HealthSun
HEALTH PLANS

Provider Manual

2021

Provider Manual

Table of Contents

Introduction and Background

Founded in 2005, HealthSun is a Medicare Advantage Plan local Medicare Managed Care Organization with administrative offices located in Miami, Florida. HealthSun Health Plans is wholly owned by Anthem, Inc.

HealthSun serves more than 50,000 members in Miami- Dade, Broward, and Palm Beach Counties. HealthSun is one of the fastest growing health plans in South Florida.

HealthSun has received a 5-Star rating every year since Calendar Year 2017 for its high performance in the Centers for Medicare and Medicaid Services (CMS) Part C and D Star Ratings. The Star Ratings measure performance in member experience and satisfaction with the plan, clinical care, and customer service. Our Star ratings demonstrate excellence in quality and operational measure.

We are proud that our members are satisfied with our services as demonstrated in our yearly independent member satisfaction survey. Our valued members are serviced through our extensive provider network and dedicated professionals. As a local plan, we recognize the healthcare needs of our community and strive to provide our members with only the best service and experience possible.

We are sincerely pleased that you have agreed to participate with the HealthSun Health Plans network of providers. We look forward to working with you to offer quality health care to your patients who participate as members of HealthSun Health Plan. It is important at the outset that you are made aware of the goals and objectives that guide HealthSun in the provision of care and service to members. Equally important is your understanding of the efforts made by HealthSun to introduce an oversight committee structure that serves to monitor and provide continuous input into the operation of HealthSun.

HealthSun is organized to ensure:

1) Members access to quality care,
2) on-going monitoring of appropriate utilization of services, and
3) Continuous evaluation and improvement in the quality of care and services delivered by participating providers to HealthSun members.

Our guiding goals are to:

- Improve and maintain member's physical and emotional status.
- Promote health and early intervention and empower members to develop and maintain healthy lifestyles.
- Involve members in treatment and care management decision-making.
- Ensure that the care and treatment provided a member is based on accepted.
- Evidenced-based medical principles, standards, and practices.

- Be accountable and responsive to member concerns and grievances.
- Utilize technology and other resources efficiently and effectively for members' welfare.
- Ensure that appropriate care and treatment is accessible to members and provided in a timely manner.

These goals are supported by the following HealthSun **operational objectives**:

- Enhancing the efficiency of resource utilization, while at the same time ensuring the delivery of high quality and accessible care and treatment.
- Proactive pursuit of methods to improve care and service to members.
- Provision of interventions designed to improve the overall health and productivity of members.
- Providing consistency and continuity in care and service throughout the HealthSun health and mental health care delivery network.
- Ensuring systematic identification and follow-up of potential quality/compliance issues
- Continuously educating and reinforcing members, physicians, hospitals, and ancillary providers about goals, objectives, and structure for providing quality, cost effective, and coordinated managed health and mental health care.
- Promoting open communication and interaction between providers and members.
- Review individual and aggregate utilization patterns.

HealthSun's Vision and Mission

Vision

Be the most innovative, valuable, and inclusive partner.

Mission

Improving lives and communities. Simplifying healthcare. Expecting more.

Values

HealthSun Key Contact List

Department Area	Contact Information	Hours of Operation
HealthSun Provider Inquiry Line (Eligibility, Benefits and Claims) **Toll-Free** **Interactive Voice Response (IVR)** **E-Fax** **E-Mail**	 **1-877-999-7776/ TTY 1-877-206-0500** **1-877-207-4900 Main** **786-393-5722** **Provider_Call_Unit@healthsun.com**	Monday – Friday 8:00 am – 5:30 pm Available to provide information to Providers regarding general provider inquiries such as Benefits, Services, Claims Processing and Payment.
Medical Management /Authorizations Department **Telephonic Requests** **Fax Requests** **E-Mail Address**	 **1-877-207-4900** **305-448-4148** Utilization_Dept@healthsun.com	 Calls to this number are free. Our hours are 8am to 8pm Monday through Friday. During October until March, we are open seven days a week.
Part D Services Department **Address** **Toll-Free** **E-Fax** **E-Mail** **Part D Coverage determinations/ Prior authorization** **Ingenio Rx- Pharmacy Helpdesk (IGRX)** **RX Claim Processing Information**	 **HealthSun Health Plans, Inc.** **9250 W. Flagler Street** **Suite. 600** **Miami, FL 33174** **1-877-336-2069 / TTY 1-877-206-0500** **877-452-7496** **RXMemberExperience@HealthSun.com** **1-833-377-4266** **RXBIN:** 020115 **PCN:** IS **RXGroup:** RX844	 Calls to this number are free. Our hours are 8am to 8pm Monday through Friday. During October until March, we are open seven days a week.
HealthSun Provider Portal & Website **Provider Portal** **Website**	 **https://provider.healthsun.com** **https://healthsun.com/providers**	Please contact your designated Provider Operations Executive to obtain access or call **(305)448-8100 Ext. 10822**

Provider Operations Department **Phone #** **E-fax** **Email**	**(305)448-8100 Ext. 10822** **(305)489-8110** **Providerservices@healthsun.com**	Available to provide information and assistance with Provider Portal Access, Demographic Changes, interested in joining Plan, General contract questions.
Claims **Claims Mailing Address** **Audit and Recovery Department** **Fax** **E-Mail Address**	**P.O Box 211154** **Eagan, MN 55121** **Attention: Claims Department** **P.O Box 330968** **Miami, FL 33133** **Attention: Audit and Recovery Department** **786-363-8144** **AuditandRecovery@healthsun.com**	Monday – Friday 8:00 am – 5:00 pm
Credentialing **Mailing Address** **Toll-Free Telephone** **E-Fax** **E-Mail**	**HealthSun Health Plans, Inc.** **9250 W. Flagler Street** **Suite. 600** **Miami, FL 33174** **Attention: Credentialing Department** **877-207-4900** **1-888-415-5826** **HSHPCredentialingGroup@healthsun.com**	Monday – Friday 8:00 am – 5:00 pm
Grievance & Appeals Department **Address** **Toll-Free** **E-Fax** **E-Mail**	**HealthSun Health Plans, Inc.** **9250 W. Flagler Street** **Suite. 600** **Miami, FL 33174** **1-877-207-4900** **1-888-589-3256** **Grievance&Appeals@healthsun.com**	Monday – Friday 8:00 am – 5:00 pm
Member Services Department (Designated for Members Only		HealthSun Member Services hours are 8 am to 8 pm Monday

Address **Toll-Free** **TTY** **E-Fax** **E-Mail**	**HealthSun Health Plans, Inc.** **9250 W. Flagler Street** **Suite. 600** **Miami, FL 33174** **1-877-336-2069** **1 (877) 206-0500** **305-448-5783** **MemberServicesStaff@healthsun.com**	through Friday. During October until March, we are open seven days a week. Member Services also has free language interpreter services available for non-English speakers. TTY number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Our hours are 8am to 8 pm Monday through Friday. During October until March, we are open seven days a week.
Compliance Reporting		
REPORTING MISCONDUCT ETHICS AND FRAUD, WASTE & ABUSE CONCERNS: • Calling the Ethics and Compliance Helpline • Submitting an online report at: • Sending an email to: • Sending a letter to:	**1-877-725-2702** www.anthemethicshelpline.com ethicsandcompliance@anthem.com Ethics Department c/o Chief Compliance Officer Anthem, Inc. Post Office Box 791 Indianapolis, IN 46206 United States	The Ethics and Compliance Helpline is available 24-hours a day, seven days a week and 365 days a year. We have an obligation to report to the Ethics Department any suspected or observed misconduct, including violations of the Code of Conduct, company policies and procedures, laws and regulations, or any other ethical concerns. The Ethics Department provides various channels to submit reports or to ask questions. You may submit your report confidentially and anonymously by contacting the Ethics Department.
AGENCY FOR HEALTHCARE ADMINISTRATION (AHCA) **Subcontractor Healthcare Facility Complaints:** • **Agency Complaint Hotline**	**1-888-419-3456**	To ensure that each of its employees or subcontractors who performs activities to report concerns pertaining to a health care facility. To ensure that plan employees or subcontractors who performs

• **Online Complaint Form** **Subcontractor Operation Concerns:** • **Agency Complaint Hotline** • **Online Complaint Form**	https://apps.ahca.myflorida.com/hcfc. **1-877-254-1055** https://apps.ahca.myflorida.com/smmc_cirts/.	activities related to the services associated with this Contract, will report to the Agency areas of concern relative to the operation of any entity covered by this Contract.

***** For questions or inquiries related to these services or other services not listed above, please contact our Provider Help Line at 1-877-999-7776**

Our Provider Help Line hours of operation are 8 a.m. to 5 p.m. Eastern Time, Monday through Friday.

Definitions & Acronyms

Ad Hoc – A report designed for a specific purpose, case, or situation.

Agency — State of Florida, Agency for Health Care Administration (AHCA), its employees acting in their official capacity, or its designee.

Agreement means this Agreement between HSPN and Provider.

Annual Enrollment Period – A set time each fall when members can change their health or drug plans or switch to Original Medicare. The Annual Enrollment Period is from October 15 until December 7.

Appeal – An appeal is something you do if you disagree with our decision to deny a request for coverage of health care services or prescription drugs or payment for services or drugs you already received. You may also make an appeal if you disagree with our decision to stop services that you are receiving. For example, you may ask for an appeal if we don't pay for a drug, item, or service you think you should be able to receive.

Centers for Medicare & Medicaid Services (CMS) – The Federal agency that administers Medicare. Chapter 2 explains how to contact CMS.

Copayment means the amount, if any, required to be paid by a Member to Participating Providers as additional payments for Covered Services at the time Covered Services are rendered in accordance with MCO's schedule of benefits applicable to the particular health services plan in which a Member is enrolled.

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

your doctor prescribes less than a full month's supply of certain drugs for you and you are required to pay a copayment.

Cost-Sharing Tier – Every drug on the list of covered drugs is in one of six (6) cost-sharing tiers. In general, the higher the cost-sharing tier, the higher your cost for the drug.

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

Covered Services means all Medically Necessary medical services required to be provided to Members under MCO's Medicare Advantage Agreement(s) and under the terms of MCO's agreements with Subscribers, including, without limitation, Primary Care Covered Services, 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 MCO's Medicare Advantage Agreement(s).

Credential or Credentialing means the process for verifying that physicians providing services under this Agreement are adequately trained, licensed, of good professional reputation and capable of working with others in the provision of Covered Services to Members. The term shall be construed to include the re-credentialing process.

DFS means Florida Department of Financial Services.

DHHS or HHS means United States Department of Health and Human Services.

Dual Eligible - A Medicare managed care recipient who is also eligible for Medicaid.

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

Medicare Advantage Dual Eligible Special Needs Plan (D-SNP) – A type of Medicare Advantage coordinated care plan focused on individuals with special needs created by Section 231 of the Medicare Modernization Act of 2003.

Eligible Provider – A provider that has an agreement with the Vendor to serve enrolled dual eligibles.

Emergency Medical Condition or Emergency means 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 women, the health of the woman or her unborn child;
- Serious impairment to bodily functions; or
- Serious dysfunction of any bodily organ or part.

Additionally, to be considered Emergency Services the transfer of the Member to a Participating Provider must be precluded because the risk to the Member's health, or the distance and nature of illness involved would make such transfer unreasonable.

Emergency Services means Covered Services that are (i) furnished by a provider qualified to furnish emergency services; and (ii) needed to evaluate or stabilize an emergency medical condition.

Encounter Data – Data elements from an Encounter service event for a fee-for-service claim or capitated services proxy claim.

Enrolled Dual Eligible – A dual eligible who is eligible to participate in, and is voluntarily enrolled in, the Vendor's D-SNP Plan. For purposes of this Contract, enrolled dual eligibles are QMB, QMB Plus, SLMB, SLMB Plus, QI, QDWI, and FBDE. This includes full duals but excludes ICP eligible recipients during the enrollment month.

Extra Help – A Medicare program to help people with limited income and resources pay Medicare prescription drug program costs, such as premiums, deductibles, and coinsurance.

Full Benefit Dual Eligible (FBDE) – An individual who does not meet the income or resource criteria for QMB or SLMB, but is eligible for Medicaid either categorically or through optional coverage groups based on Medically Needy status, special income levels for institutionalized individuals, or home and community-based waivers. Medicaid does not pay towards out-of-pocket (OOP) costs for the deductible, premium, coinsurance, or copayments for Medicare Part D prescription drug coverage.

Full Dual – An individual who has Medicare and full Medicaid coverage.

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

Grievance - A type of complaint you make about us or pharmacies, including a complaint concerning the quality of your care. This type of complaint does not involve coverage or payment disputes.

Highly Integrated Dual Eligible SNP (HIDE SNP) – Provides Medicare and Medicaid benefits under a single entity, which includes Behavioral health services coverage, consistent with state policy.

Home Health Aide – A home health aide provides services that do not need the skills of a licensed nurse or therapist, such as help with personal care (e.g., bathing, using the toilet, dressing, or carrying out the prescribed exercises). Home health aides do not have a nursing license or provide therapy.

Hospice - A member who has 6 months or less to live has the right to elect hospice. We, your plan, must provide you with a list of hospices in your geographic area. If you elect hospice and continue to pay premiums you are still a member of our plan. You can still obtain all medically necessary services as well as the supplemental benefits we offer. The hospice will provide special treatment for your state.

Hospital Inpatient Stay – A hospital stay when you have been formally admitted to the hospital for skilled medical services. Even if you stay in the hospital overnight, you might still be considered an “outpatient.”

Initial Coverage Limit – The maximum limit of coverage under the Initial Coverage Stage.

Initial Coverage Stage – This is the stage before your total drug costs including amounts you have paid and what your plan has paid on your behalf for the year have reached **$6,000**.

Initial Enrollment Period – When you are first eligible for Medicare, the period of time when you can sign up for Medicare Part A and Part B. For example, if you're eligible for Medicare when you turn 65, your Initial Enrollment Period is the 7-month period that begins 3 months before the month you turn 65, includes the month you turn 65, and ends 3 months after the month you turn 65.

Low Income Subsidy (LIS) – See "Extra Help."

Providers" are doctors and other health care professionals licensed by the state to provide medical services and care. The term "providers" also includes hospitals and other health care facilities.

MCO Provider Manual means the applicable MCO Provider Manual, as amended and revised from time to time by MCO in its sole discretion.

MCO Provider Manual means the applicable MCO Provider Manual, as amended and revised from time to time by MCO in its sole discretion.

Medicare – The Federal health insurance program for people 65 years of age or older, some people under age 65 with certain disabilities, and people with End-Stage Renal Disease (generally those with permanent kidney failure who need dialysis or a kidney transplant). People with Medicare can get their Medicare health coverage through Original Medicare a Medicare Cost Plan, a PACE plan, or a Medicare Advantage Plan.

Medicare Advantage ("MA") means an alternative to the traditional Medicare program in which private plans run by health insurance companies provide health care benefits that enrolled Medicare beneficiaries would otherwise receive directly from the Medicare program.

Medicare Advantage Organization ("MA Organization") means an entity organized and licensed by a State as a risk-bearing entity (with the exception of provider-sponsored organizations receiving waivers) that is certified by CMS as meeting the MA contract requirements.

Member means a Subscriber who (i) is enrolled in one of MCO's Medicare Advantage plans covered under this Agreement, as reflected on Attachment C hereof, and (ii) is assigned by

MCO or HSPN to Provider or to a Provider Primary Care Physician, or who has selected a Provider Primary Care Physician.

Participating Provider means a Primary Care Physician, Specialty Physician, hospital, ambulatory surgical center, home health care agency, pharmacy, multi-specialty group practice, or any other health care provider which or who has entered into an agreement with, or is otherwise engaged by, MCO to provide Covered Services to Members. Any such Participating Provider may be designated as a Participating Hospital, Participating Physician, Participating Pharmacy, etc.

Quality Improvement Program means the program of Quality Improvement established by MCO to assure the proper level and quality of care is provided including, but not limited to, MCO's policies and procedures.

Sick Care means care provided for non-urgent problems that do not substantially restrict normal activity, but could develop complications if left untreated (e.g., chronic disease).

Specialty Physician means a Participating Provider who is appropriately qualified in a certain medical specialty as determined by MCO, who provides Covered Services to Members within the range of such specialty, who elects to be designated as a Specialty Physician by MCO, and who meets all other requirements for Specialty Physicians contained in MCO's rules and regulations, including the MCO Provider Manual, and in the Agreement between MCO and the Specialty Physician.

Urgently Needed Services means Covered Services that are not Emergency Services, provided when a Member is temporarily absent from the MCO's service area (or, under unusual and extraordinary circumstances, provided when the Member is in the service area but the MCO's provider network is temporarily unavailable or inaccessible) when the services are medically necessary and immediately required (a) as a result of an unforeseen illness, injury or condition; and (b) it was not reasonable given the circumstances to obtain the services through the MCO.

Utilization Management/Utilization Management Program means the evaluation and determination of the appropriateness of patient use of medical care resources, and provision of any needed assistance to clinician and/or Member, to ensure appropriate use of resources. Utilization Management includes prior authorization, concurrent review, retrospective review, discharge planning, case management, and disease management protocols.

Well Care means a routine medical visit for one of the following: routine follow-up to a previously treated condition or illness, adult physicals, and any other routine visit for other than the treatment of an illness.

Access to Care. While this Agreement is in effect, Provider shall provide Covered Services to Members under the terms of this Agreement. Provider shall comply with HSPN's and MCO's written standards for timely access to care and Covered Services by Members. The following Covered Services may be provided to Members without authorization from MCO: (a) screening mammography and influenza vaccination Covered Services; and (b) for women, routine and preventive Covered Services from a Provider that is a women's health specialist. No Copayments shall apply to influenza and pneumococcal vaccines. Provider shall provide Covered Services to all Members on the same basis as Provider is accepting non-Members as new patients without regard to race, ethnicity, religion, gender, color, national origin, age, sexual orientation, genetic information, source of payment, any factor related to physical or mental health status, or on any other basis deemed unlawful under federal, state or local law.

Qualified Disabled and Working Individual (QDWI) – An individual who has lost Medicare Part A benefits due to a return to work, but is eligible to enroll in and purchase Medicare Part A. The individual's income may not exceed two hundred percent (200%) FPL and resources may not exceed twice the SSI limit. The individual may not be otherwise eligible for Medicaid. These individuals are eligible for Medicaid payment of the Part A premium only. Medicaid does not pay towards out-of-pocket (OOP) costs for the deductible, premium, coinsurance, or copayments for Medicare Part D prescription drug coverage.

Qualifying Individual (QI) – An individual entitled to Medicare Part A, with an income at least one hundred twenty percent (120%) FPL but less than one hundred thirty-five percent (135%) FPL, and resources that do not exceed twice the SSI limit, and who is not otherwise eligible for Medicaid benefits. This individual is eligible for Medicaid payment of the Medicare Part B premium. Medicaid does not pay towards out-of-pocket (OOP) costs for the deductible, premium, coinsurance, or copayments for Medicare Part D prescription drug coverage.

Quality Improvement Organization (QIO) – A group of practicing doctors and other health care experts paid by the Federal government to check and improve the care given to Medicare patients. See Chapter 2, Section 4 for information about how to contact the QIO for your state.

Qualified Medicare Beneficiaries (QMB) – An individual entitled to Medicare Part A, with an income of one hundred percent (100%) Federal poverty level (FPL) or less and resources that do not exceed twice the limit for Supplementary Social Security Income (SSI) eligibility, and who is not otherwise eligible for full Medicaid benefits through the State. Medicaid pays their Medicare Part A premiums, if any, Medicare Part B premiums, and Medicare deductibles and coinsurance

for Medicare services provided by Medicare providers to the extent consistent with the Medicaid State Plan. Medicaid does not pay towards out-of-pocket (OOP) costs for the deductible, premium, coinsurance, or copayments for Medicare Part D prescription drug coverage.

Qualified Medicare Beneficiaries Plus (QMB Plus) – An individual entitled to Medicare Part A, with income of one hundred percent (100%) FPL or less and resources that do not exceed twice the limit for Supplementary Security Income (SSI) eligibility, and who is eligible for full Medicaid benefits. Medicaid pays their Medicare Part A premiums, if any, Medicare Part B premiums, Medicare deductibles and coinsurance, and provides full Medicaid benefits to the extent consistent with the State Plan. These individuals often qualify for full Medicaid benefits by meeting Medically Needy standards, or by spending down excess income to the Medically Needy level. Medicaid does not pay towards the out-of-pocket (OOP) costs for the deductible, premium, coinsurance, or copayments for Medicare Part D prescription drug coverage.

Service Area – A geographic area where a health plan accepts members if it limits membership based on where people live. For plans that limit which doctors and hospitals you may use, it's also generally the area where you can get routine (non-emergency) services. The plan may disenroll you if you permanently move out of the plan's service area.

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

Special Enrollment Period – A set time when members can change their health or drug plans or return to Original Medicare. Situations in which you may be eligible for a Special Enrollment Period include: if you move outside the service area, if you are getting "Extra Help" with your prescription drug costs, if you move into a nursing home, or if we violate our contract with you.

Specific Low Income Medicare Beneficiary (SLMB) – An individual entitled to Medicare Part A, with an income that exceeds one hundred percent (100%) FPL but less than one hundred twenty percent (120%) FPL, with resources that do not exceed twice the Supplementary Security Income (SSI) limit, and who is not otherwise eligible for Medicaid. These individuals are eligible for Medicaid payment of the Medicare Part B premium only. They do not qualify for any additional Medicaid benefits. Medicaid does not pay towards out-of-pocket (OOP) costs for the deductible, premium, coinsurance, or copayments for Medicare Part D prescription drug coverage.

Specific Low-Income Medicare Beneficiary Plus (SLMB Plus) – An individual who meets the standards for SLMB eligibility, and who also meets the criteria for full State Medicaid benefits.

These individuals are entitled to payment of the Medicare Part B premium, in addition to full State Medicaid benefits. These individuals often qualify for Medicaid by meeting Medically Needy standards or by spending down excess income to the Medically Needy level. Medicaid does not pay towards out-of-pocket (OOP) costs for the deductible, premium, coinsurance, or copayments for Medicare Part D prescription drug coverage.

Urgently Needed Services – Urgently needed services are provided to treat a non-emergency, unforeseen medical illness, injury, or condition that requires immediate medical care. Urgently needed services may be furnished by network providers or by out-of-network providers when network providers are temporarily unavailable or inaccessible.

ACCRONYMS

BAA Business Associate Agreement
CAP Corrective Action Plan
CEO Chief Executive Officer
CFO Chief Financial Officer
CFR Code of Federal Regulations
CJIS Criminal Justice Information System
DCF Department of Children and Families
DPPA Driver Privacy Protection Act
D-SNP Dual Eligible Special Needs Plan
EEO Equal Employment Opportunity
EPSDT Early and Periodic Screening, Diagnostic and Treatment
FAC Florida Administrative Code
FAR Florida Administrative Register
FBDE Full Benefit Dual Eligible
FIDE SNP Fully Integrated Dual Eligible Special Needs Plan
FIPS Federal Information Processing Standards
FS Florida Statutes
HIDE SNP Highly Integrated Dual Eligible Special Needs Plan
HIPAA Health Insurance Portability and Accountability Act
HITECH Health Information Technology for Economic and Clinical Health
HMO Health Maintenance Organization
ICP Institutional Care Program
ISM Information Security Manager
IT Information Technology
MIPPA Medicare Improvement for Patients and Providers Act of 2008
MVC Model View Controller
NIEM National Information Exchange Model
NIST National Institute for Standards and Technology
OOP Out-of-pocket
PASRR Preadmission Screening and Resident Review

PHI Protected Health Information
PII Personally Identifiable Information
QDWI Qualified Disabled and Working Individual
QI Qualifying Individual
QMB Qualified Medicare Beneficiaries
QMB Plus Qualified Medicare Beneficiaries Plus
SFTP Secure File Transfer Protocol
SLMB Specific Low-Income Medicare Beneficiary
SLMB Plus Specific Low-Income Medicare Beneficiary Plus
SOC Service Organization Controls
SQL Structured Query Language
SSI Supplemental Security Income
SSL Secure Sockets Layer
SSRS SQL Server Report Services
TFS Team Foundation Server
TLS Transport Layer Security
TPL Third Party Liability
URL Uniform Resource Locator
US United States
USC United States Code
W3C World Wide Web Consortium

HealthSun Health Plans Commitment to Providers

HealthSun embraces the concept of establishing a strong partnership with our healthcare provider network. We know that this partnership requires us to continually demonstrate our commitment to communicate effectively, educate our provider partners about HealthSun's operations, and offer our providers efficient and effective avenues for addressing provider inquiries and concerns. Accordingly, HealthSun is committed to:

Provider Support

- Having exceptionally trained Provider Operations Representatives and Provider Help Line staff available to answer questions, provide claims status, and resolve problems during regular business hours.

Prompt Claims Payment

- Plan, as applicable, shall comply with the provisions of Florida prompt payment guidelines as established in Section 641.3155, F.S. that describes the timing and procedures applicable to claims for payment and overpayment submitted by the physician/provider, as well as retroactive denials of claims due to eligibility. Further, the provider shall exhaust all internal dispute resolution procedures pursuant to the Agreement as a prerequisite to

the submission of a claim by the physician/provider to the resolution organization established by AHCA, pursuant to 408.7057, F.S.
- Assisting physicians/providers to submit claims for payment via electronic format (EDI) for purposes of efficiency, tracking, and improved payment turnaround; and;
- Assisting physicians/providers in posting claims to their accounts receivable through designing an easy-to-use Explanation of Benefits (EOB).

Efficient, Practical, and High-Quality Medical Management

- Providing the most efficient methods to obtain referrals and authorizations, including the ability to request referrals/authorization on-line;
- Approving outpatient diagnostic services, ambulatory surgery, and non-urgent hospitalization requests within 24-hours of receipt of all necessary information and;
- Developing and implementing state-of-the-art health risk management, chronic care improvement, and wellness programs to assist our physicians/providers to provide the highest quality of care to their patients and to ensure the highest quality of life for their patients.

HealthSun Health Plans will Ensure

- Provision of care and services to our members is made available through our Provider Network.
- Non-discriminatory practices for prospective and current enrollees or to enrollees with physical, mental disability and or chronic illnesses.
- To maintain current membership records for providers.
- Provider Operation staff is available to Providers and their staff.
- Training and support for Providers and their Staff.
- Provider support in the provision of language services.
- To provide changes, revisions, updates, enrollment, and disenrollment data.
- Maintain an established referral support for Provider and their Staff.
- To maintain communication with providers and their staff for revisions to Policies or Procedures in accordance with Regulatory and Accreditation Agencies.
- To require compliance from Providers for Site Audits, Medical Record Review, Access Audits, QI Reviews, and other requirements as determined by HealthSun.
- To notify Provider of changes, revisions, additions, deletions and other modifications to their agreements.
- To notify and forward member Health Risk Assessment Information to Provider.

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 healthcare provider or facility recognize your rights while you are receiving medical care and that you respect the provider's or 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 healthcare provider or 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.

Contract Requirements through Policies Standards and Manuals

In addition to the provisions aforementioned, HealthSun must include Medicare Advantage (MA) related provisions in the policies and procedures that are distributed to providers and suppliers that constitute the organizations' health services delivery network.

The Following table summarizes these provisions, which may be accessed via the Code of Federal Regulations (CFR), which is available on the United States Government Printing Office website (https://www.gpo.gov/).

CONTRACT REQUIREMENTS THROUGH POLICIES, STANDARDS & MANUALS **Medicare Managed Care Manual, Chapter 11, "Medicare Advantage Application Procedures and Contract Requirements," § 100.4 – Provider and Supplier Contract Requirements. (Revised 04/25/07); Title 42. Chapter IV Subchapter B. Part 422**	
Summary of CMS Requirement	**CFR.**
Safeguard privacy and maintain records accurately and timely	422.118
Permanent "out of area" members to receive benefits in continuation area	422.54(b)
Prohibition against discrimination based on health status	422.110(a)
Pay for emergency and urgently needed services	422.100(b)
Pay for renal dialysis for those temporarily out of a service area	422.100(b)(1)(iv)
Direct access to mammography and influenza vaccinations	422.100(g)(1)
No copay for influenza and pneumococcal vaccines	422.100(g)(2)
Agreements with providers to demonstrate "adequate" access	422.112(a)(1)
Direct access to women's specialists for routine and preventive services	422.112(a)(3)
Services available 24 hours/day, 7 days/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 medial 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 & 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)
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 & performance indicators for plan benefits re: disenrollment rates for beneficiaries enrolled in the plan for the previous two years	422.504(f)(2)(iv)(A)
Disclose to CMS quality & performance indicators for the benefits under the plan regarding enrollee satisfaction	422.504(f)(2)(iv)(B)
Disclose to CMS quality & performance indicators for the benefits under the plan regarding health outcomes	422.504(f)(2)(iv)(C)
Notify providers in writing for reason for denial, suspension & termination	422.202(c)(1)
Provide 60 days' notice (terminating contract without cause)	422.202(c)(4)
Comply with Federal laws and regulations to include, 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)

CMS Specific Guidance About Provider Promotional Activites

Refer to the Chapter 3: Medicare Marketing Guidelines, §70.12 to §70.12.7 for detailed information.

As used in specific guidance about provider activities, the term "provider" refers to all providers contracted with HealthSun Health Plans, Inc. (HealthSun) and their sub- contractors, including but not limited to pharmacists, pharmacies, physicians, hospitals, and long-term care facilities. HealthSun shall ensure that any provider contracted with the plan (and its sub-contractors) performing functions on the plan sponsor's behalf related to the administration of the plan benefit,

including all activities related to assisting in enrollment and education, agrees to the same restrictions and conditions that apply to HealthSun through its contract, and shall prohibit them from steering, or attempting to steer an undecided potential enrollee toward a plan, or limited number of providers, offered either by HealthSun or another plan sponsor, based on the financial interest of the provider or agent (or their subcontractors or agents). While conducting a health screening, providers may not distribute plan information to patients.

CMS is concerned with the provider activities for the following reasons:

1) Providers may not be fully aware of all plan benefits and costs; and
2) Providers may confuse the beneficiary if the provider is perceived as acting as an agent of the plan vs. acting as the beneficiary's provider.

Providers may face conflicting incentives when acting as a plan representative. For example, some providers may gain financially from a beneficiary's selection of one plan over another plan. Additionally, providers generally know their patients' health status. The potential for financial gain by the provider steering a beneficiary's selection of a plan could result in recommendations that do not address all the concerns or needs of a potential enrollee. These provider 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 is always in the best interests of the beneficiary.

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

Following are requirements associated with provider activities. HealthSun requires that any provider contracted with the plan (and its subcontractors) comply with these requirements:

1. **Provider Activities and Materials in the Health Care Setting** – Beneficiaries often look to their health care professionals to provide them with complete information regarding their health care choices (e.g., providing objective information regarding specific plans, such as covered benefits, cost sharing, drugs on formularies, utilization management tools, eligibility requirements for Special Needs Plans). To the extent that a provider can assist a beneficiary in an objective assessment of the beneficiary's needs and potential plan options that may meet those needs, providers are encouraged to do so. To this end, providers may certainly engage in discussions with beneficiaries when patient seek information or advice from their provider regarding their Medicare options. Providers are permitted to make available and/or distribute plan marketing materials for all plans with which the provider participates and display posters or other materials announcing plan contractual relationships (including PDP enrollment applications, but not MA or MA-PD enrollment applications). However, providers cannot accept enrollment applications. Providers also cannot direct, urge, or attempt to persuade beneficiaries to enroll in a specific plan. In addition, providers cannot offer anything of value to induce plan enrollees to select them as their provider.

   Providers may inform prospective enrollees where they may obtain information on the full range of plan options. Because providers are usually not fully aware of all Medicare plan benefits and costs, they are advised to additionally refer their patients to other sources of information, such as the State Health Insurance Assistance Programs, plan marketing representatives, their State Medicaid Office, local Social Security Administration Office, https://www.medicare.gov/or 1-800-MEDICARE.

   The "Medicare and You" Handbook or "Medicare Compare Options" (from https://www.medicare.gov/), may be distributed by providers without additional approvals. There may be other documents that provide comparative and descriptive material about plans, of a broad nature, that are written by CMS or have been previously approved by CMS. These materials may be distributed by plans and providers without further CMS approval. This includes CMS Medicare Prescription Drug Plan Finder information via a computer terminal for access by beneficiaries. Plans should advise contracted providers of the provisions of these rules.

2. **Plan Activities and Materials in the Health Care Setting –** While providers are prohibited from accepting enrollment applications in the health care setting, plans or plan agents may conduct sales activities in health care settings as long as the activity takes place in the common areas of the setting and patients are not misled or pressured into participating in such activities. Common areas, where marketing activities are allowed, include areas such as 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 the space outside of where patients wait for services or interact with pharmacy providers and obtain medications.

   Plans are prohibited from conducting sales presentations, distributing, and accepting enrollment applications and soliciting Medicare beneficiaries in areas where patients

Primarily intend to receive health care services or are waiting to receive health care services. These restricted areas generally include, but are not limited to, waiting rooms, exam rooms, hospital patient rooms, pharmacy counter areas and dialysis center treatment areas (where patients interact with their clinical team and receive treatment). The prohibition against conducting marketing activities also applies to activities planned in these settings outside of normal business hours. An example of such activity includes providers sending out authorization to their members, such as nursing home members, to request that the member give permission for a plan sponsor to contact them about available plan products (through mailing, hand delivery or attached to an affiliation notice).

Only upon request by the beneficiary are plan sponsors permitted to schedule appointments with beneficiaries residing in long-term care facilities. 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 sponsor marketing materials for all plans with which the provider participates. CMS does not expect providers to proactively contact all participating plans; rather, if a provider agrees to make available and/or distribute plan marketing materials they should do so knowing it must accept future requests from other plan sponsors with which it participates. Providers are also permitted to display posters or other materials in common areas within the long-term care facility and in admission packets announcing all plan contractual relationships. Long-term care facility staff are permitted to provide residents that meet the I-SNP criteria an explanatory brochure for each I-SNP with which the facility contracts. The brochure can explain about the qualification criteria and the benefits of being an I-SNP. The brochure may have a reply card or telephone number for the resident or responsible party to call to agree to a meeting or request additional information.

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

4. **SNP Provider Affiliation Information** – Providers may feature SNPs in a mailing announcing an ongoing affiliation. This mailing may highlight the provider's affiliation or arrangement by placing the SNP affiliations at the beginning of the announcement and include specific information about the SNP. This includes providing information on special plan features, the population the SNP serves or specific benefits for each SNP. The announcement must list all other SNPs with which the provider is affiliated.

5. **Comparative and Descriptive Plan Information** – Providers may distribute printed information provided by a plan sponsor to their patients comparing the benefits of all of the different plans with which they contract. Materials may not "rank order" or highlight specific plans and should include only objective information. Such materials must have the concurrence of all plans involved in the comparison and must be approved by CMS prior to distribution (e.g., these items are not subject to File & Use). The plans must determine a lead plan to coordinate submission of these materials. CMS holds plans responsible for any comparative/descriptive material developed and distributed on their behalf by their contracting providers.

6. **Comparative and Descriptive Plan Information Provided by a Non-Benefit/Service Providing Third-Party –** Providers may distribute printed information comparing the benefits of different plans (all or a subset) in a service area when the comparison is done by an objective third party (e.g., SHIPs, State agency or independent research organizations that conduct studies). For more information on non-benefit/service providing third party providers (See § 40.14.6, "Non-Benefit/Service-Providing Third Party Marketing Materials" of the Medicare Marketing Guidelines – Chapter 3)

7. **Providers/Provider Group Web Sites** – Provider websites may provide links to plan enrollment applications and/or provide downloadable enrollment applications. The site must provide the links/downloadable formats to enrollment applications for all plans with which the provider participates. As an alternative, providers may include a link to the CMS Online Enrollment Center (OEC).

***NOTE*:** SNPs have the option to use the links, and the SNP should notify the provider that they may use the OEC link if they choose to, but it is not required.

8. **Leads from Providers** – Plans and providers are responsible for following all Federal and State laws regarding confidentiality and disclosure of patient information to plan sponsors for marketing purposes.

   This obligation includes compliance with the provisions of the HIPPA privacy rule and its specific rules regarding uses and disclosures of beneficiary information. In addition, 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").

   NOTE: *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 statute. 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 Medicare Managed Care Manual and Chapter 3 of the Medicare Prescription Drug Benefit Manual.*

Sample Can/Cannot List for Provider Interactions with Potential Plan Enrollees

Providers contracted with plans (and their subcontractors) **can**:

1) Provide the names of plans with which they contract and/or participate (See "Provider Affiliation Information" for additional information on affiliation).

2) Provide information and assistance in applying for the Low-Income Subsidy (LIS).

3) Make available and/or distribute plan marketing materials for a subset of contracted plans only as long as the providers offer the option of making available and/or distributing marketing materials to all plans with which they participate.

4) Provide objective information on plan sponsors' specific plan formularies, based on a patient's medications and health care needs.

5) Provide objective information regarding plan sponsors' plans, including information such as covered benefits, cost sharing, and utilization management tools.

6) Make available and/or distribute PDP enrollment applications, but no MA or MA-PD enrollment applications, for all plans with which the provider participates.

7) Refer their patients to other sources of information, such as SHIPs, plan marketing Representatives, their State Medicaid Office, local Social Security Administration Offices, CMS's Web site at https://www.medicare.gov/, or calling 1-800-MEDICARE.

8) Print out and share information with patients from CMS's Web site.

Providers contracted with plans (and their contractors) cannot:

1) Direct, urge, or attempt to persuade, any prospective enrollee to enroll in a particular plan or to insure with a particular company based on financial or any other interest of the provider (or subcontractor).

2) Mail marketing materials on behalf of plan sponsors.

3) Accept/collect enrollment applications.

4) Offer inducements to persuade beneficiaries to enroll in a particular plan or organization.

5) Health screenings is a prohibited marketing activity.

6) Offer anything of value to induce plan enrollees to select them as their provider.

7) Expect compensation in consideration for the enrollment of a beneficiary.

8) Expect compensation directly or indirectly from the plan for beneficiary enrollment activities.

9) Offer sales/appointment forms.

10) Distribute materials/applications within an exam room setting

11) Advertise services such as computer classes, citizenship assistance, English classes, and other non-health-related services to Medicare beneficiaries to be paid with Medicare dollars. CMS regulations at 42 CFR. §422.2268 specifically prohibit engaging in activities that could mislead or confuse Medicare beneficiaries and the marketing of non-health care related products to prospective members.

12) In addition, MA organizations may not advertise non-health related items or services as plan benefits and are responsible for ensuring that their downstream entities also adhere to this prohibition. Advertisements for non-health related items or services by an MA organization, or one of its contracted clinics, to MA plan enrollees could be construed as inappropriate steerage to particular clinics and, ultimately, into a specific MA plan that contracts with that clinic. For more information please refer to 42 CFR §422.2268

Termination of Provider Contract

HealthSun Health Plans may exercise termination of a Provider Contract with or without cause. Termination may be due to changes in networks and the necessity of membership needs, organizational business plan, or other adjustments in our network.

Termination may be due to but not limited to the following:

- Failure of Provider to comply with the medical community standards of medical practice
- Failure of Provider to meet credentialing or re-credentialing standards
- Material breach of the terms and conditions of the Provider Agreement with the Plan
- The commission of an act of fraud or theft
- The involuntary bankruptcy or insolvency of the provider not dismissed within sixty (60) days after filing.

Physician does not meet criteria for any of the following:

- Re-credentialing non-renewal due to not meeting criteria
- Provider has been indicted or convicted of a felony
- Repeated and documented non-compliance to adequate on-call and after-hours coverage
- Recommendation through HealthSun Medical Standards process
- Provider has been sanctioned, by Review Boards, governmental agency, or other similar body

Before terminating a contract with physician, provider or Network, a written explanation of the reason(s) must be provided. Notice is given to the physician, provider/network at least 60 days before the termination date, without cause as stipulated in the physician agreement. Nonetheless, HealthSun may immediately suspend or terminate a provider for cause by written notice 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 Drug Enforcement Agency (DEA); or

- Any other legal, government or other action or event, which may materially impair the ability to perform any duties or obligations under the provider's agreement with HealthSun.

Physicians terminated by HealthSun 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 participation in HealthSun are not subject to an advisory hearing review.
- The hearing review applies only to terminations initiated by HealthSun.
- The physician must submit his/her request in writing to HealthSun if they opt for an advisory hearing review.
- The request, along with supporting written documents must be dated and post marked not more than fifteen (15) calendar days following the date of the termination notice. If the request is not received within the fifteen (15) calendar day period, the physician's right to review is waived.
- An Advisory Panel Review will consist of three (3) physicians who are peers of the physician. However, at least two (2) members of the Advisory Panel must be present at the review to constitute a quorum.
- The Advisory Panel will base its recommendation on the written information presented by the physician and HealthSun, along with any additional information requested by the
- Panel.
- The review will occur prior to the effective date of the termination decision, and in most cases, within 15 business days of HealthSun' receipt of the physician's request for the review.
- A Provider Operations representative shall send a notification letter via certified or registered mail to the Provider(s) within two (2) weeks of receipt of the Advisory Panel's decision.

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 the Plan. 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, de-credentialed, relocated outside of the Plan's service area or retires.

IMPORTANT: In the event of a provider termination, the terminated provider is responsible for transferring the members' medical records.

If your name appears in the current Office of the Inspector General's (OIG) sanctioned provider listing, General Service Administration (GSA)/ System for Award Management (SAM) and/ or CMS Preclusion list your contract with HealthSun will be terminated and not subject to a hearing. If you have been reinstated into a federal health care program(s), contact HealthSun immediately.

Analysis review of the Physician's utilization patterns demonstrate difficulty in maintaining utilization rates that are comparable to those of like peers and in the current medical community and does not improve after a specified period of time with a correction action in place.

Cultural Competency

HealthSun's Cultural Competency policy provides clarity regarding the provision of cultural, linguistic and disability access services. The provisions outlined are in accordance with federal regulatory and Medicaid contract requirements, as well as National standards for Culturally and Linguistically Appropriate Services in Health and Health Care (The National CLAS Standards), as developed by the U.S. Department of Health and Human Services Office of Minority Health.

HealthSun ensures that all services, both clinical and non-clinical, are accessible to all members and are provided in a culturally competent manner, including those with limited English proficiency or reading skills and those with diverse cultural and ethnic backgrounds. Through policies and procedures HealthSun ensures that members are not discriminated against in the delivery of health care services consistent with the benefits covered by their plan based on race, ethnicity, national origin, religion, sex, age, mental or physical disability or medical condition, such as End Stage Renal Disease (ESRD), sexual orientation, claims experience, medical history, evidence of insurability (including conditions arising out of acts of domestic violence), disability, genetic information, or source of payment.

Objectives of Cultural Competency include:

- Reduce health care disparities in clinical area;
- Improve cultural competency in materials and communications;
- Improve network adequacy to meet the needs of the underserved groups; and
- Improve other areas of needs the organization deems appropriate.

HealthSun Health Plans (The Plan) promotes efforts to ensure that cover services are delivered in a culturally competent manner to all members and is responsive to members' health literacy needs, including those with language barriers as well as diverse cultural and ethical backgrounds, disabilities and regardless of gender, sexual orientation or gender identity.

The Plan is committed to developing, strengthening, and sustaining healthy provider/member relationships. Members are entitled to receive dignified, appropriate, and quality care that incorporates their cultural differences.

I. Cultural, Linguistic and Disability Competency Standards

A. The Plan requires all staff and providers to:

i. Follow the Plan's policies and procedures on providing accessible, culturally, and linguistically competent care.

ii. Ensure equal availability of services to all members, regardless of their communication needs, race, color, national origin, religion, sex, age, or disability.

iii. Provide full and equal access to healthcare services and facilities, make reasonable modifications as necessary to make services accessible and provide effective communication methods to meet the needs of all members, including those with disabilities.

iv. Provide flexible schedules to meet the needs of their members.

v. Provide members, upon request, with information regarding accessibility and languages.

vi. Provide accessible, culturally, and linguistically competent care.

vii. Communicate with members in a manner that accommodates their individual needs and preferences, including access to interpreter services (e.g. hearing impaired or hard of hearing services, language interpreter services) as needed to assist in coordinating specialized services.

II. Member Cultural Needs and Preferences

B. The Plan will maintain and update member demographic information to include race, ethnicity, and preferred language.

C. Care Management will perform a population assessment, at least annually, to assess the services utilized by the entire member population and relevant subpopulations (examples may include but are not limited to individuals who are dual-eligible, aged, blind, disabled, receiving home and community based waivers and those with special needs) to determine if the Plan is meeting all cultural, linguistic and disability access needs of the members or if there are any gaps in care with certain populations. The population assessment includes a demographic analysis of member compositions by race, ethnicity, preferred language, age group and sex.

D. Members have the right to choose any network provider based on cultural preference.

E. The staff and providers will receive Cultural Competency training as part of their new hire training and annually thereafter.

F. Care Management will receive training on health literacy and how to present health information in a manner that is easily understood by the

members and/or their caregivers.

G. The Plan addresses member language needs within the Evidence of Coverage manual and through the member portal[1] that is available to all members. The member materials are produced in English and Spanish. Other languages or format request are accomplished through translation, interpreters, or appropriate accessible formats.

H. The Plan contracts with a vendor that enables the Plan staff to communicate in the member's primary language via phone that is available 24 hours a day, 7 days a week at no charge to the member.

III. Social Determinants of Health

Through the Health Risk Assessment Tool (HRAT), HealthSun Health Plans identified members who experience barriers or challenges to obtaining appropriate access to health care services. These members would potentially benefit from referrals to community resources for social determinant needs such as housing, food access, transportation and/or employment. The Care Management team consist of subject matter experts, which includes physician, nurses and social workers, who are able to navigate each type of social determinant and provide guidance for access to community resources. HealthSun Health Plans provides and maintains list of community shelter resources for member access when needed locate on the Plans web site home page- https://www.healthsun.com/

IV. Network Provider/Subcontractor Training and Network Development

I. The Plan evaluates the cultural competency level of its network providers and contractors to ensure:

   i. Members understand that they have access to medical interpreters, signers and TDD/TYY services.

   ii. Medical care is provided with consideration of a member's race/ethnicity, language and cultural preferences that may impact/influence their health care outcomes.

   iii. Office staff has access and undergoes cultural sensitivity training and development.

   iv. Treatment plans are developed in consideration of a member's race, country of origin, native language, religion, mental and physical abilities, cultural beliefs, age, gender, sexual orientation and other characteristics that may impact/influence a members perspective on healthcare and treatment options.

   v. Office sites have posted and printed materials in English, Spanish and other prevalent languages to accommodate the members linguistic preference.

[1] https://www.healthsun.com/media/2167/multilanguage-interpreter-services.pdf

V. Staff Training and Workforce Development

J. All new employees receive cultural, linguistic and disability competency training as part of the new employee orientation process and are required to complete the training thereafter.

K. The U.S. Department of Health and Human Services' Office of Minority Health has published online educational programs to Advance Health Equity at Every Point of Contact (https://thinkculturalhealth.hhs.gov/) that is used to support staffing education.

L. Health Literacy training is provided to all Care Management staff as part of the ongoing training series. The training addressed primary issues surrounding the ability of members to understand their health conditions and related treatment or care plan steps outlined in their individualized care plan (see HSHP_PP_DSNP_ICP policy).

M. The Plan's Human Resource Department supports workforce development by recruiting, hiring, developing, and promoting culturally, linguistically, and disability-diverse workforce that reflects the diversity of the Plans membership as well as have familiarity with the counties being served.

VI. Cultural Competency Plan (CCP) and Monitoring

N. The Quality Improvement Committee (QIC) is responsible for updating the CCP annually based on the cultural, linguistic and disability access needs identified in the population assessment.

O. The Chief Medical Officer (CMO) is responsible for oversight of the CCP, including annual approval of the plan set forth within the policy.

P. The CCP addresses, at a minimum, the following:

   i. The Plan's strategy for recruiting staff with background representative of the members served;

   ii. The availability of interpreter services;

   iii. The availability of transportation services[2];

   iv. The Plan's ongoing strategy to meet the unique needs of members who have developmental disabilities and cognitive disabilities including its process;

   v. The Plan's ongoing strategy to provide services to home-bound members including its process;

   vi. The Plan's ongoing strategy to engage local organizations to collaborate on initiatives to increase and measure effectiveness of the culturally competent service delivery and its process; and

[2] State of Florida AHCA Contract

vii. Standards and performance requirements for the delivery of culturally and linguistically appropriate health care services.

Q. The QIC assist the Plan to meet the needs of its members but monitoring the health plan and provider performance as well as implementing interventions that improve the overall delivery of culturally competent services.

R. Member access to cultural, linguistic and disability services is monitored by:
   i. Regular provider outreach and training;
   ii. Comparison of the cultural and linguistic diversity of the Plan's membership to that of the Plan's Provider Network;
   iii. Member grievance and appeals;
   iv. CAHPS and/or other member satisfaction surveys;
   v. Provider ADA Compliance Attestations;
   vi. Language line and interpreter usage reports;
   vii. Provider surveys; and
   viii. Staff and stakeholder feedback.

S. The QIC completes and annual evaluation of the effectiveness of the CCP as part of the annual QI Program Evaluation. Findings will be used by the QIC to revise and develop the annual CCP for the following fiscal year.

General Compliance and Fraud, Waste and Abuse (FWA)

HealthSun is a company grounded in ethical behavior; our organization is committed to ensuring the services and programs it offers are in compliance with applicable Federal and State regulations, guidance, and contractual requirements (collectively "Requirements"). This strong commitment to ethics is the foundation of HealthSun's business relationships.

As a wholly owned subsidiary of Anthem, HealthSun has adopted and follows Anthem's Code of Conduct as well as Anthem's Ethics, Compliance and Privacy (ECP) Plan Compliance Plan". Anthem's Compliance Plan and culture are focused on continuous improvement and doing the right thing for our members, customers, and regulators, we have the privilege of supporting.

One of the critical guiding principles of our ECP program and this Compliance Plan is to ensure we have an effective program and culture preventing, detecting, and resolving issues of non-compliance. Further, our program and culture are focused on promoting and celebrating ethical decision-making. An organization's culture has a direct connection to the strength and effectiveness of their compliance program.

Code of Conduct

Our Code of Conduct is the foundation of our Ethics, Compliance and Privacy Program guiding our actions and decision-making process. By understanding the code, you help safeguard the organization's integrity and reputation as an ethical, caring company.

Unless otherwise noted, the Code applies to associates of HealthSun, its affiliates and subsidiaries, First-Tier, Downstream and Related Entities (FDRs), and our business partners.

How to Report Suspected or Detected Non-Compliance and Fraud, Waste and Abuse (FWA)

HealthSun recognizes the importance of preventing, detecting and investigating fraud, waste and abuse, and is committed to protecting and preserving the integrity and availability of health care resources. HealthSun accordingly maintains a comprehensive program to combat fraud, waste, and abuse. Fraud, waste and abuse, dishonesty or criminal conduct will not be allowed or tolerated.

All HealthSun Providers, First-Tier, Downstream and Related Entities (FDRs), suppliers and subcontractors are responsible for promptly reporting actual or suspected ethics, compliance and Fraud, Waste and Abuse (FWA) involving HealthSun, or any of its FDRs, subsidiaries or affiliated entities or agents to the Ethics and Compliance department. The Ethics and Compliance department provides various reporting mechanisms to submit reports or to ask questions. Reports to the Ethics and Compliance department can be made using one of the following channels:

- Call the Ethics and Compliance Helpline from the United States at
  1-877-725-2702
- Send an email to the
  ethicsandcompliance@Anthem.com
- Send a letter to the following address:
  Ethics and Compliance Department
  Anthem, Inc.
  Post Office Box 791
  Indianapolis, IN 46206

First-Tier Downstream and Related Entity (FDR) Compliance Oversight

Anthem's FDR Oversight Program maintains high-level oversight of HealthSun's contracted First Tier, Downstream and Related Entities (FDRs) to ensure each FDR meets applicable CMS requirements.

Compliance Policies and Standards of Conduct

CMS REQUIREMENT	FDR EXPECTATION
Compliance Policies and Standards of Conduct must be distributed to employees who support HealthSun Medicare Business. Distribution must occur: ○ Within 90 days of hire, ○ When policy updates occur, and ○ Annually thereafter	Anthem distributes the Code of Conduct and Medicare Compliance Plan Addendum to HealthSun FDRs. Distribution occurs at the time of on-boarding into the program, when material changes are made and annually.
HealthSun should ensure standards of conduct and policies are distributed to FDR employees.	FDRs must make the Code of Conduct available to all associates supporting HealthSun Business.
Alternatively, HealthSun may ensure that the FDR has comparable policies and standards of conduct of their own.	Alternatively make their own Standards of Conduct available. Distribution methods may include email blast, placement on the associate's portal, training content.

Office of Inspector General (OIG) and General Service Administration (GSA) and System for Award Management (SAM)

CMS REQUIREMENT	FDR EXPECTATION
HealthSun must review the OIG/GSA SAM list of Excluded Individuals and Entities and the GSA Excluded Parties List System **prior to hiring or contracting** of any new employee, volunteer, consultant, governing body, member, or FDR, and **monthly thereafter** to ensure that none of these persons or entities are excluded from participating in federal programs. *Sponsors shall not use federal funds to pay for services equipment or drugs prescribed or provided by a provider, supplier, employee, or FDR excluded by the DHHS, OIG or GSA SAM. Medicare Managed Care Manual Chapter.21 and Prescription Drug Benefit Manual Chapter 9.*	FDRs must screen all employees supporting Medicare business ***prior to hire*** and ***monthly thereafter*** against both the OIG and GSA exclusion lists. FDR must maintain documentation to evidence all pre-hire and monthly employee screenings. Proof of Screenings will be required during Annual Monitoring and may include exclusion screening screenshots, system generated reports, etc. At a minimum, evidence should show associate name (or identifier), date of screening, and results. FDRs must have policies in place for immediate removal of staff verified as excluded.
Included below are the OIG and GSA/SAM Sites for your convenience:	
OIG	**https://exclusions.oig.hhs.gov/**
GSA SAM	**https://www.gsa.gov/portal/same/#1#1**

Record Retention

CMS REQUIREMENT	FDR EXPECTATION
Sponsors are accountable for maintaining records for a period of 10 years of the time, attendance, topic, certificates of completion (if applicable), and tests administered to their employees, and must require FDRs to maintain records of the training of the FDR's employees. *42 C.F.R. 422.504(i) and/or* *42 C.F.R. 423.505(i))*	FDRs should have policies in place requiring at least 10 years record retention of all records, compliance records, and records specific to the function provided. The FDR's policy should include the method of retention (i.e. electronic, offsite storage, etc.)

Monitoring of Downstream Entities

CMS REQUIREMENT	FDR EXPECTATION
The sponsor must develop a strategy to monitor and audit its first tier entities to ensure they are in compliance with all applicable laws and regulations, and to ensure that the first tier entities are monitoring the compliance of the entities with which they contract. Monitoring of first tier entities for compliance program requirements must include an evaluation to confirm that the first-tier entities are applying appropriate compliance program requirements to downstream entities with which the first-tier contracts.	If the FDR subcontracts services to a delegated vendor (in support of HealthSun's Medicare business), the FDR must be monitoring all subcontractors to ensure they are in compliance with CMS requirements. FDRs will be required to provide a listing of all subcontractors supporting Anthem's Medicare business during annual monitoring. FDRs should ensure they can demonstrate monitoring of subcontractors and be able to provide supporting documentation as part of the FDR Monitoring Cycle.

Offshore Subcontracting/Locations

CMS REQUIREMENT	FDR EXPECTATION
If the FDR has a facility performing Anthem Medicare work that are located offshore (outside of U.S), CMS requires an Offshore Attestation to be submitted within thirty (30) days of contracting, including specific information about the FDR, its offshore locations, and the privacy protections in place to address risks associated with the use of offshore subcontractors.	HealthSun's FDRs shall not perform any functions, activities or services or delegate any functions or services, directly or indirectly, or contract with any person or entity that undertakes any functions, activities or services, including, without limitation, storage, processing, or accessing of Member information outside of the forty-eight (48) contiguous United States in compliance with our

	contract with the Florida Agency of Healthcare Administration (AHCA)

Reporting Compliance and Fraud, Waste and Abuse

CMS REQUIREMENT	FDR EXPECTATION
The Sponsor's written Standards of Conduct and/or policies must require all employees, members of the governing body, and FDRs to report compliance concerns and suspected or actual violations related to the Medicare program to the sponsor. Sponsors must adopt, widely publicize, and enforce a no-tolerance policy for retaliation or retribution against any employee or FDR who in good faith reports suspected FWA.	FDRs should be aware of the requirement to report compliance or FWA concerns, methods of reporting, and non-retaliation policy for reporting issues. If an FDR discovers evidence of misconduct related to payment or delivery of items or services under the contract, the FDR must conduct a timely, reasonable inquiry into that conduct. FDRs must conduct appropriate corrective actions (for example, repayment of overpayments, disciplinary actions against responsible employees) in response to the potential violation. FDRs are required to have procedures in place voluntarily self-report potential fraud or misconduct related to the MA program to Anthem.

FDR Oversight monitoring activities must be completed within no later than ninety (90) days from start date. After ninety (90) days if the monitoring continues and non-compliance is identified the FDR will placed in a Red Compliance status requiring a Corrective Action Plan, which will be tracked and monitored by the FDR Oversight Team until all items are remediated. If full remediation is not completed within a determined timeframe the FDR's deficiency will be presented to the Medicare Compliance Committee to make a determination pertaining to disciplinary actions including contract termination.

FDR Oversight Training and Education

FDR Compliance Trainings will cover compliance and education topics to inform and educate contracted vendors on applicable requirements and the Vendor Oversight processes. Content will address topics such as overviews of specific CMS regulations, HealthSun compliance requirements and processes, identified vendor compliance issues, vendor compliance risks, resolving compliance deficiencies, and various other vendor oversight topics as deemed appropriate by Vendor Oversight. Vendor Compliance Trainings will also serve as a method of publicizing the duty/expectation to report compliance issues or concerns. Material presented will include methods of reporting concerns, key compliance contacts, and notice of non-retaliation.

The FDR Newsletter content will cover compliance and education topics to inform and educate contracted vendors and business owners on applicable Medicare/HealthSun requirements and Vendor Oversight processes. Content will address topics such as Vendor Oversight updates, HealthSun requirements/updates, CMS regulatory requirements/updates, CMS training requirements, and FWA information. Newsletters will also serve as a method of publicizing the duty/expectation to report compliance issues or concerns. Bulletins will include methods of reporting concerns, key compliance contacts, and non-retaliation policy.

Vendor Oversight

While the Company may delegate the authority to perform a specific function to another delegate/vendor, administrative oversight is never delegated. The Company is accountable for all functions performed within its purview, regardless of whether those functions are performed internally, by a delegate/vendor or a sub delegate. Ultimately, the Company is responsible for ensuring delegated functions are completed in accordance with contractual and applicable Federal, State, and accreditation standards.

The objectives of the Enterprise Delegation Oversight Management Program are:

- Centrally monitor delegated oversight responsibilities for all delegated functions across all lines of business.
- Identify and implement delegation policies and procedures that meet Federal, State, contractual and accreditation standards.
- Define and implement a uniform methodology and efficient process to monitor delegate/vendor compliance with Federal, State, and contractual requirements and accreditation standards.
- Identify delegate/vendor areas for improvement, initiate appropriate actions to influence change, and ensure completion of timely follow-up evaluation.

The scope of the Enterprise Delegation Oversight Management Program is comprehensive covering all delegated functions for all delegates/vendors throughout the Company enterprise.

A Delegate/Vendor is any subcontractor that:

- Performs a core function under one of the Company's government/commercial contracts including but not limited to Call Center, Credentialing, Member Outreach, Utilization Management, Population Health Management (PHM) to include (Case Management, Disease Management and Transitional Care Management), Claims, Provider Appeals,

Network Development/Management, or any other administrative or management function that the Company is contracted to perform as approved by leadership; or

- Performs any other subcontracted function that requires specific oversight by the National Committee for Quality Assurance (NCQA), or other accreditation body; or federal/state requirements; and

- Is determined to be a delegate/vendor based on the examples and factors set forth below:

  - ✓ The function to be performed by the delegate/vendor would otherwise be performed by the Company;

  - ✓ Whether the function is something the Company is required to do or to provide under its contract with CMS, the applicable federal regulations or CMS guidance or the state agency overseeing compliance with code or regulations;

  - ✓ To what extent the function directly impacts enrollees/members;

  - ✓ To what extent the delegate/vendor interacts with enrollees/members, either verbally or in writing;

  - ✓ Whether the delegate/vendor has access to beneficiary information or personal health information;

  - ✓ Whether the delegate/vendor has decision-making authority or whether the delegate/vendor strictly takes direction from the Company;

  - ✓ The extent to which the function places the delegate/vendors in a position to commit health care fraud, waste, or abuse; and

  - ✓ The risk that the delegate/vendor could harm enrollees or otherwise violate federal or state requirements or commit Fraud, Waste and Abuse (FWA);

  - ✓ Whether the delegate/Company is accredited or certified by any appropriate external entity as approved by leadership.

The Company utilizes standardized audit tools to evaluate Entities prior to delegation and annually thereafter.

The Delegate/Vendor Oversight Management Committee (DVOMC) is the executive decision-making body for the Company's delegate/vendor oversight processes. Committee is comprised of representatives from the key business areas including Provider Services (PSO), Finance, Regulatory, Quality Management, Medicare Network, Health Care Management (HCM) to include Utilization Management, Case Management and Disease Management, Technology Services, Credentialing, Medicaid Legal, Medicare Legal, Commercial Legal, Medicaid Compliance,

Medicare Compliance, Commercial Compliance, Vendor Contracting & Management, Delegated Risk Contracting, Claims, Call Center, First-Tier, Downstream and Related Entities (FDR) and Enterprise Vendor Management (EVM), additional departments are included as needed.

In addition to the quarterly scheduled meetings, the Delegate/Vendor Oversight Management Committee may conduct ad hoc online meetings as needed. The DVOMC is the final approval authority for delegation oversight. All materials presented are approved by a quorum. A quorum is defined as one over fifty percent of the voting membership. Enterprise Delegation Oversight Management participates in all internal compliance programs as directed by the organization. The department also contributes but is not limited to, external market and accreditation audits such as NCQA and External Quality Review Organization (EQRO).

The Delegation Operations Committee (DOC) provides governance and oversight of delegated vendors including provider medical groups and ensures regulatory clinical adherence with contractual requires for Medicaid, Medicare, and commercial lines of business as applicable. Committee is comprised of representatives from the following areas: Plan leadership, Provider contracting, Medical Directors, Regulatory Compliance, Claims, UM leadership, Grievance and Appeals, Staff VP of Accreditation Clinical Adherence, Director of Clinical Compliance, Quality Management, Legal, Compliance, EDOM Auditors, as needed; additional departments are included as needed. These key positions encompass the core members of the DOC. DOC assesses oversight and compliance with contractual and applicable federal, state, and accreditation standards, regulatory and NCQA reporting and continuous readiness reviews, trends performance of delegates with the purpose of improving delegate performance, monitors Corrective Action Plan(s) activity for clinical adherence or additional actions as needed including recommendations to DVOMC for escalation/additional actions; evaluates delegate/vendor performance and provides recommendations to DVOMC; reviews and approves functional audit tools used by EDOM to conduct oversight audits, review and monitor focused audit review as needed for performance and regulatory changes. DOC recommends de-delegation to DVOMC. DOC reports to DVOMC on a quarterly basis.

Corrective Action Plans (CAPs)

If a Corrective Action Plan (CAP) is required, the Audit CAP Notification Letter will be used to outline those deficiencies and will be sent to the delegate/vendor Business Owner/Contract Manager via email.

Subject Matter Expert (SME) review requirements to be evaluated and noted at the Quarterly Joint Operations meetings, as applicable, and will be included in the Quarterly Joint Operations meeting summary report to DVOMC, as applicable.

Issued CAPs from National Contracting and Management, Health Plans, and Auditors will all be coordinated and submitted to the Delegation Oversight Committee (DOC).

Audit results to include any CAPs, will be presented to DOC for final approval and to DVOMC for review. Auditor will be notified of any questions, concerns, or recommendations by DVOMC, at which time will need to be addressed.

1. The Business Owner/Contract Manager will be included on all Vendor communication;

2. The delegate/vendor will formulate and submit a CAP plan to address any and all deficiencies according to the following timelines, determined by the severity of the deficiency, and as recommended by committee:

    - Egregious deficiencies = immediately within 1 business day;
    - Significant deficiencies = 10 business days;
    - Deficiency = within 30 calendar days.

3. The delegate/vendor will submit a CAP with all action items completed within thirty (30) Calendar days of the electronic receipt of their CAP Notification letter.

    1. If an acceptable response has not been received within the time frames noted above, a Second Notice of Deficiency will be sent to the delegate/vendor in question via electronic transmission;

    2. If a formal written response and CAP has not been received within five (5) business days after receipt of the Second Notice of Deficiency, DVOMC will refer to the Escalation process below.

Escalation Process

Any delegate/vendor that meets the following criteria will be flagged for escalation. Issues requiring escalation include but are not limited to:

1. Auditor concerns, e.g. egregious denials requiring urgent corrective action, inadequate administrative support, non-clinical personnel doing clinical assignments, obvious and significant disregard of regulations;
2. Identification of undisclosed and/or unapproved offshoring;
3. Sub-contracting without approval and/or audit;
4. Any delegate/vendor chosen for a current or upcoming regulatory, accreditation or client survey/audit that may be in jeopardy of not passing;
5. Lack of cooperation or lack of required response with EDOM request, including but not limited to:
    a) Refusal of audit;
    b) Refusal to submit documentation for an audit;
    c) Refusal to submit a CAP;

6. Conflicting delegation or contracting recommendations by DVOMC;
7. Recommendation of DOC; 8. Recommendation of DVOMC.

If any of the above listed situations arise, EDOM will immediately move to escalate the issue to the appropriate DOC meeting and/or schedule an ad hoc meeting based on the circumstances.

Options may be recommended by the DOC committee and may include but are not limited to:

1. Sending written communication to the delegate/vendor;
2. Having a Company Medical Director contact the delegate/vendor Medical Director;
3. Meeting with the delegate/vendor via telephone or in person;
4. Accelerating the deadline for CAP response;
5. Performing a Focused audit re-assessment;
6. Having the delegate/vendor Medical Director develop a CAP, including root cause analysis;
7. Engaging the appropriate legal and compliance leadership to discuss delegation or contracting options, including but not limited to financial penalties, de-delegation or termination of the delegate/vendor.

De-Delegation

If a delegate/vendor fails to perform in accordance with the delegate/vendor Contract or the terms and timeframes of an approved CAP, Enterprise Delegation Oversight Management will report its findings to DOC who will make a recommendation for de-delegation to DVOMC for consideration of action(s) including, but not limited to:

- Revocation of the non-compliant delegated activities (i.e. de-delegation);
- Recommendation to terminate delegate/vendor Contract, as outlined in the Escalation section of this program description;
- Execution of other remedies specifically identified in the delegate/vendor contract or applicable law.

The Company also reserves the right to terminate or revoke the delegate/vendor Contract, if permitted under the terms of the delegate/vendor Contract, for business reasons (e.g. termination without cause) for any imminent danger to enrollees/members or violation of any state, Federal or accrediting requirements.

Entities are notified of such actions by the Account Manager/Business Owner, inclusive of the Contract Owner and Legal. De-delegation recommendations are also reported to all appropriate Business Partners.

A delegate/vendor that has been de-delegated for failure to perform in accordance with the delegate/vendor Contract or the terms and conditions of an approved CAP, will be ineligible to apply for reconsideration of the same de-delegated activities for twelve months after the effective date of the de-delegation.

Responsibilities of the Primary Care Physician (PCP)

To comply with the requirements of accrediting agencies, HealthSun 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 twenty (24) hour-a-day, seven (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 HealthSun 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 HealthSun physician.

3. The PCP agrees to treat all HealthSun members with respect, consideration, and dignity.

4. The PCP agrees to practice his/her profession ethically and legally and provide all services in a culturally competent manner consistent with professionally recognized standards of care, accommodate those with disabilities, and not to discriminate against anyone based on race, ethnicity, national origin, religion, sex, age, marital status, mental or physical disability or medical condition, sexual orientation, claims experience, medical history, evidence of insurability (including conditions arising out of acts of domestic violence), genetic information or source of payment.

5. The PCP agrees to refer and/or admit HealthSun 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 ninety (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 HealthSun 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 submitting such requests to HealthSun. Note that referrals may not be required for certain services or benefits. Please contact HealthSun for details.

10. The PCP will consult with specialty care providers including providing necessary history and clinical data to assist the specialty care provider in his/her examination of the member and retrieve consultation and diagnostic reports from specialty care provider.

11. The PCP shall participate in any system established by HealthSun 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 S&Ds in accordance with Section 384.30 (2), F.S.

12. The PCP 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.

13. All referrals must be submitted via the web or faxed using the forms provided to the health services department before any specialty appointment, as applicable.

14. The PCP's office is responsible for notifying HealthSun of changes in staff. If a new physician is added to a group, HealthSun must approve and credential the physician before he/she treats HealthSun members.

15. The PCP agrees to participate and cooperate with HealthSun in internal and external quality improvement/management, utilization review, continuing education and other similar programs established by HealthSun.

16. The PCP agrees to cooperate with an independent review organization's activity pertaining to the provision of services for HealthSun members. The PCP also agrees to respond expeditiously to HealthSun' 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, HealthSun' grievance/appeal procedures when HealthSun notifies the PCP of any member grievances/appeals.

18. All PCPs are required to provide forty-five (45) day written notice to HealthSun if they are closing their panel to new and/or transferring HealthSun members.

19. The PCP agrees not to bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any resources against HealthSun 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. Notification that a service is not a covered benefit must be provided to the member prior to the service and be consistent with HealthSun

policy, for the member to be held financially responsible. HealthSun 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 HealthSun 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 HealthSun denies payment for a health service(s) rendered to HealthSun 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 HealthSun 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 HealthSun, which shall protect the PCP and its employees. If the PCP elects not to carry malpractice insurance, appropriate documentation must be submitted to HealthSun 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 HealthSun members, as required by state and federal laws.

25. The PCP agrees to treat all member records and information confidentially, accurately and timely, and agrees not to release such information without the written consent of the member, except as indicated herein, or as needed for compliance with state and federal laws, including Health Insurance Portability and Accountability Act (HIPAA) regulations.

26. The PCP agrees to establish procedures to obtain, identify, store and transport laboratory specimens or biological products, when applicable.

27. The PCP shall comply with applicable state and federal laws and regulations including, but not limited to, the False Claims Act (31 USC 3729 et. Seq.) and the anti-kickback statute (Section 1128B[b] of the Act), Title VI of the Civil rights Act of 1964, the

Rehabilitation Act of 1973, the Age Discrimination Act of 1975 and the Americans with Disabilities Act. D.

28. The PCP agrees to support and cooperate with HealthSun' Quality Management and Risk Management programs to provide quality care in a cost-effective and responsible manner.

29. The PCP agrees to inform HealthSun if he/she objects to the provision of any counseling, treatments, or referral services on religious grounds.

30. The PCP agrees to provide HealthSun 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 HealthSun and other providers involved in the member's care.

32. The PCP agrees to make provisions to minimize sources and transmission of infection within his/her office.

33. The PCP agrees to establish office procedures to notify public health authorities of reportable or communicable conditions.

34. 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.

35. 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.

36. The PCP agrees to document in a member's medical record whether the member has executed an advance directive.

37. The PCP agrees to provide HealthSun with sixty (60) days' notice when he/she intends to terminate an agreement to allow HealthSun to make a good faith effort to contact affected member(s) within thirty (30) days of receipt of termination notice.

38. The PCP agrees not to charge a copayment for influenza and pneumococcal vaccines.

39. The PCP agrees to follow the Medicare Communications and Marketing Guidelines found in the CMS Medicare Managed Care Manual.

40. The PCP agrees to receive approval from HealthSun prior to sending any communication(s) to HealthSun members.

41. 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 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.

42. The PCP shall inform HealthSun immediately upon exclusion from participation in the Medicare program and acknowledges that HealthSun is prohibited by federal law from contracting with a physician excluded from participation in the Medicare program.

43. 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., bloodborne 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)

Role of the Primary Care Physician

Each HealthSun 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 ninety (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 HealthSun 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 or arranging for all covered services including prescribing, directing, and authorizing all care to members who have been assigned to the PCP. The PCP is responsible for arranging coverage by a HealthSun 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 HealthSun 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 HealthSun.

All PCPs must be credentialed by HealthSun. All personnel assisting in the provision of healthcare services to HealthSun 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 HealthSun and cannot see HealthSun 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 HealthSun. PCPs must notify his/her provider services executive when a new physician requires credentialing. The PCP is responsible for the direct training and supervision of all employed physician extenders in the provision of care and directed according to Medicare regulations and applicable state licensure requirements.

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

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

Providing free oral interpretation services

Establishing standards and mechanisms to confirm the timeliness, quality, and accuracy of oral Interpretations

Establishing standards and criteria to promote the efficiency of interpreter services

Identifying points of contact when the need for interpretation is reasonably anticipated and establishing how the provider will provide timely access to interpretation services at all points of Contact

Establishing a range of interpreting services and types of resources needed to provide effective Interpreting

Creating mechanisms for promoting sensitivity to the culture of those with limited English-speaking proficiency

Establishing a policy regarding a patient's request, in a non-emergency, to use a family member or friend as the interpreter

Limitations on Member Liability Related to Plan-directed Care

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

- Consequently, when a participating provider furnishes a service or refers a member for a service that a member reasonably believes is a plan-covered service, the member cannot be financially liable for more than the applicable cost-sharing for that service. If an item or service is not explicitly excluded within the Evidence of Coverage (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 HealthSun.

- If a participating provider refers a member to an out-of-network provider for a service that is covered by HealthSun upon referral, the member is financially liable only for the applicable cost sharing for that service. PCPs are expected to coordinate care or work with HealthSun 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 (DHHS) issued guidance to assist healthcare providers in complying with Title VI. The DHHS points out that a thorough assessment of the language needs of the population served is to be conducted to develop appropriate and reasonable language assistance measures. The guidance details four factors PCPs should consider when determining the extent and types of language assistance that may be pursued:

1. The number or proportion of LEP individuals eligible to be served or likely to be encountered

2. The frequency with which the LEP individuals come into contact with the provider.
3. The nature and importance of the program, activity or service provided by the provider 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 HealthSun members**, he/she may contact our Provider Help Line at **1-877-999-7776**, 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, this must 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 Competency** 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 limited English proficiency (LEP) about the right to receive communication assistance. To reduce burden and costs, the HHS Office for Civil Rights (OCR) has translated a sample notice and taglines for use by covered entities into 64 languages.

For translated materials, visit www.hhs.gov/civil-rights/for-individuals/section-1557/translated-resources/index.html

Additional Resources to Assist You in Serving LEP Patients:

U.S. DHHS – Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition

Against National Origin Discrimination Affecting Limited English Proficient Persons:

https://www.hhs.gov/civil-rights/for-individuals/special-topics/limited-englishproficiency/guidancefederal-financial-assistance-recipients-title-VI/index.html

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

https://www.minorityhealth.hhs.gov/omh/browse.aspx?lvl=2&lvlid=34

The Americans with Disabilities Act of 1990

Under the ADA, physicians' offices are considered places of public accommodation. PCPs are required to comply with basic non-discrimination requirements that prohibit exclusion, segregation, and unequal treatment of any person with a disability. All PCP facilities must have in operation:

(i) Handicapped accessibility, including an accessible exam table and adequate space and supplies;
(ii) Good sanitation;
(iii) Fire safety procedures. To provide medical services in an accessible manner, PCPs and their staff may need training in operating accessible equipment, helping with transfers and positioning, and not discriminating against individuals with disabilities.

PCPs must furnish appropriate auxiliary aids and services where necessary to ensure effective communication. For deaf or hard-of-hearing patients, this may include written notes, readers, and telecommunication devices or an interpreter. In situations where information is more complex, such a 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 HealthSun. PCPs are required to modify policies and procedures when necessary to serve a person with disability. However, the ADA does not require providers to make changes that would fundamentally alter the nature of their service. PCPs are responsible for making reasonable efforts to accommodate members with sensory impairments. Without these, the PCP and staff might not understand the patient's symptoms and misdiagnose medical problems or prescribe inappropriate treatment.

Additional Resources Concerning ADA Requirements
U.S. Department of Justice: ADA home page, www.ada.gov

Language Assistance and Interpretation Services

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

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

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

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

Please contact our Member Services Provider Help Line at **1-877-999-7776** to coordinate these services.

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 HealthSun 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 STDs in accordance with Section 384.30 [2], F.S.).

3. Specialist agrees to practice his/her profession ethically and legally and provide all services in a culturally competent manner consistent with professionally recognized standards of care, accommodate those with disabilities, and not to discriminate against anyone based on race, ethnicity, national origin, religion, sex, age, mental or physical disability or medical condition, sexual orientation, claims experience, medical history, evidence of insurability (including conditions arising out of acts of domestic violence), genetic information, or source of payment.

4. Specialist agrees to treat all HealthSun members with respect, consideration, and dignity.

5. Specialist agrees to refer and/or admit HealthSun 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, HealthSun must approve and credential the physician before the physician treats enrollees.

7. Specialist agrees to participate and cooperate with HealthSun in any internal and external quality improvement/management, risk management review, utilization review, continuing education and other similar programs established by HealthSun.

8. Specialist agrees to cooperate with an independent review organization's activity pertaining to the provision of services for HealthSun members. Specialist also agrees to respond expeditiously to HealthSun' requests for medical records or any other documents to comply with regulatory requirements and to provide additional information when necessary to resolve/respond a member's grievance or appeal.

9. Specialist agrees to participate in, and cooperate with, HealthSun' grievance/appeal procedures when HealthSun notifies specialist of any member grievances/appeals.

10. Specialist agrees to follow all utilization and referral guidelines established by HealthSun, including, but not limited to, prior authorization requirements.

11. Specialist is required to provide forty-five (45) day written notice to HealthSun if closing his or her practice and moving to a new location and/or transferring HealthSun members.

12. Specialist agrees not to bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any resources against HealthSun 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 HealthSun policy for the member to be held financially responsible. HealthSun policy requires that the notification include the date and description of the service, an estimate of the cost to the member for such services, name and signature of the member agreeing in writing of receiving such services, name and signature of the provider, and be in at least 12-point font. Documentation of the pre-service notification must be included in the member's medical record and shall be provided to HealthSun or its designee upon request, and in a timely manner to substantiate member appeals. For additional guidance, please refer to the section titled **Limitations on Member Liability Related to Plan-directed Care** under **Role of the Specialty Care Physician.**

13. Specialist agrees that in the event HealthSun denies payment for a service(s) rendered to a HealthSun 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 HealthSun 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 HealthSun has arranged for substitute care for the member.

16. Specialist agrees to maintain malpractice insurance acceptable to HealthSun, 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 HealthSun 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 HealthSun' Quality Improvement and Risk Management programs.

21. Specialist agrees to inform HealthSun if he/she objects to provisions of any counseling, treatments, or referrals 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 HealthSun 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 HealthSun member so records may be released to HealthSun, 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 HealthSun members as quickly as possible for follow-up regarding significant problems and/or abnormal laboratory or radiological findings. In the event the member cannot be located, specialist will contact the member's PCP for assistance in contacting the member.

28. Food snacks or services provided to patients will meet their clinical needs and be prepared, stored, secured and disposed of in compliance with local health department requirements.

29. Specialist agrees to make provisions to minimize sources and transmission of infection within his/her office.

30. Specialist agrees to establish office procedures to notify public health authorities of reportable or communicable conditions.

31. Specialist agrees to maintain communication with the appropriate agencies such as local police, social services and poison control centers to provide high quality patient care.

32. Specialist agrees to retain all agreements, books, documents, papers and medical records related to the provision of services to HealthSun 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 HealthSun with sixty (60) days' notice when he/she intends to terminate an agreement to allow HealthSun to make a good faith effort to contact affected member(s) within thirty (30) days of receipt of the termination notice.

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 HealthSun prior to sending any communication(s) to HealthSun 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 HealthSun immediately upon exclusion from participation in the Medicare program and acknowledges that HealthSun 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, the Rehabilitation Act of 1973, the Age Discrimination Act of 1975 and the Americans with Disabilities Act.

42. Specialist shall have on-site written policies and procedures that are reviewed and updated annually, including an evaluation for the availability of safer medical services and devices and changes in technology. Office policies and procedures should include, but not be limited to, addressing following:

- Appointment scheduling and telephone guidelines
- Recordkeeping and general documentation requirements
- Medical records and confidentiality (e.g., HIPAA)
- Medication administration (e.g., refill policies, controlled substances, etc.)
- Infection control (e.g., bloodborne pathogens, housekeeping, sharps safety, hand hygiene, written exposure control plan)
- Corona Virus Disease (COVID-19)
- Safety program
- Hazard communications
- Hazardous drugs plan
- Fire safety
- Emergency action plans and preparedness (i.e., fire, tornado, and workplace violence)

Role of the Specialty Care Provider

Each HealthSun 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.

All referrals must be pre-approved by the PCP and be preauthorized/certified by HealthSun, except as agreed upon in certain areas. 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 'scare. 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

The Centers for Medicare and Medicaid Services (CMS) considers a participating provider to be an agent of HealthSun. If a participating provider furnishes a service or directs a HealthSun member to another provider to receive a plan-covered service without following HealthSun's internal procedures (such as obtaining the appropriate plan pre-authorization), then the member must not be penalized to the extent the provider did not follow plan rules.

- Consequently, when a participating provider furnishes a service or refers a member for a service that a member reasonably believes is a plan-covered service, the member cannot be financially liable for more than the applicable cost-sharing for that service. If an item or service is not explicitly excluded within the Evidence of Coverage (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 HealthSun.

- If a participating provider refers a member to an out-of-network provider for a service that is covered by HealthSun upon referral, the member is financially liable only for the applicable cost sharing for that service. PCPs are expected to coordinate care or work with HealthSun 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 (DHHS) issued guidance to assist healthcare providers in complying with Title VI. The DHHS points out that a thorough assessment of the language needs of the population served is to be conducted to develop appropriate and reasonable language assistance measures. The guidance details four factors PCPs should consider when determining the extent and types of language assistance that may be pursued:

1. The number or proportion of LEP individuals eligible to be served or likely to be encountered
2. The frequency with which the LEP individuals come into contact with the provider.
3. The nature and importance of the program, activity or service provided by the provider 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 HealthSun members**, he/she may contact our Provider Help Line at **1-877-999-7776**, 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, this must 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 Competency** 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 limited English proficiency (LEP) about the right to receive communication assistance. To reduce burden and costs, the HHS Office for Civil Rights (OCR) has translated a sample notice and taglines for use by covered entities into 64 languages.

For translated materials, visit www.hhs.gov/civil-rights/for-individuals/section-1557/translated-resources/index.html

Additional Resources to Assist You in Serving LEP Patients

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Against National Origin Discrimination Affecting Limited English Proficient Persons:

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

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The Americans with Disabilities Act of 1990

Under the ADA, physicians' offices are considered places of public accommodation. PCPs are required to comply with basic non-discrimination requirements that prohibit exclusion, segregation, and unequal treatment of any person with a disability. All PCP facilities must have in operation:

I. Handicapped accessibility, including an accessible exam table and adequate space and supplies;
II. Good sanitation;
III. Fire safety procedures. To provide medical services in an accessible manner, PCPs and their staff may need training in operating accessible equipment, helping with transfers and positioning, and not discriminating against individuals with disabilities.

PCPs must furnish appropriate auxiliary aids and services where necessary to ensure effective communication. For deaf or hard-of-hearing patients, this may include written notes, readers, and telecommunication devices or an interpreter. In situations where information is more complex, such a 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 HealthSun. PCPs are required to modify policies and procedures when necessary to serve a person with disability. However, the ADA does not require providers to make changes that would fundamentally alter the nature of their service. PCPs are responsible for making reasonable efforts to accommodate members with sensory impairments. Without these, the PCP and staff might not understand the patient's symptoms and misdiagnose medical problems or prescribe inappropriate treatment.

Additional Resources Concerning ADA Requirements

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

Language Assistance and Interpretation Services

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

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

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

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

Please contact our Member Services Provider Help Line at **1-877-999-7776** to coordinate these services.

Physician Office Procedures and Responsibilities

Confidentiality Statement

All providers are required to have policies on confidentiality, information regarding the patient, their health status and care, the release of information or records, electronic and fax data. Authorizations are considered confidential and should be maintained appropriately in your offices. Your staff should have instructions on your Confidentiality Standards.

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 (https://aspe.hhs.gov/report/health-insurance-portability-and-accountability-act-1996). 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 HealthSun 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.

http://www.hhs.gov/ocr/privacy/hipaa/understanding/summary/index.html

http://www.hhs.gov/ocr/privacy/hipaa/understanding/srsummary.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 HealthSun 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."

Maintaining Physician/ Practice Information Updated

Providers will notify HealthSun Health Plan of additions, changes, or deletions as follows:

- Name
- Address
- Phone, Fax, Pager, Cell Phone, E-mail
- Office Hours
- Coverage Procedures
- Change in Covering Physician
- Termination/Resignation/Hires of Licensed Health Care Professionals (i.e., PAs or APRNs)
- Corporate Name
- Tax ID Number
- NPI Numbers
- DEA Number
- Specialty Change
- Permit to Practice
- Open or closed status to enrollment
- Professional Liability Insurance Coverage
- Potential conflicts of interest
- Contract Status Change
- State, Federal or Regulatory Actions
- Other information that may affect the current contracting relationship

Continuing Medical Education

Physicians and Professionals who participate in HealthSun Health Plans Network of Providers are expected to maintain and exceed the requirements for Continuing Medical Education (CME) or (CUE) as defined by the Florida Medical Association, County Medical Associations, Board of Health, Department of Professional Regulation and other appropriate Boards.

Active Member Listing

The PCP office will receive a monthly active member listing by the end of the first week of each month. The list consists of those HealthSun members who have chosen the PCP office to provide them with PCP services. Please verify that all HealthSun patients receiving treatment in your office are on your membership listing. If you do not receive your list by the date mentioned above, please contact your assigned Provider Service Executive. If there are any questions regarding a patient's eligibility, please contact HealthSun' Provider Operations Department at the number in the Key Contact List or access the provider portal.

Appointment Scheduling Criteria

To ensure accessibility and availability of health services to HealthSun members, providers must adhere to the following standards set forth by the Centers for Medicare & Medicaid Services (CMS):

- Urgently needed services or emergency – immediate
- Services that are not 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.

Standards of Care

HealthSun is required to establish health care service accessibility and availability standards of care for all contracted providers in compliance with state and federal regulations. As a participating provider, the following standards are expected to be adhered to:

Accessibility, Availability and Service Standards

Standards: Provider Accessibility

- Routine PCP appointments available within 14-calendar days.
- Urgent Care appointments available within 24-hours.
- Regular specialty referral appointments within 30-calendar days.
- Wait time in the reception area not exceed 45-minutes

Standards: Provider Availability of Care and Treatment

- Access to physician services 24 hours per day, 7 days per week.
- Practice capacity does not exceed One (1) PCP; 3,000 patients and One (1) NP or PA: 1,000 patients.
- Transport time to the primary care provider office not to exceed 30 minutes, except in rural areas where rural community standards apply.
- Transport time to an acute care facility not to exceed 30 minutes, except in rural areas where rural community standards apply.
- Transport time to commonly used services, including specialist services, not to exceed 30 minutes, except in rural areas where rural community standards apply.

Standards: Accessibility and Availability of HealthSun Services

- HealthSun call answer times shall be within 30 seconds 95% of the time.
- HealthSun call abandonment rates shall be less than 5%.
- Translator services shall be made available for non-English speaking members.
- Interpreter services and other accommodations shall be made available to the hearing Impaired.

Standards: Availability of Basic HealthSun Services to Members

All HealthSun members are provided, **at a minimum**, the following services:

1. Pharmacy services

2. Ambulatory diagnostic and treatment services such as laboratory, radiology, physical therapy, and occupation therapy.

3. Coordination of inpatient care and services, with appropriate ancillary services for proper on-going evaluation and treatment.

4. Specialty referrals and coordination of care.

5. Health risk management for individuals who are at high risk for chronic disease based on their lifestyle behaviors.

6. Disease management and corresponding lifestyle management training for individuals with chronic diseases, particularly those who are diabetic, have CHF, major depression, and/or hypertension.

7. Access to skilled nursing facilities and tertiary services, when medically indicated.

8. Access to home health services, when medically indicated.

9. Health promotion/wellness services, including dietary counseling, smoking cessation education, and stress reduction counseling.

Affiliation

All physicians/providers should contact HealthSun to update their provider file for changes in their Professional Association (PA) affiliation(s) (e.g., partnership, physician group practice).

Licensure

Providers are required to maintain their State of Florida license current and in good standing. In addition, they must provide documentation of compliance with CEU's as required by the state Insurance Coverage as outlined in their Provider Agreement and meet State, Federal, and HealthSun Health Plan Standards as required.

Tax ID Change

All physicians/providers should contact HealthSun to update federal tax identification information; a W-9 form will be required. The IRS requires that we report payments made to you and that we have the correct information on the file for all physicians/providers to whom payments are made.

Identifying/Verifying HealthSun Members

Providers shall verify that all HealthSun patients receiving treatment in your office are either on the PCP membership list or members of the Plan. Upon signing an enrollment application, HealthSun Health plan will send the member an Acknowledgement of Enrollment Letter, to acknowledge the request for enrollment. Once the enrollment request has been approved by CMS, the member will receive an Enrollment Confirmation letter, which will be accompanied by the Member Welcome letter, which includes the Member Identification (ID) Card. The Evidence of Coverage (EOC) is provided to all of our Members at the time of enrollment. The EOC is also available to Members and Providers via the Plan's website (https://healthsun.com/plans/plans).

Each Plan Member will be identified as follows:

- HealthSun Member ID card, which indicates assignment to a specific PCP and cost sharing guidelines. All HealthSun Plan Members are sent an ID card, which will be presented at the time of each visit. When membership eligibility cannot be determined, you may contact the Provider Services Help Line at **1-877-999-7776** for "Eligibility Verification".

- Please note that possession of a card does not constitute eligibility for coverage. If a HealthSun member is unable to present his/her membership card, please call the Provider Services Help Line at **1-877-999-7776** to determine eligibility or access the provider portal.

- Verifying eligibility does not guarantee that the patient is in fact eligible at the time the services are rendered or that payment will be issued. We provide our members several options of health plans with an array of services, deductibles, and cost sharing. Payments will be made for the specific covered services provided to eligible HealthSun members after satisfaction of applicable premiums and cost sharing.

Medical Records

Clear, concise, consistent, complete, and comprehensive medical records are fundamental to maintaining and enhancing coordination and continuity of care, facilitating communication and promoting quality care. HealthSun requires all participating providers to maintain appropriate, accurate, complete and timely medical records for all HealthSun Members receiving medical services in a format required by Medicare laws, regulations, reporting requirements, CMS and plan instructions, as requested; and maintain records for a minimum of 10 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 HealthSun may be required to conduct. To comply with accreditation and regulatory requirements, periodically HealthSun may perform a medical record documentation audit of some provider medical records.

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.

HealthSun reserves the right to review any member's medical record in accordance with these standards and HIPAA privacy regulations. This right is to assure that the Quality of Care and Quality of Service being delivered to our membership is well documented and medically appropriate.

Electronic medical records, like medical records, must be kept in unaltered form and authenticated by the creator. Under data protection legislation, responsibility for patient records (irrespective of the form they are kept in) is always on the healthcare provider. The physical medical records are the property of the medical provider (or facility) that prepares them. This includes films and tracings from diagnostic imaging procedures such as X-ray, CT, PET, MRI, ultrasound, etc. The patient, however, according to HIPAA, has a right to view the originals, and to obtain copies under law.

If a member changes his/her PCP for any reason, the provider must transfer the member's medical record to the member's new PCP at the request of the Plan or the member. If a provider terminates, the provider is responsible for transferring the members' medical records.

Medical Record Content and Structure Standards

Medical Record Content and Structure Standard 1:

All medical records must be complete and up to date*.* Each member record must identify and ensure recording of the following:

- The HealthSun member's name (or ID/chart number) and birth date. This information is to be recorded on each page of the member's medical record.

- Personal/biographical data including age, sex, address, employer, home and work telephone numbers, and marital status.

- Dates for all entries.

- Legible author identification. Author identification may be a handwritten signature, initials, stamped signature, or a unique electronic identifier.

- Prominent notation of medication allergies and adverse reactions If the member has no known allergies or history of adverse reactions, this should be appropriately noted in the record (no known allergies = NKA).

- Past medical history must be easily identified and include serious accidents, operations, and illnesses. For children and adolescents (18 years and younger), past medical history relates to prenatal care, birth, operations, and childhood illnesses.

- Diagnostic information, consistent with findings, must be present and legibly recorded.

- Treatment plans, including medication information, be identified, and legibly recorded.

- Significant illnesses, medical conditions and health maintenance concerns must be identified and legibly recorded.

- For members 12 years and over, notation concerning the use of cigarettes and alcohol use and substance abuse must be legibly recorded.

- Emergency Room discharge notes and hospital discharge summaries hospital admissions, which occur while the member is enrolled in HealthSun, and prior admissions, as necessary) must be legibly recorded.

- Evidence that preventive screening and assessment are offered in accordance with the HealthSun Preventive Health Services policies, procedures, and guidelines.

- Documentation of whether or not the individual has executed an advance directive. If the individual has executed an advance directive, the advance directive must be available in the record.

Medical Record Content and Structure Standard 2:

Documentation of individual encounters must provide adequate evidence of, at a minimum:

- The history and physical expression of subjective and objective presenting complaints.
- Treatment plan / Plan of Care
- Laboratory and other diagnostic studies used.
- Therapies and prescribed regimens.
- Encounter forms or notes regarding follow up care, calls, or visits.
- Unresolved problems from previous visits.
- Consultation, lab, and imaging reports filed in the chart initialed by the PCP to signify review.

Medical Record Content and Structure Standard 3:

All medical records must be secured in a safe place.

Medical Record Content and Structure Standard 4:

All medical record entries must be neatly recorded, legible, complete, and concise, and written in black ink.

Medical Record Content and Structure Standard 5:

All records must be dated and recorded in a timely manner with the complete name and professional designation of the entrant.

Medical Record Content and Structure Standard 6:

No record should be altered, falsified, or destroyed. If a correction is introduced, the individual correcting the record should draw a single line through the item to be corrected, and date an initial the correction.

Medical Record Content and Structure Standard 7:

All telephone messages and telephone consult discussions must be clearly identified and recorded.

Privacy and Confidentiality Standards

Medical Record Privacy and Confidentiality Standard 1:

All HealthSun members' individually identifiable information whether contained in the member's medical records or otherwise is confidential. Such confidential information, whether oral or recorded in any format or medium, includes but is not limited to, a member's medical history, mental or physical condition, diagnosis, encounters, referrals, authorization, medication or treatment, which either identifies the member, or contains information, which can be used to identify the member.

Medical Record Privacy and Confidentiality Standard 2:

In general, medical information regarding a HealthSun member must not be disclosed without obtaining written authorization. The authorization must come from the member, the member's guardian, or conservator. If the authorization is signed by the member, the member's medical record must not reflect mental incompetence. If the authorization is signed by a guardian or conservator, evidence such as a Power of Attorney, Court Order, etc., must be submitted to establish the authority to authorize the release or medical information.

Medical Records Privacy and Confidentiality Standard 3:

To release member medical information, a valid and completed Medical Information Disclosure Authorization Form, prepared in plain language, must be used. The form must include the following items:

1. Name of the person or institution providing the member information.
2. Name of the person or institution authorized to receive and use the information.
3. The HealthSun member's full name, address, and date of birth.
4. Purpose or need for information and the proposed use thereof.

5. Description, extent, or nature of information to be released that identifies the information in a specific and meaningful fashion, including inclusive dates of treatment.

6. Specific date or condition upon which the HealthSun member's consent will expire, unless earlier revoked in writing, together with member's written acknowledgment that such revocation will not affect actions taken prior to receipt of the revocation.

7. Date that the consent is signed, which must be later than the date of the information to be released.

8. Signature of the member or legal representative and his or her authority to act for the member.

9. HealthSun member's written acknowledgment that information used or disclosed to any recipient other than a health plan or provider may no longer be protected by law.

10. Except where the authorization is requested for a clinical trial, it must contain a statement that it will not condition treatment or payment upon the member providing the requested use or disclosure authorization.

11. A statement that the member may refuse to sign the authorization.

Medical Records Privacy and Confidentiality Standard 4:

Pursuant to laws that allow disclosure of confidential medical information in certain specific instances, such information may be released by HealthSun without prior authorization from the member, the member's guardian, or conservator for the following reasons:

- Diagnosis or treatment, including emergencies.
- Payment or for determination of member eligibility for payment.
- Concurrent and retrospective review of services
- Claims management, claims audits, and billing and collection activities
- Adjudication or subrogation of claims
- Review of health care services with respect to medical necessity, coverage, appropriateness of care, or justification of charges
- Coordination of benefits
- Determination of coverage, including a pre-existing conditions investigation
- Risk management
- Quality assessment, measurement, and improvement, including conducting satisfaction surveys of members
- Conducting case management and discharge planning

- Conducting preventive care programs
- Coordinating specialty care, such as Maternity Management
- Detection of health care fraud and abuse
- Developing clinical guidelines or protocols
- Reviewing the competency of health care providers and evaluating provider performance
- Preparing regulatory audits and regulatory reports
- Conducting training programs
- Auditing and compliance functions
- Resolution of grievances
- Provider contracting, certification, licensing, and credentialing
- Due diligence
- Business management and general administration
- Health oversight agencies for audits, administrative or criminal investigations, inspections, licensure, or disciplinary actions, civil, administrative, or criminal proceedings or actions
- In response to court order, subpoena, warrant, summons, administrative request, or similar legal processes
- To comply with Florida law relating to workers' compensation;
- To County coroner, for death investigation;
- To public agencies, clinical investigators, healthcare researchers, and accredited non-profit educational or healthcare institutions for research, but limited to that part of the information relevant to litigation or claims where member's history, physical condition or treatment is an issue, or which describes functional work limitations, but no statement of medical cause may be disclosed;
- To organ procurement organizations or tissue banks, to aid member medical transplantation;
- To agencies authorized by law, such as the FDA;
- To State and Federal disaster relief organizations, but only basic disclosure information, such as member's name, city of residence, age, sex and general condition;
- To any chronic disease, management programs provided member's treating physician authorizes the services and care.

Medical Records Privacy and Confidentiality Standard 5:

All individual HealthSun member records containing information pertaining to alcohol or drug abuse are subject to special protection under State and Federal Regulations (Confidentiality of Alcohol and Drug Abuse Member Records, Code 42 of Federal Regulation, chapter 1, Subchapter A. Part 2). An additional and specific consent form must be used prior to releasing any medical records that contain alcohol or drug abuse diagnosis.

Medical Records Privacy and Confidentiality Standard 6:

Special consent for release of information is needed for all members with HIV/AIDS and Mental Health disorders. In general, medical information for member's who exhibit HIV/AIDS and/or mental health disorders will always be reported in compliance with Florida state law. Additional

information will be released regarding a member infected with the HIV virus only with an authorized consent.

Information released to authorized individuals/agencies shall be strictly limited to minimal information required to fulfill the purpose stated in the authorization. Any authorization specifying "any and all medical information" or other such broadly inclusive statements shall not be honored and release of information that is not essential to the stated purpose of the request is specifically prohibited.

Member Rights regarding their Protected Health Information (PHI)

All HealthSun Members have the right to request that HealthSun restrict the use and disclosure of their PHI for treatment payment; healthcare operations; or to a family member, other relative, or close friend. HealthSun does not have to agree with the restriction. If HealthSun agrees with the restriction, HealthSun may not use or disclose the members PHI in violation of the restriction, except in cases of emergency treatment or if the information is needed by HealthSun for internal operations. HealthSun may terminate its agreement to a restriction if the member agrees to such termination. In such cases, termination of the restriction is only effective for PHI HealthSun receives after HealthSun informs the member.

HealthSun has adopted the following standards for Medical Records. These are suggested standards for the content and structure, confidentiality and privacy of all medical records kept on HealthSun members. The standards are in compliance with state and federal requirements as established by the Florida Agency for Healthcare Administration (AHCA) and the Centers for Medicare and Medicaid Services (CMS).

1. Members have the right to request communication of their PHI by alternative means or at alternative locations, if the member communicates to HealthSun that the disclosure of the PHI could endanger the member. The request must be in writing.

2. Members have the right to inspect and copy their PHI that is maintained in a designated record set (e.g., medical record). HealthSun is required to provide access within thirty (30) days after receipt, in writing (sixty (60) days if the information is stored off-site). HealthSun is required to provide the information at a convenient time or place or mail the information to the member. HealthSun may charge the member a reasonable fee to cover duplicating costs, including associated labor costs and postage. Members do not have the right to access psychotherapy notes or information compiled in reasonable anticipation of, or for use in, a civil, criminal, or administrative action or proceeding. HealthSun may deny the member's request for access if a healthcare professional finds that it will endanger the member or another person.

3. Members have the right to request, in writing, an amendment to their PHI. HealthSun may deny the member's request if the PHI was not created by HealthSun or one or more of HealthSun contracted providers, or if the PHI is contained in psychotherapy notes or information compiled in reasonable anticipation of, or for use in, a civil, criminal or administrative action or proceeding. HealthSun must act on the request for an amendment within sixty (60) days (with up to a thirty (30) day extension, if needed).

Members have the right to provide an authorization for other uses and disclosures of their PHI pursuant to specific written authorization signed by the member or the member's personal representative

Encounter Process

Providers should verify eligibility prior to providing care to HealthSun members. Eligibility must be verified by requesting a HealthSun membership card and confirming eligibility by calling the Provider Services Help Line listed below.

Upon request by Plan, CMS or Governmental Agency, Provider shall certify the accuracy, completeness and truthfulness of encounter data submitted to Plan.

All cost sharing be collected according to information on the Plan's benefit grids or as per the information provided when checking eligibility.

All Encounters must be recorded and submitted to Plan. Electronic format is preferred. If you are not currently submitting them electronically and would like to, please contact your assigned Provider Operations Representative.

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

HealthSun Health Plans
P.O Box 211154
Eagan, MN 55121
Attention: Claims Department

Encounters may also be submitted electronically using the ASC X12N 837 format. HealthSun has contracted with Gateway EDI and Availity EDI clearinghouses for Electronic Claim Submissions. The Payer ID for HealthSun is HESUN and should be included with all electronic submissions. If you need assistance with electronic claim submission set up, please contact your EDI clearinghouse, Availity EDI Customer Service at 800-282-4548, TriZetto EDI Customer Service at 800-556-2231, or your HealthSun Provider Operations Representative at 305-448-8100 Extension 10822.

After Hours Access

Providers and/or Covering Providers are required to provide advice, consultation, and access to care appropriate for each Member's medical condition as described below:

- 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.
- Notification to the Plan of known Emergency Room (ER) visits and Emergency Room (ER) admits

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

- Response to urgent calls within 15 minutes; response to routine calls within 24 hours.
- After hours, response to urgent calls within 15 minutes; non-urgent response 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 emergency, which may cause this standard to be exceeded, the member should be promptly notified and given the option of waiting or rescheduling.

By monitoring compliance with these guidelines over time, HealthSun can take action to improve member service availability and access to medical services when necessary. HealthSun may monitor compliance with the above-mentioned access standards through a variety of ways including site visits, telephone audits, member surveys and complaints.

Covering Physicians

Physicians must arrange for coverage of their practice 24 hours a day, seven days per week 365 days a year. The covering physician must be a HealthSun Health Plan physician or credentialed by HealthSun Health Plans.

Disabled Members and CMS Requirements

There are Federal laws to protect the rights of persons with disabilities such as the Americans with Disabilities Act ("ADA"), Rehabilitation Act, and other protections. HealthSun Health Plans requires providers to meet the standards that ensure your facility is accessible and usable by persons with disabilities.

Language Support Services

HealthSun Health Plans will provide support services to Providers requiring assistance in communicating with members in languages that they are not proficient in.

Non-Discriminatory Notice

Providers will ensure that Members are not discriminated against in the delivery of healthcare services consistent with the benefits covered in their Policy based on race, ethnicity, national origin, religion, sex, age, mental or physical disability, sexual orientation, genetic information, or source of payment.

Advance Directive

HealthSun Health Plans, Inc. 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 health care, recognized under state law and signed by a patient, that explain the patient's wishes concerning the provisions of health care if the patient becomes incapacitated and is unable to make those wishes known. Providers are expected to advise each HealthSun member regarding his or her future health care needs and available options. Providers may give advance directive information to the patient's family or surrogate should the patient be incapacitated at the time of enrollment. Advance Directive Forms are also available at the following website www.aafp.org .

Open/Close Panel

PCP Providers may close their panel to new and/or transferring HealthSun members with at least 45 days prior written notice to the Provider Operations Department. An asterisk (*) indicating a closed panel will be placed beside your name when the provider directory is updated. Written notification to the Provider Operations Department is required if you wish to accept a new member into a closed panel or to reopen your panel to new members.

Requests for openings and closing a panel should be submitted on your letterhead to the following:

Written Requests – HealthSun Health Plans, Inc.
9250 W. Flagler Street
Suite. 600
Miami, FL 33174
Attention: Provider Operations Department
E-Fax-1-305-489-8110
E-Mail - Providerservices@healthSun.com

Safety Requirements

Providers are required to meet Safety Standards in accordance with the Occupational Safety and Health Administration (OSHA), ADA, and regulatory requirements. They are required to develop a written safety plan that includes fire and emergency activities. It should include the following Medical Emergency Procedures:

- 911 Calling.
- Obtaining emergency equipment.
- Disaster Plan and Emergency Procedures for fire, flood and other natural disasters.
- Evacuation route to be posted and reviewed with personnel.
- Evacuation plan for able Member and handicapped Members, staff, and visitors.

Upon termination as a participating provider, the records of the Members that had been under your care will be made available to the next physician(s) at no cost to that physician or to the member, and will be made available to HealthSun Health Plans upon request.

Safety drills such as fire, CPR, and weather should be held at least quarterly with staff and documented to include an evaluation of the drill. Other required safety protocols include the compliance with a sharps injury prevention program that requires the safe disposal of syringe and needles as follows:

- Disposal of intact needles and syringes into appropriate sharps containers
- Replacement of sharps containers when the fill line is reached
- Handling and disposal of filled sharps containers to a biohazardous waste contractor

Staff must be oriented on these protocols at the time of hire and annually thereafter in conjunction with the OSHA training.

Provider offices must ensure that any cleaning or hazardous materials or liquids are stored in a safe manner and that staff have received appropriate orientation related to their use and the need for the use of personal protective equipment.

Providers should ensure on-going monitoring of information related to the recall of medications and equipment maintained in offices. Should any items be subjected to recall, processes need to be implemented to notify staff, return the recalled item, contact any effected patients, and maintain a record of such activities.

Provider Compliance and Quality Reviews

Provider will comply with quality reviews conducted by HealthSun Health Plans. The reviews are conducted to ensure that the provider is in compliance when addressing Member concerns and rights. Areas of review will include site audits, Medical Record Audits, analysis of complaints and grievances, Member Satisfaction Surveys, request for Provider changes, Rapid Disenrollment Survey, Safety and Infection Control and other measurable data.

Provision of Care

All providers are required to provide services in a manner consistent with professionally recognized standards of care that are time specific and updated.

Member Participation

Providers will allow Members the right to participate in their decision making regarding their health care. Health Sun Health Plan encourages all providers to provide active Member participation in their treatment planning and course of care. This includes the Member's right to withhold resuscitative services or to forgo or withdraw life-sustaining treatment in compliance with Federal and State Laws. All Members have the right to receive information on available treatment options (including the option of no treatment) or alternative courses of care and other information specified by law. Healthcare Providers must inform the member of their treatment options in a language the member understands.

Missed Appointments

Provider will follow up with the member when an appointment has been missed. If the patient does not go to the previously scheduled appointment without prior cancellation, Provider must document within the medical records.

Providers may not charge a fee for missed appointments to cost share protected dual eligible members including QMB, QMB+ and FBD.

Disruptive Behavior

Providers who may have a member that has displayed disruptive behavior, must clearly document in the member records the incident(s) and submit them to HealthSun' Provider Operations Department. The documentation must include attempts to bring the member into compliance. A member's failure to comply with a written corrective action plan must be documented. The member must have at least one written warning regarding the implications of his/her actions. The Plan must issue approval in order for a member to be transferred out of a physician's practice. For any action to be taken, it is mandatory that copies of all supporting documentation from the member's file be submitted along with this request.

Member Initiated PCP Transfer

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

Involuntary Disenrollment

Members may not be transferred or disenrolled for pre-existing medical conditions, change in health status or periodic missed appointments. HealthSun will follow the involuntary disenrollment process set forth by the Centers for Medicare & Medicaid Services (CMS). Providers who may have a member that has displayed disruptive behavior, must clearly document in the member records the incident(s) and submit them to HealthSun' Provider Operations Department. The documentation must include attempts to bring the member into compliance. A member's failure to comply with a written corrective action plan must be documented. The member must have at least one written warning regarding the implications of his/her actions. The Plan must issue approval in order for a member to be transferred out of a physician's practice. For any action to be taken, it is mandatory that copies of all supporting documentation from the member's file be submitted along with this request.

Disenrollment may be involuntary under the following conditions:

- Loss of Medicare entitlement to Part A and/or Part B
- Fraudulent use of ID card
- The plan contract is terminated
- Member moves outside the service area or is away from the service area for more than
- six (6) consecutive months
- Member provides fraudulent information on an election form
- Member is no longer eligible for plan (e.g., SNP plans)
- Member fails to pay their Part D Income Related Monthly Adjustment Amount (IRMAA)
- If a member's behavior is so disruptive that it substantially impairs HealthSun' ability to arrange for the care of that member or other members of the plan, HealthSun may submit a request to CMS to have the member involuntarily disenrolled from the plan. Requests cannot be made as a result 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. HealthSun cannot disenroll a member because he/she chooses not to comply with any treatment regimen (CFR 42 §422.74).

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

Occupational Safety and Health Administration OSHA and Infection Control

Providers must maintain an environmentally safe practice facility. This includes ensuring equipment, lab, office, restrooms, waiting area chairs and tables, examination room, and equipment are in proper working order and comply with City, State, and Federal Regulations concerning safety and public hygiene. Providers shall be responsible for establishing an exposure control plan in compliance with OSHA standards regarding Blood borne Pathogens. In addition, provider will make all necessary provisions to minimize sources and transmissions of infection in the office. This will include good hand washing, the use of gloves/universal precautions, cleaning of rooms and equipment prior to and between patients, and the safe use of needles and syringes and multi-dose injectable.

Providers are to comply with Centers for Disease Control (CDC) hand hygiene protocols that include washing hands with soap and water or an alcohol-based gel prior to putting on gloves for patient contact and after the removal of the gloves. Hand hygiene with the use of soap and water or alcohol- based gel should be used after any patient contact. Hands should be washed with soap and water when any visible matter is present on the hands.

Protocols related to the safe use of syringe and needles are adopted from CDC/HICPAC and APIC nationally and require that each needle and syringe are used only one time for one (1) patient. The use of multi-dose vials requires compliance with USP 797 regulations. Each multi-dose vial must be labeled with a date at the time of opening and discarded within 28 days of opening unless the manufacturer's expiration date is sooner. Each vial must be wiped using friction for 6-8 seconds with an alcohol swap prior to entering with a new needle and syringe with each use. Vials may never be spiked.

Patient care areas (e.g. exam tables, counter tops, chairs) and equipment (e.g., BP cuffs, Glucometers, EKG leads) must be wiped down after each patient use with sanitizing wipes (e.g. Cavi-wipes or Clorox wipes).

Any patient determined to have presented to the office with a communicable disease should be isolated immediately, a mask applied, and the patient either discharged or transferred immediately if the disease is a reportable one. If the patient is a HealthSun member, Provider Operations should be notified immediately. Providers are also required to be in compliance with public health reporting requirements.

For provider offices who conduct minor removal of lumps and bumps, processes must be in place for either the disposal of equipment or the sterilization of equipment in autoclaves. Providers are expected to monitor the functionality of autoclaves and any failures in the sterilization processes to ensure against any injections, cross-contamination, and exposure.

Infection Control, Prevention and Safety

Infection control is an integral part in outpatient settings. All employees should be educated regarding the routes of transmission and techniques used to prevent transmission of infectious agents. Policies for infection control and prevention should be written, readily available, updated annually, and enforced. 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.

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

Included 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.

Regulatory Agency	**Web Link to Guideline/Best Practice**
CDC	Healthcare-associated Infections (HAIs) Guidelines, https://www.cdc.gov/infectioncontrol/guidelines/index.html
CDC	Healthcare-associated Infections (HAIs) Guide to Infection Prevention for Outpatient Settings – Minimum Expectations for Safe Care, http://www.cdc.gov/HAI/settings/outpatient/outpatient-care-guidelines.html
CDC	Guideline for Infection Control in Healthcare Personnel, http://www.cdc.gov/hicpac/pdf/InfectControl98.pdf
CDC	2007 Guidelines for Isolation Precautions: Preventing Transmissions of Infectious Agents in Healthcare Settings, http://www.cdc.gov/hicpac/pdf/isolation/Isolation2007.pdf
CDC	Hand Hygiene in Healthcare Settings, www.cdc.gov/handhygiene

CDC	CDC Injection Safety, www.cdc.gov/injectionsafety
OSHA	Medical and Dental Offices – A Guide to Compliance with OSHA Standards, http://www.osha.gov/Publications/OSHA3187/osha3187.html
OSHA	Safety and Health Topics: Healthcare, http://www.osha.gov/SLTC/healthcarefacilities/index.html
OSHA	Safety and Health Topics: Healthcare – Standards/Enforcement, http://www.osha.gov/SLTC/healthcarefacilities/standards.html
OSHA	Safety and Health Topics: Healthcare – Other Hazards, https://www.osha.gov/SLTC/healthcarefacilities/otherhazards.html
OSHA	Safety and Health Topics: Bloodborne Pathogens and Needlestick Prevention Standards, http://www.osha.gov/SLTC/bloodbornepathogens/index.html
OSHA Publication	Model Plans and Programs for the OSHA Bloodborne Pathogens and Hazard Communications Standards (OSHA 3186-06R 2033), www.**osha**.gov/Publications/**osha**3186.pdf
CDC	Guideline for Disinfection and Sterilization in Healthcare Facilities, https://www.cdc.gov/infectioncontrol/guidelines/disinfection/index.html
U.S. Food and Drug Administration (FDA)	Guidance for Industry and FDA Staff - Medical Device User Fee and Modernization Act of 2002, Validation Data in Premarket Notification Submissions (510(k)s) for Reprocessed Single-Use Medical Devices, https://www.fda.gov/regulatory-information/search-fda-guidancedocuments/ medical-device-user-fee-and-modernization-act-2002-validation-data-premarket-notification

Safety

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

- Processes for the management of identified hazards, potential threats, near misses and other safety concerns
- Processes for reporting known adverse incidents to appropriate local, state and/or federal agencies when required by law to do so
- Unique patient identifiers used throughout care
- Processes to reduce and avoid medication errors. Examples of such are:
  - (i) Write legible prescriptions which include dosage and indication
  - (ii) Utilize an electronic prescribing system and submit electronic requests directly to Pharmacies
  - (iii) 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 the 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.

- 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

Additional Resources

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 is important that you remain up to date on all regulatory changes as it is your responsibility to implement any applicable changes. To find specific CMS transmittals or MLN Matters® articles, please visit the CMS website at the following addresses:

CMS Transmittals Overview: http://www.cms.gov/Transmittals/01_Overview.asp

MLN Matters Articles Overview: http://www.cms.gov/MLNMattersArticles/

CMS National Coverage Determinations (NCDs):

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: https://www.cms.gov/medicare-coverage-database/overview-and-quicksearch.aspx

CMS Medicare Coverage Center: https://www.cms.gov/center/coverage.asp

Note: HealthSun provides direct access to the above-mentioned CMS websites on our HealthSun website at: https://www.HealthSunhealthplans.com/HealthSun-providers/updates under the section of CMS Transmittals and National Coverage Determinations."

HealthSun Health Plans Overview

HealthSun is a Medicare Advantage Health Maintenance Organization (HMO) with Prescription Drug Coverage approved by Medicare. Coverage under our Plan qualifies as Qualifying Health Coverage (QHC) and satisfies the Patient Protection and Affordable Care Act's (ACA) individual shared responsibility requirements.

The Medicare Program Overview

Medicare is the federal health insurance program for:

- People who are 65 or older Certain younger people with disabilities
- People with End-Stage Renal Disease –ESRD, permanent kidney failure requiring dialysis or transplant.

The different parts of Medicare help cover specific services:

- Medicare Part A (Hospital Insurance) – Covers inpatient hospital stays, care in a skilled nursing facility, hospice care, and some home health care.
- Medicare Part b (Medical Insurance) – Covers doctor's services, outpatient care medical supplies, and preventive services.
- Medicare Part D (Prescription Drug Coverage) – Helps cover the cost of prescription drugs (including recommended shots or vaccines)

With Medicare, beneficiaries have options in how they get their coverage. Once they enroll, they need to decide how to get their Medicare coverage:

- Original Medicare
- Medicare Advantage
- Medicare Prescription Drug Coverage (Part D)

Medicare Advantage Overview

Medicare Advantage is an “all in one” alternative to Original Medicare. Including Medicare Part A, Part B, and Part D. As a Medicare Advantage Plan HealthSun offers, extra benefits that Original Medicare does not cover like vision, hearing, dental, and more. Medicare Advantage Plans have yearly contracts with Medicare and must follow Medicare’s coverage rules.

Special Needs Plans (SNP)

Special Needs Plans were established by the Medicare Modernization Act (MMA) of 2003 and are designed to provide targeted care to individuals with special needs. In the MMA, Congress identified special needs individuals as:

- Dual SNP (D-SNP) – Members are eligible for Medicare + Medicaid.
- Chronic Condition SNP (C-SNP) – Members with severe or chronic conditions
- Institutional SNP (I-SNP) – Members living in an institution for 90-days or longer, such as elderly home or long –term care or skilled nursing facility, or members living in community that requires institutional level of care or attention that equals those provided in any institution.

Special Needs Plans (SNPs) are different from most Medicare Advantage Plans as focus is on beneficiaries who have special needs and would benefit from enhanced care coordination as described in the Model of Care (MOC).

CMS requires HealthSun to contract with the State of Florida’s Agency for Healthcare Administration (AHCA) to provide health care services for Florida Medicaid recipients enrolled in the Plan. HealthSun is responsible for providing/arranging for Medicare/Medicaid benefits dually eligible members enrolled with the Plan are entitled to receive.

Medicaid recipients enrolled in a D-SNP are except from enrollment into Medicaid’s Managed Care Medical Assistance (MMA) and Dental Plans. Medicaid recipients can be enrolled in Medicaid Long-Term Care Plan & a D-SNP at the same time. Since Medicare is the Primary payer, providers must bill the D-SNP or Medicare accordingly for “Full Dual” recipients (who have Medicare and Full Medicaid). Providers should also bill the D-SNP for any Medicaid-covered service not covered by Medicare.

Medicare Advantage Enrollment Periods

There are six types of election periods during which individuals may make enrollment changes for MA-PD Plans.

1. Annual Election Period (AEP) **-** The AEP is Oct. 15 through Dec. 7 of every year. During the AEP, MA eligible individuals may enroll in or disenroll from an MA plan. Any changes made take effect Jan. 1 of the following year.

2. Initial Coverage Election Period (ICEP) **-** This period begins three months immediately before the individual's first entitlement to both Medicare Part A and Part B and ends on the later of 1) the last day of the month preceding entitlement to both Part A and Part B, or 2) The last day of the individual's Part B initial enrollment period. Once an ICEP enrollment request is made and enrollment takes effect, the ICEP election has been used.

3. Initial Enrollment Period for Part D (IEP for Part D) **-** For MA, allows enrollment requests for MA-PD plans only.

4. Open Enrollment Period for Institutionalized Individuals (OEPI) **-** is Jan. 1 through March 31 of every year for individuals enrolled in an MAPD plan as of Jan. 1. During the MA OEP, MAPD 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 MAPD 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.

5. Special Election Period **–** Special election periods constitute periods outside of the usual IEP, AEP, or MA OEP when an individual may elect a plan or change his/her current plans. Below are the various types of SEPs:
    - Change in residence
    - MA contract violation
    - MA nonrenewal or terminations
    - SEPs for exceptional conditions
        - Employer/group health plan
        - Individuals who disenroll in connection with a CMS sanction
        - Individuals enrolled in cost plans that are not renewing their contracts
        - Individuals in the Program of All-inclusive Care for the Elderly (PACE)
        - Individuals who dropped a Medigap policy when they enrolled for the first time in an MA plan, and who are still in a trial period
        - Individuals with ESRD whose entitlement determination is made retroactively
        - Individuals whose Medicare entitlement determination is made retroactively
        - To coordinate with Part D enrollment periods
        - Individuals who have an involuntary loss of creditable coverage, not including a loss due to failure to pay plan premiums
        - Individuals who lose special-needs status
        - Individuals who belong to a qualified state pharmaceutical assistance program (SPAP) or lose SPAP eligibility
        - Non-U.S. citizens who become lawfully present
        - Individuals who gain, lose or have a change in their dual-eligible or LIS-eligible status
        - Disenrollment from Part D to enroll in or maintain other creditable coverage

- Enrollment in an MA plan or PDP with a plan performance rating of five stars*
- Individuals who requested materials in accessible formats but HealthSun or CMS was unable to provide required notices/information in a timely manner to allow for equal time to make enrollment decisions
- Individuals affected by a FEMA-declared weather-related emergency or major disaster

➢ SEPs for beneficiaries age 65
➢ 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.

6. Medicare Advantage Open Enrollment Period (MA OEP) **–** Starts on January 1st and ends on March 31st. Members can make a change to join another Medicare Advantage Plan or obtain coverage with Original Medicare.

Table 1.

	Medicare Advantage Open Enrollment Period (OEP)	Annual Enrollment Period (AEP)	Initial Enrollment Period (IEP) for Part D	Initial Coverage Enrollment Period (ICEP)	Initial Coverage Enrollment Period (ICEP) for Delayed Part B	5 Star Enrollment Period (SEP-R)
When are you eligible?	Starts January 1 & ends March 31.	Starts October 15 & ends December 7.	Starts 3 months before first eligible to enroll in a Medicare Part D Plan and ends 3 months after the entitlement begins.	Starts 3 months before first entitlement to Medicare Part A & enrollment in Part B and ends 3 months after the entitlement begins.	Starts 3 months before entitlement to Medicare Part A & enrollment in Part B and ends last day of the month the entitlement begins.	Every calendar year from January 1st until November 30th.
Description of eligibility	MA members can make a change to join another MA plan or obtain coverage through Original Medicare.	All Medicare beneficiaries can make as many changes to their health plan and prescription drug coverage.	New Medicare beneficiaries can enroll in a Part D Plan once entitled to Part A or enrolled in Part B.	New Medicare beneficiaries can enroll in a MA Plan once enrolled in BOTH Part A and Part B.	Medicare beneficiaries who delay enrollment in Part B when entitled to Part A can enroll in a MA Plan once enrolled in BOTH Part A and Part B.	All Medicare beneficiaries enrolled in BOTH Part A and B.
Other information	You can only use this election ONE time during this 3-month period.	You become effective with your new plan on January 1.	The IEP for Part D & the ICEP occur together as one period (7 months) when a newly eligible enrolls in BOTH Part A and Part B. If you enroll in an MA-PD Plan you have used both the IEP & ICEP. If you enroll in a PDP you have used only the IEP.		The IEP for Part D & the ICEP are separate when enrollment in Part B is delayed, limiting the ICEP to a 3-month period.	Medicare beneficiaries have a ONE time election period to enroll in a 5 star plan every calendar year.

Table 2. SEP Determination of Eligibility Questions

Type of SEP?	Examples of Questions
Change in Residence	Have you recently moved? If so, when? Where did you move from?
Employer/Union Group Health Plan (EGHP)	Do you currently have (or are leaving) coverage offered by an employer or union? Have you recently lost such coverage?
Disenroll from Part D to Enroll in Creditable Coverage	Are you a member of TriCare? Do you have or want to obtain VA benefits?
Full Dual Eligible or Other Low Income Subsidy	Do you currently have Medicaid coverage? Does your state pay for your Medicare premiums? Do you receive SSI cash benefits without Medicaid? Did you receive a letter from Medicare letting you know that you automatically qualify for extra help? How much do you pay for your prescriptions?
Retroactive notice of Medicare entitlement	Have you recently received a notice telling you that you have been approved for Medicare for a "retroactive" date? If so, when did you receive this notice?
PACE	For enrollment – are you currently enrolled in a special plan called "PACE"?
CMS/State Assignment	Have you recently received a blue letter (i.e., Reassignment notice) from Medicare? Did your state/plan send you a letter to let you know they are moving you to a different plan? Did you recently receive a yellow letter (i.e., Auto-enrollment notice) from Medicare? Have you recently received a green letter (i.e., Facilitated Enrollment notice) from Medicare?
Change in Dual/LIS Status	Have you recently gained/lost coverage under Medicaid? Did you recently receive a grey letter (i.e., Loss of Deemed Status notice) from Medicare? Did you recently receive an orange letter (i.e., Change in Extra Help Co-Payment notice) from Medicare? Did you recently receive a purple letter (i.e., Deemed Status notice) from Medicare?

HealthSun's Service Area

Although Medicare is a Federal Program, HealthSun Health Plans, Inc. is available only to individuals who live in our plan service area. To remain a member of the plan, members must continue to reside in the plan service area. Our service area includes the following counties in the State of Florida:

- **Miami-Dade County**
- **Broward County**
- **Palm Beach County**

HealthSun Health Plans Benefit Packages

HealthSun offers a variety of Medicare Advantage products with Prescription Drug Plans. In Calendar Year (CY) 2021, HealthSun will offer Dual Special Needs products across the service area. The table below identifies the plan's products available in CY 2021:

2021 PBP Plans	Regular HMO Plans (HealthAdvantage)			Low Income Subsidy Plans (MediMax)		Dual Special Needs Plans (MediSun Plus)	
County	Dade	Broward	Palm Beach	Dade/Broward	Palm Beach	Dade/Broward	Palm Beach
PBP # and Plan Names	001 **HealthAdvantage** (new name)	012 HealthAdvantage	013 HealthAdvantage	006 MediMax	014 MediMax	015 MediSun Plus	016 MediSun Plus
Target Market	General	General	General	LIS	LIS	Full /Partial Duals	Full /Partial Duals

Plan Eligibility Information

In order to enroll in one of our Medicare Advantage Plan Benefit Packages beneficiaries must meet the following criteria:

- ✓ Must have both Medicare Part A and Part B,
- ✓ Must reside in HealthSun's Service Area including Miami-Dade, Broward, and Palm Beach County,
- ✓ Must be a United States citizen or lawfully present in the United States
- ✓ Must have an eligible Election Period
- ✓ For enrollment in HealthSun's D-SNP Products beneficiaries must be dual eligible members receiving assistance from the State of Florida's Medicaid Program.

HealthSun eligibility verification does not guarantee payment If HealthSun subsequently learns that a member was ineligible on the date of the verification, no payment will be made. Therefore, it is important that providers always verify the patients' must recent insurance status.

Identifying/ Verifying HealthSun Members

Providers shall verify that all HealthSun patients receiving treatment in their office are either on the PCP's membership list or members of the Plan.

- Upon signing an enrollment application, HealthSun Health Plan will send the member an Acknowledgement of Enrollment Letter to acknowledge the request for enrollment.

- Once the enrollment request has been approved by CMS, the member will receive an **Enrollment Confirmation** letter, which will be accompanied by the **Member Welcome letter**, which includes the **Member Identification (ID) Card**.

- The Evidence of Coverage (EOC) is provided to all our Members at the time of enrollment. The EOC educates members how to get their Medicare medical care and prescription drugs covered through the plan, this booklet also explains their rights and responsibilities, what is covered, and what they pay as members of the plan. The EOC is part of the member's contract with how HealthSun covers the member's care.

  The EOC details and educates the member about detailed information regarding their HealthSun Health Plan, as follows:

MEMBER EVIDENCE OF COVERAGE BOOKLET CONTENT	
Chapter	**Description**
Chapter 1. Getting Started as a Member	Explains what it means to be in a Medicare health plan and how to use the Evidence of Coverage (EOC) booklet. Tells about materials HealthSun will send members, their plan premium, the Part D late enrollment penalty, plan membership card, and keeping their membership record up to date.
Chapter 2. Important Phone Numbers and Resources	Tells members how to get in touch with our plan, and with other organizations including Medicare, the State Health Insurance Assistance Program (SHIP), the Quality Improvement Organization, Social Security, Medicaid (the state health insurance program for people with low incomes), programs that help people pay for their prescription drugs, and the Railroad Retirement Board.
Chapter 3. Using the Plan's Coverage for Medical Services	Explains important things members need to know about getting their medical care as a member of our plan. Topics include using the providers in the plan's network and how to get care when they have an emergency.
Chapter 4. Medical Benefits Chart	Gives the details about which types of medical care are covered and not covered as a member of our plan. Explains how much members will pay as their share of the cost for their covered medical care.
Chapter 5.	Explains rules members need to follow when they get their Part D drugs. Tells how to use the plan's List of Covered Drugs

Using the Plan's Coverage for Part D Prescription Drugs	(Formulary) to find out which drugs are covered. Tells which kinds of drugs are not covered. Explains several kinds of restrictions that apply to coverage for certain drugs. Explains where to get their prescriptions filled. Tells about the plan's programs for drug safety and managing medications.
Chapter 6. What Members Pay for their Part D Prescription Drugs	Tells about the four (4) stages of drug coverage (Deductible Stage, Initial Coverage Stage, Coverage Gap Stage, Catastrophic Coverage Stage) and how these stages affect what member's pay for your drugs. Explains the six (6) cost-sharing tiers for Part D drugs and tells what members must pay for a drug in each cost-sharing tier.
Chapter 7. Asking HealthSun to Pay our Share of a Bill received for covered medical services or drugs	Explains when and how to send a bill to us when members want to ask us to pay them back for our share of the cost for covered services or drugs.
Chapter 8. Member Rights and Responsibilities	Explains the members' rights and responsibilities as a member of our plan. Tells what members can do if they think their rights are not being respected.
Chapter 9. What to do if Members have a Problem or Complaints (Coverage Determinations, appeals, complaints)	Tells members step-by-step what to do if they are having problems or concerns as members of our plan. Explains how to ask for coverage decisions and make appeals if you are having trouble getting the medical care or prescription drugs you think are covered by our plan. This includes asking us to make exceptions to the rules or extra restrictions on your coverage for prescription drugs and asking us to keep covering hospital care and certain types of medical services if you think your coverage is ending too soon. Explains how to make complaints about quality of care, waiting times, customer service, and other concerns.
Chapter 10. Ending Your Membership with the Plan	Explains when and how members can end their membership in the plan. Explains situations in which our plan is required to end their membership.
Chapter 11. Legal Notices	Includes notices about governing law and about non-discrimination.

Member Identification Card

Each HealthSun Plan member will receive a member identification (ID) card which will be presented at the time of each visit. The HealthSun Member ID Card includes:

ID Card Front:

- Health Plan logo
- the Member's last and first name
- date of birth
- Effective date of enrollment in the plan
- the Plan Benefit Packet (PBP)
- the name of the PCP
- the PCP's ID number with HealthSun
- the PCP's contact information
- HealthSun Pharmacy Processing information (Rx BIN, Rx PCN and Rx Group ID)
- PCP and Specialist Copayment information

Back of ID Card:

- Information regarding what to do in care of an emergency
- HealthSun Member Services Toll-Free number
- HealthSun Provider Services Telephone Number
- Pharmacy Helpdesk Toll-Free Telephone Number for Providers
- Hospital Admissions Toll-Free Telephone Number for Providers
- Claims Mailing Address
- Service Pre-Approval requirement Statement
- HealthSun's Website Address
- Date when the card was last issued

When membership eligibility cannot be determined, you may contact the HealthSun Provider Services Help Line for "Eligibility Verification".

Please note that possession of a card does not constitute eligibility for coverage. If a HealthSun member is unable to present his/her membership card, please call the Provider Help Line to determine eligibility or contact the Provider Services Department for access the provider portal.

Verifying eligibility does not guarantee that the patient is in fact eligible at the time the services are rendered or that payment will be issued. We provide our members several options of health plans with an array of services, deductibles and cost sharing. Payments will be made for the specific covered services provided to eligible HealthSun members after satisfaction of applicable premiums and cost sharing.

HealthSun ID Card Sample.

PCP Member Listing

The PCP office will receive a monthly active member listing by the end of the first week of each month. The list consists of those HealthSun members who have selected or may have been assigned to the PCP office to provide them with PCP services. Please verify that all HealthSun patients receiving treatment in your office are on your membership listing. If you do not receive your list by the date mentioned above, please contact your assigned HealthSun Provider Service Executive. If there are any questions regarding a patient's eligibility, please contact HealthSun' Provider Operations Department at the number in the Key Contact List or access the provider portal.

HealthSun Health Plans Covered Benefits

Member Cost-Sharing

Members are responsible to pay applicable cost sharing at the time services are rendered. The cost sharing is collected by the provider's office and is indicated on the Explanation of Benefits (EOB) notice from HealthSun.

Full payment for a provider's services consists of the HealthSun payment (capitation or fee for service) plus the member's cost sharing.

The PCP and specialist office cost sharing amounts are listed in the Summary of Benefits. Cost sharing amounts vary by benefit plan. Only one cost sharing should be collected at each service encounter.

Cost sharing amounts for Prescription Drugs also vary by benefit plan. If a member needs assistance with cost sharing, they may contact the Plan, call the Part D Services Department to verify these cost sharing amounts.

Call the Provider Services Department to verify these cost sharing amounts or review your Explanation of Benefits (EOB) notice. Examples of cost sharing that may apply are Ambulance, Outpatient surgery (facility), Urgent Care, etc.

HealthSun Member Benefits

HealthSun Medicare members receive a document referred to as an Evidence of Coverage (EOC) and a Summary of Benefits, which explains the Covered Benefits under the plan that they have chosen with HealthSun. The Evidence of Coverage defines the rights and responsibilities of the Member and HealthSun.

Members choose a PCP who provides and coordinates all care. HealthSun does not cover services that have not been provided or referred/authorized by the PCP except for emergencies and services exempt from PCP.

When applicable, members pay established cost sharing and/or deductible or coinsurance. There is no member cost sharing for influenza or pneumococcal vaccine; however, applicable cost sharing may apply for other services rendered at the same time. There are no pre-existing limitations for HealthSun.

Medical services identified as Covered Benefits in the HealthSun Evidence of Coverage or in the Summary of Benefits are covered if the service is:

- Required for a condition.
- Received from the member's PCP, referred by the member's PCP, or authorized by the member's PCP and HealthSun **except for Emergency Care and exempt services that allow direct access as described below.**
- Rendered while coverage under HealthSun is in force; and not specifically limited or excluded under HealthSun.

Medicare Covered Benefits

COVERED SERVICES
Abdominal aortic aneurysm screening A one-time screening ultrasound for people at risk. The plan only covers this screening if the member has certain risk factors and if they get a referral for it from a participating physician, physician assistant, nurse practitioner, or clinical nurse specialist. *Prior-authorization and referral are required.*
Acupuncture for chronic low back pain

Covered services include:
Up to 12 visits in 90 days are covered for Medicare beneficiaries under the following circumstances: For the purpose of this benefit, chronic low back pain is defined as:

- Lasting 12 weeks or longer;
- nonspecific, in that it has no identifiable systemic cause (i.e., not associated with metastatic, inflammatory, infectious, etc. disease);
- not associated with surgery; and
- not associated with pregnancy.

An additional eight sessions will be covered for those patients demonstrating an improvement. No more than 20 acupuncture treatments may be administered annually. Treatment must be discontinued if the patient is not improving or is regressing.

- We also cover 12 visits every year for acupuncture treatment.

Acupuncture therapy must be provided by a state-licensed Acupuncturist or state-certified physician/practitioner permitted to practice acupuncture.

Prior-authorization and referral are required.

***Alternative Medicine: Therapeutic massage**

We cover up to 24 therapeutic massage visits per year.

Services must be ordered by a physician or medical professional

***Alternative therapy: Platelet-Rich Plasma (PRP)**

Platelet-Rich Plasma (PRP) is a supplemental benefit to **promote healing and treat pain in orthopedic medicine.**

With prior approval from the plan and a referral from the member's physician, **Platelet Rich Plasm injections for Osteoarthritis Pain Management are available to treat or ameliorate the impact of illness or injury.**

There is no limit to the parts of the body this would be used for. However, at most, **treatment will be applied to any one-body part no more than three consecutive months up to twice per year.**

Diagnosis correlated with physical exam and confirmed with imaging studies such as x-ray, ultrasound, MRI, or CT scan must be established prior to initiation of treatment as well as other pre-treatment recommendations satisfied.
Prior-authorization and referral are required.

Ambulance services

- Covered ambulance services include fixed wing, rotary wing, and ground ambulance services, to the nearest appropriate facility that can provide care if they are furnished

to a member whose medical condition is such that other means of transportation could endanger the person's health or if authorized by the plan.
- Non-emergency transportation by ambulance is appropriate if it is documented that the member's condition is such that other means of transportation could endanger the person's health and that transportation by ambulance is medically required.

Please see *Emergency care* for other important information on emergency coverage and cost-sharing information.

Prior-authorization is required for non-emergency ambulance services, and may also be required for a transfer between institutions or a transfer back home from a facility following an inpatient discharge.

Annual wellness visit

Members can get an annual wellness visit to develop or update a personalized prevention plan based on their current health and risk factors. This is covered once every 12 months.

Note: Members first annual wellness visit cannot take place within 12 months of their "Welcome to Medicare" preventive visit. However, members do not need to have had a "Welcome to Medicare" visit to be covered for annual wellness visits after they have had Part B for 12 months.

Prior-authorization and referral may be required.

Bone mass measurement

For qualified individuals (generally, this means people at risk of losing bone mass or at risk of osteoporosis), the following services are covered every 24 months or more frequently if medically necessary: procedures to identify bone mass, detect bone loss, or determine bone quality, including a physician's interpretation of the results.

Prior-authorization and referral may be required.

Breast cancer screening (mammograms)

Covered services include:
• One baseline mammogram between the ages of 35 and 39
• One screening mammogram every 12 months for women age 40 and older
• Clinical breast exams once every 24 months

Prior-authorization may be required.

Cardiac rehabilitation services

Comprehensive programs of cardiac rehabilitation services that include exercise, education, and counseling are covered for members who meet certain conditions with a doctor's referral. The plan also covers intensive cardiac rehabilitation programs that are typically more rigorous or more intense than cardiac rehabilitation programs.

Prior-authorization and referral are required

Cardiovascular disease risk reduction visit (therapy for cardiovascular disease)

We cover one visit per year with the member's primary care doctor to help lower the risk for cardiovascular disease.

Prior-authorization and referral may be required.

Cardiovascular disease testing

Blood tests for the detection of cardiovascular disease (or abnormalities associated with an elevated risk of cardiovascular disease) once every 5 years (60 months).

Prior-authorization and referral may be required.

Cervical and vaginal cancer screening

Covered services include:

- For all women: Pap tests and pelvic exams are covered once every 24 months
- Women at high risk of cervical or vaginal cancer or if they are of childbearing age and have had an abnormal Pap test within the past 3 years: one Pap test every 12 months

Prior-authorization may be required.

Chiropractic services

Covered services include:

- Manual manipulation of the spine to correct subluxation
- We also cover routine care up to 12 visits every year

Colorectal cancer screening

For people 50 and older, the following are covered:

- Flexible sigmoidoscopy (or screening barium enema as an alternative) every 48 months

One of the following every 12 months:

- Guaiac-based fecal occult blood test (gFOBT)
- Fecal immunochemical test (FIT)

DNA based colorectal screening every 3 years

For people at high risk of colorectal cancer, we cover:

- Screening colonoscopy (or screening barium enema as an alternative) every 24 months

For people not at high risk of colorectal cancer, we cover:

- Screening colonoscopy every 10 years (120 months), but not within 48 months of a screening sigmoidoscopy

Prior-authorization and referral may be required.

Dental services

In general, preventive dental services (such as cleaning, routine dental exams, and dental x-rays) are not covered by Original Medicare.

We also cover the following additional dental services:

Preventive dental services:

- Up to two (2) visits every year for Oral exams
- Up to two (2) visits every year for Prophylaxis (cleanings)
- Up to two (2) visits every year for Fluoride treatment
- Up to two (2) visits every year for Bitewing dental x-rays up to 1 series
- One (1) visit every three (3) years for Full-mouth x-rays (panoramic) up to one (1) complete series

Comprehensive dental services:

- Up to two (2) Crowns every year
- Up to two (2) Root canals (Endodontics) every year
- Up to four (4) Restorative services (four teeth) every year
- Up to four (4) Simple Extractions every year
- One (1) Scaling/root planning (Periodontics) every quadrant every year
- One (1) Full mouth debridement (Periodontics) every 24 consecutive months
- One (1) Partial dentures (Prosthodontics) every three (3) years
- One (1) Total superior prosthesis (Prosthodontics) every three (3) years
- One (1) Total inferior prosthesis (Prosthodontics) every three (3) years
- Oral/maxillofacial surgery and other dental services have an annual maximum benefit for all preventive and comprehensive dental services. (amount can change yearly)
- Please refer *to Physician/Practitioner Services, including doctor's office visits*.

Depression screening

We cover one screening for depression per year. The screening must be done in a primary care setting that can provide follow-up treatment and/or referrals.

Prior-authorization and referral may be required.

Diabetes screening

We cover this screening (includes fasting glucose tests) if any of the following risk factors: high blood pressure (hypertension), history of abnormal cholesterol and triglyceride levels (dyslipidemia), obesity, or a history of high blood sugar (glucose). Tests may also be covered

if other requirements are met, like being overweight and having a family history of diabetes. Based on the results of these tests, members may be eligible for up to two diabetes screenings every 12 months.

Prior-authorization and referral may be required.

Diabetes self-management training, diabetic services and supplies

For all people who have diabetes (insulin and non-insulin users). Covered services include:

- Supplies to monitor the blood glucose: Blood glucose monitor, blood glucose test strips, lancet devices and lancets, and glucose-control solutions for checking the accuracy of test strips and monitors
- For people with diabetes who have severe diabetic foot disease: One pair per calendar year of therapeutic custom-molded shoes (including inserts provided with such shoes) and two additional pairs of inserts, or one pair of depth shoes and three pairs of inserts (not including the non-customized removable inserts provided with such shoes). Coverage includes fitting.
- Diabetes self-management training is covered under certain conditions
- Glucometers, blood test strips, and lancets are limited to the following manufacturers: Precision, TrueMatrix, TrueTest, Contour, Ascensia, and Freestyle Libre.

Prior-authorization is required for diabetic supplies, shoes, or inserts.

Durable medical equipment (DME) and related supplies

Covered items include, but are not limited to: wheelchairs, crutches, powered mattress systems, diabetic supplies, hospital beds ordered by a provider for use in the home, IV infusion pumps, speech generating devices, oxygen equipment, nebulizers, and walkers.

We cover all medically necessary DME covered by Original Medicare.

- Continuous Glucose Monitors (CGM's) must be purchased at a network retail pharmacy.
- This plan will not cover CGMs' purchased through a DME provider.
- Freestyle Libre are this plan's preferred CGM's.

The list below includes the brands and manufacturers of DME that we will cover for **Hyaluronic Acids**.

- This plan covers DUROLANE, EUFLEXXA, SUPARTZ, and Gel-SYN-3 Hyaluronic Acids. Other Hyaluronic Acid brands are covered only if deemed medically necessary by the provider.

Generally, HealthSun covers any DME covered by Original Medicare from the brands and manufacturers for Hyaluronic Acids on this list. We will not cover other brands and manufacturers for Hyaluronic Acids unless the member's doctor or other provider tells us that the brand is appropriate for the member's medical needs. However, for new members to HealthSun using a brand of DME for Hyaluronic Acids that is not on our list, we will continue

to cover this brand for up to 90 days. During this time, members should talk with their doctor to decide what brand is medically appropriate after this 90-day period.

Prior-authorization is required.

Emergency care

Emergency care refers to services that are:

- Furnished by a provider qualified to furnish emergency services, and
- Needed to evaluate or stabilize an emergency medical condition

A medical emergency is when a member, or any other prudent layperson with an average knowledge of health and medicine, believe that a patient has medical symptoms that require immediate medical attention to prevent loss of life, loss of a limb, or loss of function of a limb. The medical symptoms may be an illness, injury, severe pain, or a medical condition that is quickly getting worse. Cost sharing for necessary emergency services furnished out-of-network is the same as for such services furnished in-network.

*We also cover worldwide emergency/urgent care (outside of the U.S. and its territories):

- Worldwide emergency care
- Worldwide urgent care
- Worldwide emergency transportation

There is a maximum annual benefit amount for worldwide emergency/urgent care.
Please see *Ambulance* and *Urgently needed services* for other important coverage and cost-sharing information.

For emergency care at an out-of-network hospital requiring inpatient care after the member's emergency condition is stabilized, members must return to a network hospital in order for their care to continue to be covered or members must have their inpatient care at the out-of-network hospital authorized by the plan. The cost is the cost-sharing members would pay at a network hospital.

***Health and wellness education programs**

We provide the supplemental benefits listed below for all members enrolled in this plan.

- Health Education provided to members for whom a need for education about a specific disease or condition is identified through a health risk assessment or a physician or self-generated referral.
- Nutritional/dietary counseling provided in an individual or group setting by a nutrition professional as deemed medically necessary by the treating physician.

Hearing services

Diagnostic hearing and balance evaluations performed by the member's PCP to determine if the need of medical treatment. Services are covered as outpatient care when furnished by a physician, audiologist, or other qualified provider.

*We also cover the following:

- One (1) visit every year for Routine hearing exam
- One (1) visit every year for Fitting/evaluation for hearing aids
- Two (2) hearing aids every two (2) years

There is a maximum annual benefit amount every two (2) years for hearing aids for both ears combined.

Prior-authorization and referral are required

HIV screening

For people who ask for an HIV screening test or who are at increased risk for HIV infection, we cover:

- One screening exam every 12 months

For women who are pregnant, we cover:

- Up to three screening exams during a pregnancy

Prior-authorization and referral may be required.

Home health agency care

Prior to receiving home health services, a doctor must certify that the need for home health services and will order home health services to be provided by a home health agency. Member must be homebound, which means leaving home is a major effort.

Covered services include, but are not limited to:

- Part-time or intermittent skilled nursing and home health aide services (To be covered under the home health care benefit, skilled nursing and home health aide services combined must total fewer than 8 hours per day and 35 hours per week)
- Physical therapy, occupational therapy, and speech therapy
- Medical and social services
- Medical equipment and supplies

Prior-authorization and referral are required

Home infusion therapy

Home infusion therapy involves the intravenous or subcutaneous administration of drugs or biologicals to an individual at home. The components needed to perform home infusion include the drug (for example, antivirals, immune globulin), equipment (for example, a pump), and supplies (for example, tubing and catheters).

- Covered services include, but are not limited to:
- Professional services, including nursing services, furnished in accordance with the plan of care

- Patient training and education not otherwise covered under the durable medical equipment benefit
- Remote monitoring
- Monitoring services for the provision of home infusion therapy and home infusion drugs furnished by a qualified home infusion therapy supplier

Prior-authorization is required.

Hospice care

Members may receive care from any Medicare-certified hospice program. Members are eligible for the hospice benefit when the doctor and the hospice medical director have given a terminal prognosis certifying terminally ill conditions and 6 months or less to live if the illness runs its normal course. The hospice doctor can be a network provider or an out-of-network provider.
Covered services include:

- Drugs for symptom control and pain relief
- Short-term respite care
- Home care

For hospice services and for services that are covered by Medicare Part A or B and are related to the terminal prognosis: Original Medicare (rather than our plan) will pay for the hospice services and any Part A and Part B services related to the terminal prognosis. While members are in the hospice program, the hospice provider will bill Original Medicare for the services that Original Medicare pays for.

For services that are covered by Medicare Part A or B and are not related to the terminal prognosis: If members need non-emergency, non-urgently needed services that are covered under Medicare Part A or B and that are not related to the terminal prognosis, the cost for these services depends on whether they use a provider in our plan's network:

- If covered services are obtained from a network provider, members only pay the plan cost-sharing amount for in-network services
- If covered services are obtained from an out-of-network provider, members pay the cost-sharing under Fee-for-Service Medicare (Original Medicare)

For services that are covered by HealthSun but are not covered by Medicare Part A or B: HealthSun will continue to cover plan-covered services that are not covered under Part A or B whether or not they are related to the terminal prognosis. Members will pay their plan cost-sharing amount for these services.

For drugs that may be covered by the plan's Part D benefit: Drugs are never covered by both hospice and our plan at the same time.

Note: If members need non-hospice care (care that is not related to the terminal prognosis), the plan should be contacted to arrange the services.

When members enroll in a Medicare-certified hospice program, the hospice services and their Part A and Part B services related to the terminal prognosis are paid for by Original Medicare, not HealthSun.

Immunizations

Covered Medicare Part B services include:

- Pneumonia vaccine
- Flu shots, once each flu season in the fall and winter, with additional flu shots if medically necessary
- Hepatitis B vaccine if there is a high or intermediate risk of getting Hepatitis B
- Other vaccines if at risk and they meet Medicare Part B coverage rules
- We also cover some vaccines under our Part D prescription drug benefit

Prior-authorization may be required.

Inpatient hospital care

Includes inpatient acute, inpatient rehabilitation, long-term care hospitals and other types of inpatient hospital services. Inpatient hospital care starts the day members are formally admitted to the hospital with a doctor's order. The day before they are discharged is their last inpatient day.

Covered services include but are not limited to:

- Semi-private room (or a private room if medically necessary)
- Meals including special diets
- Regular nursing services
- Costs of special care units (such as intensive care or coronary care units)
- Drugs and medications
- Lab tests
- X-rays and other radiology services
- Necessary surgical and medical supplies
- Use of appliances, such as wheelchairs
- Operating and recovery room costs
- Physical, occupational, and speech language therapy
- Inpatient substance abuse services
- Under certain conditions, the following types of transplants are covered: corneal, kidney, kidney-pancreatic, heart, liver, lung, heart/lung, bone marrow, stem cell, and intestinal/multivisceral. If a transplant is needed, we will arrange to have the case reviewed by a Medicare-approved transplant center that will decide whether the member is a candidate for a transplant.
- Blood - including storage and administration. Coverage of whole blood and packed red cells begins only with the fourth pint of blood needed by the member - must either pay the costs for the first 3 pints of blood obtained in a calendar year or have the blood donated. All other components of blood are covered beginning with the first pint used.

- Physician services
- Additional unlimited days for inpatient stay (when medically necessary)

Note: To be an inpatient, the member's provider must write an order to admit formally as an inpatient of the hospital. Even if the member stays in the hospital overnight, the member might still be considered an "outpatient."

Prior-authorization and referral are required.

The benefit period begins the day the member goes into a hospital and ends when they have not received any inpatient hospital care for 60 days in a row. If the member goes into a hospital after one benefit period has ended, a new benefit period begins. Authorized inpatient care at an out-of-network hospital after the emergency condition is stabilized.

Inpatient mental health care

Covered services include mental health care services that require a hospital stay. Inpatient stay is covered up to 90 days for each benefit period and they have 60 additional days to use once during a lifetime ("lifetime reserve days"). There is a lifetime limit of 190 days on inpatient psychiatric hospital services in a freestanding psychiatric hospital. The 190-lifetime limitation does not apply to inpatient mental health services provided in a psychiatric unit of a general hospital.

Prior-authorization and referral are required.

The benefit period begins the day of admission into a hospital and ends when the member has not received any inpatient hospital care for 60 days in a row. If the member goes into a hospital after one benefit period has ended, a new benefit period begins.

Inpatient stay: Covered services received in a hospital or SNF during a non-covered inpatient stay

If inpatient benefits have been exhausted or if the inpatient stay is not reasonable and necessary, we will not cover the inpatient stay. However, in some cases, we will cover certain services received while a member is in the hospital or the skilled nursing facility (SNF).

Covered services include, but are not limited to:

- Physician services
- Diagnostic tests (like lab tests)
- X-ray, radium, and isotope therapy including technician materials and services Surgical dressings
- Splints, casts, and other devices used to reduce fractures and dislocations
- Prosthetics and orthotics devices (other than dental) that replace all or part of an internal body organ (including contiguous tissue), or all or part of the function of a permanently inoperative or malfunctioning internal body organ, including replacement or repairs of such devices

- Leg, arm, back, and neck braces; trusses, and artificial legs, arms, and eyes including adjustments, repairs, and replacements required because of breakage, wear, loss, or a change in the patient's physical condition
- Physical therapy, speech therapy, and occupational therapy

Prior-authorization and referral are required.

Meals: post-discharge - *Benefits may vary by Plan.*

Members are eligible to receive nutritious, precooked frozen meals delivered each day at no cost for two weeks after an overnight stay in the hospital or nursing facility, or following a surgery with an inpatient hospital stay.

Maximum of two (2) inpatient admissions per year.

Prior-authorization and referral are required

Medical nutrition therapy

This benefit is for people with diabetes, renal (kidney) disease (but not on dialysis), or after a kidney transplant when referred the member's doctor. We cover 3 hours of one-on-one counseling services during the first-year members receive medical nutrition therapy services under Medicare (this includes our plan, any other Medicare Advantage plan, or Original Medicare), and 2 hours each year after that. If the condition, treatment, or diagnosis changes, members may be able to receive more hours of treatment with a physician's referral. A physician must prescribe these services and renew their referral yearly if the treatment is needed into the next calendar year.

Prior-authorization and referral are required.

Medicare Diabetes Prevention Program (MDPP)

MDPP services will be covered for eligible Medicare beneficiaries under all Medicare health plans. MDPP is a structured health behavior change intervention that provides practical training in long-term dietary change, increased physical activity, and problem-solving strategies for overcoming challenges to sustaining weight loss and a healthy lifestyle.

Prior-authorization and referral may be required.

Medicare Part B prescription drugs

These drugs are covered under Part B of Original Medicare. Members of our plan receive coverage for these drugs through our plan. Covered drugs include:

- Drugs that usually aren't self-administered by the patient and are injected or infused while getting physician, hospital outpatient, or ambulatory surgical center services
- Drugs taken using durable medical equipment (such as nebulizers) that were authorized by the plan
- Clotting factors self-administered by injection if member has hemophilia

- Immunosuppressive Drugs, for members enrolled in Medicare Part A at the time of the organ transplant
- Injectable osteoporosis drugs, if a member is homebound, have a bone fracture that a doctor certifies was related to post-menopausal osteoporosis, and cannot self-administer the drug
- Antigens
- 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 (such as Epogen, Procrit, Epoetin Alfa, Aranesp, or Darbepoetin Alfa)
- Intravenous Immune Globulin for the home treatment of primary immune deficiency diseases

A list of Part B drugs that may be subject to Step Therapy is available in the following link: www.healthsun.com/members/prescriptions

We also cover some vaccines under our Part B and Part D prescription drug benefit.

Prior-authorization is required.

Cost Share is based on the service provided and the setting where it is received. There are some Medicare Part B Drugs that require Step Therapy in addition to obtaining prior authorization. Step Therapy is a utilization tool that requires members to first try another drug to treat their medical condition before the Plan will cover the drug the member's physician may have initially prescribed.

***Nursing hotline (Remote Access Technologies)**

Members also have access to a toll-free nurse line to speak directly to a registered nurse who will help answer health-related questions. Call our Member Services Department at 1-877-336-2069 to connect.

Obesity screening and therapy to promote sustained weight loss

For members with a body mass index of 30 or more, we cover intensive counseling to help with weight loss. This counseling is covered received in a primary care setting, where it can be coordinated with a comprehensive prevention plan.

Prior-authorization and referral are required

Opioid treatment program services

Opioid use disorder treatment services are covered under Part B of Original Medicare. Members of our plan receive coverage for these services through our plan.

Covered services include:

- FDA-approved opioid agonist and antagonist treatment medications and the dispensing and administration of such medications, if applicable

- Substance use counseling
- Individual and group therapy
- Toxicology testing

Prior-authorization and referral are required.

Outpatient diagnostic tests and therapeutic services and supplies

Covered services include, but are not limited to:

- X-rays
- Diagnostic radiological services (some examples include nuclear medicine with SPECT, CT, MRI, PET, and ultrasound)
- Radiation (radium and isotope) therapy including technician materials and supplies (therapeutic radiological services)
- Surgical supplies, such as dressings
- Splints, casts and other devices used to reduce fractures and dislocations
- Laboratory tests
- Blood - including storage and administration. Coverage of whole blood and packed red cells begins with the first pint of blood a member may need
- Other outpatient diagnostic tests (some examples of other diagnostic tests include basal metabolism readings, electroencephalograms, electrocardiograms, respiratory function tests, cardiac evaluations, allergy tests, and psychological tests)

Please see *Outpatient Hospital Services* for other important information on outpatient coverage and cost-sharing.

Prior-authorization and referral are required for diagnostic tests, labs, and blood services. The rest of the services require only a prior-authorization.

Outpatient hospital observation

Observation services are hospital outpatient services given to determine inpatient needs or if the member may be discharged. For outpatient hospital observation services to be covered, they must meet the Medicare criteria and be considered reasonable and necessary.

Observation services are covered only when provided by the order of a physician or another individual authorized by state licensure law and hospital staff bylaws to admit patients to the hospital or order outpatient tests.

Prior-authorization is required.

Outpatient hospital services

We cover medically necessary services obtained in the outpatient department of a hospital for diagnosis or treatment of an illness or injury.

Covered services include, but are not limited to:

- Services in an emergency department or outpatient clinic, such as observation services or outpatient surgery
- Laboratory and diagnostic tests billed by the hospital
- Mental health care, including care in a partial-hospitalization program, if a doctor certifies that inpatient treatment would be required without it
- X-rays and other radiology services billed by the hospital
- Medical supplies such as splints and casts
- Certain drugs and biologicals that are not self-administered

Prior-authorization and referral are required.

Outpatient mental health care

Covered services include mental health services provided by a state-licensed psychiatrist or doctor, clinical psychologist, clinical social worker, clinical nurse specialist, nurse practitioner, physician assistant, or other Medicare-qualified mental health care professional as allowed under applicable state laws.

Prior-authorization and referral are required.

Outpatient rehabilitation services

Covered services include physical therapy, occupational therapy, and speech language therapy. Outpatient rehabilitation services are provided in various outpatient settings, such as hospital outpatient departments, independent therapist offices, and Comprehensive Outpatient Rehabilitation Facilities (CORFs).

Prior-authorization and referral are required.

Outpatient substance abuse services

Covered services include intensive and traditional counseling for the treatment of drug or alcohol dependence without the use of pharmacotherapies.

Prior-authorization and referral are required.

Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers

Prior-authorization and referral are required

Over-the-counter (OTC) items - *Benefits may vary by Plan.*

We cover up to **a certain amount (changed yearly)** every month for OTC items.
The OTC benefit amount does not carry over month to month. Members must place their order from the plan-approved OTC Formulary. The OTC Formulary is provided in the member's enrollment welcome package and available on our website (www.healthsun.com)

Partial hospitalization services

"Partial hospitalization" is a structured program of active psychiatric treatment provided as a hospital outpatient service or by a community mental health center, that is more intense than the care received at the doctor's or therapist's office and is an alternative to inpatient hospitalization.

Note: Because there are no community mental health centers in our network, we cover partial hospitalization only as a hospital outpatient service.

Prior-authorization and referral are required.

Physician/Practitioner services, including doctor's office visits

Prior-authorization and referral are required for physician specialist services and other health care professional services (Members do not need an authorization for their PCP visits).

Coverage and cost-sharing information for dental services, hearing services, outpatient diagnostic tests/radiology, outpatient hospital, other outpatient services, vision, and all Medicare-covered preventive services are described under those items elsewhere in this chart.

Podiatry services

Covered services include:

- Diagnosis and the medical or surgical treatment of injuries and diseases of the feet (such as hammer toe or heel spurs)
- Routine foot care for members with certain medical conditions affecting the lower limbs
- We also cover routine foot care up to one (1) visit every three (3) months

Prior-authorization is required.

Prostate cancer screening exams

For men age 50 and older, covered services include the following - once every 12 months:

- Digital rectal exam
- Prostate Specific Antigen (PSA) test

Prior-authorization and referral may be required.

Prosthetic devices and related supplies

Devices (other than dental) that replace all or part of 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 (including a surgical brassiere after a mastectomy), . Includes certain supplies related to prosthetic devices, and repair and/or replacement of prosthetic devices and also includes some coverage following cataract removal or cataract surgery.
Prior-authorization is required.

Pulmonary rehabilitation services

Comprehensive programs of pulmonary rehabilitation are covered for members who have moderate to very severe chronic obstructive pulmonary disease (COPD) and a referral for pulmonary rehabilitation from the doctor treating the chronic respiratory disease.

Prior-authorization and referral are required

***Readmission Prevention (personal care in a home-setting) <u>Benefit may vary by Plan.</u>**

Within 10 days post inpatient discharge to a home-setting, members are eligible for an in-home assessment conducted by a qualified health practitioner to evaluate the home for risk of injury, reconcile medications, and identify additional support requirements including caregiver respite assistance.

Upon approval, we cover up to 16 hours of home-based support.
Activities of Daily Living (ADLs)

- Feeding • Bathing, dressing, grooming • Toileting • Ambulation/mobility

Instrumental Activities of Daily Living (IADLs)

- Light housekeeping • Meal preparation • Medication management

Prior-authorization and referral are required.

Screening and counseling to reduce alcohol misuse

We cover one alcohol misuse screening for adults with Medicare (including pregnant women) who misuse alcohol but aren't alcohol dependent. If a member screens positive for alcohol misuse, members can get up to 4 brief face-to-face counseling sessions per year (if member is competent and alert during counseling) provided by a qualified primary care doctor or practitioner in a primary care setting.

Prior-authorization may be required.

Screening for lung cancer with low dose computed tomography (LDCT)

For qualified individuals, a LDCT is covered every 12 months.
Eligible members are: people aged 55 – 77 years who have no signs or symptoms of lung cancer, but who have a history of tobacco smoking of at least 30 pack-years and who currently smoke or have quit smoking within the last 15 years, who receive a written order for LDCT during a lung cancer screening counseling and shared decision making visit that meets the Medicare criteria for such visits and be furnished by a physician or qualified non-physician practitioner.
For LDCT lung cancer screenings after the initial LDCT screening: the members must receive a written order for LDCT lung cancer screening, which may be furnished during any appropriate visit with a physician or qualified non-physician practitioner. If a physician or qualified non-physician practitioner elects to provide a lung cancer screening counseling and shared decision-making visit for subsequent lung cancer screenings with LDCT, the visit must meet the Medicare criteria for such visits.

Prior-authorization and referral are required.

Screening for sexually transmitted infections (STIs) and counseling to prevent STIs

We cover sexually transmitted infection (STI) screenings for chlamydia, gonorrhea, syphilis, and Hepatitis B. These screenings are covered for pregnant women and for certain people who are at increased risk for an STI when the tests are ordered by a primary care provider. We cover these tests once every 12 months or at certain times during pregnancy. We also cover up to 2 individual 20 to 30 minute, face-to-face high-intensity behavioral counseling sessions each year for sexually active adults at increased risk for STIs. We will only cover these counseling sessions as a preventive service if they are provided by a primary care provider and take place in a primary care setting, such as a doctor's office.

Prior-authorization is required.

Services to treat kidney disease

Covered services include:

- Kidney disease education services to teach kidney care and help members make informed decisions about their care. For members with stage IV chronic kidney disease when referred by their doctor, we cover up to six sessions of kidney disease education services per lifetime
- Outpatient dialysis treatments (including dialysis treatments when temporarily out of the service area, as explained in Chapter 3)
- Inpatient dialysis treatments (if admitted as an inpatient to a hospital for special care)
- Self-dialysis training (includes member training and anyone helping assisting the member with home dialysis treatments)
- Home dialysis equipment and supplies
- Certain home support services (such as, when necessary, visits by trained dialysis workers to check on home dialysis, to help in emergencies, and to check the members dialysis equipment and water supply) Certain drugs for dialysis are covered under the Medicare Part B drug benefit.

Prior-authorization and referral are required for dialysis services.

***Silver Sneakers (Physical fitness)**

The Silver Sneakers fitness membership includes access to all basic amenities at all of the participating locations. Members receive support from certified instructors and have access to group classes for desired fitness level. The program also includes health and nutritional tips along with exercise videos through the website.

Skilled nursing facility (SNF) care

This plan does not require an inpatient hospital stay prior to SNF admission. SNF stay is covered up to 100 days for each benefit period.

Prior-authorization and referral are required.

The benefit period begins the day the member is admitted to a skilled nursing facility (SNF) and ends when they have not received any skilled care in a SNF for 60 consecutive days. If aa member is admitted into a skilled nursing facility after one benefit period has ended, a new benefit period begins.

Smoking and tobacco use cessation (counseling to stop smoking or tobacco use)

Members using tobacco, but with no signs or symptoms of tobacco-related disease: We cover two counseling quit attempts within a 12-month period as a preventive service at no cost. Each counseling attempt includes up to four face-to-face visits. Members using tobacco and diagnosed with a tobacco-related disease or are, taking medicine that may be affected by tobacco: We cover cessation counseling services. We cover two counseling quit attempts within a 12-month period; however, the member will pay the applicable cost-sharing. Each counseling attempt includes up to four face-to-face visits.

Prior-authorization and referral are required.

Special Supplemental Benefits for the Chronically Ill ("Healthy Meals") *- Benefits may vary by Plan.*

Healthy Meals assists members in maintaining a healthy diet to support a medical condition or nutritional needs.

Method of meal delivery is subject to prior-authorization. Participation in a Care Management Program and a Nutritional assessment are required as a prerequisite. Members may be eligible based on qualifying clinical criteria of a chronic condition as determined by the physician. Chronic conditions are those diseases or illnesses that are expected to be present for a majority of the plan year, impact activities of daily living, and require on-going medical treatment.

Prior-authorization and referral are required.

Supervised Exercise Therapy (SET)

SET is covered for members who have symptomatic peripheral artery disease (PAD) and a referral for PAD from the physician responsible for PAD treatment. Up to 36 sessions over a 12-week period are covered if the SET program requirements are met.

The SET program must:

- Consist of sessions lasting 30-60 minutes, comprising a therapeutic exercise-training program for PAD in patients with claudication
- Be conducted in a hospital outpatient setting or a physician's office
- Be delivered by qualified auxiliary personnel necessary to ensure benefits exceed harms, and who are trained in exercise therapy for PAD
- Be under the direct supervision of a physician, physician assistant, or nurse practitioner/clinical nurse specialist who must be trained in both basic and advanced life support techniques

SET may be covered beyond 36 sessions over 12 weeks for an additional 36 sessions over an extended period of time if deemed medically necessary by a health care provider.

Prior-authorization and referral are required.

***Transportation**

We cover unlimited trips to a plan-approved location.

Prior-authorization and referral are required.

Urgently needed services

Urgently needed services are provided to treat a non-emergency, unforeseen medical illness, injury, or condition that requires immediate medical care.

*We also cover worldwide urgent care (outside of the U.S. and its territories). There is a maximum annual benefit amount for worldwide emergency/urgent care.

Please see "*Emergency care*" for emergency coverage information.

Vision care

Covered services include:

- Outpatient physician services for the diagnosis and treatment of diseases and injuries of the eye, including treatment for age-related macular degeneration. Original Medicare doesn't cover routine eye exams (eye refractions) for eyeglasses/contacts
- For people who are at high risk of glaucoma, we will cover one glaucoma screening each year. People at high risk of glaucoma include people with a family history of glaucoma, people with diabetes, African-Americans who are age 50 and older and Hispanic Americans who are 65 or older
- For people with diabetes, screening for diabetic retinopathy is covered once per year
- One pair of eyeglasses or contact lenses after each cataract surgery that includes insertion of an intraocular lens (If a member has 2u have two separate cataract operations, the member cannot reserve the benefit after the first surgery and purchase two eyeglasses after the second surgery.)

*We also cover the following:

- One (1) visit every year for routine eye exam
- Additional Eyewear: eyeglasses with lenses and frames, eyeglass lenses, eyeglass frames, and contact lenses

There is a maximum annual benefit amount for all additional eyewear combined.

"Welcome to Medicare" preventive visit

The plan covers the one-time "Welcome to Medicare" preventive visit. The visit includes a review of the member's health condition, as well as education and counseling about the

preventive services members need (including certain screenings and shots), and referrals for other care if needed.

Important: We cover the "Welcome to Medicare" preventive visit only within the first 12 months of the member receiving Medicare Part B.

D-SNP Scope of Services

As Medicare Advantage Dual Eligible Special Needs Plan (D-SNP) HealthSun has entered into a contract with the Centers for Medicare and Medicaid Services (CMS) to provide a D-SNP Plan. Under the Medicare Improvement for Patients and Providers Act of 2008 (MIPPA) and resulting regulations, CMS requires the D-SNP to enter into a contract with the State Medicaid Agency to provide or arrange for benefits to be provided, which a dually eligible individual is entitled to receive.

HealthSun Health Plans Dual Special Needs Plan meets The Bipartisan Budget Act of 2018 requirement as a Highly Integrated Dual Eligible SNP (HIDE). HealthSun is responsible for coordinating the delivery of Medicaid benefits for individuals who are eligible for such services; and provide coverage of Medicaid services, including behavioral health services, for individuals eligible for such services.

The following table includes Medicaid covered services effective January 1, 2021 to be provided when not covered by Medicare. HealthSun shall provide the covered services contained within the following Medicaid rules and associated fee schedule https://ahca.myflorida.com/medicaid/review/specific_policy.shtml

Rule No.	Policy Name
59G-4.013	Allergy Services Coverage Policy
59G-4.015	Ambulance Transportation Services Coverage Policy
59G-4.020	Ambulatory Surgical Center Services Coverage Policy
59G-4.022	Anesthesia Services Coverage Policy
59G-4.025	Assistive Case Services Coverage and Limitations Handbook
59G-4.027	Behavioral Health Overlay Services Coverage and Limitations Handbook
59G-4.125	Behavior Analysis Services
59G-4.028	Behavioral Health Assessment Services
59G-4.031	Behavioral Health Community Support Services
59G-4.370	Behavioral Health Intervention Services
59G-4.029	Behavioral Health Medication Management Services
59G-4.033	Cardiovascular Services Coverage Policy
59G-8.700	Child Health Services Targeted Case Management
59G-4.040	Chiropractic Services Coverage Policy
59G-4.055	County Health Department Services
59G-4.105	Dialysis Services Coverage Policy
59G-4.070	Durable Medical Equipment and Medical Supplies Coverage and Limitations Handbook
59G-4.085	Early Intervention Services Coverage Policy
59G-4.015	Emergency Transportation Services Coverage Policy

59G-4.087	Evaluation and Management Services Coverage Policy
59G-4.100	Federally Qualified Health Center Services
59G-4.026	Gastrointestinal Services Coverage Policy
59G-4.108	Genitourinary Services Coverage Policy
59G-4.110	Hearing Services Coverage Policy
59G-4.130	Home Health Services Coverage Policy
59G-4.140	Hospice Services Coverage Policy
59G-4.150	Inpatient Hospital Services Coverage Policy
59G-4.032	Integumentary Services Coverage Policy
59G-4.190	Laboratory Services Coverage Policy
59G-1.045	Medicaid Forms
59G-4.197	Medical Foster Care Services
59G-4.199	Mental Health Targeted Case Management Handbook
59G-4.201	Neurology Services Coverage Policy
59G-4.330	Non-Emergency Transportation Services Coverage Policy
59G-4.200	Nursing Facility Services Coverage Policy
59G-4.318	Occupational Therapy Services Coverage Policy
59G-4.207	Oral and Maxillofacial Surgery Services Coverage Policy
59G-4.211	Orthopedic Services Coverage Policy
59G-4.160	Outpatient Hospital Services Coverage Policy
59G-4.222	Pain Management Services Coverage Policy
59G-4.215	Personal Care Services Coverage Policy
59G-4.320	Physical Therapy Services Coverage Policy
59G-4.220	Podiatry Services Coverage Policy
59G-4.250	Prescribed Drug Services Coverage, Limitations and Reimbursement Handbook
59G-4.261	Private Duty Nursing Services Coverage Policy
59G-4.002	Provider Reimbursement Schedules and Billing Codes
59G-4.240	Radiology and Nuclear Medicine Services Coverage Policy
59G-4.264	Regional Perinatal Intensive Care Center Services
59G-4.030	Reproductive Services Coverage Policy
59G-4.235	Respiratory System Services Coverage Policy
59G-4.322	Respiratory Therapy Services Coverage Policy
59G-4.280	Rural Health Clinic Services
59G-4.295	Specialized Therapeutic Services Coverage and Limitations Handbook
59G-4.324	Speech-Language Pathology Services Coverage Policy
59G-4.120	Statewide Inpatient Psychiatric Program Coverage Policy
59G-4.360	Transplant Services Coverage Policy
59G-4.340	Visual Aid Services Coverage Policy
59G-4.210	Visual Care Services Coverage Policy

Please note: There may be instances when the Medicaid limit is greater than the Medicare limit. In those instances where the Medicare limit has been exhausted, the Plan shall cover the difference for those eligible recipients.

There may be instances when the Medicaid limit is greater than the Medicare limit. In those instances where there Medicare limit has been exhausted, HealthSun shall cover the difference for those eligible recipients.

Prescription Drug Coverage

Medicare Part D Covered Drugs are listed in HealthSun's Prescription Drug Formulary and are available only by Prescription. Members of the plan must generally use network pharmacies to use their prescription drug benefit. The drug formulary may change at any time and members will be notified about the changes when impacted by the change. Prescription drugs are subject to cost sharing, the cost sharing may vary according to drug tier (such as generic, brand, non-formulary) and pharmacy network affiliation (Preferred vs. Non-Preferred).

Prescription Drug Formulary

A formulary is a list of covered drugs selected by HealthSun in consultation with a team of healthcare providers, which represents the prescription therapies believed to be a necessary part of a quality treatment program. HealthSun will generally cover the prescription drugs listed in our Drug Formulary as long as the drug is medically necessary, the prescriptions is filled at a HealthSun network pharmacy, and other plan rules are followed.

Prescribers should refer to Drug Formularies when prescribing medication to a HealthSun member. Members will have lower drug costs if prescribed generics or allowed substitution of brand products. Some Benefit Plans offer no cost sharing for prescriptions, in certain Tiers, when a member uses a Preferred Pharmacy. For a copy of most current HealthSun Formularies or pharmacy directory, please visit HealthSun Website at https://www.healthsun.com/members/prescriptions.

Generic Drug Policy

HealthSun Health Plans covers both brand name drugs and generic drugs. A generic drug is approved by the Food and Drug Administration (FDA) as having the same active ingredient as the brand name drug. Generally, generic drugs cost less than brand name drug Brand name drugs, having generic equivalents, should be prescribed in generic form.

If member insists on a brand name product, which has a generic equivalent and is included in the drug formularies, member may have additional cost sharing as indicated in Member's Summary of Benefits booklet and Evidence of Coverage (EOC) available on the HealthSun's website).

For a Tier Exception, Medicare Part D Coverage Determination Form may be used. A tiering exception should be requested to obtain a non-preferred drug at lower cost sharing terms applicable to drugs in a preferred tier. You can find HealthSun's Coverage Determination form on our website https://healthsun.com/members/prescriptions under "Prescription Coverage Determination Request form". https://healthsun.com/members/prescriptions under "Prescription Coverage Determination Request form".

Formulary Changes

HealthSun Health Plans can make changes to formularies within certain limits. Medicare drug plans may only change therapeutic categories and classes in formularies once each year, to be effective January 1st of following year.

Medicare drug plans typically may not remove drugs from their formularies at any time during the plan year. A few exceptions to this general rule exist. Part D drugs may be removed from formularies when:

- Food and Drug Administration (FDA) pronounces a Part D drug unsafe
- Manufacturer removes Part D drug from market
- Brand name drug loses patent and becomes available in generic form, brand name drug is removed, and generic is added

Prior Authorizations, Quantity Limits, and Step Therapy

Some covered drugs may have additional requirements or limits on coverage. These requirements and limits may include:

- **Prior Authorization:** HealthSun Health Plans requires member, a member's appointed or authorized representative, or a member's prescribing physician or other prescriber to request a prior authorization for certain drugs prior to prescription being filled at a pharmacy. This means member, a member's appointed or authorized representative, or a member's prescribing physician or other prescriber will need to get approval from HealthSun Health Plans before filling prescriptions. If approval is not obtained, HealthSun Health Plans may not cover drug.

- **Quantity Limits:** For certain drugs, HealthSun Health Plans may limit quantity which will be covered.

- **Step Therapy:** In some cases, HealthSun Health Plans requires prescriber to have member first try certain formulary drugs to treat medical conditions before HealthSun Health Plans covers another formulary drug for the same condition. For example, if Drug A and Drug B both treat a medical condition, HealthSun Health Plans may not cover drug B unless Drug A is tried first. If Drug A does not work, HealthSun Health Plans will then cover Drug B.

Exceptions Process

There is a process for members to obtain a Part D drug which requires a Prior Authorization, Step – Therapy, have a Quantity Limitation or is not on HealthSun Health Plans' formularies. Members and Providers may request an exception under the following circumstances:

- Member is using a drug which was covered on HealthSun Health Plans formulary but has been removed during plan year for reasons other than safety
- Member was prescribed a non-formulary drug which prescriber believes is medically necessary
- Member is using a drug which was moved during plan year from preferred to non- preferred cost sharing tier
- Member's prescriber prescribed a drug which is included in HealthSun Health Plans, more expensive cost sharing tier because prescriber believes the drug included in the less expensive cost sharing tier is medically ineffective for member
- If member disagrees with amount which HealthSun Health Plans requires member to pay for a Part D prescription drug prescribed
- If there is a requirement member try another drug before HealthSun Health Plans pays for drug prescribed, or if there is a limit on quantity (or dose) of the drug and prescriber disagrees with the requirement or dosage limitation

A "**grievance**" is a type of complaint which a member or provider makes if they have any problem with HealthSun Health Plans or a plan provider.

For more information on how to file a request for an exception, grievance, or appeal, please contact HealthSun Health Plans' Part D Services Department, Member Services or your Provider Operations Representative.

Instructions for completing and submitting Exception Requests

Providers may submit Exception Requests to HealthSun Health Plans orally or in writing. To submit your request orally, please contact the HealthSun Health Plans at 1-877-336-2069. If you choose to submit your request in writing, you may use HealthSun's Coverage Request form or any form of written documentation. You can find HealthSun's Coverage Request form on our website https://healthsun.com/members/prescriptions under "Prescription Coverage Determination Request form".

- Form may be completed and submitted by member, a member's appointed or authorized representative, or a member's prescribing physician or other prescriber on behalf of member. Prescribers may utilize their staff to submit requests, as long as it has been reviewed and signed by prescriber.

- Complete all required information on form. Incomplete forms may be sent back to sender to request additional information, additional information may also be submitted verbally. Progress notes should be sent indicating diagnosis provided on form. Providers must submit to HealthSun Health Plans Part D Services Department required information within timeframes allowed by CMS, especially if a prescription has rejected at a pharmacy due to requiring an Exception Request or Prior Authorization.

    - Fax completed form to e-fax 1-844-430-1705
    - Mail completed forms and corresponding documents to:

HealthSun Health Plans
Part D Services Department
9250 W Flagler St,
Suite 600
Miami, FL 33174

- For any questions, please call Part D Services Department at: 1-877-336-2069

- If request is denied and the prescriber disagrees with the plans decision, the prescriber or member/member representative can request a redetermination. All redeterminations can be submitted in any format or by using the redetermination form located on the Plans website. Please submit all request to the address or fax located below:

HealthSun Health Plans
Appeals Department
9250 W. Flagler Street
Suite. 600
Miami, Florida 33174
Phone number: 305-447-4451
Fax number: 877-589-3526

Credentialing/Re-credentialing Process

Credentialing

Credentialing is the process by which the appropriate committee reviews documentation for each individual physician/provider to determine participation in the health plan network. Such documentation may include, but is not limited to, the applicant's education, training, clinical privileges, experience, licensure, accreditation, certifications, professional liability insurance, malpractice history, professional competency, and physical and mental impairments. The credentialing process includes verification that the information obtained is accurate and complete. The physician/provider must respond to any reasonable HealthSun Health Plans, Inc. (HealthSun) request for additional information including, but not limited to, a medical record review as well as a site visit as applicable.

HealthSun recognizes the physician's/provider's right to review information submitted in support of the credentialing application to the extent permitted by law and to correct erroneous information. Physician/provider may obtain information regarding the status of their credentialing or recredentialing process by calling HealthSun.

The credentialing process generally is required by law. The fact that the physician/provider is credentialed is not intended as a guarantee or promise of any particular level of care or services.

HealthSun Credential Committee

The Credential Committee is composed of a chairperson and participating physicians. Functions of the committee include credentialing, ongoing and periodic assessment, recredentialing, and establishment of credentialing and recredentialing policies and procedures. The physician's/provider's documentation is provided to the corporate credentials committee for approval or denial for participation in the network. Notification of approval or denial of credentials is sent to the physician/provider.

Recredentialing

Recredentialing is conducted at least every three (3) years in accordance with the HealthSun credentialing and recredentialing process. The recredentialing process is conducted with the same standards as those for initial credentialing. The decision concerning re-appointment or failure to re-appoint will be conveyed to the physician/provider in writing.

Providers Site Visits

In order to ensure conformance with standards set by the Centers for Medicare and Medicaid Services for HealthSun, a structured review of contracted practitioner medical offices and of medical record keeping practices is conducted of PCPs and high-volume specialist providers.

The structured site visit review assesses the physical accessibility and appearance of the office or clinic, appointment availability, adequacy of waiting and examining room space, safety, infection control, and confidentiality issues.

A copy of the Site Survey can be obtained by contacting the HealthSun Provider Operations Department—Refer to the Telephone Contact Numbers at the beginning of the Provider Manual.

Medical Management – Organization Determinations/Authorizations

HealthSun's Medical Management Utilization Management (UM) Program is designed to ensure members receive access to the right care in the right place at the right time. Our goal is to optimize our members' benefits by providing quality healthcare services that meet professionally recognized standards of care; are a covered benefit, medically necessary and appropriate for the individual member's condition; and provided at the most appropriate level of care.

The Medical Director's Role

The HealthSun Medical Director is responsible for directing and overseeing the Medical Care Management Department. The Medical Director addresses medical necessity (referrals and

authorizations), concurrent review, credentialing, pharmacy & therapeutics, and quality assessment and improvement. The Medical Director serves as the liaison between the health plan and the participating providers and other healthcare providers in the community. The Medical Director is not engaged in the practice of medicine while acting in the medical director's role of the health plan.

If a physician has a disagreement with a determination on a referral or pre-authorization request, they should initiate contact with the HealthSun Medical Director by calling the phone number shown on the "Contact Information" page in the introduction section of this Manual.

Pre-Authorization

HealthSun defines "pre-authorization" as having received the Plan's agreement for a service to be delivered based on evaluation of medical necessity **prior to the time the service is rendered.** Services requiring pre-authorization or notification are required with respect to medical services rendered to HealthSun Members. To make these determination providers must review the preauthorization or notification list. The list will provide the medical services that require a preauthorization. Please note that Pre-Certification, Pre-Admission, Pre-Authorization and notification requirements all refer to the same process of pre-authorization. Pre-Authorization or notification requirements for services may be obtained by contacting the Medical Management Department at **1-877-207-4900.**

Organization Determination Timeframes

Although members, their representatives, and/or providers may submit requests for authorizations (also known as organization determinations), the primary care physician (PCP) is responsible for determining whether a referral for specialty care or ancillary services is necessary. Providers must send an authorization request to HealthSun prior to the requested services being rendered, when authorization is required.

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

Standard Organization Determination Request:

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

HealthSun may extend the timeframe 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 HealthSun documents how the delay is in the interest of the enrollee.

Expedited Organization Determination Request:

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

HealthSun will make a determination and notify the member and/or member’s representative, PCP and/or treating provider/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.

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

It is HealthSun’s 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.

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 HealthSun to issue a denial notice. In addition, the member always has the right to request an organization determination on his or her own behalf.

Please note HealthSun members may participate in clinical research studies also called clinical trials. However, not all clinical research studies are open to members of our plan. Medicare first needs to approve the research study. HealthSun will review clinical guidelines to determine eligibility for the coverage. If a member chooses, participate in a study that Medicare has not approved, members may be responsible for paying all costs for their participation in the study.

In-Network Providers

HealthSun members must be referred by the PCPs or Specialists to in-network providers/ participating providers except when services cannot be provided by one of HealthSun in-network providers. Authorization is required and must be provided by HealthSun.

Emergency Services

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

Routine Transportation Authorization Process

HealthSun members may contact the HealthSun Member Services Department to coordinate Non-Emergency Transportation Services (NEMT) to schedule transportation services.

If an authorization request is received for NEMT services outside of the member's region or service area, the NEMT transportation services will be provided if the covered service(s) to be provided out of the region/service area have been authorized by the Plan.

Prior-authorization is required for NEMT services and will be required for transfers between institutions or a transfer back home from a facility following an inpatient discharge.

Physician Responsibilities for Admissions

It is ultimately the admitting physician's responsibility to obtain authorization for services specified in this section and to provide the necessary clinical and patient information to process authorization requests. Although any physician participating in an admission, either directly or through consultation, may supply pre-authorization information, ultimate accountability for this authorization falls to the physician requesting the elective admission.

Inpatient Admissions

How to Obtain Pre-Authorization
Pre-certification requests are accepted from either a PCP or specialist. Elective services require authorization *before* delivery of the service or admission. The Medical Management Department must be contacted 48 hours prior to an elective admission. Please contact HealthSun for pre-certification by calling, e-mailing, or faxing the Medical Management Department **at 1-877-207-4900**

During the pre-authorization process, the Medical Management Department will:

- Verify the current status of member eligibility and benefits.
- Verify what services will be performed, and if the services are to be per formed by a participating, in-network provider.
- For inpatient admissions, determine if the admitting diagnosis, clinical information and treatment plan are presented.
- For inpatient admissions, review admission request against medical appropriateness criteria and health management guidelines; and
- For inpatient admissions, assign an estimated length of stay (ELOS).
- Provision of pre-authorization by HealthSun for a specific service is not a guarantee of payment. Payment is subject to continuing member eligibility at the time the service is rendered.

Information Required for Inpatient Pre-Authorization

- Member name, date of birth, HealthSun ID #
- Facility name to provide service
- Expected date of admission/procedure (if date changes, notify
- Health Plan)
- Diagnosis (or a clear statement of the problem)
- Procedure code number or description
- Pertinent clinical information (a clear, concise description of the work-up, pertinent lab,
- X-ray, or other test data, and any other pertinent information reasonably providing
- justification for the requested services)
- Expected length of stay
- Bed Type (In-Patient or Outpatient)
- Anticipated discharge needs
- Treatment plan
- Other carrier information

Elective Service Pre-Authorization Lead Time Requirements

For non-emergent elective admissions and procedures, contact HealthSun at least two (2) working days before the planned service or admission. This will allow for enough time for the HSO staff to verify benefits and process the pre-certification request utilizing a pro-active approach in attempting to early identify potential care management needs of the member pre and post hospitalization and implement an interventional plan of care.

Failure to meet the lead times specified for elective admissions or procedures may result in HealthSun's inability to approve the procedure or admission for the original scheduled date. Late requests for authorization for elective services that do not meet the lead time requirements will not be given priority, will not be treated as emergencies, and will not be approved on a priority basis.

Emergency Admissions and Direct Admissions

It is the responsibility of the admitting facility and/or provider to contact HealthSun Medical Management Department within 24 hours or the next business day of any emergency or direct admission. When the hospital emergency department, PCP or Specialist office notifies HealthSun of an emergent hospital admission, the HSO staff will verify eligibility and determine benefit coverage. A determination to approve the admission or deny, based on clinical information will be made in a timely manner (within two hours of notification).

If the admission is approved, an authorization number will be provided with the total number of days authorized. If the admission is not authorized, the member, requesting facility, attending provider and the PCP will be notified of the decision with the right to appeal.

Failure to contact HealthSun about an emergency or direct admission may result in the delay of payment for services.

Concurrent Review of Inpatient Admissions

HealthSun will monitor the course of inpatient care services received by a member. A HealthSun Case Manager will conduct regular concurrent reviews of the hospital medical record either by on-site review at the hospital or by telephonic review to determine the authorization for continued length of stay. The facility will be notified regularly of the continued authorized length of stay. In the event additional continued stay is not authorized, the member, facility, attending provider, and the PCP will be notified by HealthSun.

The HealthSun Case Manager will review the medical information on regular intervals. If the Case Manager is onsite at the hospital, they will also be responsible to work with the attending provider, the hospital case management/discharge staff, the patient and/or family, and the PCP to discuss any discharge planning needs. The Case Manager will verify that the member and/or family are aware of the member's PCPs name, address, telephone number, and encourage him/her to make a post-hospitalization follow-up appointment with the PCP.

The Concurrent Review Nurse or Case Manager may also conduct any of the following:

- Review of member's chart;
- Communicate with the patient/guardian/parent;
- Discuss the case with the hospital UM staff; and/or
- Speak directly to the admitting physician regarding the progress of the case;
- Identify discharge or alternative care needs; and
- Assist the facility, physician, and/or member with post-facility care arrangements, coverage information, benefit information, etc.

If, during the course of the review, the Concurrent Review Nurse or Case Manager determines, based on established guidelines, that the available documentation indicates the patient can be transitioned to a lower level of care, the attending physician will be contacted to discuss the justification of any continued services and possible alternatives. The Concurrent Review Nurse or Case Manager, in collaboration with the HealthSun Medical Director, may reduce the authorized level of services and notify the attending physician of same, and suggest appropriate alternatives to current services.

If the attending physician disagrees with the HealthSun determination regarding denial of continued services, he or she may request a further review by the HealthSun Medical Director (Please refer to the Grievance and Appeals Section of this Manual -*Appeal Procedure for Adverse Determinations").*

Provider Complaints and Grievance Procedures

Participating providers may submit an informal complaint to HealthSun Health Plans, Inc., (HealthSun) to express dissatisfaction with the plan. This usually involves a denied claim, but may include other complaints such as contractual dispute, fee schedule issues or other general plan dissatisfactions.

If a provider has a grievance, complaint or other situation regarding any aspect of HealthSun operations, the provider should first contact their designated Provider Operations Representative to discuss the matter. In the event a provider wishes to submit a formal grievance regarding any issue described above, the provider must document in writing the circumstances and forward to their designated Provider Operations Representative at:

HEALTHSUN HEALTH PLANS, INC.

9250 W. Flagler Street,
Suite 600
Miami, Florida 33174
Attention: Provider Operations Department

The letter will be reviewed by the Provider Operations Department and other plan departments as required in order to make a determination. A response will be sent within 60 days after receipt of the letter. The response will provide the appropriate next steps should the resolution not be favorable to the provider.

Initial Grievance

Any Provider who has a grievance against HealthSun Health Plans may call the Provider Operations Department Monday through Friday, 8:00 a.m. to 5:00 p.m. They will assist the Provider in taking the information and collecting all the necessary documents to resolve the grievance.

These grievance procedures will not apply to the cases submitted by agencies like the Florida Department of Insurance Regulation (DOIR) since the deadlines given by such agencies will be followed.

Formal Grievance Procedures

1. Formal grievances shall be handled by the Provider Operations Department with the cooperation of other departments involved with complainant's concerns.

2. All medical issues shall be reviewed confidentially by the HealthSun Health Plans Medical Department (Medical Records are secured either in the Utilization Management Department or with the Provider Operations Department and are only available to appropriate HealthSun Health Plans staff). For medically related grievances, at least one other physician shall be included.

3. A resolution to the Provider's grievance shall be due within the sixty (60) day period from the receipt of the Formal Grievance, except when information needed by non-par Providers or Providers outside of the HealthSun Health Plans service area. In such cases, this period

may be extended by another thirty (30) days, if necessary. The Provider shall be advised in writing of such thirty (30) day extension. The time limitations requiring completion of the grievance process within sixty (60) days shall be tolled after HealthSun Health Plans has notified the Provider in writing that additional information is required in order to properly complete review of the complaint. Upon receipt of the additional information required, the time for completion of the grievance process shall resume. HealthSun Health Plans will communicate with the Provider during the formal grievance process.

4. A resolution letter including Formal Grievance decision and Provider's next level of rights (Committee Hearing Rights) will be sent to the Provider via certified mail. The Provider always has the right to appeal to the Agency and the Statewide Provider and Subscriber Assistance Panel. HealthSun Health Plans shall provide to the Provider written notice of the right to appeal upon completion of the full grievance procedure and supply the Agency with a copy of the final decision letter. If HealthSun Health Plans is unable to resolve the grievance to the Provider's satisfaction, the Provider is provided written notice of his/her rights to appeal HealthSun grievance decision to AHCA/Bureau of Managed Health Care, P.O. Box 12800, Tallahassee, Florida 32317-2800, and the Statewide Provider and Subscriber Assistance Panel for further review.

5. All grievance cases opened/closed are secured with the Provider Operations Department.

6. A Provider has ten (10) days from the receipt of the Formal Grievance Decision Letter to request a Grievance Committee Hearing if not satisfied with the Formal Grievance Decision.

7. Grievance Hearing Request is acknowledged in writing to the complainant within five (5) calendar days of receipt via certified mail. A tentative date and time are agreed upon with the complainant.

8. Grievance Committee meets on an as-needed basis and discusses unresolved grievances.

9. If a grievance involves a medical issue requiring medical records from out of the service area or information from a non-contracted Provider, a thirty (30) day extension is automatically granted to gather the necessary information. The Provider is notified promptly of this extension.

10. The Grievance Committee shall meet prior to the scheduled hearing to discuss their findings and resolution. If the grievance involves a mental health issue, appropriate Behavioral Health staff will be in attendance at the Committee Hearing. Medically related grievances will include at least one other physician.

11. Committee and Provider shall meet at scheduled hearing time to discuss their concerns regarding the case. Meeting notes shall be taken by the Provider Operations Department. Provider shall be advised that HealthSun Health Plans will issue a formal written response via certified mail.

12. After the Committee arrives at a decision, the Provider shall be notified of the decision via a formal written response. Provider shall be offered the next level of rights (Address of the Agency for Health Care Administration will be given to the Provider if he/she chooses to appeal the Committee's decision).

13. HealthSun Health Plans shall maintain an accurate record of each formal grievance. Each record shall include the following:

I. a. A complete description of the grievance

b. Provider's name and address

c. HealthSun Health Plans' address

II. a. A complete description of factual findings and conclusions after the completion of the full formal grievance process.

b. A complete description of the Plan's conclusions pertaining to the grievance as well as the Plan's final disposition of the grievance.

c. A statement is sent to the member regarding the current level of grievance and the remaining levels of appeal available to the Provider.

Please address all Formal Grievances to:

HEALTHSUN HEALTH PLANS, INC.
Attn: Provider Operations Grievance Department
9250 W. Flagler Street
Suite 600
Miami, Florida 33174

These grievance procedures will not apply to the cases submitted by agencies like the Florida Department of Insurance Regulation (DOIR) since the deadlines given by such agencies will be followed.

Member Complaint, Grievances and Appeals

Participating Providers must respond to the HealthSun Grievance and Appeals Department expeditiously with submission of the required medical records to comply with timeframes established by CMS and/or the State Department of Insurance for the processing of grievances and appeals. Only those records for the period designated on the request should be sent. A copy of the request letter should be submitted with the copy of the record. 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. Furthermore, Providers are also required to comply with final determination made by the Plan, CMS, local Independent Review Organization (IRE), or other governmental agency according to the timeframe set forth by CMS.

Member Grievance Process

HealthSun members have sixty (60) calendar days from the date of occurrence to file a formal grievance to the health plan.

Any Member who has a grievance against HealthSun or its providers for any matter may submit an oral or a written statement of the grievance to HealthSun. A grievance form may be requested from the Member Services or the Grievance and Appeals Department.

The written statement or Grievance Form must be forwarded to the HealthSun Grievance and Appeals Department to the following address or fax number:

HEALTHSUN HEALTH PLANS, INC.
Attn: Grievance Department
9250 W. Flagler Street
Suite 600
Miami, Florida 33174

Grievances will be resolved in accordance with the Medicare Managed Care Manual mandated by CMS.

HealthSun members will be referred to KEPRO, Florida's Quality Improvement Organization (QIO), should the grievance be relating to the quality of care or service from the plan or its providers. HealthSun member's may also send inquiries or call KEPRO directly at the following:

KEPRO
5201 West Kennedy Blvd.,
Suite 900
Tampa, Florida 33609
Telephone: (800) 455-8708

Medicare Reconsideration (Appeals)

A Reconsideration (Appeal) is a written or verbal request by a member, his/her legal guardian, authorized representative, or power of attorney; requesting the review of a service previously denied by the plan. A physician who is providing treatment to a member, upon providing notice to the member, may request an expedited or standard pre-service reconsideration on the member's behalf without having been appointed as the member's authorized representative.

To reconsider the Plan's Initial Determination to authorize a service, a request for reconsideration must be received within sixty (60) calendar days from the date of the initial determination. A decision for a reconsideration will be reviewed as expeditiously as the member's health condition requires, but no later than 72 hours (when applying the standard timeframe could seriously jeopardize the member's life, health or ability to regain maximum function); and thirty (30) calendar days for standard pre-service requests.

Participating Providers Dispute Rights

If you believe, the Plan has not paid your services according to the terms of your provider agreement, or has denied payment (without member liability) for services already rendered, you may file a written dispute for review within ninety (90) calendar days of the Plan's notification date. Please submit all documentation to support why the claim should be reprocessed (e.g. explanation of payment, copy of claim, medical records). A copy of the Dispute Form is available on the HealthSun Health Plan's website: www.healthsun.com/providers.

A resolution will be rendered and communicated to the provider within sixty (60) calendar days of your dispute receipt date. To submit a Dispute, please send the request to the Claims Review Department:

Claims Review Department
P.O Box 330968
Miami, FL 33233-0967

Member Quality of Care Investigations

The Grievance and Appeals (G&A) department develops, maintains, and implements policies and procedures for identifying, reporting, and evaluating potential quality of care (QOC) concerns or sentinel events involving HealthSun members. This includes cases reviewed as the result of a grievance submitted by members and potential quality issues (PQI) reviewed as the result of a referral received from a HealthSun Health Plan clinical associate. The Potential Quality issues are received through the intranet at the Risk Management Department and then forwarded to the

clinical personnel for review to determine the level of severity. All HealthSun Health Plan associates who may encounter clinical care/service concerns or sentinel events are informed of these policies.

Quality of Care Grievances: A complaint where a member perceives that their heath is adversely affected as a result of the omission, commission, breach or violation in standard of care or not satisfied with the quality of care received by a physician, facility, healthcare provider, or a Medicare health plan. The member or member representative can file this complaint through the health plan's grievance process or through the QIO. The QIO must determine if the quality of services (including both inpatient and outpatient services) provided by the Medicare health plan, physicians, or facility meets the appropriate standards.

QOC Classification and Point System: The point system below will be used to determine trends, patterns and be used in the re-credentialing process.

Quality of Care		
Level	**Points Assigned**	**Description**
C-0	0	Predictable/unpredictable occurrence within the standard of care. Recognized medical or surgical complication that may occur in the absence of negligence and without a QOC concern. No quality of care issue found to exist. (example, unexpected adverse reaction to a medication)
C-1	5	The issue is identified as a quality of care (QOC) issue but there was no realized adverse impact on the member based on the omission, commission, breach in medical care or administrative procedures not associated with standards of care, or an error. C1-P*) Recognized Medical or Surgical complication that may occur in the absence of negligence and without QOC concern. C1-A**) Communication, administrative, or documentation issue that adversely affected the care rendered.
C-2	10	The grievance found to be a quality of care (QOC) issue where the member had an unexpected outcome as a result of the omission, commission, breach in medical care or administrative procedures not associated with the standards of care, or an error where there was a significant chance of a serious adverse outcome but there was no lasting or permanent effect.
C-3	25	The grievance is determined to be a quality of care (QOC) where the member had an unexpected outcome or sentinel events involving as the result of the omission, commission, or error and there was death or

Quality of Care		
Level	**Points Assigned**	**Description**
		serious physical injury or illness, including loss of limb or function, not related to the natural course of the member's illness or underlying condition or permanent and/or lasting effect.
C-D***	20	Failure of a practitioner/provider to respond to a member Grievance regarding a clinical issue despite two requests per internal guidelines or failure to submit the Action Plan requested because of a confirmed QOC issue.

*P-Provider. **A-Administrative. ***D-Documentation.

Quality of Care and Service Trend Parameters

The following accumulation of QOC cases with severity levels and points, or any combination of cases totaling 20 points or more during any 12 months will be subject to trend analysis:

- 10 cases with a leveling of C-0
- 4 cases with a leveling of C-1
- 2 cases with a leveling of C-2
- 1 case with a leveling of C-3(automatic referral to the applicable Peer Review
- Committee)
- 2 Cases with a leveling of D

A 12-month cumulative level report is generated monthly and reviewed by a G&A clinical associate for trend identification. (Four similar complaints constitute a trend).

The Quality Improvement Department and the Medical Director will determine if further action is warranted, such as the need for a corrective action plan, or referral to the appropriate committee for further review and action, as appropriate.

A provider who does not submit the corrective action plan by the deadline or who does not comply with the terms of the corrective action plan will be referred to the Credentialing Committee for further action, which may include termination from the network.

Part D Coverage Determination, Exceptions And Appeals Process

Short Decision-Making Timeframes

CMS has directed every prescription drug plan to respond to requests without delay. Plans must communicate decisions on initial coverage determinations no later than 24 hours after receiving

an expedited request, or 72 hours after receiving a standard request. If a physician or other prescriber requests coverage determination on behalf of an enrollee, the physician will receive notice of the plan's decision. If the plan fails to meet the timeframe, the case goes to an Independent Review Entity (IRE) under contract with CMS for a decision on the case. The independent review entity is commonly referred to as the Part D qualified independent contractor (Part D QIC).

Requests Made by Physicians or other Prescribers

As stipulated in the Part C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance, Section 20. Representatives - an enrollee's prescribing physician or other prescriber may request a coverage determination, redetermination, *or IRE reconsideration* on an enrollee's behalf*, but* is prohibited from requesting a higher appeal without being the enrollee's representative. If the IRE issues an adverse decision, the enrollee's physician or other prescriber must become the enrollee's representative to file any further appeal on the enrollee's behalf (i.e., the physician or other prescriber would be responsible for becoming the enrollee's representative and submitting the proper representation documentation with the appeal request).

Physicians or other Prescribers Supporting Statements

Prescribing physicians or other prescribers have an important role in the exceptions process. Whenever an enrollee requests a Prior Authorization for a drug, prescribing physician or other prescriber must provide Part D Services Department with an oral or written statement to support exception request. Plan's timeframe for making a decision on an exception request does not begin until prescribing physician's supporting statement is received by plan.

Enrollee's Appeal Rights

If a member does not agree with initial coverage determination decision made by plan, enrollee has the right to appeal. An enrollee's prescribing physician or other prescriber may request a redetermination *or IRE reconsideration* on an enrollee's behalf without providing form of representation. However, the Plan will require the prescribing physician or other prescriber to submit a representation form for redetermination payment appeals. In addition, if a request is received by someone other than the enrollee that does not include the prescribing physician or other prescriber, then the plan will require a representation form.

The enrollee, prescribing physician, other prescriber, or legal representative may request any of the following types of appeals:

72 hour - Expedited Appeal

7 calendar days - Benefit Appeal

7 calendar days - Payment Appeal

If a plan issues an adverse redetermination, the member will receive a notice, which includes information on how to request reconsideration by the Part D QIC. Detailed information can be found in the members Evidence of Coverage. All appeal inquiries may be made to the Appeals Department at (305) 448-8100 or via fax at (877) 589-3256.

Medicare Risk Adjustment and Coding

The HealthSun Health Plan Risk Adjustment (RA) Coding Analyst/Coders purpose

The HealthSun Health Plan has established a team of RA analysts/coders to review medical records and assist the provider in documenting each condition to the highest level of specificity to accurately reflect the patient's true health status at the time of the encounter.

Risk Adjustment and Data Submission

Risk adjustment is the process used by CMS to adjust the payments made to Medicare Advantage Organizations (MAOs) based on the collective health status of the MAO's members. Risk adjustment was implemented to pay MAOs more accurately for the predicted health cost expenditures of members by adjusting payments based on demographics (age and gender) as well as health status. Diagnosis data collected from encounter and claim data is required to be submitted by the MAO to CMS for purposes of risk adjustment. Because CMS requires that MAOs submit "all ICD-10 codes for each beneficiary", HealthSun also collects diagnosis data from the members' medical records created and maintained by the provider.

Under the CMS risk adjustment model, the MAO is permitted to submit diagnosis data from face-to-face encounters only. These include inpatient hospital, outpatient hospital and physician encounters.

Risk Adjustment Data Validation (RADV) Audits

As part of the risk adjustment process, CMS will perform RADV audits in order to validate the MA members' diagnosis data that was previously submitted by the MAO. These audits are typically performed once a year. If the MAO is selected by CMS to participate in a RADV audit, the MAO and the providers that treated the MA members included in the audit will be required to submit medical records to validate the diagnosis data previously submitted.

Medical Record Documentation Requirements (Risk Adjustment)

Medical records significantly impact risk adjustment because:

- They are a valuable source of diagnosis data;
- They dictate what ICD-10 Code is assigned;
- They are used to validate diagnosis data that was previously provided to CMS by the MAO.

Because of this, the provider plays an extremely important role in ensuring that the best documentation practices are established.

CMS record documentation requirements include:

- Patient's name and date of birth should appear on all pages of record;
- The date of service should be clearly documented for each encounter;
- Patient's condition(s) should be clearly documented in record;
- The documentation must show that the condition was monitored, evaluated, assessed/addressed, or treated (MEAT);;
- The documentation describing the condition and MEAT must be legible
- The documentation must be clear, concise, complete and specific;
- When using abbreviations, only standard and appropriate abbreviations should be used because some abbreviations have multiple meanings, the abbreviation that is appropriate for the context in which it is being used should be applied;
- Physician's signature, credentials and date must appear on the record and must be legible.

Medicare Risk Adjustment (MRA): Training and Education

Training and education are an essential part of every compliance program; and this is true of HealthSun's MRA compliance program. To help HealthSun, the Delivery Network and its wholly owned subsidiaries meet this requirement, HealthSun's Compliance team requires that all Providers, practitioners, and facilities complete appropriate Compliance and Medicare Risk Adjustment training to help ensure all Providers, practitioners, and facilities are prepared to perform the work functions assigned to them in a manner that complies with MRA rules and CMS regulations.

- Regular and required training:
    - Make available onboarding training and regular retraining for providers, coders and staff, as applicable;
    - Conduct training at least annually and following audits for providers, coders, and staff, as applicable;
    - Review education and training materials at least annually and update as needed;
    - Engage certified coding educators.
- Certifications:
    - Providers should hire certified coders to perform coding activities;

- Coders should participate in continuing education (for staff who perform MRA coding, auditing and/or training);
- Coders must complete minimum amount of continuing education units to maintain certification.

Leverage HealthSun educators and training materials at **https://healthsun.com/providers**

Claims and Encounters

General Claims Information

HealthSun Health Plans Claims Department adheres to prompt payment laws as specified in the Centers of Medicare and Medicaid Services and Florida Statute 641.3155.

A “clean claim” is one that does not require investigation or external development. Clean claims must be processed within 30 days of receipt date.

Claims that do not meet the definition of “clean” claims are “Other” claims.

“Other” claims require additional documentation or investigation.

Invalid or incomplete electronic claims will be returned as unable to-process. Notification of rejection is provided by the Clearinghouse.

Resubmission of rejected claims is subject to timely filing requirements.

Clean Claim Definition

To meet the HealthSun definition of a "clean claim" a claim must:

- Complete all required fields with accurate and valid information on a CMS 1500; or UB-04 or as required for electronic submission in accordance to the Medicare claims processing manual;

- Include any additional data elements (i.e. copy of the Referral Form, Pre- Certification Form, medical documentation) required by HealthSun as specified in this manual or other official notices from HealthSun issued from time to time only for paper claims;

- Include any primary payer’s Explanation of Payment (EOP) or payment voucher showing the amount paid by the third party if the member is covered by another insurance or HMO carrier other than HealthSun;

- Indicate services which are provided consistent with any referrals or authorizations necessary as directed by HealthSun;

- The claim must not involve an investigation for coordination of benefits (COB), or member eligibility;

- Be filed in a timely fashion in accordance with the provider contract;

- Provider must maintain a valid written assignment of benefits from the member on file. This will serve as evidence that the provider is entitled to payment for service. HealthSun reserves the right to review the original signed assignment document at any time;

- Separate charges must be itemized on separate lines. Medical records documentation must validate the scope of services provided and billed.

Other Claim Definition

*** An "unclean claim" is defined as an incomplete claim, a claim that is missing any of the above information, or a claim that has been suspended in order to get more information from the provider. If you submit incomplete or inaccurate information, we may reject the claim, delay processing, or make a payment determination (e.g., denial, reduced payment) that may be adjusted later when complete information is obtained. ***

Provider acknowledges and agrees that no reimbursement is due for a covered service unless performance of that covered service is fully and accurately documented in the member's medical record prior to the initial submission of any claim. Furthermore, provider acknowledges and agrees that at no time shall members be responsible for any payments to provider except for applicable copayments, coinsurance, deductibles, and non-covered 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 HealthSun policy, in order for the Member to be held financially responsible. HealthSun policy requires that the notification include the date and description of the service, name and signature of the Member, name, and signature of the Provider, and be in at least 12-point font. Documentation of that pre-service notification shall be provided to HealthSun or its designee upon request and including timely to substantiate Member appeals. In addition, consistent with current Medicare policy for non-covered services, HealthSun will not issue payment for a particular surgical or other invasive procedure to treat a particular medical condition when the practitioner erroneously performs:

a. A different procedure altogether
b. The correct procedure but on the wrong body part
c. The correct procedure but on the wrong patient. HealthSun will also not cover hospitalizations and other services related to these non-covered procedures.

Overpayments include, but are not limited to, situations in which a Provider has been overpaid by HealthSun due to 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, HealthSun will notify the Provider of the refund amount due in writing via mail. The Provider is responsible for immediately refunding to HealthSun the overpayment amount according to the instructions stated in the written notification. If a refund is not issued, HealthSun may recoup the monies due from any future payments.

Claims must be submitted to the correct address. For information on where to send your claims, please refer to the "Key Contact List" at the beginning of this manual. The member's HealthSun ID card will also list the claims address. **Submitting claims to the incorrect address will result in delay of processing.** All claims for payment, whether electronic or non- electronic must be submitted within the timeframe stipulated in the HealthSun agreement.

If the notice of payment or denial of submitted claims is not received within forty (40) days, please contact the HealthSun Provider Help Line or your assigned Provider Operations Representative. The HealthSun Claims Status Telephone Queue is dedicated to answering inquiries related to billing, status and payment of claims. To ensure short wait times the HealthSun Claims representatives will review three (3) accounts per inquiry. The hours of operation are Monday through Friday between 8:00 a.m. and 5:30 p.m.

Providers are encouraged to submit claims and/or encounters electronically. If you are not currently submitting electronically, contact your Provider Operations Representative or the Provider Help Line at (877) 999-7776.

Electronic Claims Submission

Advantages to Electronic Claim Filing

HealthSun encourages filing claims electronically. Benefits of filing via electronic media include:

- Decrease in turnaround time for payment;
- Streamlines the billing process;
- Reduction in Costs for Filing (i.e. postage costs, forms cost, printing costs, labor);
- Confirmation of Receipt;
- Prompt Identification of omitted/incorrect information;
- Ability for Provider to quickly track number of rejected versus accepted claims.

Claims Clearinghouse:

HealthSun has contracted with Trizzetto and Availity EDI for Electronic Claim Submissions (EDI). The Payor ID Number for HealthSun is HESUN. There is no enrollment required to send claims electronically, but the pay ID number (HESUN) must always be placed on the claim. If you need assistance with getting set up to submit claims electronically, please contact your EDI provider

Trizzetto EDI Customer Service at 800-556-2231 or Availity 1-800-282-4548. In addition, your HealthSun Provider Operations representative can assist you by calling 305-448-8100.

Validating Electronic Claims and Notices of Receipt

The contracted clearinghouse edits electronic claims received for file format and required fields only. The clearinghouse performs validation of the Provider's claim information. The clearinghouse will send the provider a rejection notice for the claim or the batch indicating whether the claim or batch was rejected.

Rejected claims and/or batches are the responsibility of the provider to correct and resubmit. The clearinghouse confirmation notices will not serve to support any claims appeals to HealthSun should one become necessary (i.e. for filing deadlines).

Each claim will either be accepted or rejected in its entirety, not on a line-by-line basis, based upon information provided in the service lines. HealthSun will provide a confirmation report to the clearinghouse of both accepted and rejected claims.

Claims for services filed electronically should not also be filed on paper. This creates a duplicate claim. Disputes to previously processed electronic claims should be submitted to the Claims Review Department on paper; not submitted electronically as a new claim.

Transmission Frequency

Electronic claims can be transmitted daily; however, claims transmitted on Saturday and Sunday are not downloaded into HealthSun claims processing system until the following business day.

The unique HealthSun Provider ID number is required on electronically (and paper) submitted claims. Contact your Provider Operations Representative if you need to verify your assigned HealthSun Provider ID.

Provider Identification (ID) Number Requirements

The nine (9)-digit Federal Tax ID number and your NPI number will be required on all claims submitted to HealthSun.

Failure to place the Tax ID number or your NPI number on a claim or submitting a claim with a wrong number will cause the claim to be denied or to be considered deficient and to be returned. Resubmission with a Tax Id and NPI number will be required for claims processing.

Paper Claims Submission

General Requirements

HealthSun requires paper claims to be filed on a CMS-1500 or UB- 04 form with accurate and valid information. All required sections of the CMS -1500 or UB- 04 must be completed. Paper claims received on non-standard claim forms will be returned to the provider for resubmission on the appropriate claim form.

HealthSun will not accept super-bills or similar submissions as valid claims. Preferably, claims should be computer generated or typed.

Claim Signature Requirements

When filing a paper claim, the physician or provider's handwritten signature (or signature stamp) must be in the appropriate block of the claim form (box 31).

Providers delegating signature authority to a member of the office staff or to a billing service remain responsible for the accuracy of all information on a claim submitted for payment.

Initials are only acceptable for first and middle names for corrected claims that were previously signed off by the physician. The last name must be spelled out.

Claims prepared by computer billing services or office-based computers may have "Signature on File" in the signature block along with the printed name of the provider. For claims prepared by a billing service, the billing service must retain a letter on file from the provider authorizing the service.

Optical Character Recognition (OCR)

HealthSun utilizes optical character recognition of paper claims to improve the accuracy and efficiency of processing the claims. Providers are encouraged to file claims that meet the elements required to enable scanning. Failure to do so results in delays in claims processing.

Do's and Don’ts pertaining to the quality of paper claims submission.

Paper Claim Submission Do’s	Don’ts
Use original claim forms	Do not - Submit a copy of the original Form. Do print a new claim on an original claim form.
Use black ink for data entered on the claim form	Don't - Use red ink - this ink color cannot be "read" by the OCR system
Print/type data on claims	Don't - Use mixed fonts on the same form
Make sure data prints within the defined Boxes on the claim form.	Don't- Use dashes or slashes in date Fields. Do use the eight-digit date format (mmddyy)

Paper Claim Submission Do's	Don'ts
Select a standard font with clear Characters. Times Roman font works well	Don't - Use italics or script fonts
Ensure print on claim/attachment is dark, clear, and legible. Photocopies and faxed copies with small print are often blurry and unreadable. Do circle information on attachments to identify critical criteria.	Do not - Highlight information on the claim-highlighting is not visible to the OCR system.
Use all capital letters	Don't - use correction fluid
Use a laser printer for best results. Characters printed by dot matrix or impact printer may be difficult to "read" by OCR	Don't - Use proportional fonts (Courier is a good example of a font that is not proportional)
Use white correction tape for corrections	Don' t - Put notes on the top or bottom of the claim form
Submit notes on 8 "x 11" paper	
Use a six-digit date format (010210)	Don't Submit more than six lines on the CMS 1500 claim form
Replace printer toner often	Don't print slashes over the zeroes
	Don't submit handwritten forms

Where to Submit Paper Claims

For paper claims from physician and ancillary providers, mail to

HealthSun Health Plans Inc.
P.O. Box 211154
Eagan, MN 55121
Attention: Claims Department

Claims submission via email or fax is not acceptable.

If a provider wishes to have proof of receipt by individual claim, the provider must request this and must include a list of the exact claims enclosed in the package. The list should include the following information:

- Member Name;
- Member ID;
- Date(s) of Service; and
- Billed Amount Total.

HealthSun will verify that the specifically listed claims are enclosed in the package and return confirmation to the provider via mail.

Providers will be responsible for completing the information on the CMS 1500 form within the time frame specified in their contract. The claims should include the following:

- Patient name (Box 2)
- Patient ID number (Box 1A)
- Patient DOB (Box 3)
- Patient address and telephone number (Box 5)
- Other insurance information (Box 9)
    - Insured name
    - Insurance name
    - Policy/ Group number
- Attach other insurance EOP's to show payment or denial
- If patient's condition is related to: (Box 10)
    - Employment (Worker's Compensation)
    - Auto Accident
    - Other Accident
- Insured's Policy Group (Box 11)
- Patient Signature (Box 12 & 13)
- Date of current illness (Box 14)
- Dates of Patient unable to work (Box 16)
- Name of referring provider Box 17)
- Referring Provider NPI# (Box 17B)
- Hospitalization dates (Box 18)
- ICD-10 Diagnosis Code(s) (Box 21)
- Authorization number (Box 23)
- Date(s) of Service (Box 24A)
- Place of Service (Box 24B)
- CPT and HCPC Codes. Modifiers when applicable (Box 24 D)
- Diagnosis code pointer (Box 24 E)
- Charges (Box 24F)
- Days or Units (Box 24G)
- Rendering Provider NPI (Box 24J)
- Federal TID number (Box 25)
- Patients account number-Optional (Box 26)
- Accept assignment- Y or N (Box 27)
- Total charge (Box 28)
- Amount paid (Box 29)
- Signature of Physician or supplier of service (Box 31)
- Service Facility location information (Box 32)
- Service Location NPI (Box 32A)
- Billing Provider Information (Box 33)
- Billing Providers NPI # (Box 33A)

Overpayments

Overpayments include, but are not limited to, situations in which a Provider has been overpaid by HealthSun due to incorrect claims processing such as billing errors, ineligible members, or Coordination of Benefits. In the event of an overpayment, HealthSun will notify the Provider of

the refund amount due in writing via mail. The Provider is responsible for immediately refunding to HealthSun the overpayment amount according to the instructions stated in the written notification. If a refund is not issued, HealthSun may recoup the monies due from any future payments.

Coordination of Benefits and Subrogation

As a participating provider with HealthSun we require 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 the Plan immediately. You can contact the Plans Provider Services Department at (305) 448-8100 Ext. 10822

HealthSun is subject to the rules and regulations as defined by the Social Security Act and the CMS Medicare Secondary Payment (MSP) provision. Medicare Advantage Organizations are allowed four (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
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 End Stage Renal Disease (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 payors. Workers' Compensation assumes full liability for the payment of items and services related to a claim meeting their coverage requirements.

When a Member has coverage, other than with HealthSun, which requires or permits coordination of benefits from a third-party payor in addition to HealthSun, HealthSun will coordinate its benefits with such other payor(s). In all cases, HealthSun 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, HealthSun 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 payor(s); or
(iii) the difference between allowed billed charges and the amount paid by the other payor(s). In no event, however, will HealthSun, when its plan is a secondary payor, pay an amount, which, when combined with payments from the other payor(s), exceeds the rates set out in the prevailing agreement; provided, however, if Medicare is the primary payer, HealthSun will, to the extent required by applicable law, regulation or Centers for Medicare/Medicaid Services (CMS) Office of Inspector General (OIG) guidance, pay Provider an amount up to the amount HealthSun would have paid, if it had been primary, toward any applicable unpaid Medicare deductible or coinsurance.

Recovery: Provider and HealthSun agree to use reasonable efforts to determine the availability of other benefits, including other party liability, and to obtain any information or documentation required by HealthSun and Provider to facilitate coordination of such other benefits. Upon request by HealthSun. Provider will provide HealthSun with a copy of any standard Provider forms used to obtain the necessary coordination of benefits information.

Payment Adjustment: Provider and HealthSun agree that retroactive adjustment to the payment including but not limited to claims payment errors, data entry and incorrectly submitted claims shall be submitted to Audit and Recovery Department.

Coding

HealthSun requires use of standard CPT, ICD-10 and HCPCS coding, unless otherwise directed by HealthSun as outlined in this Manual or Participating Provider contract.

Diagnosis codes should be billed with the highest degree of specificity. Use fourth and fifth digits whenever applicable. If a diagnosis code requires a fourth or fifth digit, and is not coded as such, the claim will be denied.

New and Deleted Codes

Providers must bill for services using current CPT, ICD-10 (as applicable) and HCPCS codes and modifiers that are appropriate for the service provided. Annually, as CPT and HCPCS codes are added and deleted from the American Medical Association (AMA) and CMS listings of valid codes, HealthSun policy will be the following:

- New codes are accepted upon implementation date.
- Deleted codes are accepted up to the effectiveness in accordance to coding guidelines.
- HealthSun will only accept HIPAA approved code sets.

Unlisted Codes

HealthSun will accept a provider's use of an unlisted code only when the physician/provider's contract with HealthSun specifically requires use of the unlisted code.

For unlisted supplies (e.g., HCPCS code El399), the claim should include a detailed description of the supply. The description can be written in detail on the claim form or provided as an attachment (i.e. a copy of the supply invoice) and the validated medical documentation.

If billing for an unlisted drug, physician/provider must include a detailed description, medical documentation and the dosage given.

If a claim is filed using an unlisted code and a valid code is available, unless specifically allowed by physician/provider contract, HealthSun will deny the service or supply and the claim for that service or supply will need to be re-filed by the physician or provider.

Accurate Coding

To code accurately, it is necessary to have a working knowledge of medical terminology and to understand the characteristics, terminology, and conventions of ICD-10. Transforming descriptions of diseases, injuries, conditions, and procedures into numerical designations (coding) is a complex activity and should not be undertaken without proper training.

Originally, coding allowed retrieval of medical information by diagnoses and operations for medical research, education and administration. Coding today is used to describe the medical necessity of a procedure and facilitate payment of health services, to evaluate utilization patterns and to study the appropriateness of health care costs. Coding provides the basis for epidemiological studies and research into the quality of health care. Incorrect or inaccurate coding can lead to investigations of fraud and abuse. Therefore, coding must be performed correctly and consistently to produce meaningful statistics to aid in planning for the health needs of the nation.

Follow the steps below to code correctly:

1. Identify the reason for the visit. (e.g., sign, symptom, diagnosis, conditions to be coded).
2. Always consult the Alphabetic Index, Volume 2, before turning to the Tabular List.
3. Locate the main entry term.
4. Read and interpret any notes listed with the main term.
5. Review entries for modifiers.
6. Interpret abbreviations, cross-references, symbols, and brackets.
7. Choose a tentative code and locate it in the Tabular List.
8. Determine whether the code is at the highest level of specificity.
9. Consult the color-coding and reimbursement prompts, including the age and sex edits.
10. Assign the code.

Service Location Codes

HealthSun accepts valid CMS place of service codes. Consultations and professional services rendered in a hospital setting will be processed according to the level of care authorized and in accordance to the Medicare Guidelines. Improper coding, including procedure and location coding may result in denial of the claim.

Reimbursement will also be made based on the applicable locality where service was rendered in accordance with Medicare Guidelines. (i.e., Miami Dade County, Broward County, and Palm Beach County).

Claims Filing Deadlines

Initial Claim Filing

Initial claims must be submitted within thirty (30) up to one-hundred and eighty (180) days as listed in the HealthSun Provider agreement (filing days may vary, reference your Provider Agreement) following the date on which the Covered Health Services were rendered, or for continuous Covered Health Services, for which one charge will be made. Claims not received at HealthSun within the period stipulated in the Provider agreement will be denied and are to be considered waived by the physician. These services are not to be billed to the member for payment.

Hospitals should provide current insurance information to hospital-based physicians when available to allow those physicians to file claims to HealthSun in a timely manner.

Initial Claim Filing When There is Another Insurance

HealthSun payment as a secondary payer will not exceed the amount specified according to contract, less the primary payer's payment amount.

Exceptions to the Filing Deadline

Providers who fail to meet the filing deadline may request reconsideration of their claim through the claims review process. HealthSun recognizes there are instances where extenuating circumstances may result in missing the filing deadline (e.g. theft or destruction of Provider's records, death or disability of Provider, complete system failure). In these instances, providers must submit a written dispute to the HealthSun Claims Review Unit. HealthSun may waive the filing deadlines at its sole discretion. Provider will need to evidence that the claim was filed within the allowable time.

NOTE: If an exception to the filing deadline is granted by HealthSun and multiple claims are involved; the physician/provider should submit all claims as a batch to the Claims Department/Appeals Unit. At that time an adjustment will be done to the original submission. All request for adjustments or appeals on contracts are to be submitted 120 days from the date of receipt of denial and or underpayments.

Claims Dispute

If you believe, the Plan has not paid your services according to the terms of your provider agreement, or has denied payment (without member liability) for services already rendered, you may file a written dispute for review within ninety (90) calendar days of the Plan's notification date. Please submit all documentation to support why the claim should be reprocessed (e.g. explanation of payment, copy of claim, medical records). A copy of the Dispute Form is available on the HealthSun Health Plan's website: www.healthsun.com/providers.

A resolution will be rendered and communicated to the provider within sixty (60) calendar days of your dispute receipt date. To submit a Dispute, please send the request to the Claims Review Department:

HealthSun Health Plans, Inc.
Audit and Recovery Department
Attention: Disputes Unit
9250 W. Flagler Street,
Suite 600
Miami, FL 33174

Email: Claimsdispute@healthsun.com

Claims Audits

HealthSun Health Plans reserves the right to audit all claims, itemized bills, and applicable medical records documentation for billing appropriateness and accuracy.

Within the timeframes allowed by the applicable governing agency (AHCA, CMS or DFS), HealthSun Health Plans may audit a claim and itemize for appropriateness of charges and compliance with billing procedures for the approved care of the Member. Per Florida Statute 641.315 (5), HealthSun Health Plans has the right to dispute certain charges. The claim will either

be (i) processed for undisputed charges; or (ii) deny requesting additional information within the period required by the applicable regulatory agency.

As already specified in your Agreement or in this Provider Manual in cases where a payment has already been made and it is determined after the audit the provider has been overpaid, Healthsun Health Plans will request a refund for such payments. Provider must reimburse Plan or dispute refund request within 35 days of receipt of such request. Refund checks should be mailed to:

HealthSun Health Plans, Inc.
Audit and Recovery
9250 W. Flagler Street,
Suite 600
Miami, FL 33174

Any overpayment dispute should be submitted via e-mail or fax to:

- E-mail: AuditandRecovery@healthsun.com
- Fax: 786-363-8144

As already specified in your Agreement or in this Provider Manual in cases where a payment has already been made and it is determined after the audit that provider has been overpaid, HealthSun Health Plans will request a refund for such payments. Provider must reimburse Plan or dispute refund request within 35 days of receipt of such request. Any payments or disputes should be mailed to the address above.

If Provider agrees to coordinate joint audits with HealthSun Health Plans prior to any payment, HealthSun Health Plans will schedule such audits. Since claims must be processed within strict timeframes, this would require that the Provider allow joint audits within 3 days of the request.

Interim Bills

Interim bills will not be accepted for DRG or APC Claims. In order to properly adjudicate a claim paid on a Medicare Allowable basis, the patient must be discharged.

Itemized Statements

HealthSun Health Plans may require itemized statements as deemed necessary and appropriate.

Charge Audit

Auditors shall conduct both pre-payment and post-payment claim reviews to ensure correct reimbursement and contract compliance. Our Audit Team will conduct the following types of pre-payment claim reviews: (1) claims that fall into an APC or DRG outlier status, (2) claims that will pay to a percentage of charges, and (3) Principle Diagnosis Code or DRG discrepancies (4) CPT unbundling.

Auditors will review claims for accuracy of charges and description of services, overpayments and underpayments. Line-by-line charge audits will also focus on: (1) unbundling or bundling of

charges, (2) charging for an item or service that is considered non-covered for payment, (3) high-volume items and (4) high-cost services and supplies. The following parameters will be used during an audit:

1. Non-allowable charges, including but are not limited to the following:
   - Re-usable equipment and surgical instruments.
   - Routine supplies that are included in the cost of the room where services were provided. Examples: surgical drapes, gowns, gloves, masks, irrigation solutions, sterile saline solutions, IV tubing, oxygen masks, oxygen supplies, and syringes. Added fees charged for non-routine handling of laboratory specimens processed within the facility (e.g., STAT fees).
2. Room and board, including but not limited to the following services and supplies:
   - All nursing staff services including, but not limited to coordinating the delivery of care, patient education and supervising the performance of other staff members to whom they have delegated patient care activities.
   - Room and complete linen service.
   - Dietary service including all meals, therapeutic diets, required nourishment, dietary supplements and dietary consultation.
   - Thermometers, blood pressure apparatus, gloves, tongue blades, cotton balls and other similar items used in the examination of patients.
   - Routine supplies provided as part of routine care including, but not limited to:
     - Wipes, swabs, bibs, scales, body lotion, bedpan, bedside commode, water pitcher, patient gown, breast pump, nursing pads, petroleum jelly, hydrogen peroxide, and diapers (baby or adult).
     - Administration of medications including IV's.
     - Postpartum services.
     - Recreation therapy
     - Interpretation, rental or reading of patient monitoring equipment in the OR, ICU,
3. L&D, and ER. (e.g., pulse oximetry, fetal monitoring). Incremental nursing charges (ER, OB, nursery, critical care, OR, etc.) are included in the room charge.
4. Critical care room charges include, in addition to the above, all standard equipment such as monitors, suction devices, feeding pumps, IV poles, transducers, and IV pumps.

Such items will be disputed, and total charges will be reduced by these amounts prior to payment.

Members Enrolled in Hospice

It is important that your staff and/or billing company understands the process required to bill the Fiscal Intermediary for CMS for members of our Plan that are enrolled in hospice. Please communicate this information to your staff and/or billing company as appropriate.

What is Hospice?

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

A specially trained team of professionals and caregivers provide care for the "whole person", including his or her physical, emotional, social and spiritual needs.

Services may include physical care, counseling, drugs, equipment, and supplies for terminal illness and related condition(s). Care is generally provided in the home. Hospice is not 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 biological for pain relief and symptom management
- Hospice aide and homemaker services
- Physical, occupational, and speech-language pathology therapy services
- Short-term inpatient and respite care
- Social worker services
- Grief and loss counseling for the member and his or her family

When a member/patient enrolled in hospice receives care from your practice or facility, it is very important that all the care be coordinated with their hospice physician. Once a Member is enrolled in hospice, HealthSun is only responsible for services that are not related to hospice diagnosis, as long as the service provided is a Medicare covered benefit. HealthSun enrolls Hospice members into a new group effective the 1st 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. The Plan will continue to assist in coordination of the member's care to the best of its ability, however, the payment process to provider's changes.

For Hospice diagnosis related care, providers need to bill the Medicare-approved hospice organization with which the patient is enrolled. For care not related to the hospice related diagnosis, that is a Medicare covered benefit, providers need to bill the Fiscal Intermediary for CMS directly. If a Member's hospice is revoked during a month, you must continue to bill the hospice organization or the Fiscal Intermediary for CMS through the end of that month. HealthSun is only responsible for additional benefits not covered by Medicare, i.e. the transportation benefit. Any claims received by HealthSun for Medicare- covered services that are not additional plan benefits, will be denied by the Plan.

Note: A member who has elected hospice and requires medical treatment for a non-hospice condition and do one of the following:

(1) Use plan providers and services. In such a case, the member only pays plan allowed cost-sharing, and the provider would directly bill FFS for (Parts A and B services); or

(2) Use non-network providers and be treated under FFS. In such a case, if the service were not emergent/urgent care, the member would pay the total FFS allowed cost sharing.

When hospice services are requested by a Member, confirmed with the Centers for Medicare & Medicaid Services (CMS) and updated in the Plan's system, the Member is sent a new enrollment 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 their system is updated.

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

Quality and Performance Ratings

HealthSun Health Plans would like Providers to understand the Measures and Rating System for the Quality and Performance Ratings. Below please find a brief explanation of this Program. HealthSun is strongly committed to providing high-quality care, benefits and programs that meet or exceed all CMS quality benchmarks. The structure and operations of the CMS star rating system ensures that pay-for-performance funding is used to protect or, in some cases, to increase benefits and to keep member premiums low.

The ratings are captured in the following areas:

- HEDIS
- HOS (Health Outcome Survey)
- CAHPS (Consumer Assessment of Health Care Provider and System)
- CMS Part C Measures
- CMS Part D Measures

We encourage our Providers to assist in meeting these goals by committing to the following:

- Encourage the member to obtain preventive screenings annually or when recommended.
- Identify noncompliant patients at the time of their appointment.
- Make sure that all encounters and claims are correct and with appropriate codes.
- Submit clinical data to HealthSun.
- Communicate clearly with the member and document the communication in the chart.

CMS Star Ratings

The Centers for Medicare & Medicaid Services (CMS) uses a five-star rating system to measure Medicare beneficiaries' experience with their health plans and the health care system. This rating system applies to all Medicare Advantage (MA) lines of business:

- Health Maintenance Organization (HMO);
- Preferred Provider Organization (PPO);
- Private Fee-for-Service (PFFS) and
- Prescription drug plans (PDP).
-

The scale ranges from one to five stars, where a rating of one star represents "poor" quality and five stars represents "excellent" quality. The program is a key component in financing health care benefits for MA plan enrollees. In addition, the ratings are posted on the CMS consumer website, www.medicare.gov, to give beneficiaries help in choosing among the MA plans offered in their area.

CMS Goals for the Five-star Rating System

- Implement provisions of the Affordable Care Act
- Clarify program requirements
- Strengthen beneficiary protections
- Strengthen CMS' ability to distinguish stronger health plans for participation in Medicare Parts C and D and to remove consistently poor performers

How Are Star Ratings Derived?

A health plan's rating is based on measures in five categories:

- Members' compliance with preventive care and screening recommendations
- Chronic condition management
- Plan responsiveness, access to care and overall quality
- Customer service complaints and appeals
- Clarity and accuracy of prescription drug information and pricing

Benefits to Providers

- Improved patient relations
- Improved health plan relations
- Increased awareness of patient safety issues
- Greater focus on preventive medicine and early disease detection
- Strong benefits to support chronic condition management

Benefits to Members

- 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 health care that matches their individual needs

For More Information

To learn more about the CMS five-star quality rating system, visit http://www.cms.gov/PrescriptionDrugCovGenIn/06_PerformanceData.asp

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, HealthSun collects data from a randomly selected sample of members' medical records for HEDIS®. Medicare Advantage Plans are required to report their results annually to the Center for Medicare and Medicaid (CMS), NCQA, CMS and the Agency for Health Care Administration (AHCA) use this information to monitor the performance of health plans.

HEDIS® – Healthcare Effectiveness Data and Information Set

HEDIS contains 76 measures across eight "domains" of care:

- Effectiveness of care (Quality)
- Access/availability of care
- Use of services
- Cost of care
- Health Plan descriptive information
- Health Plan stability
- Informed health care choice
- Satisfaction with the experience of care

As a Primary Care Physician, certain measures are indicative of your practice for preventive care and chronic condition management.

Preventive Screening Measures:

- **Adult BMI Assessment (new measure**)- Members 18-74 years of age who had an outpatient visit and who had body mass index (BMI) documented during the measurement year or the year prior to the measurement year

- **Breast Cancer Screening** - Female members 40-69 years old who had a mammogram during the measurement year or prior year

- **Colorectal Cancer Screening** –Members 50-75 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

- **Flexible sigmoidoscopy** during the measurement year or 4 years prior to the measurement year

- **Colonoscopy** during the measurement year or nine years prior to the measurement year.

- **Glaucoma Screening in Older Adults** – Members 65 years old and older, without a prior diagnosis of glaucoma suspect, who received a glaucoma eye exam by and eye care professional for early identification of glaucomatous conditions

Respiratory Condition Measures

- **Use of Spirometry testing in the Assessment & Diagnosis of Chronic Obstructive Pulmonary Disease** (COPD) – Members 40 years old and older with a new diagnosis or newly active COPD disease who received appropriate spirometry testing to confirm the diagnosis.

- **Pharmacotherapy Management of COPD Exacerbation** – The percentage of COPD exacerbations for members 40 years and older who had an acute inpatient discharge or ED encounter and were dispensed appropriate medications (systemic corticosteroid within 14 days of event or bronchodilator within 30 days of event)

Cardiovascular Measures

- **Cholesterol Management for patients with Cardiovascular Conditions** – The percentage of members 18-75 years of age who were discharged alive for acute myocardial infarction (AMI), coronary artery bypass graft (CABG) or percutaneous trans luminal coronary angioplasty (PTCA) from January 1-November 1 of the year prior to the measurement year, or who had a diagnosis of ischemic vascular

disease (IVD) during the measurement year and the year prior to the measurement year, who had each of the following during the measurement year.

- **LDL –C Screening performed**

- **LDL-C controlled** (<100mg/dl)

- **Controlling High Blood Pressure** – Members 18-85 years of age who had a diagnosis of hypertension (HTN) and whose blood pressure was adequately controlled (<140/90) during the measurement year.

- **Persistence of Beta-Blocker Treatment after a Heart Attack** - The percentage of members 18 years of age and older during the measurement year who were hospitalized and discharged alive from July 1 of the year prior to the measurement year to June 30 of the measurement year with a diagnosis of Acute Myocardial Infarction (AMI) and who received persistent beta-blocker treatment for 6 months after discharge.

Diabetes Measures

- **Comprehensive Diabetes Care** – Members 18-75 years of age, with a diagnosis of diabetes (type 1 or type 2) who had each of the following:

    - HbA1c testing performed during the measurement year
    - HbA1c poorly controlled (>9.0%) performed during the measurement year
    - HbA1c Good Control (<8.0%)
    - Eye exam (retinal or dilated) by an eye care professional (optometrist or ophthalmologist) performed during the measurement year or a negative retinal (no evidence of retinopathy) by an eye care professional in the year prior to the measurement year
    - LDL-C screening performed during the measurement year
    - LCL-C controlled (<100mg/dl) performed during the measurement year
    - Monitoring for Diabetic Nephropathy during the measurement year
    - Blood pressure (BP) monitoring: Well controlled: Two rates are reported: (a) Members who had Blood Pressure Control (<140/90mm Hg) (b) Members who had Blood Pressure Control (<130/80 mm Hg)

Musculoskeletal Measures

- **Disease Modifying Anti-Rheumatic Drug Therapy in Rheumatoid Arthritis** – (DMARD) Members diagnosed with rheumatoid arthritis who have had at least one ambulatory prescription dispensed for a disease modifying anti-rheumatic drug

- **Osteoporosis Management in Women who had a Fracture** – Female members 67 years and older who suffered a fracture and who had either a bone mineral

density test (BMD) or Rx to treat or prevent osteoporosis in the 6 months after the fracture.

Behavioral Health Measures

- **Follow up care After Hospitalization for Mental Illness-** Members who were hospitalized for treatment of selected mental health disorders and who had an outpatient visit, an intensive outpatient encounter or partial hospitalization with a mental health practitioner. Two rates are reported:

    - Follow up within 30 days of discharge
    - Follow up within 7 days of discharge

- **Antidepressant Medication Management** – Assesses the different facets of the successful pharmacological management of depression for members 18 years and older who were diagnosed with a new episode of major depression

    - Acute Phase 12-week treatment phase
    - Continuation Phase remained on an antidepressant for at least six months

Medication Management Measures

- **Annual Monitoring for Patients on Persistent Medications –** Members 18 years and older who received at least a 180-day supply of ambulatory medication therapy for the selected therapeutic agent during the measurement year. These medications include:
    - ACE inhibitors or ARB
    - Digoxin
    - Diuretics
    - Anticonvulsants

- **Potentially Harmful Drug-Disease Interactions in the Elderly –** The percentage of Medicare members 65 years of age and older who have evidence of an underlying disease, condition, or health concern, and who were dispensed an ambulatory prescription for a contraindicated medication concurrent with or after the diagnosis. For all three indicators a lower rate represents better performance:
    - A history of falls and a prescription for a Tricyclic RX anti psychotics or sleep agents
    - Dementia and a prescription for a Tricyclic anti- depressant or anticholinergic agents
    - Chronic Renal Failure and a prescription for non-aspirin NSAIDS of COX-2
    - Selective NSAIDS

- **Use of High Risk Medications in the Elderly**– Members 65 years old or older who received at least one high risk medication, and the percentage who received at least two different high risk medications which include specific prescription drugs in the following categories: Antianxiety, Antiemetic, Analgesic, Antihistamines, Antipsychotic, Amphetamines, Barbiturates, Long-acting benzodiazepines, Calcium channel blockers, Gastrointestinal antispasmodics, Belladonna alkaloids, Skeletal muscle relaxants and Oral Estrogen.

Access/Availability of Care Measures

- **Adults' Access to Preventive/Ambulatory Health Services** – ambulatory or preventive care visit during the measurement year during the measurement year

Consumer Assessment of Healthcare Providers and System Survey (CAHPS)

Overview

The CAHPS survey is conducted annually by the Centers for Medicare & Medicaid Services (CMS) to assess the experiences of beneficiaries in Medicare Advantage plans.

The survey is typically conducted in early spring of the reporting year by mail, with Telephonic follow-up for non-responders. The CAHPS survey measures members' experiences with the plan over the previous six months. The survey sample is drawn from all individuals who had been members of a plan for at least six months. Although beneficiaries provide ratings of their "plans," the unit of analysis is not a health and/or prescription drug plan but rather a health and/or prescription drug plan contract. HealthSun contracts with a CMS-approved Medicare vendor to conduct the survey. Results are produced annually and compared to national benchmarks.

The survey has approximately 70 questions with the results reported in composites. Some questions apply to member satisfaction related to the service provided by the health plan and some reflect the member's perception of the patient-physician relationship or communication.

Getting Needed Care: Getting Appointments with Specialists

Question: In the last 6 months, how often was it easy to get appointments with specialists?

Getting Needed Care: Getting Needed Care, Tests, or Treatment

Question: In the last 6 months, how often was it easy to get the care, tests, or treatment you thought you needed through your health plan?

Getting Care Quickly: Getting Care Needed Right Away

Question In the last 6 months, when you needed care right away, how often did you get care as soon as you thought you needed? [Scored only for those who needed care right away in the last six months.]

Getting Care Quickly: Getting Appointments

Question: In the last 6 months, not counting the times when you needed care right away, how often did you get an appointment for your health care at a doctor's office or clinic as soon as you thought you needed? [Scored only for those who needed an appointment for health care in the last six months.]

Getting Care Quickly: Getting Seen Within 15 Minutes of Your Appointment

Question: In the last 6 months, how often did you see the person you came to see within 15 minutes of your appointment time? [Scored only for those who went to a doctor's office or clinic for care in the last six months.]

Doctors Who Communicate Well: Providing Clear Explanations

Question: In the last 6 months, how often did your personal doctor explain things in a way that was easy to understand?

Doctors Who Communicate Well: Listening Carefully

Question: In the last 6 months, how often did your personal doctor listen carefully to you?

Doctors Who Communicate Well: Showing Respect for What Patients Have to Say

Question: In the last 6 months, how often did your personal doctor show respect for what you had to say?

Doctors Who Communicate Well: Spending Enough Time With Patients

Question: In the last 6 months, how often did your personal doctor spend enough time with you?

Overall Rating of Specialist

Question: We want to know your rating of the specialist you saw most often in the last 6 months. Using any number from 0 to 10, where 0 is the worst specialist possible and 10 is the best specialist possible, what number would you use to rate that specialist?

Overall Rating of Health Plan

Question: Using any number from 0 to 10, where 0 is the worst health plan possible and 10 is the best health plan possible, what number would you use to rate your health plan?

Overall Rating of Care Received

Question: Using any number from 0 to 10, where 0 is the worst health care possible and 10 is the best health care possible, what number would you use to rate all your health care in the last 6 months?

Medicare-Specific and HEDIS Measures: Influenza Vaccination

Question: Have you had a flu shot during the annual flu season (September through March)?

Medicare Specific and HEDIS Measures: Pneumonia Shot

Question: 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.

Health Outcome Survey (HOS)

What is HOS?

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

How does HOS affect HealthSun Members your patients?

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. Members are asked questions about overall physical and mental health status. They also are asked if they had a discussion about or received counseling or intervention from their physician on the following topics:

- **Management of urinary incontinence**

- **Physical activity in older adults**
- **Fall risk management**
- **Osteoporosis testing in older women**

HealthSun participating physicians are encouraged to provide assessment and counseling for members in these particular areas.

How does HOS work?

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

Who conducts the survey?

A CMS-approved Medicare survey vendor conducts the survey.

For more information about HOS, please contact your Provider Operations Representative.

Risk Management

HealthSun's Risk Management Program is designed to identify, investigate, track, and analyze adverse incidents. It is also intended to prevent the occurrence of incidents or accidents throughout HealthSun and its contracted providers.

Under Florida Law, it is the duty of all healthcare providers to report all adverse incidents, whether actual or potential, to the HealthSun's Risk Manager. The incident report must be completed and filed with the HealthSun's Risk Manager within three (3) business days of the incident or accident.

Adverse or untoward incidents should be reported immediately to HealthSun's Risk Manager by submitting a report to RiskManagement@healthsun.com since these incidents need to be reported to the Agency for Health Care Administration (AHCA) within seventy-two (72) business hours of occurrence. Examples of these serious Incidents include;

- Death of a patient;
- Severe brain or spinal damage to a patient;
- Performance of a surgical procedure on the wrong patient;
- A surgical procedure unrelated to the patient's diagnosis or medical needs being performed on any patient.

Incident Reports

Incident Reports are considered confidential. Providers are prohibited from keeping a copy of the Incident Report in a member's medical record and from making a notation in the member's medical record that an Incident Report was completed. HealthSun's Risk Manager will review the Original Incident Report and evaluate the Incident in order to determine whether it meets the requirements for filing with the applicable State Agencies.

When completing the report, the individual should refrain from documenting personal opinions or subjective information. This is not to be included in the report. The individual involved in the incident, or who observed or discovered the incident should complete the report. The report shall contain only the facts available at the time of the occurrence.

Delegated Providers

The guidelines and responsibilities outlined in this section are applicable to all HealthSun delegated providers. The information provided is designed primarily for the provider's administrative staff responsible for the implementation or administration of certain functions that HealthSun has delegated to provider.

Downstream Education

Administrative staff of the delegated provider bears a responsibility to educate downstream physicians and health care providers, as well as any providers to whom they sub-delegate activities (who require preapproval to perform any delegated function from HealthSun), about HealthSun's policies and procedures. Explanations of any special circumstances which justify variation from the guidelines set forth in this section, should be documented, retained, and discussed with HealthSun prior to implementation. HealthSun expects to periodically review and approve all downstream educational material to confirm that all information mentioned in this appendix is referenced.

The following information should be incorporated into the delegate's business practices as it relates to the functions delegated by HealthSun.

HealthSun, Legal, Regulatory and Accreditation Requirements for Delegated Providers

Delegates are required to allow HealthSun to monitor the quality and effectiveness of any delegated function through periodic audits performed by HealthSun. HealthSun will provide

advance notification of 10 days before performing an on-site review or such shorter notice as may be imposed on HealthSun by a federal or state regulatory agency or accreditation organization. The documentation for review may include, but is not limited to the following:

- Current policies and procedures;
- Standard of Conduct;
- Compliance of Fraud Waste and Abuse Training;
- Documentation of the OIG/GSA exclusion list review;
- Monitoring of delegated entities audits and corrective action plan in order to ensure compliance with all applicable laws and regulation;
- Program or plan description;
- Annual program work plan and evaluation;
- Specified files;
- Reports including analysis as specified by HealthSun for all functions delegated;
- Pertinent committee meeting minutes.

In addition, the delegated provider will comply with the following requirements:

- Allow any regulatory agency to examine, at any time, information the agency deems relevant to determine the financial solvency of the delegate or to review the delegate's ability to meet its responsibilities in connection with any function delegated to delegate by HealthSun.

- Agrees that HealthSun retains the right to modify, rescind, or terminate at any time any or all delegated activities.

- Submit any material change in the performance of delegated functions to HealthSun for review and approval, prior to the effective date of the proposed changes.

- Notify HealthSun of any sanctions incurred by the delegate following review by a federal state or accreditation organization (within 10 days of such sanction).

- Comply with the Employee Retirement Income Security Act (ERISA) requirements.

- Comply with the Health Insurance Portability and Accountability Act (HIPAA) requirements. If required by state and/or federal law, rule or regulation, will obtain and maintain in good standing, a third-party administrator license/certificate and or a utilization review license or certification.

- Ensure that personnel who carry out the delegated services have appropriate training, licensure, and/or certification.

- Upon request, will submit to HealthSun financial information as proof of its continued financial solvency. Financial information submitted should include the following:

- Recent audited financial statements (balance sheet, statement of operations, statement of cash flows, and notes to the financial statements). If the audited financial statements are over six months old, the delegate will provide current internal financials with projections (e.g., six months ended financials or quarterly reports).

- If delegate has not been audited, delegate will provide recent internally prepared financial statements (balance sheet, statement of operations, and cash flow statement). Delegate's chief financial officer and/or owner should certify/attest to their correctness by adding his/her signature to the financial statements provided to HealthSun.

- The delegate and contracted providers agree to safeguard beneficiary privacy and confidentiality and ensure accuracy of beneficiary records.

- All claims shall be processed for covered services rendered to members and payments made to the delegate on a timely basis in accordance with applicable federal and state laws, rules and regulations regarding the timeliness of claims payments. For purposes of this section, a claim is approved or denied “promptly” if it is approved or denied within the time provided for by CMS and any applicable “Prompt payment” state statutes.

- Ensure that under no circumstance, including without limitation, insolvency of HealthSun or delegate, or any expiration, nonrenewal or termination of performance, regardless of the cause, will delegate or any employee or contractor of delegate, inclusive of any sub-delegate, bill, seek payment or attempt to collect payment, other than authorized copayments and deductibles, for any of the delegated functions and/or activities from HealthSun members.

- Provide timely notification to HealthSun of the termination of any participating provider and ensure compliance with provider network access standards necessary to comply with any applicable state and federal laws, rules and regulations, accreditation standards applicable to HealthSun.

- Delegate and contracted providers agree to comply with Medicare laws, rules, regulations, reporting requirements, and CMS instructions.

- Delegate and contracted providers agree to audits and inspection by CMS and/ or its designees and to cooperate, assist and provide information as requested.

- Will ensure, when medically necessary services are available 24 hours a day, 7 days a week. Primary care physicians must have appropriate backup for absences.

- All services, clinical and nonclinical, will be provided in a skillful manner and accessible to all members, including those with limited English proficiency, limited reading skills, hearing impairment, or those with diverse cultural and ethnic backgrounds.

- Ensure that Medical Management decision-making is based only on appropriateness of care and service, and existence of coverage.

- Agree not to specifically reward physicians or other individuals conducting utilization review for issuing denials of coverage or service care. Agrees not to provide financial incentives for Medical Management decision makers that may result in under-utilization.

- Agree that HealthSun reserves the right to perform an on-site review with ten (10) business days notification to delegate for routine assessments or such shorter notice as may be imposed on HealthSun by a federal or state regulatory agency or accreditation organization and HIPAA regulations.

- Agree to render covered services in accordance with the rules of ethics and conduct of all applicable state and federal rules, laws, and regulations. Proven misconduct may lead to a corrective action plan, up to termination of the contract**.**

Delegated Provider Downstream Contract Content

The delegate and when applicable its subcontractors, will make available to HealthSun samples of contracts with physicians and providers and ensure compliance with the legal and regulatory contractual requirements, including HIPAA regulations. Delegate is not required to make available to HealthSun contractual provisions relating to financial arrangements with delegate's physicians and providers.

Physician and provider contract content should include, but should not be limited to the following:

- Notification of physician/specialist/specialist group's termination: The contract executed between the delegate and specialist/specialist group must state either the delegate or HealthSun will be responsible for notifying the affected members of the termination.
- Physicians/providers cooperate with quality improvement (QI) activities.
- HealthSun and delegate have access to physician/provider medical records to the extent permitted by state and federal law.
- Physicians/providers need to maintain the confidentiality of member information and records.
- Physicians/providers may freely communicate with members about their treatment regardless of benefit coverage limitations.
- A listing of all individuals or entities that are party to the written agreement.
- Definitions for termination used in the contract referenced above.
- Conditions for participation as a participating provider.

- Obligations and responsibilities of the delegate and the participating provider, including any obligations for the participating provider to participate in the delegate's management, quality improvement, complaint, or other programs.
- Events that may result in the reduction, suspension, or termination of network participation privileges.
- The specific circumstance under which the network may require access to member's medical records as part of the delegate's programs or health benefits.
- Health care services to be provided and any related restrictions.
- Requirements for claims submission and any restrictions on billing of members.
- Participating provider payment methodology and fees.
- Mechanisms for dispute resolution by participating providers. Term of the contract and procedures for terminating the contract.
- Requirements with respect to preserving the confidentiality of patient health information.
- Prohibitions regarding discrimination against members.
- Physicians and providers agree to hold members harmless and not bill more than their coinsurance/copays or indemnity balances that are the member's responsibility under his/her Plan.

Note: Health plans, first tier, and downstream entities are prohibited from employing or contracting with individuals excluded from participation in Medicare.

Systems and File Retention

The delegate will furnish any and all staffing and systems necessary to receive eligibility data from HealthSun and provide HealthSun all data as required by state and federal laws, rules and regulations, and HealthSun. The documents include without limitation claims and encounters, credentialing, utilization review/medical management, quality improvement, and other documentation records, files or data pertaining to functions delegated. The records must be maintained for a period of ten (10) years.

Grievances & Appeals

HealthSun member appeals/grievances and expedited appeals are not delegated, including an appeal made by a physician/provider on behalf of the member. HealthSun maintains all member rights and responsibility functions.

Provider Information Technology (IT) Access

HealthSun Health Plans will provide IT Access to those Providers who have met the criteria. Prior to having access to our system, all Providers will be required to complete our Provider IT Access Request Form. At that time, all of the individuals that will need to have access to the HealthSun system shall sign the IT Agreement.

It is understood that all of the information that the Provider and their staff members will have access to is considered Proprietary and Confidential. As such, information transmitted by, received from, or stored in this system is the property of HealthSun Health Plans and the use of any software or business equipment is only to be used for job-related purposes. Further, Providers and staff are not permitted to use a code, access a file, or retrieve, copy download or use any stored communication unless authorized to do so in writing by HealthSun Health Plans. All pass codes are the property of HealthSun Health Plans.

Computer Information Security

It is a violation of Florida law to disclose computer passwords; penalties range from a Class B misdemeanor to a felony depending on the related monetary damage. Computer passwords should be considered highly confidential. Providers and staff should never disclose computer passwords to anyone other than those individuals in the HealthSun organization that have official capacity.

Computer Software

Staff who uses software licensed to HealthSun or an entity owned by HealthSun must abide by applicable software license agreements and may copy licensed software only as permitted by the license. Unauthorized duplication of copyrighted software is a violation of federal copyright law. Provider and their staff should direct any questions about applicable software license agreements to HealthSun Health Plans IT Department.

Confidential Information

Providers and staff my use confidential information in the performance of their official duties, that information must not be shared with others. No violation of HIPAA guidelines will be tolerated, all confidential information will be kept in compliance with applicable laws, regulations, policies, and procedures. Confidential information includes personnel data, member information, research data, financial data, strategic plans, marketing strategies, membership lists and data, supplier and subcontractor information, and proprietary computer software. When HealthSun collects information from individuals, such as members, it is required to disclose to the individual their rights under federal regulations.

HITECH Legislation Impacts Health Care Providers

The Health Information Technology for Economic and Clinical Health Act (HITECH) imposes new privacy and security obligations on physicians and other health care providers, as well as

companies currently regulated as HIPAA-covered entities, such as health plans and clearinghouses. It also expands the definition of HIPAA-covered entities to include vendors who provide third-party services to health care providers, such as billing companies, customer service centers, accounting firms, and others.

In addition, health care providers and all HIPAA-covered entities are now required to develop plans for responding to security breaches of Protected Health Information (PHI), notifying affected individuals and the Department of Health and Human Services (HHS) within sixty (60) days of a breach. HITECH also strengthens enforcement strategies for HIPAA and HITECH violations, and increases fines for many violations.

The security breach provisions of HITECH took effect in September 2009; however, HHS will not impose sanctions for breaches discovered before February 22, 2010. The other provisions of HITECH that affect PHI, such as business associate liability; new limitations on the sale of protected health information, marketing, and fundraising communications; and stronger individual rights to access electronic medical records, took effect on Feb. 17, 2010.

Physicians should be aware of this legislation and the effect it may have on their practices. All health care providers are affected by HITECH, even those who are not currently using an electronic health records system. Practices using electronic billing, clearinghouses or a third-party billing service are subject to HITECH's provisions, and need to discuss its implementation with the providers of those services to ensure compliance.

HITECH, ARRA and HIPAA are complex pieces of legislation. HealthSun encourages physicians to seek legal and professional advice from experts, such as attorneys and local and national medical associations. The following national medical associations both have valuable information about HITECH available on their websites:

American Medical Association

(http://www.ama-assn.org/ama1/pub/upload/mm/368/hipaa-guidance.pdf)

American Academy of Family Physicians

(http://www.aafp.org/online/en/home/publications/news/news-now/government medicine/20090318hipaa-security-rules.html)

Member Assistance Programs

State & Federal Assistance Programs

Helping HealthSun Health Plans Members Attain Public Assistance Benefits through State and Federal Cost-Sharing Programs.

HealthSun Health Plans maintains a specially trained Member Assistance Department that offers a variety of services designed to help members apply for public assistance through the Medicaid

programs and the Extra Help. HealthSun has been assisting health plan members attain dual eligibility status, navigate application processes and securing financial assistance through Florida's Medicaid cost-sharing programs.

On January 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) and Qualified Individuals – 1 (QI1) or any full Medicaid program are now automatically eligible for the Extra Help 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 since the eligibility, standards are higher, than the ones 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 that 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)** is a cash assistance program administered by the Social Security Administrations. Members automatically receive Medicaid, which pays for the Medicare premiums (Part A and B), Medicare Deductibles and Medicare coinsurance within the prescribed limits and automatically qualify for LIS.

- **Qualified Medicare Beneficiaries (QMB)** is a Medicaid program, which pays for the 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)** is a Medicaid program which pays for the Medicare Part B premium and members are automatically eligible for LIS.

- **Qualifying Individuals 1 (QI1)** is a Medicaid program which pays for the Medicare Part B premium and members are automatically eligible for LIS.

The HealthSun Member Assistance Department assists members to obtain Medicaid and with the periodic renewal process of Medicaid, through a variety of eligibility pathways. These services are offered, at no additional cost, to all HealthSun Medicare Advantage health plan members. Dual eligible members are also allowed to take advantage of special election periods that may not be available to other Medicare Advantage members and can enroll in a HealthSun Dual Special Needs Plan (SNP) at any time during the calendar year.

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

- Have Medicare Part A (Hospital Insurance)
- Be a Florida resident
- Be a U.S. citizen or a qualified alien
- Have monthly income range and type as specified by program. *
- Have assets value and types as specified by program. *
- Amounts may vary. Please check current year's dual-eligibility 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. Social Security Administration offers a program known as The Extra Help or Low-Income Subsidy (LIS) and is a federal assistance with the cost of Medicare prescription drug plan.

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. With the 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 small cost sharing for each prescription.

Low Income Subsidy members are also allowed to take advantage of special election periods that may not be available to other Medicare Advantage members and can switch plans at any time during the calendar year.

To be eligible for the Low-Income Subsidy, a Medicare beneficiary must:

- Have monthly income range and type as specified by program**
- Have assets value and types as specified by program. **
- Reside in the United States.

**Amounts may vary. Please review the current year's LIS eligibility standards.

HealthSun is committed to Helping Members Maximize Health Benefits through their Medicare Dual Eligibility Outreach Program.

HealthSun has partnership status as an ACCESS/Florida Assisted Facility through the Florida Department of Children and Families (DCF). The Member Assistants routinely performs the following services for health plan members:

- Assist members in understanding what verifications are necessary in order for the DCF to determine eligibility for the State program;
- Assist members in verifying case status and eligibility;
- Assist members in understanding the availability of public assistance benefits and services administered by the DCF; including Food Stamps and Cash assistance as well as the different Medicaid programs.
- Ascertain the status of a member's Medicaid coverage; and
- Notify the DCF if HealthSun has case information in possession, custody or control concerning a member that is inconsistent with DCF member-specific information.

As an ACCESS/Florida Assisted Facility, Member Assistants have 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 (HIPPA) 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; and
- DCF Security Awareness training – available only to Assisted Facility ACCESS Community Partners.

If you have questions and would like additional information, please contact our Member Services Department.

Medication Therapy Management Program (MTMP)

All members are automatically enrolled in the MTMP, upon meeting program criteria. However, members may choose to opt-out of the program or portions of the program. For example, members may opt-out of the Comprehensive Medical Review (CMR) component of the MTMP but remain eligible for the Targeted Medication Review and associated follow-up.

Should a member desire to permanently opt-out of the plan's MTMP, plan will honor request and not re-target member in future contract years; however, if the member actively seeks enrollment into the MTMP at a later time, perhaps due to a level of care change, plan must allow member to participate as long as they meet the necessary MTMP requirements.

Within sixty (60) days of becoming eligible for the MTMP, member will receive an offer by mail to complete a telephonic Comprehensive Medication Review (CMR) with a qualified health care

provider. In addition, member will receive by mail, a quarterly list of updated prescription medications taken during previous quarter. Members will be instructed to take this list to each prescriber and pharmacy visit. Prescriber will be able to review therapy and make any necessary adjustments.

Communication to members may contain diet and exercise tips, information specific to their disease states, Frequently Asked Questions (FAQ) about their disease states, and tips about compliance. In addition, they will be directed to an online website where various other electronic tools will be available (health tracker, personal monthly calendar, and glossary of health terms).

Prescribers may be mailed quarterly Targeted Medication Reviews (TMR) conducted systematically if any drug-drug interactions or other medication concerns are identified.

Purpose of the MTM Program:

- To 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, which provide improved care to members.
- Interventions should result in health benefits and cost effectiveness for members.

HealthSun MTMP Eligibility:

Member must have three or more of the following chronic diseases:

- Bone disease-arthritis-osteoarthritis
- Bone disease-arthritis-osteoporosis
- Bone disease-arthritis-rheumatoid arthritis
- Chronic heart failure (CHF)
- Diabetes
- Dyslipidemia
- Hypertension
- Mental health-depression
- Respiratory disease-chronic obstructive - Chronic Obstructive Pulmonary
- Disease (COPD))
- Opioid overutilization

Member must have filled eight or more covered Part D drugs.

Are likely to incur annual costs for covered Part D drugs, which exceed $4,376 as specified by the Medicare.

Quality Improvement Program (D-SNP)

Introduction

Health Sun Health Plans currently operates a Medicare Advantage Plan in south Florida, which includes dually eligible Medicare and Medicaid recipients within the following counties: Miami-Dade, Broward, and Palm Beach. HealthSun is expanding its existing Medicare Advantage Plan to offer dual eligible beneficiaries the opportunity to enroll in a Special Needs Plan (SNP) to further compliment and provide programs that focus on the complex health needs of this specific group of individuals for plan year 2021.

HealthSun is committed to provide all members access to optimum quality and cost-effective medical care. To achieve this, there is an overarching Medicare Advantage Quality Improvement (QI) Program in place that complies with the requirements governing the Medicare Advantage program as established in accordance with 42 CFR 422.152. The purpose is to provide a formal ongoing process by which the organization will utilize objective measures to monitor and evaluate the clinical and operational quality of services provided to the members covered under Medicare Advantage.

The QI Department's structure is responsible for executing the QI Program as well as the D-SNP Medicare Advantage QI Program. This D-SNP Medicare Advantage QI Program description is a subset and will therefore be overseen and in conjunction with the overarching Medicare Advantage QI Program description.

This D-SNP Medicare QI Program description is specifically for the following contract that includes the D-SNP plan benefit packages [1] which is CMS Contract H5431 Medicare Advantage plan and Special Needs Plans (SNPs) for Duals.

Purpose

HealthSun and its network providers are committed to the delivery of optimal and cost-effective health care to its enrollees. HealthSun aims for continuous improvements in the quality of health care services and the health status of the population served. A comprehensive QI Program directs the QI Department's activities.

This D-SNP QI Program encompasses all aspects of care delivered by the health plan network providers. This includes, but is not limited to, medical, mental health, chemical dependency and pharmacy services which are provided in ambulatory, hospital, emergency department, home or care home and skilled nursing facility settings. In addition to continuous assessment of the clinical elements of health care, the D-SNP QI Program looks at administrative services conducted through the operational departments within the plan, which include, but are not limited to, customer service, appeals and grievances, credentialing, provider relations, claims and sales and marketing.

The D-SNP QI Program description is designed to meet state and federal regulations, the Centers for Medicare & Medicaid Services (CMS) contractual requirements and applicable accreditation standards as described in the Medicare Advantage QI program. Per CMS, every Quality Improvement (QI) MA Program must:[3]

[3] Code of Federal Regulations Quality Improvement: https://www.ecfr.gov/cgi-bin/text-idx?SID=3f7c5338ca80a6ef50daec6e9e76e7a1&mc=true&node=sp42.3.422.d&rgn=div6

1. Create a QI program plan that sufficiently outlines the elements of the plan's quality improvement program 42 CFR §422.152(a)(1)

2. Develop and implement a chronic care improvement program (CCIP) 42 CFR §422.152(c)

3. Develop and maintain a health information system (42 CFR §422.152(f)(1))

4. Encourage providers to participate in CMS and HHS QI initiatives (42 CFR §422.152(a)(4))

5. Implement a program review process for formal evaluation of the impact and effectiveness of the QI Program at least annually (42 CFR §422.152(f)(2))

6. Correct all problems that come to its attention through internal surveillance, complaints, or other mechanisms (42 CFR §422.152(f)(3))

7. Contract with an approved Medicare Consumer Assessment of Health Providers and Systems (CAHPS®) vendor to conduct the Medicare CAHPS® satisfaction survey of Medicare enrollees (42 CFR §422.152(b)(5))

8. Measure performance under the plan using standard measures required by CMS and report its performance to CMS (42 CFR §422.152(e)(i))

9. Develop, compile, evaluate, and report certain measures and other information to CMS, its enrollees, and the general public. Responsible for safeguarding the confidentiality of the doctor-patient relationship and report to CMS in the manner required cost of operations, patterns of utilizations of services, and availability, accessibility, and acceptability of Medicare approved and covered services (42 CFR §422.516(a))

In 2010, the Patient Protection and Affordable Care Act (ACA) reinforced the importance of the Model of Care (MOC) as a fundamental component of D-SNP quality improvement by requiring the National Committee for Quality Assurance (NCQA) to execute the review and approval of D-SNPs' MOC based on standards and scoring criteria established by CMS. The QI structure works with business partners to ensure the MOC meets criteria and execution:[4] of the 4 sections of the MOC as outlined:

- MOC 1 Description of D-SNP Population
- MOC 2 Care Coordination
- MOC 3 Provider Network
- MOC 4 MOC Quality Measurement and Performance Improvement

The D-SNP QI Program and QI Department structure is accountable to lead the efforts of the MOC revisions and the D-SNP QI program annual evaluation as well as developing applicable QI policies and training and enhancing technology and reporting for executing all metrics as

[4] SNP MOC guidelines: https://snpmoc.ncqa.org/wp-content/uploads/MOC-Scoring-Guidelines_CY-2021-1.pdf

described within MOC 4 of the approved D-SNP MOC. The following requirements govern the D-SNP MOC Quality Measurement and Performance Improvement (MOC 4) oversight and execution:

Element A: MOC Quality Performance Improvement Plan

1. Describes the overall quality improvement plan and how the organization delivers or provides for appropriate services to SNP beneficiaries, based on their unique needs
2. Describes specific data sources and performance and outcome measures used to continuously analyze, evaluate and report MOC quality performance
3. Describes how its leadership, management groups, other SNP personnel and stakeholders are involved with the internal quality performance process
4. Describes how D-SNP-specific measurable goals and health outcomes objectives are integrated in the overall performance improvement plan, as described in MOC 4, Element B

Element B: Measurable Goals and Health Outcomes for the MOC

1. Identify and define the measurable goals and health outcomes used to improve the health care needs of D-SNP beneficiaries
2. Identify specific beneficiary health outcome measures used to measure overall D-SNP population health outcomes at the plan level
3. Describe how the D-SNP establishes methods to assess and track the MOC's impact on SNP beneficiaries' health outcomes
4. Describe the processes and procedures the D-SNP will use to determine if health outcome goals are met
5. Describe the steps the D-SNP will take if goals are not met in the expected time frame

Element C: Measuring Patient Experience of Care (SNP Member Satisfaction)

1. Describe the specific D-SNP survey used
2. Explain the rationale for the selection of a specific tool
3. Describe how results of patient experience surveys are integrated into the overall MOC performance improvement plan
4. Describe steps taken by the D-SNP to address issues identified in survey responses

Element D: Ongoing Performance Improvement Evaluation of the MOC

1. Describe how the organization will use the results of the quality performance indicators and measures to support ongoing improvement of the MOC
2. Describe how the organization will use the results of the quality performance indicators and measures to continually assess and evaluate quality
3. Describe the organization's ability for timely improvement of mechanisms for interpreting and responding to lessons learned through the MOC performance evaluation
4. Describe how the performance improvement evaluation of the MOC will be documented and shared with key stakeholders

Element E: Dissemination of D-SNP Quality Performance Related to the MOC

1. Describe how performance results and other pertinent information will be shared with multiple stakeholders
2. State the scheduled frequency of communications with stakeholders
3. Describe the methods for ad hoc communication with stakeholders
4. Identify the individuals responsible for communicating performance updates in a timely manner

The D-SNP QI Program and QI Department structure must support the CMS D-SNP MOC audit protocol as related to Plan Performance Monitoring and Evaluation of the MOC [OMB No: 0938-1000 (Expires: 06/30/2023) CMS-10191] which are:

- QI Department must collect, analyze, and evaluate the MOC (e.g., specific data sources, specific performance, and outcome measures, etc.)
- QI Department must use the analyzed results of performance measures to improve the MOC (e.g., internal committee and other structured mechanism)
- QI Department must develop and implement corrective actions when applicable
- QI Department must demonstrate evidence of communicating performance monitoring results and improvements to stakeholders and/or leadership, in accordance with the MOC
- QI Department must have appropriate personnel responsible for oversight of the MOC's evaluation and monitoring process
- QI Department's organizational chart must accurately reflect the personnel administering the MOC program and their reporting structure

The goals of the D-SNP QI Program have been designed to support the different D-SNP Medicare Advantage programs with specific attention to data collection to establish baseline measurements, identify opportunities for improvement and to ultimately measure the positive difference an intervention or process change would result in.

The HealthSun D-SNP QI Program's goals are designed to develop a comprehensive, meaningful, and soundly executed quality improvement, utilization, and care management strategy. Key indicator data are generated and are analyzed to evaluate performance and determine whether further actions are required to meet the needs of the membership.

The goals of the QI Program are:

- To improve and maintain members' physical and emotional status
- To promote health and early intervention and empower members to develop and maintain healthy lifestyles
- To involve members in treatment and care management decision-making
- To ensure that the care and treatment provided to members is based on accepted evidenced-based medical principles, standards, and practices
- To be accountable and responsive to member concerns and grievances
- To utilize technology and other resources efficiently and effectively for member welfare
- To ensure that appropriate care and treatment is accessible to members and provided in a timely manner
- To ensure that quality initiatives are directly relevant to the membership

- To ensure that cultural and linguistic sensitivity is displayed at all time, including recognition of such needs in the member through materials and programs
- To ensure programs and services related to the health care needs of the population served including any complex needs and issues
- To foster a patient centered medical home delivery process within the provider network

HealthSun's overall goals for the care management of the chronic or disabling conditions of D-SNP include:

- 100% of the population will have HRA attempted within 90 days of enrollment
- Increase PCP visits by 10% to contribute to a decrease of inpatient hospitalizations and ER utilization
- 100% non-urgent behavioral health authorizations within 15 days when medically indicated
- 90% compliance with Access to Care Standards for medical and behavioral health care services established by health plan
- 50% of the members see a provider in his/her patient center medical team
- Access to affordable care
- Members have pharmacy coverage as a benefit
- Members have limited co-pays that ensures affordable care
- Monitoring of providers related to ER utilization, inpatient admissions, number of readmissions within 30 days, & average LOS for acute inpatient admissions
- Transportation services for members to get to appointments to be measured by the percent of members using the services
- Improved coordination of care through PCP (gatekeeper) through:

    - Care coordination through either PCP or specialist approved by health plan as PCP
    - Members visit PCP within 30 days following discharge from inpatient stay or ER visit
    - 50% of the members see a health care provider within his/her patient centered medical team
    - 90% of the PCPs receive plan of care (POC) from health plan within 90 days of member enrollment

- Improve transitions of care across the health plan with settings, providers, and services
- Health plan staff to review inpatient admission to acute care hospital daily and communicate to care manager
- Health plan staff to review ER visits daily and communicate to care manager
- 90% of members receive care coordination attempts at least every 90 days
- 100% of members with acute or sub-acute transitions have updated plan of care (POC) for transition services
- 50% of the members see a health care provider within his/her patient centered medical team
- Improved access to preventive health services:

    - 95% of members will receive preventive health attempts every 90 days
    - Clinics will offer flu/pneumonia vaccine at least annually and home nurse visits for vaccine will be offered at least annually

- 50% of the member will see health care provider within his/her patient centered medical team

- Ensure appropriate utilization of services
- Bi-annual monitoring of ER and inpatient admissions to determine appropriate utilization
- At least annual monitoring of behavioral health utilization of appropriate services
- 50% of the members see a health care provider within his/her patient centered medical team
- Improved member health outcomes through:

  - 3% reduction of the utilization of ER or 75th percentile for current HEDIS benchmark
  - 3% reduction of inpatient hospitalization or 75th percentile for current HEDIS benchmarks
  - 5% reduction of re-admissions to hospital after an acute care discharge or at least a 4 star rating
  - 3% increase in the members receiving flu/pneumonia vaccine annually
  - 5% increase in the members at or below the 50th percentile nationally who have control of HbgA1c (<8.0%) from HEDIS 2020 baseline
  - 3% increase in the members with a completed advanced directive in the medical record

Objectives

The following D-SNP QI objectives are designed to assist the health plan in meeting its goals:

- QI Department develops an annual D-SNP QI Work Plan that outlines activities, objectives, responsible person(s), and timeframes that is reviewed and approved by the QM Committee with status reporting to the Committee throughout the year
- QI Department develops, implements, and monitor action plans to improve medical and behavioral health care for the D-SNP members
- QI Department develops applicable clinical and service quality improvement projects/interventions that are relevant to the populations served by the health plan
- QI Department develops, executes, and monitors performance of the CCIPs, including any relevant to the D-SNP populations served
- QI Department includes network practitioners and providers in the development, monitoring, and evaluation of performance improvement projects, any applicable policies/procedures, guidelines, standards, and interventions to improve outcomes
- QI Department facilitates continuity of care and transition of care between providers and facilities to promote exchange of information, appropriate diagnosis, treatment, and referral of medical as well as behavioral health disorders
- QI Department analyzes the provider network access and availability standards to improve member access to necessary medical services, behavioral health services and facility providers
- QI Department completes a comprehensive analysis of all QI studies or monitoring results against performance goals, benchmarks when available, and previous performance
- QI Department identifies barriers to improvement, opportunities to pursue and acts when performance goals are not met

- When applicable, the QI Department develops improvement projects using either the PDSA cycle or 10 element improvement process
- QI Department monitors and improves compliance with applicable accreditation standards and federal regulatory requirements governing managed care organizations

In addition to supporting data collection as stated above, this D-SNP QI Program also supports the overall goals and objectives of the care coordination/management function as defined within the Care Management Program description which includes:

To coordinate and integrate care across the multi-specialty, multi-setting care continuum:

Coordinate care among the treating physicians, including primary care physicians, specialists, supportive services as well as community services
Focus on optimal outcomes and develop strategies for the best possible member care techniques
Identify opportunities to forge relationships between HealthSun's care managers, the member's network providers and the member themselves to deliver the best care in the optimal care setting
Assist each member with attaining maximum independence and quality of life

To facilitate communication with all physicians, provider, and care team members:

- A HealthSun care manager shall identify and coordinate issues such as needed community services or appropriate access to care, as well as other member concerns
- The clinical pharmacist on the team helps address poly-pharmacy-related issues, including medication errors and subsequent adverse outcomes, including avoidable hospitalizations and readmissions
- Educate members regarding their rights and responsibilities associated with participation in the HealthSun care management program
- Monitor how providers collaborate with the ICT and contribute to a beneficiary's ICP to provide necessary specialized services [5]
- Encourage its providers to participate in CMS and HHS quality improvement initiatives[6]
    - Participation with CCIP if applicable
    - Participation in Performance Programs

- Monitor how network providers utilize appropriate clinical practice guidelines and nationally recognized protocols appropriate to D-SNP's target population [7]
- Provide oversight if challenges are identified where the use of clinical practice guidelines and nationally recognized protocols need to be modified or are inappropriate for specific vulnerable SNP beneficiaries
- Provide oversight regarding how decisions to modify clinical practice guidelines or nationally recognized protocols are made, incorporated into the ICP, communicated to the ICT and acted upon by the ICT
- Provide oversight of SNP providers and how they maintain continuity of care using the care transition protocols outlined in MOC 2, Element E

To coordinate comprehensive management of care and SNP quality of care:

[5] Ibid SNP MOC guidelines MOC 3 Element A factor 4
[6] Ibid Code of Federal Regulations Quality Improvement
[7] Ibid SNP MOC guidelines MOC 3 Element B factor 1

- Collaborate and facilitate delivery of the care management plan as agreed upon by all the member's care providers
- Adherence to evidence-based clinical guidelines to provide the most consistent approach to the plan
- Evaluate all activities and interventions for continuous quality improvement
- Use input from the applicable committees

To promote ethical decision-making regarding the initiation and discontinuance of treatment plans about end of life issues and advance directive management:

- Assess all members to determine their choice for required services, treatment plans and any therapy, including development for an action plan which shall address end of life issues or treatment choices when appropriate
- Collaborate with the member and multi-disciplinary care team during the decision making and planning process
- Options for end-of-life management including hospice are discussed in conjunction with the providers, when deemed appropriate

To increase member, provider, and stakeholder satisfaction through appropriate medical management:

- Monitor member, provider, and client satisfaction to determine levels of satisfaction
- Monitor quality of life in all members on a regular basis
- Develop and implement processes to monitor quality of care
- Continually track and report services delivered to members and their resulting outcomes by analysis data such as but not limited to prior authorization data, claims data and medical record review
- Develop interventions to improve clinical outcomes which are identified as below the industry or clinical standards of practice

Scope of the D-SNP QI Program

The QI Program provides a mechanism for the coordination of both quality improvement and quality management activities. The scope of this program includes the objective and systematic monitoring of the quality and safety of health care services provided to HealthSun members. To improve organizational performance, collaborative and specific indicators of both processes and outcomes of care are developed, measured and assessed by all appropriate departments in a timely manner. The program has two major components: clinical and service. The range of the clinical activities is extensive, encompassing preventive care, acute care, chronic care, and care provided for special populations. It monitors provider credentialing and compliance, member education, health outcomes, screening, practice guidelines, delegation, and medical record documentation. The service component of the program monitors accessibility of care, member/provider satisfaction, and member/provider complaints and appeals.

QI Model

HealthSun's quality improvement philosophy is based on an improvement process involving a multi-element process that is structured with a systematic approach with goal setting that includes the following:

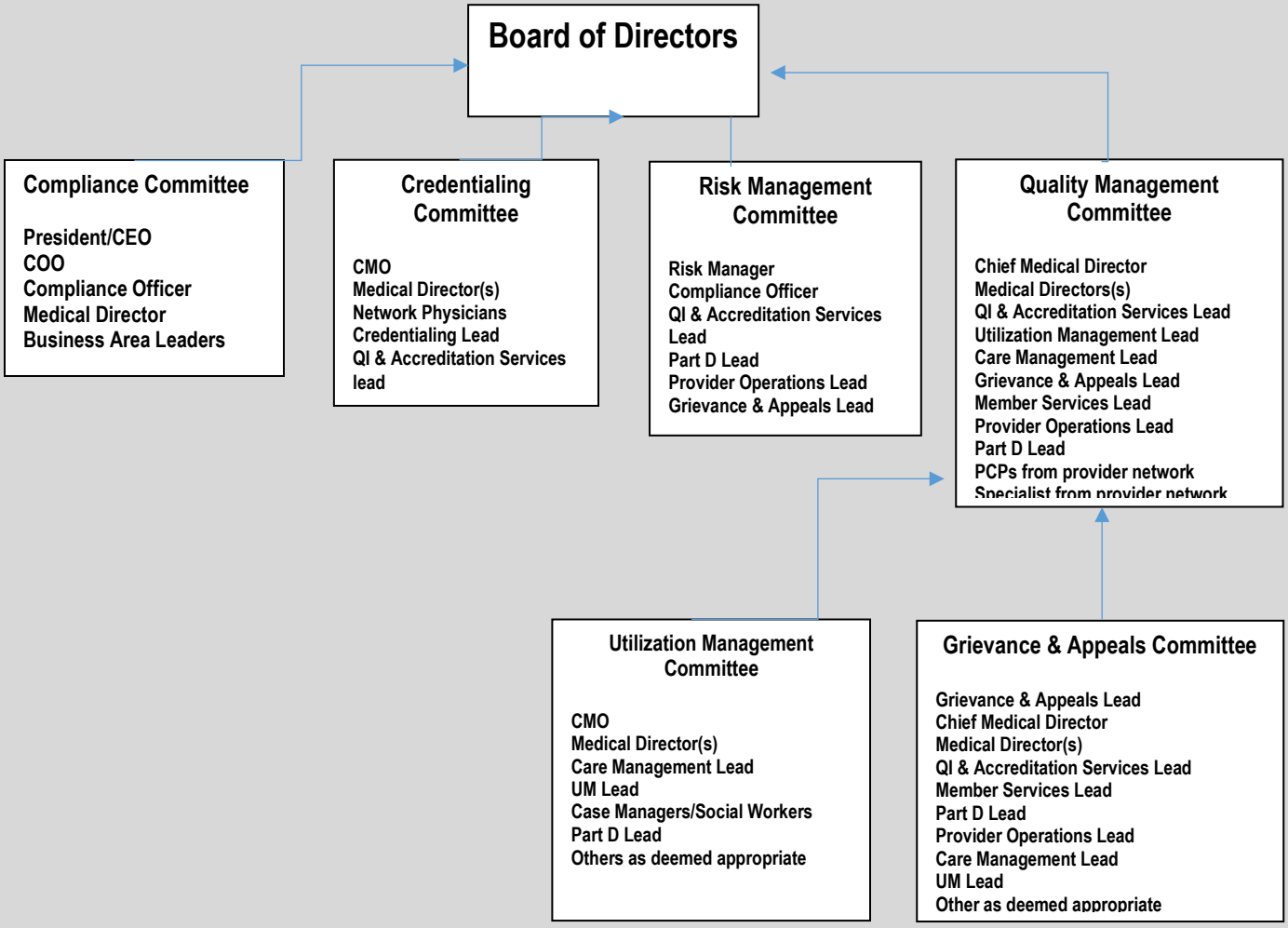
- Identification of a problem or issue and its significance to the health plan action for continuous quality improvement
- Establishment of a goal that is measurable using benchmarks when available
- Development of a methodology to determine current performance
- Collection and analysis of the data to determine frequency, source, and comparison to the established goal to determine the extent of the issue or problem
- Establishment and implementation of interventional activities
- Re-measurement of the performance to determine if interventions were successful and if improvement to reach the goal is still required, implementation of continued intervention is conducted, and another re-measurement conducted in accordance with the timeline.
- Reporting of findings throughout the health plan with specific reporting to the QM Committee

HealthSun's D-SNP QI Program utilizes this model with the committee processes and ensures the efforts are documented in committee minutes and applicable action plans and improvement projects are in place. If two consecutive re-measurement cycles do not meet goals, there will be a reassessment of the established goal and an evaluation of root cause and impact analysis to determine any required changes.

Committee Structure

HealthSun maintains a committee structure for oversight of administrative and clinical program operations for the management of the D-SNP population. The Credentialing Committee is responsible for the review of provider licensing and competency. The QM Committee reviews clinical program metrics, including pharmacy utilization data, ensures the use of Clinical Practice Guidelines by practitioners and, monitors utilization and encounter data for the appropriate and timeliness of services. Additionally, HealthSun has developed a D-SNP sub-committee of the QM Committee with a specific focus on monitoring all aspects of program performance. The diagram below provides an overview of the committee structure and a detailed description of the accountabilities of each committee. The QM Committee will be accountable to monitor D-SNP performance

Committee Structure



Quality Management (QM) Committee:

The functions of the QM Committee supported by the QI Department include, but are not limited to:

- Establishing priorities for all applicable QI Programs under the Medicare Advantage umbrella
- Integrating all departments and operational functions relative to the goals and objectives of the QI Program and MOC
- Ensuring effective implementation of the QI Program
- Review of analysis and evaluation of trend data from quality assessment special studies and activities and/or department reports and making recommendations to the Board of Directors, as necessary
- Review of Medical Management (Utilization) metrics as described within the associate work plan
- Review of and disseminating of an annual QI Program Evaluation Report (annual effectiveness evaluation)

- Providing a forum within the organization for discussion of clinical and non-clinical issues related to the quality of care and service provided members
- Review of individual provider and aggregate utilization problems and initiation of corrective actions
- Review of QI projects performance and progress to benchmarked goals
- Overseeing of formulary management in conjunction with the Part D Department and the pharmacy benefit manager including the addition and deletion of formulary items
- Review of reports and information from the pharmacy benefit manager in conjunction with Part D
- Responding to pharmacy practice issues, ensuring quality, cost effective drug, and therapeutics management
- Provision of oversight for all medical care and utilization management activities to include inpatient and outpatient service authorizations, complex case management, non-participating provider authorizations, and special programs (e.g., chronic care improvement program; health risk management program)
- Monitoring and evaluation of all medical record documentation procedures and utilization reports
- Identifying opportunities for program/service improvement relative to preventive health, health promotion, and disease management
- Conducting professional medical standards (peer review) activities that may involve the professional competence or conduct of providers whose conduct adversely affects, or could adversely affect, the welfare of Medicare members and recommends remedial action as necessary to the QM Committee
- Provision of oversight to ensure that participating PCPs and physician specialists utilize established protocols and evidenced-based guidelines for the provision of acute, chronic, and disease management care and services
- Reviewing, evaluating, and disseminating information regarding new technologies and treatment protocols and guidelines to primary care and specialist-contracted providers
- Ensuring the systematic evaluation of provider performance and provision of the interpretation of these data to practitioners
- Provision input for re-credentialing of providers to the Credentialing Committee.

    - Acts in an advisory capacity to the QM Committee in all matters pertaining to drug utilization
    - Reviews and advises the QM Committee regarding adverse drug reaction reports and drug usage issues
    - Reviews the drug formulary
    - Reviews and participates in quality improvement activities related to prescriptions and medications
    - Selects appropriate educational programs and initiatives related to pharmacy use
    - Reviews and approves pharmacy criteria, protocols, policies, and procedures for appropriate drug utilization

Credentialing Committee

The Credentialing Committee is composed of primary care and specialist providers from the contracted provider network, the Chief Medical Officer, Medical Director(s), QI & Accreditation Services, and the Credentialing Coordinator. The Credentialing Committee is scheduled to meet

relative to network development activities and credentialing demands. The Credentialing Committee:

- Has decision-making authority regarding credentialing and re-credentialing of individual providers as either PCPs or specialists and organizational providers
- Responds to recommendations from the QM Committee regarding providers whose conduct adversely affects the quality of care provide by HealthSun
- Assesses the performance of providers including the re-credentialing cycle of individual providers utilizing the findings of medical standards review (adherence to medical record standards, clinical and preventive guidelines, patient satisfaction information, utilization patterns, risk management issues, and quality of care concerns)

Grievance and Appeals Committee

The Grievance and Appeals Committee is composed of the Chief Medical Director, Grievance and Appeals Coordinator, Member Services Department lead, Senior VP, Services and Compliance Department lead. The Grievance and Appeals Committee meets on an as needed basis relative to the filing of formal grievances and appeals from beneficiary and/or providers. This is usually 2-3 times annually. The Grievance and Appeals Committee:

- Monitors all appeals and grievances procedures for CMS Part C and Part D, and HealthSun's AHCA Contract[8] to ensure compliance with policies and procedures
- Evaluates all complaints, grievances, and appeals to determine potential quality issues related to provider/beneficiary relations, and care and services provided
- Reviews all grievance and appeals reports (Part C and D) and, as applicable, those required by HealthSun's AHCA Contract
- Ensures satisfactory and timely resolution of grievances and appeals

Risk Management Committee

The Risk Management Committee is charged with overseeing the Risk Management Program of the health plan, as directed by the Board of Directors. The responsibilities of this Committee include, but are not limited to:

- Monitoring of potential risks in health care delivery of the health plan and its network of providers
- Review of all adverse incidents reports and performance of root cause analysis on such incidents with implementation of interventions as needed
- Patterning and trending of incidents over time
- Development of policies and procedures and on-going review of existing policies to ensure compliance with state, federal (CMS), and accreditation requirements
- Oversight of staff and network related to risk management issues and the provision of education to staff on risk management and incident reporting

The Risk Management Committee is comprised of the Risk Manager, Compliance Officer, Chief Operating Officer, senior leadership to include Part D lead, Provider Operations lead, QI &

[8] "AHCA Contract" means the agreement between HealthSun Health Plans, Inc. and AHCA for the purpose of providing and paying for Medicare Advantage Dual Eligible Special Needs Plan (D-SNP) Medicaid Covered Services to Members.

Accreditation lead, Member Services lead, G&A lead, Medical Management lead, CMO, and other applicable health plan departments. The Committee must meet on at least a quarterly basis.

Compliance Committee

The Committee supports HealthSun Health Plans, Inc. Compliance and Anthem's Medicare Compliance Committee. The Committee will direct and oversee HealthSun Compliance oversight activities affecting Anthem's Medicare Compliance.

The Committee has the following functions, duties, and authority:

- Review, discuss and approve HealthSun Business unit Metrics, status of corrective action plans (CAPs) including closure, if applicable.
- Review, discuss and approve HealthSun specific issues and risks reported to Compliance.
- Review First-Tier, Downstream and Related Entity Compliance Status.
- Review and approve HealthSun Business Area P&Ps
- Findings of internal monitoring and oversight
- Review and discuss Complaints Tracking Module received by the Plan

The HealthSun Compliance Committee reports quarterly to Anthem's Medicare Compliance Committee.

The HealthSun Compliance Director II is the Chairperson of the Committee. The Committee shall consist of Members and Participants. Members or their designees (proxy) shall be entitled to vote on issues and approve actions before the Committee. Participants or their designees shall attend and provide input at Committee meetings but shall not be permitted to votes unless appointed as a designee for a Member. Members and identified Participants for the Committee shall include representation from each of the areas listed below. Other individuals may be invited to speak or present at Committee meetings on an ad hoc basis at the Committee's or Chairperson's discretion (e.g. HealthSun Business Owners, Medicare Program Compliance, etc.) The Committee shall meet quarterly or as determined by the Chairperson of the Committee. Each Committee Member shall attend each meeting or appoint a designee to participate on their behalf. If a Member is not able to attend and does not send a designee, at least a majority of the remaining Members must be present in order to vote or approve any actions presented at the Committee meeting.

Organizational Structure and Departmental Roles and Responsibilities:

The Chief Medical Officer serves as chair of the QM Committee, which itself includes senior management representation from all operational and administrative functions, including clinical, business, and administrative staff. The QM Committee has representation from all department heads and there are several committees, representing administrative and clinical staff from across the organization, that report directly to the QM Committee. This includes the Risk Management Committee (who also reports to the Board of Directors), Credentialing Committee, Grievance and Appeals Committee, and other ad hoc committees established for the purpose of QI or related activities at the departmental structure and focus and creates system and dynamic responses that are truly organic in their approach and outcomes.

Executive leadership and department heads are responsible for company-wide commitment to data-driven quality improvement. As members of the QI Committee, leaders oversee all improvement efforts and ensure that adequate attention and resources are dedicated to QI initiatives from their functional areas.

The QM Committee and its subcommittees have representation from ALL operational areas relevant for each committee's charge. QI staff support these committees and all initiatives regardless of their operational focus, and all departments are involved with improvement activities.

The Plan's management, staff, consumers/beneficiaries, and providers are active participants in the QI Program. They are essential in assessing the health care and service to the Plan members and recommending improvement strategies as needed. As an integral part of the QI Program, these participants will assist in identifying, planning, evaluating, and monitoring processes and outcomes related to member care and service. The QI program has a mechanism for enrollees to participate in the selection of project topics and the formulation of project goals.

HealthSun is committed to the integration of quality improvement activities throughout the organization. Activities may involve interface with provider contracting related to recommendations for contract status and developing contract language. Provider Operations staff works with QI and the Medical Management Department staff to address areas of concern. Provider Operations also conducts practice site surveys and facility assessments and works with quality improvement in developing improvement strategies.

The Credentialing, Provider Operations, and QI staff coordinate efforts regarding completion of credentialing activities.

Member Services is integrated into QI activities by providing data on members for follow-up to the QM Department. There is also a direct interface for processing member complaints and grievances both concurrently and retrospectively.

Roles and Responsibilities

The Board of Directors is the governing body of HealthSun and has accountability and oversight of the QI Program. The Board of Directors' has delegated annual review and approval of the QI Program, Program Evaluation and Work plan, which includes the evaluation of this MOC, to the QM Committee along with other responsibilities as outlined below.

The Board of Directors has delegated the following to the QM Committee:

- Review and approval of the QI Program (DSNP & Non-SNP)
- Review and approval of the annual evaluation of the QI Program
- Review and approval of clinical and non-clinical QI studies and projects (including CCIP)
- Review and acceptance of the strategies and programs for the care and management of members with chronic conditions
- Ensuring that sufficient resources are allocated to accomplish the goals and objectives of the QI Program

The QI & Accreditation Services lead is responsible for the day-to-day QI activities. This individual works closely with the Chief Medical Officer and other health plan Medical Director(s) to ensure implementation of quality activities and ensures demonstrated health care improvements are achieved and with the Compliance Officer to ensure CMS and State related QI compliance. The QI & Accreditation Services lead is supported by the QI Departmental Staff.

Chief Medical Officer (CMO): A board-certified physician with an active license who has experience in Geriatrics as well as managed care and Medicare programs. With the assistance and support of the Medical Directors, the CMO is responsible for assuring the appropriate use of clinical practice guidelines as it applies to case management and providers and evaluates the effectiveness of the Model of Care. The CMO monitors the use of clinical practice guidelines via ICT conferences, review of medical records and Plans of Care, data analysis and peer review. The CMO is responsible for oversight of UM, CM, DM, QI, and Credentialing departments. The CMO is responsible for assisting in the design and implementation of the QI Program to ensure all quality activities are prioritized based on membership needs and will be appropriately integrated with Medical Management program. The CMO works with the Credentialing team to ensure current licensure and competency of providers.

QI & Accreditation Services Lead: A RN with an active license in the state of practice with over three years previous experience in Quality Management or a bachelor's degree with over five years of experience in Quality Management. This individual will be responsible for planning and directing QI activities. The lead will oversee initiatives related to all QI programs as well as provider quality improvement processes while working with the Medical Management team to evaluate the effectiveness of the Model of Care. The Director oversees the development of an annual QI Work Plan and will be responsible for the annual QI Program Evaluation. The lead is responsible for reviewing and revising the QI Program Description, working with the Credentialing Manager to assure current licensure and competency of providers and is a beneficiary of the QI committee. The lead coordinates with senior leadership to address all QI initiatives.

Collaboration with other HealthSun departments

Clinical and service indicators of quality are established and monitored on a regular basis by different HealthSun departments to assess D-SNP plan performance. Key indicators are designed to reflect the demographic characteristics, prevalence of disease, and/or utilization of services of the enrollees. The monitors and indicators have targets established and are measured on a periodic basis with the frequency appropriate to the indicator as described in the SNP QI Work Plan. Benchmark information external to HealthSun are used in setting goals or thresholds, when available. All indicators are trended to change over time and are included in the annual program evaluation. Indicators, which are outside established control limits, may provide the basis for quality improvement projects.

The Quality Staff performs routine review and evaluation of performance for those business partners supporting the MOC. The following includes but not limited to monitoring for MOC 1 Description of SNP population:

Metric to Be Reported	**Data Source**	**System/Platform**	**Business Partner**
MOC 1			

Metric to Be Reported	**Data Source**	**System/Platform**	**Business Partner**
Number of new enrollees increased for the D-SNP	CMS MRR/TRR		Enrollment
Cite the number of new enrollee qualifying disease states for the D-SNP	Enrollment/CM and Claims Data Files		Enrollment
Cite the number of disenrollment for the D-SNP	CMS MRR/TRR		Enrollment
Age/Gender of the population for D-SNP type	CMS MRR/TRR		Enrollment
Income/Poverty level for D-SNP type annually	Marketing data for all service areas		Enrollment
Educational Level for D-SNP type	Marketing data, HRA		Enrollment
Disease state prominence within the population	No external data source unless PDE data is used		Strategic Initiatives Data Evaluation
Utilization of services by diagnosis for D-SNP type for inpatient/SNF/HH/specialty			Strategic Initiatives Data Evaluation
Behavioral health diagnosis, top 2-3 for D-SNP type	No external data source unless PDE data is used for BH medication class drug identification		Strategic Initiatives Data Evaluation
Percentage of duals YOY-SNP	CMS MRR/TRR-LIS Indicator		Strategic Initiatives Data Evaluation
Percentage of increase in SNP diagnosis eligibility month to month	CMS MRR/TRR		Strategic Initiatives Data Evaluation

Metric to Be Reported	**Data Source**	**System/Platform**	**Business Partner**
a) Utilization of certain benefits designed to support the target population-can be the highest cost benefits such as ICU, acute care, SNP a. Potentially Preventable Emergency Room Visits (PPVs) b. Potentially Preventable Hospital Admissions (PPAs) c. Potentially Preventable Readmissions (PPRs)			Strategic Initiatives Data Evaluation
Marketing efforts for member engagement/education-this can be measured by the educational mailings done either through care mgmt. or marketing	No outside data sources		Marketing
Increase/decrease of the identified vulnerable population by service area-reported as those members who meet MVB stratification criteria (MDFlow)			Strategic Initiatives Data Evaluation

The following includes but not limited to monitoring for MOC 2: Care Coordination:

Metric to Be Reported	**Data Source**	**System/Platform**	**Business Partner**
MOC 2			
Total SNP Membership Combined D SNP			Clinical MOC Dashboard
Total SNP Membership defined for D-SNP			Clinical MOC Dashboard
Initial HRA			Clinical MOC Dashboard

Metric to Be Reported	**Data Source**	**System/Platform**	**Business Partner**
Number of new enrollees eligible for an initial assessment			Clinical MOC Dashboard
Number of initial assessments performed within 90 days from the enrollment effective date			Clinical MOC Dashboard
Number of initial assessments performed after 90 days (but no more than 364 days of enrollment effective date)			Clinical MOC Dashboard
Number of initial assessment members refused to participate			Clinical MOC Dashboard
Number of initial assessments classified as unable to reach			Clinical MOC Dashboard
Annual/Reassessment HRAs			Clinical MOC Dashboard
Number of enrollees eligible for an annual reassessment			Clinical MOC Dashboard
Number of annual reassessments performed of eligible members due for a reassessment within 364 days of last HRA or the date of the initial HRA completion			Clinical MOC Dashboard
Total of reassessments performed after 365 days			Clinical MOC Dashboard
Total number of assessment/reassessments members refused to participate in			Clinical MOC Dashboard
Total number of reassessments unable to reach			Clinical MOC Dashboard
ICPs-Individualized Care Plans			Clinical MOC Dashboard
Number of enrollees eligible for an ICP			Clinical MOC Dashboard
Number of ICPs Completed			Clinical MOC Dashboard

Metric to Be Reported	**Data Source**	**System/Platform**	**Business Partner**
Number of ICP Refusals			Clinical MOC Dashboard
Number of ICPs unable to reach			Clinical MOC Dashboard
ICTs-Interdisciplinary Care Team Conferences			Clinical MOC Dashboard
Number of enrollees eligible for an ICT			Clinical MOC Dashboard
Number of ICTs Completed			Clinical MOC Dashboard
Number of ICT Refusals			Clinical MOC Dashboard
Number of ICTs unable to reach			Clinical MOC Dashboard
Transitions of Care			Clinical MOC Dashboard
Identify the number of members, by D-SNP, who had appropriate transition of care performed			Clinical MOC Dashboard
Measurable Outcomes			Clinical MOC Dashboard
Confirm each care plan includes goals, interventions and measurable outcomes			Clinical MOC Dashboard

The following includes, but is not limited to, monitoring for MOC 3: Provider Network

Metric to Be Reported	**Data Source**	**System/Platform**	**Business Partner**
MOC 3-Report for D-SNP Type			
Number of PCPs per county-Network Adequacy Report-by 5 designations			Network
Number of Specialists per county-Network Adequacy Report-by 5 designations			Network
Number of access/availability grievances or complaints about access to care/appointments			Network
Clinical Practice Guideline Adherence	See MOC 4 Tab		Network
Provider Education of MOC			Network
Network Provider Completion Rate			Network
Non-network Provider Completion Rate			Network
Improve Network Adequacy for Specialty Providers			Network

The following includes, but is not limited to, monitoring for MOC 4: MOC Quality Measurement and Performance Improvement:

D-SNP MOC Metric to Be Reported	**Data Source**	**System/Platform**	**Business Partner**
MOC 4 Report D-SNPs			
Colorectal Cancer Screening			
Care of Older Adult (ACP, Medication Review, Functional Assessment, Pain Assessment)			
Use of Spirometry for COPD (SPR)			
Pharmacotherapy Management of COPD (pce)			
Controlling Blood Pressure (CBP)			
Persistence of Beta blocker after Heart Attack (pbh)			
Osteoporosis Mgt in women post fracture (OMW)			
Antidepressant medication Mgt (amm)			
Follow-up After hospitalization mental health (FUH)			
Medication review post hospitalization (mrp)			
Potentially harmful Drug-Disease Interaction in elderly (dde)			
Use of High risk Medications in elderly (dae)			

Key Stakeholder of SNP QI Performance

The QI Department develops communication of key elements reflecting the MOC performance and shares them across the Plan and with staff, providers, members and stakeholders such as the plan's Board of Directors or QM Committee aligned with MOC 4 Element E requirements.[9] The QI Department educates its stakeholders with updates regarding performance measures and/or changes in the model of care for the D-SNP via the documented meeting minutes, program evaluation documentation, Member/ Provider Newsletters.

[9] SNP MOC NCQA: https://snpmoc.ncqa.org/wp-content/uploads/MOC-Scoring-Guidelines_CY-2021-1.pdf

The QI Department makes information about improvements to the MOC available to providers and beneficiaries on at least an annual basis and more often if appropriate. To achieve true integration and initiate collaborative activities, information about the MOC and other quality program activities are communicated openly throughout the HealthSun provider network, posted on the health plan website, and made available to beneficiaries, community partners, and stakeholders.

Primary methods the QI Department will use to communicate this information include the following:

• Reports to committee meetings
• Formal newsletters
• Intermittent targeted mailings
• Electronic communications using HealthSun website and email where available

Results of final annual changes and recommendations is communicated to all involved stakeholders through written communication, including newsletters, bulletins, press releases, and face to face activities for issues pertaining to the providers network. All information is posted in the employees, members and providers webpages and is available for review by stakeholders and regulatory agencies, including CMS and AHCA.

The QI Department develops communication plans regarding results of the annual quality evaluation, which are reported within all committees that support the quality process. Results, barriers, best practices, and lessons learned are communicated through these committees. Results are shared with the Board of Directors annually.

In summary, the QI Department communicates a variety of information to all stakeholders who are defined to include providers, employed staff, members, and designated caregivers.

Examples of communications may include but are not limited to:

- Letters/memos/faxes
- Provider bulletins
- Committees
- Website

Performance results and any other pertinent information of the ongoing D-SNP MOC evaluation and progress towards goals are reported in the Organizational Quality Structure and validated at the QM Committee. These committees include key staff from all organizational areas. Changes and improvements to the MOC are also communicated through, staff meetings, work groups, regulatory trainings, and Board of Directors Meetings. The key stakeholders include but not limited to:

- Boards of directors.
- SNP personnel and staff.
- SNP provider networks.
- SNP beneficiaries and caregivers.
- The public.
- Regulatory agencies.

For providers and members, performance results and pertinent information are shared through:

- Newsletters
- Provider and member portals
- Provider meetings, scheduled throughout the year

If requested, results are shared with our state regulatory agencies.

Frequency of communications with stakeholders

The QI Department understands the importance of timely and effective communication among stakeholders. As such, HealthSun has defined the following communication frequency:

- QM Committees meets at least 3 times annually
- Care Plan is shared with the member and provider no less than annually or as needed. It can be shared thru an annual bulletin or publication among other mechanisms.
- Staff meetings monthly

SNP MOC performance results and pertinent information related to the SNP population, as well as performance standards and indicators of clinical quality activities are communicated at the following frequency:

- Board of Directors annually
- Quality Committee quarterly
- Staff annually
- Annual publications are available to members and providers

Ad hoc communications are produced periodically throughout the year. Available means of distribution may include:

- Mail
- phone
- e-mail
- Faxed communications.

When necessary, communication may be delivered by printed media, trainings, Intranet, or workgroups. Communications are also available at the member and provider portals.

Individuals Responsible for Communicating Performance Updates

The QI Director is responsible for all communications associated with healthcare aspects of the MOC. The Chief Medical Officer is responsible of communicating the quality performance of the MOC to the different stakeholders. The QM Committee chair and QI department lead is responsible of communicating issues regarding MOC performance to the QM Committee including the annual evaluation that outlines meeting of the established goals.

Other senior management staff may also be responsible depending on the topic that the communication addresses. For example, encouragement to network providers to participate in

certain quality improvement projects, pertaining to the MOC, may also need the Provider Operations interventions.

SNP QI Program Documents

Model of Care

Program Description

The QI Department reviews and revises the SNP QI Program description at least annually and as needed.

Work Plan

The QI Department and QI Committee annually formulate the QI Work Plan with input from subcommittees, department managers, provider clinics, and delegated entities. The QI Work Plan is monitored and updated quarterly. The QI Work Plan includes the following:

- Objectives for the year and program scope,
- Activities planned for that year, including clinical care and service, utilization, care management, and disease management
- Time frame within which each activity is achieved,
- Person(s) responsible for each activity,
- Planned monitoring of previously identified issues, and
- Planned evaluation of the SNP QI Program.

Program Evaluation

The QM Committee formally evaluates the SNP QI Program. The assessment includes the following:

- Performance evaluation of MOC 1- 4
- Description of completed and ongoing QI activities
- Trending of measures to assess performance in the quality of clinical care and quality of service through:
    - Analysis of whether there have been demonstrated improvements in the quality of clinical and quality of service to enrollees,
    - Evaluation of the overall effectiveness of the SNP QI Program, and
    - Evidence that quality and service activities have contributed to meaningful improvement in the quality of clinical care and quality of services provided to enrollees.
    - Recommendation for changes in QI activities to improve outcomes.
- Analysis of the QI Work Plan to determine if activities are being completed on time or if changes need to be made.

Committee Minutes

The QI Department maintains minutes for each QM Committee meeting. The minutes are dated and signed following the committee's review and approval.

Confidentiality

Confidentiality is observed throughout the QI Program. Internal staff and external participants and consultants to the program are made aware of the confidential nature of the proceedings as they occur. It is the responsibility of the QIC to develop and monitor the overall confidentiality policy. Confidentiality is observed as follows:

- Committee members sign confidentiality statements annually and all guests must sign confidentiality statements.
- Enrollees, prospective enrollees, and providers are informed of HealthSun's policies regarding the use and release of identifiable information.
- The QM Committee has been designated as the committee to assess and oversee corporate confidentiality policies and practices.
- Contracts with providers outline standards for confidentiality and providers are reviewed for the standards in the credentialing and re-credentialing process.
- To prevent conflict of interest, no person may participate in a review, evaluation, or final disposition of any issue/case in which he/she is or has been professionally involved or where judgment may be compromised.
- All policies and procedures meet the standards as identified in the Balanced Budget Act Of 1997 (BBA) regarding Health Insurance Portability and Accountability Act of 1996 (HIPAA) and confidentiality and privacy of health information.

Signatures

This QI Program description was reviewed and approved by the QM Committee on December 28, 2020.

Dual Special Needs Plan Care Management Program 2021 (D-SNP)

HealthSun Health Plans' (HealthSun) Dual-Special Needs Plan (D-SNP) Care Management Program is designed to implement a comprehensive integrated series of services and processes that actively optimizes the use of the health plans benefits and health care resources available to its D-SNP members while maintaining a high quality of patient care. The Care Management Program serves to coordinate the delivery of medically appropriate, cost effective healthcare for those identified members who suffer from persistent, chronic, substantially life threatening and/or altering conditions that require focused treatments and interventions that span across a variety of domains including medical, social, functional, financial and behavioral. The Care Management

Program requires active participation of plan network physicians as well as HealthSun Plans' Chief Medical Officer, medical director(s), medical management staff, and physician reviewers.

The key components of the program include the identification of those D-SNP members who are most vulnerable and demonstrate a high risk for potential complications of their condition(s), evaluation of needed healthcare services and resources to support their needs, and the implementation of goals and interventions that facilitate improved health care outcomes through continuity and coordination of their healthcare needs. Additionally, decision protocols (criteria) used by HealthSun are based upon evidenced based clinical practice guidelines and input from network providers who participate in the development and/or adoption of such criteria. This evidence based clinical guidance is reviewed and approved at least every other year by the Quality Management Committee. To support the care management processes, HealthSun has employed both permanent and contracted staff to provide a seamless process that focuses on episodes of care, catastrophic events and/or chronic illness, mental health, social and end-of-life needs of these special needs members.

This program is governed by and in compliance with the regulatory requirements set forth by the Centers for Medicare and Medicaid Services (CMS) as described in 42 CFR §422.101(f)(i)[10]; 42 CFR §422.152(g)(iv)[11]; Medicare Managed Care Manual[12], Chapter 16b, Section 20.2 and Chapter 5, Section 20.2.1 and 20.2.3.

Overview Goals and Objectives

HealthSun Health Plans' Care Management Program has been designed to ensure effective and efficient utilization of resources that provide these members with the continuity and coordination of appropriately needed services to ensure the best outcome for each individual member. The program aims to identify and implement cost-effective practices to meet the health care needs of members in all health care settings.

The Care Management Program Goals are to:

- Provide a single point of contact for the D-SNP members.
- Improve access to essential services such as medical, behavioral health and social services.
- Improve access to affordable and quality care.
- Improve the coordination of services through the engagement of the members and/or their caregiver, treating providers and assigned Case Manager (CM).
- Improve member engagement in the D-SNP Care Management Program through increased participation in the completion of the Health Risk Assessment (HRA) tool,
- Individualized Care Plan (ICP) development and Interdisciplinary Care Team (ICT) meetings.

[10] Electronic Code of Federal Regulations- https://www.ecfr.gov/cgi-bin/text-idx?node=pt42.3.422&rgn=div5#se42.3.422_1101
[11] Electronic Code of Federal Regulations- https://www.ecfr.gov/cgi-bin/text-idx?node=pt42.3.422&rgn=div5#se42.3.422_1152
[12] Medicare Managed Care Manual- https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS019326

- Improve the members' Transitions of Care (TOC) by creating a seamless process between all settings, providers and health services.
- Implement and manage the specific goals/initiatives outlined in the Chronic Care Improvement Program (CCIP) directly to the D-SNP members (Refer to the CCIP Description and Quality Program Description).
- Improve and ensure the appropriate utilization of services.
- Improve the members' health outcomes.

The Care Management Program Objectives are to:

Ensure the delivery of quality-based Case Management (CM) services by:

- Coordinating a population-based CM model that assist in managing a members' health care needs using resources that promote focused and positive healthcare outcomes.
- Identification of at-risk members and those most vulnerable to provide focused and appropriate interventions that foster ongoing health maintenance and improvement.
- Removing barriers that interfere in a member being able to receive appropriate care and treatment for care such as transportation support to get to and from medical appointments.
- Serving as a member advocate in coordinating multiple health care resources to avoid unnecessary hospital admission or readmissions.
- Promoting wellness and prevention across the continuum of care.
- Assisting in linking members to community resources.
- Assessing a members' health educational needs, providing them with self-help tools and directing them to the appropriate resources that will support their health care needs.
- Coordinating Transitions of Care when required to ensure continuity of care provided and avoid the interruption of care/services.
- Improve medication management and adherence through a Medication Therapy Management Program (MTMP), as well as care management activities by measuring adherence rates to decrease therapeutic duplication.
- Improve member health outcomes through the coordination of Medicare and Medicaid benefits as demonstrated by documented case interventions.
- Monitor the progress and/or evidence toward achieving stated goals and provide evidenced of action the D-SNP Care Management Program will take if the goals are not met within the expected timeframe.
- Ensure CM activities comply with the D-SNP Model of Care (MOC) as well as all CMS, Code of Federal Regulation, local, state, and national regulatory requirements and guidelines.[13]
- Identify, develop, and implement cost-effective programs to meet selected health care needs of HealthSun members in the most effective and appropriate settings.
- Oversee, monitor, and review the adequacy of health care delivery, making recommendations relative to the provision of health care services, utilizing quality improvement techniques.

[13] CMS Managed Care Manual Chapter 5 and 16b: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS019326

- Identify, develop and implement cost effective standards of care that reflect the quality and service commitment of the providers as well as the expectations and needs of the members
- Ensure that providers are able to serve as an advocate for the member.

Staff Roles and Responsibilities

HealthSun's Board of Directors retains ultimate responsibility and authority over the D-SNP Care Management Program through the Quality Management Committee. The Quality Management Committee reviews the program on an annual basis by conducting an annual evaluation, the results of which are shared with all appropriate stakeholders. To achieve the goals of the Care Management Program, the health plan employs a system-wide approach through on-going collaboration with the Chief Medical Officer, medical directors, the organization's medical management staff, network physicians, and other ancillary providers in order to apply case management activities throughout the health plan and its network of providers.

HealthSun utilizes priority evidenced-based logic/technology logic within the care management platform to validate eligibility of the D-SNP members for the Care Management Program, beginning with enrollment into the plan. The clinical staff within the Care Management Program, including but not limited to the Case Manager (CM), Medical Director and the members' primary care physician team, are responsible for identifying the members' health care services, needs, barriers to care, and coordinating services required to support the members throughout the care continuum.

The D-SNP Care Management Program relies on the following staff roles and responsibilities to implement the above outlined goals and initiatives:

A. Chief Medical Officer

The Chief Medical Officer (CMO) has the overall responsibility for ensuring that quality medical services are provided in the most efficient and cost-effective manner. The CMO serves as a resource and medical liaison between the Plan and the local delivery unit's care management, utilization and quality management and other medical delivery issues such as continued stay review and retrospective review of identified cases. The CMO, medical director(s), and/or physician advisors, participate in all referrals from the medical management staff and denials of services. This individual also coordinates the involvement of other specialist and practitioners as needed in the review of cases.

B. Medical Director (MD)

The Medical Director will be a board-certified physician with an active license in the state of Florida, who provides clinical leadership and guidance for all clinical aspects of the D-SNP program. The Medical Director reports directly to the CMO of HealthSun and will be a member of the executive leadership team. The Medical Director has a central role in implementation of the D-SNP program through leadership, facilitation, and communication. The Medical Director provides clinical expertise in clinical quality improvement (QI) initiatives and utilizes medical training and experience, along with managerial skills, to lead the D-SNP team in accomplishing program objectives for improving care and service to members. This MD is responsible for oversight of clinical decision-making aspects of the D-SNP program and plays an important role in communicating and collaborating with clients, practitioners, providers, delegated entities (as applicable) and external review vendors. The Medical Director conducts consultations

with the D-SNP care management staff including, but not limited to CM, Utilization management (UM), QI and Pharmacy, to provide education on appropriate member interventions based on assessment results, and clinical education related to the clinical conditions of members. The Medical Director also provides peer consultations with practitioners and may conduct outreach calls to members, as need is identified.

C. Director of D-SNP Care Management

The Director is either an RN or Social Worker with an active unrestricted licensure or certification in a health or human services discipline within the state of Florida that allows the professional to conduct an assessment independently as permitted within the scope of practice of the discipline; three years' full-time equivalent of direct clinical care to the member (specific experience may include home care, discharge planning, rehab, long-term care (LTC)); experience in a supervisory/leadership role; and experience with Medicare/Medicaid programs. The Director is responsible for the following:

- Providing leadership and overall operational day-to-day responsibility for the effectiveness of CM for D-SNP members' activities across the continuum of health to assist staff in meeting members' needs and achieve departmental goals.
- Overseeing appropriate delivery of the D-SNP program by the CM as outlined within the MOC and the Agency for Health Care Administration (AHCA) contract that includes completion of the HRA, Initial Care Plan, and ensures the Care Plan will be implemented and updated annually.
- Ensuring the screening, assessment, planning, facilitating, monitoring, and adjustment activities for members in CM/DM is performed appropriately, making recommendations for program changes when indicated.
- Ensuring all CM/DM activities are being performed based on the policies and procedures that support the program.

D. RN Case Manager

The Registered Nurse (RN) Case Manager (CM) is an RN who has an active license in the state of Florida with experience in managed care, Medicare and/or Medicaid and/or with the D-SNP population. The CM is responsible for the following:

- Assisting the member in the timely completion of the HRA as well as performing annual updates and completing any/all additional condition specific assessments that will support the application of the members' care need;
- Coordinating the members' care based on the findings identified within the HRA as well as other data sources that support the member management process;
- Creating and updating the members' ICP in coordination with the member/caregiver and Primary Care Physician (PCP) to develop and execute interventions and goals within the care plan;
- Organizing ICT meetings for management of the members' health needs through the care plan and documenting within the members' case the outcome discussion;
- Acts as a liaison for the ICT in conjunction with the PCP (gatekeeper) and the member/caregiver;
- Collaborating with other care management team members to support the member through TOC events;

- Assisting the member to avoid further downgrade of condition(s) by placement at the appropriate level of care;
- Providing resources and benefits available to assist and educate the member/caregiver to develop and/or improve self-management skills and achieve quality of life;
- Reviewing and approving stratification data of the member and/or revises based on an assessment of the member's needs;
- Making updates to a members' ICP when there is a status change or completion of interventions or goals;
- Coordinating and implementing both the members' care needs when appropriate and as allowed within the regulatory and benefit guidelines;
- Facilitating and expediting the access to specialists, services and therapies, including the seamless transition between facilities and levels of care to ensure seamless care coordination; and
- Being the primary contact for the member/caregiver, PCP, specialists and ancillaries related to the Care Management Program.
- Documenting in the members' case accurately and timely to ensure coordination of the member's care needs; and
- Adhering to all CMS, Code of Federal Regulations, local/state/national regulatory requirements and guidelines as well as those outlined within the MOC and the AHCA contract.

E. **Social Worker**

The Social Worker (SW) has an active license in the state of Florida with experience in managed care, Medicare and/or Medicaid and/or with the D-SNP population. The SW is be responsible for the following:

- Performing psychological, social and economic care management interventions for members with severe/persistent mental or emotional disorders;
- Performing telephonic behavioral health comprehensive assessments of members' environmental, behavioral, psychological, economic and social factors;
- Assisting in the development of individualized and culturally sensitive care plans in collaboration with the member's assigned CM, identifying problems, interventions, barriers and goals;
- Performing telephonic re-assessments, care plan revisions and evaluating the effectiveness of the members' care plan;
- Establishing a therapeutic relationship based on knowledge of human behavior, well developed observational and communication skills;
- Recognizing early signs of a members' decompensation that requires immediate case management intervention that promotes and motivates compliance with treatment plan;
- Serving as an additional point of contact during transitions of care;

- Co-managing member cases with the CM to address psycho-social, economic and cultural issues that may impact the members' care needs;
- Serving as a primary socio-economic resource for the D-SNP Care Management Team;
- Intervening at the member and provider level when appropriate;
- Documenting in the members' case accurately and timely to ensure coordination of the members' care needs; and
- Adhering to all CMS, Code of Federal Regulations, local/state/national regulatory requirements, and guidelines as well as those outlined within the MOC and AHCA contract.

F. HRA Specialist (Non-Clinical)

The HRA Specialist is responsible for the following:

- Supporting the CM in outreaching to the members to ascertain completion of the HRA when needed;
- Serving as a contact for the D-SNP members to coordinate CM engagement;
- Assisting members in the coordination of services when appropriate and under the guidance of CM;
- Working closely with the CM and/or SW staff regarding socio-economic issues, such as needed community services or to assist in the establishment of appropriate access to care;
- Generating and coordinating various member and provider written communications;
- Documenting in the members' case accurately and timely to ensure coordination of the members care needs; and
- Adhering to all CMS, Code of Federal Regulations, local/state/national regulatory requirements, and guidelines as well as those outlined within the MOC and AHCA contract.
-

G. TOC Coordinator (Non-Clinical)

The TOC Coordinator is responsible for the following:

- Assisting in the coordination of transitions of care that includes, but are not limited to, skilled or rehabilitation facilities, home care services, durable medical equipment (DME) and outpatient treatment services (i.e. rehabilitation services)
- Review of daily census to track and report to the CM daily all pending and immediate member discharges to identify additional transitional needs and alert the CM of the members pending discharge status.
- Validating the location and contact information of the members post discharge.
- Validating the available discharge summaries and attach to the members' cases within the care management system.
- Assist the members in coordinating transportation to appointments, as needed.
- Conducting timely follow-ups with the members and/or their designated caregivers post transition to ensure planned services have been provided as planned.

- Communicating with the members' PCP/Specialist to confirm or schedule follow up appointments within 48 hours of discharge.
- Providing the Concurrent Reviewers and CM with ongoing support throughout the entire transition process.

H. Interdisciplinary Care Team (ICT)

The ICT is comprised of the member and/or their caregiver, the member's primary care or specialist physicians, the HealthSun CM, Medical Director and Pharmacist, and any ancillary providers, including dieticians who are actively engaged in the member's care needs. The CM is the primary point of contact and is responsible for the coordination of meetings and documenting within the member's case any outcome of discussions that occurs with the ICT and providing copies to the team members when necessary. The primary role of the ICT is to assist in the development of the member's ICP in collaboration with all parties involved that includes, but is not limited to, establishing a self-management plan that identifies both short and long-term needs, interventions and goals. The ICP is revised in accordance with a member's risk stratification level (see below section for risk stratification process outline)

Care Management Program Delivery

Confidentiality and Release of Patient Health Information (PHI)

All D-SNP Care Management staff adhere to all applicable federal and state regulations, which are designed to safeguard the rights and privacy of the members enrolled in the health plan. Authorization is required and obtained from the member or their designated caregiver to use or disclose the members' PHI, unless otherwise permissible by law. If the member has a designated caregiver, there must be a valid document, such as a Power of Attorney, Healthcare Proxy, Guardianship, or HIPAA Authorization for Use and Disclosure form, to support the release of any information.

Disclosure of a member's PHI is considered permissible in the performance of the D-SNP Care Management if it is made to the following entities:

- Providers who are actively engaged in designing and/or implementing a treatment plan and/or
- Government agencies who are required to fulfill their legal responsibility, when appropriate. Documentation must be included as to the purpose for requesting the information and the legal responsibility held by the governing agency.

If disclosure of PHI is required through a court order, the request is referred to the Compliance and Privacy Department for evaluation and management of the request. They are responsible to review and authorize the legitimacy of the information, determine what information is being requested, the purpose for disclosure and identify the limitations of the PHI to be released. All PHI files are stored in the secured care management system, accessible only by the designated person(s) listed within the request and stored for the appropriate length of time as required by legal statue. The system stored PHI is protected through a multi-level security process, which prevents access by unauthorized staff and/or person(s).

D-SNP Case Management Engagement

Eligibility for the D-SNP Care Management Program occurs automatically at the time of the member's completed enrollment in the D-SNP Plan. Members are assumed to be in the program unless they choose to opt-out, which can occur through a call from the member or their authorized representative to the Care Management department, via mail notification and/or when they submit a hard copy of their HRA as there is an opt-out opportunity question at the end of the assessment letter. If opting out, HealthSun will continue to monitor for change in health status and opportunity to re-engage. Additionally, the re-engagement referral may come from a practitioner, discharge planner, UM and/or member/caregiver.

For those members who have not completed an HRA, the HRA Specialist in coordination with the CM will make several outreach attempts via phone call to obtain a completed HRA. An Unable to Reach (UTR) letter is sent to the member and/or their authorized representative and the members' primary care physician (PCP) if outreach calls are unsuccessful. The PCP is asked to assist in completing the HRA in coordination with the member and returning a copy to the plan for input into the member's case file.

The CM contacts a new member within the first 90 days of enrollment to welcome them into the program and provide information regarding the D-SNP Care Management Program, including the purpose, reason for eligibility, and process for participating. A follow up mailing will occur post the initial welcome call to provide the member with additional information about the program and include the CM contact information. Additional communications are arranged thereafter that are dependent upon the member's needs and risk stratification, which includes educational mailings and a copy of their ICP.

Monitoring for D-SNP Care Management Enrollees

The D-SNP Care Management Program provides specialized case management, chronic condition education, care transition support, end of life and behavioral health management services to members with medical and/or behavioral issues or problems that may affect their quality of life and health outcomes. Examples of the Care Management activities from which interventions are developed include the:

- Degree and complexity of illness/condition(s) that is severe or complicated and/or
- Level of treatment/management that is intensive and/or complex and/or
- Amount of resources required to regain or maintain optimal health or improved function that is extensive, requiring complicated coordination.

Early identification and effective management of targeted D-SNP members can result in improved quality of care and reductions in inappropriate medical costs. Members who have or are expected to have health care needs that require extensive use of medical resources are assessed for tailored care management services. Although services are customized in the member's Individualized Care Plan, Most Vulnerable Beneficiaries (MVB)/High-risk members often use more services and require more tailored services due to the complexities of their needs. Such services include, but are not limited to, the following:

- 30-day post discharge plan program
- Pharmacy program

- Home Health Aid services
- End of life or palliative care services
- Coordination of community and benefit resources
- Cultural and Linguistic resource services

D-SNP members are monitored by the D-SNP Care Management staff for any changes in their health or living conditions, such as the following:

A. Newly diagnosed chronic conditions (three or more major diagnoses).
B. Members with two or more of the following:
    i. Acute care admissions for management of a chronic condition within six months;
    ii. Emergency room visits within three months;
    iii. Lack of adherence to prescribed medications; or
    iv. Lack of adherence with physician visits or other services
    v. Complex care transitions, including alternative placement and complicated discharge plans.
C. Underutilization of services.
D. Socioeconomic indicators – suspected elder abuse/neglect, homelessness, poor living conditions, lack of water or electricity, lack of food, no known support system or limited financial resources.
E. Falls within the last six months.
F. At risk for unplanned care transition (example: frail member living alone with cognitive impairments and complex medical regimen).

Components of D-SNP Care Management

As stated above, the member will receive the initial Health Risk Assessment (HRA) that is included within their Welcome Kit. The HRA is completed as expeditiously as possible, but no later than ninety (90) days from the date the member is enrolled into the D-SNP plan. The CM team is responsible for ensuring that the HRA has been completed and will make multiple attempts, but no less than three within the first 30 days to contact the member for completion). The CM team utilizes the D-SNP Care Management system to enter the HRA information and then will coordinate a follow-up call in accordance with the members identified risk level that is determined by HealthSun's proprietary stratification process and/or the HRA tool when completed. The stratification process is used to assist in improving the care coordination process by triggering the intensity and frequency of care management required to support a member's health care and psychosocial needs.

The CM will outreach to the member to review the HRA findings and create an ICP that supports the member's health care needs. Goals and interventions are reviewed for member engagement into the care plan process. A D-SNP Care Management letter is mailed to the member within 30 days, confirming their ongoing participating in the program. A separate letter is sent to their PCP no later than 30 days informing them of their patient's participation in the D-SNP Care Management program and explaining the components of the program. The primary care physician will also receive a copy of the members ICP. If the member is applicable for other programs (e.g. CCIP), the CM will update the ICP to reflect that as well.

The HRA will be updated by the CM on an annual basis and/or sooner if there is an unexpected change in the member's health status or treatment.

Ongoing Care Management

Ongoing follow up with each D-SNP member/caregiver occurs on a frequency based upon the assigned risk level. The Care Manager assigns the risk level after completion of the HRA as well as utilizing proprietary stratification information that is uploaded into the care management system. For members participating in the Care Management Program, the following risk factors are used to determine their risk level and outreach coordination:

Low Risk (scoring correlates with but is not exclusive to a member's condition being stable, few co-morbidities, stable support system and/or access to care).

- Review of ICP progress towards completion of interventions and achievement of care plan goals (frequency dictated by individualized care plan, usually between 90 to 180 days of care plan creation) updating the care plan when there is a health status change and annual care planning. The annual HRA is also used when performing an update to the ICP.
- Reassessment and evaluation of risk stratification by members of the ICT (i.e. CM with assistance as needed from Medical Directors, Clinical Manager and/or PCP) for significant changes in member's health and annually.
- Monitoring of adherence to treatment regimen and guidelines.
- Educational needs identified through the HRA (e.g., fall risk prevention) will be identified on the ICP (i.e., care plan) and addressed with the member/caregiver through follow-up calls or home/facility visits and periodically thereafter to enhance knowledge and self-management.
- ICP will address all individualized HRA findings in correlation with the risk stratification findings as well as interventions that support the findings and implementation of the ICP that includes but is not limited to referrals and coordination of services with providers and access to benefits.
- Copy of care plan sent to PCP and/or specialists who will be encouraged to provide input and actively participate in those goals identified within the Care Plan.
- Ongoing monitoring of utilization to assist in evaluating disease status.
- Effective communication with ICT providers through care coordination of appointments, primary/specialist care, transportation, and other assistance as needed to facilitate care for the members.
- Transition of care assistance and interventions for planned and unplanned transitions to and from a hospital, nursing facility, rehab or other. If hospitalized, on-site or telephonic hospital reviews by the Concurrent Review Nurse who will assist with discharge planning, transition of care interventions and referrals, as indicated.

Moderate Risk (scoring correlates with, but is not exclusive to, member's condition and needing assistance to improve self-management and access to care), includes all of the above with the following additional CM expectations.

- Regular review on ICP progress towards completion of interventions and achievement of care plan goals (frequency dictated by individualized care plan, with minimum between 60

to 120 days after ICP completion), updating the care plan when there is a change in a members health status or risk stratification and annual care planning review and revision. The annual HRA update is utilized when performing an update to the members' ICP.

- Increased frequency of calls and/or meetings with member/caregiver and other members of the ICT to meet the members' increased identified needs.
- Additional assessments as identified and updating the ICP with any additional findings including interventions.
- Symptom management including addressing needs such as working with the member on health goals and avoidance of exacerbations.
- Provide additional emotional support to the member and/or caregiver as needed.

All of the above activities for Low and Moderate Risk are performed with a call frequency of at least bi-monthly. Additional calls will occur as often as needed and/or as required by the members' health status changes.

High Risk (scoring correlates with, but is not exclusive to, condition(s) uncontrolled and/or multiple exacerbations and/or co-morbidities with higher support needs to improve self or caregiver management and access to care):

- Review of the ICP in correlation with the ICT to ensure interventions are appropriate and goals are being met.
- Adjustments to the ICP may need to occur more frequently with this risk population as their health status may change at frequent intervals due to their vulnerability and/or due to frequent changes in their condition.
- High risk members may require weekly contact depended upon their health status and needs.

The CM will communicate the member's risk stratification results to the ICT. The identified health risk is documented in the ICP as described above and with member outreach assigned based on the below table:

Risk Group	Acuity Level Description	Expected Frequency of Outreach/Contact
Complex/ High	Member's clinical presentation is volatile and apt to lead to more serious injury/illness and/or exacerbation of condition warranting an inpatient stay on an Intensive Care Unit; OR Member has suffered a recent exacerbation or injury/illness and has been provided resources to help stabilize situation but is not considered clear of any risk of returning to an unstable status.	At least 1-2 times/week.
Moderate	Member has suffered a recent exacerbation or injury/illness and resources are in place to help stabilize, and member is at moderate risk of suffering further decrease in health.	At least once/month.

Low	Member is well connected to resources and demonstrates ability to effectively self-manage health care.	At least once every six months.

Individualized Care Plan (ICP) and Interdisciplinary Care Team (ICT)

As stated above, a comprehensive reassessment occurs when there is a significant change in a member's condition or treatment or needs, however, a follow up HRA is performed annually, at a minimum. The individualized care plan is revised when the member's condition or treatment significantly changes or at a minimum and is updated annually. During each contact with the member by the D-SNP CM staff, progress against current care plan goals are documented in the electronic care plan.

The ICP remains an important part of the member's care coordination process. The CM is responsible for the development, implementation and updating of the members care plan and sharing this information with the ICT. The ICP is completed within the first 30 days after the completion of a member's HRA and updated as a member's health care status needs change. The key components of the HRA are implemented into the care plan along with, but not limited to the following:

- Results/problems identified from the HRA including risk stratification and other assessment findings (health conditions; environmental, psychosocial, and cognitive challenges; functional limitations; social and behavioral problems, etc.)
- Key contact person for communicating Care Plan recommendations, on-going transition of care needs, etc. (i.e. Member, Caregiver, or Legal or Authorized Representative)
    - Member/Caregiver/Legal or Authorized Representative contact information
    - PCP information
    - ICT information
- Member's preferences for communication (i.e. telephonic, face-to-face, written), including barriers to communication (i.e. hearing impairment, visual impairment, etc.).
- Member's pharmacy data available and confirmed with member.
- Member's preferences for care and planned interventions (as agreed to by the member/caregiver).
- Measurable short and long-term goals. These include member/caregiver self-management goals and objectives, which allows members to attain success while moving forward on easily obtainable objectives.
- Identification of barriers to achieving goals, including:
    - Any cultural or linguistic considerations
    - Limits with activities of daily living, cognitive function, visual or hearing impaired
    - Social determinants of health

- Behavioral Health (BH) referrals to delegated entity, when applicable. This will be included as part of the member's ICP for ongoing management and monitoring for identified goals and interventions in correlation with the BH provider.
- Measurable outcomes for goals Met, Not Met, or Unable to fully meet due to identified barriers and evidence of how goal was achieved as appropriate.
- Specific preferences, services and benefits required to accomplish goals or that will improve the member's status (i.e. standing authorized referrals for a chronic condition, transportation, community resources including support groups, home safety assessment, referral to disease management, risk prevention programs, wellness, etc.).
- Documentation of referrals made to specific disease management programs.
- Add on benefits identified that would further meet the member's specific care needs including those identified as being most vulnerable. The benefits will be tailored to support the member's needs based on identified preferences (i.e. supplemental meals, additional transportation, assistance for activities of daily living, etc.). These benefits will be offered to include members that are frail, disabled, approaching End Stage Renal Disease (ESRD) after enrollment, end-of-life, and those experiencing multiple or complex chronic conditions.
- Ongoing documentation of all communications, interventions and ongoing care needs including any updates and/or revisions that have been made within the ICP.
- Additional assessment will be completed when necessary to identify the extent of a member's condition and risk, which will be included in the ICP.

All members will have an ICT (Details in ICT P&P) that is comprised of different professional disciplines that support a members care needs.[14] The primary participants include, but are not limited to, the member and/or their caregiver, PCP and/or specialist, health plan's CM, Medical Director and/or SW, Pharmacist and any additional clinical or ancillary staff such as behavioral health and dietician.

Internal weekly or bi-weekly interdisciplinary rounds are held that include the Concurrent Review team as well as the assigned CM when there is a DSNP member who is in the inpatient setting and requires coordination of care and services for a safe and timely discharge. This is separate from and in addition to the formal ICT meetings that are outlined within the ICP Policy. The CM is required to attend these meetings when appropriate and responsible for documenting any discussions and outcome results within the care management system that may affect the members' outcome. The CM is also responsible for making any adjustments to the ICP when needed and sharing these changes with the ICT membership.

Care Management Program Case Closure

As stated, a member is automatically enrolled and remains in the Care Management Program for the duration of their enrollment in the D-SNP plan. A member's case will only be closed if one of the following occurs:

[14] ECFR.gov: 42 CFR 422.101 (f) (1) (iii); 42 CFR 422.152 (g) (2) (iv)

- The member disenrolls from the health plan
- The member expires

A member may Opt-Out of the Care Management Program, however they will continue to receive care planning with education and monitoring of utilization for assistance with an intervention in transition of care needs and wellness needs (similar to those members who are low risk).

Initial and Annual Training

All staff, both employed and contracted, are required to undergo the D-SNP Model of Care training. This will be done at time of hire and annually. Training will include, but not be limited to, the following:

- Medicare 101
- Coordination of Medicare and Medicaid
- Linguistic and Cultural Sensitivity
- Specialized Tailored Benefits to Meet D-SNP Member Needs
- Care Management Process Overview
- Care Management MOC Requirements (i.e. HRAT, ICP, ICT, etc.)
- Transitions of Care Process
- Quality Improvement Program
- Chronic Care Improvement Program

In addition, the CM will receive initial and annual or as needed training specific to the Model of Care of the D-SNP, which includes but is not limited to the following (also see attachment D-SNP CM Training):

- Full review of benefits and add-on services
- Behavioral health referrals and access to care
- Coordinating Home and Community Based Services; locating resources to address social barriers affecting ability to seek appropriate medical / behavioral health care and close gaps in care, e.g. transportation, food, clothing, housing, etc.
- Coordination with the ICT (physicians, social workers, community support workers, caregiver, etc.) to increase compliance with the plan of care
- The D-SNP Care Management goals
- Health Risk Assessment and Stratification
- Care Plan Development and documentation in the Care Management electronic system
- Evidence-based, nationally recognized guidelines
- D-SNP policies and procedures

- Educational materials for the D-SNP: specific processes and workflows of care management for the program are reviewed as well as evidence-based guidelines

D-SNP Care Management Program Annual Evaluation and Revision

It is the responsibility of the plan's QI Department to perform no less than annually, an evaluation of this Care Management Program. This program is reviewed against its goals and objectives and success in meeting the goals/objectives. Components of the evaluation include:

- **Population Assessment:** Annually, the entire health plan's population characteristics and needs are assessed, resulting in any needed changes to the case management and disease management processes and resources to address the D-SNP member's needs. The population assessment is a component of the Model of Care and Care Management Evaluation, which is performed annually by the plan's Quality Department and staff with oversight by the QI & Accreditation Services Lead. The QM Committee approves the annual evaluation and updates.

  The population data collected and analyzed includes but is not limited to gender, age, language, educational level and geographic location. Utilization data is collected and analyzed for Medicaid/Medicare members in the D- SNP program that identifies the utilization of benefits/services and top 10 diagnoses and/or comorbidities. Sources for data include, but are not limited to HEDIS data, enrollment data, risk management data, utilization management data, grievance and appeals, member feedback (e.g. call center reports, surveys), health risk assessment data, marketing and pharmacy data. Other sources of data may include National Committee for Quality Assurance (NCQA), The State of Healthcare Quality annual report, Center for Disease Control and Prevention (CDC) and Florida's annual health External Quality Review Organization (QRO) report.

- **Measuring Effectiveness:** The D-SNP Care Management Program is evaluated and updated annually by the Director of the D-SNP Care Management, Chief Medical Officer and the D-SNP Medical Director. Annual evaluation and updates are approved by the QM Committee.

  Annually, measures of the D-SNP Care Management effectiveness are identified and analyzed using the following methods:

  - Identifying a relevant process or outcome.
  - Using valid methods that provide quantitative results.
  - Setting a performance goal.
  - Clearly defining measure specifications.
  - Analyzing results.
  - Identifying opportunities for improvement, if applicable.
  - Developing a plan for intervention and re-measurement.

Based on the results of the effectiveness measurement and analyses, at least one intervention to improve the D-SNP Care Management performance is implemented per measurement and a re-measurement is performed, using methods consistent with initial measurements.

Forms

Spanish versions of the following forms are available upon request b contacting the Provider Help Line included in Key Contact List included with this manual.

2021 Coverage Determination Request Form-English

HealthSun
HEALTH PLANS

REQUEST FOR MEDICARE PRESCRIPTION DRUG COVERAGE DETERMINATION

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

Address:
9250 W Flagler St, Suite 600
Miami, FL 33174
Attention: Part D Department

Fax Number: (844) 430-1705

You may also ask us for a coverage determination by phone at (877) 336-2069.

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.

HealthSun complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-877-336-2069. (TTY: 1-877-206-0500). ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-877-336-2069. (TTY: 1-877-206-0500).

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Name of prescription drug you are requesting (if known, include strength and quantity requested per month):

Type of Coverage Determination Request

☐ I need a drug that is not on the plan's list of covered drugs (formulary exception).*

☐ I have been using a drug that was previously included on the plan's list of covered drugs, but is being removed or was removed from this list during the plan year (formulary exception).*

☐ I request prior authorization for the drug my prescriber has prescribed.*

☐ I request an exception to the requirement that I try another drug before I get the drug my prescriber prescribed (formulary exception).*

☐ I request an exception to the plan's limit on the number of pills (quantity limit) I can receive so that I can get the number of pills my prescriber prescribed (formulary exception).*

☐ My drug plan charges a higher copayment for the drug my prescriber prescribed than it charges for another drug that treats my condition, and I want to pay the lower copayment (tiering exception).*

☐ I have been using a drug that was previously included on a lower copayment tier, but is being moved to or was moved to a higher copayment tier (tiering exception).*

☐ My drug plan charged me a higher copayment for a drug than it should have.

☐I want to be reimburse 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)*:

_____

_____

_____

_____

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HealthSun
HEALTH PLANS

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		
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:	

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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 RELAVENT 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**
OPIOIDS – (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**

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H5431_PTDCOVDETREQ022_C_ENG Rev. 12/30/2020

HealthSun
HEALTH PLANS

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 _____

_____

_____

_____

_____

_____

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H5431_PTDCOVDETREQ022_C_ENG Rev. 12/30/2020

2021 B vs D Coverage Determination Form- English

HealthSun HEALTH PLANS

B VS D COVERAGE DETERMINATION FORM

This form may be sent to us by mail or fax:
Address: 9250 W Flagler St, Suite 600 Miami, FL 33174
Fax: (844) 430-1705
You may also ask us for a coverage determination by phone at (877) 336-2069

TODAY'S DATE: _____	**PHYSICIAN NAME:** _____
MEMBER NAME: _____	**PHYSICIAN PHONE:** _____
CARDHOLDER ID: HS# _____	**PHYSICIAN FAX:** _____
MEMBER DATE OF BIRTH: _____	**DIAGNOSIS:** _____

☐ **REQUEST FOR EXPEDITED REVIEW [24 HOURS]**
BY CHECKING EXPEDITED REVIEW BOX, REQUEST WILL BE PROCESSED WITHIN 24 HOURS OF RECEIPT.

Circle name of drug being requested or indicate in "other" if not found, and check **YES** or **NO** to their corresponding question.

ORAL ANTIMETICS:				
CHLORPROMAZINE	GRANSETRON	PROCHLORPERAZINE	Will oral anti-emetic be full replacement for intravenous administration within 48 hours of cancer treatment?	☐ YES ☐ NO
DRONABINOL	ONDANSETRON	ONDANSETRON		
Other: _____ (Please indicate name of other drug)				
ORAL CHEMOTHERAPY:				
ETOPOSIDE	MYLERAN	TREXALL	Is drug being used for cancer treatment?	☐ YES ☐ NO
HYCAMTIN	RHEUMATREX	VEPESID		
METHOTREXATE	SUTENT	ZORTRESS		
	TEMODAR			
Other: _____ (Please indicate name of other drug)				
PROPHYLACTIC VACCINES:				
COMVAX	RABAVERT INJ	TETANUS TOX	Is the vaccines being given to TREAT an injury or direct exposure to a disease or condition?	☐ YES ☐ NO
DIP/TET PED	TENVAC		Will the patient get the vaccine from the pharmacy?	☐ YES ☐ NO
IMOVAX RABIE	TET/DIP TOX		Will the vaccine be administered in a physician office from a physician's supply?	☐ YES ☐ NO
Other: _____ (Please indicate name of other drug)				
HEPATITIS B VACCINE:				
RECOMBIVAX HB	RECOMBIVA-HB		Is the patient at High or Intermediate risk for Hepatitis?	☐ YES ☐ NO
Other: _____ (Please indicate name of other drug)				
IV IMMUNE GLOBULINS:				
ATGAM	GAMMAGARD	GAMUNEX-C	Is the diagnosis primary immune deficiency disease?	☐ YES ☐ NO
CARIMUNE NF	GAMMAPLEX	PRIVIGEN GAMASTAN	Is the drug being administered at the patient's home?	☐ YES ☐ NO
GAMASTAN	GAMUNEX	THYMOGLOBULIN		
Other: _____ (Please indicate name of other drug)				
ESRD:				
ARANESP	SALM/CALCITONIN 200MG/ML		Does the patient have Chronic Kidney Disease stage V (ESRD)?	☐ YES ☐ NO
DOXERCALCIFEROL	CALCITRIOL		Is patient on dialysis?	☐ YES ☐ NO
Other: _____ (Please indicate name of other drug)				
INHALATION DRUGS:				
ACETYLCYSTEINE	IPRATROP/ALBUTEROL	TOBI	Is the drug being used in a nebulizer?	☐ YES ☐ NO
ALBUTEROL	LEVALBUTEROL	TOBRAMYCIN		
BUDESONIDE SOL	NABUPENT	VENTAVIS		
CROMOLYN SOD	PULMICORT	VIRAZOLE		
IPRATROPIUM BROM	PULMOZYME			
Other: _____ (Please indicate name of other drug)			Where will the drug be used? Check a box below ☐ Home ☐ Hospital ☐ SNF Specify _____ ☐ Nursing Home Specify _____	
PARENTERAL NUTRITION:				

AMINOSYN	FREAMINE	NAGLAZYME
CLINIMIX	HEPATASOL	PREMASOL
CLINIMIX E	INTRALIPID	PROCALAMINE
CLINISOL SF	LEVOCARNITINE	PROSOL
DEXTROSE	LIPOSYN II-III	TROPHAMINE

Other: _____ (Please indicate name of other drug

INJECTABLE/INFUSIBLE DRUGS:

ABRAXANE	ELLENCE	MUSTARGEN
ALDURAZYME	EPIRUBICIN	NAGLAZYME
ALIMTA	ERBITUX	NIPENT
AMBISOME	ETOPOSIDE	ONCASPAR
AMPHOTERICIN	FABRAZYME	OXALIPLATIN
ARRANON	FASLODEX	PACLITAXEL
ARZERRA	FIRMAGON	PENTOSTATIN
AVASTIN	FLUDARABINE	PERJETA
BELEODAQ	FLUOROURACIL	PROCAINAMIDE
BICNU	FOLOTYN	PROLASTIN
BLEOMYCIN	FOSCARNET	PROLEUKIN
BUSULFEX	FUSILEV	RITUXAN
CANCIDAS	GANCICLOVIR	SYNERCID
CAPASTAT	GEMCITABINE	TEFLARO
CARBOPLATIN	HALAVEN	TOPOSAR
CEREZYME	HERCEPTIN	TOPOTECAN
CISPLATIN	IDAMYCIN	TORISEL
CYTARABINE	IDARUBICIN	TREANDA
CLOLAR	IFOSFAMIDE	TRELSTAR
COSMEGEN	INTRON A	TRISENOX
CUBICIN	IRINOTECAN	TYGACIL
DOXORUBICIN	ISTODAX	TYSABRI
DACARBAZINE	IXEMPRA	UVADEX
DAUNORUBICIN	JEVTANA	VECTIBIX
DEPO-PROVERA	KEPIVANCE	VELCADE
DEXRAZOXANE	LEUPROLIDE	VINBLASTINE
DOCEFREZ	LEUPROLIDE ACET	VINCASAR
DOCETAXEL	LIDOCAINE	VINCRISTINE
DOXIL	MELPHALAN	VINORELBINE
DOXORUBICIN	METRONIDAZOLE 5 MG/ML	YERVOY
ELAPRASE	MITOMYCIN	ZALTRAP
ELIGARD	MITOXANTRON	ZANOSAR
ELITEK		

Other: _____ (Please indicate name of other drug)

Is the therapy being provided because of a non-functioning digestive tract? ☐ YES ☐ NO

INFUSIBLE DRUGS:

Where will the drug be infused? Check a box below

☐ Home ☐ Hospital ☐ SNF Specify _____ ☐ Nursing Home Specify _____

Is the drug being administered using the infusion pump or an implantable pump? ☐ YES ☐ NO

If medication is infused using another method, please indicate _____

INJECTABLE DRUGS:

Will the patient get the drug from the pharmacy? ☐ YES ☐ NO

Will the drug be administered in a physician's office from a physician's supply? ☐ YES ☐ NO

REQUESTOR'S NAME: _____ REQUESTOR'S SIGNATURE: _____

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H5431_BVSD_ENG_C Rev. 12/30/2020

2021 Grievance Appeal- English

HealthSun
HEALTH PLANS
9250 W Flagler St, Suite 600 Miami, FL 33174
Attn: Grievance and Appeals Department

GRIEVANCE/APPEAL FORM

Last Name: _____ **First Name:** _____ **Middle Initial:** ____

Home Address: _____ **City:** _____ **State** ____ **Zip Code:** _____

Home Telephone: _____ **DOB:** _____ **Member ID:** _____
MM/DD/YYYY *HealthSun ID#*

Medicare ID: _____

Date(s) of Service or Occurrence: _____

Below, please describe the nature of your grievance/appeal and any facts you feel should be considered in the review of your grievance/appeal: (Use additional sheet(s) if necessary. If your grievance/appeal involves unpaid bills, please attach a copy of the bill(s) or a completed claim form).

_____

_____

_____

_____

_____

_____.

REQUEST FOR REVIEW

I HEREBY request a review of the grievance/appeal described above and understand that the receipt of this Grievance/Appeal Form by HealthSun Health Plans (HSHP) constitutes a request for review. I understand that in order for HSHP to review my grievance/appeal, HSHP may need medical or other records or information relevant to my grievance/appeal. Accordingly, I authorize persons or entities that have any medical or other records or knowledge of me to release such information to HSHP in order for HSHP to complete its review of my grievance/appeal. This information will not be released to any other organization or individual except as permitted under Federal and State Law, pursuant to court orders or subpoenas. HSHP has established appropriate safeguards to ensure the privacy and confidentiality of all medical information and to prevent unauthorized access to it.

_____ _____
Member Signature **Date**

I understand that HealthSun Health Plans will contact me within five (5) working days from the date of receipt to acknowledge this grievance/appeal. Your benefits will continue during the course of this grievance /appeal as long as you remain enrolled in HealthSun Health Plans, Inc.

Internal Use Only

Received by: _____ Date/time: _____

☐ By Mail ☐ By Telephone ☐ In Person ☐ Other:_____

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H5431_GRVAPPEALF_C_ENG Rev. 12/30/2020

HealthSun
HEALTH PLANS

Request for Redetermination of Medicare Prescription Drug Denial

Because we HealthSun Health Plans denied your request for coverage of (or payment for) a prescription drug, you have the right to ask us for a redetermination (appeal) of our decision. You have 60 days from the date of our Notice of Denial of Medicare Prescription Drug Coverage to ask us for a redetermination. This form may be sent to us by mail or fax:

Address:
HealthSun Health Plans
Att: Appeals Department
9250 W Flagler St, Suite 600
Miami, FL 33174

Fax Number:
877-589-3256

You may also ask us for an appeal through our website at www.HealthSun.com. Expedited appeal requests can be made by phone at 305-447-4451 or 877-336-2069. TTY user should call 877-206-0500.

Who May Make a Request: Your prescriber may ask us for an appeal on your behalf. If you want another individual (such as a family member or friend) to request an appeal for you, that individual must be your representative. Contact us to learn how to name a representative.

Enrollee's information

Enrollee's Name _____ *Date of Birth* ____/____/_____

Enrollee's Address _____

City _____ *State* _____ *Zip Code* _____

Phone _____

Enrollee's Plan ID Number _____

Complete the following section ONLY if the person making this request is not the enrollee:

Requestor's Name _____

Requestor's Relationship to Enrollee _____

Address _____

City _____ *State* _____ *Zip Code* _____

Phone _____

Representation documentation for appeal requests made by someone other than enrollee or the enrollee's prescriber:

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ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-877-336-2069. (TTY: 1-877-206-0500).

Attach documentation showing the authority to represent the enrollee (a completed Authorization of Representation Form CMS-1696 or a written equivalent) if it was not submitted at the coverage determination level. For more information on appointing a representative, contact HealthSun Health Plans at 305-447-4458 (Toll Free 877-336-2069) or 1-800-Medicare.

Prescription drug you are requesting:

Name of drug: _____ *Strength/quantity/dose:* _____

Have you purchased the drug pending appeal? ☐ Yes ☐ No

If "Yes":
Date Purchased: _____ Amount paid: $ _____ (attach copy of receipt)

Name and telephone number of pharmacy: _____

Prescriber's Information

Name _____

Address _____

City _____ *State* _____ *Zip Code* _____

Office Phone _____ *Fax* _____

Office Contact Person _____

Important Note: Expedited Decisions
If you or your prescriber believe that waiting 7 days for a standard decision could seriously harm your life, health, or ability to regain maximum function, you can ask for an expedited (fast) decision. If your prescriber indicates that waiting 7 days could seriously harm your health, we will automatically give you a decision within 72 hours. If you do not obtain your prescriber's support for an expedited appeal, we will decide if your case requires a fast decision. You cannot request an expedited appeal if you are asking us to pay you back for a drug you already received.

☐ **CHECK THIS BOX IF YOU BELIEVE YOU NEED A DECISION WITHIN 72 HOURS**
If you have a supporting statement from your prescriber, attach it to this request.

Please explain your reasons for appealing. Attach additional pages, if necessary. Attach any additional information you believe may help your case, such as a statement from your prescriber and relevant medical records. You may want to refer to the explanation we provided in the Notice of Denial of Medicare Prescription Drug Coverage.

_____
_____
_____
_____

Signature of person requesting the appeal (member, member's prescriber or representative):

_____ **Date:** _____

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ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-877-336-2069. (TTY: 1-877-206-0500).

H5431_PTD004_C_ ENG Rev. 12/30/2020

2021 Direct Member Reimbursement-English

HealthSun HEALTH PLANS

Medicare Part D Prescription Drug Reimbursement Form

This form can be sent via mail, email or fax:

Mail: PO Box 52077
Phoenix, Arizona 85072-2077

Email: RxPaperClaim_AnthemMEDD@CVSHealth.com **Fax:** (401)-652-1911

Cardholder Information

Cardholder ID #_____

Cardholder Name (*Last, First MI.*)_____

Date of Birth_____ Street Address_____
_____ City_____ State_____ Zip_____

Other Prescription Drug Coverage

1. Is the patient eligible for primary prescription drug coverage from another insurance company? □ Yes □ No
2. If yes, did the patient submit the claim to this other insurance company? *(If yes, include the Explanation of Benefits from the other insurance company.)* □ Yes □ No
3. Did the other insurance company pay as the primary insurer? □ Yes □ No

Pharmacy Information

Pharmacy Name_____ Pharmacy NPI_____

Address_____ Phone _____
City_____ State_____ Zip_____

Physician Information

Name_____ Physician NPI _____

Physician Address_____

Phone _____ City_____ State_____ Zip _____

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H5431_DMR_C_ ENG Rev. 12/30/2020

Prescription Detail

Date of Service _____ Rx #_____NDC _____
Drug Name_____ Qty_____ Day Supply ____
Drug Cost _____

1. Is this a compound Rx? □ Yes □ No
2. Was this prescription filled in a foreign country? □ Yes □ No

Compound Prescriptions Only *(if covered)*

11-digit NDC Number	Ingredient Name	Quantity	Ingredient Cost
		Total Paid by Cardholder	

Medicare Part D Vaccine Claim Only *(If covered)*	Admin Fee_____ Total Paid by Cardholder _____

Requestor's Signature

Signature_____ Date _____

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H5431_DMR_C_ ENG Rev. 12/30/2020

2021 Lost, Damaged, Stolen Medication Form

HealthSun
HEALTH PLANS

LOST/DAMAGED/STOLEN MEDICATION FORM

ALL LOST MEDICATION REQUEST FORMS MUST BE SENT TO RX MEMBER EXPERIENCE AT: RXMEMBEREXPERIENCE@HEALTHSUN.COM PHONE: 877-336-2069 FAX: 877-452-7496

FOR CONTROLLED SUBSTANCES CIII - CV PLEASE ATTACH THE PRESCRIPTION(S) TO THIS FORM.

Member's Information

Name:	Date of Birth:	Sex: F M
ID #		
Phone Number:		
Address:		Apt.#
City:	State:	Zip Code:

Pharmacy Name/Telephone Number: _____

When did member lose medication(s): _____

How did member lose medication(s): (Please describe**)** _____

_____

_____

Prescribing Physician's Information

Dr.		
Address:	City:	State : Zip
Phone: Fax:	Office Contact Name:	

Requestor's Signature: _____ **Date:** _____

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H5431_LMF_C_ENG Rev. 12/30/2020

DRUG NAME	QUANTITY AND DAY SUPPLY	DIRECTIONS

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H5431_LMF_C_ENG Rev. 12/30/2020

2021 Medication Sync Request Form

HealthSun
HEALTH PLANS

MEDICATION SYNC REQUEST FORM

ALL MEDICATION SYNC REQUEST FORMS MUST BE SENT TO PART D RX MEMBER EXPERIENCE AT:
RxMemberExperience@HealthSun.com - **Phone: 877-336-2069 Fax: 877-452-7496**

PLEASE ATTACH THE PRESCRIPTION(S) TO THIS FORM

REMINDER: All previous prescriptions must be discontinued in pharmacy system before processing new attached prescriptions.

Member's Information

Name:	Date of Birth / / Sex F M
ID #	
Requestor's Name (CENTER/PCP OFFICE)	Members Phone Number:
Address:	Apt.#
City: State:	Zip Code:

Name of medications to be synced: _____

_____

_____

_____

Prescribing Physician's Information

Dr.	
Address	City State Zip
Phone: Fax #	Office Contact Name:

Requestor's Signature: _____ **Date:** _____

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H5431_MSRF_C_ENG Rev. 12/29/2020

FORM APPROVED OMB NO 0938-1269
Expiration 2/28/2022

HealthSun HEALTH PLANS

HOSPICE INFORMATION FOR MEDICARE PART D PLANS

SECTION I -HOSPICE INFORMATION TO OVERRIDE AN "HOSPICE A3 REJECT" OR TO UPDATE HOSPICE STATUS

A. Purpose of the form (please check all appropriate boxes):

Admission ☐ **Proactive Rx Communication** ☐ **A3 Reject Override** ☐ **Termination** ☐

To: Medicare Part D Plan		From: Hospice Provider Information	
Plan Name	HealthSun Health Plans	Hospice Name	
PBM Name	IngenioRx	Address	
Phone #	(877) 336-2069	Phone #	( ) -
Fax #	(844) 430-1705	Fax #	( ) -
		NPI	
Contact Name	Part D Services Department	Contact Name	

Plan Sponsor Website Link: www.HealthSun.com

B. Patient Information		Prescriber Information	
Patient Name		Prescriber Name	
Patient DOB		Prescriber NPI	
Patient ID # (HICN)		Name	
Hospice Admit Date		Address	
Hospice Discharge Date		Contact Name	
Principal Diagnosis Code		Phone Number	( ) -
Other Diagnosis Code (s)		Fax #	( ) -
Unrelated Diagnosis Code (s)		Hospice Affiliated YES ☐ NO ☐	

For change in hospice status update documentation is required. Please check to indicate which document is attached.
Notice of Election ☐ Notice of Termination /Revocation ☐

C. Hospice Pharmacy Benefit Manager (PBM) Information

PBM Name		BIN		Cardholder ID	
Phone #	( ) -	PCN		Group ID	

D. Prior Authorization Process: Enter a separate line for each Analgesic, Antinauseant (antiemetic), Laxative, and Antianxiety drug (anxiolytic) Medication that is **Unrelated** to Terminal Prognosis . Drugs outside of these four classes do not require prior authorization.

Medication Name and Strength	Dosing Schedule	Quantity/ Month	Rationale to Support the Medication is Unrelated to Terminal Prognosis (Optional)

E. Signature of Hospice Representative or Prescriber (Required).

Representative _____ Date__/__/____

Title _____

Prescriber* _____ Date____/____/_____

* If the prescriber of the medication is unaffiliated with the Hospice provider, has the prescriber confirmed with the Hospice provider that the medication is unrelated to the terminal prognosis? Yes ☐ No ☐

1

SECTION II – PLAN OF CARE
(Optional)

Hospice Name		Hospice NPI	

Patient Name		Patient ID# (HICN)		Patient DOB	/ /

Additional Medications Under Hospice Plan of Care and Designation of Financial Responsibility					
Medication Name and Strength	Hospice	Patient	Medication Name and Strength	Hospice	Patient
	☐	☐		☐	☐
	☐	☐		☐	☐
	☐	☐		☐	☐
	☐	☐		☐	☐
	☐	☐		☐	☐
	☐	☐		☐	☐
	☐	☐		☐	☐
	☐	☐		☐	☐
	☐	☐		☐	☐
	☐	☐		☐	☐

Signature of Hospice Representative

Representative _____ Date____/_____/_____

Signature of Beneficiary or Beneficiary Authorized Representative

Beneficiary/Representative _____ Date____/_____/____

H5431_HPA&POC_C_ENG Rev. 12/24/2020

HealthSun
HEALTH PLANS

VACATION REQUEST FORM

ALL VACATION REQUEST FORMS MUST BE SENT TO THE RX MEMBER EXPERIENCE DEPARTMENT AT: RXMEMBEREXPERIENCE@HEALTHSUN.COM PHONE: 877-336-2069. FAX: 877-452-7496

FOR CONTROLLED SUBSTANCES CIII - CV PLEASE ATTACH THE PRESCRIPTION(S) TO THIS FORM.

Member's Information

Name:	Date of Birth: Sex: F M
ID #	
Requestor's Name (CENTER/PCP OFFICE)	Members Phone Number:
Address: Apt.#	
City: State: Zip Code:	

►WILL BE AUTHORIZED TWO WEEKS PRIOR TO MEMBERS DEPARTURE DATE ◄

When is member leaving on vacation: _____

Length of vacation (Vacation supplies cannot exceed 90 days) _____

Pharmacy Name/Telephone Number: _____

Prescribing Physician's Information

Dr.	
Address:	City: State: Zip:
Phone # Fax #	Office Contact Name:

Requestor's Signature: _____ **Date:** _____

HealthSun complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-877-336-2069. (TTY: 1-877-206-0500). ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-877-336-2069. (TTY: 1–877-206-0500).
H5431_VSF_C_ENG Rev. 12/30/2020

HealthSun
HEALTH PLANS

DRUG NAME	QUANTITY AND DAY SUPPLY	DIRECTIONS

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H5431_VSF_C_ENG Rev. 12/30/2020

2021 D-SNP MOC Training and General Compliance Attestation

Dual Eligible Special Needs Plan (D-SNP) Model of Care Training & Medicare Compliance Program Guidelines Annual First Tier[1] Attestation

The Centers for Medicare & Medicaid Services (CMS) requires all contracted medical providers and staff to receive basic training about the Special Needs Plans (SNP) Model of Care. Additionally, per the provisions of the Agency for Health Care Administration (AHCA) Contract[2], HealthSun is required to provide training to network providers to ensure its enrolled dual eligible members receive the appropriate benefits and services.

This training and completion of an attestation are required for new providers and annually thereafter.

As a HealthSun provider, you are required to complete HealthSun's Dual Eligible Special Needs Plans (D-SNP) Model of Care (MOC) training upon on-boarding, and annually thereafter. In addition, you must be in compliance with the Compliance Program and Fraud, Waste and Abuse Education requirements. These requirements are combined for you in this single attestation. Upon completion of this attestation, please submit the form via email to HealthSun Provider Relations Department at providerservices@healthsun.com, or via Fax 305-489-8110.

I. **HealthSun D-SNP-MOC**
This attestation confirms you or your organization completed the HealthSun's Dual Eligible Special Needs Plans (D-SNPs) Model of Care (MOC) Training[3] and adhere to the requirements of the HealthSun's D-SNP MOC

II. **Compliance and Program and Fraud Waste and Abuse (FWA) Training and Education Requirements**
This attestation confirms your commitment to comply with the following CMS requirements:

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[1] *First Tier Entity is any party that enters into a written arrangement, acceptable to CMS, with an MAO or Part D plan sponsor or applicant to provide administrative services or health care services to a Medicare eligible individual under the MA program or Part D program.*

[2] *"AHCA Contract" means the agreement between HealthSun Health Plans, Inc. and AHCA for the purpose of providing and paying for Medicare Advantage Dual Eligible Special Needs Plan (D-SNP) Medicaid Covered Services to Members.*

[3] *The HealthSun D-SNP Model of Care Training is available on the HealthSun's Website and Provider Portal.*

1. **Code of Conduct and/or Compliance Policies**
   My organization has a Code of Conduct and/or Compliance Program Policies that explain our commitment to comply with federal and state laws, ethical behavior and compliance program operation. The Code of Conduct and or Compliance Policies are distributed to employees within ninety (90) days of hire, upon revision and annually thereafter.

2. **US Department Health & Human Services Office of Inspector General (OIG) and General Services Administration's System for Award Management (SAM) exclusion screening.**
   My organization screens the OIG[4] and the SAM[5] exclusion lists prior to hire or contracting, and monthly thereafter, for all employees and downstream entities. My organization immediately removes any person/entity from working on HealthSun's Medicare business if found on either of these lists, and we will notify HealthSun right away.

3. **Reporting Mechanisms**
   My organization communicates to employees how to report suspected or detected non-compliance or potential Fraud, Waste, or Abuse, and that it is their obligation to report without fear of retaliation or intimidation against anyone who reports in good faith. My organization requests employees to report concerns and maintains confidential and anonymous mechanisms for employees to report internally. In turn, we (our organization) will report these concerns to HealthSun as applicable.

4. **Offshore Operations**
   If my organization and/or our downstream entities perform work that involves the receipt, processing, transferring, handling, storing or accessing of Protected Health Information (PHI) offshore, my organization understands and acknowledges that we will not, in connection with any functions, activities or services related to HealthSun's business, perform any work outside of the United States.

5. **Downstream entity oversight (*please mark as appropriate for your organization)***
   - ☐ *My organization **does not contract** downstream entities or uses downstream* entities for HealthSun business.
   - ☐ My organization ***contracts with downstream entities*** to conduct HealthSun business and conducts oversight to ensure that they abide by all laws, rules and regulations that apply to us as a first tier entity. This includes ensuring that my organization's:
     - Contractual agreements with downstream entities contain all CMS required provisions.
     - Downstream entities comply with the Medicare Compliance Program requirements described in this attestation.

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[4] *https://exclusions.oig.hhs.gov*

[5] *https://www.sam.gov/SAM/*

- Downstream entities comply with any applicable Medicare operational requirements.

6. **Operational Oversight**
   My organization conducts internal oversight of the services that we perform for HealthSun and ensure compliance is maintained with applicable laws, rules and regulations including CMS regulatory/sub-regulatory guidance.

7. **Record Retention**
   My organization maintains supporting documentation and records for a period of 10 years in accordance to federal and HealthSun contract requirements after training completion for all employees supporting HealthSun's business, and can furnish the documentation upon request. (*Samples of documentation may include and it is not limited to FWA, General Compliance training, OIG/GSA Exclusion documentation, monitoring/audit records).*

Attestation

I hereby certify that I am an authorized representative of the Provider/Physician named below and the statements above made are true and correct to the best of my knowledge.

Name of Provider/FDR/Organization	
Tax ID/ Employer ID	
Name of Authorized Representative	
Authorized Representative Title	
Signature of Authorized Representative	
Date	

Please complete this section below:

Name of MSO/Group/Practice:

_____

Name of Practitioner/Provider/Staff Member	Rendering NPI Number (as applicable)

Please submit this attestation form via email to HealthSun's Provider Relations Department at providerservices@healthsun.com or via Fax 305-489-8110.

H5431_PO_DSNP_ProviderTrainingAttestation_Rev.102020

3

2021 Preclusion Attestation

Healthsun Health Plans, Inc. Medicare
Attestation for Preclusion List

I, *<insert full name>* as the *<insert title>* of *<vendor name>* certify as an authorized representative that to the best of my knowledge we have reviewed the Preclusion list received for *<insert month and year>* and attest to the following (please check appropriate box and complete as necessary):

- ☐ No providers from the Network of *<vendor name>* were found on the exclusion list for the month/year cited above
- ☐ Provider(s) from the network of *<vendor name>* were identified on the list and *<insert # of members impacted>* members were impacted and communication was sent on *<insert date communication was sent>*. Provider (s) have been terminated from the network.

Sincerely,

_____ _____
Signature Date

_____
Print Name

_____ _____
Title Organization Mailing Address

Medicare Preclusion List Attestation - 2020

HealthSun
HEALTH PLANS

Request for Redetermination of Medicare Prescription Drug Denial

Because we HealthSun Health Plans denied your request for coverage of (or payment for) a prescription drug, you have the right to ask us for a redetermination (appeal) of our decision. You have 60 days from the date of our Notice of Denial of Medicare Prescription Drug Coverage to ask us for a redetermination. This form may be sent to us by mail or fax:

Address:
HealthSun Health Plans
Att: Appeals Department
3250 Mary Street, Suite 400
Coconut Grove, Florida 33133

Fax Number:
877-589-3256

You may also ask us for an appeal through our website at www.HealthSun.com. Expedited appeal requests can be made by phone at 305-447-4451 or 877-336-2069. TTY user should call 877-206-0500.

Who May Make a Request: Your prescriber may ask us for an appeal on your behalf. If you want another individual (such as a family member or friend) to request an appeal for you, that individual must be your representative. Contact us to learn how to name a representative.

Enrollee's information

Enrollee's Name _____ *Date of Birth* ____/____/_____

Enrollee's Address _____

City _____ *State* _____ *Zip Code* _____

Phone _____

Enrollee's Plan ID Number _____

Complete the following section ONLY if the person making this request is not the enrollee:

Requestor's Name _____

Requestor's Relationship to Enrollee _____

Address _____

City _____ *State* _____ *Zip Code* _____

Phone _____

Representation documentation for appeal requests made by someone other than enrollee or the enrollee's prescriber:

1

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H5431_2017PTD004_ENG

Attach documentation showing the authority to represent the enrollee (a completed Authorization of Representation Form CMS-1696 or a written equivalent) if it was not submitted at the coverage determination level. For more information on appointing a representative, contact HealthSun Health Plans at 305-447-4458 (Toll Free 877-336-2069) or 1-800-Medicare.

Prescription drug you are requesting:

Name of drug: _____ *Strength/quantity/dose:* _____

Have you purchased the drug pending appeal? ☐ Yes ☐ No

If "Yes":
Date Purchased: _____ Amount paid: $ _____ (attach copy of receipt)

Name and telephone number of pharmacy: _____

Prescriber's Information

Name _____

Address _____

City _____ *State* _____ *Zip Code* _____

Office Phone _____ *Fax* _____

Office Contact Person _____

Important Note: Expedited Decisions
If you or your prescriber believe that waiting 7 days for a standard decision could seriously harm your life, health, or ability to regain maximum function, you can ask for an expedited (fast) decision. If your prescriber indicates that waiting 7 days could seriously harm your health, we will automatically give you a decision within 72 hours. If you do not obtain your prescriber's support for an expedited appeal, we will decide if your case requires a fast decision. You cannot request an expedited appeal if you are asking us to pay you back for a drug you already received.

☐ **CHECK THIS BOX IF YOU BELIEVE YOU NEED A DECISION WITHIN 72 HOURS**
If you have a supporting statement from your prescriber, attach it to this request.

Please explain your reasons for appealing. Attach additional pages, if necessary. Attach any additional information you believe may help your case, such as a statement from your prescriber and relevant medical records. You may want to refer to the explanation we provided in the Notice of Denial of Medicare Prescription Drug Coverage.

_____
_____
_____
_____

Signature of person requesting the appeal (member, member's prescriber or representative):

_____ **Date:** _____

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H5431_2017PTD004_ENG

2021 Appointment of Representative

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

Form Approved OMB No.0938-0950

Appointment of Representative

Name of Party	Medicare Number (beneficiary as party) or National Provider Identifier (provider or supplier as party)

Section 1: Appointment of Representative

To be completed by the party seeking representation (i.e., the Medicare beneficiary, the provider or the supplier):
I appoint this individual, _____, to act as my representative in connection with my claim or asserted right under Title XVIII of the Social Security Act (the Act) and related provisions of Title XI of the Act. I authorize this individual to make any request; to present or to elicit evidence; to obtain appeals information; and to receive any notice in connection with my claim, appeal, grievance or request wholly in my stead. I understand that personal medical information related to my request may be disclosed to the representative indicated below.

Signature of Party Seeking Representation		Date
Street Address		Phone Number (with Area Code)
City	State	Zip Code
Email Address (optional)		

Section 2: Acceptance of Appointment

To be completed by the representative:
I, _____, hereby accept the above appointment. I certify that I have not been disqualified, suspended, or prohibited from practice before the Department of Health and Human Services (HHS); that I am not, as a current or former employee of the United States, disqualified from acting as the party's representative; and that I recognize that any fee may be subject to review and approval by the Secretary.
I am a / an _____
(Professional status or relationship to the party, e.g. attorney, relative, etc.)

Signature of Representative		Date
Street Address		Phone Number (with Area Code)
City	State	Zip Code
Email Address (optional)		

Section 3: Waiver of Fee for Representation

Instructions: This section must be completed if the representative is required to, or chooses to, waive their fee for representation. (Note that providers or suppliers that are representing a beneficiary and furnished the items or services may not charge a fee for representation and **must** complete this section.)
I waive my right to charge and collect a fee for representing _____ before the Secretary of HHS.

Signature	Date

Section 4: Waiver of Payment for Items or Services at Issue

Instructions: Providers or suppliers serving as a representative for a beneficiary to whom they provided items or services must complete this section if the appeal involves a question of liability under section 1879(a)(2) of the Act. (Section 1879(a)(2) generally addresses whether a provider/supplier or beneficiary did not know, or could not reasonably be expected to know, that the items or services at issue would not be covered by Medicare.) I waive my right to collect payment from the beneficiary for the items or services at issue in this appeal if a determination of liability under §1879(a)(2) of the Act is at issue.

Signature	Date

Charging of Fees for Representing Beneficiaries before the Secretary of HHS

An attorney, or other representative for a beneficiary, who wishes to charge a fee for services rendered in connection with an appeal before the Secretary of HHS (i.e., an Administrative Law Judge (ALJ) hearing or attorney adjudicator review by the Office of Medicare Hearings and Appeals (OMHA), Medicare Appeals Council review, or a proceeding before OMHA or the Medicare Appeals Council as a result of a remand from federal district court) is required to obtain approval of the fee in accordance with 42 CFR 405.910(f).

The form, "Petition to Obtain Representative Fee" elicits the information required for a fee petition. It should be completed by the representative and filed with the request for ALJ hearing, OMHA review, or request for Medicare Appeals Council review. Approval of a representative's fee is not required if: (1) the appellant being represented is a provider or supplier; (2) the fee is for services rendered in an official capacity such as that of legal guardian, committee, or similar court appointed representative and the court has approved the fee in question; (3) the fee is for representation of a beneficiary in a proceeding in federal district court; or (4) the fee is for representation of a beneficiary in a redetermination or reconsideration. If the representative wishes to waive a fee, he or she may do so. Section III on the front of this form can be used for that purpose. In some instances, as indicated on the form, the fee **must** be waived for representation

Approval of Fee

The requirement for the approval of fees ensures that a representative will receive fair value for the services performed before HHS on behalf of a beneficiary, and provides the beneficiary with a measure of security that the fees are determined to be reasonable. In approving a requested fee, OMHA or Medicare Appeals Council will consider the nature and type of services rendered, the complexity of the case, the level of skill and competence required in rendition of the services, the amount of time spent on the case, the results achieved, the level of administrative review to which the representative carried the appeal and the amount of the fee requested by the representative.

Conflict of Interest

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

Where to Send This Form

Send this form to the same location where you are sending (or have already sent) your: appeal if you are filing an appeal, grievance or complaint if you are filing a grievance or complaint, or an initial determination or decision if you are requesting an initial determination or decision. If additional help is needed, contact 1-800-MEDICARE (1-800-633-4227) or your Medicare plan. TTY users please 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 believe you've been discriminated against. Visit https://www.cms.gov/about-cms/agency-Information/aboutwebsite/cmsnondiscriminationnotice.html, or call 1-800-MEDICARE (1-800-633-4227) for more information.

Form CMS-1696 (Rev 08/18)

2021 Model Waiver of Liablility Statement

Waiver of Liability Statement

Enrollee's Name	Enrollee ID Number
Provider	Dates of Service
Health Plan	

I hereby waive any right to collect payment from the above-mentioned enrollee for the aforementioned services for which payment has been denied by the above-referenced health plan. I understand that the signing of this waiver does not negate my right to request further appeal under 42 CFR §422.600.

Signature	Date


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