - Dispensed a systemic corticosteroid (or there was evidence of an active prescription) within 14 days of the event
 - Dispensed a bronchodilator (or there was evidence of an active prescription) within 30 days of the event

Cardiovascular Measures

- **Controlling High Blood Pressure** – The percentage of members 18-85 who had a diagnosis of hypertension (HTN) and whose blood pressure (BP) was adequately controlled (<140/90 mm Hg) during the measurement year.

Note: The representative BP is most recent BP reading during the measurement year on or after the second diagnosis of hypertension. If multiple BP measurements occur on the same date or are noted in the chart on the same date, use the lowest systolic and lowest diastolic BP reading. If no BP is recorded during the measurement year, assume the member is “not controlled.”

- **Persistence of Beta-blocker Treatment After a Heart Attack** – The percentage of members 18 and older during the measurement year who were hospitalized and discharged from July 1 of the year prior to the measurement year to June 30 of the measurement year with a diagnosis of myocardial infarction (AMI) and who received persistent beta-blocker treatment for six months after discharge.
- **Statin Therapy for Patients with Cardiovascular Disease** – The percentage of males 21-75 and females 40-75 years of age during the measurement year, who were identified as having clinical atherosclerotic cardiovascular disease (ASCVD) and met the following criteria. The following rates are reported:
 - Received statin therapy. Members who were dispensed at least one high or moderate-intensity statin medication during the measurement year.

- Statin adherence 80 percent. Members who remained on a high-intensity or moderate-intensity statin medication for at least 80 percent of the treatment period.
- **Cardiac Rehabilitation** - The percentage of members 18 and older, who attended cardiac rehabilitation following a qualifying cardiac event, including myocardial infarction, percutaneous coronary intervention, coronary artery bypass grafting, heart and heart/lung transplantation, or heart valve repair/replacement. Four rates are reported:
 - Initiation. The percentage of members who attended two or more sessions of cardiac rehabilitation within 30 days after a qualifying event.
 - Engagement 1. The percentage of members who attended 12 or more sessions of cardiac rehabilitation within 90 days after a qualifying event.
 - Engagement 2. The percentage of members who attended 24 or more sessions of cardiac rehabilitation within 180 days after a qualifying event.
 - Achievement. The percentage of members who attended 36 or more sessions of cardiac rehabilitation within 180 days after a qualifying event.

Diabetes Measures

- **Hemoglobin A1c Control for Patients With Diabetes** – Percentage of members 18-75 with a diagnosis of diabetes (Type 1 or Type 2) whose hemoglobin A1c (HbA1c) was at the following levels during the measurement year:
 - HbA1c control (less than 8 percent)
 - HbA1c poor control (greater than 9 percent)
- **Blood Pressure Control for Patients With Diabetes** – Percentage of members 18-75 with a diagnosis of diabetes (Type 1 or Type 2) whose BP was adequately controlled (less than 140/90 mm Hg) for the most recent BP reading.
- **Eye Exam for Patients With Diabetes** – Percentage of members 18-75 years old, with a diagnosis of diabetes (Type 1 or Type 2) who had a retinal or dilated eye exam by an eye care professional (optometrist or ophthalmologist) in the measurement year or a negative retinal or dilated eye exam (negative for retinopathy) by an eye care professional in the year prior to the measurement year.
- **Statin Therapy for Patients with Diabetes** – The percentage of members 40-75 during the measurement year with diabetes who do not have clinical atherosclerotic cardiovascular disease (ASCVD) who met the following criteria. Two rates are reported:
 - **Received Statin Therapy.** Members who were dispensed at least one statin medication of any intensity during the measurement year.
 - **Statin Adherence 80 percent.** Members who remained on a statin medication of any intensity for at least 80 percent of the treatment period.

- **Kidney Health Evaluation for Patients With Diabetes** - The percentage of members 18–85 with diabetes (Type 1 and Type 2) who received a kidney health evaluation, defined by an estimated glomerular filtration rate (eGFR) and a urine albumin-creatinine ratio (uACR), during the measurement year. A urine albumin creatinine ratio or both a urine albumin and urine creatinine test with service dates four days or less apart are acceptable for the uACR component.

Musculoskeletal Measures

- **Osteoporosis Management in Women Who Had a Fracture** – Percentage of female members 67-85 who suffered a fracture and who had either a bone mineral density (BMD) test or a prescription for a drug to treat osteoporosis in the six months after the fracture.
- **Osteoporosis Screening in Older Women** - The percentage of women 65-75 who received osteoporosis screening.

Behavioral Health Measures

- **Follow-up After Hospitalization for Mental Illness** – The percentage of discharges for members 6 and older who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses and who had a follow-up visit with a mental health practitioner. Two rates are reported:
 - The percentage of discharges for which the member received follow-up within 30 days after discharge.
 - The percentage of discharges for which the member received follow-up within seven days after discharge.
- **Follow-up After Emergency Department Visit for Mental Illness** – The percentage of emergency department (ED) visits for members 6 and older with a principal diagnosis of mental illness or intentional self-harm who had a follow-up visit for mental illness. Two rates are reported:
 - The percentage of ED visits for which the member received follow-up within 30 days of the ED visit (31 total days).
 - The percentage of ED visits for which the member received follow-up within seven days of the ED visit (eight total days).
- **Follow-up After High-intensity Care for Substance Use Disorder** – The percentage of acute inpatient hospitalizations, residential treatment, or detoxification visits for a diagnosis of substance use disorder (SUD) among members 13 and older that result in a follow-up visit or service for SUD. Two rates are reported:
 - The percentage of visits or discharges for which the member received follow-up for substance use disorder within the 30 days after the visit or discharge.
 - The percentage of visits or discharges for which the member received follow-up for substance use disorder within the seven days after the visit or discharge.

- **Follow-up After Emergency Department Visit for Substance Abuse** – The percentage of ED visits for members 13 and older with a principal diagnosis of SUD, or any diagnosis of drug overdose, for which there was follow-up. Two rates are reported:
 - The percentage of ED visits for which the member received follow-up within 30 days of the ED visit (31 total days).
 - The percentage of ED visits for which the member received follow-up within seven days of the ED visit (eight total days).
- **Antidepressant Medication Management** – The percentage of members 18 and older who were treated with antidepressant medication, had a diagnosis of major depression, and who remained on an antidepressant medication treatment. Two rates are reported.
 - Effective Acute-Phase Treatment. The percentage of members who remained on an antidepressant medication for at least 84 days (12 weeks).
 - Effective Continuation Phase Treatment. The percentage of members who remained on an antidepressant medication for at least 180 days (six months).
- **Pharmacotherapy for Opioid Use Disorder** – The percentage of new opioid use disorder (OUD) pharmacotherapy events with OUD pharmacotherapy for 180 or more days among members 16 and older with a diagnosis of OUD.
- **Adherence to Antipsychotic Medications for Individuals With Schizophrenia** – The percentage of members 18 and older during the measurement year with schizophrenia or schizoaffective disorder who were dispensed and remained on an antipsychotic medication for at least 80 percent of their treatment period.

Care Coordination

- **Advance Care Planning** – The percentage of adults 66–80 with advanced illness, an indication of frailty, or who are receiving palliative care, and adults 81 years of age and older who had advance care planning during the measurement year.
- **Transitions of Care** – The percentage of discharges for members 18 and older who had each of the following. Four rates are reported:
 - Notification of Inpatient Admission. Documentation of receipt of notification of inpatient admission on the day of admission or through two days after the admission (three total days).
 - Receipt of Discharge Information. Documentation of receipt of discharge information on the day of discharge or through two days after the discharge (three total days).
 - Patient Engagement After Inpatient Discharge. Documentation of patient engagement (e.g., office visits, visits to the home, telehealth) provided within 30 days after discharge.
 - Medication Reconciliation Post-Discharge. Documentation of medication reconciliation on the date of discharge through 30 days after discharge (31 total days).

- **Follow-up After Emergency Department Visit for People With Multiple High-risk Chronic Conditions** – The percentage of ED visits for members 18 and older who have multiple high-risk chronic conditions who had a follow-up service within seven days of the ED visit.

Overuse/Appropriateness

- **Non-recommended PSA-based Screening in Older Men** – The percentage of men 70 and older who were screened unnecessarily for prostate cancer using prostate-specific antigen (PSA)-based screening. Note: A lower rate indicates better performance.
- **Appropriate Treatment for Upper Respiratory Infection**– The percentage of episodes for members 3 months and older with a diagnosis of upper respiratory infection (URI) that did not result in an antibiotic dispensing event.
- **Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis** – The percentage of episodes for members ages 3 months and older with a diagnosis of acute bronchitis/bronchiolitis that did not result in an antibiotic dispensing event.
- **Potentially Harmful Drug-Disease Interactions in Older Adults** – The percentage of Medicare members 65 and older who have evidence of an underlying disease, condition, or health concern, and who were dispensed an ambulatory prescription for a potentially harmful medication, concurrent with or after the diagnosis. Report each of the three rates separately and as a total rate.
 - A history of falls and a prescription for anticonvulsants, antipsychotics, benzodiazepines, nonbenzodiazepine hypnotics, or antidepressants (SSRIs, tricyclic antidepressants, and SNRIs).
 - Dementia and a prescription for antipsychotics, benzodiazepines, nonbenzodiazepine hypnotics, tricyclic antidepressants, or anticholinergic agents.
 - Chronic kidney disease and prescription for Cox-2 selective NSAIDs or nonaspirin NSAIDs.

Total rate (the sum of the three numerators divided by the sum of the three denominators). Members with more than one disease or condition may appear in the measure multiple times (i.e., in each indicator for which they qualify).

- **Use of High-risk Medications in Older Adults (DAE)** – The percentage of Medicare members 67 and older who had at least two dispensing events for the same high-risk medication. Three rates are reported:
 - The percentage of Medicare members 67 and older who had at least two dispensing events for high-risk medications to avoid from the same drug class.
 - The percentage of Medicare members 67 and older who had at least two dispensing events for high-risk medications to avoid from the same drug class, except for appropriate diagnoses.
 - Total rate (the sum of the two numerators divided by the denominator, deduplicating for members in both numerators).

- **Use of Opioids at High Dosage** – The proportion of members 18 and older who received prescription opioids at a high dosage (average morphine milligram equivalent dose [MME] ≥ 90) for more than 15 days during the measurement year.
- **Use of Opioids From Multiple Providers** – The proportion of members 18 and older, receiving prescription opioids for more than 15 days during the measurement year who received opioids from multiple providers. Three rates are reported:
 - Multiple prescribers: The proportion of members receiving prescriptions for opioids from four or more different prescribers during the measurement year.
 - Multiple pharmacies: The proportion of members receiving prescriptions for opioids from four or more different pharmacies during the measurement year.
 - Multiple prescribers and multiple pharmacies: The proportion of members receiving prescriptions for opioids from four or more different prescribers and four or more different pharmacies during the measurement year (i.e., the proportion of members who are numerator compliant for both the multiple prescribers and multiple pharmacies rates).
- **Risk of Continued Opioid Use** – The percentage of members 18 and older who have a new episode of opioid use that puts them at risk for continued opioid use. Two rates are reported:
 - The percentage of members whose new episode of opioid use lasts at least 15 days in a 30-day period.
 - The percentage of members whose new episode of opioid use lasts at least 31 days in a 62-day period.

Note: A lower rate indicates better performance

Access/Availability of Care Measures

- **Adults' Access to Preventive/Ambulatory Health Services** – The percentage of members 20 and older who had ambulatory or preventive care visit during the measurement year.
- **Initiation and Engagement of Substance Use Disorder Treatment** – The percentage of members with new SUD episodes that result in treatment initiation and engagement. Two rates are reported:
 - Initiation of SUD Treatment. The percentage of new SUD episodes that result in treatment initiation through an inpatient SUD admission, outpatient visit, intensive outpatient encounter, partial hospitalization, telehealth visit, or medication treatment within 14 days.
 - Engagement of SUD Treatment. The percentage of new SUD episodes that have evidence of treatment engagement within 34 days of the initiation.

Risk-Adjusted Utilization

- **Plan All-cause Readmission** – For members 18 and older, the number of acute inpatient and observation stays during the measurement year that were followed by an unplanned acute

readmission for any diagnosis within 30 days and the predicted probability of an acute readmission.

- **Hospitalization Following Discharge From a Skilled Nursing Facility** – For members 65 and older, the percentage of SNF discharges to the community that were followed by an unplanned acute hospitalization for any diagnosis within 30 and 60 days.
- **Acute Hospital Utilization** – For members 18 and older, the risk-adjusted ratio of observed-to-expected acute inpatient and observation stay discharges during the measurement year.
- **Emergency Department Utilization** – For members 18 and older, the risk-adjusted ratio of observed to expected ED visits during the measurement year.
- **Hospitalization for Potentially Preventable Complications** – For members 67 and older, the rate of discharges for ambulatory care sensitive conditions (ACSC) per 1,000 members and the risk-adjusted ratio of observed to expected discharges for ACSC by chronic and acute conditions.
- **Ambulatory care sensitive condition** – An acute or chronic health condition that can be managed or treated in an outpatient setting. The ambulatory care conditions included in this measure are:
 - Chronic ACSC:
 - Diabetes short-term complications
 - Diabetes long-term complications
 - Uncontrolled diabetes
 - Lower-extremity amputation among patients with diabetes
 - COPD
 - Asthma
 - Hypertension
 - Heart failure
 - Acute ACSC:
 - Bacterial pneumonia
 - Urinary tract infection
 - Cellulitis
 - Pressure ulcer

Special Needs Plans (SNP) Measures

CMS also collects audited data from all SNPs that have 30 or more members enrolled. CMS/NCQA are monitoring and evaluating at the individual SNP benefit package level.

The following is a list of HEDIS measures selected for SNP benefit packages:

- Breast Cancer Screening (BCS)
- Care for Older Adults (COA)
- Appropriate Testing for Pharyngitis Use of Spirometry Testing in the Assessment and Diagnosis of COPD (SPR)
- Pharmacotherapy of COPD Exacerbation (PCE)
- Controlling High Blood Pressure (CBP)
- Persistence of Beta Blocker Treatment After a Heart Attack (PBH)
- Statin Therapy for Patients With Cardiovascular Disease (SPC)
- Cardiac Rehabilitation (CRE)

- Comprehensive Diabetes Care (CDC)
- Statin Therapy for Patients With Diabetes (SPD)
- Kidney Health Evaluation for Patients with Diabetes (KED)
- Antidepressant Medication Management (AMM)
- Follow-up After Hospitalization for Mental Illness (FUH)
- Follow-up After Emergency Department Visit for Mental Illness (FUM)
- Follow-up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA)
- Pharmacotherapy for Opioid Use Disorder (POD)
- Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA)
- Use of Opioids at High Dosage (HDO)
- Use of Opioids From Multiple Providers (UOP)
- Risk of Continued Opioid Use (COU)
- Appropriate Treatment for Upper Respiratory Infection (URI)
- Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (AAB)

SNP-only measures

- **Care for Older Adults** – The percentage of members 66 and older who had each of the following:
 - Medication review
 - Functional status assessment
 - Pain assessment

Ways healthcare providers can support HEDIS initiatives, based on NCQA guidelines:

- Submit appropriately coded claims/encounters data for each service rendered in a timely manner.
- Submit encounters electronically and work rejected reports completely.
- Provide lab data as requested.
- Keep accurate, legible and complete medical records for their patients.
- Help ensure HEDIS-related preventive screenings, tests and vaccines are performed timely.
- Allow access to or provide records as requested (online capability).

3. Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey

Overview

NCQA and CMS require health plans to conduct a member satisfaction survey, called the Consumer Assessment of Healthcare Providers and Systems (CAHPS®). A random sample of health plan members is selected from eligible MA contracts to participate in the CAHPS program each year. Results are produced annually and compared with national benchmarks. The surveys are administered in early spring by mail, with telephonic follow-up for non-responders; results are available later in the year.

CAHPS is a member survey that gauges satisfaction with services provided by the health plan and member perception of provider accessibility, the patient-physician relationship and healthcare provider communication. The survey has approximately 68 questions; results are reported in composites and overall ratings. Below are the CAHPS categories applicable to providers and facilities along with respective sample questions applied towards the Star Ratings.

Getting Needed Care:

- In the last six months, how often did you get an appointment to see a specialist as soon as you needed?
- In the last six months, how often was it easy to get the care, tests or treatment you needed?

Getting Appointments and Care Quickly:

- In the last six months, when you needed care right away, how often did you get care as soon as you needed?
- In the last six months, how often did you get an appointment for a check-up or routine care as soon as you needed?

Care Coordination:

- In the last six months, when you visited your personal doctor for a scheduled appointment, how often did he or she have your medical records or other information about your care?
- In the last six months, when your personal doctor ordered a blood test, X-ray, or other test for you, how often did someone from your personal doctor's office follow up to give you those results?
- In the last six months, when your personal doctor ordered a blood test, X-ray, or other test for you, how often did you get those results as soon as you needed them?
- In the last six months, how often did you and your personal doctor talk about all the prescription medicines you were taking?
- In the last six months, did you get the help you needed from your personal doctor's office to manage your care among these different providers and services?
- In the last six months, how often did your personal doctor seem informed and up to date about the care you got from specialists?

Overall Rating of Healthcare Quality:

- Using any number from 0 to 10, where 0 is the worst healthcare possible and 10 is the best healthcare possible, what number would you use to rate all your healthcare in the last six months?

Medicare Specific and HEDIS Measures: Pneumonia Shot:

- Have you ever had a pneumonia shot? This shot is usually given only once or twice in a person's lifetime and is different from the flu shot. It is also called the pneumococcal vaccine.

4. Health Outcome Survey (HOS)

The Health Outcomes Survey (HOS) is a CMS survey that gathers meaningful health status data from people with Medicare. Like the CMS Healthcare Effectiveness Data and Information Set (HEDIS) and CAHPS, HOS is part of an integrated system for use in quality improvement activities and to establish accountability in managed care. All managed care plans with MA contracts, including CarePlus, must participate.

A random sample of Medicare beneficiaries receives a baseline survey. Two years later, the same respondents are surveyed for follow-up measurement. Survey completion is voluntary. The difference in the scores for the two-year period shows if a member's physical and mental health status is categorized as better than, the same as, or worse than expected. Member responses are shared with CarePlus for use in quality improvement initiatives.

HOS may be of interest to physicians as they could receive questions about the survey from their Medicare patients. Survey questions pertain to patient-physician relationships and help identify areas for improving member health outcomes. Five HOS measures (two functional health measures and three HEDIS Effectiveness of Care measures) are included in the annual Medicare Part C Star Ratings:

Functional Health (Outcome) measures

- Improving or Maintaining Physical Health
- Improving or Maintaining Mental Health

HEDIS Effectiveness of Care measures

- Monitoring Physical Activity
- Improving Bladder Control
- Reducing the Risk of Falling

Who conducts the survey?

A CMS-approved Medicare survey vendor conducts the survey.

For more information about the CMS Star Ratings, HEDIS®, CAHPS and HOS, please email CarePlus' Stars Maximization department at CPHP.STARSDEPT@careplus-hp.com

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MEDICATION THERAPY MANAGEMENT (MTM)

Medication Therapy Management (MTM) is a Medicare-designed program that assists members to ensure their medications are working to maintain optimum health. This service is provided at no additional cost to qualified members and is not considered a Medicare Part D benefit.

Purpose:

- Optimize therapeutic outcomes for individual members
- Optimize drug therapies
- Improve medication use
- Reduce risk of adverse events and drug interactions
- Increase member adherence and compliance with prescription drugs
- Identify interventions that promote safety, effectiveness, and cost savings opportunities for members

Medicare-required Criteria for MTM Eligibility:

- Beneficiary must have multiple chronic diseases.
- Beneficiary must have filled multiple covered Part D drugs.
- Beneficiary must be likely to incur annual Part D drug costs of more than \$5,330 for 2024.

CarePlus MTM Eligibility:

- Have three of the five core chronic disease conditions listed below
- Take eight or more chronic maintenance Part D Medications in a 90-day period
- Have anticipated cost of medications above a predetermined dollar amount (\$5,330 per year for 2024) (e.g., if a member is expected to spend more than \$1,332.50 in a quarter, it can be assumed he/she will spend at least \$5,330 in a year.)

OR

Be qualified for the Drug Management Program because:

- Beneficiary is taking an opioid medication prescribed by more than one provider and/or using more than one pharmacy; or
- Beneficiary had a drug-related hospital visit in the last 12 months and has been prescribed an opioid in the last 6 months

Core Chronic Conditions:

- Bone disease – Osteoarthritis
- Diabetes
- Depression
- Chronic obstructive pulmonary disease (COPD)
- Congestive heart failure (CHF)

CarePlus MTM Program Design:

CarePlus will notify the beneficiary of the comprehensive medication review (CMR) opportunity through the MTM notification letter once determined eligible for the MTM program. The phone number to the Member Services department is provided so the member can call and schedule a CMR.

MTM consultations allow beneficiaries to speak with qualified healthcare providers (e.g., pharmacist, MTM qualified provider) about their CMR and/or any identified drug-related problems. The healthcare provider will then work through the targeted interventions by consulting with beneficiaries and serving as their advocates in contacting prescribers, as necessary, to resolve drug therapy problems. Targeted Medication Reviews (TMRs) are performed if a pharmacist identifies a potential medication issue that needs attention after a CMR. The qualified healthcare provider will reach out to the beneficiary and/or prescriber via telephone, face to face, mail, or fax.

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STEP THERAPY FOR PART B DRUGS

CMS now allows MA plans to apply step therapy for physician-administered and other Medicare Part B drugs.

Step therapy is a type of prior authorization for drugs that require patients to initiate treatment for a medical condition with the most preferred drug therapy. Patients then progress to other therapies only if necessary.

If healthcare providers do not stock our preferred drug in their office, they may be able to obtain the preferred drug from a pharmacy (i.e., a pharmacy can ship the medication to the office). A list of specialty and mail-order pharmacies can be found in the Provider Directories on our website at [CarePlusHealthPlans.com/Directories](https://www.CarePlusHealthPlans.com/Directories). A full list of pharmacies is also available via the Pharmacy Finder Tool at [CarePlusHealthPlans.com/Pharmacy-Finder](https://www.CarePlusHealthPlans.com/Pharmacy-Finder).

CarePlus will require a review of some injectable drugs and biologics for step therapy requirements in addition to current review requirements. The affected drugs/devices are indicated on the Part B Step Therapy Preferred Drug List at [CarePlusHealthPlans.com/CarePlus-Providers/Pharmacy-Resources](https://www.CarePlusHealthPlans.com/CarePlus-Providers/Pharmacy-Resources).

The step therapy requirement will not apply to patients who are already actively receiving treatment with a nonpreferred drug (have a paid drug claim within the past 365 days).

MA patients subject to the step therapy requirement may:

- Request expedited exception reviews for step therapy prior authorization requests.
- Appeal a denied request for a nonpreferred drug due to step therapy requirements.

As of Jan. 1, 2020, CarePlus no longer offers a Drug Management Care Coordination Program for patients subject to step therapy or who take a preferred drug on the Part B Step Therapy Drug List. Per CMS guidance, health plans do not have to couple step therapy with a rewards and incentives program. Instead, MA plans must incorporate anticipated savings from implementing Part B step therapy into their bid amounts for each plan, which may be used to provide supplemental benefits and/or lower premiums to the plans' enrollees.

Time Frames for Part B Medications – Standard Requests (Standard Organization Determination):

CarePlus will make a determination and notify the member and/or the member's representative, PCP and/or treating physician/facility, of its determination as expeditiously as the member's health condition requires; but no later than 72 hours after the date CarePlus receives the request for a standard organization determination.

Time Frames for Part B Medications – Expedited Requests (Expedited Organization Determination):

All requests submitted and labeled as "ASAP," "Urgent," "STAT," or "Expedited" will be treated as an expedited request.

CarePlus will make a determination and notify the member and/or member's representative, PCP and/or treating physician and/or facility of its determination as expeditiously as the member's health condition requires, but no later than 24 hours after receiving the request for an expedited organization determination.

Authorization requests are reviewed in a consistent manner, based on the clinical information received and per the applicable criteria that includes Medicare Guidelines, LCDs and NCDs, MCG, Florida Medicaid Coverage, Evidence of Coverage (EOC), and clinical practice guidelines.

It is CarePlus' policy that a CarePlus medical director and/or pharmacist make the final determination prior to an adverse determination (or denial) being issued for requested services.

Note: CarePlus may not extend time frames for Part B organization determinations

Reference:

www.cms.gov/newsroom/fact-sheets/medicare-advantage-prior-authorization-and-step-therapy-part-b-drugs

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AUTHORIZATION REQUESTS

Organization Determinations – Health Services Department

CarePlus has a preauthorization lists (PAL) for medical services and medications (i.e., medications that are delivered in the physician's office, clinic, outpatient, or home setting) that require preauthorization prior to services being provided or administered. You can access the CarePlus PAL by visiting:

CarePlusHealthPlans.com/PAL

Although members, their representatives, and/or providers may submit requests for authorizations (also known as organization determinations), the PCP is responsible for determining whether a referral for specialty care or ancillary services is necessary. Providers must send an authorization request to CarePlus prior to the requested services being rendered when authorization is required. Referrals to specialists can be completed online via Availity or *PWS (*sunsetting July 2024). Please note: Although members enrolled in an Open Access plan are encouraged to keep the PCP updated, members are not required to obtain a PCP referral before seeking covered services from in-network providers.

- Telephonic precertification requests for dates of services that will occur within three days or sooner from the date of the call should be made utilizing 1-800-201-4305.
 - A maximum of five telephonic precertification requests will be accepted per call.
 - All necessary information (e.g., member demographics, procedure/diagnosis codes, provider information, Tax Identification Number, NPI number, etc.) should be readily available when calling the CarePlus Health Services department.
- Precertification requests for dates of service greater than three days from the date of the call, should be submitted electronically via Availity (Availity.com) or PWS (www.CarePlus-HP.com/PWS.htm) or via fax.
 - Dade fax: 1-888-790-9999
 - Broward and Palm Beach fax: 1-866 832-2678
 - All other counties fax: 1-888-634-3521
 - Use [Health Services Preauthorization Form](#) for fax requests
- Providers calling to inquire on an approved authorization will be redirected to utilize PWS or Availity (this does not apply to specialist physicians).

It is very important the requesting provider and/or PCP include any pertinent clinical notes to support the request, including diagnosis and procedure codes.

A provider may submit an authorization as expedited when the enrollee or his/her physician believes that waiting for a decision under the standard time frame could place the enrollee's life, health, or ability to regain maximum function in serious jeopardy.

Note: Expedited requests cannot be submitted through PWS or Availity. Expedited requests must be submitted through the Health Services Department (HSD) phone or fax line. Please refer to the Key Contacts List for contact details.

Authorization requests are reviewed in a consistent manner, based on the clinical information received and per the applicable criteria that includes Medicare guidelines, local and national coverage

determinations, MCG, Florida Medicaid coverage, Evidence of Coverage (EOC) and clinical practice guidelines.

It is CarePlus' policy that the chief medical officer and/or medical director make the final determination prior to an adverse determination (or denial) being issued for requested services for lack of medical necessity. The CarePlus Health Services Department will issue an Integrated Denial Notice (IDN) to the member and the provider(s), including the right to request an appeal with the health plan for all adverse determinations.

It is important to note; if a member disagrees with a practitioner's decision, to decline and/or to provide a service that the member has requested or offers alternative services; this is not an organization determination but rather a treatment decision. However, if a practitioner reduces or prematurely discontinues a previously authorized service/course of treatment, this would be considered an organization determination as defined by CMS and would require the provider notify CarePlus to issue a denial notice. In addition, the member always has the right to request an organization determination on his or her own behalf.

Important: CarePlus members can participate in experimental and investigational treatment, and/or clinical trials. CarePlus will utilize guidance from Humana's Technology Assessment Forum, Pharmacy and Therapeutics Committee, and/or Clinical Trials Medical Coverage Policy to determine eligibility for coverage.

Pre-Determinations:

For procedures or services that are investigational or experimental (or that may have limited benefit coverage), or for any service not on our preauthorization list, you can request a **Pre-Determination** on behalf of the patient prior to providing the service. You may be contacted if additional information is needed.

Initiate a Pre-Determination for medical services by submitting a written, fax, or telephone request:

- Submit by fax: 1-800-266-3022
 - **When submitting a Pre-Determination request via fax, please write "Pre-Determination" on your request.**
- Submit by calling 1-800-523-0023
 - **When requesting a Pre-Determination via phone, please advise CarePlus you're requesting a "Pre-Determination."**

Note: A non-specific code should be used only when a more specific code is not available to describe the service. Procedures/services not specifically defined or classified may be subject to a pre-service review. If you submit a preauthorization or predetermination request that includes an unlisted or miscellaneous code, be sure to include a detailed description of the service, along with any documentation to support your request. This step will help avoid the need for post-service medical necessity review.

Time Frames for Standard Requests (Standard Organization Determination):

CarePlus will make a determination and notify the member and/or the member's representative, PCP and/or treating physician/facility, of its determination as expeditiously as the member's health condition requires; but no later than 14 calendar days after the date CarePlus receives the request for a standard organization determination.

CarePlus may extend the time frame up to 14 calendar days. This occurs if the member requests an extension, or if the extension is justified due to the need for additional information and CarePlus documents how the delay is in the interest of the enrollee.

Time Frames for Expedited Requests (Expedited Organization Determination)

All requests submitted and labeled as "ASAP," "Urgent," "STAT" or "Expedited" will be treated as an expedited request.

CarePlus will make a determination and notify the member and/or member's representative, PCP and/or treating physician and/or facility of its determination as expeditiously as the member's health condition requires, but no later than 72 hours after receiving the request for an expedited organization determination.

PARTICIPATING PROVIDERS

PCPs must refer all CarePlus members to participating network providers except when the requested services cannot be provided by one of CarePlus' participating network providers.

EMERGENCY SERVICES

CarePlus does not require referrals or prior authorizations for emergency services. If a member is seen in an ED and the PCP is notified, it is then the responsibility of the PCP to schedule a timely follow-up visit in his/her office.

HOSPITAL ADMISSIONS

IMPORTANT: CarePlus requires notification for all observation status and authorization for inpatient admissions.

Elective Admissions:

- When a PCP or specialist identifies the need to schedule a hospital admission, refer to the Preauthorization List for services requiring authorization. Preauthorization must be submitted to the CarePlus Pre-certification department at least five days prior to the scheduled admission date.
- PCP will notify CarePlus Pre-certification department of his/her intent to admit as soon as the admission is scheduled and will complete a preauthorization request form, including all supporting medical information, diagnosis codes, and procedure codes for a determination to be made. The hospital must notify CarePlus within 24 hours after the admission.

- Verify member eligibility and benefits for a specific service.
- Evaluate the medical necessity and appropriateness of services.
- CarePlus uses the following medical guideline criteria for medical determinations: Medicare LCDs and NCDs, MCG and Humana coverage policies.

If the elective admission is based on medical necessity and the criteria for medical necessity are met, an authorization is provided to the PCP, requesting physician, and the facility that is requesting the admission. If the elective admission does not meet medical necessity criteria and the plan is not able to obtain necessary information, the authorization request may not be approved. If there is an adverse determination, the CarePlus Health Services department will issue an Integrated Denial Notice (IDN) to the member and the provider(s), including the right to request an appeal with the health plan.

Admissions via Emergency Room:

- The hospital will be responsible for notifying the PCP, the admitting panel physician group call center listed in the important numbers above (if the PCP does not do his/her own admissions), and CarePlus of the admission. The notification should occur within 24 hours after the admission of the member.
- Member eligibility and benefit coverage will be verified by the plan.
- An authorization number or notification of denial will be provided by the plan in a timely manner.
- Notification of admission after member's discharge will result in a retrospective medical necessity review.

Inpatient Utilization Management

A CarePlus Utilization Management (UM) nurse will conduct initial review for medical necessity of the hospital admission. CarePlus UM nurses are available to support hospital staff who may be experiencing barriers during the discharge planning process of CarePlus members.

Discharge Planning

- The objective of discharge planning is to facilitate an appropriate and safe transition of care.
- The CarePlus UM nurse collaborates with the facility case management staff, attending physician, other healthcare providers, and the member/caregiver, throughout the hospitalization as needed to help facilitate a safe discharge.
- The facility is responsible for submitting ALL discharge orders for infusion, home health care (HHC), and durable medical equipment (DME) directly to the plan's provider.
- The facility should submit orders of wound care and ostomy supplies to the plan.
- Any post discharge follow-up appointment and transportation should be coordinated with the PCP office.
- Once the process is finalized, copies of the authorization for discharge services will be faxed to the PCP.

Note: If a hospital determines that an enrollee no longer needs inpatient care but is unable to obtain the agreement of the physician, the hospital may request a BFCC-QIO review. However, this should not occur until the hospital has consulted with CarePlus. Hospitals must notify the enrollee that the review has been requested.

NOTIFICATION OF HOSPITAL DISCHARGE APPEAL RIGHTS

Medicare beneficiaries who are hospital inpatients have a statutory right to appeal to the Beneficiary and Family Centered Care Quality Improvement Organization (BFCC-QIO) for an expedited review when a hospital with physician concurrence, determines that inpatient care is no longer necessary.

Hospitals must notify Medicare beneficiaries who are hospital inpatients about their hospital discharge appeal rights. Hospitals must use the “Important Message from Medicare” (IM), a statutorily required notice, to explain the beneficiary’s rights as a hospital patient, including discharge appeal rights. The IM is available in English and Spanish, and in PDF and Word format by CMS (see the link at the end of this section). Hospitals should utilize the appropriate version of the IM based on the language the beneficiary best understands.

Hospitals must issue the IM within two calendar days of the admission, must obtain the signature of the beneficiary or his/her representative, and provide a copy at that time. Hospitals also will deliver a copy of the signed notice as far in advance of discharge as possible, but no more than two calendar days before discharge. However, when discharge cannot be predicted in advance, the follow-up copy may be delivered as late as the day of discharge, if necessary, giving the member at least four hours to consider their right to request a BFCC-QIO review. If the hospital delivers the follow-up notice and the status subsequently changes, so that the discharge is beyond the two-day time frame, hospitals must deliver another copy of the signed notice again within two calendar days of the new planned discharge date. Hospitals may NOT develop procedures for delivery of the follow up copy routinely on the day of discharge.

Regardless of the competency of the Medicare beneficiary, if the hospital is unable to personally deliver a notice to a representative, then the hospital should telephone the representative to advise him/her of the beneficiary’s right as a hospital patient, including the right to appeal the discharge decision. The date the hospital conveys this information to the representative, whether in writing or by telephone, is the date of receipt of the notice. Additionally, the telephone contact should be confirmed by a written notice mailed on that same date as the telephone contact. When direct phone contact cannot be made, send the notice to the representative by certified mail, return receipt requested, or other delivery method that requires signed verification of delivery. The date that someone at the representative’s address signs (or refuses to sign) the receipt is the date received. If both the hospital and the representative agree, hospitals may send the notice by fax or email; however, hospitals must meet HIPAA privacy and security requirements.

Note: Beneficiaries who are being transferred from one inpatient hospital setting to another inpatient hospital setting, do not need to be provided with the follow-up copy of the IM notice prior to leaving the original hospital, since this is still considered to be the same level of care. Medicare beneficiaries always have the right to refuse care and may contact the BFCC-QIO if they have a quality of care issue. The receiving hospital must deliver the IM notice from Medicare according to the procedures in these instructions.

Hospitals must place dated copies of the initial IM notice and any subsequent follow-up notices in the beneficiary’s medical file and document all telephone conversations with the beneficiary’s representative (if applicable). Hospitals must demonstrate compliance with this process.

Medicare beneficiaries have until midnight of the day of discharge to make a timely request to the BFCC-QIO. The beneficiary is not financially responsible (except applicable coinsurance or deductible) furnished before noon of the calendar day after the date the beneficiary receives notification from the BFCC-QIO. Liability for further inpatient hospital services depends on the BFCC-QIO. The BFCC-QIO will notify CarePlus that the beneficiary has filed a request for immediate review (appeal). CarePlus and/or hospitals must provide the BFCC-QIO with all the necessary information by telephone or in writing at the BFCC-QIO's discretion.

- If the BFCC-QIO agrees with the plan/hospital, the BFCC-QIO will notify the beneficiary and liability for continued services begins at noon of the day after the BFCC-QIO notifies the beneficiary, or as determined by the BFCC-QIO.
- If the BFCC-QIO agrees with the beneficiary, the BFCC-QIO notifies the beneficiary and advises the beneficiary of not having financial liability for continued stay other than applicable coinsurance or deductible. A follow up copy of the IM will need to be delivered once discharge is once again determined.

For additional information regarding Hospital Discharge Appeal Process and Notices, please visit the CMS website at www.cms.gov/Medicare/Medicare-General-Information/BNL/index.html.

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MEDICARE OUTPATIENT OBSERVATION NOTICE (MOON)

On Aug. 6, 2015, Congress enacted the Notice of Observation Treatment and Implication for Care Eligibility (NOTICE) Act, which requires all hospital and critical access hospitals (CAHs) to provide written notification and an oral explanation of such notification to individuals receiving observation services as outpatient for more than 24 hours. All hospitals and CAHs were required to begin using the Medicare Outpatient Observation Notice (MOON) notification no later than March 8, 2017, and thereafter.

MOON was developed to inform all Medicare beneficiaries when they are an outpatient receiving observation services and are not an inpatient of the hospital or CAH. In accordance with the statute, the notice must include the reasons the individual is an outpatient receiving observation services and the implications of receiving outpatient services, such as required Medicare cost-sharing and post-hospitalization eligibility for Medicare coverage of skilled nursing facility services. Hospitals and CAHs must deliver the notice no later than 36 hours after observation services are initiated or sooner if the individual is transferred, discharged, or admitted.

Notice Instructions: Medicare Outpatient Observation Notice

Page 1 of the MOON

The following blanks must be completed by the hospital. Information inserted may be typed or legibly hand-written in 12-point font or the equivalent.

Patient Name: Fill in the patient's full name or attach patient label.

Patient ID number: Fill in an ID number that identifies this patient, such as a medical record number or the patient's birthdate or attach a patient label. This number should not be the patient's Social Security number.

"You're a hospital outpatient receiving observation services. You are not an inpatient because": Fill in the specific reason the patient is in an outpatient, rather than an inpatient stay.

Page 2 of the MOON

Additional Information: This may include, but is not limited to, Accountable Care Organization (ACO) information, notation that a beneficiary refused to sign the notice, hospital waivers of the beneficiary's responsibility for the cost of self-administered drugs, Part A cost sharing responsibilities if the beneficiary is subsequently admitted as an inpatient, physician name, specific information for contacting hospital staff, or additional information that may be required under applicable state law.

Hospitals may attach additional pages to this notice if more space is needed for this section.

Oral Explanation: When delivering the MOON, hospitals and CAHs are required to explain the notice and its content, document that an oral explanation was provided, and answer all beneficiary questions to the best of their ability.

Signature of Patient or Representative: Have the patient or representative sign the notice to indicate that he or she has received it and understands its contents. If a representative's signature is not legible, print the representative's name by the signature.

Date/Time: Have the patient or representative place the date and time that he or she signed the notice.

Information on the MOON including a copy of the English and Spanish forms and additional instructions may be found at the CMS website at: www.cms.gov/Medicare/Medicare-General-Information/BNI/MOON.html

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NOTICE OF MEDICARE NON-COVERAGE (NOMNC) FOR A SKILLED NURSING FACILITY (SNF) STAY FACT SHEET

CMS requires that members enrolled in a Medicare Advantage (MA) health plan, have the right to an expedited review by a Beneficiary and Family Centered Care Quality Improvement Organization (BFCC-QIO), in Florida, Keystone Peer Review Organization Inc. (KEPRO), when they disagree with the decision that their services from a SNF should end.

The NOMNC document is to be issued for every discharge no later than two days in advance of the services ending. The NOMNC document informs the patient the date coverage of services ends and describes the member appeal process.

WHAT YOU MUST DO

- Provide a current NOMNC document to CarePlus beneficiaries or authorized representative and obtain their signature on the form (refer to the “Who Must Sign” below for guidance).
- Fax a copy of the signed and dated document to CarePlus to 1-866-229-1538 and keep a copy in the patient’s medical record as required by CMS.
- The effective date or “services will end” date is considered the last full day of coverage (effective date of coverage termination).

NOMNC DOCUMENT PROCESS

- The NOMNC is a standardized notice. Therefore, plans and providers may not re-write, re-interpret or insert non-OMB-approved language into the body of the notice except where indicated. The CMS form number and the OMB control number must be displayed on the notice.
- The document must be properly completed by the SNF and include the facility name, full address, 10-digit phone and fax numbers as the header. Do not use CarePlus’ information as header.
- The document must be signed and a copy faxed to CarePlus at 1-866-229-1538 no later than two days before a patient’s coverage of services from your facility is due to terminate.
- The document must include the name and telephone numbers (including TTY) of the applicable BFCC-QIO, as shown below.

KEPRO

Telephone: 1-888-317-0751

TTY: 771 to appeal.

- The document must include CarePlus’ name and contact information, as shown below, for the enrollees use in case an expedited appeal is requested or in the event the enrollee or BFCC-QIO seeks the plan’s identification.

CarePlus Health Plans Inc.

P.O. Box 277810

Miramar, FL 33027

Telephone: 1-800-794-5907 (TTY: 711)

Fax: 1-800-956-4288

- If services are expected to be less than two days, deliver the notice upon admission.

- The document must be signed by the beneficiary or designated representative, or in absence of a signature, the document must note the said person who was presented with the document including date, time, name of person, relationship, contact phone number. **The documentation will indicate that the staff person told the representative the date the patient's financial liability begins, the QIO phone number, the patient's appeal rights, and how and when to initiate an appeal.** Also include the name, organization and contact number of the staff person initiating the contact, the name of the representative contacted by phone, the date and time of the telephone contact, and the telephone number called. (Include in the middle of Page 2 of the document under "Additional Information (Optional).") Refer to the **Who Must Sign** section of this facility manual (below) for more details.
- If the patient chooses to appeal, he or she must contact the KEPRO to request a review no later than noon on the day before services are to end. The KEPRO appeal decision generally is completed within 48 hours of the patient's request for a review.
- The facility must provide all appropriate medical records to the KEPRO via fax at 1-833-868-4058 by the end of business day on the same day the records are requested by the KEPRO or by the time frame noted on the KEPRO Request for Medical Record form. This applies seven days a week, including weekends and holidays. Records can include but are not limited to: evaluations and therapy notes, physician progress notes, physician's orders, nurse's notes, medication records, and any other pertinent information from admission date through the date of appeal. CarePlus is required to issue a Detailed Explanation of Non-coverage (DENC) to the patient and provide a copy to the KEPRO and the SNF to deliver to the beneficiary or the representative no later than close of business the day the KEPRO's notification that the patient requested an appeal is issued or the day before coverage ends, whichever is less. The intent of the requirement that the beneficiary or representative receive the DENC is to make sure that those who choose to appeal are made aware of the reasoning for the coverage termination and have an opportunity to present their views to the KEPRO.
- Failure to comply exactly with this process will result in non-payment of days for facility-related delays.

Where to find current NOMNC Document (Form CMS 10123-NOMNC)

- The English version of the NOMNC can be found under the **Forms** section of this document; if you need a Spanish version of the NOMNC, please reach out to your CarePlus Provider Services executive.
- CMS instructions on the NOMNC can be found at www.cms.gov/Medicare/Medicare-General-Information/BNI/FFS-Expedited-Determination-Notices. Select the "Instructions for Notice of Medicare Non-Coverage" PDF under the downloads section.

Where to find additional information

- CMS requirement 42 CFR 422.624(b) (2) can be found as a final rule published in the April 4, 2003, edition of the Federal Register, Vol. 68, No. 16652.
- CMS provides detailed explanations of the appeal process on the website at: www.cms.gov/Medicare/Appeals-and-Grievances/MMCAG/index.html
- Contact the CarePlus field care manager for your facility if you have additional questions.

Sample of SNF Appeal Scenario

CarePlus authorizes Jane Doe to receive care from a SNF from May 25 through June 4. The NOMNC is delivered to Ms. Doe on June 2, to advise that the SNF services are scheduled to terminate on June 4. Ms. Doe feels she needs additional services and decides to appeal.

Date	Member	KEPRO and CarePlus
May 25	Jane Doe is beginning a pre-authorized course of care at a SNF	CarePlus authorizes the SNF admission.
June 2	Jane Doe receives the required two-day advance notice of the NOMNC with an effective date that SNF services will end. In this case, June 4 would be Jane Doe's day of discharge from the SNF.	The SNF delivers a current NOMNC document which is signed by the member or designated representative. A copy of the signed document is faxed to CarePlus at 1-866-229-1538
June 3	If Jane Doe does not agree with discharge, Jane Doe must file appeal with KEPRO by noon.	If Jane Doe appeals, KEPRO notifies the SNF to provide all pertinent medical records and a copy of the NOMNC and also notifies CarePlus to complete a detailed notice by end of day.
June 4	If Jane appealed, she should receive a decision from KEPRO by end of day.	KEPRO decision will overturn or uphold the discharge decision and date. If Jane Doe does not appeal and receives no services after this date, she has no liability.
June 5	<p>Last certified day.</p> <p>If KEPRO agrees with original discharge date, Jane Doe is liable for care starting today.</p> <p>This date is considered the discharge date for the SNF. The last payable date to the facility is June 4, as CarePlus does not pay for day of discharge.</p>	If KEPRO overturns CarePlus' decision to discontinue SNF care, CarePlus is liable for services through the date given by the KEPRO. If CarePlus determines that no additional SNF days are required beyond the date specified by KEPRO, the facility must issue a new NOMNC document.

WHO MUST SIGN?

- Beneficiaries (or their authorized representative) whose coverage for services will end. The beneficiary must be able to understand that he/she may appeal the decision. If a patient is able to comprehend the notice, but is either physically unable to sign, or needs the assistance of an interpreter to translate it or an assistive device to read or sign it, valid delivery may be achieved by documenting the use of such assistance. Furthermore, if the patient refuses to sign the notice, the notice is still valid as long as the provider documents that the notice was given, but the patient refused to sign including date, time, name, relationship, and contact phone number. **The documentation *will* indicate that the staff person told the representative the date the patient's financial liability begins, the QIO phone number, the patient's appeal rights, and how and when to initiate an appeal.** Also include the name, organization, and contact number of the staff person

initiating the contact, the name of the representative contacted by phone, the date and time of the telephone contact, and the telephone number called. (Include in the middle of Page 2 of the NOMNC, “Additional Information (Comments).”

- **If the beneficiary is not able to comprehend the contents of the notice,** it must be delivered to and signed by the patient’s representative. If the representative is not available to receive and sign the notice, they must be contacted by telephone to advise him/her when the patient’s services will no longer be covered. The facility must identify itself to the representative and provide a contact number for questions about the discharge plan. It must describe the purpose of the call which is to inform the representative about the right to file an appeal. The information provided must, at a minimum, include the following:
 - The date services end, and when the patient’s liability begins. The date services will end is the same as the discharge date.
 - How to get a copy of a detailed notice describing why the patient’s services are not being provided.
 - A description of the particular appeal right being discussed (e.g., BFCC-QIO vs. expedited);
 - When (by what time/date) the appeal must be filed to take advantage of the particular appeal right.
 - The entity required to receive the appeal, including any applicable name, address, telephone number, fax number, or other method of communication the entity requires in order to receive the appeal in a timely fashion.
 - Provide at least one telephone number of an advocacy organization, or 1-800-MEDICARE, that can provide additional assistance to the representative in further explaining and filing the appeal.
 - Additional documentation that confirms whether the representative, in the writer’s opinion, understood the information provided.

The date the facility conveys this information to the representative, whether in writing or by telephone, is the date of receipt of the notice. Place a dated copy of the notice in the patient’s medical file and document the telephone contact with the member’s representative (as listed above) on the notice itself (middle of Page 2, “Additional Information (Comments),” and in a separate entry in the patient’s file or attachment to the notice.

The documentation will indicate that the staff person told the representative the date the patient’s financial liability begins, the QIO phone number, the patient’s appeal rights, and how and when to initiate an appeal. Also include the name, organization and contact number of the staff person initiating the contact, the name of the representative contacted by phone, the date and time of the telephone contact, and the telephone number called.

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CARE MANAGEMENT PROGRAM

Program Philosophy:

CarePlus is dedicated to providing quality, cost-efficient healthcare programs for its members. All programs are developed using a personal care approach to establish a professional relationship with the member or caregiver. These programs may utilize written educational materials, regular member mailings and telephonic assessment and education, as indicated. Each program will utilize the member's PCP as the primary point of contact in the direction and management of the member. In addition, members of the interdisciplinary care team (ICT) will be engaged, as appropriate, for those members being care-managed with an individualized care plan developed and implemented. CarePlus Care Management directly supports our members who are not attributed to a value-based provider. Members with needs who have a value-based provider are referred back to the provider for any Care Management needs. In the rare instance that a value-based provider has difficulty with providing needed services, a single-event request can be sent to CarePlus from the provider (Provider Referral) to request assistance.

Program Goals:

- To provide patient-centered and comprehensive care management programs for the education and management of members with comorbidities and/or who experience a transition of care.
- To promote the PCP as the key person in helping the member maintain or achieve optimal health.
- To ensure that healthcare services/needs are met throughout the member's duration of enrollment with plan.

Care Management:

CarePlus monitors health-related conditions and attempts to provide a holistic care management experience to members to enable them to better understand and self-manage their health. All CarePlus members may request to be evaluated for care management services. Members who are non-SNP and are not followed by a Value-Based provider and are identified with complex medical conditions are referred to the care management team to have their needs assessed. Members are encouraged to participate in care management, to ensure they receive education regarding their specific healthcare needs and self-care management. They have direct access to a care manager who can assist them in complying with the prescribed treatment plan and their overall wellbeing.

Care management services are offered to members who meet one or more of the following:

- All members who are enrolled in a Special Needs Plan (SNP)
- Members identified through the stratification process, which includes:
 - Medicare data files
 - Behavioral health diagnosis data
 - Utilization (i.e., hospital admissions, ER visits, readmissions, etc.)
 - Pharmacy data
 - Predictive modeling
 - Claims data
 - Health risk assessment (HRA) data

- Members referred by their PCP or other healthcare provider
- Members referred by the CarePlus field/utilization case manager

Care Management services include, but are not limited to:

- Medical care management
- Interdisciplinary team meetings
- Individualized care plans
- Post discharge transition of care management
- Referrals for home visits for homebound and/or high risk members
- Medication reconciliation
- Social services

Referral to Care Management

To learn more about our care management program, refer a member to the care management program, or speak with one of our care managers, please call Monday – Friday, 8 a.m. – 5 p.m., Eastern time:

- For Non-SNP members: 1-866-657-5625
- For SNP members: 1-800-734-9592

Transplant Services/Inquiries

In order to initiate the transplant evaluation and clearance process, you may refer your patient directly to one of our Humana Transplant Network participating facilities.

You can locate a participating transplant facility by going directly to the Humana Transplant Network Locator through the following link: [National Transplant Network Locator - Humana](#)

Please be alert to select the type of transplant. Not all participating facilities are in network for each transplant type. Once the facility has accepted and cleared your patient for transplant evaluation, you may submit a request directly to CarePlus for authorization:

FAX: 1-844-692-5765

PHONE: 1-866-657-5625

EMAIL: CPHP_HSD_Transplant_Team@humana.com

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SPECIAL NEEDS PLANS (SNPs)

CarePlus offers three types of Special Needs Plans (SNPs) for members who reside within the CarePlus service area:

- CareComplete Platinum (HMO C-SNP) and CareComplete Platinum (HMO-POS C-SNP) for individuals diagnosed with at least one of the following chronic conditions: cardiovascular disorders, chronic heart failure, or diabetes
- CareBreeze Platinum (HMO C-SNP) and CareBreeze Platinum (HMO-POS C-SNP) for individuals diagnosed with Chronic Lung Disorders
- CareNeeds Plus (HMO D-SNP) and CareNeeds Platinum (HMO D-SNP) for individuals who are dually enrolled in both Medicare and Medicaid

These plans offer eligible members focused benefits as well as the advantages of an interdisciplinary-care team (ICT) approach to patient care. This team approach to care is dependent on the active involvement of the member's PCP.

Eligibility Requirements for CareComplete Platinum Plans

- Entitled to Medicare Part A
- Enrolled in Medicare Part B through age or disability
- Resident within the plan's service area
- Diagnosed with one or more of the following:
 - Diabetes mellitus
 - Cardiovascular disorder, specifically cardiac arrhythmias, coronary artery disease, peripheral vascular disease, and/or chronic venous thromboembolic disorder
 - Chronic heart failure

Eligibility Requirements for CareBreeze Platinum Plans

- Entitled to Medicare Part A
- Enrolled in Medicare Part B through age or disability
- Resident within the plan's service area
- Diagnosed with one or more of the following chronic lung disorders including:
 - Asthma
 - Chronic bronchitis (a condition of COPD)
 - Emphysema (a condition of COPD)
 - Pulmonary fibrosis (inflammation of the lungs)
 - Pulmonary hypertension (high blood pressure in the arteries leading from the heart to the lungs)

- Members enrolled in a Chronic SNP must have their physician or physician's office confirm the qualifying condition either verbally or in writing by the last day of the first month of enrollment; written confirmation can be provided by obtaining the physician's signature on the Chronic Condition Verification Form. This form is intended to substantiate that the applicant has an appropriate diagnosis for participation in the plan. If CarePlus does not receive confirmation of the member's chronic condition by the last day of the first month of enrollment, the patient's coverage under the Chronic SNP will be involuntarily terminated.

Sample Chronic Condition Verification Form

To be completed and returned to the plan by the member's physician or physician's office by the last day of the first month of enrollment.



Chronic Condition Verification Form for Special Needs Plans (SNP)

The beneficiary listed below has applied for enrollment in a Special Needs Medicare health plan through CarePlus Health Plans, Inc. This plan will provide the beneficiary with additional benefits related to his or her condition, such as supplemental drug coverage. For the beneficiary to qualify, a provider or provider's office must confirm his or her diagnosis. If we do not receive confirmation of the qualifying condition from the provider/provider's office in a timely manner, the beneficiary may be disenrolled from the plan. Your assistance is appreciated.

To Be Completed by the Beneficiary

Last Name: _____ First Name: _____ MI: _____
Address: _____
City: _____ State: _____ Zip: _____
Date of Birth: _____ Gender: ☐ Male ☐ Female
Medicare Number: _____ Physician Name: _____
Physician Phone Number: _____ Physician Facsimile Number: _____
My signature below authorizes information about my chronic condition to be shared
with CarePlus Health Plans, Inc.
Beneficiary Signature: _____ Date: _____

To Be Completed by the Provider/Provider's Office

By signing this form, you confirm the patient has been diagnosed with any of the following conditions:

- ☐ Diabetes ☐ Cardiovascular Disorders ☐ Chronic Heart Failure
☐ Chronic Lung Disorder (Asthma, Chronic Bronchitis, Emphysema, Pulmonary Fibrosis, Pulmonary Hypertension)

Confirmation provided by:

_____ <i>Signature</i>	_____ <i>Date</i>
_____ <i>Printed Name or Stamp</i>	_____ <i>Title</i>
_____ <i>Practice Name and Address</i>	_____ <i>Phone Number</i>

Please return this form within 5 days of receipt to the following address or fax:

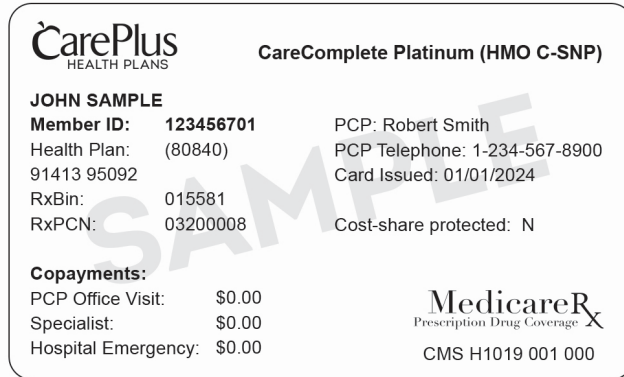
CarePlus Health Plans, Inc.
P.O. Box 14733
Lexington, KY 40512-4642
Fax: 1-855-819-8679

H1019_HSChronicVeriForm2024_C

Sample Chronic SNP Member ID Card (enlarged for better visibility)

You can easily identify C-SNP members by locating the plan name on the front of the CarePlus member ID card, as shown here:

Chronic SNP: CareBreeze Platinum (HMO C-SNP) and CareComplete Platinum (HMO C-SNP)



CarePlus
HEALTH PLANS

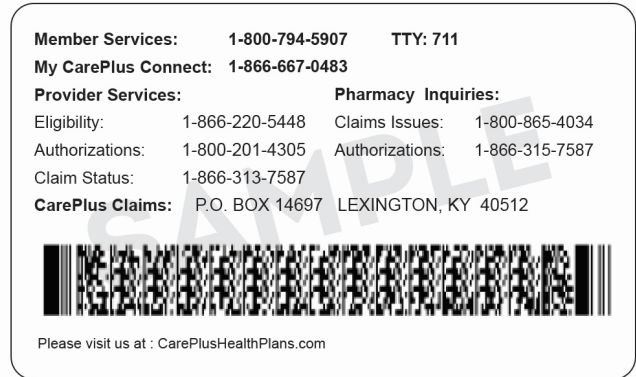
CareComplete Platinum (HMO C-SNP)

JOHN SAMPLE
Member ID: 123456701
 Health Plan: (80840)
 91413 95092
 RxBin: 015581
 RxPCN: 03200008

PCP: Robert Smith
 PCP Telephone: 1-234-567-8900
 Card Issued: 01/01/2024
 Cost-share protected: N

Copayments:
 PCP Office Visit: \$0.00
 Specialist: \$0.00
 Hospital Emergency: \$0.00

MedicareRx
 Prescription Drug Coverage
 CMS H1019 001 000




Member Services: 1-800-794-5907 TTY: 711
My CarePlus Connect: 1-866-667-0483

Provider Services: Eligibility: 1-866-220-5448
 Authorizations: 1-800-201-4305
 Claim Status: 1-866-313-7587

Pharmacy Inquiries: Claims Issues: 1-800-865-4034
 Authorizations: 1-866-315-7587

CarePlus Claims: P.O. BOX 14697 LEXINGTON, KY 40512



Please visit us at : CarePlusHealthPlans.com

Note: If a member loses SNP eligibility, he or she will be disenrolled from the plan.

Eligibility Requirements for CarePlus' Dual Eligible SNP – CareNeeds Plus Plan (HMO D-SNP) and CareNeeds Platinum (HMO D-SNP)

- Entitled to Medicare Part A
- Enrolled in Medicare Part B through age or disability
- Resident within the CarePlus' service area
- Receive some level of assistance from the state Medicaid program
- Qualified Medicare Beneficiary (QMB/QMB+), Specified Low-Income Medicare Beneficiary (SLMB/SLMB+), Full Benefit Dual Eligible (FBDE), Qualified Individual (QI) or a Qualified Disabled Working Individual (QDWI).

Important Note: All contracted providers caring for CarePlus members enrolled in CareNeeds Plus (HMO D-SNP) and CareNeeds Platinum (HMO D-SNP) should be knowledgeable about the benefits covered, including "wrap" benefits provided to QMB+, SLMB+ and FBDEs per CarePlus' contract with the state of Florida. Also, providers should never bill cost-share protected dual members (QMB, QMB+, SLMB+, FBDE).

Sample Dual Eligible SNP Member ID Card (enlarged for better visibility)

You can easily identify D-SNP members by locating the plan name on the front of the CarePlus member ID card, as shown here:

Dual Eligible SNP: CareNeeds Platinum (HMO D-SNP)

CarePlus HEALTH PLANS		CareNeeds Platinum (HMO D-SNP)	
JOHN SAMPLE			
Member ID:	123456701	PCP:	Robert Smith
Health Plan:	(80840)	PCP Telephone:	1-234-567-8900
	91413 95092	Card Issued:	01/01/2024
RxBin:	015581		
RxPCN:	03200008	Cost-share protected:	Y
Copayments: PCP Office Visit: \$0.00 Specialist: \$0.00 Hospital Emergency: \$0.00		MedicareRx Prescription Drug Coverage CMS H1019 001 000	
		Member Services: 1-800-794-5907 TTY: 711 My CarePlus Connect: 1-866-667-0483	Pharmacy Inquiries: Eligibility: 1-866-220-5448 Claims Issues: 1-800-865-4034 Authorizations: 1-800-201-4305 Authorizations: 1-866-315-7587 Claim Status: 1-866-313-7587 CarePlus Claims: P.O. BOX 14697 LEXINGTON, KY 40512
			
		Please visit us at : CarePlusHealthPlans.com	

Note: If a member loses SNP eligibility and is not reinstated to the plan’s qualifying eligibility level within the six-month deeming period, he or she will be disenrolled from CarePlus.

Overview of CarePlus’ Model of Care for SNPs

CarePlus’ Model of Care (MOC) addresses preventive care as well as acute and chronic disease management across the healthcare continuum. This process is member-centric and based on an ICT approach, which includes participation by members, members’ families and/or care givers, PCPs, care managers, specialists, ancillary providers, and/or vendors involved in the treatment of the member. CarePlus incorporates evidence-based management protocols or nationally recognized guidelines when applicable. PCPs are the clinical leaders of the ICTs. Care managers function as the member’s single point of contact and are responsible for coordinating care across the continuum of need, managing the overall treatment plan, and utilizing community resources, allied healthcare professionals, mental health professionals, and other providers as needed. Providers can call CarePlus’ Care Management Team for SNP member-related issues at 1-800-734-9592, Monday – Friday, 8 a.m. – 5 p.m., Eastern time.

CarePlus’ MOC for SNPs is comprised of four sections which meet CMS standards.

MOC 1: DESCRIPTION OF SNP POPULATION (GENERAL POPULATION)

ELEMENT A: DESCRIPTION OF OVERALL SNP POPULATION

CarePlus follows all sales/marketing guidelines outlined by CMS to be compliant with identifying beneficiaries for the Dual Eligible SNP plan. CarePlus offers SNPs for dual-eligible members, targeting categories of dual-eligible beneficiaries the state of Florida deems eligible. To qualify for the D-SNP, CarePlus validates that the beneficiary is:

- Entitled to Medicare Part A and enrolled in Medicare Part B through age or disability
- Resident within the plan’s service area
- Eligibility is based on certain levels of Medicaid eligibility based on the specific requested plan

CarePlus follows all sales/marketing guidelines outlined by CMS to be compliant with identifying beneficiaries for a Chronic Condition SNP (C-SNP). In order for a member to enroll in a C-SNP, the

member must be diagnosed with the applicable condition, return required forms verifying the diagnosis, and reside within the plan's service area.

This SNP cardiovascular disease, chronic heart failure, chronic lung disorder, diabetes mellitus (CVD/CHF/CLD/DM) MOC focuses on members who may have complex medical needs and increased psychosocial needs that impact compliance and health outcomes. This population is identified through:

- Entitlement to Part A and enrolled in Part B of Medicare through age or disability.
- Confirmed chronic heart failure diagnosis or confirmed cardiovascular diagnosis of one of the following cardiac arrhythmias, coronary artery disease, peripheral vascular disease, and/or chronic venous thromboembolic disorder, and/or confirmed diagnosis of diabetes mellitus.
- Confirmed diagnosis of chronic lung disorder.
- Reside within the plan's service area.

ELEMENT B: SUBPOPULATION-MOST VULNERABLE MEMBERS:

CarePlus/Humana Management Services' methods of risk stratification and evaluating level of acuity are dynamic to best guide the most appropriate level and intensity of intervention. There are multiple methods available to stratify and evaluate the level of acuity and to identify the most vulnerable members. The methods available include predictive analytics, proprietary algorithms, HRAs and other assessments. The system stratification identifying the most vulnerable population occurs using proprietary algorithms built in the clinical platform or with the HRA. The use of predictive analytics assist the care management team in identifying the SNP members most at risk for poorer health outcomes and the need for additional services and specialized programs to address their complex needs. This analysis identifies members with certain combinations of co-morbidities, frailty, predicted high cost claims, and pharmacy related issues (e.g., inappropriate medications, major poly-pharmacy, and medication adherence). The system provides initial stratification for the member of high or low. The most vulnerable population are stratified as high. In addition, members who are candidates for the stratification of high are prospectively identified based on their predicted cost and the presence of chronic conditions, rather than reactively targeted because they have already become high-cost users and have high cost conditions.

Following the stratification into severity levels of assumed care management for outreach prioritization, the care manager is prompted by their care management queue to analyze the HRA results. The care manager may review recent claims, hospitalizations, medications, or use additional targeted assessments to further evaluate and analyze the system stratification. This analysis provides a foundation to identify issues of concern. The care manager outreaches to the member and on the first successful outreach with the member reviews the HRA results and utilizes the results of the HRA to mutually design the individualized care plan (ICP) with the member.

The stratified HRA results assist the care manager in identifying beneficial steps to maximize health outcomes. The care manager is able to establish targeted goals, objectives, and interventions based upon the risks identified from the HRA with the member. Information gathered during the HRA process is also used to determine continuity of care needs and/or potential ICT needs for the member.

MOC 2: CARE COORDINATION

ELEMENT A: SNP STAFF STRUCTURE

CarePlus has a functional structure to ensure all required services are coordinated through qualified staff with appropriate oversight. Roles include clinical and administrative functions for CarePlus and Humana.

CarePlus' Care Management Program operates within an interdisciplinary MOC and is responsible for coordinating care in a seamless manner across the healthcare continuum using an ICT approach for CarePlus members. The ICT's overall care management role includes member and caregiver evaluation, reevaluation, care planning and plan implementation, member advocacy, health support, health coaching and education, support of the member's self-care management, and ICP evaluation and modification as appropriate.

Communication with members is primarily telephonic, however outreach may also include face-to-face interactions, secure member portal, voice activated technology, electronically, and/or by mail.

ELEMENT B: HEALTH RISK ASSESSMENT TOOL

A health risk assessment (HRA) is required by CMS for all SNP members. CarePlus utilizes the approved HRA for SNP members. The HRA produces a current health status profile and an overall risk score for each SNP member. The HRA tool scores risk across several health domains: medical, functional, cognitive, social, behavior (psychosocial and mental health), and financial risks. The HRA focuses on the acute chronic needs of the member.

ELEMENT C: INDIVIDUALIZED CARE PLAN (ICP)

All SNP members are required to have an initial HRA upon enrollment in care management and a subsequent ICP. For actively managed members, all ICP information is shared, discussed, and mutually designed with the member and/or caregiver on an ongoing basis as the member works with his or her care manager.

ICPs are created, reviewed and updated at a minimum with each successful member contact. ICPs may also be updated with each transition and/or significant changes in member's healthcare status. The care management plan includes an assessment of the member's progress toward overcoming barriers to care and meeting treatment goals. When it has been identified that the member's agreed-upon goals have not been met the following steps are taken:

- Barriers to achieving identified goals are defined and discussed
- Goals are modified as warranted or desired by the member and/or caregiver
- Alternative actions are created to succeed in achieving the newly identified goals
- Changes and revisions to the ICP are documented

Care management interventions can be broadly categorized by the area of focus and services specifically tailored to the beneficiary's needs which may include the following:

- **Medication Review:** Thorough and ongoing medication reviews, screening for member medication knowledge and adherence gaps, and offering of printed and/or verbal education on medications. Care managers also may arrange for pharmacist review of complex medication regimens, or regimens for which numerous interactions are identified through drug interaction reviews. In addition, care managers coordinate and facilitate communication with the physician as needed, help members obtain devices that promote adherence (pill boxes, pill cutters, reminders, etc.), and refer members with financial need to pharmacy assistance programs.
- **Care Coordination:** The care manager leads the ICT and engages the support of other internal and external resources, makes appropriate referrals, participates in care team conferences, and requests case reviews. The care manager also facilitates communication between members and physicians and providers regarding progress toward goals, i.e., the need to adjust therapy to enable a member to reach goals and refer members to physicians and providers to evaluate condition, symptoms, medication, end of life planning, durable medical equipment needs, and home health issues or needs.
- **Care Transitions and Post-discharge Support:** Care managers work closely with the UM team to coordinate a seamless member transition between levels of care. Post discharge support needs are addressed in order to maximize member recovery and mitigate preventable readmissions.
- **Connections to Community Resources:** Care managers evaluate needs for additional resources and support services for members, often collaborating with other staff. This multidisciplinary team locates and helps members to access services that include transportation, meal services, pharmacy assistance, and help with Medicaid applications.
- **Coordination and Access to Benefits:** Care managers evaluate member needs and support awareness of access to plan benefits and assist in coordination Medicare and Medicaid benefits. External input also is included in an ICP, when available. External input may come from:
 - Primary healthcare providers/physicians
 - Hospital discharge planners
 - In-home nursing and social worker visits
 - Behavioral healthcare providers
- **Health Education:** Care managers provide members with approved educational materials related to specific health conditions and concerns. They also provide verbal coaching and written education on other general health topics common in the Medicare population, along with referrals to community-based education resources.
- **Health and Function:** Evaluation of the member's physical and psychological health and functional status to provide education and health support and assist the member and/or caregiver to manage their diseases as well as comorbid conditions such as COPD, CHF, depression, dementia, chronic kidney disease, and end-stage renal disease to maintain optimal function and quality of life.
- **Interpersonal and Social Relationships:** Care managers refer members to other ICT members, providers, and community resources to address issues such as food insecurities, social isolation and social networking, cognition and dementia, elder abuse and caregiver strain.
- **Knowledge of When to Call the Physician:** Care managers assist members to be informed healthcare consumers and to establish a regular source of healthcare. They provide written and verbal education regarding warning signs of heart failure, diabetic complications, as well as common co-morbid complications including COPD and depression. They also help members

establish an emergency contact and action plan. Members may be supported via three-way calls or warm transfers to physicians and providers for things such as making an appointment or consulting with a pharmacist.

- **Preventive and Screening Services:** Care managers educate and provide reminders for obtaining health and preventions screening tests and services related to HEDIS measures, annual flu vaccine, colon and breast cancer screens, etc. They also support members in monitoring progress toward goals and self-management of their chronic health conditions.
- **Self-care Management and Personal Healthcare Preferences:** Care managers support self-care management and healthy behaviors based on the member's stage of readiness to change. Referrals are made to providers or community-based resources for smoking cessation, alcohol or substance abuse, nutrition, physical activity, and weight management.

It is imperative for providers to support the maintenance of the ICP by working collaboratively with the care manager and ensuring treatment plans, appropriate interventions, and member needs are properly identified and each ICP is developed to address the following:

- Development of a care management plan, including prioritized goals that consider the member's and caregiver's goals, preferences, and desired level of involvement in the care management plan
- Identification of barriers to meeting their goals or complying with the plan
- Development of a schedule for follow-up and communication
- Development and communication of their self-management plans
- A process to assess their progress against care management plans

Each ICP outlines:

- Goals and objectives as agreed upon by the member and/or caregiver
- Specific services, resources, and benefits that will be accessed to meet the stated goals and objectives, as well as to fill any gaps in the member's current level of care
- End-of-life planning for members who have not participated in this type of planning and wish to do so
- Any services or resources for which a member may qualify based on diagnoses, disability or other criteria (such as financial), are included in the ICP to ensure members are able to access all appropriate programs
- A follow-up schedule that allows both the member and his/her care manager to stay on track with meeting the stated objectives of the plan

Copies of the ICP are shared with the member when a member experiences a change in condition. Providers may also receive copies of ICPs. In addition, elements of the ICP are discussed as needed via phone with any or all members of the ICT, members, and providers.

ELEMENT C: Face-to-Face Encounters:

Factor 1: Face-to-Face Essentials:

An annual face-to-face encounter is required by CMS for all SNP members. The objective conducting or facilitating an annual face-to-face encounter between a participant or participants of the ICT and the

member is to improve health outcomes, identify needs and risks, reduce gaps, and increase collaboration between the member and the member's ICT. A face-to-face encounter includes in-person visits and/or a real-time, visual, interactive telehealth visit. The face-to-face encounter will occur within the first 12 months of a member's enrollment and at least annually thereafter with the member and/or the member's caregiver's consent.

Factor 2: Identifying Appropriate Personnel:

Qualifying face-to-face encounters consist of either in-person visits or through a real-time, visual, interactive telehealth visit. The primary personnel responsible for completing the annual face-to-face encounter are participants of the ICT, which includes employed associates/providers, contracted staff, vendors, and CarePlus affiliated associates/providers.

ELEMENT D: INTERDISCIPLINARY CARE TEAM (ICT)

The CarePlus Care Management Team delivers its services to CarePlus members within a multi-disciplinary care team model. Care management is delivered telephonically.

The ICT is member-centric and based on a collaborative approach. The ICTs overall care management role includes member and caregiver evaluation, reevaluation, care planning and plan implementation, member advocacy, health support, health coaching and education, support of the member's self-care management and ICP evaluation and modification, as appropriate. At the center of the ICT model are those who serve at the core and most closely interact with one another. The care manager functions as the single point of contact for all ICT participants and is responsible for coordinating care across the continuum of need. The ICT includes at minimum, the member and/or caregiver, the member's PCP, and the care manager. The care manager facilitates the participation of members as part of their own ICT by directly interacting with the member, the member's caregiver and the member's primary care provider.

Care managers use the HRA results to develop an ICP that includes specific interventions designed to meet the member's needs. The care manager will identify which interventions need further collaboration from ICT participants including, but not limited to, dealing with acute and chronic needs as well as health promotion and crisis intervention. The composition and structure of the ICT supporting any given member will be driven by the member's specific set of medical, behavioral, long-term care, and socio-environmental needs.

The key elements and outcomes of a person-centered ICP and ICT include:

- Forging an alliance between members and healthcare providers
- Developing the plan in partnership with the member (and family/caregiver as appropriate) and the provider/treatment team
- Ensuring the plan is individualized and based on member input regarding preferences, abilities, strengths, goals and cultural identity
- Ensuring written materials are readily understandable for the member
- Immediately directing the service delivery and recovery process
- Improving person-centered and individually defined recovery goals and outcomes

While the ICT is a collaborative effort among the member, care manager, the member's PCP and other parties, the care manager, on behalf of the member, directs the ICT while acting as a member liaison and advocate. The MOC is physician and provider-inclusive, with PCPs driving the medical treatment plan and care managers advancing the physician's treatment plan. Improved coordination of care among healthcare providers will be achieved by having the care manager as the designated single point of contact and facilitator of seamless transitions of care across healthcare settings, care providers, and services.

CarePlus recognizes effective and timely communication among all parties involved in the care planning and coordination processes is the key to ensure positive health outcomes and improved health status for the member. To this end, various methods are used to communicate with the beneficiary and members of the ICT.

Any number of additional support participants based on the member's ever-changing needs may be included as members of the ICT. These ICT participants may include but are not limited to the medical director, the clinical pharmacist, social workers, behavioral health specialists and CarePlus UM nurse. The ICT collaboration can be done via face-to-face, written and/or telephonic communication.

CarePlus communicates a variety of information to practitioners, providers, delegates, and members. Examples of provider communications may include, but are not limited to:

- Letters/memos/faxes
- Committee minutes or reports
- Provider bulletins, notices and newsletters
- Online and hard-copy reports
- Provider educational sessions
- Written instructive communications
- Quality improvement plans
- Internet/intranet (CarePlus website, email, databases)
- Provider manual for physicians, hospitals, and healthcare providers

ICT care coordination meetings may be scheduled or ad hoc, and may be held telephonic, web-based, or accomplished through written communication. The occurrence and frequency of the meetings are different for each member, based on the individual level of care and healthcare needs of the member. Providers and SNP members can call CarePlus' Care Management Team at 1-800-734-9592.

ELEMENT E: CARE TRANSITIONS PROTOCOLS

The CarePlus Care Management Team's objective to maintain continuity of care is to optimize a high-quality member experience during care transitions in an effort to avert complications, unnecessary hospital readmissions, and emergency room visits. CarePlus' Care Management Team works actively to coordinate transitions, when notified, before and after admission including transitions from home to a different healthcare setting, from one healthcare setting to another, including, but not limited to, in-patient/acute facilities, skilled nursing, rehabilitation and long-term care/custodial facilities, and from a healthcare setting to home, inclusive of members receiving home healthcare. This type of support is needed to ensure continuity of care.

CarePlus recognizes that transitions of care are important events in a member's life where the plan can coordinate care and communicate with the ICT. Various census communications are modes of communicating member information for this purpose. The plan gathers the information on the census to coordinate care when member moves from one setting to another, such as when they are admitted or discharged from a hospital or skilled nursing facility.

MOC 3: PROVIDER NETWORK

ELEMENT A: SPECIALIZED EXPERTISE

CarePlus offers SNP members a comprehensive-care-centered primary care network with medical and surgical specialists available to augment and support PCPs, as well as the needs of the targeted populations. This network includes, but is not limited to, acute care facilities, long-term care facilities, skilled nursing facilities, laboratories, radiography facilities, rehab facilities, rehabilitative specialists, mental and social health specialists, home health specialists, and end-of-life care specialists. Although CarePlus' SNPs offer a comprehensive network of physicians and providers, should members develop needs for services outside the current network, CarePlus may grant approval for utilization of out-of-network facilities when appropriate.

ELEMENT B: USE OF CLINICAL PRACTICE GUIDELINES (CPGs) AND CARE TRANSITION PROTOCOLS

CarePlus' credentialing process routinely checks and ensures that potential providers have the capabilities to provide evidence-based wellness, preventive care, and continual assistance for chronic conditions before being accepted into our networks. Evidence proves that preventive care and frequent/consistent care of chronic conditions lowers the advent of major conditions and decreases use of emergency room visits and readmissions. Providers are encouraged to meet these baseline criteria and are routinely evaluated throughout their contract period with CarePlus.

Physicians and providers agree to comply with CarePlus' quality assurance, quality improvement, accreditation, risk management, utilization review, utilization management, clinical trial, and other administrative policies and procedures, as applicable to the specific physician or provider.

CarePlus CPGs are adopted from clinically sound and reputable agencies. These guidelines are from national organizations generally accepted as experts in their fields, such as the American Diabetes Association (ADA), American College of Cardiology (ACC), American Heart Association (AHA), National Heart Lung and Blood Institute (NHLBI), American Psychiatric Association (APA), American Academy of Child and Adolescent Psychiatry (AACAP), National Kidney Foundation (NKF), and the Agency for Healthcare Research and Quality (AHRQ). The CPGs are available on CarePlus' Website at CarePlusHealthPlans.com/CarePlus-Providers/Updates.

CarePlus' Care Management Program and care transition protocols include notifying the provider of a planned or unplanned transition. To maintain continuity of care, providers receive notification of any care transition their member experiences. The provider receives the necessary information in order to initiate coordination and contact with the member. Additionally, the CarePlus UM nurse is in constant contact with the CarePlus medical director regarding the member's status, procedures, and care needs.

ELEMENT C: MODEL-OF-CARE TRAINING FOR THE PROVIDER NETWORK

Written provider contracts require all employed/contracted providers to deliver services in accordance with nationally recognized clinical protocols and guidelines when available. Annual model-of-care training may be facilitated in-person by a CarePlus representative or via web-based training available through CarePlus' Health Plan Provider Webpage: (CarePlusHealthPlans.com/CarePlus-Providers/SNP).

MOC 4: QUALITY MEASUREMENT AND PERFORMANCE IMPROVEMENT

ELEMENT A: MOC QUALITY PERFORMANCE IMPROVEMENT PLAN

CarePlus' quality improvement program description (QIPD) contains detailed descriptions of quality improvement initiatives, which serve as a roadmap for the SNP program quality activities, including MOC performance and outcomes monitoring. Key factors in measuring quality indices are tracking measures and outcomes such as HEDIS, lab values, and the practice of healthy behaviors. The QIPD is designed to detect whether the overall structure of the MOC accommodates members' unique healthcare needs by establishing health outcomes and service goals to evaluate the effectiveness of the MOC.

CarePlus uses data collection, measurement and analysis to track issues that are relevant to the SNP population. CarePlus has developed or adopted corporate quantitative measurement activities to assess performance and identify and prioritize areas for improvement related to medical and behavioral health issues. CarePlus identifies affected membership, selects appropriate samples, and collects valid and reliable data collected through tools. The quality improvement process activities include:

- Monitoring system-wide issues
- Identifying opportunities for improvement
- Determining the root cause
- Exploring alternatives and developing a plan of action
- Activating the plan, measuring results, evaluating effectiveness of actions, and modifying approaches as needed

In addition, CarePlus develops service goals to ensure the appropriate services are delivered to members. The developed goals include:

- Improving access and affordability of the healthcare needs for the SNP population
- Improving coordination of care and appropriate delivery of services through the direct alignment of the HRA, ICP, and ICT
- Enhancing care transitions across all healthcare settings and providers for SNP beneficiaries
- Ensuring appropriate utilization of services for preventive health and chronic conditions

ELEMENT B: MEASUREABLE GOALS AND HEALTH OUTCOMES FOR THE MODEL OF CARE

Health outcomes and service goals are established to perform ongoing evaluation of the effectiveness of CarePlus D-SNP/C-SNP MOC. To achieve the overall goals of the program, CarePlus has established measurable goals to evaluate and measure the quality of care, outcomes, service, and access for

members. For each metric, goals have been established based on current experience and evidence-based medicine found by researching current literature and utilizing current NCQA standards and guidelines.

CarePlus developed measurable goals and health outcomes used to improve the healthcare needs of CarePlus D-SNP/C-SNP members. These goals address the D-SNP/C-SNP members' needs and attempts to encourage engagement with members' healthcare needs, educate the members on the available services and how the services can be used, and allows members to make conscious decisions about their healthcare and their benefits.

To obtain details related to the MOC evaluation, please send an email to CPHP_SNPinfo@careplus-hp.com. In the subject line, please write "MOC evaluation."

ELEMENT C: MEASURING EXPERIENCE OF CARE (SNP MEMBER SATISFACTION)

Annually, a SNP specific telephonic member satisfaction survey is conducted using internal/external resources. The survey focuses on higher acuity members because these members are touched more often by the program and are, therefore, best equipped to evaluate satisfaction.

ELEMENT D: ONGOING PERFORMANCE IMPROVEMENT EVALUATION OF THE MOC

The CarePlus SNP Quality Improvement Model of Care Evaluation (QIE), performed annually by CarePlus' Care Management Team, is an evaluation of CarePlus' SNP Quality Improvement Program. The annual SNP QIE also serves as a tool to summarize MOC performance, describing the SNP model of care success, barriers and limitations encountered throughout the year, and recommendations for future initiatives and improvements. The CarePlus SNP QI program description is developed using information and insights obtained from the SNP QI Evaluation.

ELEMENT E: DISSEMINATION OF SNP MOC QUALITY PERFORMANCE

The CarePlus SNP Quality Improvement Model of Care Evaluation is presented as an executive summary to the Corporate Quality Improvement Committee. During the committee meeting a discussion occurs between key stakeholders, the committee provides recommendations and follow-up items are suggested.

NOTE: If you have any questions regarding CarePlus' Model of Care for our Dual Eligible and Chronic SNPs, please call Humana Management Services for CarePlus SNPs at 1-800-734-9592. Our phone line is open Monday – Friday, 8 a.m. – 5 p.m., Eastern time.

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Physician Responsibilities with Medicare Advantage SNPs

Below is a summary of responsibilities specific to providers who render services to CarePlus members enrolled in a SNP. These are intended to supplement the terms within the provider agreement.

- Provide or arrange for all medically necessary care and services in accordance with SNP plan benefit procedures. For those members enrolled in a Dual Eligible SNP, plan services, benefits and/or procedures must also be integrated with the agency's Medicaid plan services, pursuant to our contracts with CMS and the state of Florida. Refer to CarePlus' website, [CarePlusHealthPlans.com/CarePlus-Providers/SNP](https://www.CarePlusHealthPlans.com/CarePlus-Providers/SNP), for a complete listing of covered Dual Eligible SNP services and a link to the Agency for Health Care Administration's "Adopted Rules." Please note that the covered benefits/services listings are subject to change on an annual basis. You can contact your assigned provider services executive or call the Provider Operations inquiry line at 1-866-220-5448, Monday – Friday, 8 a.m. – 5 p.m., Eastern time, to request that a copy of the listings be mailed to you if you do not have internet access.
- Deliver appropriate care for the problems presented by members, including preventive, acute and chronic healthcare and services.
- Encourage members to complete the initial and annual CarePlus HRA forms and incorporate the results into the individual member care plan.
- Encourage members and/or caregivers to actively participate in care planning and communicate the importance of a healthy lifestyle.
- Provide education on healthcare, preventive health services, and potential high risks as identified for the individual member.
- Provide pharmacotherapy consultation.
- Conduct assessments of the member's needs and make appropriate specialty and care management referrals when member's needs are identified.
- Serve as the central point of contact for the coordination of care between CarePlus, members, caregivers, family, and/or specialists caring for members to assure access to quality care and cost-effective health services delivery.
- Develop plan of care in accordance with nationally recognized clinical protocols and guidelines and applicable plan quality management and utilization management programs.
- Ensure that all necessary information is recorded in the member's medical record*, such as:
 - Individualized care plan
 - Treatment, consultation, laboratory and diagnostic reports
 - Member office visits, ER visits and inpatient admissions (i.e., hospital, psychiatric, rehabilitation, etc.)
 - Medical history (i.e., problem list, allergies, medications, surgeries, immunizations, surgical procedures, screenings, etc.)
 - Efforts to contact the member

*Please refer to the **Medical Record Documentation Standards** section for additional details pertaining to medical record documentation.

- Assess, diagnose, and treat members in collaboration with the CarePlus' ICT. Furthermore, you must participate in ICT meetings on a regular basis, as required by CarePlus.

- Notify the assigned care manager of missed appointments so that CarePlus can follow-up with the member.
- Ensure that members at the end-of-life understand their choices in how to receive care and are aware of their rights by providing information or assistance on developing advance directives (e.g., Five Wishes®), medication management, home-based or hospice care, etc.
- Facilitate access to referrals to the CarePlus provider network, as well as out-of-network providers, when necessary, prior to the delivery of services and provide notification to the ICT.
- Consult with specialty providers including providing necessary history and clinical data to assist the specialty provider in his/her examination of the member. Retrieve consultation and diagnostic reports from specialty provider.
- Provide follow-up care to assess the outcomes of the primary care treatment regimen and specialist recommendations.
- Assure HIPAA compliance and accessibility of information to maintain and provide the sharing of records and reports.
- Transfer copies of medical records to other CarePlus physicians/providers upon request and at no charge to CarePlus, the member, or the requesting party, unless otherwise agreed upon.
- Assist CarePlus with early identification of transitions-of-care needs and ensure the member's confidentiality is protected during the transition process.
- Provide follow-up care to members after receipt of emergency or inpatient hospital services.
- Facilitate access to community resources as needs are identified.
- Be knowledgeable of Dual Eligible SNP's covered benefits and/or services and benefits offered by the state's Medicaid program not covered by CarePlus' Dual Eligible SNPs to facilitate integration of benefits for the members.
- For all qualified Medicare beneficiaries (QMB/QMB+) member(s), specified low-income Medicare beneficiaries (SLMB+), and other full benefit dual eligibles (FBDE) enrolled in CarePlus' applicable Dual Eligible SNP products, providers will: (i) not file claims for Medicaid reimbursement with the Medicaid fiscal agent for any member enrolled in a D-SNP; (ii) not file additional claims for Medicaid deductibles, copayment, or coinsurance reimbursement with the Medicaid fiscal agent for any member enrolled in a D-SNP; (iii) not balance bill any D-SNP member for services covered under this agreement as such members are not liable for cost sharing obligations. **Note:** CMS' prohibition on billing dual-eligible members applies to all MA providers – not only those who accept Medicaid. Furthermore, balance billing restrictions apply regardless of whether the state Medicaid agency is liable to pay the full Medicare cost-sharing amounts.
- In no event, including, but not limited to, nonpayment by the plan, insolvency of the plan, or breach of the provider agreement by either party, shall the provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against any Dual Eligible SNP member or a person acting on their behalf for fees that are the responsibility of the plan or state Medicaid agency.
- For dual-eligible SNP members, a "Y" on the "Cost-share protected" field on the front of the member ID card will identify if a member is cost-share protected. Providers should only collect copayment, coinsurance, deductibles, or other cost-share amounts from dual eligible SNP members if they do not have a "Y" on the "Cost-share protected" field on the member ID card. For additional questions concerning cost-share protected dual eligibles, please call the provider services queue for "Eligibility Verification" at 1-866-313-7587, Monday – Friday, 8 a.m. – 5 p.m., Eastern time.

MANDATORY – Initial and Annual Provider SNP Trainings

Federal and state regulations require that CarePlus conduct outreach and develop educational materials and/or trainings to ensure contracted providers understand the benefits available under SNPs and their critical role as healthcare providers to SNP patients. CarePlus providers are required to receive SNP training upon initial contracting and annually thereafter.

For your convenience, CarePlus has created an education-on-demand presentation that may be accessed on the CarePlus website. This presentation will help you understand the benefits offered to your CarePlus-covered SNP members and your responsibilities, as defined by CMS, in coordinating care for them.

You can access the presentation at any time by visiting the CarePlus website, CarePlusHealthPlans.com/CarePlus-Providers/SNP. Under “Required Annual Training,” select “CarePlus SNP Provider Education Parts 1 and 2.” Please note that CarePlus must maintain a record of training participation for our contracted providers to substantiate its compliance with the above-mentioned regulatory requirements. Therefore, you will be asked to enter your provider information prior to viewing the presentation.

If you would prefer to receive face-to-face training, simply contact your assigned provider services executive.

To learn more about CarePlus SNPs or if you have any SNP-related questions, please contact your provider services executive, email CarePlus at CPHP_SNPInfo@CarePlus-HP.com or call the CarePlus Provider Operations inquiry line at 1-866-220-5448, Monday – Friday, 8 a.m. – 5 p.m., Eastern time.

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SOCIAL SERVICES DEPARTMENT

State and Federal Assistance Programs

Helping CarePlus members attain public assistance benefits through state and federal programs.

CarePlus maintains a specially trained Social Services department that offers a variety of services designed to help members apply for public assistance through state and federal assistance programs. CarePlus has been assisting members attain dual eligibility status, navigate application processes and secure financial assistance through the state of Florida's Department of Children and Families and Social Security Administration programs since 2002.

On Jan. 1, 2006, prescription drug coverage for dual eligible members shifted from state-funded Medicaid to federally funded Medicare Part D plans. As a result, Medicare beneficiaries who qualify as a Qualified Medicare Beneficiary (QMB), Special Low-Income Medicare Beneficiary (SLMB), Qualified Individuals (QI) and Qualified Disabled and Working Individuals (QDWIs) or any full Medicaid program are now automatically eligible for the Extra Help program, also known as Low Income Subsidy (LIS), a federal program that assists members with the cost of prescription drug coverage. If a member is not automatically eligible to receive the LIS and, because the eligibility standards are higher than those for Medicaid, a separate application can be filed at the Social Security Administration.

Attaining dual-eligibility status can help those most in need of financial aid.

Dual-eligible members are individuals who qualify for federally administered Medicare programs as well as the state administered Medicaid programs because of their low-income and assets, age, and/or disability status. These Medicaid programs are:

- Supplemental Security Income (SSI) – A cash assistance program administered by the Social Security Administration. Members automatically receive Medicaid which pays Medicare premiums (Part A and B), Medicare deductibles and Medicare coinsurance within the prescribed limits and automatically qualifies recipients for LIS.
- Qualified Medicare Beneficiaries (QMB) – A Medicaid program which pays Medicare premiums (Part A and B), Medicare deductibles and Medicare coinsurance within the prescribed limits. QMB members automatically qualify for LIS.
- Special Low-Income Medicare Beneficiary (SLMB) – A Medicaid program which pays for the Medicare Part B premium, and members are automatically eligible for LIS.
- Qualifying Individuals (QI) – Medicaid program which pays for the Medicare Part B premiums. Members are automatically eligible for LIS.

The CarePlus Social Services department assists members with the application process for state and federal assistance, change requests in status, as well as, renewal processes. These services are offered, at no additional cost, to all CarePlus members. Dual-eligible members also are allowed to take advantage of special election periods that may not be available to other MA members. With this selection, individuals can consider other available CarePlus plans they may be eligible for; including the dual SNP plan, once per quarter for the first three quarters of the year.

To be eligible for dual-eligibility status, a Medicare beneficiary must:

- Have Medicare Part A, B, or both*
- Be a Florida resident
- Be a U.S. citizen or a qualified resident
- Have countable income and asset ranges as specified by program**

* Eligibility may vary based on Medicaid programs requirements.

**Please check current income/assets thresholds.

Non-dual eligible members may still qualify for extra help with Medicare prescription drug plan cost.

While prescriptions may be covered by Medicaid for certain people, Medicaid does not cover the costs of prescription drugs for Medicare beneficiaries. The Social Security Administration offers a program known as Extra Help or Low Income Subsidy (LIS), which provides federal assistance with the cost of Medicare prescription drug plan (Part D only). The LIS provides:

- Payment of all or most of the annual deductible
- Coverage during the “doughnut hole” or gap period
- Payment of monthly plan premiums up to the base amount

Medicare beneficiaries **MUST** enroll in a Medicare prescription drug plan to obtain prescription drug coverage, even if they qualify for the Extra Help program. With Extra Help, individuals who enroll in a Medicare prescription drug plan have the benefit of full prescription coverage similar to prescription coverage provided by Medicaid. Individuals are responsible for a small copayment or coinsurance for each prescription, depending on the individual’s income/assets and phase of drug coverage.

LIS members also are allowed to take advantage of special election periods that may not be available to other MA members and can switch plans once per quarter for the first three quarters of the year.

To be eligible for LIS, a Medicare beneficiary must:

- Have countable income and asset ranges as specified by program*
- Reside in the United States

* Please check current income/assets thresholds.

CarePlus is committed to helping members maximize health benefits through its Medicare dual-eligibility outreach program.

CarePlus has established a Department of Children and Families (DCF) Application Processing Center, housing eight state case workers whose responsibility is to determine eligibility for state assistance programs. As such, the Social Services department routinely performs the following services:

- Assists members with state and federal program education, as well as gathering the required documentation for the timely submission necessary to determine eligibility.
- Assists members in verifying case status and eligibility
- Assists members in understanding the availability of public assistance benefits and services administered by DCF, including food stamps and cash assistance, as well as the different Medicaid programs

- Ascertains the status of a member's Medicaid coverage
- Notifies DCF if CarePlus has case information in possession, custody, or control concerning a member that is inconsistent with DCF member-specific information
- Assists members in challenging Medicaid determinations through DCF fair hearing process
- Assists members with comprehensive assessment and review for Long-Term Care services (CARES) referrals and renewal process
- Assists members in reporting status changes (change of address, expenses, income, assets, etc.)

As a DCF ACCESS Florida Partner, every associate of the CarePlus Social Services department has undergone special training by DCF in the following areas:

- Use or disclosure of confidential case file information, including information governed by the Health Insurance Portability and Accountability Act (HIPAA) of 1996
- The availability of public assistance benefits and services administered by the DCF
- The application process for public assistance programs
- ACCESS Florida initiative and community partner's role in the initiative
- DCF Security Awareness training – available only to DCF ACCESS Florida Partners

If you have questions and would like additional information, please contact our Social Services Department at 855-392-3900, Monday – Friday, 8 a.m. – 5 p.m., Eastern time.

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Health and Wellness Education

The CarePlus Wellness Education Program (WE Program) brings members educational information either in a social setting or in the comfort of home through CarePlus Link. Programs are available in English or Spanish.

The WE Program educators are committed to design, develop, and facilitate wellness educational presentations based on the Seven Dimensions of Wellness.

Wellness Education Program

- Provides in person group presentations to members, led by Health and Wellness educators who travel to provider offices, wellness centers, and different locations.
- Members who live within the travel area of the event are sent invitations notifying them of the topic being offered, location, date, and time.
- These are member engaging events, in which light snacks and giveaways are provided.
- Health and Wellness educators are available throughout different plan territories.
- Available presentation topics include: Aging and sexual health, social isolation, nutrition, high blood pressure, Alzheimer's, sleep, and obesity among many others.

CarePlus Link / Conexión CarePlus

Presentations are accessible to CarePlus members from the comfort of their home or web enabled device. At various dates and times, CarePlus Link (Conexión CarePlus in Spanish) offers a series of phone and web-based virtual presentations.

- Presentations are live, which are supported and led by a host, and includes a guest speaker/facilitator for the session.
- CarePlus Link offers the same presentations as the WE Program.
- Four presentations from our STARS team regarding the Member's Perfect Experience Circle are featured.
- The Social Services department is featured regularly and presents about state and federal assistance programs available to members.
- Up-to-date program information, available to members within the CarePlus link booklet, can be obtained by visiting the CarePlus website or by calling Member Services to have a copy sent by mail.

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BILLING PROCEDURES

Claims submitted for processing should be in a HIPAA-accepted 837P file format and filed electronically using the **CarePlus Payer ID No. 95092** to **Availity** at [Availity.com](https://www.availity.com). If all electronic data interchange (EDI) methods have failed and the provider has contacted his/her provider services executive, the provider may then submit the claim on a properly completed CMS-1500 form within the time frame specified by contract. The approved 1500 claim form accommodates reporting needs for ICD-10 and aligns with requirements in the Accredited Standards Committee X12 (ASC X12) Health Care Claim: Professional (837P) Version 5010 Technical Report Type 3.

- Patient name
- Patient CarePlus ID number (This is not the Medicare Beneficiary Identifier (MBI))
- Group number
- Patient date of birth
- Patient address and telephone number
- Other insurance information
 - Insured name
 - Insurance name
 - Policy/group number
- Attach other insurance EOBs to show payment or denial
- If patient's condition is related to:
 - Employment (Worker's Compensation)
 - Auto accident
 - Other accident
- Referring physician (when applicable)
- Referring physician's NPI number
- Authorization number
- ICD-10 Diagnosis Code(s)
- Date(s) of service
- Place of service and type of service
- CPT-4 HCPC Procedure Codes and (modifiers when applicable)
- Charges
- Days or units
- CHCU-family planning
- EMG
- COB
- Federal Tax Identification Number
- Patients account number
- Accept assignment – Y or N
- Total charges
- Amount paid
- Balance due
- Name of physician or supplier of service
- NPI number of physician or supplier of service

- Billing provider's NPI number
- Name and address of facility where services were rendered (if other than home or office)
- Physician name and address, according to the contract
- Plan assigned provider number
- Part B Drug NDC numbers

Reimbursement is due for a covered service and/or if claim is complete for a covered service only when performance of that covered service is fully and accurately documented in the member's medical record prior to the initial submission of any claim.

Providers must submit a corrected claim within 180 days from the date of service or within the specified time frame outlined in their provider agreement.

Providers are encouraged to submit claims and/or encounters electronically. If you are not currently submitting electronically, contact your provider services executive to get connected.

A "clean" claim is one that has no defect, impropriety, lack of any required substantiating documentation or particular circumstance requiring special treatment that prevents timely payment. **Failure to submit a properly completed "clean" claim will delay processing.**

EDI Corrections and Reversals REQUIRED

The 837 TR3 defines what values submitters must use to signal to payers that the inbound 837P contains a reversal or correction to a claim that has previously been submitted for processing. For Professional 837 claims, 2300 CLM05-3 (Claim Frequency Code) must contain a value from the National UB Data Element Specification Type List Type of Bill Position 3. Values supported for corrections and reversals are:

- 7 = Replacement of prior claim
- 8 = Void/cancel of prior claim

The following coding **MUST BE USED**:

- Loop 2300
- Segment CLM05-3 = 7
- Segment REF01 = F8
- Segment REF02 = **the 10-digit original document number** – no dashes or spaces

PAPER Corrections and Reversals REQUIRED

- Enter in **Box 22** Resubmission Code field the frequency code applicable: 7 (replacement of prior claim) or 8 (void/cancel of prior claim)
- Enter in **Box 22** Original REF number field the document number assigned to the original/previously submitted bill located on the remit advice or ERA.

For Clinical Trial: CMS billing requirements for Clinical Trial/Registry/Study

For **professional** claims, the eight-digit clinical trial number is preceded by the two alpha characters of CT (use CT only on paper claims) must be placed in field 19 of the paper claim form CMS-1500 (e.g., CT12345678).

For **institutional** claims, the eight-digit clinical trial number without the two alpha characters of CT must be billed with value code 'D4' paper claim form CMS-1450 (e.g., 12345678).

For both **professional and institutional** electronic claims equivalent 837P/837I in Loop 2300 REF02(REF01=P4) (do not use CT on the electronic claim, e.g., 12345678).

When a clinical trial claim includes:

- ICD-10 code Z00.6 (in either the primary or secondary positions) and
- Modifier Q0 (numeral 0 versus the letter O) and/or Q1 (numeral 1 versus the letter i), as appropriate (outpatient claims only)

OVERPAYMENT OF A PROVIDER

Overpayments include, but are not limited to, situations in which a provider has been overpaid by CarePlus because of an error in processing, incorrectly submitted claims, an incorrect determination that the services were covered, a determination that the covered individual was not eligible for services at the time services were rendered, or another entity is primarily responsible for payment of the claim. In the event of an overpayment, CarePlus will notify the provider of the refund amount due in writing via mail, facsimile, or email. The provider is responsible for immediately refunding to CarePlus the overpayment amount according to the instructions stated in the written notification. If a refund is not issued, CarePlus may recoup the monies due from any future payments due to the provider.

BALANCE BILLING/MEMBER RESPONSIBILITY

As a member of a Medicare Advantage plan, CarePlus members are not responsible for balances remaining after payment from the plan is applied to the member's account. The member's sole payment responsibility is for any applicable copayments, coinsurance, deductibles, and noncovered services provided to such members. Notification that a service is not a covered benefit must be provided to the member prior to the service and be consistent with CarePlus policy, in order for the member to be held financially responsible. CarePlus policy requires that the notification include the date and description of the service, an estimate of the cost to the member for such services, name and signature of the member agreeing in writing of receiving such services, name and signature of the provider, and be in at least 12-point font. Documentation of pre-service notification must be included in the member's medical record and shall be provided to CarePlus or its designee upon request, within a timely manner to substantiate member appeals.

In the event of a denial of payment for health services rendered to CarePlus members determined not to be medically necessary by the plan, a provider shall not bill, charge, seek payment, or have any recourse against member for such services, unless the member has been advised in advanced that the services are not medically necessary and has agreed in writing to be financially responsible for those services pursuant to the above-mentioned CarePlus policy. Please refer to the section titled "Limitations on

Member Liability Related to Plan-directed Care” under “Role of the Primary Care Physician (PCP)” for additional guidance.

MEDICARE ALLOWABLE FOR UNLISTED SERVICE or PROCEDURE CODE

For claims filed with an “unlisted” service or procedure code and/or with a procedure code that has no RVU assigned, documentation must include a written description of the service and the appropriate medical reports related to the service, including the NDC number for drugs or a copy of the invoice for equipment, if applicable. Unlisted procedure codes are defined as CPT or HCPCS code descriptions that include one of the following: NOC, NEC, NOS, unlisted, not specified, miscellaneous, or special report. Each claim will be reviewed manually and CarePlus will assign the allowable fee based on established fees for comparable services.

In addition, consistent with current Medicare policy for noncovered services, CarePlus will not issue payment for a particular surgical or other invasive procedure to treat a particular medical condition when the practitioner erroneously performs: 1) a different procedure altogether; 2) the correct procedure but on the wrong body part; or 3) the correct procedure but on the wrong patient. CarePlus also will not cover hospitalizations and other services related to these noncovered procedures.

Claims must be submitted to the correct payer ID number electronically or to the P.O. Box when all EDI methods have failed. For information on where to send your claims, please refer to the Key Contact List at the beginning of this manual. The member’s CarePlus ID card also will list the claims address.

Submitting claims to the incorrect address will result in delay of processing. Furthermore, if you do not receive a payment or denial within 60 days submitting your claim, please contact CarePlus inbound contact representatives at 1-866-313-7587 to obtain a status update.

EFT/ERA Enrollment Process to Support Healthcare Claim Payments and Remittance Advices

To enroll in EFT/ERA, you must register with Availity. Download the EFT/ERA form via the Availity Portal and email the completed form to CPHP_EFT_ERA_ENROLLMENTS@humana.com.

You also can mail your completed form to:

CarePlus Health Plans
Attention: Finance
4030 Boy Scout Blvd. Suite 1000
Tampa, FL 33607

Additional information: CarePlus works with Availity to send ERAs to physicians/providers. Please work with your system vendor or billing service to enroll in ERA for CarePlus Health Plans. To enroll directly with Availity:

- Go to [Availity.com](https://www.availity.com) and enter login credentials.
- Select **My Providers | Enrollments Center** in the top navigation bar.
- Select **Transaction Enrollment** under **Multi-Payer Enrollments**.
- Note: The CarePlus Health Plans payer ID for Availity is 95092.
- If you have questions about the form, please call Availity Client Services at 1-800-282-4548, Monday – Friday, 8 a.m. – 8 p.m., Eastern time.

- In addition to EFT/ERA services, Availity provides access to Remittance Viewer Application with the option to download PDFs of your 835s.

CLAIMS STATUS TELEPHONE QUEUE

CarePlus inbound-contacts representatives will be able to assist you in answering inquiries related to billing, status and payment of claims. To ensure short wait times, the representatives will review five accounts per inquiry. You can reach the Claims Status Line at 1-866-313-7587. Hours of operation are Monday – Friday, 8 a.m. – 5 p.m., Eastern time.

To better assist you, there is a secure mailbox for you to retrieve copies of remits without having to place a phone call. You can send your requests via email to provider.requests@careplus-hp.com. Please make sure to include a claim number and check information in your email request. This email account is checked throughout each business day, and a reply to your correspondence will be sent within 72 business hours. If additional information is needed to fulfill your request, you may receive a follow-up email message requesting the information.

Note: Using this email address with your chosen email solution may provide limited to no security in protecting confidential information. For that reason, please do not include information that you consider to be confidential within email messages sent to this email address. If you must send confidential information, please use your organization's secure email solution, or utilize our secure fax option available at 1-813-463-7809.

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MEMBERS ENROLLED IN HOSPICE

What is Hospice?

Hospice is a program of care and support for people who are terminally ill. It is available as a benefit under Medicare Hospital Insurance (Part A). The focus of hospice is on care, not treatment or curing an illness. Emphasis is placed on helping people who are terminally ill live comfortably by providing comfort and relief from pain. Some important facts about hospice are:

- A specially trained team of professionals and caregivers provide care for the “whole person,” including his or her physical, emotional, social, and spiritual needs.
- Services may include physical care, counseling, drugs, equipment, and supplies for terminal illness and related condition(s).
- Care is generally provided in the home.
- Hospice isn’t only for people with cancer.
- Family caregivers can get support.

When all the requirements are met, the Medicare hospice benefit includes:

- Physician and nursing services
- Medical equipment and supplies
- Outpatient drugs or biologicals for pain relief and symptom management
- Hospice aide and homemaker services
- Physical, occupational, and speech-language pathology therapy services
- Short term inpatient and respite care
- Social worker services
- Grief and loss counseling for the member and his or her family

When a member/patient enrolled in hospice receives care from your practice or facility, it is very important that all of the care is coordinated with their hospice physician. Once a member is enrolled in hospice, CarePlus is not financially responsible for any services covered by Medicare regardless of whether the care is related to the hospice diagnosis, as long as the service provided is a Medicare-covered benefit. CarePlus enrolls hospice members into a new group effective the first of the month, following election of hospice, and removes them from the group at the end of the month, if the member terminates or revokes the hospice benefit. CarePlus will continue to assist in coordination of the member’s care to the best of its ability; however, the payment process for providers changes.

Claims received by CarePlus for members enrolled in hospice will be denied with the appropriate denial code except for the following:

- Claims for non-Medicare covered supplemental benefits/added benefits covered by CarePlus (e.g., non-Medicare covered transportation, vision, dental, hearing, etc.).
- Claims for preauthorized, non-hospice related services submitted by a participating provider with a Medicare Explanation of Medicare benefits (EOMB) will be processed by CarePlus at the

difference between the Medicare allowable and the provider's CarePlus contract allowable, minus any applicable copayment. **NOTE:** This section only applies to non-hospice-related services. The member will be subject to Original Medicare fee-for-service cost-sharing for nonauthorized services or for services received from a nonparticipating provider.

The table below summarizes the cost-sharing and provider payments for services furnished to a member who elects hospice:

Type of Service	Enrollee Coverage Choice	Enrollee Cost-Sharing	Payments to Providers
Hospice program	Hospice program	Original Medicare cost sharing	Original Medicare
Non-hospice ¹ , Parts A and B	MA plan or Original Medicare	MA plan cost-sharing, if enrollee follows MA plan rules	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	MA plan
Supplemental	MA Plan	MA plan cost-sharing	MA plan

Notes:

- 1) The term "hospice care" refers to Original Medicare items and services related to the terminal illness for which the member 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 member entered the hospice.
- 2) If the member chooses Original Medicare for coverage of covered, non-hospice care, Original Medicare services and also follows plan requirements, then, as indicated, the member pays plan cost-sharing and Original Medicare pays the provider. CarePlus must pay the provider the difference between Original Medicare cost-sharing and plan cost-sharing, if applicable.
- 3) An HMO member who chooses to receive services out of network has not followed plan rules and therefore is responsible to pay fee-for-service cost-sharing.

When hospice services are requested by a member, confirmed with CMS, and updated in CarePlus' system, the member is sent a new enrollment ID card reflecting a new group number beginning with RH*. This process may take time, depending on when the hospice form is received by CMS and when its system is updated.

It is important that your staff and/or billing company understands the process required to bill the fiscal intermediary for CMS for CarePlus members who are enrolled in hospice. Please communicate this information to your staff and/or billing company as appropriate.

Contact Information for the fiscal intermediary is as follows:

First Coast Service Options Inc.

- Medicare Part A: Provider Contact Center – 1-888-664-4112
 - IVR System – 1-877-602-8816
- Medicare Part B: Provider Contact Center – 1-866-454-9007
 - IVR System – 1-877-847-4992

Additional Resources:

Medicare Claims Processing Manual – Chapter 11: Processing Hospice Claims
Section 30.4 – Claims from Medicare Advantage Organizations

www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c11.pdf

Medicare Managed Care Manual – Chapter 4: Benefits and Beneficiary Protections
Section 10.4 – Hospice Coverage

www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/mc86c04.pdf

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HOSPICE CPT CODING AND FAQ

How do I bill for hospice services?

Hospice Care: Overview

If one of your patients has a terminal illness, with about six months or less to live, your patient can choose either standard Medicare coverage or hospice care. When someone chooses hospice benefits, he/she may continue to rely on a private doctor and at the same time make use of the hospice physician. As of Aug. 5, 1997, hospice care is available for two 90-day periods and an unlimited number of 60-day periods during the hospice patient's lifetime.

Hospice services (including those of the hospice physician) are billed under Part A to the intermediary, which pays 100 percent of Medicare's approved charges. Services for an attending physician not connected to the hospice are billed to the carrier. Such services by an attending physician should be coded with the GV modifier [MCM 4175.1].

What Medicare Will Pay For

Medicare hospice benefits pay for treatment designed to keep your patient as comfortable as possible. Attempts to cure the condition that brings your patient to the hospice don't fall under this benefit. (The carrier's medical staff makes the decision about what is and isn't palliative care). However, you can bill Medicare for curative treatment that isn't part of the terminal condition, just as you ordinarily would, whether you're the patient's private doctor or you work for the hospice.

CMS requires Medicare beneficiaries with Part D coverage who are under hospice care to get prior authorization for prescriptions that fall under the following drug classes: analgesics, anti-nauseants (anti-emetics), laxatives, and anti-anxiety drugs. As previously stated, these medications will be covered under Medicare Part D only if they are prescribed for diagnoses unrelated to the member's terminal illness.

Once hospice coverage is elected, the patient isn't eligible for Medicare Part B services related to the treatment and management of his/her terminal illness. One big exception is that professional services of an attending physician may be billed under Part B. To qualify as an attending physician, the patient must identify at the time he/she elects hospice coverage, the physician (doctor of medicine or osteopathy) who has the most significant role in his/her medical care. The attending physician doesn't have to be employed by the hospice, and the patient still may be treated by a hospice-employed physician.

Two Paths for Reimbursement

You can bill the carrier for treatment and management of a hospice patient's terminal illness and get paid 80 percent of the Medicare fee schedule amount (plus the co-insurance and deductible) – as long as you are the attending physician, and you don't furnish the services under a payment arrangement with the hospice. When billing Medicare Part B, make sure to indicate the following in item 19 of the Form CMS-1500: "Hospice patient. Dr. _____ is the attending physician and is not employed by the hospice."

However, if you furnish the services related to a hospice patient's terminal illness under a payment arrangement with the hospice, such services are considered hospice services and are billed by the hospice to the fiscal intermediary. (You don't bill the carrier). Hospice physician services are paid by the hospice intermediary at 100 percent of Medicare approved charges.

To bill properly, as of Dec. 21, 2000, a physician must certify that the patient is terminally ill, which is defined as having a medical prognosis of a life expectancy of six months or fewer if the illness runs its normal course [42 CFR §418.3; Program Memo AB-02-009].

Revoked or Exhausted Benefits

If the patient's hospice benefits have been revoked or exhausted, the carrier will pay all medically necessary physician services (even to hospice-employed physicians) at the regular fee schedule amount [MCM 4175], 4175.1].

Modifiers for Special Situations in Hospice

Special modifiers should be used for the following circumstances [MCM 4175.1, 4175.2]:

- If another physician covers for the designated attending physician, the services of the substituting physician are billed by the designated attending physician under the reciprocal or locum tenens billing instructions [MCM 3060.6, 3060.7 see Locum tenens, reciprocal billing chapter]. In such instances, the attending physician bills using the GV modifier and either the Q5 or Q6 modifier.
- Medically necessary Part B services that physicians furnish to patients after their hospice benefits are exhausted or revoked should be billed without the GV or GW modifiers.
- Services unrelated to a hospice patient's terminal condition should be coded with the GW modifier "service not related to the hospice patient's terminal condition."

Don't Bill DME, Supplies or Therapy for Terminal Condition

DME, supplies, and independent speech and physical therapy claims related to the hospice patient's terminal condition are not payable by Part B. The hospice is required to bill and be paid for such services through its intermediary [MCM 4175.4].

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CLAIMS AUDITS

CarePlus reserves the right to audit all claims, itemized bills, and applicable medical records documentation for billing appropriateness and accuracy.

Payment integrity review:

CarePlus operates a payment integrity review program to facilitate accurate claim payments and detect/prevent fraud, waste, and abuse. CarePlus will review claim payments within 24 months from the last date of claim payment, except in cases of fraud or waste and abuse.

CarePlus will conduct select medical record review on pre-payment and post-payment basis. The pre and post payment review processes will be requested based on Medicare criteria and Medicare and AMA coding requirements (an example of items reviewed include, but are not limited to, records to substantiate coding and charges, incorrect code selection, unit errors, duplicate charges, codes not supported by the diagnosis, items not separately payable, etc.). These reviews will confirm that the most appropriate and cost-effective supplies were provided and that the records document the medical necessity, setting and level of service that was provided to the patient is supported by the records.

The Treatment, Payment and Health Care Operations (TPO) exception under the HIPAA Privacy Rule (45 CFR 164.506) allows the release of medical records containing protected health information (PHI) between covered entities without additional authorization for the payment of healthcare claims. Healthcare professionals who believe that an additional release authorization for this review is necessary should obtain from CarePlus members their authorization for release of the medical records to CarePlus, along with the healthcare professional's consent-to-treatment forms, or the requirement will be waived if permitted by law.

Below you will find a description of the pre-payment, post-payment, and dispute process of the CarePlus payment integrity program.

- Pre-payment review, CarePlus (or its designee) will request medical records to document and support the codes and charges billed. An initial request letter will be sent requesting the medical records be submitted within 45 days of the request. Three additional attempts will be made to obtain records; eight weeks from the initial request date a remittance advice will be sent to the provider denying the claim due to lack of medical records. Records that are received within the time frame will be reviewed and a remittance advice will be sent to the provider and the claim adjusted accordingly.
- Post-payment review, CarePlus (or its designee) will request medical records to document and support the codes and charges billed.
 - An initial request letter will be mailed to the provider requesting that the records be provided within 45 days from the date of the letter. A final notice will be sent to the provider allowing an additional 45 days from the date of the letter. A refund request letter will be sent to the provider if the records are not received within 45 days of the final request for medical records request. The provider will have 45 days from the date on the refund request letter to send a refund check before the paid amount of the claim is recouped due to medical records not received. Review of medical records received within the time frame will be completed, if an overpayment is found, a refund request will be sent. If a refund is not received within 45 days,

the paid amount of the claim will be recouped. If an underpayment is found, notice will be sent to the provider to submit a corrected claim for additional payment.

- On-site review, CarePlus or the designee will contact the healthcare professional's review representative to schedule an on-site review. The healthcare professionals are asked to respond to a scheduling request within 30 days of receipt of the request and schedule the review on a mutually agreed date and time and submit an itemized bill prior to the visit, if requested. The healthcare providers should respond to a scheduling request within 30 days of receipt of the request and schedule the review on a mutually agreed upon date and time. If a scheduled date is not confirmed by the provider within 30 days of the initial request, CarePlus or the designee will attempt to contact the facility via phone, email, or letter. If there is still no response, two additional attempts will be made (30 days apart). If CarePlus or its designee is still unsuccessful at scheduling a date for the post-pay on-site review after these attempts, a denial may be issued for all review-related claims. Once the review has been scheduled, the denial will be reversed and the claims will be processed, providing that the scheduled date is within applicable contractual and federal guidelines.

CarePlus or the designee will notify the healthcare professional of the review results of the on-site review via letter or by conducting exit conferences within 30 days from the date CarePlus or its designee completes the review (or on an alternative agreed-upon date).

- Disputes, providers not in agreement with the explanation or findings may dispute in writing with the reason for the dispute and complete medical records for the services being disputed. CarePlus will not accept a payment integrity dispute after 12 months from the final notice of request for medical records related to a pre or post payment medical records denial. Notwithstanding the foregoing, all disputes must be submitted within the specific time frames set out in any applicable contract or as otherwise required by applicable federal law. If you do not submit a written request to dispute the review findings or if your request is not received within the required time frame, the original review findings will be final.

Disputes should be mailed to:

CarePlus Health Plans, Inc.
P.O. Box 14697
Lexington, KY 40512

Interim bills: Interim bills will not be accepted for MS-DRG or APC Claims. To properly adjudicate a claim paid on a Medicare Allowable basis, the patient must be discharged.

Itemized statements: CarePlus may require itemized statements as deemed necessary and appropriate.

Note: CarePlus may contract with vendors to conduct audits on the plan's behalf.

COORDINATION OF BENEFITS AND SUBROGATION

As a participating provider, CarePlus requires that you notify the plan of any third-party information you may have received and that you assist the plan in complying with the Medicare secondary payer rules. In addition, if you are notified of a Medicare set-aside plan, please notify CarePlus immediately.

CarePlus is subject to the rules and regulations as defined by the Social Security Act and the CMS Medicare Secondary Payment (MSP) provision. MA organizations are allowed four provisions in which Medicare is considered a secondary payer.

1. Employer group health plans (EGHP) and large group health plans (LGHP)
2. Liability insurance plans
3. No-fault insurance plans
4. Workers' Compensation plans (WC)

Employer Group Health Plans (EGHP)

Policy: Coverage under a health plan offered by an employer in which a Medicare beneficiary is covered as:

1. An employee (age 65 or older) or
2. As a dependent under another subscriber (of any change) covered under such plan

NOTE: Medicare is the secondary payer for beneficiaries assigned to Medicare under the ESRD benefit for up to 30 months beginning when the individual becomes eligible for Medicare, if the beneficiary was not otherwise eligible due to age or disability

Liability Insurance and No-fault Insurance

Policy: Types of liability include, but are not limited to, automobile liability, malpractice, homeowner's liability, product liability and general casualty insurance. Medicare is considered the secondary payer to all liability and no-fault insurance providers.

Workers' Compensation (WC)

Policy: Medicare does not coordinate benefits with Workers' Compensation payers. Workers' Compensation assumes full liability for the payment of items and services related to a claim meeting coverage requirements.

When a member has coverage, other than with CarePlus, which requires or permits coordination of benefits from a third-party payer in addition to CarePlus, CarePlus will coordinate its benefits with such other payer(s). In all cases, CarePlus will coordinate benefits payments in accordance with applicable laws and regulations and in accordance with the terms of its health benefits contracts. When permitted to do so by such laws and regulations and by its health benefits contracts, CarePlus will pay the lesser of: (i) the amount due under the prevailing agreement; (ii) the amount due under the prevailing agreement less the amount payable or to be paid by the other payer(s); or (iii) the difference between allowed billed charges and the amount paid by the other payer(s). In no event, however, will CarePlus, when it is a secondary payer, pay an amount, which, when combined with payments from the other payer(s), exceeds the rates set out in the prevailing agreement; provided, however, if Medicare is the primary payer, CarePlus will, to

the extent required by applicable law, regulation, or CMS Office of Inspector General (OIG) guidance, pay the provider an amount up to the amount CarePlus would have paid, if it had been primary, toward any applicable unpaid Medicare deductible or coinsurance.

Recovery: Providers and CarePlus must use reasonable efforts to determine the availability of other benefits, including other party liability, and to obtain any information or documentation required by CarePlus and the provider to facilitate coordination of such other benefits. Upon request by CarePlus, providers must provide CarePlus with a copy of any standard provider forms used to obtain the necessary coordination of benefits information.

Payment Adjustment: Providers and CarePlus must submit retroactive adjustment to the payment including but not limited to, claims payment errors, data entry and incorrectly submitted claims, to recovery of over/under payment process.

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PARTICIPATING PROVIDER GRIEVANCES AND REQUESTS FOR CLAIMS RECONSIDERATION

Participating providers can submit a complaint to CarePlus to express dissatisfaction with the plan and to request reconsiderations of a claim denial or payment amount.

Requests for Review of Denied Claims: Participating providers can request a review of service or claim payment denials by the Plan. To obtain a review, providers should call CarePlus provider services queue at 1-866-313-7587, the number that is listed on the back of the Member's ID card, or send a written request to the CarePlus Claims address at P.O. Box 14697, Lexington, KY 40512-4697.

Provider Claims Reconsideration Process: If, upon receipt of an initial claim determination from CarePlus via electronic or paper Remittance Advice, the provider disagrees with the determination made by CarePlus and would like to request a reconsideration/reopening of the issue, providers may do so by contacting CarePlus via written correspondence to the mailing address:

CarePlus Correspondence
P.O. Box 14697
Lexington, KY 40512-4697

When submitting a written request for reconsideration/reopening the following information must accompany the request: provider name and Tax ID, member name and identification number, date of service, claim number, name of the provider of services, charge amount, payment amount, and a brief description of the basis for the contestation. In addition, be sure to include any relevant supporting documentation (medical records, copy of invoice, etc.).

If a provider has a grievance regarding any aspect of CarePlus operations, the provider should first contact their designated provider services executive to discuss the matter. In the event a provider wishes to submit a formal grievance or request a **second-level review** of a previously reviewed claim denial or payment dispute, the provider must document in writing the circumstances and forward to his or her designated provider services executive at:

CarePlus Health Plans Inc.
Attn: Provider Operations department
P.O. Box 277810
Miramar, FL 33027

The letter will be reviewed by the provider operations department and other plan departments as required in order to make a determination. A response will be sent within 60 days after receipt of the letter.

Note: The above provisions of this section are to be considered as separate and distinct from the arbitration provisions set forth in provider's Agreement.

Important Note for Delegated Providers:

Claim issues or provider disputes must be submitted directly to the delegated entity and reviewed by the delegated entity's claim resolution process. For additional details, please refer to the delegated entity you are affiliated to and/or your participating provider agreement with said entity.

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MEMBER GRIEVANCES AND APPEALS

CarePlus is mandated to meet CMS requirements for processing member grievance and appeals. This information is provided to you so that you may assist CarePlus members with this process, should they request your assistance. CarePlus has a designated department and representatives who handle all member grievances and appeals.

GRIEVANCE PROCESS

A **grievance** is an expression of dissatisfaction with any aspect of the operations, activities, or behavior of CarePlus or its providers in the provision of health care, or prescription drugs services or benefits, regardless of whether any remedial action is requested.

A grievance may be filed by a member or his or her representative, either orally or in writing to CarePlus. The Grievance or Appeal Form is available for download from our website at CarePlusHealthPlans.com/Members/forms-tools-resources.

The member/ representative may also call our Member Services department at 1-800-794-5907 (TTY: 711) to request a Grievance or Appeal Form. The written grievance request may be submitted to the Grievance and Appeals department at the following address or fax number:

CarePlus Health Plans
Attention: Grievance & Appeals department
P.O. Box 277810
Miramar, FL 33027
Fax: 1-800-956-4288

If the Grievance or Appeal Form is not used, the member/representative has the right to submit his/her own *written* request to CarePlus. At minimum, the following information must be provided:

- Member's name, address, phone number, and identification number
- Details of the issue
- Previous contact with CarePlus
- Date of service/occurrence
- Provider name (if applicable)
- Description of relief sought
- Member's signature or that of the authorized representative
- Date grievance was signed.

Otherwise, the member/representative can call CarePlus' Member Services at 1-800-794-5907 (TTY: 711) and have the information detailed above ready for the Member Services representative. From Oct. 1 to March 31, we are open seven days a week, from 8 a.m. to 8 p.m. From April 1- Sept. 30, we are open Monday – Friday, 8 a.m. – 8 p.m.

CarePlus reviews grievances and notifies the member and/or representative of its resolution as expeditiously as the member's health requires, but no later than 30 calendar days from the date the

grievance is received for standard grievances or within 24 hours for expedited grievance requests.

- The time frame for a standard grievance may be extended an additional 14 calendar days if either the member or member's representative requests an extension, or if CarePlus justifies the necessity for additional information and documents that the extension is in the best interest of the member.

A **quality-of-care** grievance may be filed through CarePlus' grievance process (listed above) and/or a quality improvement organization (QIO). The quality-of-care grievance review will determine whether the quality of services (including inpatient and outpatient services) provided by CarePlus or a provider meets the professionally recognized standards of healthcare, including whether appropriate healthcare services have been provided or have been provided in appropriate settings. QIO submissions must be sent to KEPRO, Florida's Beneficiary and Family-Centered Quality Improvement Organization (BFCC-QIO) at:

KEPRO
Beneficiary and Family-centered Care Quality Improvement Organization (BFCC-QIO)
5201 West Kennedy Blvd., Suite 900
Tampa, FL 33609
Toll-free Phone: 1-888-317-0751 (TTY)
Fax: 1-844-878-7921

Representatives filing on behalf a member

- A **representative** is an individual appointed by a member, or authorized under state or other applicable law, to act on behalf of a member involved in an appeal or grievance. Unless otherwise provided in the applicable law, the representative will have all of the rights and responsibilities of a member in filing a grievance, or in dealing with any of the levels of the appeals process.
- A member may appoint any individual (such as a relative, friend, advocate, attorney) to act as his or her representative. However, if a member wishes to appoint a representative to act on his or her behalf, the member must submit a written representative statement to CarePlus. The Appointment of Representative Form is preferred and can be found on the CarePlus website at CarePlusHealthPlans.com/Resources but a member may submit an equivalent written notice to make the appointment. A notice is equivalent if it:
 - Includes the name, address, and telephone number of the member
 - Includes the member's Medicare Beneficiary Identifier (MBI) or CarePlus member number
 - Includes the name, address and telephone number of the individual being appointed
 - Includes the appointed representative's professional status or relationship to the party
 - Includes a written explanation of the purpose and scope of the representation
 - Contains a statement that the member is authorizing the representative to act on his or her behalf for the claim(s) at issue, and a statement authorizing disclosure of individually identifying information to the representative
 - Is signed and dated by the member making the appointment
 - Is signed and dated by the individual being appointed as representative, and is accompanied by a statement that the individual accepts the appointment

- Unless revoked, the representation is valid for one year from the date the appointment is signed by both the member and the representative.

NOTE: A provider or physician may not charge a member for representation in filing a grievance, organization/coverage determination or appeal. Administrative costs incurred by a representative during the appeals process are not reasonable costs for Medicare reimbursement purposes.

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MEDICARE APPEALS PROCESS

An **appeal** includes any of the procedures that deal with the review of adverse initial determinations made by CarePlus on healthcare services or prescription drug benefits a member believes he or she is entitled to receive, including delay in providing (when a delay would adversely affect the health of the member), arranging for, or approving the healthcare services/drug coverage, or any amounts the member must pay for a service or drug.

Appeal levels:

There are five levels of Medicare appeals:

1. Reconsideration [Part B and C]/ Redetermination [Part D]
2. Independent Review Entity (IRE): MAXIMUS Federal (Part C) and C2C Innovative Solutions Inc. (Part D).
3. Hearing by an administrative law judge (ALJ) or attorney adjudicator if the amount in controversy is met
4. Medicare Appeals Council (Council)
5. Judicial review if the amount in controversy is met

Medical care: includes medical items and services (Medicare Part C) as well as Medicare Part B prescription drugs. In some cases, different rules apply to a request for a Part B prescription drug. Please refer to the time frames listed below to see how Part B prescription drugs are different from the time frames for Part C medical items and services.

A **reconsideration** is an appeal to CarePlus about a medical care coverage decision. This is the member's first step in the appeals process which involves the review of an adverse organization determination, the evidence and findings upon which it was based, and any other evidence submitted or obtained.

A **redetermination** is an appeal to CarePlus about a Part D prescription drug coverage decision. This is the member's first step in the appeals process, which involves CarePlus re-evaluating an adverse coverage determination, the findings upon which it was based, and any other evidence submitted or obtained.

Requesting a standard reconsideration/redetermination:

- A member, member's representative, or treating physician (subject to the notice requirements listed below) may request a standard reconsideration/redetermination by filing a written request with CarePlus to the mailing address or fax referenced in the **Member Grievance and Appeals** section.
 - Completion of the Grievance or Appeal Form is preferred, but the requestor may submit his or her own form as long as it contains the following information:
 - Member's name, address, telephone number and member ID number
 - Reasons for the appeal, including identifying which denial is being appealed
 - Provider name and contact information

- Requestor's name and signature (optional) unless proof of authorized status is necessary
- Date the appeal was signed
- Submission of any supporting evidence
- For prescription drug requests:
 - Prescription drug being requested
 - If the appeal relates to a decision by CarePlus to deny a drug that is not on CarePlus' formulary, the physician/prescriber must indicate that all the drugs on any tier of CarePlus' formulary would not be as effective to treat the member's condition as the requested off-formulary drug or would harm the member's health.

The Grievance or Appeal Form is available for download from our website at [CarePlusHealthPlans.com/Resources](https://www.CarePlusHealthPlans.com/Resources). You may also contact our Member Services department to request a Grievance or Appeal Form.

For Part D appeals, the Medicare Part D Redetermination Request Form is available for download on our website at [CarePlusHealthPlans.com/Members/Member-Resources/Grievance-Appeal](https://www.CarePlusHealthPlans.com/Members/Member-Resources/Grievance-Appeal). You may also contact our Member Services department to request a redetermination request form.

Standard reconsideration/redeterminations requests from physicians:

- A physician who is providing treatment to a member may, upon providing notice to the member, request a standard reconsideration/redetermination on the member's behalf without submitting a representative form.
 - If the reconsideration/redetermination comes from the member's PCP within CarePlus' network, no member notification is required.
 - If the reconsideration/redetermination comes from either a physician within CarePlus' network, or a non-contracted physician, and the member's records indicate he or she visited the physician at least once before, CarePlus can assume the physician has informed the member about the request and no further verification is needed.
 - If it appears to be the first contact between the physician requesting the reconsideration/redetermination and the member, CarePlus will need to confirm that the physician notified the member about his/her reconsideration/redetermination request.

Note: Contracted providers do not have appeal rights. Contracted provider disputes involving plan payment denials are governed by the provider dispute provisions in the contract between the provider and CarePlus (refer to Participating Provider Grievances and Requests for Claims Reconsideration for details).

Requesting expedited reconsiderations/redeterminations:

- A member, member's representative, or any physician/prescriber regardless of whether they are affiliated with CarePlus, may request that CarePlus expedite a reconsideration/redetermination in situations where applying the standard time frame could seriously jeopardize the member's life, health, or ability to regain maximum function.

- A physician/prescriber does not need to be an authorized representative to request an expedited appeal on behalf of the member.
Note: A request for payment of a service already provided to the member is not eligible to be reviewed as an expedited appeal.
- To request an expedited reconsideration/redetermination, the member, member's representative, or physician/prescriber must submit an oral or written request (See **Requesting a standard reconsideration/redetermination** section above for necessary items) directly to CarePlus by either calling CarePlus' Member Services department or mailing/ faxing the request at the contact information noted above (under CarePlus Health Plans).
Note: While exact words are not required, the physician/prescriber must indicate that applying the standard time frame could seriously jeopardize the life or health of the member, or the member's ability to regain maximum function. If CarePlus receives this expedited request from a physician/prescriber, then we will process the appeal under expedited time frames.

Time frames:

- A reconsideration/redetermination request must be filed within 60 calendar days from the date of the notice of the organization/coverage determination (initial denial).
 - CarePlus will extend a time frame for filing a reconsideration/redetermination only if good cause is shown. A request for good cause must be submitted in writing and state why the request was not filed on time. Good cause will be determined on a case-by-case basis.
- CarePlus will render a decision as expeditiously as the member's health requires but no later than:
 - Part C reconsiderations
 - 72 hours for expedited Part C reconsiderations
 - 30 calendar days for a standard pre-service Part C reconsiderations
 - 60 calendar days for Part C payment reconsiderations
 - Part B drug requests
 - 72 hours for expedited Part B drug requests
 - 7 calendar days for standard pre-service Part B drug requests
 - Part D redeterminations
 - 72 hours for expedited Part D redeterminations
 - 7 calendar days for standard pre-service Part D redeterminations
 - 14 calendar days for Part D payment redeterminations

NOTE: In some cases, time frames for standard/expedited pre-service reconsiderations (Part C only) may be extended if either the member or member's representative requests an extension, or if CarePlus justifies the need for additional information and documents that the extension is in the best interest of the member.

Further appeal levels:

If the adverse organization/coverage determination is upheld by CarePlus, the member or member's representative can seek additional review from the subsequent appeal levels.

- For medical care, a treating physician can request an organization determination or a Level 1 appeal on the member's behalf without being a representative. If the appeal is denied at Level 1, it will be automatically forwarded to Level 2. To request any appeal after Level 2, the physician must be appointed as the member's representative.
- For Part D prescription drugs, the physician or other prescriber can request a coverage determination, Level 1, or Level 2 appeal on the member's behalf. To request an appeal after Level 2, the physician or prescriber must be appointed as the member's representative.

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MEDICAID APPEALS PROCESS

Members enrolled in CareNeeds Plus (HMO D-SNP) may appeal the plan's denial of "wrap" benefits available to QMB+, SLMB+, and FBDEs per CarePlus' contract with the state of Florida.

Requesting an appeal

- A member, authorized representative, or legal representative of the state may request an appeal orally or in writing by either calling CarePlus' Member Services department or mailing/ faxing the request at the contact information noted above (under CarePlus Health Plans).
- A physician/prescriber must be appointed as the member's authorized representative to request an appeal on behalf of the member.

Time frames:

An appeal must be filed within 60 calendar days from the date of the notice of adverse benefit determination (initial denial).

CarePlus will render a decision as expeditiously as the member's health requires but no later than:

- 72 hours for expedited appeals
- 30 calendar days for standard appeals

NOTE: In some cases, time frames for the appeal may be extended if either the member or member's representative requests an extension, or if CarePlus justifies the need for additional information and documents that the extension is in the best interest of the member.

Further appeal levels:

If the appeal is upheld by CarePlus, the member or member's representative can seek additional review by requesting a State Fair Hearing through the Agency for Health Care Administration (AHCA) Medicaid Hearing Unit within 120 calendar days from the date listed on the plan's appeal decision letter. The State Fair Hearing Officer will review the appeal and issue a decision.

If the member is receiving services during the plan appeal and qualifies for a continuation of services, the member can file a request for the services to continue no later than 10 calendar days from the date of the appeal decision letter.

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CAREPLUS COVERED BENEFITS

Please refer to a member's EOC for a specific description of their benefits as benefits vary by plan. Please refer to CarePlus' PAL at [CarePlusHealthPlans.com/PAL](https://www.CarePlusHealthPlans.com/PAL) for items and services that require authorization.

PHYSICIAN/PROFESSIONAL OFFICE VISITS

Medical and surgical care in a physician's or other medical professional's office.

ROUTINE PHYSICAL EXAM

Members are covered for an annual comprehensive exam in addition to any Medicare-covered annual exams. Any labs or diagnostic procedures ordered as a result of this exam are covered as separate services according to the member's plan benefits.

EMERGENCY/URGENT SERVICES

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

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

Emergency services are covered inpatient and outpatient services that are:

- Furnished by a provider qualified to furnish emergency services, and
- Needed to evaluate or stabilize an emergency medical condition

Urgently needed services are covered outpatient services that are provided:

- When a member is temporarily absent from the plan's service area when the services are medically necessary and immediately required (treatment should not be postponed but it's not an emergency situation), or
- As a result of an unforeseen illness, injury, or condition, or
- When a member is in the plan's service area and in need of immediate, medically necessary treatment, but the CarePlus' provider network is temporarily unavailable or inaccessible (e.g. care is needed after provider's normal business hours or when member's provider is away from office for extended period, and it is not reasonable to postpone treatment, given the circumstances).

CarePlus will cover emergent/urgent medical care including emergency transportation anywhere in the world.

OUTPATIENT HOSPITAL OBSERVATION

Observation services are outpatient services provided in a hospital setting to determine if admittance to the hospital as an inpatient is necessary or if the patient may be discharged. Overnight stays in the hospital may be considered as outpatient observation. Only room/board and nursing/monitoring services are included in the costs of an outpatient hospital observation visit. Physician and any diagnostic services are billed separately. Written orders from a state licensed provider is required for coverage of observation services.

HEARING

MEDICARE-COVERED SERVICES: Covered services include diagnostic hearing and balance evaluations furnished by a physician, audiologist or other qualified provider to determine if medical treatment is required. Members may receive audiology services furnished personally by an audiologist without a physician/non-physician practitioner (NPP) order for non-acute hearing assessment unrelated to disequilibrium, or hearing aids, or examinations for the purpose of prescribing, fitting, or changing hearing aids. The service may be performed once every 12 months, per beneficiary.

SUPPLEMENTAL ROUTINE SERVICES: Coverage for hearing service varies according to the county and plan. Hearing discounts are described in the Valued-Added Items and Services (VAIS) brochure.

HOME HEALTHCARE

Home healthcare services will be covered when a member meets all of the following criteria:

- Confined to home
- Under a plan of treatment with a written physician order established and periodically reviewed by a physician
- Home health agency approved by the Medicare program
- In need of intermittent skilled nursing care, physical therapy, speech therapy, or occupational therapy.

INPATIENT HOSPITAL SERVICES

Inpatient hospital services include all items and medically necessary services that provide appropriate care during a stay in a participating hospital. These services include room and board, nursing care, medical supplies, and all diagnostic and therapeutic services. CarePlus shall be responsible for Part A inpatient care to members who, at the time of disenrollment, are under inpatient care until the time of his/her discharge. Member cost-shares vary by plan, benefit period, and number of days spent in the hospital.

CarePlus shall not be responsible for coverage of Part A inpatient services for inpatient care already being provided at the time of enrollment of a member. Hospitals and providers should bill either the member's insurance carrier prior to CarePlus or Medicare directly.

LABORATORY SERVICES

Laboratory services are **ONLY** provided by Laboratory Corporation of America (Labcorp).

OUTPATIENT SERVICES

Outpatient services may include the following services provided in an outpatient hospital setting or free-standing facility: therapeutic, radiological and diagnostic procedures and tests such as labs, x-rays, mammograms, colonoscopies, advanced imaging, nuclear medicine, and radiation therapy; surgical services and supplies, wound care, and hyperbaric oxygen treatments; sleep studies; emergency services; as well as mental health care and substance abuse services, including Opioid treatment services. Covered services and member cost-sharing varies by plan.

VISION CARE (MEDICARE-COVERED)

Includes outpatient physician services for the diagnosis and treatment of diseases and injuries of the eye, including treatment for age-related macular degeneration and cataracts, glaucoma and diabetic screenings.

Includes one pair of eyeglasses or contact lenses after each cataract surgery. See the EOC or contact CarePlus for specific limitations and exclusions.

VISION SERVICES (ROUTINE)

Vision services vary according to the county and plan. Vision discounts are described in the VAIS brochure. Please contact CarePlus for additional details. Please refer member inquiries to CarePlus' Member Services department.

MEDICARE PART B PRESCRIPTION DRUGS

These drugs are covered under Part B of Original Medicare. A Part B medication request (also known as buy and bill) is when the physician obtains the medication from any drug provider and bills CarePlus. Buy and Bill (physician purchased injectable/infusible drugs) will continue to be processed by the CarePlus Precertification Department.

Members of CarePlus receive coverage for the following drugs through our plan. Some limitations, restrictions, and/or member cost-share may apply.

- Drugs that usually are not self-administered by the patient and are injected or infused in a professional setting
- Drugs that are taken using DME (i.e., nebulizers or infusion pump) that were authorized by the plan
- Clotting factors, administered through injections if member has hemophilia
- Immunosuppressive drugs, if the patient was enrolled in Medicare Part A at the time of the organ transplant.
- Injectable osteoporosis drugs if:
 - The member is a woman with osteoporosis who meets the criteria for Medicare home health benefit

- The member has a bone fracture and a doctor certifies it was related to post-menopausal osteoporosis
- A doctor certifies that the drug cannot be self-administered
- Antigens if they're prepared by a doctor and are given by a properly instructed person (who could be the patient) under appropriate supervision
- Certain oral anti-cancer drugs and anti-nausea drugs
- Certain drugs for home dialysis, including heparin, the antidote for heparin when medically necessary, topical anesthetics and erythropoiesis-stimulating agents (e.g., Epogen®, Procrit®, epoetin alfa, or darbepoetin alfa)
- Intravenous immune globulin for the home treatment of primary immune deficiency diseases

DRUG REPLACEMENT (WHITE-BAG) MEDICATIONS

All requests for injectable or infusible drugs that are obtained from the patient's pharmacy with a prescription and that are shipped directly to the provider's office for administration, will be billed under the patient's Part D benefit. These are called drug replacement or white-bag medications and are processed by the CarePlus Pharmacy Department.

If the drug requires a coverage determination, you may contact our CarePlus Pharmacy Utilization Management Unit in one of the following ways:

- Send the request electronically via covermymeds® at www.covermymeds.com/main/prior-authorization-forms/careplus/.
- Call 1-866-315-7587, Monday – Friday, 8 a.m. – 8 p.m., Eastern time. You may also leave a voicemail after hours.
- Fax the request, along with applicable supporting documentation, to 1-800-310-9071.

Please indicate on the coverage determination form that the medication request is a drug replacement request.

The procedural codes for the administration and office visit will continue to be processed by the CarePlus Precertification Department. Please submit your request utilizing the [Health Services Preauthorization Form](#) to one of the fax numbers indicated at the bottom of the form.

MEDICARE PART D PRESCRIPTION DRUGS

COVERED: All Medicare drug plans are required to have formularies that address all medically necessary drugs. Plans are required to cover almost all drugs within these protected classes: anti-neoplastics, anti-HIV/AIDS drugs, immunosuppressant, anti-psychotics, anti-depressants, and anti-convulsants.

NOT COVERED:

There are three general rules about drugs that Medicare drug plans will not cover under Part D:

- Our plan's Part D drug coverage cannot cover a drug that would be covered under Medicare Part A or Part B.

- Our plan cannot cover a drug purchased outside the United States and its territories.
- Our plan usually cannot cover off-label use. “Off-label use” is any use of the drug other than those indicated on a drug’s label as approved by the Food and Drug Administration. Coverage for “off-label use” is allowed only when the use is supported by certain reference books. These reference books are the American Hospital Formulary Service Drug Information, the DRUGDEX Information System, for cancer, the National Comprehensive Cancer Network and Clinical Pharmacology, or their successors.

Also, by law, there are certain types of drugs that Medicare must exclude from Part D:

- Non-prescription drugs (also called over-the-counter drugs)
- Drugs used to promote fertility
- Drugs used for the relief of cough or cold symptoms
- Drugs used for cosmetic purposes or to promote hair growth
- Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations
- Drugs used for the treatment of sexual or erectile dysfunction
- Drugs used for treatment of anorexia, weight loss, or weight gain
- Outpatient drugs for which the manufacturer seeks to require that associated tests or monitoring services be purchased exclusively from the manufacturer as a condition of sale

For your patients who have Medicare and Medicaid, check with your state Medicaid program as most programs are continuing to cover all or some of these excluded drugs. For full duals enrolled in CarePlus Dual Eligible Special Needs Plans, any Part D excluded drugs included on Florida Medicaid’s Prescription Drug List is covered by CarePlus.

***Some CarePlus plans cover some of the excluded erectile dysfunction drugs. Please contact the plan for details. You can access the CarePlus Prescription Drug Guides on our website at CarePlusHealthPlans.com/PrescriptionDrugGuides.**

****Some CarePlus plans also cover certain prescription vitamins: Folic acid 1 mg, vitamin D₂ 50,000 units, and injectable B-12 (cyanocobalamin). Please contact the plan for details. You can access the CarePlus Prescription Drug Guides on our website at CarePlusHealthPlans.com/PrescriptionDrugGuides.**

MENTAL HEALTHCARE SERVICES – INPATIENT

Coverage is provided but varies for inpatient mental healthcare provided for patients confined to an acute care facility or a psychiatric facility.

- Acute care facility/general hospital coverage for mental health is limited to 90 days per stay (plus 60 lifetime reserve days available to extend stays until reserve days are exhausted). Once lifetime reserve days are exhausted, all stays are limited to 90 days. There is no limit to the number of stays.
- Psychiatric facility coverage for mental health is limited to 190 days per lifetime in a Medicare-certified psychiatric facility.

The benefit days used under the Original Medicare program will count toward the 190 day lifetime reserve days when the member enrolls in a MA plan.

MENTAL HEALTHCARE SERVICES – OUTPATIENT

Covered services include outpatient group and individual therapy visits and partial hospitalization for treatment of mental illness and/or substance abuse provided by a Medicare-qualified mental health professional. Full dual members enrolled in CareNeeds Plus (HMO D-SNP) or CareNeeds Platinum (HMO D-SNP) are also covered for Mental Health Targeted Case Management and Community Behavioral Health services.

OUTPATIENT REHABILITATION SERVICES

Covered services include physical therapy, occupational therapy, speech language therapy, cardiac rehab services, intensive cardiac rehab services, pulmonary rehab services and comprehensive outpatient rehabilitation facility (CORF) services. The plan will cover those services which are to be provided by licensed, independently practicing providers who are Medicare certified.

PERSONAL HOME CARE SERVICES

Benefit provides short-term assistance with daily living activities (ADLs) to members at home. Qualifying members must reside at home (not in a nursing facility or health facility providing 24/7 care) and require assistance with at least two of the following ADLs: bathing, dressing, toileting, transferring, walking/mobility, or eating/feeding. PCP must refer member to CarePlus' Home Health provider who will authorize services for members who qualify. Only offered on certain CareNeeds Plus (HMO D-SNP) and CareNeeds Platinum (HMP D-SNP) plans. Please contact CarePlus for details.

SKILLED NURSING FACILITY SERVICES

For CarePlus members to receive skilled nursing services, they must need daily skilled nursing or skilled rehabilitation care or both. Members are covered for 100 days each benefit period. The benefit periods end when the member has not received hospital or skilled nursing care for 60 consecutive days. If the member goes into the hospital after one benefit period has ended, a new benefit period begins.

Nursing Facility Transitional Days – Full dual members enrolled in CareNeeds Plus (HMO D-SNP) or CareNeeds Plus Platinum (HMO D-SNP) are covered for up to 120 days in a nursing facility when skilled care is no longer approved, and member is awaiting approval for Long-Term Services and Supports.

AMBULANCE SERVICES

Covered ambulance services include fixed wing, rotary wing, and ground ambulance services, to the nearest appropriate facility that can provide care only if they are furnished to a member whose medical condition is such that other means of transportation are contraindicated (could endanger the person's health). The member's condition must require both the ambulance transportation itself and the level of service provided in order for the billed service to be considered medically necessary.

DURABLE MEDICAL EQUIPMENT (DME) AND RELATED SUPPLIES

Examples of covered items include, but are not limited to: wheelchairs, crutches, hospital bed, IV infusion pump, oxygen equipment, nebulizer, and walker. CarePlus maintains a list of covered manufacturers and brands on our website at [CarePlusHealthPlans.com/Plans](https://www.CarePlusHealthPlans.com/Plans).

PROSTHETIC DEVICES AND RELATED SUPPLIES

CarePlus covers devices that replace body part or function. These include but are not limited to: colostomy bags and supplies directly related to colostomy care, pacemakers, braces, prosthetic shoes, artificial limbs, and breast prostheses.

WIGS

Most CarePlus plans include a benefit that provides an allowance toward the cost of a wig for members who suffer hair loss as a result of chemotherapy treatments. Please refer to the member's plan EOC or contact Member Services. Members may purchase wigs from any retailer and submit proof of purchase to CarePlus for reimbursement.

KIDNEY/RENAL DIALYSIS FOR END-STAGE RENAL DISEASE

CarePlus covers dialysis services for members with end-stage renal disease (ESRD) either at home or at a facility. The venue for dialysis will be determined by the provider for the member. CarePlus will also cover renal dialysis when member is temporarily out of the service area. Member cost-sharing for service and supplies varies by plan.

DIABETES SELF-MONITORING, TRAINING AND SUPPLIES*

Covered services for all members who have diabetes (insulin and noninsulin users) include:

- Blood glucose monitor, blood glucose test strips, and lancet devices. Diabetic monitoring supplies have a \$0 copayment when obtained from a CarePlus network pharmacy or diabetic supplier. CarePlus covers ACCU-CHEK® by Roche and Trividia products.
- One pair per calendar year of therapeutic custom-molded shoes (including inserts provided with such shoes) and two additional pairs of inserts, or one pair of depth shoes and three pairs of inserts (not including the non-customized removable inserts provided with such shoes). Coverage includes fitting. Member cost-share varies by plan.
- Self-management training.

DENTAL SERVICES (MEDICARE-COVERED)

Limited to dental services inextricably linked to medical procedures covered under Medicare such as the extraction of teeth to prepare the jaw for radiation treatments of neoplastic disease.

DENTAL SERVICES (ROUTINE)

Covered dental plan services vary according to the county and the plan. Dental discounts are described in the VAIS brochure. Please contact CarePlus for additional details. Please refer member inquiries to CarePlus' Member Services department.

PODIATRY SERVICES (MEDICARE COVERED)

Medicare covered podiatry services include:

- Foot exams and treatment of injuries and diseases of the feet (such as a hammer toe or heel spurs)
- Treatment for disease-related nerve damage or other medically necessary foot care

Specialist visit copayment varies by plan.

PODIATRY SERVICES (ROUTINE)

CarePlus also covers unlimited routine foot care for members with certain medical conditions such as flat feet or other structural misalignments; or, for the removal of corns, warts, calluses; or, for hygienic care. Specialist visit copayment varies by plan.

CHIROPRACTIC SERVICES (MEDICARE-COVERED)

Medicare covered chiropractic services are limited to medically necessary manual manipulation of spine to correct subluxation that can be demonstrated by X-ray. Specialist visit copayment varies by plan.. The initial/new patient exam is not covered for most members. This visit is only covered for full dual CarePlus D-SNP members.

CHIROPRACTIC SERVICES (ROUTINE)

CarePlus also covers up to 12 routine chiropractic visits per year for manual manipulation of the spine. Specialist visit copayment varies by plan. The initial/new patient exam is not covered for most members. This visit is only covered for full dual CarePlus HMO D-SNP members. .

ACUPUNCTURE FOR CHRONIC LOW BACK PAIN (MEDICARE-COVERED)

Members with a documented history of chronic low back pain lasting 12 weeks or longer may be referred to a network acupuncturist for up to 20 acupuncture treatments annually (12 initial visits within 90 days and, with demonstrated improvement, an additional eight may be approved). Refer to CMS guidance and/or member's EOC for additional criteria.

ACUPUNCTURE (ROUTINE)

Members may self-refer to a network acupuncturist for up to 25 visits annually. Benefit is not available on all plans. Refer to member's EOC. Discounts are also available through CarePlus VAIS program.

CHRONIC CONDITION CARE ASSISTANCE

Certain chronically ill members who have a demonstrated need to receive additional assistance to meet their care plan goals, and who are actively engaged with care management services and meet the program criteria, can receive up to \$500 per year of additional assistance for primarily health-related or non-primarily health-related expenses to address their unique needs. Assistance can include, but is not limited to:

- Adult day care
- Alternative therapies
- Caregiver services
- Home and bathroom safety devices
- Meal delivery services
- Medical expense assistance
- Medical supplies and prosthetics
- Non-medical transportation
- Pest control
- Utilities

FLEX ALLOWANCE

Benefit provides members a spending account card preloaded with an annual allowance that can be used to pay out-of-pocket costs for covered vision, hearing, and preventive and comprehensive dental services at in-network providers accepting Visa. Not available on all plans. See member's CarePlus plan EOC for availability or additional details.

CAREESSENTIALS ALLOWANCE

Benefit provides members a spending account card preloaded with an allowance that members can use only in the issued month to purchase healthy foods/beverages and other necessities from participating retailers in-store or online. Our members also can use this allowance to pay for eligible items and services such as:

- Over-the counter (OTC) and personal care products
- Pet care supplies, such as pet food, toys, and flea prevention products
- Bills such as utilities, rent, and mortgage
- And more

Please see member's EOC for additional information. Not available on all plans.

WELLNESS AND HEALTHCARE PLANNING

Members can utilize [CarePlusHealthPlans.com/Members/Health-and-Wellness/Programs/Advance-Care-Planning](https://www.CarePlusHealthPlans.com/Members/Health-and-Wellness/Programs/Advance-Care-Planning) to access MyDirectives, where they can complete and register to store completed forms such as a living will, a medical power of attorney, a do-not-attempt-resuscitation form, and an organ donation form.

POINT OF SERVICE (POS) SUPPLEMENTAL BENEFIT

Members enrolled in plans with a POS option may access certain Medicare A/B benefits from non-network providers. Services covered OON are reflected in the EOC. Most plans with this benefit limit have access to non-network providers within the plan's service area while Orlando CareOne Plus members may utilize providers in Puerto Rico for these services.

TRANSPORTATION SERVICES

Non-emergency medical transportation services to plan-approved locations such as network doctor offices, VA clinics, and fitness centers offering SilverSneakers fitness program. Trip arrangements must be made three weekdays prior to appointment date.

Members may contact CarePlus' transportation vendor, Alivi NEMT Network, directly to schedule transportation. Alivi NEMT Network has the capability to identify whether a location is a CarePlus-approved location and verify member's benefits. In the event a member requests to schedule transportation to a non-plan approved location or a one way trip that exceeds 35 miles, an authorization is required.

Process:

- Member contacts Alivi NEMT Network to request transportation.
- Location member is requesting flags as a non-plan approved location or exceeds 35 miles.
- Alivi NEMT Network informs the member the location is not plan approved and refers them to contact the plan to initiate an authorization request.
- Member contacts the plan to request an authorization.
- The PCP can also create/request an authorization via Availity or *PWS (*sunset July 2024). PCP will add the address to the authorization before faxing to Alivi NEMT Network.
- PCP will fax the authorization to Alivi NEMT Network at 305-402-0980.
- Alivi NEMT Network will note the authorization/reference number and address on the member's file. The member will need to contact Alivi NEMT Network or CarePlus Member Services to schedule transportation to the authorized address/location.

HEALTH AND WELLNESS

CarePlus offers a series of health and wellness education programs and services that address such concerns as fitness, nutrition, and smoking cessation.

Note: Certain health and wellness benefits may be limited or not available on some plans. Please view member's EOC or contact CarePlus for further details.

- SilverSneakers® fitness program
- Meal programs (post hospital/SNF discharge)
- Over-the-counter drugs and supplies
- Smoking cessation (available only on CareNeeds Plus (HMO D-SNP) and CareNeeds Platinum (HMO D-SNP) plans)

MEDICAL NUTRITION THERAPY

Medical Nutritional Therapy is available for any CarePlus member with diabetes, renal disease (but not on dialysis), and after a transplant.

KIDNEY DISEASE EDUCATION SERVICES

Educational services are available to qualifying members to teach kidney care and help members make informed decisions about their care.

PREVENTIVE CARE AND SCREENING TESTS

CarePlus covers and arranges for appropriate preventive screenings such as:

- Abdominal aortic aneurysm screening
- Alcohol misuse screening and counseling
- Annual wellness visit including personalized prevention plan services
- Bone mass measurements
- Cancer screenings (breast, cervical, vaginal, colorectal, prostate)
- Cardiovascular disease risk reduction visit and screening
- Depression screening
- Diabetes screening
- Diabetes self-management training
- EKG screening (covered as result of IPPE screening once per lifetime)
- Glaucoma screening
- Hepatitis B and C virus screening
- HIV screening
- Immunizations (e.g., COVID-19, flu, RSV, etc.)
- Initial preventive physical exam (IPPE) (“Welcome to Medicare” physical exam)
- Lung cancer screening with low dose computed tomography (LDCT)
- Medical nutrition therapy (for Medicare beneficiaries with diabetes or renal disease)
- Medicare Diabetes Prevention Program
- Obesity screening and therapy
- Screening for sexually transmitted infections (STIs) and high intensity behavioral counseling to prevent STIs
- Smoking and tobacco-use cessation counseling services

Providers may refer to www.cms.gov/Medicare/Prevention/PrevntionGenInfo/medicare-preventive-services/MPS-QuickReferenceChart-1.html for the most up-to-date list of Medicare-covered preventive services.

DIRECT ACCESS WITHOUT AN AUTHORIZATION/REFERRAL

CarePlus members may receive the following services without a referral or preauthorization:

- Emergency services from network providers or from out-of-network providers
- Influenza (flu), COVID-19, and pneumonia vaccinations received from a network provider
- Most Medicare-covered preventive screenings/services from a network provider
- Renal (kidney) dialysis services received at a Medicare-certified dialysis facility when the member is temporarily outside the plan's service area
- Routine chiropractic services from a network provider up to 12 visits per calendar year
- Routine dermatology services from a network provider
- Routine podiatry services from a network provider
- Routine women's healthcare, which includes breast exams, mammograms (X-rays of the breast), Pap test, and pelvis exams provided by a network provider
- Supplemental benefits such as routine dental care, routine vision care, routine hearing services, and routine transportation (one-way trips 35 miles or less to plan approved locations) when available as a plan benefit and received from a network provider
- Urgently needed services from network providers or from out-of-network providers when network providers are temporarily unavailable or inaccessible (e.g., when the member is temporarily outside of the plan's service area)

NOTE: CarePlus policy allows for the auto-approval of certain codes that are typically performed in conjunction with another primary service. For example, an authorized Evaluation & Management Services CPT code billed with a diagnostic test which is not included in the authorization. Add-on codes are reimbursable services when reported in addition to the appropriate primary service by the same provider reporting the same federal Tax Identification Number.

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MEDICARE PRESCRIPTION DRUG COVERAGE (PART D)

What is covered, what's not?

Covered: All Medicare drug plans have formularies that address most medically necessary drugs. Plans are required to cover almost all drugs within these protected classes: antineoplastic, anti-HIV/AIDS drugs, immunosuppressant (for prophylaxis of organ transplant rejection), anti-psychotics, anti-depressants, and anticonvulsants. The list of the covered drugs is included in the Prescription Drug Guides that are available at [CarePlusHealthPlans.com/PrescriptionDrugGuides](https://www.careplushealthplans.com/PrescriptionDrugGuides). The information is listed by service area and plan.

Not covered:

There are three general rules about drugs that Medicare drug plans will not cover under Part D:

- Our plan's Part D drug coverage cannot cover a drug that would be covered under Medicare Part A or Part B.
- Our plan cannot cover a drug purchased outside the United States and its territories.
- Our plan usually cannot cover off-label use. "Off-label use" is any use of the drug other than those indicated on a drug's label as approved by the Food and Drug Administration. Generally, coverage for "off-label use" is allowed only when the use is supported by certain reference books. These reference books are the American Hospital Formulary Service Drug Information, DRUGDEX Information System, for cancer, the National Comprehensive Cancer Network and Clinical Pharmacology, or their successors.

Also, by law, there are certain types of drugs that Medicare must exclude from Part D:

- Cough and cold medicines[†]
- Drugs used for anorexia, weight loss, or weight gain
- Drugs used for cosmetic purposes or hair growth
- Drugs used for the treatment of sexual or erectile dysfunction*
- Fertility drugs
- Non-prescription drugs (also called over-the-counter drugs)
- Outpatient drugs for which the manufacturer seeks to require that associated tests or monitoring services be purchased exclusively from the manufacturer as a condition of sale
- Prescription vitamins and minerals; except prenatal vitamins and fluoride preparations**

For your patients who have both Medicare and Medicaid, check with your state Medicaid program as most programs are continuing to cover all or some of these excluded drugs.

*Some CarePlus plans cover some of the excluded erectile dysfunction drugs. Please contact the plan for details. You may access the CarePlus Prescription Drug Guides on our website at [CarePlusHealthPlans.com/PrescriptionDrugGuides](https://www.careplushealthplans.com/PrescriptionDrugGuides).

** Some CarePlus plans also cover certain vitamins when prescribed by a provider: Folic acid 1mg, vitamin D₂ 50,000 units, and injectable B-12 (cyanocobalamin). Please contact the plan for details. You may access the CarePlus Prescription Drug Guides on our website at [CarePlusHealthPlans.com/PrescriptionDrugGuides](https://www.careplushealthplans.com/PrescriptionDrugGuides).

‡Cough and cold medications are covered in clinically relevant situations other than those of symptomatic relief of cough and/or colds.

What is a coverage determination or an exception?

A **coverage determination** is an initial decision (e.g., approval or denial) made by CarePlus about whether a drug prescribed for an enrollee is covered by the plan and the amount, if any, the enrolled is required to pay for the prescription. Some drugs in the formulary may require prior authorization, may have step therapy requirements or quantity limitations. If a drug requires a coverage determination, the patient, the patient's appointed representative, or the patient's prescribing physician or other prescriber will need to request and receive approval from CarePlus before this drug may be covered.

CarePlus has placed these requirements on select high-risk or high-cost medications to promote safe and effective drug utilization. We want to make sure these medications do not interfere with others the patient may be taking or add to the patient's costs unnecessarily. The CarePlus Pharmacy Utilization Management Unit and therapeutics committees, with input from physicians, manufacturers, peer-reviewed literature, standard compendia, and other experts, establish coverage determination criteria.

An **exception request** is a type of coverage determination. Exception requests are granted when CarePlus determines that the requested drug is medically necessary for the patient. Therefore, providers must submit a statement to CarePlus to support the request.

There are different types of exceptions, such as:

1. A **tiering exception**: A request that will allow patients to obtain a non-preferred drug in a higher cost-sharing tier at the more favorable cost-sharing terms applicable to drugs in a lower cost-sharing tier. For this type of exception, your supporting statement must indicate:
 - The preferred drug would not be as effective as the requested drug in the higher cost-sharing tier for treating the patient's condition, and
 - The preferred drug would have adverse effects for the patient, or both.
2. A **formulary exception**: A request for a Medicare Part D drug that is not included on the CarePlus formulary or does not meet our formulary utilization rules, such as quantity limits or step therapy. For this type of exception, your supporting statement must indicate:
 - The non-formulary drug is necessary for treating the patient's condition.
 - All covered Medicare Part D drugs on any tier of the plan's formulary would not be as effective and/or would have adverse effects.
 - The number of doses under a dose restriction has been or is likely to be ineffective, or
 - The alternative drug listed on the formulary or required to be used in accordance with step therapy has been or is likely to be ineffective or cause an adverse reaction.

If the request is approved, the drug will be covered at a pre-determined cost-sharing level, and patient, patient's appointed representative, or patient's prescribing physician or other prescriber would not be

able to request a tier exception for a non-formulary drug approved under the formulary exception process.

Requesting a coverage determination or exception

A coverage determination or exception may be requested by the patient, patient's appointed representative, or patient's prescribing physician or other prescriber.

If you would like to submit a coverage determination or exception request on behalf of your patient with CarePlus-coverage, you may contact our CarePlus Pharmacy Utilization Management Unit in one of the following ways:

- Send the request electronically via covermymeds® at www.covermymeds.com/main/prior-authorization-forms/careplus/.
- Call 1-866-315-7587, Monday – Friday, 8 a.m. – 8 p.m., Eastern time. You may also leave a voicemail after hours.
- Fax the request, along with applicable supporting documentation, to 1-800-310-9071.

For your convenience, you may call the CarePlus Pharmacy Utilization Management Unit at 1-866-315-7587 to request a coverage determination form specifically designed for the drug that is being requested. This form will include specific questions to ensure all required information is obtained for the review.

You also may use the Request for Medicare Prescription Drug Coverage Determination form that is available in the CarePlus Provider Manual and at CarePlusHealthPlans.com/Members/Drug-Coverage-Determination. This is a general form that may require our CarePlus Pharmacy Utilization Management Unit to contact you to obtain additional information that is specific to the drug being requested. Mail a statement to:

CarePlus Health Plans Inc.
Attn: CarePlus Pharmacy Utilization Management Unit
P.O. Box 277810
Miramar, FL 33027

Once the coverage determination or exception request is submitted, CarePlus must notify you of our decision no later than 24 hours (expedited) or 72 hours (standard) from the date and time the request is received. For all exception requests, you must provide a statement supporting the request. CarePlus must receive this supporting statement before the review of an exception request can begin. The coverage determination or exception request will be expedited if we determine, or you inform us, that the patient's life, health, or ability to regain maximum function may be seriously jeopardized by waiting for a standard request.

Once a coverage determination has been made, the appeals process may be triggered if the request is denied. Please refer to the **Member Grievance and Appeals** section for further details.

CREDENTIALING/REREDENTIALING PROCESS

Credentialing: Credentialing refers to a process performed by CarePlus to verify and confirm that an applicant (physician and/or other provider type) meets the established policy standards and qualifications for consideration in CarePlus' provider network. When applicable, an applicant may be presented to the credentials committee which is comprised of physicians in various specialties for review and recommendation. Initial credentialing is performed when an application is received, and recredentialing is conducted at least every three years thereafter or as otherwise required by state regulations and at the discretion of the CarePlus.

Required supporting documentation must be submitted with each credentialing application. Such documentation/information may include, but is not limited to, licensure, education, training, clinical privileges, work history, accreditation, certifications, professional liability insurance, malpractice history, professional competency, and any physical or mental impairments. Documentation submitted by an applicant and/or provider's office is verified for accuracy and completeness. At the discretion of CarePlus, an applicant may be required to submit additional information.

CarePlus recognizes a provider's right to review information submitted in support of his/her credentialing application to the extent permitted by law and to correct erroneous information. At any time during the credentialing process, a provider may request the status of his/her application by calling the Provider Operations inquiry line at 1-866-220-5448, Monday – Friday, 8 a.m. – 5 p.m., Eastern time. The fact that a provider is credentialed is not intended as a guarantee or promise of any particular level of care or service.

Council for Affordable Quality Healthcare (CAQH): CarePlus, through its parent company Humana Inc., is a member of the Council for Affordable Quality Healthcare (CAQH), which is an online single-entry national database that eliminates the need for providers to complete and submit multiple credentialing applications. Physicians and other healthcare providers who are members of CAQH can provide CarePlus with the appropriate information in lieu of completing a CarePlus credentialing or recredentialing application. CarePlus requires network physicians to use CAQH ProView™ to submit credentialing information to the plan. Please be sure to grant our parent company, Humana Inc., access to the CAQH Proview application. Facilities and organization providers requiring credentialing must complete a paper CarePlus credentialing application. For additional details please contact CarePlus.

Credentials Committee: The credentials committee is conducted at a corporate level through its parent company in Louisville, Kentucky. The credentials committee is composed of a chairperson and employed and participating physicians/providers. Functions of the committee include credentialing, ongoing and periodic assessment of current policies/procedures, recredentialing, and the establishment of policies and procedures based on current guidelines and regulations. The physician's/provider's documentation is provided to the corporate credentials committee for approval or denial for participation in the network. Notification of approval or denial of credentials is sent to the physician/provider.

Recredentialing: Recredentialing is conducted at least every three years in accordance with the CarePlus credentialing and recredentialing process. The decision concerning re-appointment or failure to re-appoint will be conveyed to the physician/provider in writing.

MEDICARE RISK ADJUSTMENT

Under the MA program, MA plans are paid a set premium to cover the costs of health services for their members. CMS uses demographic and disease data for each member to determine the individual premium. The amount of the premium does not vary based on actual use of health services. This payment system, known as Medicare risk adjustment (MRA), allows CMS to adjust its premium payments to MA plans based on the expected healthcare costs of its members.

The purpose of MRA is to protect member access to services and to protect the financial condition of physicians and other healthcare providers and health plans in a way that is proportionate with the level of healthcare needed by members. CMS more accurately covers a given member's anticipated health expenditures by considering the variation in per capita cost that occurs, based on the health status of the individual. Increased payment accuracy benefits members, physicians, and other healthcare providers, MA plans and the Medicare program.

The role of physicians and other healthcare providers

Diagnosis data from physicians and other healthcare providers is used to determine whether an individual member suffers from certain diseases that are expected to lead to higher healthcare costs for that member. CMS requires all health plans to submit Health Insurance Portability and Accountability Act (HIPAA)-compliant 837 claims transactions to CMS for Medicare risk adjustment.

Obligations of MA plans and providers

- MA organizations must annually attest to the accuracy of risk adjustment data to CMS.
- As part of the provider participation agreement, by submitting claims to CarePlus the provider is attesting to the accuracy of the data the provider has submitted, including diagnosis codes.
- Providers have an obligation to correct any erroneous data submitted to CarePlus.
- Providers are responsible for maintaining an accurate and complete medical record for each Medicare patient.
- Providers are responsible for participating in any CarePlus medical record reviews or audits related to coding and documentation.

All diagnoses submitted for risk-adjusted payment must meet the following criteria:

- Documented in a medical record based on a face-to-face encounter with an acceptable physician or other healthcare provider type (e.g., physician, hospital)
- Assigned based on dates of service within the relevant data collection period
- Coded in accordance with standard industry guidelines (ICD-10)
- Based not solely on laboratory or other diagnostic tests, such as radiology reports

In addition to facilitating payment accuracy, good medical record documentation and coding practices, risk adjustment also helps ensure that MA plan members receive the care they need for their health conditions and that they can take advantage of disease management and other programs available through their MA plans. To improve medical record documentation and coding practices, physicians and other healthcare providers should consider the following suggestions:

- Use an electronic medical records (EMR) system.
- Confirm that all diagnosis codes are included in the claim submission. For professional services, physicians and other healthcare providers should have the capacity to submit 12 diagnosis codes.
- Ensure procedure and diagnosis codes on the form are current when using a superbill, encounter sheet or checkout form.
- Provide full and accurate documentation – ascertain that diagnoses are supported.
- Purchase and use updated coding books or software each year. Make sure the practice management system is updated.
- Use a certified coder or health information management professional for coding and billing functions.

For more information, please email the MRA Department at CPHPMRAUnit.GRP@humana.com.

Remainder of this page intentionally left blank

Forms

Spanish versions of the forms are available upon request

Sample First Occurrence/Patient Warning Letter

<Date>

Dear <Patient>:

The purpose of this letter is to notify you that we need your immediate cooperation. You may recall that we discussed our patient-physician relationship in my office on <date of last visit or discussion>. Also present were <insert names of those present or relationship to patient (e.g., wife, husband, nurse, etc.)>.

The patient-physician relationship is one that must be based upon trust, understanding and mutual respect. If these elements are absent, it is very difficult to provide the type of care that you and every other patient deserve.

The primary difficulty has been <insert clear description of problem behavior along with date(s) and time(s) displayed>. <Document what has been done to address the matter and how attempts to resolve the matter have failed.>

Your behavior must change if you wish to continue to receive services at <insert office name>. At future appointments, you will be expected to <insert specific recommendation for cooperation>.

We are willing to continue to provide services if there are no additional behavioral problems. If this matter is not corrected, it could result in the need to terminate our professional relationship. It is our mission and desire to provide medical assistance to our patients in a professional manner. We urge you to convey your concerns to us, but we ask that you do so in an appropriate way.

If you have questions, please contact <insert office manager name/designee> at <insert phone number>. We are open <Monday through Friday, 8 a.m. to 5 p.m.>.

With best regards,

<insert signatory information>

921SFL1214-D

Second Occurrence/Warning Letter, Including Notification to Health Plan

<Date>

Dear <Patient>:

You may recall that we notified you in writing on <insert date of first letter> that if <insert specific behavior> was not corrected, it could result in the need to terminate our professional relationship. In spite of this notification, you have continued to be uncooperative in abiding by our medical office policies.

Your continued refusal to cooperate was evident on <list date(s) and time(s) negative behavior was displayed>. <Document what has been done to address the matter and how attempts to resolve the matter have failed.> Accordingly, this has made it difficult for me to continue our professional relationship. I cannot continue to assume responsibility for your care under such circumstances and have notified your health plan of this matter.

If you have questions about next steps, please contact your health plan at the phone number located on the back of your member identification (ID) card.

If you have questions about this letter, please contact <insert office manager name/designee> at <insert phone number>. We are open <Monday through Friday from 8 a.m. to 5 p.m.>

With best regards,

<insert signatory information>

921SFL1214-E

CarePlus Health Plans Inc.
Physician Initiated Transfer Request Form (pg 1)

Member's/POA Name(s): _____

Member ID Number: _____ Effective Date: _____

Date of Birth: _____ Phone: _____

Address: _____

City, State, Zip: _____

Please answer all questions below and provide evidence detailing incidents/actions:

1. Justification for proposal to transfer this member is as follows: (Cite specifics as to frequency and type of demonstration disruptive, unruly, abusive or uncooperative behavior. Include how long member has been receiving services at office and dates seen, copy of warning letters and/or details and sequence of events. Use additional sheets if necessary.)
2. Mental status of member-behavioral health:
3. Functional status of member:
4. Diagnosis and medical summary of member's condition:

CarePlus Health Plans, Inc.
Physician Initiated Transfer Request Form (pg 2)

5. Social Support systems available to member:

6. Summary of efforts to resolve problem:

7. Other options offered to member prior to consideration of transfer (must be completed):

8. Attach separate statement(s), medical records and other appropriate documentation (e.g., police report) from requesting provider describing his/her experience with the member.

PCP/Group Name: _____

Provider Number _____

PCP Contact Person: _____ Phone: _____

Signature of PCP or Administrator: _____

Date: _____

Please forward by mail, fax or email to the following:

CarePlus Health Plans Inc.
Attention: Provider Operations
PO Box 277810
Miramar, FL 33027

Phone 1-866-220-5448 • Fax 1-866-449-5668 • Email CPHPProvOpsCompliance@careplus-hp.com



Request for Provider Crisis Contact/Location Information

Please complete and submit this form if a disaster or other crisis requires evacuation of your area and/or relocation of your office(s). CarePlus' Member Services will use this information to assist CarePlus-covered patients in locating their physicians and other healthcare providers during emergency situations.

Note to provider groups: A separate form should be completed for each individual physician/provider in the group if the information is not the same for everyone in the group.

Physician's/provider's name:		Effective date of relocation:	
Group name:	Specialty:	Tax ID no.	
Original office physical address prior to disaster			
Street:	City, State:	ZIP code:	
Office phone: ()	Fax: ()		
Relocation office physical address		Temporary <input type="checkbox"/>	Permanent <input type="checkbox"/>
Street:	City, State:	ZIP code:	
Office phone:	Fax:		
Office contact name (office administrator)			
Name:	Office or cell phone:	Email:	
Relocation billing address		Temporary <input type="checkbox"/>	Permanent <input type="checkbox"/>
Street/P.O. Box:	City, State:	ZIP code:	
Phone:			
Current email address:			
Claims payment to (check one): Group <input type="checkbox"/> Individual <input type="checkbox"/>			
Has the address changed for claims payment checks? Yes <input type="checkbox"/> No <input type="checkbox"/> Permanent <input type="checkbox"/> Temporary <input type="checkbox"/>			
New claims payment address (if applicable)			
Street/P.O. Box:	City, State:	ZIP code:	
National Provider Identifier (NPI) no.:			
Unique physician identification no. (UPIN):			
Medicare no.:			
Medicaid no.:			
Drug Enforcement Administration license no.:			
State medical license no.:			

Please submit this form to CarePlus' Provider Operations Department using one of the following methods:

Mail	Fax	Provider Services Executive
Attention: Provider Operations Dept. PO Box 277810, Miramar, FL 33027	1-866-449-5668	Please scan the form and email it to your assigned provider services executive.

LC6106FL0720-B H1019_POWebCrisisContactLocationForm2021



Health Services Preauthorization Form

Submit preauthorization requests to CarePlus Health Plans (CPHP) via [Availability](#) or [Provider Web Services \(PWS\)](#)

Use this form for non-urgent requests by faxing to the corresponding number at the bottom of the form. Attach supporting medical documentation with your request.

Preauthorization guidance is available at the [CarePlus Health Plans website](#).

For urgent/same-day services, call the CarePlus Utilization Management provider line at **1-800-201-4305**. Expedited requests must meet the Centers for Medicare & Medicaid Services (CMS) definition: "The healthcare professional or member believes the member's health, life or ability to regain maximum function can be jeopardized if the standard 14 calendar-day timeframe is applied."

REQUEST TYPE(S) ☐ New request ☐ Updated request ☐ Outpatient preauthorization request ☐ Elective inpatient preauthorization request

PART B DRUG REQUEST. If Part B drug, select one box below:

- ☐ The drug is billed, dispensed and administered by physician office, infusion clinic or outpatient facility,
☐ The drug is billed and shipped from a retail pharmacy to the physician's office or facility (non-self administered infusible drug),
Fax request directly to CPHP Pharmacy at **1-800-310-9071**.

Date of request: _____

Appointment date/time: _____

Valid for: ☐ 30 days ☐ 60 days ☐ 90 days ☐ 1 year

First Date: _____ Last Date: _____

PATIENT INFORMATION

First name: _____ Last name: _____
CarePlus member ID no.: _____ Date of birth: _____ Phone no.: _____

REQUESTING PHYSICIAN/PROVIDER INFORMATION (Check only PCP or Specialist)

☐ PCP ☐ Specialist

Name: _____ Sender's name: _____

Provider ID no.: _____ Tax ID no.: _____ NPI no.: _____

Phone no.: _____ Fax no.: _____

TREATING PROVIDER INFORMATION

Provider name: _____ Facility name: _____

Provider ID no.: _____ Facility ID no.: _____

Tax ID no.: _____ Tax ID no.: _____

NPI no.: _____ NPI no.: _____

Address: _____ Address: _____

Provider phone no.: _____ Provider fax no.: _____

Visits: ☐ Initial ☐ Follow-up Number of visits requested: _____

Provider participates with the CPHP network: ☐ Yes ☐ No

Healthcare facility participates with the CPHP network: ☐ Yes ☐ No

Is request related to an accident? ☐ Yes ☐ No If yes, please specify: ☐ Automobile ☐ Worker's comp ☐ Other _____

ICD-10 diagnosis code/description*	Procedure code/description*	Quantity

* required field(s)

The transmitted information is intended only for the person or entity to which it is addressed. It might contain confidential material. If you receive this document in error, please contact the sender, and delete or destroy the material/information.

336803FL1023 | H1019 HS PrvdPreAuthReqForm 2024

CarePlus Health Plans fax numbers:

Broward and Palm Beach counties: **1-866-832-2678**

Miami-Dade county: **1-888-790-9999**

All others: **1-888-634-3521**



ADMISSION NOTIFICATION FORM

PHONE # 800/201-4305 FAX # 866/229-1538 (24 hours)

AFTER HOURS PH # 800/201-4305

Request Date: _____

Hospital: _____ PROV # _____

Patient's Name: _____

CarePlus I.D #: _____

Admit Source: (Please choose one)

-Admission after ER: _____

-Direct admission from PCP/Specialist office: _____

-Admitted after outpatient procedure or surgery: _____

Type of Admission ordered by MD: (Please circle one) FULL OBS

Patient's Diagnosis (Description and ICD10-CM code) _____

Attending Physician : _____ Phone: _____

Admission Date: _____ Admission Time: _____

Requested by _____

Phone number: _____ Ext: _____ Fax: _____

Comments:

PLEASE ATTACH FACESHEET

UPDATED 3/5/2021



**10749 Marks Way
Miramar, FL 33025
Phone: (800) 526-1490 Fax: (800) 526-1491
Glucose Meter/Supplies Order Form**

Patient Name: _____ Date: _____

Patient ID#: _____ DOB: _____

Address: _____

City: _____ State: _____ Zip: _____ Phone: _____

TRUE METRIX Meters and Test Strips

Please circle requested information below:

Meter needed?	Yes	No	
Test strips – quantity	#50	#100	Other _____
Lancets – quantity	#100		Other _____
Test frequency – number of times patient tests per day	QD	BID	TID QID Other _____
Refills	PRN		Other _____

Physician Name (please print or type): _____ NPI: _____

Physician Signature: _____ Phone: _____

Fax: _____

Note: The following information must be confirmed by the member's physician:

- The patient who will be provided with a no-cost glucose meter has been diagnosed as having diabetes and is capable of being trained to use the particular device prescribed in an appropriate manner.
- In some cases, the patient may not be able to perform this function, but a responsible individual can be trained to use the equipment and monitor the patient to ensure that the intended effect is achieved. This is permissible if the record is properly documented by the patient's physician.

By providing the information requested and signing this form, you are confirming the information noted above. For questions regarding fax transmittal, call 1-800-526-1490. Please allow 10 days for delivery.

CONFIDENTIAL-

DO NOT PHOTOCOPY

DO NOT PLACE WITH MEDICAL RECORD



MEMBER OCCURRENCE REPORT

PREPARED FOR QA PURPOSES AND FOR LEGAL COUNSEL IN ANTICIPATION OF LITIGATION

COMPLETE ALL APPLICABLE INFORMATION

Hu-51 9/2010

IDENTIFYING DATA- LOCATION OF OCCURRENCE	Date of Occurrence		Time
	Provider/Facility Information Related to Occurrence (if available, please fill out information below):		
	Provider Name		
	If physician, specialty		
	Address		
	City	State	Zip
	Phone	Physician ID #	
	Location of Occurrence / Facility Name		
	If Humana Facility, Facility ID #		
	Address of Facility		
City	State	Zip	

MEMBER/PATIENT INFORMATION	Name		
	Address		
	City	State	Zip
	DOB	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	
	Phone	Other Phone	
	Member ID Number	Member Type/ LOB	
	Member Selling Ledger (if known)		
	Primary Complaint/ Diagnosis		
	Medical Treatment Required --select--		
	If member hospitalized, name of facility		Date admitted
Name of Provider rendering care		Phone	
City	State	Zip	

Utilize the space provided. Give a brief, factual description of occurrence to include exact location of occurrence, any injury/illness, body part affected, treatment required and reaction of involved person/witness.

---select---	Damage --select--	Body Part (Indicate Right, Left, Upper, Lower)
--------------	-------------------	------------------------------------------------

Describe Facts of Occurrence: (If typed, press enter at the end of each line.)

--	--	--

Person(s) who witnessed or were directly involved in the occurrence other than the person listed above

Name		Name	
Address		Address	
City	State	City	State
Phone #	Other #	Phone #	Other #
Reported By		Title	
Name		Date	

In addition to Risk Management, Occurrence was reported to the following department(s):

Completed By	Print Name	Title
	Signature	Date

FORWARD TO HUMANA RISK MANGAGER/DESIGNEE UPON COMPLETION



Consent for Release of Protected Health Information (PHI)

This form is used to authorize consent for CarePlus to communicate PHI to the person(s) or organization below.

Member information (person whose information will be released):

Name: Date of birth:
First Middle Last Month / Day / Year
Address:
Street City State ZIP Code
Member ID: Telephone number (with area code):
☐ Home ☐ Cell*

I understand that this authorization will allow CarePlus and its affiliates to use or disclose any protected health** information CarePlus and its affiliates maintain, including mental health, HIV, health status or substance abuse records. This also includes sharing information on mail-order pharmacy, wellness products, and health programs with the person being authorized.

This information may be disclosed to, and used by, the following individuals or organizations:

Name: Date of birth: Relationship:
Address: City:
State: ZIP Code: Phone:
☐ Home ☐ Cell*
Name: Date of birth: Relationship:
Address: City:
State: ZIP Code: Phone:
☐ Home ☐ Cell*

I understand:

This consent is valid until I cancel it. I can cancel my consent at any time by submitting a written notice to CarePlus. If I cancel consent, it will not apply to any information previously released with this authorization. Once information is shared, CarePlus cannot prevent the person or organization who has access to it from sharing that information with others, and this information may not be protected by federal privacy regulations.

I am not required to sign this consent and CarePlus cannot base decisions regarding treatment or payment on whether I sign it.

Date:

Signature of Member or Legal Representative: _____

☐ Member ☐ Legal Representative

Please note: Legal representatives must attach copies of authorizations as required by law. Examples include healthcare power of attorney, healthcare surrogate, living will, or guardianship papers.

After you complete and sign the form, please fax it to 1-855-819-8679. OR, if you prefer, mail your completed form to: CarePlus Health Plans, Inc., PO Box 14733, Lexington, KY 40512-4642.

* By giving your cell phone number, you give CarePlus permission to make calls to your cell.

** Health includes Medical, Dental, Pharmacy, Behavioral Health, Vision, Long-Term Care information.

If you have any questions, please call Member Services at 1-800-794-5907; TTY: 711. From October 1 - March 31, we are open 7 days a week; 8 a.m. to 8 p.m. From April 1 - September 30, we are open Monday - Friday, 8 a.m. to 8 p.m. You may always leave a voicemail after hours, Saturdays, Sundays, and holidays and we will return your call within one business day.

H1019_CPHPConsentForm2023_C

FLHJJ9YEN 0722

Important: At CarePlus, it is important you are treated fairly. CarePlus Health Plans, Inc. complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, ancestry, ethnicity, sex, sexual orientation, gender, gender identity, disability, age, marital status, religion, or language in their programs and activities, including in admission or access to, or treatment or employment in, their programs and activities. The following department has been designated to handle inquiries regarding CarePlus' non-discrimination policies: Member Services, PO Box 277810, Miramar, FL 33027, 1-800-794-5907 (TTY: 711). Auxiliary aids and services, free of charge, are available to you. 1-800-794-5907 (TTY: 711). CarePlus provides free auxiliary aids and services, such as qualified sign language interpreters, video remote interpretation, and written information in other formats to people with disabilities when such auxiliary aids and services are necessary to ensure an equal opportunity to participate.

This information is available for free in other languages. Please call our Member Services number at 1-800-794-5907. Hours of operation: October 1 - March 31, 7 days a week, 8 a.m. to 8 p.m. April 1 - September 30, Monday - Friday, 8 a.m. to 8 p.m. You may leave a voicemail after hours, Saturdays, Sundays, and holidays and we will return your call within one business day.

Español (Spanish): Esta información está disponible de forma gratuita en otros idiomas. Favor de llamar a Servicios para Afiliados al número que aparece anteriormente.

Kreyòl Ayisyen (French Creole): Enfòmasyon sa a disponib gratis nan lòt lang. Tanpri rele nimewo Sèvis pou Manm nou yo ki nan lis anwo an.



APPOINTMENT OF REPRESENTATIVE

Name of Party	Medicare Number (beneficiary as party) or National Provider Identifier (provider or supplier as party)

Section 1: Appointment of Representative

To be completed by the party seeking representation (i.e., the Medicare beneficiary, the provider or the supplier):

I appoint the individual named in Section 2 to act as my representative in connection with my claim or asserted right under Title XVIII of the Social Security Act (the "Act") and related provisions of Title XI of the Act. I authorize this individual to make any request; to present or to elicit evidence; to obtain appeals information; and to receive any notice in connection with my claim, appeal, grievance or request wholly in my stead. I understand that personal medical information related to my request may be disclosed to the representative indicated below.

Signature of Party Seeking Representation		Date
Street Address		Phone Number (with Area Code)
City	State	Zip Code
Email Address (optional)	Fax Number (optional)	

Section 2: Acceptance of Appointment

To be completed by the representative:

I, _____, hereby accept the above appointment. I certify that I have not been disqualified, suspended, or prohibited from practice before the Department of Health and Human Services (HHS); that I am not, as a current or former employee of the United States, disqualified from acting as the party's representative; and that I recognize that any fee may be subject to review and approval by the Secretary.

I am a / an _____
(Professional status or relationship to the party, e.g. attorney, relative, etc.)

Signature of Representative		Date
Street Address		Phone Number (with Area Code)
City	State	Zip Code
Email Address (optional)	Fax Number (optional)	

Section 3: Waiver of Fee for Representation

Instructions: This section must be completed if the representative is required to, or chooses to, waive their fee for representation. (Note that providers or suppliers that are representing a beneficiary and furnished the items or services may not charge a fee for representation and must complete this section.)

I waive my right to charge and collect a fee for representing _____ before the Secretary of HHS.

Signature	Date

Section 4: Waiver of Payment for Items or Services at Issue

Instructions: Providers or suppliers serving as a representative for a beneficiary to whom they provided items or services must complete this section if the appeal involves a question of liability under section 1879(a)(2) of the Act. (Section 1879(a)(2) generally addresses whether a provider/supplier or beneficiary did not know, or could not reasonably be expected to know, that the items or services at issue would not be covered by Medicare.)

I waive my right to collect payment from the beneficiary for the items or services at issue in this appeal if a determination of liability under §1879(a)(2) of the Act is at issue.

Signature	Date

INSTRUCTIONS AND REGULATION REQUIREMENTS

Instructions

Name of Party (required): This is the name of the person or entity which has standing to file a claim or appeal (the name of the person who has Medicare, or the name of the provider or supplier).

Medicare Number or National Provider Identifier (required): This must be completed when the person or entity appointing a representative has a Medicare number or National Provider Identifier. If not applicable, fill in, "not applicable".

All fields in Sections 1 and 2 are required unless noted as optional within the field. See the regulation at [42 CFR 405.910](#).

Charging of Fees for Representing Beneficiaries before the Secretary of HHS

An attorney, or other representative for a beneficiary, who wishes to charge a fee for services rendered in connection with an appeal before the Secretary of HHS (i.e., an Administrative Law Judge (ALJ) hearing or attorney adjudicator review by the Office of Medicare Hearings and Appeals (OMHA), Medicare Appeals Council review, or a proceeding before OMHA or the Medicare Appeals Council as a result of a remand from federal district court) is required to obtain approval of the fee in accordance with 42 CFR 405.910(f).

The form, OMHA-118, "Petition to Obtain Approval of a Fee for Representing a Beneficiary" elicits the information required for a fee petition. It should be completed by the representative and filed with the request for ALJ hearing, OMHA review, or request for Medicare Appeals Council review. Approval of a representative's fee is not required if: (1) the appellant being represented is a provider or supplier; (2) the fee is for services rendered in an official capacity such as that of legal guardian, committee, or similar court appointed representative and the court has approved the fee in question; (3) the fee is for representation of a beneficiary in a proceeding in federal district court; or (4) the fee is for representation of a beneficiary in a redetermination or reconsideration. If the representative wishes to waive a fee, he or she may do so. The form, OMHA-118, may be found at: <https://www.hhs.gov/sites/default/files/OMHA-118.pdf>

Approval of Fee

The requirement for the approval of fees ensures that a representative will receive fair value for the services performed before HHS on behalf of a beneficiary, and provides the beneficiary with a measure of security that the fees are determined to be reasonable. In approving a requested fee, OMHA or Medicare Appeals Council will consider the nature and type of services rendered, the complexity of the case, the level of skill and competence required in rendition of the services, the amount of time spent on the case, the results achieved, the level of administrative review to which the representative carried the appeal and the amount of the fee requested by the representative.

Conflict of Interest

Sections 203, 205 and 207 of Title XVIII of the United States Code make it a criminal offense for certain officers, employees and former officers and employees of the United States to render certain services in matters affecting the Government or to aid or assist in the prosecution of claims against the United States. Individuals with a conflict of interest are excluded from being representatives of beneficiaries before HHS.

Where to Send This Form

Send this form to the same location where you are sending (or have already sent) your: appeal if you are filing an appeal, grievance or complaint if you are filing a grievance or complaint, or an initial determination or decision if you are requesting an initial determination or decision. If additional help is needed, contact 1-800-MEDICARE (1-800-633-4227, TTY users call 1-877-486-2048), or your Medicare plan.

You have the right to get Medicare information in an accessible format, like large print, Braille, or audio. You also have the right to file a complaint if you feel you've been discriminated against. Visit <https://www.medicare.gov/about-us/accessibility-nondiscrimination-notice>, or call 1-800-MEDICARE (1-800-633-4227) for more information. TTY users can call 1-877-486-2048.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0950. The time required to prepare and distribute this collection is 15 minutes per notice, including the time to select the preprinted form, complete it and deliver it to the beneficiary. If you have comments concerning the accuracy of the time estimates or suggestions for improving this form, please write to CMS, PRA Clearance Officer, 7500 Security Boulevard, Baltimore, Maryland 21244-1850.

Form CMS-1696 (Rev 09/21)

2

H1019 GRVAPLCMS1696Form2024 C

IMPORTANT

At CarePlus, it is important you are treated fairly.

CarePlus Health Plans, Inc. complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, ancestry, ethnicity, sex, sexual orientation, gender, gender identity, disability, age, marital status, religion, or language in their programs and activities, including in admission or access to, or treatment or employment in, their programs and activities.

The following department has been designated to handle inquiries regarding CarePlus' non-discrimination policies: Member Services, PO Box 277810, Miramar, FL 33027, **1-800-794-5907 (TTY: 711)**.

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Español (Spanish): Esta información está disponible de forma gratuita en otros idiomas. Favor de llamar a Servicios para Afiliados al número que aparece anteriormente.

Kreyòl Ayisyen (French Creole): Enfòmasyon sa a disponib gratis nan lòt lang. Tanpri rele nimewo Sèvis pou Manm nou yo ki nan lis anwo an.



CP REV 02.19.24

Multi-Language Insert
Multi-language Interpreter Services

Form Approved
OMB# 0938-1421

English: We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at 1-800-794-5907 (TTY: 711). Someone who speaks English can help you. This is a free service.

Spanish: Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llame al 1-800-794-5907 (TTY: 711). Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

Chinese Mandarin: 我们提供免费的翻译服务, 帮助您解答关于健康或药物保险的任何疑问。如果您需要此翻译服务, 请致电 1-800-794-5907 (TTY: 711)。我们的中文工作人员很乐意帮助您。这是一项免费服务。

Chinese Cantonese: 您對我們的健康或藥物保險可能存有疑問, 為此我們提供免費的翻譯服務。如需翻譯服務, 請致電 1-800-794-5907 (TTY: 711)。我們講中文的人員將樂意為您提供幫助。這是一項免費服務。

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Form CMS-10802 (Expires 12/31/25)

Grievance or Appeal Form



If you have a grievance or appeal related to your CarePlus plan or any aspect of your care, we want to hear about it. You can use this form to tell us what happened and let us know how we can help. Please provide complete information, so we can address your issue.

This form, along with any supporting documents (such as medical records, medical bills, a copy of your Explanation of Benefits, or a letter from your doctor), may be sent to us by mail or fax:

Address: CarePlus Health Plans, Inc.
PO Box 277810
Miramar, Florida 33027
Attn: Grievance/Appeals Department

Fax Number: 1-800-956-4288

If you need assistance with this form, please call Member Services at 1-800-794-5907; TTY: 711. From October 1 - March 31, we are open 7 days a week, 8 a.m. to 8 p.m. From April 1 - September 30, we are open Monday - Friday, 8 a.m. to 8 p.m. You may always leave a voicemail after hours, Saturdays, Sundays, and holidays and we will return your call within one business day.

1 Who is the member?

Member name (first and last)		
CarePlus member ID number		Member birthdate (MM/DD/YY)
Street address		City
State	Zip code	Phone number (with area code)

2 What is the issue?

For a specific medical service or medication, please provide the details below:

Medical service/medical equipment or medication	
Provider (Physician, Facility, Prescriber)	
Provider phone number (with area code)	Provider fax number
Is this a request for reimbursement? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>*If yes, please include a copy of the bill, receipt or proof of payment (receipts).</i>	
Service date(s) (MM/DD/YY) <i>*N/A if care has not been received</i>	Claim number (if you have one)

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2 What is the issue? (Continued)

What should we know about this issue? Please be as specific as possible about what happened and who was involved. Include any dates of service or contact with CarePlus employees, healthcare providers or pharmacies. If you run out of room, feel free to write on the back or add an extra page.

What additional information can you share? Please attach copies of any supporting information or documents that we should review, such as medical records, medical bills, a copy of your Explanation of Benefits, or a letter from your provider.

What documents have you attached?

- | | |
|--------------------------------------------------|------------------------------------------------------|
| <input type="checkbox"/> Explanation of Benefits | <input type="checkbox"/> Receipts (Proof of Payment) |
| <input type="checkbox"/> Medical bill(s) | <input type="checkbox"/> Letter from your provider |
| <input type="checkbox"/> Medical records | <input type="checkbox"/> Other _____ |

Does your appeal need to be expedited? If you or your physician/prescriber believe that waiting for a standard decision (7 calendar days for a Part B/Part D prescription drug appeal or 30 calendar days for a medical pre-service/equipment appeal) could seriously harm your life, health or ability to regain maximum function, you can ask for an expedited (fast) decision. If your physician or prescriber indicates that waiting for a standard decision could seriously harm your health, we will automatically give you a fast decision. If you do not obtain your physician or prescriber's support for an expedited appeal, we will decide if your case requires a fast decision. You *cannot* request an expedited appeal if you are asking us to review a service or drug you already received.

- ☐ Please check this box if you believe you need an expedited decision within 72 hours. If you have a supporting statement from your physician or prescriber, attach it to this request.

H1019_GRVAPLForm2024_C

3 Do you need to appoint a representative?

Skip this section if you are the member acting on behalf of yourself.

If you are not the member and aren't sure if you're authorized to work with CarePlus on the member's behalf, please complete the Appointment of Representative (AOR) Form CMS-1696, which can be found on the CarePlus' website at www.careplushealthplans.com/members/forms-tools-resources requested by contacting Member Services at 1-800-794-5907; TTY: 711. Both you and the member must sign and complete the AOR Form. If you are already legally authorized to act as the member's representative under state law, please attach the appropriate documentation so we can review (for example: court appointed guardian, Durable Power of Attorney, health care proxy, etc.).

4 Sign and Submit

Member Signature (or physician/prescriber) (optional)	Date
Member Printed Name (or physician/prescriber)	

OR

Authorized Representative Signature (Only if you filled out the AOR form or attached other legal documentation)	Date
Authorized Representative Printed Name	

Thanks for taking the time to inform us of this issue. We'll be in touch with you if we have any questions, and we'll get back to you as soon as we complete our review of the issue.

H1019_GRVAPLForm2024_C

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CP REV 02.19.24

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Form Approved
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Form CMS-10802 (Expires 12/31/25)

This form may be sent to us by mail or fax:

Address:
PO Box 277810
Miramar, FL 33027
Attention: Pharmacy Department

Fax Number:
1-800-310-9071

You may also ask us for a coverage determination by phone at 1-800-794-5907 or through our website at www.careplushealthplans.com.

Who May Make a Request: Your prescriber may ask us for a coverage determination on your behalf. If you want another individual (such as a family member or friend) to make a request for you, that individual must be your representative. Contact us to learn how to name a representative.

Enrollee's Information

Enrollee's Name		Date of Birth
Enrollee's Address		
City	State	Zip Code
Phone	Enrollee's Member ID #	

Complete the following section ONLY if the person making this request is not the enrollee or prescriber:

Requestor's Name		
Requestor's Relationship to Enrollee		
Address		
City	State	Zip Code
Phone		

Representation documentation for requests made by someone other than enrollee or the enrollee's prescriber:

Attach documentation showing the authority to represent the enrollee (a completed Authorization of Representation Form CMS-1696 or a written equivalent). For more information on appointing a representative, contact your plan or 1-800-Medicare.

Name of prescription drug you are requesting (if known, include strength and quantity requested per month):

H1019_PHACDRequestForm2024_C

Type of Coverage Determination Request

- ☐ I need a drug that is not on the plan's list of covered drugs (formulary exception). *
- ☐ I have been using a drug that was previously included on the plan's list of covered drugs, but is being removed or was removed from this list during the plan year (formulary exception). *
- ☐ I request prior authorization for the drug my prescriber has prescribed. *
- ☐ I request an exception to the requirement that I try another drug before I get the drug my prescriber prescribed (formulary exception). *
- ☐ I request an exception to the plan's limit on the number of pills (quantity limit) I can receive so that I can get the number of pills my prescriber prescribed (formulary exception). *
- ☐ My drug plan charges a higher copayment for the drug my prescriber prescribed than it charges for another drug that treats my condition, and I want to pay the lower copayment (tiering exception). *
- ☐ I have been using a drug that was previously included on a lower copayment tier, but is being moved to or was moved to a higher copayment tier (tiering exception). *
- ☐ My drug plan charged me a higher copayment for a drug than it should have.
- ☐ I want to be reimbursed for a covered prescription drug that I paid for out of pocket.

***NOTE: If you are asking for a formulary or tiering exception, your prescriber MUST provide a statement supporting your request. Requests that are subject to prior authorization (or any other utilization management requirement), may require supporting information. Your prescriber may use the attached "Supporting Information for an Exception Request or Prior Authorization" to support your request.**

Additional information we should consider (*attach any supporting documents*):

Important Note: Expedited Decisions

If you or your prescriber believe that waiting 72 hours for a standard decision could seriously harm your life, health, or ability to regain maximum function, you can ask for an expedited (fast) decision. If your prescriber indicates that waiting 72 hours could seriously harm your health, we will automatically give you a decision within 24 hours. If you do not obtain your prescriber's support for an expedited request, we will decide if your case requires a fast decision. You cannot request an expedited coverage determination if you are asking us to pay you back for a drug you already received.

☐ **CHECK THIS BOX IF YOU BELIEVE YOU NEED A DECISION WITHIN 24 HOURS (if you have a supporting statement from your prescriber, attach it to this request).**

Signature:

Date:

H1019_PHACDRequestForm2024_C

Supporting Information for an Exception Request or Prior Authorization

FORMULARY and TIERING EXCEPTION requests cannot be processed without a prescriber's supporting statement. PRIOR AUTHORIZATION requests may require supporting information.

☐ **REQUEST FOR EXPEDITED REVIEW:** By checking this box and signing below, I certify that applying the 72 hour standard review time frame may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.

Prescriber's Information			
Name		NPI Number, DEA Number, or TAX ID	
Address			
City	State	Zip Code	
Office Phone		Fax	
Prescriber's Signature			Date
Diagnosis and Medical Information			
Medication:	Strength and Route of Administration:		Frequency:
Date Started: <input type="checkbox"/> NEW START	Expected Length of Therapy:		Quantity per 30 days
Height/Weight:	Drug Allergies:		
DIAGNOSIS – Please list all diagnoses being treated with the requested drug and corresponding ICD-10 codes. <small>(If the condition being treated with the requested drug is a symptom e.g. anorexia, weight loss, shortness of breath, chest pain, nausea, etc., provide the diagnosis causing the symptom(s) if known)</small>			ICD-10 Code(s)
Other RELEVANT DIAGNOSES:			ICD-10 Code(s)

DRUG HISTORY: (for treatment of the condition(s) requiring the requested drug)		
DRUGS TRIED <small>(if quantity limit is an issue, list unit dose/total daily dose tried)</small>	DATES of Drug Trials	RESULTS of previous drug trials FAILURE vs INTOLERANCE (explain)

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What is the enrollee's current drug regimen for the condition(s) requiring the requested drug?	
DRUG SAFETY	
Any FDA NOTED CONTRAINDICATIONS to the requested drug?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Any concern for a DRUG INTERACTION with the addition of the requested drug to the enrollee's current drug regimen?	<input type="checkbox"/> YES <input type="checkbox"/> NO
If the answer to either of the questions noted above is yes, please 1) explain issue, 2) discuss the benefits vs potential risks despite the noted concern, and 3) monitoring plan to ensure safety	
HIGH RISK MANAGEMENT OF DRUGS IN THE ELDERLY	
If the enrollee is over the age of 65, do you feel that the benefits of treatment with the requested drug outweigh the potential risks in this elderly patient?	<input type="checkbox"/> YES <input type="checkbox"/> NO
OPIOIDS – (please complete the following questions if the requested drug is an opioid)	
What is the daily cumulative Morphine Equivalent Dose (MED)?	<div style="border: 1px solid black; padding: 2px;">mg/day</div>
Are you aware of other opioid prescribers for this enrollee? If so, please explain.	<input type="checkbox"/> YES <input type="checkbox"/> NO
Is the stated daily MED dose noted medically necessary?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Would a lower total daily MED dose be insufficient to control the enrollee's pain?	<input type="checkbox"/> YES <input type="checkbox"/> NO
RATIONALE FOR REQUEST	
<p><input type="checkbox"/> Alternate drug(s) contraindicated or previously tried, but with adverse outcome, e.g. toxicity, allergy, or therapeutic failure [Specify below if not already noted in the DRUG HISTORY section earlier on the form: (1) Drug(s) tried and results of drug trial(s) (2) if adverse outcome, list drug(s) and adverse outcome for each, (3) if therapeutic failure, list maximum dose and length of therapy for drug(s) trialed, (4) if contraindication(s), please list specific reason why preferred drug(s)/other formulary drug(s) are contraindicated]</p> <p><input type="checkbox"/> Patient is stable on current drug(s); high risk of significant adverse clinical outcome with medication change A specific explanation of any anticipated significant adverse clinical outcome and why a significant adverse outcome would be expected is required – e.g. the condition has been difficult to control (many drugs tried, multiple drugs required to control condition), the patient had a significant adverse outcome when the condition was not controlled previously (e.g. hospitalization or frequent acute medical visits, heart attack, stroke, falls, significant limitation of functional status, undue pain and suffering),etc.</p> <p><input type="checkbox"/> Medical need for different dosage form and/or higher dosage [Specify below: (1) Dosage form(s) and/or dosage(s) tried and outcome of drug trial(s); (2) explain medical reason (3) include why less frequent dosing with a higher strength is not an option – if a higher strength exists]</p> <p><input type="checkbox"/> Request for formulary tier exception Specify below if not noted in the DRUG HISTORY section earlier on the form: (1) formulary or preferred drug(s) tried and results of drug trial(s) (2) if adverse outcome, list drug(s) and adverse outcome for each, (3) if therapeutic failure/not as effective as requested drug, list maximum dose and length of therapy for drug(s) trialed, (4) if contraindication(s), please list specific reason why preferred drug(s)/other formulary drug(s) are contraindicated]</p>	

H1019_PHACDRequestForm2024_C

<input type="checkbox"/> Other (explain below)
Required Explanation

Important

At CarePlus, it is important you are treated fairly.

CarePlus Health Plans, Inc. complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, ancestry, ethnicity, sex, sexual orientation, gender, gender identity, disability, age, marital status, religion, or language in their programs and activities, including in admission or access to, or treatment or employment in, their programs and activities.

The following department has been designated to handle inquiries regarding CarePlus’ non-discrimination policies: Member Services, PO Box 277810, Miramar, FL 33027, 1-800-794-5907 (TTY: 711).

Auxiliary aids and services, free of charge, are available to you. 1-800-794-5907 (TTY: 711)

CarePlus provides free auxiliary aids and services, such as qualified sign language interpreters, video remote interpretation, and written information in other formats to people with disabilities when such auxiliary aids and services are necessary to ensure an equal opportunity to participate.

This information is available for free in other languages. Please call our Member Services number at 1-800-794-5907. Hours of operation: October 1 - March 31, 7 days a week, 8 a.m. to 8 p.m. April 1 - September 30, Monday - Friday, 8 a.m. to 8 p.m. You may leave a voicemail after hours, Saturdays, Sundays, and holidays and we will return your call within one business day.

Español (Spanish): Esta información está disponible de forma gratuita en otros idiomas. Favor de llamar a Servicios para Afiliados al número que aparece anteriormente.

Kreyòl Ayisyen (French Creole): Enfòmasyon sa a disponib gratis nan lòt lang. Tanpri rele nimewo Sèvis pou Manm nou yo ki nan lis anwo an.

Request for Redetermination of Medicare Prescription Drug Denial

Because we, CarePlus, denied your request for coverage of (or payment for) a prescription drug, you have the right to ask us for a redetermination (appeal) of our decision. You have 60 days from the date of our Notice of Denial of Medicare Prescription Drug Coverage to ask us for a redetermination. This form may be sent to us by mail or fax:

Address:
P.O. Box 277810
Miramar, FL 33027

Fax Number:
1-800-956-4288

You may also ask us for an appeal through our website at www.careplushealthplans.com
Expedited appeal requests can be made by phone at 1-800-794-5907.

Who May Make a Request: Your prescriber may ask us for an appeal on your behalf. If you want another individual (such as a family member or friend) to request an appeal for you, that individual must be your representative. Contact us to learn how to name a representative.

Enrollee's Information

Enrollee's Name _____ Date of Birth _____

Enrollee's Address _____

City _____ State _____ Zip Code _____

Phone _____

Enrollee's Member ID Number _____

Complete the following section ONLY if the person making this request is not the enrollee:

Requestor's Name _____

Requestor's Relationship to Enrollee _____

Address _____

City _____ State _____ Zip Code _____

Phone _____

Representation documentation for appeal requests made by someone other than enrollee or the enrollee's prescriber:

Attach documentation showing the authority to represent the enrollee (a completed Authorization of Representation Form CMS-1696 or a written equivalent) if it was not submitted at the coverage determination level. For more information on appointing a representative, contact your plan or 1-800-Medicare.

H1019_GRVAPLRedeterminationReqForm2024_C

Prescription drug you are requesting:

Name of drug: _____ Strength/quantity/dose: _____

Have you purchased the drug pending appeal? ☐ Yes ☐ No

If "Yes":

Date purchased: _____ Amount paid: \$ _____ (attach copy of receipt)

Name and telephone number of pharmacy: _____

Prescriber's Information

Name _____

Address _____

City _____ State _____ Zip Code _____

Office Phone _____ Fax _____

Office Contact Person _____

Important Note: Expedited Decisions

If you or your prescriber believe that waiting 7 days for a standard decision could seriously harm your life, health, or ability to regain maximum function, you can ask for an expedited (fast) decision. If your prescriber indicates that waiting 7 days could seriously harm your health, we will automatically give you a decision within 72 hours. If you do not obtain your prescriber's support for an expedited appeal, we will decide if your case requires a fast decision. You cannot request an expedited appeal if you are asking us to pay you back for a drug you already received.

☐ **CHECK THIS BOX IF YOU BELIEVE YOU NEED A DECISION WITHIN 72 HOURS (if you have a supporting statement from your prescriber, attach it to this request).**

Please explain your reasons for appealing. Attach additional pages, if necessary. Attach any additional information you believe may help your case, such as a statement from your prescriber and relevant medical records. You may want to refer to the explanation we provided in the Notice of Denial of Medicare Prescription Drug Coverage and have your prescriber address the Plan's coverage criteria, if available, as stated in the Plan's denial letter or in other Plan documents. Input from your prescriber will be needed to explain why you cannot meet the Plan's coverage criteria and/or why the drugs required by the Plan are not medically appropriate for you.

Signature of person requesting the appeal (the enrollee or the representative):_____
Date: _____

H1019_GRVAPLRedeterminationReqForm2024_C

IMPORTANT

At CarePlus, it is important you are treated fairly.

CarePlus Health Plans, Inc. complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, ancestry, ethnicity, sex, sexual orientation, gender, gender identity, disability, age, marital status, religion, or language in their programs and activities, including in admission or access to, or treatment or employment in, their programs and activities.

The following department has been designated to handle inquiries regarding CarePlus' non-discrimination policies: Member Services, PO Box 277810, Miramar, FL 33027, **1-800-794-5907 (TTY: 711)**.

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Español (Spanish): Esta información está disponible de forma gratuita en otros idiomas. Favor de llamar a Servicios para Afiliados al número que aparece anteriormente.

Kreyòl Ayisyen (French Creole): Enfòmasyon sa a disponib gratis nan lòt lang. Tanpri rele nimewo Sèvis pou Manm nou yo ki nan lis anwo an.



CP REV 02.19.24

Multi-Language Insert
Multi-language Interpreter Services

Form Approved
OMB# 0938-1421

English: We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at 1-800-794-5907 (TTY: 711). Someone who speaks English can help you. This is a free service.

Spanish: Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llame al 1-800-794-5907 (TTY: 711). Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

Chinese Mandarin: 我们提供免费的翻译服务, 帮助您解答关于健康或药物保险的任何疑问。如果您需要此翻译服务, 请致电 1-800-794-5907 (TTY: 711)。我们的中文工作人员很乐意帮助您。这是一项免费服务。

Chinese Cantonese: 您對我們的健康或藥物保險可能存有疑問, 為此我們提供免費的翻譯服務。如需翻譯服務, 請致電 1-800-794-5907 (TTY: 711)。我們講中文的人員將樂意為您提供幫助。這是一項免費服務。

Tagalog: Mayroon kaming libreng serbisyo sa pagsasaling-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggamot. Upang makakuha ng tagasaling-wika, tawagan lamang kami sa 1-800-794-5907 (TTY: 711). Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

French: Nous proposons des services gratuits d'interprétation pour répondre à toutes vos questions relatives à notre régime de santé ou d'assurance-médicaments. Pour accéder au service d'interprétation, il vous suffit de nous appeler au 1-800-794-5907 (TTY: 711). Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.

Vietnamese: Chúng tôi có dịch vụ thông dịch miễn phí để trả lời các câu hỏi về chương sức khỏe và chương trình thuốc men. Nếu quý vị cần thông dịch viên xin gọi 1-800-794-5907 (TTY: 711) sẽ có nhân viên nói tiếng Việt giúp đỡ quý vị. Đây là dịch vụ miễn phí.

German: Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter 1-800-794-5907 (TTY: 711). Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

Korean: 당사는 의료 보험 또는 약품 보험에 관한 질문에 대해 드리고자 무료 통역 서비스를 제공하고있습니다 . 통역 서비스를 이용하려면 전화 1-800-794-5907 (TTY: 711) 번으로 문의해 주십시오 . 한국어를 하는 담당자가 도와 드릴 것입니다 . 이 서비스는 무료로 운영됩니다 .

Russian: Если у вас возникнут вопросы относительно страхового или медикаментного плана, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвоните нам по телефону 1-800-794-5907 (TTY: 711). Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

Arabic: إننا نقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة تتعلق بالصحة أو جدول الأدوية لدينا. للحصول على مترجم فوري, ليس عليك سوى الاتصال بنا على (برقياً: 1-800-794-5907 (711)). سيقوم شخص ما يتحدث العربية بمساعدتك. هذه هي خدمة مجانية.

Hindi: हमारे स्वास्थ्य या दवा की योजना के बारे में आपके किसी भी प्रश्न के जवाब देने के लिए हमारे पास मुफ्त दुभाषिया सेवाएँ उपलब्ध हैं। एक दुभाषिया प्राप्त करने के लिए, बस हमें 1-800-794-5907 (TTY: 711) पर फोन करें। कोई व्यक्ति जो हिंदी बोलता है आपकी मदद कर सकता है। यह एक मुफ्त सेवा है।

Italian: È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per un interprete, contattare il numero 1-800-794-5907 (TTY: 711). Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

Portuguese: Dispomos de serviços de interpretação gratuitos para responder a qualquer questão que tenha acerca do nosso plano de saúde ou de medicação. Para obter um intérprete, contacte-nos através do número 1-800-794-5907 (TTY: 711). Irá encontrar alguém que fale o idioma Português para o ajudar. Este serviço é gratuito.

French Creole: Nou genyen sèvis entèprèt gratis pou reponn tout kesyon ou ta genyen konsènan plan medikal oswa dwòg nou an. Pou jwenn yon entèprèt, jis rele nou nan 1-800-794-5907 (TTY: 711). Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.

Polish: Umożliwiamy bezpłatne skorzystanie z usług tłumacza ustnego, który pomoże w uzyskaniu odpowiedzi na temat planu zdrowotnego lub dawkowania leków. Aby skorzystać z pomocy tłumacza znającego język polski, należy zadzwonić pod numer 1-800-794-5907 (TTY: 711). Ta usługa jest bezpłatna.

Japanese: 当社の健康保険と薬品処方薬プランに関するご質問にお答えするために、無料の通訳サービスがあります。通訳をご用命になるには、1-800-794-5907 (TTY: 711) にお電話ください。日本語を話す人が支援いたします。これは無料のサービスです。

Form CMS-10802 (Expires 12/31/25)

SAMPLE
EMERGENCY EVACUATION PLAN

_____ [Employing Office]

_____ [Location]

_____ [City, State, Zip]

This plan was prepared by:

Name: _____ Title: _____

City, State, Zip: _____

Signature: _____ Date: _____

INTRODUCTION

During certain emergency conditions, it may be necessary to evacuate a building. **Examples of emergencies where evacuation may be required include: smoke/fire, gas leak, bomb threat, power outages, extreme weather, etc.** Pre-planning and rehearsal are effective ways to ensure that building occupants recognize the evacuation alarm and know how to respond. Practicing an evacuation during a non-emergency drill provides training that will be valuable in an emergency situation.

This plan is for the safety and well-being of the employees of _____. It identifies necessary management and employee actions during fires and other emergencies. Education and training is provided so that all employees know how and understand the contents of the Emergency Evacuation Plan.

LOCATION OF PLAN

Each employee of this office has been provided a copy of this plan. A copy will also be maintained at _____.

Any questions concerning this plan should be directed to plan preparer, _____.

PERSONNEL RESPONSIBILITIES DURING EVACUATION PROCEDURES

- **Evacuation and Reporting Emergencies**

An employee, upon discovering a fire, or any type of emergency, shall immediately notify other employees in the area of the situation and sound an appropriate alarm. The employee is to immediately evacuate the building via the shortest and safest route. **DO NOT USE ELEVATORS.** Employees must be aware and ready to assist patients with special needs (i.e., hearing, or sight-impaired, on crutches, in a wheelchair). As soon as safely as possible, the situation shall be reported to the appropriate outside emergency personnel.

EMERGENCY TELEPHONE NUMBERS

Police and/or Fire Department	911
Medical Emergencies	911
Miami-Dade Police Non Emergency.....	(305) 476-5423
American Association of Poison Control Centers.....	1-800-222-1222
Miami Animal Control Center	(786) 594-1189

Within this office, the following personnel have the duty to ensure that outside emergency personnel have been contacted. They are responsible for coordinating with

outside emergency personnel on the scene and providing directions to the site of the emergency. These personnel are listed in descending order of availability:

1.	_____	_____
	Name	Phone
2.	_____	_____
	Name	Phone
3.	_____	_____
	Name	Phone

- **Accounting for Employees**

After exiting the building, all employees are to assemble for roll call at the following location:

The following employees are responsible for ensuring that employees comply with this requirement, conducting a roll call and reporting to outside emergency personnel the last known location of any missing employees. Those responsible for reporting are listed in descending order of availability:

1.	_____
	Name
2.	_____
	Name
3.	_____
	Name

- **Rescue and Medical Duties**

The following personnel are trained and certified in both cardiopulmonary resuscitation (CPR) and general first aid. In case of medical emergency, they are available to assist until outside emergency personnel reach the scene.

1.	_____	_____
	Name	Phone
2.	_____	_____
	Name	Phone
3.	_____	_____
	Name	Phone

Shutting Down

In order to minimize the damage or danger from a fire or other emergency, this office has determined that certain critical operations should be shut down immediately. The following personnel are responsible for shutting down the listed critical operations:

Name of Personnel

Critical Operation(s)

{Insert name of facility}
{Facility address}
{Facility Phone and fax number}
Notice of Medicare Non-Coverage

Patient name: <insert name> Patient number: <ID>
The Effective Date Coverage of Your Current <insert provider type>
Services Will End: <insert date>

- Your Medicare provider and/or health plan have determined that Medicare probably will not pay for your current <insert provider type> after the effective date indicated above.
 - You may have to pay for any services you receive after the above date.
-

Your Right to Appeal This Decision

- You have the right to an immediate, independent medical review (appeal) of the decision to end Medicare coverage of these services. Your services will continue during the appeal.
 - If you choose to appeal, the independent reviewer will ask for your opinion. The reviewer also will look at your medical records and/or other relevant information. You do not have to prepare anything in writing, but you have the right to do so if you wish.
 - If you choose to appeal, you and the independent reviewer will each receive a copy of the detailed explanation about why your coverage for services should not continue. You will receive this detailed notice only after you request an appeal.
 - If you choose to appeal, and the independent reviewer agrees services should no longer be covered after the effective date indicated above;
 - Neither Medicare nor your plan will pay for these services after that date.
 - If you stop services no later than the effective date indicated above, you will avoid financial liability.
-

How to Ask For an Immediate Appeal

- You must make your request to your Quality Improvement Organization (also known as a QIO). A QIO is the independent reviewer authorized by Medicare to review the decision to end these services.
- Your request for an immediate appeal should be made as soon as possible, but no later than noon of the day before the effective date indicated above.
- The QIO will notify you of its decision as soon as possible, generally no later than two days after the effective date of this notice if you are in Original Medicare. If you are in a Medicare health plan, the QIO generally will notify you of its decision by the effective date of this notice.
- Call your QIO at: KEPRO, Telephone: 1 (888) 317-0751, TTY 711 to appeal, or if you have questions.

See page 2 of this notice for more information.

If You Miss The Deadline to Request An Immediate Appeal, You May Have Other Appeal Rights:

- If you have Original Medicare: Call the QIO listed on page 1.
- If you belong to a Medicare health plan: Call your plan at the number given below.

Form CMS 10123-NOMNC (Approved 12/31/2011)
H1019_HSNOMNCLE2024_C

OMB approval 0938-0953

Plan contact information: **CarePlus Health Plans, Inc.**, PO Box 277810, Miramar, FL 33027-7810; Please call Member Services at 1-800-794-5907; TTY: 711. From October 1 - March 31, we are open 7 days a week, 8 a.m. to 8 p.m. From April 1 - September 30, we are open Monday - Friday, 8 a.m. to 8 p.m. You may always leave a voicemail after hours, Saturdays, Sundays, and holidays and we will return your call within one business day.

Additional Information (Optional): Only to be used when the patient is incapable or incompetent and the provider cannot obtain the signature of the patient's representative through direct personal contact.

NOTIFICATION

Select one: ☐ Telephonic outreach ☐ Refusal to Sign ☐ Unable to Sign

- Name and relationship: _____ Phone #: _____
 - Notice of Medicare non-coverage & appeal rights explained: Y / N
 - Provided effective date of _____ as date of skilled services ending: Y / N
 - Provided financial liability begin date of _____: Y / N
 - Informed that a request for an immediate appeal should be made as soon as possible, but no later than noon the day before the effective date: Y / N
 - QIO - KEPRO Telephone # 1-888-317-0751 given: Y / N
 - Informed that if the deadline to appeal with the QIO is missed, an appeal through CarePlus Health Plans phone number 1-800-794-5907 can be requested: Y / N
 - Confirmed that the representative understood all information as explained: Y / N
 - Date of contact: _____ Time of contact: _____ a.m. / p.m.
 - Name and title of the staff person initiating the contact: _____
 - (When applicable:) Reason for refusal/unable to sign: _____
-

UNABLE TO GIVE INFORMATION

- Name and relationship of the person attempted to call: _____
- Phone #: _____
- Date of first call: _____ Time of first call: _____ a.m. / p.m.
- Date of second call: _____ Time of second call: _____ a.m. / p.m.

*Mail a copy of letter to the contact person by certified mail with return receipt, on same day as the 2nd attempt.

Please sign below to indicate you received and understood this notice.

I have been notified that coverage of my services will end on the effective date indicated on this notice and that I may appeal this decision by contacting my QIO.

Signature of Patient or Representative

Date

IMPORTANT

At CarePlus, it is important you are treated fairly.

CarePlus Health Plans, Inc. complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, ancestry, ethnicity, sex, sexual orientation, gender, gender identity, disability, age, marital status, religion, or language in their programs and activities, including in admission or access to, or treatment or employment in, their programs and activities.

The following department has been designated to handle inquiries regarding CarePlus' non-discrimination policies: Member Services, PO Box 277810, Miramar, FL 33027, **1-800-794-5907 (TTY: 711)**.

Auxiliary aids and services, free of charge, are available to you. 1-800-794-5907 (TTY: 711).

CarePlus provides free auxiliary aids and services, such as qualified sign language interpreters, video remote interpretation, and written information in other formats to people with disabilities when such auxiliary aids and services are necessary to ensure an equal opportunity to participate.

This information is available for free in other languages. Please call our Member Services number at 1-800-794-5907. Hours of operation: October 1 - March 31, 7 days a week, 8 a.m. to 8 p.m. April 1 - September 30, Monday - Friday, 8 a.m. to 8 p.m. You may leave a voicemail after hours, Saturdays, Sundays, and holidays and we will return your call within one business day.

Español (Spanish): Esta información está disponible de forma gratuita en otros idiomas. Favor de llamar a Servicios para Afiliados al número que aparece anteriormente.

Kreyòl Ayisyen (French Creole): Enfòmasyon sa a disponib gratis nan lòt lang. Tanpri rele nimewo Sèvis pou Manm nou yo ki nan lis anwo an.



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Multi-Language Insert
Multi-language Interpreter Services

Form Approved
OMB# 0938-1421

English: We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at 1-800-794-5907 (TTY: 711). Someone who speaks English can help you. This is a free service.

Spanish: Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llame al 1-800-794-5907 (TTY: 711). Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

Chinese Mandarin: 我们提供免费的翻译服务, 帮助您解答关于健康或药物保险的任何疑问。如果您需要此翻译服务, 请致电 1-800-794-5907 (TTY: 711)。我们的中文工作人员很乐意帮助您。这是一项免费服务。

Chinese Cantonese: 您對我們的健康或藥物保險可能存有疑問, 為此我們提供免費的翻譯服務。如需翻譯服務, 請致電 1-800-794-5907 (TTY: 711)。我們講中文的人員將樂意為您提供幫助。這是一項免費服務。

Tagalog: Mayroon kaming libreng serbisyo sa pagsasaling-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggamot. Upang makakuha ng tagasaling-wika, tawagan lamang kami sa 1-800-794-5907 (TTY: 711). Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

French: Nous proposons des services gratuits d'interprétation pour répondre à toutes vos questions relatives à notre régime de santé ou d'assurance-médicaments. Pour accéder au service d'interprétation, il vous suffit de nous appeler au 1-800-794-5907 (TTY: 711). Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.

Vietnamese: Chúng tôi có dịch vụ thông dịch miễn phí để trả lời các câu hỏi về chương sức khỏe và chương trình thuốc men. Nếu quý vị cần thông dịch viên xin gọi 1-800-794-5907 (TTY: 711) sẽ có nhân viên nói tiếng Việt giúp đỡ quý vị. Đây là dịch vụ miễn phí.

German: Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter 1-800-794-5907 (TTY: 711). Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

Korean: 당사는 의료 보험 또는 약품 보험에 관한 질문에 대해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 1-800-794-5907 (TTY: 711) 번으로 문의해 주십시오. 한국어를 하는 담당자가 도와 드릴 것입니다. 이 서비스는 무료로 운영됩니다.

Russian: Если у вас возникнут вопросы относительно страхового или медикаментного плана, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвоните нам по телефону 1-800-794-5907 (TTY: 711). Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

Arabic: إننا نقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة تتعلق بالصحة أو جدول الأدوية لدينا. للحصول على مترجم فوري, ليس عليك سوى الاتصال بنا على (برقياً: 711) 1-800-794-5907. سيقيم شخص ما يتحدث العربية بمساعدتك. هذه هي خدمة مجانية.

Hindi: हमारे स्वास्थ्य या दवा की योजना के बारे में आपके किसी भी प्रश्न के जवाब देने के लिए हमारे पास मुफ्त दुभाषिया सेवाएँ उपलब्ध हैं। एक दुभाषिया प्राप्त करने के लिए, बस हमें 1-800-794-5907 (TTY: 711) पर फोन करें। कोई व्यक्ति जो हिंदी बोलता है आपकी मदद कर सकता है। यह एक मुफ्त सेवा है।

Italian: È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per un interprete, contattare il numero 1-800-794-5907 (TTY: 711). Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

Portuguese: Dispomos de serviços de interpretação gratuitos para responder a qualquer questão que tenha acerca do nosso plano de saúde ou de medicação. Para obter um intérprete, contacte-nos através do número 1-800-794-5907 (TTY: 711). Irá encontrar alguém que fale o idioma Português para o ajudar. Este serviço é gratuito.

French Creole: Nou genyen sèvis entèprèt gratis pou reponn tout kesyon ou ta genyen konsènan plan medikal oswa dwòg nou an. Pou jwenn yon entèprèt, jis rele nou nan 1-800-794-5907 (TTY: 711). Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.

Polish: Umożliwiamy bezpłatne skorzystanie z usług tłumacza ustnego, który pomoże w uzyskaniu odpowiedzi na temat planu zdrowotnego lub dawkowania leków. Aby skorzystać z pomocy tłumacza znającego język polski, należy zadzwonić pod numer 1-800-794-5907 (TTY: 711). Ta usługa jest bezpłatna.

Japanese: 当社の健康保険と薬品処方薬プランに関するご質問にお答えするために、無料の通訳サービスがあります。通訳をご用命になるには、1-800-794-5907 (TTY: 711) にお電話ください。日本語を話す人が支援いたします。これは無料のサービスです。

Form CMS-10802 (Expires 12/31/25)

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