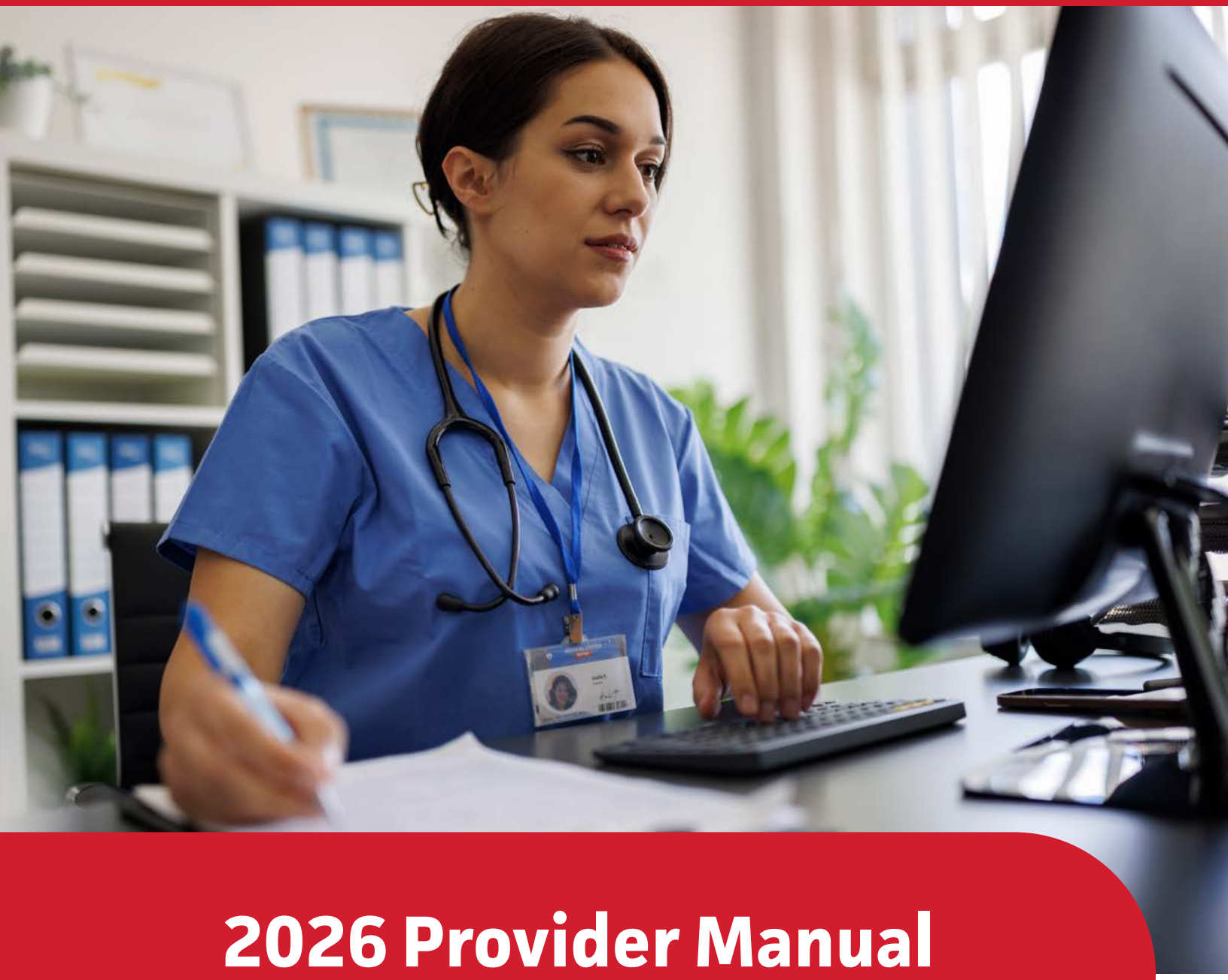


2026 Provider Manual

For physicians, hospitals, and healthcare providers

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CarePlus HEALTH PLANS™

CarePlus HEALTH PLANS

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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.

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

This manual furnishes all such participating providers and their office staff with important information concerning CarePlus policies and procedures, claims submission and adjudication requirements and guidelines used to administer CarePlus health plans. Other policies and procedures are posted online.

This manual replaces and supersedes any and all other previous versions and is located on CarePlusHealthPlans.com. A paper copy can be obtained at any time upon request to your designated provider services executive. Any capitalized terms not otherwise defined herein shall have the meaning as set forth in the agreement.

Except as may otherwise be set forth in the agreement, providers are contractually required to comply with all provisions contained in this manual. Revisions to this manual constitute revisions to CarePlus' policies and procedures. Variations in applicable laws, regulations and governmental agency guidance including, but not limited to, state or federal laws, regulations and/or changes to such laws, regulations or guidance may create certain requirements related to the content in this manual that are not expressly set forth in this manual.

Any requirements under applicable law, regulation or guidance that are not expressly set forth in the content of this manual are 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. Note: State laws and/or regulations do not affect the adjudication of claims for MA members. CarePlus may deny payment for any services or supplies for which a provider failed to comply with CarePlus' policies and procedures.

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 clinical judgment or treatment recommendations made by providers.

Referrals: For patients with HMO plans, referrals may be required. If a patient requires specialized treatment beyond the scope of a primary care physician (PCP), they can be referred to a specialist for consultation and/or treatment. CarePlus contracts with specialists in the plan's service area. See the providers' section of CarePlusHealthPlans.com for CarePlus' claims payment policy on ordering provider and referring provider requirements.

Methods for submitting referral requests are outlined within this manual and on CarePlus' website. The PCP will receive a referral number from CarePlus if the referral request is:

1. Completed and CarePlus determines the services are covered under the provider agreement;
2. Provided by an approved provider/facility; and
3. A referral number does not override member eligibility, provider agreement exclusions, etc.

Prior to the specialist rendering services, prior authorization also must be obtained by the specialist for any additional medications or services on the prior authorization and notification list.

The status of a referral can be verified by accessing Availity Essentials™ or by calling 866-220-5448. After the patient has been treated, the specialist's findings, diagnosis and recommendation for treatment should be sent to the patient's PCP. The specialist also must submit claim/ encounter data to CarePlus.

Prior authorization for medications and services on the prior authorization and notification list is required. The list is at CarePlusHealthPlans.com/PAL, or a copy can be requested from CarePlus Provider Services at 866-220-5448. Note: Original Medicare does not cover some services or supplies when they are ordered/referred unless certain requirements (e.g., qualifications of the ordering/referring provider, billing requirements) are satisfied. CarePlus follows Original Medicare billing and enrollment requirements for services and supplies covered under Original Medicare.

Provider training and education: Upon initial contracting with CarePlus, a provider is assigned a provider services executive who serves as the liaison between the provider and CarePlus. CarePlus and your assigned provider services executive will provide useful tools, resources and educational materials on how to do business with CarePlus, including navigating CarePlus' systems and care management model. These tools and resources will be used to demonstrate partnership opportunities to help deliver high quality and evidence-based clinical care that drive value and performance. Any questions regarding these tools or issues relating to agreements should be directed to your provider services executive.

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CarePlus HEALTH PLANS

KEY CONTACTS LIST

Department/Area	Contact Information
CarePlus member eligibility and benefits	Availity Essentials (www.availity.com) OR Call us at: 866-220-5448
Provider emergency hotline	877-210-5318
Authorizations Pre-service telephonic requests For dates of service occurring within 3 days Pre-service electronic requests For dates of service greater than 3 days, please utilize Availity Pre-service fax requests Preferred form for fax requests: Health Services Prior Authorization Form Inpatient hospital and post-acute facility requests 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: 866-220-5448 Availity: (www.availity.com) Dade: 888-790-9999 Broward and Palm Beach: 866-832-2678 All other counties: 888-634-3521 Inpatient notifications: Availity: (www.availity.com) Inpatient fax: 866-229-1538
Transplant services/inquiries	Availity: (www.availity.com) Phone: 866-421-5663 Fax: 502-508-9300 e-mail: Transplant@humana.com
Care management	Non-SNP: 866-657-5625 care_plus_care_management_referrals@humana.com SNP: 800-734-9592 hms_case_management_program@humana.com
Pharmacy Utilization Management Authorizations Prior Authorizations and Exceptions	CarePlusHealthPlans.com/Providers/Pharmacy-Resources Phone: 866-315-7587 Fax: 800-310-9071

Department/Area	Contact Information
Pharmacy Technical Help Desk Call Center	SS&C Pharmacy Help Desk 800-522-7487
CarePlus website – Information for providers webpage	CarePlusHealthPlans.com/Providers This webpage provides you with access to useful provider publications and trainings.
Claim status/inquiries	Availity (www.availity.com) OR Phone: 866-220-5448
Claims address	Availity (www.availity.com) CarePlus Payer ID No. 95092 OR P.O Box 14601 Lexington, KY 40512-4601
Provider Operations address	CarePlus Health Plans, Inc. Attention: Provider Operations Dept. P.O. Box 19007 Green Bay, WI 54307
Laboratory services	Labcorp (All counties) 800-877-5227 Labcorp.com
Pharmacy mail order	CenterWell Pharmacy® (All counties) Phone: 800-526-1490 (TTY: 711)
Ethics Help Line	877-584-3539 EthicsHelpline.com
Fraud, Waste & Abuse (FWA) Hotline	800-614-4126

Provider Services at: 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: 800-526-1490	Refer to CarePlus' PAL at CarePlusHealthPlans.com/PAL for items and services that require prior 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)	Alivi Vision Network (All counties) 888-863-0249	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) 800-738-1889	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) 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) 800-333-3389 Option 2	Authorizations are required for all Medicare-covered services received from a participating Ear, Nose and Throat (ENT) physician. Participating ENTs can be utilized for diagnostic hearing services only. Authorizations are not required for supplemental/routine hearing testing and hearing aids through HearUSA.

ADDITIONAL SERVICES (CONTACT INFORMATION)

Service	Telephone and Addresses	Authorization – Referrals
		Members may self-refer for a Medicare-covered hearing exam once every 12 months. Refer to CarePlus' PAL at CarePlusHealthPlans.com/PAL for items and services that require authorization.
Chiropractic services	**Alivi/Quality Managed Health Care** (All counties) 786-441-8500 Option 3	Members may self-refer to a network provider up to 12 times per calendar year for manual manipulation of the spine. Refer to CarePlus' PAL at CarePlusHealthPlans.com/PAL for items and services that require authorization.
Podiatry services	**PodAmerica** (Broward, Miami-Dade and Palm Beach) Please refer to the Provider Directory for list of providers **Health Network One** (Brevard, Clay, Duval, Flagler, Hillsborough, Indian River, Lake, Marion, Orange, Osceola, Pasco, Pinellas, Polk, Seminole, St. Johns, Sumter and Volusia) 800-595-9631	Members may self-refer to a participating provider and **do not** require an authorization for routine foot care. Refer to CarePlus' PAL at CarePlusHealthPlans.com/PAL for items and services that require authorization.
Wound care Tracheotomy/ Mastectomy Supplies	**Advance Care Solutions** (All counties) Phone: 877-748-1977 Fax: 877-748-1985	For all ostomy, urological, tracheotomy and mastectomy supplies. Refer to CarePlus' PAL at CarePlusHealthPlans.com/PAL for items and services that require authorization.
Transportation*	**Alivi NEMT Network** (All counties) 888-998-4640	Contact Alivi NEMT Network to schedule transportation. ***Rules/exclusions may apply. Please refer to the "CarePlus Covered Benefits" section within this manual for rules/exclusions.**
Acupuncture*	**Alivi/Quality Managed Health Care** (All counties) 786-441-8500 Option 3	Routine Acupuncture is limited to 25 visits per calendar year. 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.

ADDITIONAL SERVICES (CONTACT INFORMATION)

Service	Telephone and Addresses	Authorization – Referrals
		***Exclusions may apply depending on the plan and county.** Refer to CarePlus' PAL at CarePlusHealthPlans.com/PAL for items and services that require authorization.
Integrative Services and Well Being * (Massage therapy)	**Wholehealth Networks Inc. (Tivity Health)** (All counties)	Refer to CarePlus' PAL at CarePlusHealthPlans.com/PAL for items and services that require authorization. ***Exclusions may apply depending on the plan and county. Contact your provider services executive or Provider Services for details.**
Health and wellness education	**Tivity Health SilverSneakers® Fitness program** 888-423-4632 SilverSneakers.com	Members must visit participating fitness centers and enroll in person. Members can create an account at SilverSneakers.com/StartHere to access fitness locations near them, download their 16-digit ID number, SilverSneakers LIVE classes, SilverSneakers On-Demand videos and much more. Refer members to the CarePlus Provider Directory or the CarePlus Member Services department for participating locations.
Post discharge meals	**NationsMarket, LLC** 800-999-0288	CarePlus members may receive up to 14 fresh meals delivered to their home after an inpatient stay in a hospital or nursing facility. A member may only utilize this benefit 4 times per year within 30 days of an inpatient stay in a hospital or nursing facility.
CarePlus Spending Account Card*	**Nations Benefits** 866-441-2971 (TTY:711)	With certain CarePlus plans, eligible members may receive a CarePlus Spending Account Card to help support their health. The card makes it easy to spend certain benefit allowances. Members of plans with a CareEssentials Allowance can use this allowance at participating retailers to buy eligible products

ADDITIONAL SERVICES (CONTACT INFORMATION)

Service	Telephone and Addresses	Authorization – Referrals
		such as groceries, personal care items, over-the-counter (OTC) items, and supplies for their home or to pay for monthly expenses such as utilities or rent. Certain plans include an additional OTC allowance on the CarePlus Spending Account Card. Members can use this allowance at participating retailers to help buy the approved OTC products they need such as vitamins, allergy, cold and flu medicine, and first aid. Unused balances roll over until the end of the year. Any remaining allowances expire at the end of the plan year or upon member disenrollment. ***Exclusions may apply depending on the plan and county. Contact your provider services executive or 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 800-595-9631	Members can 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) 800-595-9631	Refer to CarePlus' PAL at CarePlusHealthPlans.com/PAL for items and services that require authorization.
Durable medical equipment	**Adapt Health** (Broward, Miami-Dade and Palm Beach) Phone: 800-253-0383 Fax: 800-331-2097 **Integrated Home Care Services** (Brevard, Clay, Duval, Flagler, Hillsborough, Indian River Lake, Marion, Orange, Osceola, Pasco, Pinellas, Polk, Seminole, St. Johns, Sumter and Volusia)	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.

ADDITIONAL SERVICES (CONTACT INFORMATION)

Service	Telephone and Addresses	Authorization – Referrals
	Phone: 844-215-4264 Fax: 844-215-4265	
Home health	**One Homecare Solutions** (Broward, Miami-Dade and Palm Beach) Phone: 855-441-6900 Fax: 855-441-6941 **Integrated Home Care Services** (Brevard, Clay, Duval, Flagler, 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: 855-441-6941	Refer to CarePlus' PAL at CarePlusHealthPlans.com/PAL for items and services that require authorization.
Mental health	**Carelon Behavioral Health, Inc.** (All counties) Phone: 833-227-3757	Members should contact Carelon directly for appointments. 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.
Admitting panel	**TBIM Hospitalists (TBIM)** (Hillsborough) 813-497-4467 **Mid Florida Hospital Specialist** (Orange and Seminole) 321-207-0174 **Greater Orlando Hospitalist Group** (Orange and Seminole) 407-423-4682 **Dr. William Muñoz** (Osceola) 407-248-8862	The hospital is responsible for contacting the appropriate hospitalist company for admitting assignment. Contact your provider services executive or Provider Services for details.

***For questions or inquiries relating to these services or services not listed above, please call Provider Services at: 866-220-5448 ***

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

DEFINITIONS

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

A. **CarePlus Health Plans Inc. (CarePlus) –** 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 3-month periods from Jan. 1–March 31, April 1–June 30, July 1–Sept. 30, and Oct. 1–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 at 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 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 a Late Enrollment Penalty (LEP) determination.

N. Interdisciplinary Care Team (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 is also expected to coordinate their 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 ICT is to foster frequent, structured and documented communication among disciplines to establish, prioritize and achieve treatment goals.

O. Medicare Advantage Organization (MAO) – 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. Medicare Advantage (MA) 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 plan enrollee** means an MA eligible individual who has elected an MA plan offered by an MA organization.

R. **Medicare Advantage Prescription Drug (MAPD) 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, 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 PCP agreement.

EE. **Primary care services –** covered services customarily provided by a PCP in their office as well as services customarily provided by an attending PCP to institutionalized members. 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 benefit that allows the enrollee the option of receiving specified services outside of the plan's provider network but within the plan's service area or the plan's designated POS service area.

GG. **Prior authorization 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 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 MA plans) –** a geographic area approved by CMS within which an MA-eligible individual must reside to enroll in a particular plan offered by CarePlus.

JJ. **Special Needs Plans (SNP) –** 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 their 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) Because 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 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 their 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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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 (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)
Provide coverage for emergency and urgently needed services consistent with Medicare Advantage requirements	422.100 and 422.113
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, 7 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)

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 2 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: 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 2 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/Providers/Educational-Resources/Compliance. If you are unable to access the internet, please call Provider Services at 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 2 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 Provider Services at 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/Providers/Educational-Resources/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
    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 (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
    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/Providers/Educational-Resources/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/Providers/Educational-Resources/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: 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: 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 member
- 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 member's diagnosis or medical condition
- Surgical repair of damage to a member resulting from a planned procedure, where the damage was not a recognized specific risk, as disclosed to the member 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 CarePlus within 3 calendar days. The information submitted to CarePlus is used for state-mandated 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 designated provider services executive.
- In writing by the independent physician or office staff. The incident report should be sent to your designated provider services executive. Facsimiles should be avoided because of lack of confidentiality.

Group physicians and their staff 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 designated provider services executive.
- In writing by the group medical director/group physician leader or office staff. The incident report should be sent to your 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. All information reported to the plan will remain strictly confidential in accordance with the policy and procedure on confidentiality.

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MEMBERS' RIGHTS AND RESPONSIBILITIES

CarePlus adheres to certain rules of accrediting and regulatory agencies concerning member rights. CarePlus members have certain rights and responsibilities when being treated by CarePlus-contracted providers. The rights and responsibilities statement below, though not intended to be exhaustive, reminds members and providers of their complementary roles in maintaining a productive relationship.

CarePlus members have the right to:

1. Be provided with information about their plan, its services and benefits, its providers and the rights and responsibilities of members.
2. Choose a PCP from our network of affiliated providers and to change to another PCP in the CarePlus network.
3. Request a practitioner who has their same race, ethnicity and/or language as themselves if there is a practitioner available in their network.
4. Discuss their medical record with their physician and receive, upon request, a copy of that record.
5. Participate with providers in making decisions about their healthcare.
6. Have a candid discussion with their provider about appropriate or medically necessary treatment options for their conditions, regardless of cost or benefit coverage.
7. Expect reasonable access to medically necessary healthcare services, regardless of gender, race, national origin, religion, physical abilities or source payment.
8. File a formal complaint or appeal, as outlined in the plan's grievance procedure, and expect a response to that complaint within a reasonable period of time.
9. Be treated with courtesy and respect, with appreciation for their dignity and protection of their right to privacy.
10. Make recommendations regarding the plan's "rights and responsibilities" policies.
11. Expect CarePlus to adhere to all privacy and confidentiality policies and procedures.
12. Have an initial health risk assessment conducted for care within the first 90 days of enrollment.
13. Have direct access to a women's health specialist, within the network, for routine and preventive health services, such as mammography screening and influenza vaccinations, which are provided as basic benefits for women.
14. Have direct access to influenza vaccinations for routine and preventive health services provided as basic benefits. Certain preventive health services, such as influenza and pneumococcal vaccines, do not require a copayment.
15. Receive services that are provided in a culturally competent manner.
16. Receive treatment for any emergency medical condition.
17. Select an in-network provider and not be balance billed for medically necessary covered services.
18. Receive an Explanation of Benefits (EOB) and discuss that EOB with the plan.
19. File a claim or have a claim filed by a provider on their behalf.
20. Request and receive an organization determination from the plan regarding the services or treatment being requested, if members disagree with their physician about a denial of service.

CarePlus members have the responsibility to:

1. Give the plan and their healthcare provider complete and accurate information needed for their care.
2. Understand their health problems and participate in developing agreed-upon treatment goals with their healthcare provider.

3. Read and be aware of all material distributed by the plan explaining policies and procedures regarding services and benefits.
4. Obtain and carefully consider all information they may need or desire to give informed consent for a procedure or treatment.
5. Be considerate and cooperative in dealing with the plan providers and respect the rights of fellow members.
6. Schedule appointments, arrive on time for scheduled visits and notify their healthcare provider if they must cancel or be late for a scheduled appointment.
7. Express opinions, concerns or complaints in an Accreditation constructive manner.
8. Inform CarePlus of any change in their contact information, such as address or phone number, even if these changes are only temporary.
9. Pay all premiums and applicable copayments, coinsurance and deductible amounts by the due date.
10. Follow healthcare facility rules and regulations affecting patient care and conduct.
11. Carry their CarePlus identification card with them at all times and use it while enrolled in the plan.
12. Follow the plans and instructions for care that they have agreed upon with their providers.

Note: In some states, providers are required by law to post members' rights and responsibilities. To be in compliance with CMS' member's rights and responsibilities, CarePlus has a process in place for current and prospective beneficiaries to exercise choice in obtaining Medicare services.

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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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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, 7-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 their 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 or prior authorization request in Availity. Note that referrals/authorizations 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 their 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 member.

13. All referrals must be submitted via Availity, 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 and appeal procedures when CarePlus notifies the PCP of any member grievances and 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 of 1996 (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 members 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 their 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 their 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 member'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 prior 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 4 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 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. For additional details, please refer to the US Department of Health and Human Services at www.hhs.gov/civil-rights/for-individuals/section-1557/fs-disability/index.html

The Americans with Disabilities Act (ADA) 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, 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

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 their 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 members.

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 and appeal procedures when CarePlus notifies specialist of any member grievances and 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 their 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 includes 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 and Facility.

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 their 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 time frames (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 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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RESPONSIBILITIES OF THE FACILITY

1. Facility must have 24 hours, 7 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 member.

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 to receive 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 and 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 ADA.

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 members with complete information concerning their diagnosis, evaluation, treatment and prognosis and the use of the healthcare system. Facility will give 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, members 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 members 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 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.

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 ADA 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).

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 prior authorization 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 prior authorization), 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 and facilities 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

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 4 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.

Providers must have an appropriate response for the LEP patients they serve, such as use of translated documents, bilingual office staff and use of a family member or an interpreter, when necessary. In the event a provider is unable to arrange for **language translation services for non-English speaking or LEP CarePlus members**, he/she may call Member Services at 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 healthcare or healthcare 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. For additional details, please refer to the HSS website at www.hhs.gov/civil-rights/for-individuals/section-1557/fs-disability/index.html

The Americans with Disabilities Act of 1990

Under the ADA, physicians' offices are considered places of public accommodation. Providers are required to comply with basic non-discrimination requirements that prohibit exclusion, segregation and unequal treatment of any person with a disability. All providers 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, providers and their staff may need training in operating accessible equipment, helping with transfers and positioning, and not discriminating against individuals with disabilities.

Providers 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 provider 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. Providers are required to modify policies and procedures when necessary to serve a person with a disability. However, the ADA does not require providers to make changes that would fundamentally alter the nature of their service. Providers are responsible for making reasonable efforts to accommodate members with sensory impairments. Without these, the provider 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: 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 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.

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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 member must be notified of their credentials and the possibility of not being seen by a medical doctor. Notwithstanding the foregoing, a member's request to be seen by a physician, rather than a physician extender, should always be honored. All progress notes made by 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. However, nurse practitioners and physician assistants are subject to credentialing and must go through the credentialing and vetting process.

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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 Provider Services 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 their 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** (www.availity.com) using the **CarePlus Payer ID No. 95093**.

If you are not submitting encounters electronically and would like to, please contact your assigned provider services executive or Provider Services at 866-220-5448, 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 14601
Lexington, KY, 40512-4601

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 and providers always ask the patient for their 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 Account.CarePlusHealthPlans.com/. After creating a member portal account and signing 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

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

There are 6 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 3 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 second month after the month in which they are first entitled to Part A and enrolled in Part B, or
2) The last day of the individual's Part B initial enrollment period, whichever is later.

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

Each year, the AEP is Oct. 15–Dec. 7. 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.

Each year, the MA OEP is Jan. 1–March 31 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 their 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)
    - Enrollment into a Fully Integrated Dual Eligible (FIDE) SNP, Highly Integrated Dual Eligible (HIDE) SNP or Applicable Integrated Plan (AIP) for dually eligible individuals who are enrolled in or in the process of enrolling in the D-SNPs affiliated Medicaid MCO
    - 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 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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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 member's eligibility, please call CarePlus Provider Services at 866-220-5448.

IDENTIFYING/VERIFYING CAREPLUS MEMBERS

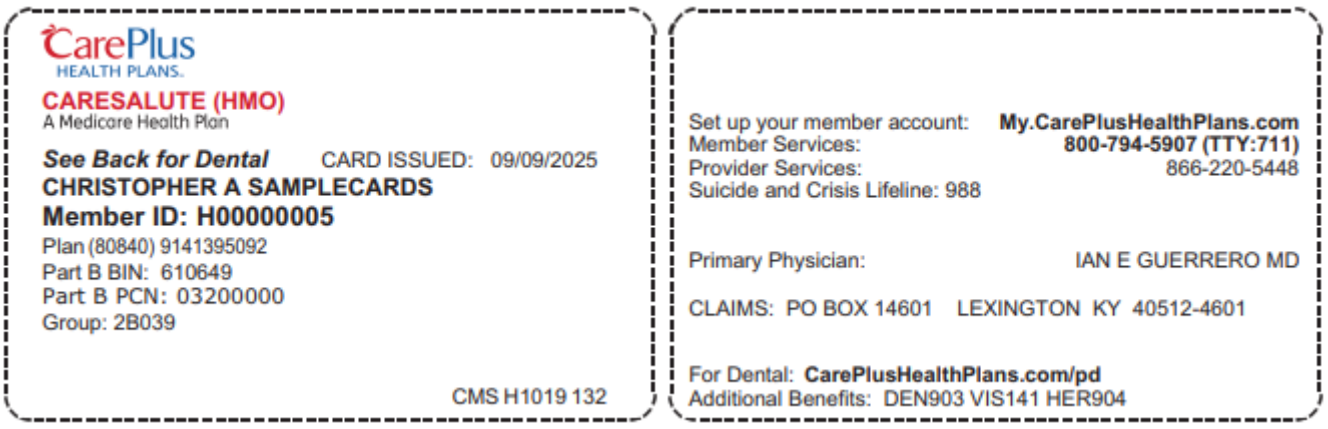
Upon receipt of an enrollment application, CarePlus sends members a member identification (ID) card and a Verification of Enrollment letter. Once CMS accepts the enrollment, CarePlus then sends members the Confirmation of Enrollment letter.

Each CarePlus member is identified by a CarePlus member ID number, which indicates assignment to a specific PCP. 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 (www.availity.com) or call Provider Services for eligibility verification at 866-220-5448, 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 their membership card, please call Provider Services 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.

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



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 (www.availity.com).

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

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 their 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. 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 their 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
P.O. Box 19007
Green Bay, WI 54307

By fax
866-449-5668

A PCP understands and agrees that CarePlus may, in its sole discretion, close the PCP's panel and stop assigning new members to the PCP upon written notice to the PCP. In such event, the PCP's panel will remain closed until notified in writing by CarePlus.

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 866-449-5668.

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's 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 their 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 their 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 printed versions of **Five Wishes®** booklets available 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 Provider Services at 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/.

Members can visit CarePlusHealthPlans.com/Members/Health-and-Wellness/Programs/Advance-Care-Planning to access more information advance care planning.

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/Providers/Educational-Resources/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. P.O. Box 19007 Green Bay, WI 54307	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 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 in which 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 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 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/Providers/Educational-Resources/Updates.

Regulatory Agency	Web Link to Guideline/Best Practice
Centers for Disease Control and Prevention (CDC)	Healthcare-associated Infections (HAIs) Guidelines
CDC	Guideline for Infection Control in Healthcare Personnel
CDC	Healthcare-associated Infections (HAIs) Guide to Infection Prevention for Outpatient Settings – Minimum Expectations for Safe Care
CDC	2007 Guidelines for Isolation Precautions: Preventing Transmissions of Infectious Agents in Healthcare Settings
CDC	Hand Hygiene in Healthcare Settings
CDC	Injection Safety
Occupational Safety and Health Administration (OSHA)	Medical and Dental Offices – A Guide to Compliance with OSHA Standards
OSHA	Safety and Health Topics: Healthcare
OSHA	Safety and Health Topics: Healthcare – Standards/Enforcement
OSHA	Safety and Health Topics: Healthcare – Other Hazards
OSHA	Safety and Health Topics: Blood-borne Pathogens and Needlestick Prevention Standards
OSHA Publication	Model Plans and Programs for the OSHA Blood-borne Pathogens and Hazard Communications Standards (OSHA 3186-06R 2033)
CDC	Guideline for Disinfection and Sterilization in Healthcare Facilities
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

- 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 and visitor volume.
3. There is adequately marked patient and 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 or 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.

- All PCP changes are effective on the first of the month.
- The PCP office must send their medical records to the newly selected PCP office.

PHYSICIAN-INITIATED MEMBER TRANSFER

As part of their 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 their 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 their 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 their 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 their 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 the 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:

  1. Threats of violence, stalking, harassment or acts of violence or aggression
  2. Lawsuit or claim filed against physician
  3. Fraud or criminal activity (e.g., forged prescriptions, altered medical records, identity theft or theft in office)
  4. Inappropriate physical contact with staff

5. Failed drug screen, in violation of practice policy/pain management contract
6. 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 Provider Services at 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 Member Services for assistance at 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 6 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 they choose 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 their 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 the member's behavior is not related to the use or 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 3 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 mentioned above, CarePlus must send the member or their 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, 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 their 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.
- 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 unless immediate termination is required.
- The physician review panel will present a written decision to the physician via certified or registered mail..

Should a provider elect to terminate their 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 HHS' opt-out list, the CMS preclusion list, General Service Administration's System of Award Management (SAM) list and the OIG's sanction list as often as required by federal regulations. Should a provider's name appear on a current OIG/CMS excluded-provider listing, CarePlus will take immediate action to terminate the provider's network participation and, if applicable, take appropriate corrective actions. Other sanctions (e.g., loss of professional license) also are grounds for immediate termination.

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: https://www.cms.gov/training-education/medicare-learning-networkr-mln/resources-training/mln-matters-articles

CMS NATIONAL COVERAGE DETERMINATIONS (NCDs) & 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/Providers/Educational-Resources/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. You can access the medical and pharmacy coverage policies by visiting: CarePlusHealthPlans.com/PAL.

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.

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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 their 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:	DOs:
• 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.	• 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

• DO NOT conduct health screenings during a health plan marketing or 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 or 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.	information. These discussions may occur in areas where care is delivered. • 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.

For additional information and applicable policies and procedures, please call your assigned provider services executive or call CarePlus Provider Services at 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 subcontractor at substantial financial risk for services that the physician, physician group or subcontractor does not furnish itself, CarePlus must assure that all physicians, physician groups and subcontractors 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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Scope and Purpose

CarePlus' quality improvement (QI) program guides and directs activities to enhance care and treatment for our CarePlus-covered patients. By aligning with our company-wide commitment to ***Health First***, the program supports continuous quality improvement across the organization. It adheres to the standards set by CMS' National Quality Strategy (NQS), which aims for a resilient, high-value health system promoting quality outcomes, safety, equity and accessible care for all individuals.

To accomplish this, CarePlus supports and collaborates with physicians and other healthcare professionals to deliver integrated care to their CarePlus-covered patients, ensuring ongoing monitoring, evaluation and improvement in the quality of healthcare services.

The primary aim of the QI program is to monitor, evaluate and facilitate improvement in the quality of healthcare services provided to CarePlus-covered patients. The program is based on contractual, governmental, accreditation and organizational requirements and guidelines. Data is systematically tracked and analyzed for trends on a monthly, quarterly and annual basis, enabling the identification of improvement opportunities and, when necessary, conducting root-cause analyses. CarePlus may use practitioner performance data for quality improvement activities.

Performance Monitoring

Performance monitoring is the key to assessing the quality of healthcare services and measuring the effectiveness of the quality improvement program. Mechanisms are in place to encourage providers to participate in quality improvement initiatives for the health plan as well as governmental agencies such as CMS and HHS. Performance monitors are selected based on the Quality Improvement Evaluation (QIE) from the previous year. Interventions are evaluated and refined to achieve demonstrable improvement in the QI program requirements and quality measures. Performance reporting includes measurement tools from internal quality processes and various regulatory bodies such as CMS and state agencies. Quality outcome information is made available to CMS to assist members in comparing health coverage options and plan selection. CarePlus indicators are found in the CarePlus QI Work Plan.

Program activities are conducted at the corporate and market level. Metrics and performance to goal, along with identified barriers and actions for improvement, are reported at the corporate and market level, per the QI Work Plan schedule. Monitoring activities are designed for a broader range of healthcare issues with a focus on identifying areas of vulnerability, risks, and tracking and trending-related data. This is performed through, but is not limited to:

- Provider site visits
- Review of provider practice patterns and provider experience
- Medical record documentation reviews
- Review of population health outcomes, e.g., HEDIS, chronic care management, value-based 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 Consumer Assessment of Healthcare Providers and System (CAHPS) and Health Outcomes Survey (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), other digital health innovations

Quality of Care Issues

Member, providers, internal and external entities, e.g., Florida's Beneficiary and Family Centered Care Quality Improvement Organization (BFCC-QIO) and CMS, communicate potential quality of care issues to the health plan. 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.

These referrals are investigated, analyzed, monitored and evaluated for trends. 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. Issues with implications for risk management are referred to the risk and/or law department.

Beneficiary Complaints

- As required by the Medicare statute and regulations, CarePlus participates with the Florida BFCC-QIO, Acentra Health. 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. The selected guidelines are reviewed bi-annually by the corporate Clinical Practice Guidelines Committee (CPGC), which is comprised of Humana/CarePlus network physicians, with varying specialty expertise and backgrounds. Once the CPGC has reviewed the guidelines, their recommendations are also presented to CarePlus' Quality Committee for feedback and approval that is specific to the CarePlus population. CarePlus' Quality Committee are also comprised of CarePlus network Physicians.

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 CarePlus patient/population. 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/Providers/Educational-Resources/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 and Prevention (CDC)
Recommended Adult Immunization Schedule – United States, 2024/CDC

Asthma care
Global Initiative for Asthma (GINA)
2023 Global Initiative for Asthma (GINA) Report: Global Strategy for Asthma Management and Prevention Updated/Global Initiative for Asthma

Atrial fibrillation
National Institute of Health (NIH)
Atrial Fibrillation: Diagnosis and Management National Institute for Health and Care Excellence (NICE) 2022

Back pain
Department of Veterans Affairs Department of Defense (VA/DoD)
Department of Veterans Affairs Department of Defense (VA/DoD) Guideline for the Diagnosis and Treatment of Low Back Pain 2022

Cholesterol management
Department of Veterans Affairs Department of Defense (VA/DoD)
Lipids Management for Cardiovascular Disease Risk Reduction (2025) - VA/DOD Clinical Practice Guidelines

Chronic obstructive pulmonary disease (COPD)
Global Initiative for Chronic Obstructive Lung Disease (GOLD)
Global Strategy for The Diagnosis, Management and Prevention of Chronic Obstructive Pulmonary Disease, 2023 Update/The Global Initiative for Chronic Obstructive Lung Disease (GOLD)

COVD-19
Infectious Disease Society of America
Infectious Disease Society of America, Guidelines on the treatment and management of patients with COVID-19 2023

Depression (for primary care providers)

Department of Defense (VA/DoD)
Managing Depression in Primary Care – 2020 Veterans Affairs/Department of Defense (VA/DoD)

Diabetes care
American Diabetes Association (ADA)
Standards of Medical Care in Diabetes – 2023/ American Diabetes Association (ADA)

Fall Prevention
British Geriatric Society
Age and Aging Global Falls Guideline Task Force World Guidelines for Falls Prevention and Management for Older Adults: A Global Initiative 2022

Headache
Department of Veterans Affairs Department of Defense (VA/DoD)
The Primary Care Management of Headache – 2023 – VA/DoD

Heart failure
Cardiology/American Heart Association
2022 AHA/ACC/HFSA Guideline for the Management of Heart Failure: A Report of the American College of Cardiology/American Heart Association Joint Committee on Clinical Practice Guidelines | Circulation (ahajournals.org)

Heart risk calculator
American College of Cardiology (ACC)
Heart risk calculator (ASCVD Risk Estimator Plus)/ACC 2023

Human immunodeficiency virus
National Institute of Health (NIH)
HIV Clinical Information 2024

Hypertension
American College of Cardiology (ACC)
Harmonization of the American College of Cardiology/American Heart Association and European Society of Cardiology /European Society of Hypertension Blood Pressure/Hypertension Guidelines: Comparisons, Reflections, and Recommendations 2022

Insomnia
Department of Veterans Affairs Department of Defense (VA/DoD)
The Management of Chronic Insomnia Disorder and Obstructive Sleep Apnea -2025- VA/DoD

Kidney disease
National Kidney Foundation (NKF)
KDOQI Guidelines/Commentaries

Medical records documentation guidelines

CarePlus has adopted guidelines based on accreditation and state medical record documentation (MRD) requirements, via www.careplushealthplans.com

CarePlus Provider Manual, pages 89-91

Opioid 1

Centers for Disease Control and Prevention (CDC)

CDC Clinical Practice Guideline for Prescribing Opioids for Pain (CDC) 2022

Opioid 2

Health and Human Services (HHS)

HSS Guide for Clinicians on the Appropriate Dosage Reduction or Discontinuation of Long-Term Opioid Analgesics/ Health and Humana Services (HHS) 2019

Oxygen therapy

American Thoracic Society

Home Oxygen Therapy for Adults with Chronic Lung Disease An Official American Thoracic Society Clinical Practice Guideline/ American Thoracic Society 2020

Palliative/end of life hospice

National Coalition for Hospice and Palliative Care (NCHPC)

National Coalition for Hospice and Palliative Care Clinical Practice Guidelines for Quality Palliative Care, 4th edition 2018

Preventive care guidelines

U.S. Preventive Services Task Force (USTFPS)

Preventive Services Selector/ United States Task Force on Preventive Services (USTFPS) 2024

Primary prevention of cardiovascular disease and stroke

ACC/AHA Task Force on Clinical Practice Guidelines

2019 Guideline on the Primary Prevention of Cardiovascular Disease Guideline/ ACC/AHA Task Force

Sickle cell anemia

American Society of Hematology

ASH Clinical Practice Guidelines

Sleep apnea

American Society of Anesthesiologists

Practice Guidelines for the Perioperative Management of Patients with Obstructive Sleep/ American Society of Anesthesiologists Task Force on Perioperative Management of Patients with Obstructive Sleep Apnea 2014

Syphilis

Centers for Disease Control Prevention (CDC)

Centers for Disease Control Prevention (CDC) Sexually Transmitted Infections Guidelines: Syphilis 2021

Telehealth
American Medical Association (AMA)
2022 American Medical Association Digital Health Implementation Play Book Series

Transgender 1
American College of Obstetricians and Gynecologist (ACOG)
Committee Opinion Health Care for Transgender and Gender Diverse Individuals – 2021 – American College of Obstetricians and Gynecologists (ACOG)

Transgender 2
World Processional Association for Transgender Health (WPATH)
Standards of Care for the Health of Transgender and Gender Diverse People, Ver 8

Urinary Incontinence (Female)
National Institute of Health (NIH)
Female Urinary Incontinence Evidence-Based Treatment Pathways: An Infographic for shared decision making – 2022 – Journal of Women's Health

Urinary Incontinence (Male)
National Institute of Health (NIH)
Lower Urinary Tract Symptoms in Men Management National Institute for Health and Care Excellence (NICE) 2015

Valvular heart disease
American College of Cardiology (ACC)/American Heart Association (AHA)
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/ ACC/ AHA Task Force

Well-woman routine care
The American College of Obstetricians and Gynecologists (ACOG)
Recommendations for Well-Woman Care 2023/ American College of Obstetricians and Gynecology (ACOG)

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

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

Diagnosis or objective findings
Diagnosis or clinical impressions must be in the record.

Consults, lab and 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 PCP, 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 and 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 or 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 may have regarding CarePlus' QI Program, please email cphpqmdepartment.grp@humana.com.

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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/admnsimp/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 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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- 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 2 to 3 times their proportion of the elderly population. In a national study, the vast majority of abusers were family members (approximately 90%), 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 Abused (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 and 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 or 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 their 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 or 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 hotline 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

At CarePlus, we recognize the persistent challenges faced by racial and ethnic minorities in accessing quality healthcare. Despite advancements in overall health, these populations often encounter barriers that result in lower quality care, reduced likelihood of receiving routine medical services and higher rates of morbidity and mortality compared to non-minorities. We are dedicated to developing strategies that eliminate health disparities and encourage healthcare providers to critically evaluate their practices to ensure equity in care.

Background

In 2000, HHS launched the Healthy People 2010 initiative, aiming to enhance the overall health of Americans while eliminating racial and ethnic health disparities. A pivotal report[1] by the Institute of Medicine (IOM) in 2003 highlighted the existence of these disparities and deemed them unacceptable due to their association with adverse health outcomes. This report has since sparked renewed efforts to comprehend the underlying causes of disparities, identify contributing factors and design effective interventions to mitigate or eliminate these inequities.

CarePlus initiatives

CarePlus is committed to delivering healthcare services equitably to all members, regardless of race, ethnicity, age, language, disability, gender identity, socioeconomic status, veteran status or religion. Our initiatives include:

Diverse provider network: We ensure that the number of minority providers within our network reflects the diversity of our member population, enhancing accessibility and cultural relevance in care.

Community partnerships: We actively partner with underserved communities through corporate national grants aimed at removing barriers to healthy living and facilitating access to quality healthcare services.

Bilingual support services: Our member service representatives are fluent in both English and Spanish, and we maintain a Spanish-language website to ensure accessibility for all members and visitors.

Cultural competency education: We mandate cultural competency training for all CarePlus associates, fostering an understanding of diverse cultural needs and promoting equitable care delivery.

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 is committed to enhancing awareness of care disparities and promoting equitable, culturally competent care by providing physicians and other healthcare providers with a variety of resources and materials, including the following tools.

Web-based module for continuing education credit

- ❑ **A Physician's Practical Guide to Culturally Competent Care**, a guide from HHS' Office of Minority Health (9.0 free continuing medical education credits).
  Physician's Site (hhs.gov)

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.
  Culturally and Linguistically Appropriate Services

Toolkits for clear health communication and language services

- ❑ **Ask Me 3™**, Good Questions for Your Good Health, a quick and effective tool from the Institute for Healthcare Improvement that encourages patients and families to ask specific questions to their providers to better understand their health conditions and what they need to do to stay healthy.
  Ask Me 3: Good Questions for Your Good Health (ihi.org)

- ❑ **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.
  Guide to Providing Effective Communication and Language Assistance Services (hclsig.thinkculturalhealth.hhs.gov)

Frameworks and guidelines for culturally appropriate care

- ❑ **National Healthcare Quality and Disparities Reports**, a collection of the annual reports that track disparities related to the quality of and access to healthcare, published by AHRQ.
  National Healthcare Quality and Disparities Reports (ahrq.gov)

- ❑ **One Size Does Not Fit All**: **Meeting the Health Care Needs of Diverse Populations**, a guide from The Joint Commission.
  One Size Does Not Fit All: Meeting the Health Care Needs of Diverse Populations (pdfs.semanticscholar.org)

Additional sources that address healthcare disparities

- ❑ **National Healthcare Quality and Disparities Reports**, a collection of the annual reports that track disparities related to the quality of and access to healthcare, published by AHRQ.
  National Healthcare Quality and Disparities Reports (ahrq.gov)

- ❑ **Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care**, the landmark report that raised awareness of clinical disparities among diverse populations, published by IOM.
  Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care (pubmed.ncbi.nlm.nih.gov)

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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 (MAPD) plans. 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 clinical advisor or provider services executive.

How Are Star Ratings Derived?

An MA health plan's Star Rating is based on measures that fall into 5 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 4 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 incentives.

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 (HEI) 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 adherence[1]
- Create office practices to follow up with referrals to specialist to ensure timely referral processing and knowledge of visit outcomes or care plan
- Review CMS-administered annual surveys, which have been developed to evaluate population health outcomes and patient satisfaction with the healthcare system

1. https://pmc.ncbi.nlm.nih.gov/articles/PMC3442762/

For More Information

To learn more about the CMS Five-star Quality Rating System, visit https://www.cms.gov/newsroom/fact-sheets/2025-medicare-advantage-and-part-d-star-ratings

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

To learn more about the HOS, visit https://www.hosonline.org/en/.

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2026 Centers for Medicare & Medicaid Services (CMS) Star Ratings Measures

Healthcare Effectiveness Data and Information Set (HEDIS®)	
BCS-E	Breast cancer screening
CBP	Controlling blood pressure
COA – FSA	Care for older adults – functional status assessment
COA – MDR	Care for older adults – medication review
COL-E	Colorectal cancer screening
EED	Diabetes care – eye exam
GSD	Diabetes care – blood sugar controlled
FMC	Follow-up after emergency department visit for people with multiple high-risk chronic conditions
OMW	Osteoporosis management in women who had a fracture
PCR	Plan all-cause readmissions
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®) measured March-June of the following year	
CC	Care coordination
CS	Customer service
FLU	Annual flu vaccine
GACQ	Getting appointments and care quickly
GNC	Getting needed care
GNRx	Getting needed prescription drugs (Part D)
RHCQ	Overall rating of health care quality
RDP	Overall rating of drug plan (Part D)
RHP	Overall rating of health plan

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

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

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

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

Patient safety	
COB	Concurrent use of opioids and benzodiazepines
MAD	Medication adherence for diabetes medications
MAH	Medication adherence for hypertension (renin-angiotensin system [RAS] antagonists)
MAC	Medication adherence for cholesterol (statins)
POLY–ACH	Polypharmacy: Use of multiple anticholinergic medications in older adults
POLY–CNS	Polypharmacy: Use of multiple central nervous system active medications in older adults
SUPD	Statin use in persons with diabetes

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 several volumes and includes 93 measures across 6 domains:

- Effectiveness of care
- Access or availability of care
- Experience of care
- Utilization and risk adjusted utilization
- Health plan descriptive information
- Measures reported 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 and Screening Measures

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

Respiratory Condition Measures

- Appropriate Testing for Pharyngitis – The percentage of episodes for members 3 years old 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). 2 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 6 months after discharge.

- Statin Therapy for Patients with Cardiovascular Disease – The percentage of males 21–75 and females 40–75 years old 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%. Members who remained on a high-intensity or moderate-intensity statin medication for at least 80% 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 lung transplantation, or heart valve repair or replacement. 4 rates are reported:

  - Initiation. The percentage of members who attended 2 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

- Glycemic Status Assessment – Percentage of members 18–75 years old 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%)
  - HbA1c poor control (greater than 9%)

- Blood Pressure Control for Patients With Diabetes – Percentage of members 18–75 years old 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%. Members who remained on a statin medication of any intensity for at least 80% 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 4 days or less apart are acceptable for the uACR component.

Musculoskeletal Conditions 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 6 months after the fracture.

- Osteoporosis Screening in Older Women - The percentage of women 65–75 who received osteoporosis screening.

- 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 7 days of the ED visit (8 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 7 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 7 days of the ED visit (8 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 (6 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 Measures

- 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 old 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 2 days after the admission (3 total days).
  - Receipt of Discharge Information. Documentation of receipt of discharge information on the day of discharge or through 2 days after the discharge (3 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 7 days of the ED visit.

Overuse/Appropriateness Measures

- 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 3 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 3 numerators divided by the sum of the 3 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 2 dispensing events for the same high-risk medication. 3 rates are reported:
    - The percentage of Medicare members 67 and older who had at least 2 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 2 dispensing events for high-risk medications to avoid from the same drug class, except for appropriate diagnoses.
    - Total rate (the sum of the 2 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. 3 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 4 or more different prescribers and 4 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 and Availability of Care Measures

- Adults' Access to Preventive or 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

Measures Reported Using Electronic Clinical Data Systems

- Breast cancer screening – Percentage of female members 50-74 years old who had a mammogram any time on or between Oct. 1, 2 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 2 years prior to the measurement year
  - CT colonography during the measurement year or the 4 years prior to the measurement year
  - Flexible sigmoidoscopy during the measurement year or 4 years prior to the measurement year
  - Colonoscopy during the measurement year or 9 years prior to the measurement year

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-E)
- 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 or 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

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

- Submit appropriately coded claims or 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. Participants may complete the survey on the web or by mail. Non-respondents receive a follow-up telephone call and results are available later in the year.

The CAHPS survey 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 66 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 6 months, how often did you get an appointment to see a specialist as soon as you needed?
- In the last 6 months, how often was it easy to get the care, tests or treatment you needed?

Getting Appointments and Care Quickly:

- In the last 6 months, when you needed care right away, how often did you get care as soon as you needed?
- In the last 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 6 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 6 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 6 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 6 months, how often did you and your personal doctor talk about all the prescription medicines you were taking?
- In the last 6 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 6 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 6 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 Medicare enrollees. Like the NCQA's Healthcare Effectiveness Data and Information Set (HEDIS®) measures and the CAHPS program, 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. 2 years later, the same respondents are surveyed for follow-up measurement. Survey completion is voluntary. The difference in the scores for the 2-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.

The 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 3 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 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 $1,276 for 2026

CarePlus MTM Eligibility:

- Have 3 of the 10 core chronic disease conditions listed below
- Take 8 or more chronic maintenance Part D Medications in a 90-day period
- Have anticipated cost of medications above a predetermined dollar amount ($1,276 per year for 2026) (e.g., if a member is expected to spend more than $319 in a quarter, it can be assumed they will spend at least $1,276 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 1 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 – Arthritis (including osteoporosis, osteoarthritis and rheumatoid arthritis)
- Alzheimer's disease
- Diabetes
- Dyslipidemia
- End-stage renal disease (ESRD)
- Human immunodeficiency virus/acquired immunodeficiency syndrome (HIV/AIDS)
- Hypertension
- Chronic congestive heart failure (CHF)

- Respiratory disease (including asthma, chronic obstructive pulmonary disease [COPD] and other chronic drug disorders)
- Mental health (including depression, schizophrenia, bipolar disorder and other chronic or disabling mental health conditions)

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 MedWatchers vendor 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 (TMR) 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. A full list of pharmacies is also available via the Pharmacy Finder Tool at 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 or devices are indicated on the Part B Step Therapy Preferred Drug List at CarePlusHealthPlans.com/CarePlus-Providers/Pharmacy-Resources.

The designation of preferred status does not mean a drug is always exempt from a step therapy requirement. Please refer to the specific criteria contained in our coverage criteria policies, which is posted at CarePlusHealthPlans.com/PAL. Also on that page, you can find the Medicare prior authorization list which displays step therapy indicators on the drugs that are impacted by a step therapy requirement.

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 reward and incentive programs. 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 or 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, LCD and NCD, 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 medically necessary 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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Organization Determinations – Utilization Management Department

CarePlus has a prior authorization 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 prior authorization 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 or prior authorization for specialty care or ancillary services is necessary. PCPs must send a referrals and prior authorization requests to CarePlus prior to the requested services being rendered when a referral or authorization is required. Prior authorization requests to specialists can be completed online via Availity. 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.

- Prior authorization requests should be submitted electronically via Availity (www.availity.com)
- Telephonic prior authorization should be made utilizing 866-220-5448.
    - 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 Utilization Management department.
- Fax requests may be submitted as follows;
    - Dade fax: 1-888-790-9999
    - Broward and Palm Beach fax: 1-866 832-2678

All other counties fax: 1-888-634-3521. Use of the Health Services Prior Authorization form fax requests is preferred.

Providers calling to inquire on an approved authorization will be redirected to utilize Availity.
It is very important the PCP include all 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 Availity. If a request needs to be expedited due to the seriousness of a patient's condition, call 866-220-5448.
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, Humana Medical Coverage Policies, 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 Utilization Management department will issue the adverse determination to the

member and the provider(s), including the right to request an appeal with the health plan for all adverse determinations. CarePlus does not reward doctors, other individuals or plan employees for denying coverage or encourage underuse of services.

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. The CarePlus coverage policies are available on CarePlusHealthPlans.com/PAL.

Advanced Coverage Determinations:

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

Initiate an ACD for medical services by submitting a written, fax or telephone request:

- Mail written request to:
  CarePlus Health Plans Inc.
  P.O. Box 14601
  Lexington, KY, 40512-4601
- Submit by fax to 888-790-9999
- Submit by telephone at 866-220-5448

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 prior authorization 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 7 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)

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.

TRANSPLANT SERVICES

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 sure 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 notification directly to CarePlus in **Availity**. Prior authorization (PA) is only required when the patient is ready to receive the transplant. All other services, including listing and post-transplant care, do not require PA.

Notification and Transplant PA Requests: Availity
Phone: 866-421-5663
Fax: 502-508-9300

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 inpatient and observation admissions.
Elective Admissions:

- When a PCP or specialist identifies the need to schedule a hospital admission, refer to the Prior authorization List for services requiring authorization. Prior authorization must be submitted to the CarePlus Pre-certification department at least 7 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 prior authorization 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 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 Utilization Management department will issue an adverse determination notice to the member and the provider(s), including the right to request an appeal with the health plan.

Concurrent Inpatient Admissions:

- The hospital will be responsible for notifying the PCP and CarePlus of the admission within 24 hours after the member's admission.
- Each admission will be reviewed for medical necessity and compliance with contractual requirements.
- Notification of admission after a member's discharge will result in a retrospective medical necessity review.
- If the admission does not meet medical necessity criteria or the plan is not able to obtain necessary information, the authorization request may not be approved.
- In case of an adverse determination by a CarePlus medical director, the CarePlus Utilization Management department will issue an adverse determination notice to the member and the provider(s), including the right to request an appeal with the health plan.
- Upon discharge of a CarePlus member, providers must inform the plan of the discharge date and disposition.

Discharge Planning

- The objective of discharge planning is to facilitate an appropriate and safe transition of care.
- The hospital's attending physician/PCP are responsible for establishing the discharge plan.
- The facility is responsible for submitting ALL discharge related orders (e.g., infusion, home health care [HHC] and durable medical equipment [DME]) directly to the plan's provider. Any post discharge follow-up appointment and transportation should be coordinated with the PCP office.
- In the case of a complex discharge need, a Utilization Management associate will collaborate with the facility case management staff, attending physician or other healthcare providers as needed to help facilitate a safe discharge.

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

CMS requires that hospitals deliver the Important Message from Medicare (IM) to all Medicare beneficiaries, including MA plan members who are hospital inpatients. Hospitals are required to provide the IM to the MA member upon admission and at least 2 days prior to the anticipated last covered date. The notice must be given on the standardized CMS IM form.

The form and instructions regarding the IM are on the CMS website at CMS.gov Medicare General Information Beneficiary Notices Initiative.

The IM informs hospitalized MA beneficiaries about their hospital discharge appeal rights. MA members who are hospital inpatients have the statutory right to request an "immediate review" by a quality improvement organization (QIO) when CarePlus, along with the hospital and physician, determines that inpatient care is no longer necessary.

Guidelines for IM notification by telephone: If the hospital staff is unable to personally deliver the IM to the patient or their representative, then the hospital staff should telephone the patient or representative to advise them of a member's rights as a hospital patient, including the right to appeal a discharge decision. At a minimum, the telephone notification should include:

- The name and telephone number of a contact at the hospital
- The beneficiary's planned discharge date and the date when the beneficiary's liability begins
- The beneficiary's rights as a hospital patient, including the right to appeal a discharge decision
- How to get a copy of a detailed notice describing why the hospital staff and physician believe the beneficiary is ready to be discharged
- A description of the steps for filing an appeal
- When (by what time/date) the appeal must be filed to take advantage of the liability protections
- To whom to appeal, including any applicable name, address, telephone number, fax number or other method of communication the entity requires to receive the appeal in a timely fashion

Note: The date the hospital staff conveys this information to the representative, whether in writing or by telephone, is the date of receipt of the notice.

The hospital is required to:

- Confirm the telephone contact by written notice mailed to the member's authorized representative on that same date.
- Place a dated copy of the notice in the member's medical file and document the telephone contact with either the member or their representative on either the notice itself or in a separate entry in the member's file.
- Ensure the documentation indicates the staff person told the member or representative the planned discharge 17 date, the date that the beneficiary's financial liability begins, the beneficiary's appeal rights and how and when to initiate an appeal.
- Ensure the documentation includes the name of the staff person initiating the contact, the name of the member or representative contacted by phone, the date and time of telephone contact and the telephone number called.
- When direct phone contact with a member or a member's representative cannot be made, the hospital must:

- Send the notice to the member or representative by certified mail (return receipt requested) or via another delivery method that requires signed verification of delivery. The date of signed verification of delivery (or refusal to sign the receipt) is the date received.
- Place a copy of the notice in the member's medical file and document the attempted telephone contact to the member or their representative.
- Ensure that the documentation includes:
  - The name of the staff person initiating the contact
  - The name of the member or member's representative
  - The date and time of the attempted call
  - The telephone number called

Right to appeal a hospital discharge: When members choose to appeal a discharge decision, the hospital or their Medicare health plan must provide them with the Detailed Notice of Discharge (DND). These requirements were published in a final rule, CMS-4105-F: Notification of Hospital Discharge Appeal Rights, which became effective July 2, 2007.

When the CMS QIO notifies the hospital and CarePlus of an appeal, CarePlus will provide the hospital with a DND. The hospital is responsible for delivering the DND as soon as possible to the member or their authorized representative on behalf of CarePlus, but no later than noon of the day after the QIO notifies CarePlus or the hospital of the appeal. The facility must fax a copy of the DND to the QIO and to CarePlus.

For more information about notification of termination requirements, hospitals can visit the CMS website at CMS.gov Medicare General Information Beneficiary Notices Initiative.

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MEDICARE OUTPATIENT OBSERVATION NOTICE (MOON)

The Federal Notice of Observation Treatment and Implication for Care Eligibility Act (NOTICE ACT) Public Law 114-42 was passed Aug. 6, 2015, and amended Section 1866(a)(1) of the Social Security Act. The amendment requires hospitals and critical access hospitals (CAHs) to provide the MOON to Original Medicare beneficiaries and MA plan members or their authorized representatives. This includes beneficiaries who do not have Part B coverage, beneficiaries who are subsequently admitted as an inpatient prior to the required delivery of the MOON and beneficiaries for whom Medicare is the primary or secondary payer. The MOON is intended to inform beneficiaries who receive observation services for more than 24 hours that they are outpatients, not inpatients, and the reasons for their status.

Important information:

- Effective March 8, 2017, hospitals and CAHs are responsible to provide the written MOON and a verbal explanation of the notice to all Original Medicare and MA beneficiaries who receive outpatient observation services for more than 24 hours.
- The MOON must be provided to the beneficiary (or the beneficiary's authorized representative) no later than 36 hours after observation services begin and may be delivered before a beneficiary receives 24 hours of observation services as an outpatient.
- If the beneficiary is transferred, discharged or admitted, the MOON still must be delivered no later than 36 hours following initiation of observation services.
- The start time of observation services is measured as the clock time observation services are initiated in accordance with a physician's order.
- Hospitals and CAHs must use the Office of Management and Budget (OMB)-approved MOON (CMS-10611) and instructions available on the CMS website at CMS.gov Medicare General Information Beneficiary Notices Initiative.
- Additional information about the MOON can be found on the CMS Medicare Learning Network site (MLN Matters No. 9935) CMS.Gov Medicare FFS MA Moon information/bni.

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

CMS requires that physicians and other healthcare providers give the Notice of Medicare Non-Coverage (NOMNC) to MA health plan members at least 2 days prior to termination of SNF, home health agency (HHA) or comprehensive outpatient rehabilitation facility (CORF) services. Additionally, if the member's SNF services are expected to be fewer than 2 calendar days, the NOMNC should be delivered at the time of admission. For HHA or CORF services, the notice needs to be given no later than the next-to-the-last time services are furnished. The NOMNC informs members how to request an expedited determination from their QIO if they disagree with the termination.

The form and instructions regarding the NOMNC are available on the CMS website at CMS.gov.

Practitioners also can contact their quality improvement organizations (QIO) for forms or additional information. Forms also can be obtained from CarePlus' local health services UM department. No modification of the text on the CMS NOMNC is allowed.

For the NOMNC to be valid:

- The member must be able to comprehend and fully understand the notice contents.
- The member or their authorized representative must sign and date the notice as proof of receipt.
- The notice must be the standardized CMS NOMNC form.

If a member refuses to sign the NOMNC, the member's refusal to sign, the date, time, name of person who witnessed the refusal and their signature must be documented on the NOMNC. Valid delivery does not preclude the use of assistive devices, witnesses or interpreters for notice delivery. Any assistance used with delivery of the notice also must be documented. If a member is not able to comprehend and fully understand the NOMNC, a representative may assume responsibility for decision-making on the member's behalf; in such cases, the representative, in addition to the member, must receive all required notifications. The following specific information is required to be given when contacting a member's representative of the NOMNC by phone:

- The member's last day of covered services and the date when the beneficiary's liability is expected to begin
- The member's right to appeal a coverage termination decision
- A description of how to request an appeal by a QIO
- The deadline to request a review, as well as what to do if the deadline is missed
- The telephone number of the QIO to request the appeal

The date when the information is verbally communicated is considered the NOMNC's receipt date. Practitioners must document the telephone contact with the member's representative on the NOMNC on the day that it is made, indicating all the previous information was included in the communication. The annotated NOMNC also should include:

- The name of the staff person initiating the contact
- The name of the representative contacted by phone
- The date and time of the telephone contact
- The telephone number called

A dated copy of the annotated NOMNC must be placed in the member's medical file, mailed to the representative the same day as the telephone contact and faxed to the practitioner's local CarePlus health services UM department.

Right to appeal a NOMNC (Fast-track Appeal): CMS offers fast-track appeal procedures to Medicare enrollees, including MA members, when coverage of their SNF, HHA or CORF services will soon end. CMS contracts with QIOs to conduct these fast-track appeals.

When notified by CarePlus or the QIO that the member has requested a fast-track appeal, SNFs, HHAs and CORFs must:

- Provide medical records and documentation to CarePlus and the QIO, as requested, no later than close of the calendar day on which they are notified. This includes, but is not limited to, weekends and holidays.
- Deliver the Detailed Explanation Non-Coverage (DENC) form that is provided by CarePlus (or that is delegated to the practitioner to complete) to members or their authorized representatives no later than close of the calendar day on which they are notified, including on weekends and holidays. The DENC provides specific and detailed information concerning why the SNF, HHA or CORF services are ending.

For more information about notification of termination requirements, practitioners can visit the CMS website at: CMS.gov Medicare General Information.

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Program philosophy

CarePlus is committed to delivering quality, cost-efficient healthcare programs that are designed with a personal care approach. CarePlus aims to monitor health conditions and deliver a holistic care management experience, enabling members to better understand and manage their health. All members may request an evaluation for care management services. Our programs incorporate:

- **Educational materials:** to empower members with knowledge.
- **Regular communications:** to keep members informed and engaged.
- **Telephonic assessments:** to provide personalized education and support.

Our care management programs center around the member's PCP, who acts as the primary contact for the direction and management of the member's care. The interdisciplinary care team (ICT) is also engaged as needed, ensuring that care-managed members receive a customized and effective care plan.

Program goals:

- **Patient-centered care:** to provide comprehensive care management programs focused on educating and managing members with comorbidities or those experiencing transitions of care.
- **PCP engagement:** to promote the PCP as a pivotal figure in helping members achieve or maintain optimal health.
- **Continuity of care:** to ensure that healthcare services are consistently provided throughout the member's enrollment with the plan.

Eligibility for care management:

- Members enrolled in a Special Needs Plan (SNP)
- Members identified through a stratification process involving:
    - Medicare data files
    - Behavioral health diagnosis data
    - Utilization metrics (hospital admissions, ER visits, etc.)
    - Pharmacy data
    - Predictive modeling
    - Claims data
    - Health risk assessments (HRA)
- Referrals from PCP or other healthcare providers
- Referrals by CarePlus Utilization Management nurses
- Member self-referral

Services included in care management:

- Care coordination
- Interdisciplinary team approach
- Individualized care plan
- Educational materials regarding disease management or health promotion
- Post-discharge transition of care management
- Referrals for home visits for homebound or high-risk members
- Medication reconciliation
- Community resource assistance

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:** 866-657-5625
  care_plus_care_management_referrals@humana.com
- **For SNP members:** 800-734-9592
  hms_case_management_program@humana.com

Transplant Care Management

CarePlus members who require transplant services may receive specialty case management from experienced care managers and coordinators. The Transplant clinical team provides benefit guidance, direction to National Transplant Network (NTN) facilities and education to members involved in transplant care. The transplant clinical team supports members and providers throughout the pre- and post-transplant process. You can refer a member by contacting the transplant team.

Email: Transplant@humana.com
Phone: 866-421-5663
Fax: 502-508-9300

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CarePlus offers 3 types of Special Needs Plans (SNP) for members who reside within the CarePlus service area:

- CareComplete (HMO C-SNP) and CareComplete Platinum (HMO C-SNP) for individuals diagnosed with at least 1 of the following chronic conditions: cardiovascular disorders, chronic heart failure and/or diabetes
- CareBreeze (HMP C-SNP) and CareBreeze Platinum (HMO C-SNP) for individuals diagnosed with chronic lung disorders
- CareNeeds Plus (HMO D-SNP), CareNeeds Platinum (HMO D-SNP) and CareNeeds Extra (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 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 and 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 1 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 and 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 1 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 (C-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 C-SNP will be involuntarily terminated the last day of the second month.

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.

Verification of Chronic Condition (VCC)

The member listed below has enrolled in a CarePlus Chronic Condition Special Needs Plan (C-SNP). To qualify for this Special Needs Plan, member diagnosis of the qualifying condition(s) must be verified by a physician or physician's office. **Please review the information below and send the completed verification to CarePlus right away. Members whose condition(s) cannot be verified are disenrolled from the plan.**

Member's Name: _____ Date of Birth: _____

Address: _____

CarePlus ID: _____ Medicare ID: _____

Proposed Effective Date: _____

My signature below authorizes information about my chronic condition to be shared with CarePlus. Note: While CarePlus does not require your signature, your physician may require this to release your personal information to us.

_____ _____

Member Signature Date

To Be Completed by the Physician/Physician's Office

Please check all the boxes that apply. By signing this form, you confirm the patient has been diagnosed with one or more of the following severe or disabling chronic conditions.

- ☐ None
- ☐ Diabetes
- ☐ Chronic Heart Failure
- ☐ Chronic Lung Disease: Asthma, Cystic Fibrosis, Emphysema, Chronic Bronchitis, Pulmonary Fibrosis, Pulmonary Hypertension, Chronic Obstructive Pulmonary Disease (COPD)
- ☐ Cardiovascular Disease: Cardiac Arrhythmias, Coronary Artery Disease, Peripheral Vascular Disease, Valvular Heart Disease

Confirmation provided by:

_____ _____

Physician/Office Staff Signature Date

_____ _____

Printed Name or Stamp Phone

Physicians/Office Staff can use the following ways to send the VCC to CarePlus:

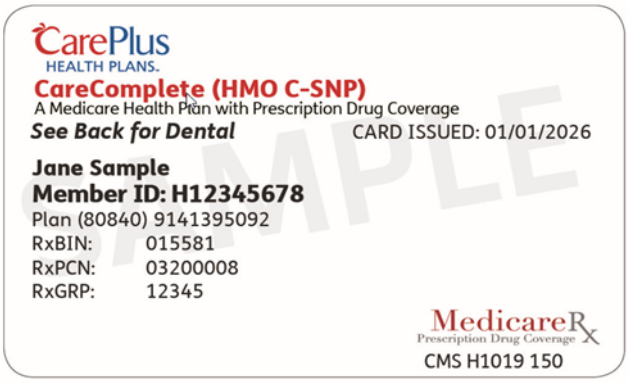
- Fax this completed form to **1-877-889-9936**, or
- Scan this completed form and email to **CarePlus_VCC@careplus-hp.com**, or
- Call us at **1-877-271-5229** (Monday-Friday, 8 a.m. to 6 p.m., Eastern time)

H1019_FLHMSK6EN_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 (HMO C-SNP), CareBreeze Platinum (HMO C-SNP), CareComplete (HMO C-SNP) and CareComplete Platinum (HMO C-SNP)



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 (HMO D-SNP), CareNeeds Platinum (HMO D-SNP) and CareNeeds Extra (HMO D-SNP)*

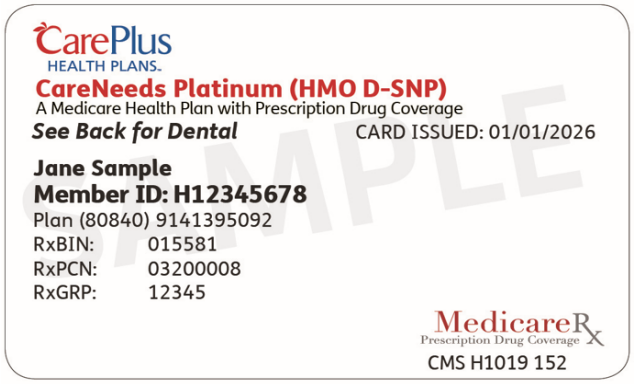
- Entitled to Medicare Part A
- Enrolled in Medicare Part B through age or disability
- Resident within the CarePlus' service area
- Receive some level of assistance from the state Medicaid program
- Qualified Medicare Beneficiary (QMB/QMB+), Specified Low-Income Medicare Beneficiary (SLMB/SLMB+), Full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

  Important Note: All contracted providers caring for CarePlus members enrolled in CareNeeds Plus (HMO D-SNP), CareNeeds Platinum (HMO D-SNP) and CareNeeds Extra (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 Plus (HMO D-SNP), CareNeeds Platinum (HMO D-SNP) and CareNeeds Extra (HMO D-SNP)



Note: If a member loses SNP eligibility and is not reinstated to the plan's qualifying eligibility level within the 6 month deeming period, he or she will be disenrolled from CarePlus.

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. If you have questions, please call the CarePlus' Provider Services at 866-220-5448, Monday – Friday, 8 a.m. to 5 p.m., Eastern time. If you prefer, you can email your inquiries to CPHP_SNPInfo@careplus-hp.com.

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

Physician responsibilities with Medicare Advantage SNP

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/Providers/Educational-Resources/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 and services listings are subject to change on an annual basis. You can contact your assigned provider services executive or call Provider Services at 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 a 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 a 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 their 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 and 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 receiving 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 SNP 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 cost-share protected dual-eligible SNP members (QMB/QMB+, SLMB+ and FBDEs), providers may verify a member's Medicaid eligibility using Availity (www.availity.com). For questions concerning cost-share protected dual eligibles, please call Provider Services for "Eligibility Verification" at 866-220-5448, Monday – Friday, 8 a.m. – 5 p.m., Eastern time.

MANDATORY – Initial and Annual Provider SNP Training

Federal and state regulations require that CarePlus conduct outreach and develop educational materials and/or training to ensure contracted providers understand the benefits available under SNP 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/Providers/Educational-Resources/SNP. Under "CarePlus SNP Provider Training," select "CarePlus SNP Provider Education" to access the training. 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 SNP or if you have any SNP-related questions, please contact your provider services executive, email CarePlus at CPHP_SNPInfo@CarePlus-HP.com or call CarePlus Provider Services at 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. SLMB members are automatically eligible for LIS.
- Qualifying Individuals (QI) – Medicaid program which pays for the Medicare Part B premiums. QI 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 and the 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 for which they may be eligible, including the dual SNP, once per quarter for the first 3 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 program requirements.
**Please check current income and 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 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 3 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 and 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 8 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 disease, sleep and obesity, among many others.

CarePlus Link / Conexión CarePlus

Presentations are accessible to CarePlus members from the comfort of their home and 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 include a guest speaker or facilitator for the session.
- CarePlus Link offers the same presentations as the WE Program.
- 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 at CarePlusHealthPlans.com/Link or by calling Member Services which can be found on the back of the member ID card to have a copy sent by mail.

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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 www.availity.com. If all electronic data interchange (EDI) methods have failed and the provider has contacted their 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 member 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 and group number
- Attach other insurance EOB 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 (when applicable)
- ICD-10 Diagnosis Code(s)
- Date(s) of service
- Place of service and type of service
- CPT-4 HCPCS 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 or 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 8 digit clinical trial number is preceded by the 2 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 8 digit clinical trial number without the 2 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 MA 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 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 non-covered 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 a delay in processing.** Furthermore, if you do not receive a payment or denial within 60 days submitting your claim, please contact CarePlus Provider Services at 866-220-5448.

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

To enroll in EFT/ERA, you must register with Availity at www.availity.com. CarePlus works with Availity to send ERA to physicians and 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 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 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 a PDF of your 835.

CLAIMS STATUS TELEPHONE QUEUE

CarePlus Provider Services can assist with answering inquiries related to billing, status and payment of claims. You can reach Provider Services at 866-220-5448. Hours of operation are Monday – Friday, 8 a.m. – 5 p.m., Eastern time.

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 their 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 their family

When a member has 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 or 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 an 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 – 888-664-4112
  - IVR System –877-602-8816

- Medicare Part B: Provider Contact Center – 866-454-9007
  - IVR System –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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How do I bill for hospice services?

Hospice Care: Overview

If one of your patients has a terminal illness, with about 6 months or less to live, your patient can choose either standard Medicare coverage or hospice care. When someone chooses hospice benefits, they 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 2 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 their terminal illness. One notable 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 they elect hospice coverage, the physician (doctor of medicine or osteopathy) who has the most significant role in their 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 6 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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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 and 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; 8 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.

- The following only applies to disputes concerning Provider Payment Integrity's (PPI) medical record review findings made during the post-payment review of a claim. Providers are offered up to 2 opportunities to dispute the medical record review findings (Levels One and Two). Dispute requests are reviewed by licensed or certified personnel who were not the individuals who made the initial findings.

  - Please submit all levels of disputes to the following address or fax number:
    Humana Provider Payment Integrity Disputes
    P.O. Box 14279
    Lexington, KY 40512-4279
    Fax: 888-815-8912

  Level One
  - Level One disputes will be reviewed by licensed or certified personnel appropriate for the claim type (certified coder, physician, registered nurse, pharmacist, etc.). These personnel are different from the individuals who made the initial findings and those who conduct Level Two reviews.

  Level Two
  - Level Two disputes must be submitted within 60 calendar days from the date of the Level One dispute determination letter. Level Two disputes may be reviewed by an independent and external third-party entity.
  - The third-party entity differs from those who conducted prior reviews. The entity is URAC-accredited with an expansive network of actively licensed medical doctors and coders certified by the American Academy of Professional Coders or the American Health Information Management Association.
  - 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 or state law.
  - Unless otherwise stated in the contract, an in-network qualified healthcare provider may submit a dispute request within 18 months from the receipt of the original claim determination. An out-of-network qualified healthcare provider may submit a dispute request within 180 days from the receipt of the original claim determination.
  - If a provider does not submit a written request to dispute the review findings or if their request is not received within the required time frame, the original review findings will be final.

- 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, 2 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 14601
Lexington, KY 40512-4601

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.

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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 4 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. WC 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, that 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(s) to the payment including but not limited to, claims payment errors, data entry and incorrectly submitted claims, to recovery of over or under payment process.

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PARTICIPATING PROVIDER REQUESTS FOR CLAIMS RECONSIDERATION/DISPUTES

Participating providers can 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 at 866-220-5448 or send a written request to the CarePlus claims address at P.O. Box 14601, Lexington, KY 40512-4601

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 dispute it, providers may do so by contacting CarePlus Provider Services at 866-220-5448 or via written correspondence to the mailing address:

CarePlus Correspondence
P.O. Box 14601
Lexington, KY 40512-4601

When submitting a written request for a dispute/reopening, providers should include all of the following information:

- Provider name
- Provider NPI and Tax ID
- Member name and identification number
- Date of service
- Relationship of the subscriber to the patient
- Claim number
- Charge amount
- Payment amount
- Proposed correct payment amount
- Difference between the amount paid and the proposed correct payment amount
- Brief description of the basis for the contestation request
- Relevant supporting documentation (e.g., medical records, copy of invoice, referral form)

NOTE: Claims disputes must be received by CarePlus within 18 months of the date the claim was paid—unless state or federal law or the agreement requires another time frame—or the claim will not be reopened.

If the provider is unsatisfied with the outcome of the review of their dispute, they can submit a second dispute following the same process outlined above.

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 with and/or your participating provider agreement with said entity.

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 their representative, either orally or in writing to CarePlus. The Grievance or Appeal Form is available for download from our website at CarePlusHealthPlans.com/Grievance.

The member or their representative may also call Member Services at 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 Grievance and Appeals Dept.
P.O. Box 14165
Lexington, KY 40512-4165

If the Grievance or Appeal Form is not used, the member or their representative has the right to submit their 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 or 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 or their representative can call CarePlus' Member Services Department at 800-794-5907,If they use a TTY, call TTY: 711. Have the information detailed above ready for the Member Services representative**.** The member/representative can call 7 days a week, 8 a.m. – 8 p.m. An automated phone system may answer the call during weekends and holidays..

CarePlus reviews grievances and notifies the member and/or their 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 the appropriate settings. QIO submissions must be sent to Acentra Health, Florida's Beneficiary and Family-Centered Quality Improvement Organization (BFCC-QIO) at:

Acentra Health
Beneficiary and Family-centered Care Quality Improvement Organization (BFCC-QIO)
5201 W. Kennedy Blvd., Suite 900
Tampa, FL 33609
Toll-free phone: 888-317-0751
(TTY): 711
Fax: 844-878-7921

Representatives filing on behalf of 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 under the applicable law, the representative will have all 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 or attorney) to act as their representative. However, if a member wishes to appoint a representative to act on their 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/Representative 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 ID 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 their 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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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 5 levels of Medicare appeals:

1. Reconsideration (Part B and C) and Redetermination (Part D)
2. Independent Review Entity (IRE): C2C Innovative Solutions Inc. (Part C and 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 or redetermination:

A member, member's representative or treating physician (subject to the notice requirements listed below) may request a standard reconsideration or redetermination by filing a written request with CarePlus.

The written request may be submitted to the Grievance and Appeals department at the following address or fax number:

Part C Reconsideration Requests

CarePlus Health Plans
CarePlus Grievance & Appeals department
P.O. Box 14165

Part D Redetermination Requests

CarePlus Health Plans
Attention: Grievance & Appeals department
P.O. Box 14165

Lexington, KY 40512-4165
Fax: 888-556-2128

Lexington, KY 40512-4165
Fax: 877-556-7005

Completion of the Grievance or Appeal Form is preferred, but the requestor may submit their 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 or 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. 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-Rights/Appeals. You may also contact our Member Services department to request a redetermination request form.

Standard reconsideration or redeterminations requests from physicians:

- A physician who is providing treatment to a member may, upon providing notice to the member, request a standard reconsideration or redetermination on the member's behalf without submitting a representative form.
  - If the reconsideration or redetermination comes from the member's PCP within CarePlus' network, no member notification is required.
  - If the reconsideration or 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 or redetermination and the member, CarePlus will need to confirm that the physician notified the member about their reconsideration or 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 or redeterminations:

- A member, member's representative, any physician or prescriber regardless of whether they are affiliated with CarePlus, may request that CarePlus expedite a reconsideration or 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 or 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 or redetermination, the member, member's representative, physician or prescriber must submit an oral or written request (See **Requesting a standard reconsideration or redetermination** section above for necessary items) directly to CarePlus by either calling CarePlus (Part C Reconsiderations: 800-794-5907 or Part D Redeterminations: 800-451-4651) or mailing or faxing the request at the contact information noted above.

  Note: While exact words are not required, the physician or 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 or prescriber, then we will process the appeal under expedited time frames.

Time frames:

- A reconsideration or redetermination request must be filed within 65 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 or 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 reconsiderations
    - 30 calendar days for standard requests for an item or service reconsiderations
    - 60 calendar days for payment reconsiderations
  - Part B drug requests
    - 72 hours for expedited requests
    - 7 calendar days for standard requests
  - Part D redeterminations
    - 72 hours for expedited redeterminations
    - 7 calendar days for standard redeterminations
    - 14 calendar days for standard payment redeterminations

NOTE: In some cases, time frames for standard and expedited 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 or coverage determination is upheld by CarePlus, the member or member's representative can seek additional review from the subsequent appeal levels. The CarePlus resolution letter will provide additional information on next level appeals.

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Members enrolled in CareNeeds Plus (HMO D-SNP) or CareNeeds Extra (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, mailing or faxing the request at the contact information noted above (under CarePlus Health Plans).
- A physician or 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 65 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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A service must be medically necessary and covered by the member's contract to be paid by the plan. The plan determines whether services are medically necessary as defined either by the member's summary plan description or Evidence of Coverage. To verify covered or excluded services, check benefits on Availity Essentials (www.availity.com; registration required) or call CarePlus Customer Care department at the number listed on the back of the patient's CarePlus ID card. All services may be subject to applicable copayments, deductibles and coinsurance. CarePlus utilizes the criteria stated within the Clinical Review Guidelines section of this manual for any medical necessity review. You may also refer to a member's EOC for a complete list of member benefits and specific descriptions which may vary by plan. Please refer to CarePlus' PAL at CarePlusHealthPlans.com/PAL for items and services that require authorization.

PHYSICIAN AND 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 AND 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 the

office for an extended period, and it is not reasonable to postpone treatment, given the circumstances).

CarePlus will cover emergent and 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 and board and nursing or 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 may 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 or non-physician practitioner (NPP) order for non-acute hearing assessment unrelated to disequilibrium, hearing aids or examinations for the purpose of prescribing, fitting or changing hearing aids. The service may be performed once every 12 months, per member.

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 may be covered when a member meets all 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 may 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 their 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)

Vision care may include 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 1 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.

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 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 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 are processed by the CarePlus Utilization Management department. Please submit your request utilizing the preferred Health Services Prior Authorization 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 3 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 D_2 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 or general hospital coverage for mental health is the same as any other care received in an acute care facility as an inpatient. Coverage is for unlimited days per stay and there is no limit to the number of stays. Member cost-share may vary based on plan and benefit intervals.

- 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 the 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), CareNeeds Platinum (HMO D-SNP) or CareNeeds Extra (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 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 (ADL) 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 2 of the following ADL: bathing, dressing, toileting, transferring, walking and mobility or eating and feeding. PCP must refer the member to CarePlus' Home Health provider who will authorize services for members who qualify. Only offered on certain CareNeeds Plus (HMO D-SNP), CareNeeds Platinum (HMP D-SNP) and CareNeeds Extra (HMO D-SNP) plans. Please contact CarePlus for details.

D-SNP full duals younger than 21 are eligible for unlimited personal home care if determined medically necessary. This is a Medicaid "wrap" benefit based on CarePlus' D-SNP contract with AHCA.

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), CareNeeds Plus Platinum (HMO D-SNP) or CareNeeds Extra (HMO D-SNP) are covered for up to 120 days in a nursing facility when skilled care is no longer approved and the member is awaiting approval for long-term services and supports.

AMBULANCE SERVICES

Covered ambulance services may 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 for the billed service to be considered medically necessary.

DURABLE MEDICAL EQUIPMENT (DME) AND RELATED SUPPLIES

Covered items may include, but are not limited to wheelchairs, crutches, hospital bed, IV infusion pump, oxygen equipment, nebulizer and walker.

PROSTHETIC DEVICES AND RELATED SUPPLIES

CarePlus may cover devices that replace a 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

Some 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 the 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 non-insulin users) may include:

- Blood glucose monitor, blood glucose test strips and lancet devices. Diabetic monitoring supplies have a 0% co-insurance when obtained from a CarePlus network pharmacy or diabetic supplier.
- 1 pair per calendar year of therapeutic custom-molded shoes (including inserts provided with such shoes) and 2 additional pairs of inserts, or 1 pair of depth shoes and 3 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 may 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 or new patient exam is not covered for most members. This visit is only covered for full dual CarePlus D-SNP members as a Medicaid "wrap" benefit per CarePlus' D-SNP contract with AHCA.

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 or 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 8 may be approved). Refer to CMS guidance and/or the member's EOC for additional criteria. When routine acupuncture is available on a member's plan,

providers should apply visits to routine benefit first before applying to Medicare-covered benefit, as routine benefit is available at no cost to members and Medicare-covered visits may have an associated member copay (varies by plan).

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

Members should be advised to talk with their CarePlus Care Manager for more information about eligibility and available resources.

CAREPLUS SPENDING ACCOUNT CARD

CareEssentials Allowance

Benefit provides members a spending account card preloaded with a monthly allowance that members can use to buy food and produce; OTC products; household supplies from a national network of retailers; non-medical transportation; general supports for living such as rent assistance, internet and utilities; and aging support including household assistive devices, air-quality equipment and pest control. Members must have a qualifying chronic health condition to qualify for this allowance. Please see member's EOC for additional information. Available on CareComplete (150), CareComplete Platinum (109, 121 and 130), CareBreeze (154) and CareBreeze Platinum (118, 123, 124 and 151-002) plans.

OTC + CareEssentials Allowance

Benefit provides members a spending account card preloaded with a monthly allowance that members can use to buy approved OTC health and wellness products at participating retailers or through the plan's approved OTC mail-order vendor, CenterWell Pharmacy. Plus, members who have certain qualifying chronic condition(s) and meet other program criteria may also use the money for eligible groceries,

utilities, rent and more. Please see member's EOC for additional information. Available on CareOne Plus (001, 006, 057 and 113), CareNeeds Platinum (023 and 146), CareNeeds Plus (073), CareNeeds Extra (152 and 153) and CareAccess (144 and 148).

POINT OF SERVICE (POS) SUPPLEMENTAL BENEFIT

Members enrolled in plans with a POS option may access certain Medicare Part A and Part B benefits from non-network providers. Services covered out-of-network (OON) are reflected in the EOC. Most plans with this benefit 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. Members must utilize their network PCP for all primary care 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 3 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.

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 the member's EOC or contact CarePlus for further details.

- SilverSneakers® fitness program
- Meal programs (post hospital or SNF discharge)
- Over-the-counter drugs and supplies
- Smoking cessation (additional counseling sessions available only on CareNeeds Plus (HMO D-SNP), CareNeeds Platinum (HMO D-SNP) and CareNeeds Extra (HMO S-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 (STI) and high intensity behavioral counseling to prevent STI
- Smoking and tobacco-use cessation counseling services

Providers may refer to the Medicare Preventive Services quick reference chart for the most up-to-date list of Medicare-covered preventive services.

DIRECT ACCESS WITHOUT A REFERRAL OR PRIOR AUTHORIZATION

CarePlus members may receive the following services without a referral or prior authorization:

- 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 or 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 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 TIN.

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What is and isn't covered?

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. The information is listed by service area and plan.

Not covered:

There are 3 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 medicine‡
- 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 [OTC] 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 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.

** Some CarePlus plans also cover certain vitamins when prescribed by a provider: Folic acid 1mg, vitamin D_2 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.

‡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 a member is covered by the plan and the amount, if any, the member 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 member, member's appointed representative, or member'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 member may be taking or add to the member'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 member. 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 members 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 member's condition, and
    - The preferred drug would have adverse effects for the member, 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 member'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 member, member's appointed representative, or member'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 member, member's appointed representative, or member's prescribing physician or other prescriber.

If you would like to submit a coverage determination or exception request on behalf of your CarePlus-covered patient, you may contact our CarePlus Clinical Pharmacy Review in one of the following ways:

- Send the request electronically via covermymeds® at www.covermymeds.com/main/prior-authorization-forms/careplus/.
- Call 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 800-310-9071.

For your convenience, you may call the CarePlus Pharmacy Utilization Management Unit at 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 Clinical Pharmacy Review
P. O. Box 14601
Lexington, KY 40512-4601

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 member'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: 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 3 years thereafter or as otherwise required by state regulations and at the discretion of CarePlus.

Required supporting documentation must be submitted with each credentialing application. Such documentation or 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 their 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 their application by calling Provider Services at 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 and providers. Functions of the committee include credentialing, ongoing and periodic assessment of current policies and procedures, recredentialing and the establishment of policies and procedures based on current guidelines and regulations. The physician's or 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 or provider.

Recredentialing: Recredentialing is conducted at least every 3 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 or provider in writing.

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, 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.

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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>

SAMPLE

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>

SAMPLE

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 or 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 the 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 the 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 their 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
P.O. Box 19007
Green Bay, WI 54307

Phone 866-220-5448 ● Fax 866-449-5668 ● Email CPHPProvOpsCompliance@careplus-hp.com

CarePlus HEALTH PLANS

ADMISSION NOTIFICATION FORM

PHONE # 800-220-5448 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:

_____

FACH FACESHEET UPDATED 11/13/2025

Care and communication on your terms

Your privacy and well-being are important to us. There may be times when you want a family member or friend to talk to CarePlus on your behalf.

To make that possible, you must first complete a consent for release of protected health information form. This form will allow you to choose a trusted individual who can have access to your protected health information. We would consider this person to be your family or friend caregiver.

This is not a power of attorney (POA). To have someone help you enroll or to request account changes or updates, you must submit a POA or other authorization under state law to allow them to act on your behalf. You can submit POA and PHI consent forms together.

If you complete the PHI form and grant authorization to someone, we will consider that individual your caregiver who can:

- Speak to CarePlus on your behalf about the plan—but may not make or request any account changes or updates (unless they are your POA or have other legal authorization from the state to act on your behalf)
- Keep track of your benefits and claims
- Get answers to healthcare coverage questions
- Receive helpful information and advice on caregiving from CarePlus

How to get started*

You have three options for completing and submitting your consent form.

1. If you have a MyCarePlus account or plan to create one after enrolling, you can complete a consent form online from the "My Resources" page.
2. Your agent can utilize one of our sales systems to help you complete a consent form electronically as part of your enrollment.
3. Complete the paper form included with this packet (after you have submitted your application and received your CarePlus member ID card).

You don't need to use this consent form to authorize an individual if you are also submitting a POA or other legal authorization for the same individual.

*If you have previously submitted a consent form for this individual, you do not need to submit again at this time. We will notify you if your consent is due to expire.

Consent for release of PHI

CarePlus HEALTH PLANS

Consent for release of protected health information

Member information (person whose information will be released):

Name: _____ Date of birth: ____ / ____ / ____
First Middle Last Month Day Year

Address: _____
Street City State ZIP

Member ID: _____ Phone #: _____ ☐ Home ☐ Cell*

I understand that this authorization will allow CarePlus and its affiliates to use or disclose the protected health† information (PHI) described below:

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: ____ / ____ / ____
Month Day Year

Address: _____
Street City State ZIP

Email: _____ Phone #: _____
☐ Home ☐ Cell*

Relationship: ☐ Spouse ☐ Sibling ☐ Parent ☐ Child ☐ Agent/Broker ☐ Friend ☐ Organization

I understand:

- I am not required to fill out this consent and CarePlus cannot base decisions regarding treatment, payment, enrollment or eligibility for benefits on whether I submit it.
- Disclosures may include information from past, present, and/or future treating providers.
- This consent is valid until I cancel my CarePlus membership. I can cancel my consent at any time through my MyCarePlus account or 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.

Member or Legal Representative signature _____

☐ Member ☐ Legal Representative Date: ____ / ____ / ____

Please note: **Legal representatives must attach copies of authorization 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., P.O. 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.
CarePlus will follow the more stringent of all federal and state laws and regulations.

H1019_FLHMQ3YEN_C For CarePlus Use Only

CarePlus HEALTH PLANS.

Notice of Availability - Auxiliary Aids and Services Notice

English: Free language, auxiliary aid, and alternate format services are available. Call **1-800-794-5907 (TTY: 711)**.

العربية [Arabic]: تتوفر خدمات اللغة والمساعدة الإضافية والتنسيق البديل مجانًا. اتصل على الرقم **1-800-794-5907 (الهاتف النصي: 711)**.

Հայերեն [Armenian]: Հասանելի են անվճար լեզվական, աջակցման և այլընտրանքային ձևաչափի ծառայություններ: Զանգահարե՛ք՝ **1-800-794-5907 (TTY: 711)**:

বাংলা Bengali: বিনামূল্যে ভাষা, আনুষঙ্গিক সহায়তা, এবং বিকল্প বিন্যাসে পরিষেবা উপলব্ধ। ফোন করুন **1-800-794-5907 (TTY: 711)** নম্বরে।

简体中文 Simplified Chinese：我们可提供免费的语言、辅助设备以及其他格式版本服务。请致电 **1-800-794-5907**（听障专线：**711**）。

繁體中文 Traditional Chinese：我們可提供免費的語言、輔助設備以及其他格式版本服務。請致電 **1-800-794-5907（聽障專線：711）**。

Kreyòl Ayisyen Haitian Creole: Lang gratis, èd oksilyè, ak lòt fòma sèvis disponib. Rele **1-800-794-5907 (TTY: 711)**.

Hrvatski Croatian: Dostupni su besplatni jezik, dodatna pomoć i usluge alternativnog formata. Nazovite **1-800-794-5907 (TTY: 711)**.

فارسی [Farsi]: خدمات زبان رایگان، کمک های اضافی و فرمت های جایگزین در دسترس است. با **1-800-794-5907 (TTY: 711)** تماس بگیرید.

Français French: Des services gratuits linguistiques, d'aide auxiliaire et de mise au format sont disponibles. Appeler le **1-800-794-5907 (TTY: 711)**.

Deutsch German: Es stehen kostenlose unterstützende Hilfs- und Sprachdienste sowie alternative Dokumentformate zur Verfügung. Telefon: **1-800-794-5907 (TTY: 711)**.

Ελληνικά Greek: Διατίθενται δωρεάν γλωσσικές υπηρεσίες, βοηθήματα και υπηρεσίες σε εναλλακτικές προσβάσιμες μορφές. Καλέστε στο **1-800-794-5907 (TTY: 711)**.

ગુજરાતી Gujarati: નિઃશુલ્ક ભાષા, સહાયક સહાય અને વૈકલ્પિક ફોર્મેટ સેવાઓ ઉપલબ્ધ છે. **1-800-794-5907 (TTY: 711)** પર કૉલ કરો.

עברית Hebrew: שירותים אלה זמינים בחינם: שירותי תרגום, אביזרי עזר וטקסטים בפורמטים חלופיים. נא התקשר למספר **1-800-794-5907 (TTY: 711)**

Hmoob Hmong: Muaj kev pab txhais lus, pab kom hnov suab, thiab lwm tus qauv pab cuam. Hu **1-800-794-5907 (TTY: 711)**.

This notice is available at **CarePlusHealthPlans.com/MLI**.

GHHNOA2025CP

Italiano Italian: Sono disponibili servizi gratuiti di supporto linguistico, assistenza ausiliaria e formati alternativi. Chiama il numero **1-800-794-5907 (TTY: 711)**.

日本語 Japanese:言語支援サービス、補助支援サービス、代替形式サービスを無料でご利用いただけます。**1-800-794-5907 (TTY: 711)** までお電話ください。

ភាសាខ្មែរ Khmer៖ សេវាកម្មផ្នែកភាសា ជំនួយ និង សេវាកម្មជាទម្រង់ផ្សេងជំនួសអាចរកបាន។ ទូរសព្ទទៅលេខ **1-800-794-5907 (TTY: 711)**។

한국어 Korean: 무료 언어, 보조 지원 및 대체 형식 서비스를 이용하실 수 있습니다. **1-800-794-5907 (TTY: 711)**번으로 문의하십시오.

Diné Navajo: Saad t'áá jiik'eh, t'áadoole'é binahjį' bee adahodooníłígíí diné bich'į' anídahazt'i'í, dóó łahgo át'éego bee hada'dilyaaígíí bee bika'aanída'awo'í dahóló. Kohjį' hodíilnih **1-800-794-5907 (TTY: 711)**.

Polski Polish: Dostępne są bezpłatne usługi językowe, pomocnicze i alternatywne formaty. Zadzwoń pod numer **1-800-794-5907 (TTY: 711)**.

Português Portuguese: Estão disponíveis serviços gratuitos de ajuda linguística auxiliar e outros formatos alternativos. Ligue **1-800-794-5907 (TTY: 711)**.

ਪੰਜਾਬੀ Punjabi: ਮੁਫ਼ਤ ਭਾਸ਼ਾ, ਸਹਾਇਕ ਸਹਾਇਤਾ, ਅਤੇ ਵਿਕਲਪਿਕ ਫਾਰਮੈਟ ਸੇਵਾਵਾਂ ਉਪਲਬਧ ਹਨ। **1-800-794-5907 (TTY: 711)** 'ਤੇ ਕਾਲ ਕਰੋ।

Русский Russian: Предоставляются бесплатные услуги языковой поддержки, вспомогательные средства и материалы в альтернативных форматах. Звоните по номеру **1-800-794-5907 (TTY: 711)**.

Español Spanish: Los servicios gratuitos de asistencia lingüística, ayuda auxiliar y servicios en otro formato están disponibles. Llame al **1-800-794-5907 (TTY: 711)**.

Tagalog Tagalog: Magagamit ang mga libreng serbisyong pangwika, serbisyo o device na pantulong, at kapalit na format. Tumawag sa **1-800-794-5907 (TTY: 711)**.

தமிழ் Tamil: இலவச மொழி, துணை உதவி மற்றும் மாற்று வடிவ சேவைகள் உள்ளன. **1-800-794-5907 (TTY: 711)** ஐ அழைக்கவும்.

తెలుగు Telugu: ఉచిత భాష, సహాయక మద్దతు, మరియు ప్రత్యామ్నాయ ఫార్మాట్ సేవలు అందుబాటులో గలవు. **1-800-794-5907 (TTY: 711)** కి కాల్ చేయండి.

(TTY: 711) 1-800-794-5907 مفت زبان، معاون امداد، اور متبادل فارمیٹ کی خدمات دستیاب ہیں۔ کال Urdu: اردو

Tiếng Việt Vietnamese: Có sẵn các dịch vụ miễn phí về ngôn ngữ, hỗ trợ bổ sung và định dạng thay thế. Hãy gọi **1-800-794-5907 (TTY: 711)**.

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB No. 0938-0950
Expires: 08/31/2025

Appointment of Representative

Use this form to appoint a representative to act on your behalf for your claim, appeal, grievance or request. By signing this form and appointing this representative, you agree that the representative will be the main contact and have authority to make requests, present evidence, get information, and receive all communication about your action. This person may see your personal medical information. **All fields in Sections 1 and 2 are required unless marked optional.**

Section 1: Information about the person appointing the representative

This section must be completed by the patient, provider or other person appointing a representative.

Name	Medicare Number or National Provider Identifier
Mailing address	Phone number (with area code) ( ) -
City	State / ZIP code
Email (optional)	Fax (optional) ( ) -
Signature	Date signed (mm/dd/yyyy) / /

Section 2: Information about the representative

This section must be completed by the representative.

Representative name

Professional status or relationship to the person in Section 1 (attorney, relative, etc.)

Mailing address	Phone number (with area code) ( ) -
City	State / ZIP code
Email (optional)	Fax (optional) ( ) -

By signing below, you agree to act as a representative and certify that you haven't been disqualified, suspended, or prohibited from practice before the Department of Health and Human Services (HHS) or otherwise disqualified from acting as a representative. Any fee to be charged for acting as a representative may be subject to review and approval by the Secretary. If you're charging a fee, go to instructions on page 2.

Signature	Date signed (mm/dd/yyyy) / /

Representative must complete the sections below, if applicable (go to instructions on page 2)

Section 3: Waiver of fee for representation

Providers and suppliers who furnished the items or services at issue can't charge a fee for representation and must sign below to waive their fee. Representatives who choose to waive their fee for representation must also sign below.

I waive my right to charge and collect a fee for representing the person in Section 1 before the Secretary of HHS.

Signature	Date signed (mm/dd/yyyy) / /

Section 4: Waiver of payment for items or services at issue

If you're a provider or supplier and you furnished items or services to the patient you're representing, if the appeal involves a question of whether you or the patient didn't know, or couldn't reasonably be expected to know, that Medicare wouldn't cover the items or services.

I waive my right to collect payment from the patient for the items or services at issue in this appeal if a determination of liability under §1879(a)(2) of the Act is made.

Signature	Date signed (mm/dd/yyyy) / /

Instructions and Regulation Requirements

Instructions

All fields in Sections 1 and 2 are required unless marked "optional." If the person or entity appointing a representative doesn't have a Medicare number or National Provider Identifier, fill in "not applicable." Go to the regulation at 42 CFR 405.910: **ECFR.gov/current/title-42/chapter-IV/subchapter-B/part-405/subpart-I/section-405.910**

Waiver of Fee for Representation Section 3 is required when a representative is required, or has agreed, to waive or not charge a fee for their representation. Waiver of Payment for Items or Services at Issue Section 4 is required if a provider or supplier who furnished items or services to the patient represents the patient and liability (knowledge of non-coverage) under §1879(a)(2) of the Act is at issue in the appeal. Go to 42 CFR 405.910(f).

An appointment of a representative is considered valid for one year from the date this form is signed by both the person appointing a representative and the appointed representative. A completed form can be used for other appeals or actions during the one-year period it's valid. Unless revoked, the representation is valid for the duration of the claim, appeal, grievance, or request for which it was filed.

Charging fees for representing patients before the Secretary of HHS

An attorney, or other representative for a patient, who wants 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 have the fee approved in accordance with 42 CFR 405.910(f).

The representative should complete the form OMHA-118, "Petition to Obtain Approval of a Fee for Representing a Beneficiary" and file it with the request for ALJ hearing, OMHA review, or request for Medicare Appeals Council review. Fee approval 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 approved the fee; (3) the fee is for representing a patient in a proceeding in federal district court; or (4) the fee is for representing a patient in a redetermination or reconsideration. Representatives are permitted to waive their fee if they choose. Get form OMHA-118 here: **HHS.gov/sites/default/files/OMHA-118.pdf**

A provider or supplier who furnished the items or services to a Medicare patient that are the subject of the appeal may represent that patient in an appeal, but the provider or supplier may not charge the beneficiary any fee associated with the representation. (42 CFR 405.910(f)(3).)

Approval of fee

The fee approval requirement ensures that a representative is paid fairly for their services and that patient fees are 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, the amount of time spent on the case, the results achieved, the level of administrative review needed, and the amount of the fee requested.

Conflict of interest

Sections 203, 205 and 207 of Title XVIII of the United States Code make it a criminal offense for certain current and former officers and employees of the United States to render certain services in matters affecting the government or to aid or assist in prosecuting claims against the United States. Individuals with a conflict of interest are excluded from serving as representatives of patients before HHS.

Where to send this form

Send this form to the same location you send your claim, appeal, grievance, or request.

Get help & more information

For questions about this form, contact your Medicare plan or call 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048.

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 **Medicare.gov/about-us/accessibility-nondiscrimination-notice**, or call 1-800-MEDICARE for more information.

Paperwork Reduction Act: 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.

Notice of Availability - Auxiliary Aids and Services Notice

English: Free language, auxiliary aid, and alternate format services are available. Call **1-800-794-5907 (TTY: 711)**.

العربية [Arabic]: تتوفر خدمات اللغة والمساعدة الإضافية والتنسيق البديل مجانًا. اتصل على الرقم **1-800-794-5907 (الهاتف النصي: 711)**.

Հայերեն [Armenian]: Հասանելի են անվճար լեզվական, աջակցման և այլընտրանքային ձևաչափի ծառայություններ: Զանգահարե՛ք՝ **1-800-794-5907 (TTY: 711)**:

বাংলা Bengali: বিনামূল্যে ভাষা, আনুষঙ্গিক সহায়তা, এবং বিকল্প বিন্যাসে পরিষেবা উপলব্ধ। ফোন করুন **1-800-794-5907 (TTY: 711)** নম্বরে।

简体中文 Simplified Chinese：我们可提供免费的语言、辅助设备以及其他格式版本服务。请致电 **1-800-794-5907**（听障专线：**711**）。

繁體中文 Traditional Chinese：我們可提供免費的語言、輔助設備以及其他格式版本服務。請致電 **1-800-794-5907（聽障專線：711）**。

Kreyòl Ayisyen Haitian Creole: Lang gratis, èd oksilyè, ak lòt fòma sèvis disponib. Rele **1-800-794-5907 (TTY: 711)**.

Hrvatski Croatian: Dostupni su besplatni jezik, dodatna pomoć i usluge alternativnog formata. Nazovite **1-800-794-5907 (TTY: 711)**.

فارسی [Farsi]: خدمات زبان رایگان، کمک های اضافی و فرمت های جایگزین در دسترس است. با **1-800-794-5907 (TTY: 711)** تماس بگیرید.

Français French: Des services gratuits linguistiques, d'aide auxiliaire et de mise au format sont disponibles. Appeler le **1-800-794-5907 (TTY: 711)**.

Deutsch German: Es stehen kostenlose unterstützende Hilfs- und Sprachdienste sowie alternative Dokumentformate zur Verfügung. Telefon: **1-800-794-5907 (TTY: 711)**.

Ελληνικά Greek: Διατίθενται δωρεάν γλωσσικές υπηρεσίες, βοηθήματα και υπηρεσίες σε εναλλακτικές προσβάσιμες μορφές. Καλέστε στο **1-800-794-5907 (TTY: 711)**.

ગુજરાતી Gujarati: નિઃશુલ્ક ભાષા, સહાયક સહાય અને વૈકલ્પિક ફોર્મેટ સેવાઓ ઉપલબ્ધ છે. **1-800-794-5907 (TTY: 711)** પર કૉલ કરો.

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Hmoob Hmong: Muaj kev pab txhais lus, pab kom hnov suab, thiab lwm tus qauv pab cuam. Hu **1-800-794-5907 (TTY: 711)**.

This notice is available at **CarePlusHealthPlans.com/MLI**.

GHHNOA2025CP

Italiano Italian: Sono disponibili servizi gratuiti di supporto linguistico, assistenza ausiliaria e formati alternativi. Chiama il numero **1-800-794-5907 (TTY: 711)**.

日本語 Japanese:言語支援サービス、補助支援サービス、代替形式サービスを無料でご利用いただけます。**1-800-794-5907 (TTY: 711)** までお電話ください。

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한국어 Korean: 무료 언어, 보조 지원 및 대체 형식 서비스를 이용하실 수 있습니다. **1-800-794-5907 (TTY: 711)**번으로 문의하십시오.

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Русский Russian: Предоставляются бесплатные услуги языковой поддержки, вспомогательные средства и материалы в альтернативных форматах. Звоните по номеру **1-800-794-5907 (TTY: 711)**.

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Tagalog Tagalog: Magagamit ang mga libreng serbisyong pangwika, serbisyo o device na pantulong, at kapalit na format. Tumawag sa **1-800-794-5907 (TTY: 711)**.

தமிழ் Tamil: இலவச மொழி, துணை உதவி மற்றும் மாற்று வடிவ சேவைகள் உள்ளன. **1-800-794-5907 (TTY: 711)** ஐ அழைக்கவும்.

తెలుగు Telugu: ఉచిత భాష, సహాయక మద్దతు, మరియు ప్రత్యామ్నాయ ఫార్మాట్ సేవలు అందుబాటులో గలవు. **1-800-794-5907 (TTY: 711)** కి కాల్ చేయండి.

(TTY: 711) 1-800-794-5907 مفت زبان، معاون امداد، اور متبادل فارمیٹ کی خدمات دستیاب ہیں۔ کال Urdu: اردو

Tiếng Việt Vietnamese: Có sẵn các dịch vụ miễn phí về ngôn ngữ, hỗ trợ bổ sung và định dạng thay thế. Hãy gọi **1-800-794-5907 (TTY: 711)**.

Grievance or Appeal Form

CarePlus HEALTH PLANS

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 Grievance and Appeals Dept.
P.O. Box 14165
Lexington, KY 40512-4165

Fax Number: 888-556-2128

If you need assistance with this form, please call Member Services at **800-794-5907**. If you use a TTY, call **711.** You can call us seven days a week, from 8 a.m. to 8 p.m. Please note that our automated phone system may answer your call during weekends and holidays. For 24-hour service, you can visit us at **CarePlusHealthPlans.com**.

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? ☐ Yes ☐ No *If yes, please include a copy of the bill, receipt or proof of payment (receipts).	
Service date(s) (MM/DD/YY) *N/A if care has not been received Claim number	
Claim number (if you have one)	

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.

_____

_____

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_____

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?

- ☐ Explanation of Benefits
- ☐ Medical bill(s)
- ☐ Medical records
- ☐ Receipts (Proof of Payment)
- ☐ Letter from your provider
- ☐ 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.

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 CarePlusHealthPlans.com/members/forms-tools-resources requested by contacting Member Services at 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_GRVAPLForm2026_C

Notice of Availability - Auxiliary Aids and Services Notice

English: Free language, auxiliary aid, and alternate format services are available. Call **1-800-794-5907 (TTY: 711)**.

العربية [Arabic]: تتوفر خدمات اللغة والمساعدة الإضافية والتنسيق البديل مجانًا. اتصل على الرقم **1-800-794-5907 (الهاتف النصي: 711)**.

Հայերեն [Armenian]: Հասանելի են անվճար լեզվական, աջակցման և այլընտրանքային ձևաչափի ծառայություններ: Զանգահարե՛ք՝ **1-800-794-5907 (TTY: 711)**:

বাংলা Bengali: বিনামূল্যে ভাষা, আনুষঙ্গিক সহায়তা, এবং বিকল্প বিন্যাসে পরিষেবা উপলব্ধ। ফোন করুন **1-800-794-5907 (TTY: 711)** নম্বরে।

简体中文 Simplified Chinese：我们可提供免费的语言、辅助设备以及其他格式版本服务。请致电 **1-800-794-5907**（听障专线：**711**）。

繁體中文 Traditional Chinese：我們可提供免費的語言、輔助設備以及其他格式版本服務。請致電 **1-800-794-5907（聽障專線：711）**。

Kreyòl Ayisyen Haitian Creole: Lang gratis, èd oksilyè, ak lòt fòma sèvis disponib. Rele **1-800-794-5907 (TTY: 711)**.

Hrvatski Croatian: Dostupni su besplatni jezik, dodatna pomoć i usluge alternativnog formata. Nazovite **1-800-794-5907 (TTY: 711)**.

فارسی [Farsi]: خدمات زبان رایگان، کمک های اضافی و فرمت های جایگزین در دسترس است. با **1-800-794-5907 (TTY: 711)** تماس بگیرید.

Français French: Des services gratuits linguistiques, d'aide auxiliaire et de mise au format sont disponibles. Appeler le **1-800-794-5907 (TTY: 711)**.

Deutsch German: Es stehen kostenlose unterstützende Hilfs- und Sprachdienste sowie alternative Dokumentformate zur Verfügung. Telefon: **1-800-794-5907 (TTY: 711)**.

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اردو Urdu: مفت زبان، معاون امداد، اور متبادل فارمیٹ کی خدمات دستیاب ہیں۔ کال **(TTY: 711) 1-800-794-5907**

Tiếng Việt Vietnamese: Có sẵn các dịch vụ miễn phí về ngôn ngữ, hỗ trợ bổ sung và định dạng thay thế. Hãy gọi **1-800-794-5907 (TTY: 711)**.

REQUEST FOR MEDICARE PRESCRIPTION DRUG COVERAGE DETERMINATION

This form may be sent to us by mail or fax:

Address:
CarePlus Health Plans, Inc.
Attention: CarePlus Clinical Pharmacy Review
P. O. Box 14165
Lexington, KY 40512-4165

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 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 PHACDRequestForm2026 C 1

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.

☐ 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:**

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 timeframe 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: ☐ **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. (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)		**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 (if quantity limit is an issue, list unit dose/total daily dose tried)	**DATES of Drug Trials**	**RESULTS of previous drug trials FAILURE vs INTOLERANCE (explain)**

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?	☐ **YES**	☐ **NO**
Any concern for a **DRUG INTERACTION** with the addition of the requested drug to the enrollee's current drug regimen?	☐ **YES**	☐ **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?	☐ **YES**	☐ **NO**
OPIODS – (please complete the following questions if the requested drug is an opioid)		
What is the daily cumulative Morphine Equivalent Dose **(MED)**?	_____	**mg/day**
Are you aware of other opioid prescribers for this enrollee? If so, please explain.	☐ **YES**	☐ **NO**
Is the stated daily MED dose noted medically necessary?	☐ **YES**	☐ **NO**
Would a lower total daily MED dose be insufficient to control the enrollee's pain?	☐ **YES**	☐ **NO**

RATIONALE FOR REQUEST

☐**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]

☐**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.

☐ **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]

☐ **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]

☐ **Other** (explain below)

Required Explanation

_____

_____

_____

_____

Notice of Non-Discrimination

CarePlus Health Plans, Inc. complies with applicable Federal civil rights laws and does not discriminate or exclude people because of their race, color, religion, gender, gender identity, sex, sexual orientation, age, disability, national origin, military status, veteran status, genetic information, ancestry, ethnicity, marital status, language, health status, or need for health services. CarePlus Health Plans, Inc.:

- Provides people with disabilities reasonable modifications and free appropriate auxiliary aids and services to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language assistance services to people whose primary language is not English, which may include:
  - Qualified interpreters
  - Information written in other languages

If you need reasonable modifications, appropriate auxiliary aids, or language assistance services contact **800-794-5907 (TTY: 711)**. If you believe that CarePlus Health Plans, Inc. has not provided these services or discriminated on the basis of race, color, religion, gender, gender identity, sex, sexual orientation, age, disability, national origin, military status, veteran status, genetic information, ancestry, ethnicity, marital status, language, health status, or need for health services, you can file a grievance in person or by mail or email with CarePlus Health Plans, Inc. Non-Discrimination Coordinator at P.O. Box 14618, Lexington, KY 40512-4618, **800-794-5907 (TTY: 711)**, or **Accessibility1@CarePlus-HP.com**. If you need help filing a grievance, CarePlus Health Plans, Inc.'s Non-Discrimination Coordinator can help you.

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- U.S. Department of Health and Human Services, 200 Independence Avenue, S.W., Room 509F, HHH Building Washington, D.C. 20201. **800-368-1019, 800-537-7697 (TDD).**

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GHHNDN2026CP

Notice of Availability - Auxiliary Aids and Services Notice

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Հայերեն [Armenian]: Հասանելի են անվճար լեզվական, աջակցման և այլընտրանքային ձևաչափի ծառայություններ: Զանգահարե՛ք՝ **1-800-794-5907 (TTY: 711)**:

বাংলা Bengali: বিনামূল্যে ভাষা, আনুষঙ্গিক সহায়তা, এবং বিকল্প বিন্যাসে পরিষেবা উপলব্ধ। ফোন করুন **1-800-794-5907 (TTY: 711)** নম্বরে।

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GHHNOA2025CP

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Português Portuguese: Estão disponíveis serviços gratuitos de ajuda linguística auxiliar e outros formatos alternativos. Ligue **1-800-794-5907 (TTY: 711)**.

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தமிழ் Tamil: இலவச மொழி, துணை உதவி மற்றும் மாற்று வடிவ சேவைகள் உள்ளன. **1-800-794-5907 (TTY: 711)** ஐ அழைக்கவும்.

తెలుగు Telugu: ఉచిత భాష, సహాయక మద్దతు, మరియు ప్రత్యామ్నాయ ఫార్మాట్ సేవలు అందుబాటులో గలవు. **1-800-794-5907 (TTY: 711)** కి కాల్ చేయండి.

اردو Urdu: مفت زبان، معاون امداد، اور متبادل فارمیٹ کی خدمات دستیاب ہیں۔ کال **(TTY: 711) 1-800-794-5907**

Tiếng Việt Vietnamese: Có sẵn các dịch vụ miễn phí về ngôn ngữ, hỗ trợ bổ sung và định dạng thay thế. Hãy gọi **1-800-794-5907 (TTY: 711)**.

Request for Redetermination of Medicare Prescription Drug Denial

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. **Use this form to appeal this decision.**

- You may ask for an appeal within 65 days of the date of our Notice of Denial of Medicare Prescription Drug Coverage.
- You can also file an appeal through our website at www.CarePlusHealthPlans.com/appeal
- Expedited appeal requests can be made by phone at 1-800-451-4651.

Your prescriber may ask us for an appeal on your behalf. If you want another individual (like a family member or friend) to file an appeal for you, that person must be your representative. Contact us to learn how to name a representative.

Plan Enrollee Information

Enrollee's Name: _____

Member ID Number: _____Date of Birth(MM/DD/YYYY): _____

Mailing address: _____

City, State, ZIP code: _____

Phone: _____

Prescription & Prescriber information

Name of drug you asked for: _____

Strength/quantity/dose: _____

Prescriber name: _____

Office address: _____

City, State, ZIP Code: _____

Office phone: _____Office fax: _____

Office contact person: _____

Did you already purchase this drug? ☐ Yes ☐ No

If YES:

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Date purchased: _____ Amount paid:_____
(attach copy of receipt)

Pharmacy name: _____

Pharmacy phone number:

Do you need an expedited (fast) decision?

☐ **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).**

- 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'll automatically give you a decision within 72 hours. You can't ask for an expedited appeal if you're asking us to pay you back for a drug you already got.
- If you don't get your prescriber's support for an expedited appeal, we'll decide if your case requires a fast decision.

Explain why you think this drug should be covered

- Attach any additional information you think may help your case, like statement from your prescriber or medical records.
- Include a copy of the Notice of Denial of Medicare Prescription Drug Coverage
- Attach any additional information you think may help your case, like statement from your prescriber or medical records.
- Your prescriber will need to explain why you can't meet our plan's coverage rules and/or why the drugs required by the plan aren't medically appropriate for you.
- Other information we should consider: _____

_____

Representative Information

Complete this section ONLY if the person making this request is not the enrollee or the enrollee's prescriber. You must attach documentation showing your authority to represent the enrollee (like a completed 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.

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Representative name: _____
Relationship to enrollee: _____
Street address: _____
City, State, ZIP code: _____
Phone: _____

Sign & submit this form

Signature of person requesting the appeal (the enrollee or the representative):

_____ Date: _____

Fax or mail your completed form and any supporting information to:

Address:
CarePlus Health Plans
Grievances and Appeals
P.O. Box 14165
Lexington, KY 40512-4165

Fax Number:
1-877-556-7005

CarePlus HEALTH PLANS.

Y0040_GHHMJZQEN_C

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  - Qualified sign language interpreters
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Tagalog Tagalog: Magagamit ang mga libreng serbisyong pangwika, serbisyo o device na pantulong, at kapalit na format. Tumawag sa **1-800-794-5907 (TTY: 711)**.

தமிழ் Tamil: இலவச மொழி, துணை உதவி மற்றும் மாற்று வடிவ சேவைகள் உள்ளன. **1-800-794-5907 (TTY: 711)** ஐ அழைக்கவும்.

తెలుగు Telugu: ఉచిత భాష, సహాయక మద్ధతు, మరియు ప్రత్యామ్నాయ ఫార్మాట్ సేవలు అందుబాటులో గలవు. **1-800-794-5907 (TTY: 711)** కి కాల్ చేయండి.

اردو Urdu: مفت زبان، معاون امداد، اور متبادل فارمیٹ کی خدمات دستیاب ہیں۔ کال **(TTY: 711) 1-800-794-5907**

Tiếng Việt Vietnamese: Có sẵn các dịch vụ miễn phí về ngôn ngữ, hỗ trợ bổ sung và định dạng thay thế. Hãy gọi **1-800-794-5907 (TTY: 711)**.

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.....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)
_____	_____
_____	_____
_____	_____

