2024 PROVIDER MANUAL

Renaissance Physicians

CARE THAT REVOLVES AROUND YOU.

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RENAISSANCE PHYSICIANS IS HERE FOR YOU

Renaissance Physicians is a physician-run organization with local groups of primary care physicians (PCPs) and a full specialist network. The goal is to grow and maintain a highly desired managed health care delivery system in which the IPA accepts responsibility for a wide range of medical services, including primary care, specialty care, laboratory, part B drugs, and diagnostic procedures.

Renaissance Physicians encourages the PCP to take the lead on coordinating care both of a preventive nature as well as chronic conditions with collaborative engagement from preferred specialist network. Due to the vast geography of the IPA, providers are grouped into a geographic networks called a POD (Physician Organized Delivery systems) centralized around a group of hospitals with full set of PCPs and Specialists who have enhanced relationships and aligned incentives. Providers work together to coordinate the care of the patient and make the navigation of healthcare easier.

This manual contains the operating policies and procedures of the IPA as well as health plan references as they relate to the day-to-day participating physicians and their patients. The IPA requires continual communication between the physicians and the management company, CareAllies, to ensure a consistent working relationship and timely notification of any and all practice related changes. You will receive updates to this manual as changes to the policies and procedures occur.

Renaissance Physicians

- Non-profit corporation
- Renaissance contracts with health plans
- Renaissance contracts with LLCs and providers
- City-wide specialty panel
- Board comprised of PCPs and Specialists
- Physician owned and led

Advantages of Renaissance

- One integrated contracting unit
- Physicians/providers set metrics and performance standards
- Ability to contract with PPOs through Clinically Integrated Network
- City-wide specialty network
- Superior physician satisfaction
- Greater physician-involvement and best practice sharing
- Aligned incentives with engaged management company

Renaissance Commitment

- Focus on greater Houston and Golden Triangle market
- Partnerships with health plans that benefit providers
- Point of service resources to supplement offices for quality
- Proactive provider education and process improvement strategies

- Robust group and physician level reporting
- Ongoing physician and staff education

Value Based Reimbursement
- Value based capitation rates for PCPs
- Competitive specialty capitation contracts
- Specialist True Ups
- Surplus funds distributed based on quality and total medical cost achievements to at risk providers
- Disciplined regular reimbursement review

Duties of Renaissance
- Maintains Ultimate financial risk
- Credentialing
- Utilization/Quality management
- Creation of guiding principles
- Contracting and Physician reimbursement
- Financial reserve discipline

Duties of LLC
- Provider network development
- Management of LLC utilization
- Communication and engagement of network
- Provider and Patient Satisfaction
- Problem resolution

PHYSICIAN RIGHTS AND RESPONSIBILITIES

Physician Rights:

- IPA encourages your feedback and suggestions on how service may be improved within the organization.
- If an acceptable patient-physician relationship cannot be established with an IPA patient who has selected you as his/her Primary Care Physician, you may request that IPA have that patient removed from your care.
- You may request claims reconsideration on any claims submissions in which you feel are not paid according to payment policy.
- You may request an appeal on any claims submission in which you feel are not paid in keeping with the level of care rendered or clinical guidelines.

Physician Responsibilities:

- You have agreed to treat all IPA patients the same as all other patients in your practice, regardless of the type or amount of reimbursement.
- Primary Care Physicians must provide continuous 24 hours, 7 days a week access to care for Health Plan patients. During periods of unavailability or absence from the practice, you must arrange coverage for your members. Please notify the IPA of the physician who is providing coverage for your practice.
- Primary Care Physicians shall use best efforts to provide patient care to new patients within three (3) months of enrollment with IPA.
- Primary Care Physicians shall use best efforts to provide follow-up patient care to patients that have been in the hospital setting within three 3 days of hospital discharge.
- Primary Care Physicians are responsible for the coordination of routine preventive care along with any ancillary services that need to be rendered with authorization.
- All providers are required to code to the highest level of specificity necessary to describe a patient's acuity level. All coding should be conducted in accordance with CMS guidelines and all applicable state and federal laws.
- All providers are required to actively promote and participate in all quality initiatives inclusive of any and all chart audits, patient preventive care, and patient satisfaction activities.
- Specialists must provide specialty services upon referral from the Primary Care Physician and work closely with the referring physician regarding the treatment the patient is to receive. Specialists must also provide continuous 24 hour, 7 days a week access to care for patients.
- Specialists are required to coordinate the referral process (i.e. obtain authorizations) for further care that they recommend. This responsibility does not revert back to the Primary Care Physician while the care of the patient is under the direction of the Specialist.
- In the event you are temporarily unavailable or unable to provide patient care or referral services to an IPA patient, you must arrange for another IPA physician to provide such services on your behalf. This coverage cannot be provided by an Emergency Room. For capitated physicians, the covering physician must agree to

seek payment for services rendered to your patients from you only, but submit an encounter to the IPA with proper notation for covering services.

- You have agreed to treat Participating Health Plan's patients the same as all other patients in your practice, regardless of the type or amount of reimbursement.
- You have agreed to provide continuing care to participating patients.
- You have agreed to utilize IPA participating physicians/facilities when services are available and can meet your patient's needs. Approval prior to referring outside of the contracted network of providers may be required.
- You have agreed to participate in IPA's peer review activities as they relate to the Quality Management/Utilization Review program.
- You have agreed to allow IPA Inpatient Managers to follow your patients in the hospital and other inpatient settings.
- You may not balance bill a patient for providing services that are covered by IPA. This excludes the collection of standard copays. You may bill a patient for a procedure that is not a covered benefit if you have followed the appropriate procedures outlined in the "Claims" section of this manual.
- You have agreed to provide the IPA Encounter Data for all services outlined in the "Encounter Data" section of this manual. Such data must be received within 95 days from the date of service. Any data received after 95 days will not be included in true-up or any other financial calculations.
- All claims must be received within 95 days from the date of service or the timeframe specified in your contract.
- Adoption and usage of portals and software applications available to physicians for quality and cost management as well as care coordination.

Patient Request for Patient Transfer

The providers in the IPA strive to promote the health and wellness of the patients in managed care plans through participation in a quality, comprehensive, preventive, and therapeutic health care delivery system.

A strong physician/patient relationship is one of the most important factors necessary to accomplish that mission. When there is a breakdown in the patient/physician relationship, it may be in the best interest of all concerned to have the patient transfer to another provider. Having an expedient process for handling such requests, and effecting transfers when appropriate, should have a positive impact on both patient satisfaction and provider morale.

The requesting provider needs to take the appropriate steps to ensure that the transferring patient has continued access to care during the transitional period.

Procedure

A provider may request to have a patient transfer to another provider due to the following behaviors:

• Fraudulent use of services or benefits.
• Threats of physical harm to a provider or office staff.
• Non-payment of required copay for services rendered.

• Receipt of prescription medications or health services in a quantity or manner, which is not medically beneficial or medically necessary.
• Refusal to accept a treatment or procedure recommended by the provider. If refusal is incompatible with the continuation of the patient/physician relationship, the provider should indicate if he/she believes that no professionally acceptable alternative treatment or procedure exists.
• Repeated refusal to comply with office procedures essential to the functioning of the provider's practice or to accessing benefits under the managed care plan
• Other behavior that has resulted in serious disruption of the patient/ physician relationship.
• The provider should make reasonable efforts to address patient behavior that has an adverse impact on the patient/physician relationship, through education and counseling, and, if medically indicated, referral to appropriate specialists. Such efforts, including efforts to educate the patient regarding office procedures and treatment recommendations, should be carefully documented. A sample letter to address patient education is provided.

A provider who wants to request that a patient transfer to the care of another provider should submit the following to the IPA office:
• Completed form: Physician Requests Transfer of Patient from Panel
• Attach all supporting documentation indicating efforts that have been made to counsel/educate the patient on the importance of being compliant (i.e., letter to patient, medical records, chart notes, documentation of missed appointments, and calls/reminders to the patient).
• Send the form and all supporting documentation to the Provider Relations Representative of the IPA.
• The IPA Medical Advisor reviews all provider requests for adequacy and appropriateness.

The IPA forwards provider requests to the managed care plan for action. The IPA office logs and tracks the provider requests and follows up once a week with the managed care plan.

During the period the provider's request is being processed by the IPA/managed care plan, the provider should continue to provide care to the patient. It is expected that the managed care plan will respond to a provider's request within seven (7) calendar days of receipt. The provider should be aware that the managed care plan may share the provider's request/documentation with the affected patient. If the managed care plan is not able to salvage the relationship, the IPA will be notified. At that time, the requesting provider may, if they choose, notify the patient in writing of thirty (30) day notice to select another provider in accordance with State law.

Generally, it is the responsibility of the managed care plan to send the patient notice that he or she must transfer to another provider. It is expected that the managed care plan will send a copy of such notice to both the IPA and the requesting provider. The IPA expects the managed care plan to instruct the patient to select a new provider within thirty (30) days of receiving the notice (transitional period).

The requesting physician must provide care to the patient during the thirty (30) day transitional period. When the patient selects a new provider, the managed care plan will promptly inform the requesting provider so proper measures can be made to complete the transfer process. If the

patient fails to pick a new provider after the thirty (30) day transitional period, the managed care plan will assign the patient to a new provider.

PHYSICIAN REQUESTS TRANSFER OF MEMBER FROM PANEL

Physician Name: _____ **POD:** _____

The member referenced below is not following the accepted standards set by our office in order to maintain an effective treatment plan or a satisfactory patient/physician relationship. The information below is provided so that the Health Plan can notify the member of such termination request advising his/her to select a new Primary Care Physician.

MEMBER NAME: _____ **ID#** _____

HEALTH PLAN: Renaissance Physicians (RP)

This member has displayed the following behavior:

___ Fraudulent use of services or benefits.

___ Threats of physical harm to a physician or his or her office staff.

___ Non-payment of required co-payment for services rendered.

___ Receipt of prescription medications or health services in a quantity or manner which is not medically beneficial or not medically necessary.

___ Refusal to accept a treatment or procedure recommended by the physician, if such refusal is incompatible with the continuation of the patient/physician relationship. The physician should also indicate if he or she believes that no professionally acceptable alternative treatment or procedure exists.

___ Repeated refusal to comply with office procedures essential to the functioning of the physician's practice or to accessing benefits under the managed care plan.

___ Other behavior which has resulted in serious disruption of the patient/physician relationship.

COMMENTS TO SUBSTANTIATE THE ABOVE BEHAVIOR:

_____

_____

DATE(S) MEMBER WAS COUNSELED/EDUCATED: _____

_____

SUPPORTING DOCUMENTATION MUST BE ATTACHED TO SUBSTANTIATE THAT THE MEMBER WAS COUNSELED/EDUCATED ON THE ISSUES DESCRIBED ABOVE. (i.e., medical records, chart notes, incident reports, that documents the member was called and reminded of the appointment; documentation of no shows; documentation of recommended treatment plan, counseled, etc.)

The above member has been counseled and educated and there has not been any improvement or progress. It is necessary for this member to be removed from my panel and to seek medical services elsewhere. I will continue to provide treatment for 30-45 days to allow the Health Plan to assist the member in the selection of another PCP.

SIGNATURE OF REQUESTING PCP: _____

TYPE OR PRINT NAME: _____

DATE: _____

COUNSELING/EDUCATION LETTER TO MEMBER

DATE

Name
Address
City, State Zip

RE: Patient Name
ID#:

Dear

As your primary care physician, my goal is to advocate and support activities which contribute to your health and wellness. This can be accomplished through a partnership with you in a patient/physician relationship that is based on mutual trust, cooperation and adherence to accepted office procedure.

It has been brought to my attention that this relationship has been threatened by the following:

_____

_____

_____

This behavior is unacceptable and will not be tolerated. The accepted office policy(s)/procedure(s) are:

_____

_____

_____

Unless you are willing to correct this behavior, I will have no choice but to request that you be removed from my panel. A response is requested from you within 14 days of receipt of this letter.

Sincerely,
PCP

Closing Patient Panels

When a participating Primary Care Physician elects to stop accepting new patients, the provider's patient panel is considered closed. If a participating Primary Care Physician closes his or her patient panel, the decision to stop accepting new patients must apply to all patients regardless of insurance coverage. Providers may not discriminate against patients by closing their patient panels for IPA's patients only, nor may they discriminate among patients by closing their panel to certain product lines. Providers who decide that they will no longer accept any new patients must notify the Network Management Department, in writing, at least 60 days before the date on which the patient panel will be closed or the time frame specified in your contract.

Medical Record Standards

The IPA requires the following items in patient medical records:

- Identifying information of the patient.
- Identification of all providers participating in the patient's care and information on services furnished by these providers.
- A problem list, including significant illnesses and medical and psychological conditions.
- Presenting complaints, diagnoses, and treatment plans.
- Prescribed medications, including dosages and dates of initial or refill prescriptions.
- Information on allergies and adverse reactions (or a notation that the patient has no known allergies or history of adverse reactions).
- Information on advanced directives.
- Past medical history, physical examinations, necessary treatments, and possible risk factors for the patient relevant to the particular treatment.

Note: Unless otherwise specifically stated in your provider services agreement. Medical records shall be provided at no cost to IPA and IPA patients.

Access and Availability Standards for Providers

- A Primary Care Physician (PCP) must have their primary office open to receive patients at least 20 hours per week.
- The PCP must ensure that coverage is available 24 hours a day, seven days a week.
- PCP offices must be able to schedule appointments for patients at least two (2) months in advance of the appointment.
- A PCP must arrange for coverage during absences with another participating provider in an appropriate specialty, which is documented on the Provider Application and agreed upon in the Provider Agreement.

Primary Care Access Standards

Appointment Type	Access Standard
Urgent	Immediately
Non-Urgent/Non-Emergent	Within one (1) week
Routine and Preventive	Within 30 Business Days
On-Call Response (After Hours)	Within 30 minutes for emergency
Waiting Time in Office	30 minutes or less

Specialist Access Standards

Appointment Type	Access Standard
Urgent	Immediately
Non-Urgent/Non-Emergent	Within one (1) week
Elective	Within 30 days
High Index of Suspicion of Malignancy	Less than seven (7) days
Waiting time in office	30 minutes or less

Behavioral Health Access Standards

Appointment Type	Access Standard
Emergency	Within 6 hours of the referral
Urgent/Symptomatic	Within 48 hours of the referral
Routine	Within ten (10) business days of the referral*

After-hours Access Standards
All participating providers must return telephone calls related to medical issues. Emergency calls must be returned within 30 minutes of the receipt of the telephone call. Non-emergency calls should be returned within a 24-hour time period. A reliable 24 hours a day/7 days a week answering service with a beeper or paging system and on-call coverage arranged with another participating provider of the same specialty is preferred.

Plan Notification Requirements for Providers

Participating providers must provide written notice to the IPA no less than 60 days in advance of any changes to their practice or, if advance notice is not possible, as soon as possible thereafter.

The following is a list of changes that must be reported to the IPA and Provider Customer Service:

- Practice address
- Billing address
- Fax or telephone number
- Hospital affiliations
- Practice name
- Providers joining or leaving the practice (including retirement or death)
- Provider taking a leave of absence
- Practice mergers and/or acquisitions
- Adding or closing a practice location
- Tax Identification Number (please include W-9 form)
- NPI number changes and additions
- Changes in practice office hours, practice limitations, or gender limitations

By providing this information in a timely manner, you will ensure that your practice is listed correctly in the Provider Directory.

Please note: Failure to provide up to date and correct information regarding demographic information regarding your practice and the physicians that participate may result in the denial of claims for you and your physicians.

Provision of Health Care Services

Participating providers shall provide health care services to all patients, consistent with the

benefits covered in their policy, without regard to 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, source of payment, or any other bases deemed unlawful under federal, state, or local law.

Participating providers shall provide covered services in a culturally competent manner to all patients by making a particular effort to ensure those with limited English proficiency or reading skills, diverse cultural and ethnic backgrounds, and physical or mental disabilities receive the health care to which they are entitled. Examples of how a provider can meet these requirements include but are not limited to: translator services, interpreter services, teletypewriters or TTY (text telephone or teletypewriter phone) connection.

IPA offers interpreter services and other accommodations for the hearing- impaired. Translator services are made available for non-English speaking or Limited English Proficient (LEP) patients. Providers can call IPA customer service at 832-553-3300 to assist with translator to TTY services if these services are not available in their office location.

PROVIDER INFORMATION

The IPA recognizes Family Medicine, General Practice, Geriatric Medicine, and Internal Medicine physicians as Primary Care Physicians (PCPs). Any employed mid-level practitioners rendering services must be listed on contracts and will not be assigned patients but will have data aggregated at their level for purposes of reporting.

The IPA may recognize Infectious Disease Physicians as PCPs for patients who may require a specialized physician to manage their specific health care needs.
All contracted credentialed providers participating with IPA are listed in the region-appropriate Provider Directory, which is provided to patients and made available to the public.

The Role of the Primary Care Physician (PCP)

Each patient must select an IPA Participating Primary Care Physician (PCP) at the time of enrollment. The PCP is responsible for managing all the health care needs of patients as follows:

- Manage the health care needs of patients who have chosen the physician as their PCP.
- Schedule new patient's initial visit with physician within 90 days of enrollment,
- On the patient's first visit to the provider office, patient should be seen by the Physician. On subsequent visits the physician is to be available for questions at all scheduled visits when supervising a PA or NP and to review all coding and quality initiatives before submission to ensure accuracy and appropriateness.
- Abide by CMS guidelines and regulations.
- Ensure that patients receive treatment as frequently as is necessary based on the patient's condition.
- Develop an individual treatment plan for each patient.

Inpatient Manager Program

- IPA requires that in certain IPA PODs, patients admitted to participating health care facilities should be assigned to the designated Inpatient Manager (IPM) for coordination of care throughout the entire stay. Health care facilities will receive notice of the designated Inpatient Manager and are required to follow the proper protocol of assigning patients to the designated Inpatient Manager.

Providers Designated as Primary Care Physicians (PCPs)

- Submit accurately and timely claims and encounter information for clinical care coordination.
- Comply with pre-authorization procedures.
- Refer patients to designated IPA participating providers.
- Comply with Quality Management and Utilization Management programs.
- Participate in IPA directed Coding and Quality Initiatives.
- Use appropriate IPA designated ancillary and facility providers.
- Comply with emergency care procedures.
- Comply with access and availability standards as outlined in this manual,

including after-hours care.
- Bill on the CMS 1500 claim form, preferably electronically, in accordance with billing procedures.
- Ensure that, when billing for services provided, coding is specific enough to capture the acuity and complexity of a patient's condition and ensure that the codes submitted are supported by proper documentation in the medical record.
- Comply with IPA Preventive Screening and Clinical Guidelines.
- Adhere to medical record standards as outlined in this manual.

The Role of the Specialist Physician

Each patient is entitled to see a Specialist Physician for certain services required for treatment of a given health condition. The Specialist Physician is responsible for the following:

- Provide specialty health care services to patients as needed.
- Collaborate with the patient's Primary Care Physician to enhance continuity of health care and appropriate treatment.
- Provide consultative and follow-up reports to the referring physician within 72 hours of encounter.
- Comply with access and availability standards as outlined in this manual including after-hours care.
- Comply with pre-authorization and referral process.
- Comply with Quality Management and Utilization Management programs.
- Bill on the CMS 1500 claim form in accordance with billing procedures.
- Ensure that, when billing for services provided, coding is specific enough to capture the acuity and complexity of a patient's condition and ensure that the codes submitted are supported by proper documentation in the medical record.
- Refer patients to designated IPA participating providers.
- Use appropriate IPA designated ancillary and facility providers.
- Submit encounter information accurately and timely.
- Adhere to medical record standards as outlined in this manual.

Administrative, Medical, and Reimbursement Policy Changes

From time to time, the IPA may amend, alter, or clarify its policies. Examples of this include, but are not limited to, regulatory changes, changes in medical standards, and modification of Covered Services. Specific IPA policies and procedures may be obtained by calling our Provider Services Department at **1-832-553-3300**.

The IPA's will communicate changes to the Provider Manual using a variety of methods including but not limited to:

- Annual Provider Manual Updates
- Letter
- Email
- Provider Newsletters

Providers are responsible for the review and inclusion of policy updates in the Provider

Manual and for complying with these changes upon receipt of these notices.

Communication Among Providers

- The PCP should provide the Specialist Physician with relevant clinical information regarding the patient's care at the time of referral
- The Specialist Physician must provide the PCP with information about his/her visit with the patient within 72 hours of encounter.
- The PCP must document in the patient's medical record his/her review of any reports, labs, or diagnostic tests received from a Specialist Physician.

Provider Marketing Guidelines

CMS expects contracted providers to remain neutral when assisting beneficiaries with enrollment decisions. Guidance offered by a provider is expected to be based solely on what is best for the patient.

CMS makes a distinction between communications and marketing materials. Marketing materials are considered information intended to influence beneficiaries' decisions: details about benefits, premiums, and cost sharing; star ratings, rankings, and measurements; and how one plan compares to another.

Communication materials do not provide this type of information. For example, a health plan can create a branded flyer on how to find help for social determinants of health or a flyer about where to find the most appropriate places for care. These are both considered communication materials.

CMS has specific rules and regulations around what providers can and cannot do in a healthcare setting and elsewhere related to Medicare Advantage (MA) plans and benefits. The bullets below provide guidance as to what CMS considers acceptable and unacceptable provider marketing and communication activities:
What providers may do with respect to Medicare Advantage:

- Display plan-approved marketing materials and enrollment forms in common areas (e.g., waiting rooms, entryways, conference rooms)
- Distribute or display plan-approved communication materials about MA plans (including in areas where care is being delivered)
- Distribute unaltered, printed materials created by CMS
- Announce new or continuing affiliations with MA plans, once a contract has been signed (announcements cannot be a veiled means of marketing a plan)
- Answer questions about or discuss the merits of MA plans (e.g., "Plan X has an excellent diabetes management program that would fit your needs.")
- Refer patients to other sources of information, including plan marketing representatives (note: any potential relationship between providers and sales agents should be analyzed for compliance with applicable laws)
- Provide information and assistance in applying for the low-income subsidy

What providers cannot do with respect to Medicare Advantage:

- Offer anything of value to persuade patients to select the provider or a particular MA plan
- Accept or collect scope of appointment or enrollment forms
- Conduct marketing activities or distribute marketing materials or enrollment forms in areas where care is delivered or where it can be perceived that the office is endorsing a specific plan (e.g., exam rooms, treatment areas, hospital patient rooms, and/or distributed by office staff.)
- Attempt to persuade a patient to enroll in a plan based on the provider's own interests
- Mail marketing materials on behalf of an MA plan
- Conduct health screenings as a marketing activity
- Accept compensation from an MA plan for any marketing or enrollment activities performed on behalf of the MA organization

CREDENTIALING AND RE-CREDENTIALING PROGRAM

All practitioner and organizational applicants to the IPA must meet basic eligibility requirements and complete the credentialing process prior to becoming a participating provider. Once an application has been submitted, the provider is subject to a rigorous verification process that includes primary and secondary source verifications of all applicable information for the contracted specialty(s). Upon completion of the verification process, providers are subject to a peer review process whereby they are approved or denied participation with the IPA. No provider can be assigned a health plan effective date or be included in a provider directory without undergoing the credentialing verification and peer review process. All providers who have been initially approved for participation are required to re-credential at least once every three years in order to maintain their participating status.

Practitioner Selection Criteria

The IPA utilizes specific selection criteria to ensure that practitioners who apply to participate meet basic credentialing and contracting standards. At minimum these include, but are not limited to:

- Holds appropriate, current and unencumbered licensure in the state of practice as required by state and federal entities.
- Holds a current, valid, and unrestricted federal DEA and state controlled substance certificate as applicable.
- Is board-certified or has completed appropriate and verifiable training in the requested practice specialty.
- Maintains current malpractice coverage with limits commensurate with the community standard in which practitioner practices.
- Participates in Medicare and has a Medicare number and/or a National Provider Identification number.
- Has not been excluded, suspended, and/or disqualified from participating in any Medicare, Medicaid, or any other government health related program.
- Is not currently opted out of Medicare.
- Has admitting privileges at a participating facility as applicable.

Credentialing and Re-credentialing Process

Once a practitioner has submitted an application for initial consideration, The IPA's Credentialing Department will conduct primary source verification of the applicant's licensure, education and/or board certification, privileges, lack of sanctions or other disciplinary action, and malpractice history by querying the National Practitioner Data Bank. The credentialing process generally takes up to ninety (90) days to complete, but can in some instances take longer. Once credentialing has been completed and the applicant has been approved, the practitioner will be notified in writing of their participation effective date.

To maintain participating status, all practitioners are required to re-credential at least every three (3) years. Information obtained during the initial credentialing process will

be updated and re-verified as required. Practitioners will be notified of the need to submit re-credentialing information at least 4 months in advance of their three-year anniversary date. Three (3) separate attempts will be made to obtain the required information via mail, fax, email, or telephonic request. Practitioners who fail to return re-credentialing information prior to their re-credentialing due date will be notified in writing of their termination from the network.

Organizational Provider Selection Criteria

When assessing organizational providers, the IPA utilizes the following criteria:

- Must be in good standing with all state and federal regulatory bodies.
- Has been reviewed and approved by an accrediting body.
- If not accredited, can provide appropriate evidence of successfully passing a recent state or Medicare site review, or meets other health plan criteria.
- Maintains current professional and general liability insurance as applicable.
- Has not been excluded, suspended, and/ or disqualified from participating in any Medicare, Medicaid, or any other government health related program.

Organizational Provider Application and Requirements

1. A completed Ancillary/Facility Credentialing Application with a signed and dated attestation.
2. If responded "Yes" to any disclosure question in the application, an appropriate explanation with sufficient details/information is required.
3. Copies of all applicable state and federal licenses (i.e. facility license, DEA, Pharmacy license, etc.).
4. Proof of current professional and general liability insurance as applicable.
5. Proof of Medicare participation.
6. If accredited, proof of current accreditation.
7. Note: Current accreditation status is required for DME, Prosthetic/Orthotics, and non-hospital based high tech radiology providers who perform MRIs, CTs and/or Nuclear/PET studies.
8. If not accredited, a copy of any state or CMS site surveys that occurred within the last three years including evidence that the organization successfully remediated any deficiencies identified during the survey.

Credentialing Committee and Peer Review Process

All initial applicants and re-credentialed providers are subject to a peer review process prior to approval or re-approval as a participating provider. The Medical Director may approve providers, who meet all of the acceptance criteria. Providers who do not meet established thresholds are presented to the Credentialing Committee for consideration. The Credentialing Committee is comprised of contracted primary care and specialty providers, and has the authority to approve or deny an appointment status to a provider. All information considered in the credentialing and re-credentialing process must be obtained and verified within one hundred eighty (180) days prior to presentation to the Medical Director or the Credentialing Committee.

All providers must be credentialed and approved before being assigned a participating effective date.

Non-discrimination in the Decision-making Process

The IPA's credentialing program is compliant with all guidelines from the National Committee for Quality Assurance (NCQA), Centers for Medicare & Medicaid Services (CMS), and state regulations as applicable. Through the universal application of specific assessment criteria, ensures fair and impartial decision-making in the credentialing process, and does not make credentialing decisions based on an applicant's race, gender, age, ethnic origin, sexual orientation, or due to the type of patients or procedures in which the provider specializes.

Provider Notification

All initial applicants who successfully complete the credentialing process are notified in writing of their IPA effective date. Providers are advised not to see IPA's patients until they receive notification of their plan participation and effective date. Applicants who are denied by the Credentialing Committee will be notified via a certified letter within sixty (60) days of the decision outcome detailing the reasons for the denial/term and any appeal rights to which the provider may be entitled.

Appeals Process and Notification of Authorities

In the event that a provider's participation is limited, suspended, or terminated, the provider is notified in writing within sixty (60) days of the decision. Notification will include a) the reasons for the action, b) outline of the appeals process or options available to the provider, and c) the time limits for submitting an appeal. A panel of peers will review all appeals. When termination or suspension is the result of quality deficiencies, the appropriate state and federal authorities, including the National Practitioner Data Bank (NPDB) are notified of the action.

Confidentiality of Credentialing Information

All information obtained during the credentialing and re-credentialing process is considered confidential and is handled and stored in a confidential and secure manner as required by law and regulatory agencies. Confidential practitioner credentialing and re-credentialing information will not be disclosed to any person or entity except with the written permission of the practitioner or as otherwise permitted or required by law.

Ongoing Monitoring

The IPA conducts routine, ongoing monitoring of license sanctions, Medicare/Medicaid sanctions, and the CMS Opt Out list between credentialing cycles. Participating providers who are identified as having been sanctioned, are the subject of a complaint review, or are under investigation for or have been convicted of fraud, waste, or abuse are subject to review by the Medical Director or the Credentialing Committee who may

elect to limit, restrict or terminate participation. Any provider who's license has been revoked or has been excluded, suspended, and/or disqualified from participating in any Medicare, Medicaid, or any other government health related program or who has opted out of Medicare will be automatically terminated from the IPA plan.

CLAIMS

Claims Submission

While IPA prefers electronic submission of claims, both electronic and paper claims are accepted. If interested in submitting claims electronically, contact Provider Customer Service at **1-832-553-3300** for assistance.

All completed claims forms should be forwarded to the address noted below:

Renaissance Physicians
Attn: Claims
PO Box 2888
Houston, TX 77252-2888

RP Professional Claims Electronic Payment ID Numbers:

- RENGQ (all caps) - as payor ID for HCFA only
- Emdeon - 76066 - payor ID for HCFA and UB-04

Timely Filing

As an IPA provider, you have agreed to submit all claims within the time specified in your contract. Claims submitted with dates of service beyond the timeframe are not reimbursable.

Claim Format Standards

Standard CMS required data elements must be present for a claim to be considered a clean claim and can be found in the CMS Claims Processing Manuals. The link to the CMS Claims Processing Manuals is:

https://www.cms.gov/manuals/downloads/clm104c12.pdf

The IPA can only pay claims, which are submitted accurately. The provider is at all times responsible for an accurate claims submission. While IPA will make its best effort to inform the provider of claims errors, the claim accuracy rests solely with the provider.

Physicians in the same group practice who are in the same specialty must bill and be paid as though they were a single physician. If more than one service is provided on the same day to the same patient by the same physician or more than one physician in the same specialty in the same group, they must bill and be paid as though they were a single physician. For example, only one evaluation and management service may be reported unless the evaluation and management services are for unrelated problems.

Instead of billing separately, the physicians should select a level of service representative of the combined visits and submit the appropriate code for that level.
Physicians in the same group practice, but who are in different specialties may bill and be paid without regard to their patient in the same group.

Claim Payment

The IPA pays clean claims according to contractual requirements and the Centers for Medicare & Medicaid Services (CMS) guidelines. A clean claim is defined as a claim for a Covered Service that has no defect or impropriety. A defect or impropriety includes, without limitation, lack of data fields required by IPA or substantiating documentation, or a particular circumstance requiring special handling or treatment, which prevents timely payment from being made on the claim. The term shall be consistent with the Clean Claim definition set forth in applicable federal or state law, including lack of required substantiating documentation for non-participating providers and suppliers, or particular circumstances requiring special treatment that prevents timely payment from being made on the claim. If additional substantiating documentation involves a source outside of IPA, the claim is not considered clean.

Offsetting

As a contracted provider, you will be informed of any overpayments or other payments you may owe us within 365 days of the date on the Explanation of Benefits or within the timeframe as noted in your Agreement. You will have sixty (60) days from receipt of notification seeking recovery to refund us. We will provide you with the patient's name, patient's identification number, and claim number, your patient account number, date of service, a brief explanation of the recovery request, and the amount or the requested recovery. If you have not refunded us within the sixty (60) days recovery notice period, we will offset the recovery amounts identified in the initial notification, or in accordance with the terms of your Agreement.

Pricing

Original Medicare typically has market-adjusted prices by code (i.e. CPT or HCPCS) for services that Original Medicare covers. However, there are occasions where IPA offers a covered benefit for which Medicare has no pricing. In order to expedite claims processing and payment in these situations, the IPA will work to arrive at a fair market price by researching other external, publicly available pricing sources, such as other carriers, fiscal intermediaries, or state published schedules for Medicaid. The IPA requests that you make every effort to submit claims with standard coding. As described in this Manual and/or your Agreement, you retain your rights to submit a Request for Reconsideration if you feel the reimbursement was incorrect.

Claims Encounter Data

Providers who are being paid under capitation must submit claims in order to capture encounter data as required per your IPA's Provider Agreement.

Explanation of Payment (EOP)/Remittance Advice (RA)

The EOP/RA statement is sent to the provider after coverage and payment have been determined by IPA. The statement provides a detailed description of how the claim was processed.

Non Payment/Claim Denial

Any denials of coverage or non-payment for services by IPA will be addressed on the Explanation of Payment (EOP) or Remittance Advice (RA). An adjustment/denial code will be listed per each billed line if applicable. An explanation of all applicable adjustment codes per claim will be listed below that claim on the EOP/RA. Per your contract, the patient may or may not be billed for services denied by IPA. The patient may not be billed for a covered service when the provider has not followed the IPA's procedures. In some instances, providing the needed information may reverse the denial (i.e. authorization number, etc.). When no benefits are available for the patient, or the services are not covered, the EOP/RA will alert you to this and you may bill the patient.

Processing of Hospice Claims

When a Medicare Advantage (MA) patient elects hospice care, but chooses not to dis-enroll from the plan, the patient is entitled to continue to receive any MA benefits which are not responsibility of the hospice through the IPA. Under such circumstances the premium the IPA receives from CMS is adjusted to hospice status. As of the day the patient is certified as hospice, the financial responsibility for that patient shifts from IPA to Original Medicare.

During a hospice election, Original Medicare covers all Medicare–covered services rendered with cost-sharing of Original Medicare. IPA will remain financially responsible for any benefits above Original Medicare benefits that are non- hospice related. Non-Medicare covered services, such as vision eyewear allowable, prescription drug claims, and medical visit transportation will remain the responsibility of IPA. Plan cost-sharing will apply to IPA covered services. If the patient chooses original Medicare for coverage of covered, non-hospice-care, original Medicare services and also follows MA plan requirements, then, the patient pays plan cost-sharing and original Medicare pays the provider. IPA will pay the provider the difference between original Medicare cost-sharing and plan cost-sharing, if applicable. Plan rules must still be followed and apply for both professional and facility charges. An HMO patient who chooses to receive services out of network has not followed plan rules and therefore is responsible to pay FFS cost-sharing; A PPO patient who receives services out of network has followed plan rules and is only responsible for plan cost-sharing. The patient need not communicate to the plan in advance his/her choice of where services are obtained.

When a patient revokes hospice care, financial responsibility for Medicare-covered services will return to the health plan on the first of the month following the revocation. The following are the submission guidelines for Medicare Advantage patients enrolled in Hospice:

Hospice-Related Services

- Submit the claim directly to CMS.

- Medicare hospices bill the Medicare fee-for-service contractor for patients who have coverage through Medicare Advantage just as they do for patients, or beneficiaries, with fee-for- service coverage. Billing begins with a notice of election for an initial hospice benefit period, and followed by claims with types of bill 81X or 82X. If the patient later revokes election of the hospice benefit, a final claim indicating revocation, through use of occurrence code 42 should be submitted as soon as possible so the patient's medical care and payment is not disrupted.
- Medicare physicians may also bill the Medicare fee-for-service contractor for patients who have coverage through Medicare Advantage as long as all current requirements for billing for hospice beneficiaries are met. These claims should be submitted with a GV or GW modifier as applicable. Medicare contractors process these claims in accordance with regular claims processing rules. When these modifiers are used, contractors are instructed to use an override code to assure such claims have been reviewed and should be approved for payment by the Common Working File in Medicare claims processing systems.
- As specified above, by regulation, the duration of payment responsibility by fee-for-service contractors extends through the remainder of the month in which hospice is revoked. MA plan patients that have elected hospice may revoke hospice election at any time, but claims will continue to be paid by fee- for-service contractors as if the beneficiary were a fee-for- service beneficiary until the first day of the month following the month in which hospice was revoked.

Non-Hospice Services

- For Part A services not related to the patient's terminal condition, submit the claim to the fiscal intermediary using the condition code 07.
- For Part B services not related to the patient's terminal condition, submit the claim to the Medicare carrier with a "GW" modifier.
- For services rendered for the treatment and management of the terminal illness by a non-hospice employed attending physician, submit the claim to the fiscal Intermediary/ Medicare carrier with a "GV" modifier.

Additional & Supplemental Benefits

- Submit the claim to IPA. For additional detail on hospice coverage and payment guidelines, please refer to 42 CFR 422.320-Special Rules for Hospice Care. Section (C) outlines the Medicare payment rules for patients who have elected hospice coverage. The Medicare Managed Care Manual, Chapter 11, Sections 40.2 and 50, and the CMS Program Memorandum AB-03-049 also outline payment responsibility and billing requirements for hospice services. This documentation is also available online at the CMS website: www.cms.gov.

Dual Eligible Patients

Some of your patients may have an IPA as their primary insurance payer and Medicaid as their secondary payer. This will require you to coordinate the benefits of these "dual eligible" patients by determining whether the patient should be billed for the deductibles and copayments, or coinsurances associated with their benefit plan. Providers may not assess a QMB (Qualified Medicare Beneficiary) or QMB- Plus for copayments, coinsurances, and/or

deductibles.

Providers will accept as payment in full IPA's payment and will not seek additional payment from the state or dual eligible patients. Additional information concerning Medicaid provider participation is available at www.myrpo.com.

A patient's level of Medicaid eligibility can change due to their medical and financial needs. The IPA encourages you to verify patients' Medicaid eligibility when rendering services, which will help you determine if the patient owes a deductible or copay.

Medicaid eligibility can be obtained by using the Medicaid telephonic Eligibility Verification System. If you do not have access to the system, please contact your State Medicaid provider for additional information.

Please note: Each state varies in their decision to cover the cost-share for populations beyond QMB and QMB+.

Cost-sharing Chart.

Patient's Medicaid Plan	Patient's liability Patient owes deductibles and copayments associated with benefit plan	Medicaid provides benefits Patient not liable for deductibles and copayments associated with benefit plan
Medicaid (FBDE)	No	Yes
QMB Only	No	Yes
QMB+	No	Yes
SLMB	Yes	No
SLMB+	Yes	No

Patient's Medicaid Plan	Patient's liability Patient owes deductibles and copayments associated with benefit plan	Medicaid provides benefits Patient not liable for deductibles and copayments associated with benefit plan
QI-1	Yes	No
QDWI	Yes	No

Coordination of Benefits and Subrogation Guidelines

General Definitions

Coordination of Benefits (COB): is the process of determining and reconciling individual payor liability for reimbursement when a patient is eligible for benefits coverage under more than one insurance company or other payor type (e.g., Medicare, Medicaid). Terms and conditions within the Summary of Benefits for each plan will generally dictate which payor is primary or secondary and any mathematical formula associated for calculating each payor's portion of coverage. Coordinating payment of these plans will provide benefit coverage up to but not exceeding one hundred (100) percent of the allowable amount. The respective primary and secondary payment obligations of the two coverages are determined by the Order of Benefits Determination Rule contained in the National Association of Insurance Commissioners (NAIC) COB Model Regulations Guidelines.

Order of Benefit Determination Rule: Rules which, when applied to a particular patient covered by at least two plans, determine the order of responsibility each plan has with respect to the other plan in providing benefits for that patient. A plan will be determined to have Primary or Secondary responsibility for a person's coverage with respect to other plans by applying the NAIC rules.

Primary: This carrier is responsible for costs of services provided up to the benefit limit for the coverage or as if no other, coverage exists.

Secondary: This carrier is responsible for the total allowable charges, up to the benefit limit for the coverage less the primary payment not to exceed the total amount billed (maintenance of benefits).

Allowable Expense: Any expense customary or necessary, for health care services provided as well as covered by the patient's health care plan.

Conclusion: COB is applying the NAIC rules to determine which plan is primarily responsible and plan would be in a secondary position when alternate coverage exists. If COB is to accomplish its purpose, all plans must adhere to the structure set forth in the Model COB regulations.

Basic NAIC Rules for COB

Birthday Rule

The primary coverage is determined by the birthday that falls earliest in the year, understanding both spouses are employed and have coverage. Only the day and month are taken into consideration. If both patients have the same date of birth, the plan which covered the patient the longest is considered primary.

General Rules
The following table contains general rules to follow to determine a primary carrier:

If the Patient/Beneficiary	The Below Conditions Exists	Then the Below Program Pays First	The Below Program Pays Secondary
Is age 65 or older, and is covered by a Group Health Plan (GHP) through current employment or a family patient's current employment	The employer has more than 20 employees, or at least one employer is a multi-employer group that employs 20 or more employees	The Group Health Plan (GHP) pays primary	IPA/Medicare pays secondary
Is age 65 or older and is covered a Group Health Plan (GHP) through current employment or a family patients current employment	The employer has less than 20 employees	IPA /Medicare pays primary	Group Health Plan (GHP) pays secondary
Is entitled based on disability and is covered by a Large Group Health Plan (LGHP) through his/her current employment or through a family patients current employment	The employer has 100 or more employees or at least one employer is a multi-employer group that employs 100 or more employees	The Large Group Health Plan (LGHP) pays primary	IPA /Medicare pays secondary
Is entitled based on disability and is covered by a Large Group Health Plan (LGHP) through his/her current employment or through a family patients current employment	The employer employs less than 100 employees	IPA /Medicare pays primary	Large Group Health Plan (LGHP) pays secondary

Is age 65 or older or entitled based on disability and has retirement insurance only	Does not matter the number of employees	IPA /Medicare pays primary	Retirement Insurance pays secondary
Is age 65 or older or is entitled based on disability and has COBRA coverage	Does not matter the number of employees	IPA/Medicare pays primary	COBRA pays secondary
Becomes dually entitled based on age/ESRD	Had insurance prior to becoming dually entitled with ESRD as in block one above	The Group Health Plan (GHP) pays primary for the first 30 months	IPA/Medicare pays secondary (after 30 months IPA pays primary)
Becomes dually entitled based on age/ESRD but then retires and keeps retirement insurance	Had insurance prior to becoming dually entitled with ESRD as in block one above and then retired	The Retirement Insurance pays primary for the first 30 months	IPA/Medicare pays secondary (after 30 months IPA pays primary)

If the Patient/Beneficiary	The Below Conditions Exists	Then the Below Program Pays First	The Below Program Pays Secondary
Becomes dually entitled based on age/ESRD but obtains COBRA through employer	Had insurance prior to becoming dually with ESRD as in block above and picks up COBRA coverage	COBRA insurance pay primary for the months (or until the drops the COBRA coverage	IPA/Medicare pays (after 30 months IPA pays primary)
Becomes dually entitled on disability/ESRD	Had insurance prior to becoming dually with ESRD as in block three above	The Large Group Plan (LGHP) pays	IPA/Medicare pays (after 30 months IPA pays primary)
Becomes dually entitled on disability/ESRD but obtains COBRA through employer	Had insurance prior to becoming dually with ESRD as in block three above and picks the COBRA coverage	COBRA insurance pay primary for the months or until the drops the COBRA coverage	IPA/Medicare pays (after 30 months IPA pays primary)

Basic Processing Guidelines for COB

For the IPA to be responsible as either the primary or the secondary carrier, the patient must follow all HMO rules (i.e. pay copays and follow appropriate process).
When the IPA is the secondary insurance carrier:

- All IPA's guidelines must be met in order to reimburse the provider (i.e. pre-certification, etc.).
- The provider collects only the copayments required when applicable.
- Be sure to have the patient sign the "assignment of benefits" sections of the claim form.
- Once payment and/or EOB are received from the other carriers, submit another copy of the claim with the EOB of IPA for reimbursement. Be sure to note all authorization numbers on the claims and attach a copy of the referral form if applicable.

When the IPA is the primary insurance carrier:

- The provider collects the copayment required under the patient's plan.
- Submit the claim to the IPA first
- Be sure to have the patient sign the "assignment of benefits" sections of the claim form.
- Once payment and/or remittance advise (RA) has been received from IPA, submit a copy of the claim with the RA to the secondary carrier for adjudication.
- Please note that the IPA is a total replacement for Medicare.
- Medicare cannot be secondary when patients have an IPA.
- Medicaid will not pay the copay for the Participating Plan's patients.

Worker's Compensation

The IPA does not cover worker's compensation claims.
When a provider identifies medical treatment as related to an on-the-job illness or injury, the IPA must be notified. The provider will bill the worker's compensation carrier for all services rendered, not the IPA.

Subrogation

Subrogation is the coordination of benefits between a health insurer and a third party insurer (i.e. property and casualty insurer, automobile insurer, or worker's compensation carrier), not two health insurers. Claims involving Subrogation or Third Party Recovery (TPR) will be processed internally by the IPA's Claims Department. COB protocol, as mentioned above, would still apply in the filing of the claim.

Patients who may be covered by third party liability insurance should only be charged the required copayment. The bill can be submitted to the liability insurer. The provider should submit the claim to the IPA with any information regarding the third party carrier (i.e. auto insurance name, lawyers name, etc.). All claims will be processed per the usual claims procedures.

The IPA uses an outside vendor for review and investigation of all possible subrogation cases. This vendor coordinates all requests for information from the patient, provider and attorney's office and assists with settlements. For claims related questions, please contact Customer Service at 1-832-553-3300. A Provider Representative will gladly provide assistance.

Appeals

An appeal is a request for the IPA to review a previously made decision related to medical necessity, clinical guidelines, or prior authorization and referral requirements. You must receive a notice of denial, or remittance advice before you can submit an appeal. Refer to the Appeals section under Health Services for more information.

Reconsiderations

You have up to 180 days to request reconsideration of a claim. You may request claim reconsideration if you feel your claim was not processed appropriately according to the IPA's claim payment policy or in accordance with your provider agreement. A claim reconsideration request is appropriate for disputing denials such as coordination of benefits, timely filing, or missing information. Payment retractions, underpayments/overpayments, as well as coding disputes should also be addressed through the claim reconsideration process. The IPA will review your request, as well as your provider record, to determine whether your claim was paid correctly.

You may request reconsideration by submitting the completed request form to:

Renaissance Physicians
Attn: Reconsiderations
PO Box 2888
Houston, TX 77252-2888
Fax: 1-832-553-3418

PATIENT INFORMATION

Eligibility Verification

All participating providers are responsible for verifying a patient's eligibility at each and every visit. You can verify patient eligibility the following ways:

- Call the Health Plan – You must call the Health Plan to verify eligibility when the patient cannot present identification or does not appear on your monthly eligibility list. Please note: the Health Plan should have the most updated information, therefore, call the Health Plan for accuracy.
- HSConnect – Health Services' web portal, HSConnect, allows our providers to verify patient eligibility online
- Ask to see the patient's Identification Card – Each patient is provided with an individual patient identification card. Noted on the ID card is the patient's identification number, plan code, name of PCP, copayment, and effective date. Since changes do occur with eligibility, the card alone does not guarantee the patient is eligible.
- Pursue additional proof of identification – Each PCP is provided with a monthly Eligibility Report upon request, which lists new and current IPA's patients with their effective dates. Please be sure to refer to the most current month's Eligibility Report.
- See ID Cards in Health Plan sections.

Eligibility Guarantee Form

If your office decides to see a patient that does not have identification, you should have the patient sign an Eligibility Guarantee form. Please keep a copy of the signed form in patient's file. Please visit www.myrpo.com/providers/provider-resources for a copy of the form.

Maximum Out-of-Pocket (MOOP)

The Maximum Out-of-Pocket (MOOP) benefit is now a part of all benefit plans. Patients have a limit on the amount they will be required to pay out-of-pocket each year for medical services, which are covered under Medicare Part A and Part B. Once this Maximum Out-of-pocket expense has been reached, the patient no longer is responsible for any out- of-pocket expenses, including any cost shares, for the remainder of the year for covered Part A and Part B services (excluding the patient's Medicare Part B premium and the IPA's plan premium).

Patient Hold Harmless

Participating providers are prohibited from balance billing the IPA's patients including, but not limited to, situations involving non-payment by IPA, insolvency of IPA, or IPA's breach of its Agreement.

Provider shall not bill, charge, collect a deposit from, seek compensation or reimbursement from, or have any recourse against patients or persons, other than the IPA, acting on behalf of patients for Covered Services provided pursuant to the Participating Provider's Agreement.

The provider is not, however, prohibited from collecting copayments, coinsurances or

deductibles for covered services in accordance with the terms of the applicable patient's Benefit Plan.

Patient Confidentiality

IPA knows that patients' privacy is extremely important to them, and we respect their right to privacy when it comes to their personal information and health care. We are committed to protecting our patients' personal information. IPA does not disclose patient information to anyone without obtaining consent from an authorized person(s), unless we are permitted to do so by law. Because you are a valued provider to the IPA, we want you to know the steps we have taken to protect the privacy of our patients. This includes how we gather and use their personal information. The privacy practices apply to all of IPA's past, present, and future patients.

When a patient joins a Medicare Advantage plan, the patient agrees to give IPA access to Protected Health Information. Protected Health Information ("PHI"), as defined by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), is information created or received by a health care provider, health plan, employer or health care clearinghouse, that: (i) relates to the past, present, or future physical or behavioral health or condition of an individual, the provision of health care to the individual, or the past, present or future payment for provision of health care to the individual; (ii) identifies the individual, or with respect to which there is a reasonable basis to believe the information can be used to identify the individual; and (iii) is transmitted or maintained in an electronic medium, or in any form or medium. Access to PHI allows IPA to work with providers, like yourself, to decide whether a service is a Covered Service and pay your clean claims for Covered Services using the patients' medical records. Medical records and claims are generally used to review treatment and to do quality assurance activities. It also allows IPA to look at how care is delivered and carry out programs to improve the quality of care patients receive. This information also helps manage the treatment of diseases to improve our patients' quality of life.

Patients have additional rights over their health information.
They have the right to:

- Send IPA a written request to see or get a copy of information about them, or amend their personal information that they believe is incomplete or inaccurate. If we did not create the information, we will refer patient to the source of the information. Request that we communicate with them about medical matters using reasonable alternative means or at an alternative address, if communications to their home address could endanger them.
- Receive an accounting of IPA's disclosures of their medical information, except when those disclosures are for treatment, payment, or health care operations, or the law otherwise restricts the accounting.

As a Covered Entity under HIPAA, providers are required to comply with the HIPAA Privacy Rule and other applicable laws in order to protect patient PHI. To discuss any breaches of the privacy of our patients, please contact the CareAllies Privacy Steward at Patricia.Swan@CareAllies.com.

Patient Rights and Responsibilities

Patients have the following rights:

The right to be treated with dignity and respect

Patients have the right to be treated with dignity, respect, and fairness at all times. IPA must obey laws against discrimination that protect patients from unfair treatment. These laws say that IPA cannot discriminate against patients (treat patients unfairly) because of a person's race, disability, religion, gender, sexual orientation, health, ethnicity, creed, age, or national origin. If patients need help with communication, such as help from a language interpreter, they should be directed to call Customer Service. Customer Services can also help patients file complaints about access to facilities (such as wheelchair access). Patients can also call the U.S. Department of Health and Human Services' Office for Civil Rights at **1-800-368-1019** or TTY/TDD **1-800-537-7697**, or the Office for Civil Rights in their area for assistance.

The right to see participating providers, get covered services, and get prescriptions filled within a reasonable period of time

Patients will get most or all of their health care from participating providers, that is, from doctors and other health providers who are part of IPA. Patients have the right to choose a participating provider (IPA will work with patients to ensure they find physicians who are accepting new patients). Patients have the right to go to a women's health specialist (such as a gynecologist) without a referral. Patients have the right to timely access to their providers and to see specialists when care from a specialist is needed. Patients also have the right to timely access to their prescriptions at any network pharmacy. "Timely access" means that patients can get appointments and services within a reasonable amount of time. The Evidence of Coverage explains how patients access participating providers to get the care and services they need. It also explains their rights to get care for a medical emergency and urgently needed care.

The right to know treatment choices and participate in decisions about their health care

Patients have the right to get full information from their providers when they receive medical care, and the right to participate fully in treatment planning and decisions about their health care. Providers must explain things in a way that patients can understand. Patients have the right to know about all of the treatment choices that are recommended for their condition including all appropriate and medically necessary treatment options, no matter what their cost or whether they are covered by IPA. This includes the right to know about the different medication management treatment programs offers and those in which patients may participate.

Patients have the right to be told about any risks involved in their care.

Patients must be told in advance if any proposed medical care or treatment is part of a research experiment and be given the choice to refuse experimental treatments. Patients have the right to receive a detailed explanation from IPA if they believe that a health plan provider has denied care that they believe they are entitled to receive or care they believe they should continue to receive. In these cases, patients must request an initial decision. "Initial decisions" are discussed in the patients' Evidence of Coverage.

Patients have the right to refuse treatment.
This includes the right to leave a hospital or other medical facility, even if their doctor advises them not to leave. This also includes the right to stop taking their medication. If patients refuse treatment, they accept responsibility for what happens as a result of refusing treatment.

The right to make complaints
Patients have the right to make a complaint if they have concerns or problems related to their coverage or care. Patients or an appointed/authorized representative may file "Appeals," "grievances," concerns and Coverage Determinations. If patients make a complaint or file an appeal or Coverage Determination, IPA must treat them fairly (i.e., not discriminate against them) because they made a complaint or filed an appeal or Coverage Determination. To obtain information relative to appeals, grievances, concerns and/or Coverage Determinations, patients should be directed to call Customer Service.

The right to get information about their health care coverage and cost
The Evidence of Coverage tells patients what medical services are covered and what they have to pay. If they need more information, they should be directed to call Customer Service. Patients have the right to an explanation from IPA about any bills they may get for services not covered by IPA. The IPA must tell patients in writing why IPA will not pay for or allow them to get a service and how they can file an appeal to ask IPA to change this decision. Staff should inform patients on how to file an appeal, if asked, and should direct patients to review their Evidence of Coverage for more information about filing an appeal.

The right to get information about IPA, health plan providers, drug coverage, and costs
Patients have the right to get information about the IPA and operations. This includes information about our financial condition, about the services we provide, and about our health care providers and their qualifications. Patients have the right to find out from us how we pay our doctors. To get any of this information, patients should be directed to call Customer Service. Patients have the right to get information from us about their Part D prescription coverage. This includes information about our financial condition and about our network pharmacies. To get any of this information, staff should direct patients to call Customer Service.

The right to get more information about patients' rights
Patients have the right to receive information about their rights and responsibilities. If patients have questions or concerns about their rights and protections, they should be directed to call Customer Service. Patients can also get free help and information from their State Health Insurance Assistance Program (SHIP).

The right to take action if a patient thinks they have been treated unfairly or their rights are not being respected
- If patients think they have been treated unfairly or their rights have not been respected, there are options for what they can do.

- If patients think they have been treated unfairly due to their race, color, national origin, disability, age, sexual orientation, or religion, we must encourage them to let us know immediately. They can also call the Office for Civil Rights in their area.
- For any other kind of concern or problem related to their Medicare rights and protections described in this section, patients should be encouraged to call Customer Service.

The right to take action if a patient thinks they have been treated unfairly or their rights are not being respected

- If patients think they have been treated unfairly or their rights have not been respected, there are options for what they can do.
- If patients think they have been treated unfairly due to their race, color, national origin, disability, age, sexual orientation, or religion, we must encourage them to let us know immediately. They can also call the Office for Civil Rights in their area.
- For any other kind of concern or problem related to their Medicare rights and protections described in this section, patients should be encouraged to call Customer Service.

The right to use advance directives (such as a living will or a power of attorney)

Patients have the right to ask someone such as a family member or friend to help them with decisions about their health care. Sometimes, people become unable to make health care decisions for themselves due to accidents or serious illnesses. If a patient wants to, he/she can use a special form to give someone they trust the legal authority to make decisions for them if they ever become unable to make decisions for themselves. Patients also have the right to give their doctors written instructions about how they want them to handle their medical care if they become unable to make decisions for themselves. The legal documents that patients can use to give their directions in advance of these situations are called "advance directives." There are different types of advance directives and different names for them. Documents called "living wills" and "powers of attorney for health care" are examples of advance directives.

If patients decide that they want to have an advance directive, there are several ways to get this type of legal form. Patients can get a form from their lawyer, from a social worker, from the IPA provider, or from some office supply stores. Patients can sometimes get advance directive forms from organizations that give people information about Medicare. Regardless of where they get this form, keep in mind that it is a legal document.

Patients should consider having a lawyer help them prepare it. It is important for the patient to sign this form and keep a copy at home. Patients should give a copy of the form to their doctor and to the person they name on the form as the one to make decisions for them if they cannot. Patients may want to give copies to close friends or family members as well.

If patients know ahead of time that they are going to be hospitalized and they have signed an advance directive, they should take a copy with them to the hospital. If patients are admitted to the hospital, the hospital will ask them whether they have signed an advance directive form and whether they have it with them. If a patient has not signed an advance directive form or does not have a copy available during admission, the hospital has forms available and will ask if the patient wants to sign one.

Remember, it is a patient's choice whether he/she wants to fill out an advance directive (including whether they want to sign one if they are in the hospital). According to law, no one can deny them care or discriminate against them based on whether or not they have signed an advance directive. If patients have signed an advance directive and they believe that a doctor or hospital has not followed the instructions, patients may file a complaint with their State Board of Medicine or appropriate state agency (this information can be found in the patient's Evidence of Coverage).

Advance Directive for Healthcare – Provider Responsibility

The Federal Patient Self-Determination Act grants patients the right to participate in health care decision-making, including decisions about withholding resuscitative services or declining/withdrawing life sustaining treatment. In accordance with guidelines established by the Centers for Medicare & Medicaid Services (CMS) and the health plan's policies and procedures, Cigna requires all Participating Providers to have a process in place pursuant to the intent of the Patient Self Determination Act.

All providers contracted directly or indirectly with the health plan may be informed by the patient that the patient has executed, changed or revoked an advance directive. At the time a service is provided, the provider should ask the patient to provide a copy of the advance directive to be included in his/her medical record.

Providers are required to document in a prominent place of a patient's medical record whether the patient has executed an advanced directive.

If the Primary Care Physician (PCP) and/or treating provider cannot as a matter of conscience fulfill the patient's written advance directive, he/she must inform the patient and the health plan. The health plan and the PCP and/or treating provider will arrange for a transfer of care. Participating Providers may not condition the provision of care or otherwise discriminate against an individual based on whether the individual has executed an advance directive. However, nothing in The Patient Self-Determination Act precludes the right under state law of a provider to refuse to comply with an advance directive as a matter of conscience.

Texas state forms in English and Spanish can be found on the Texas Health and Human Services website: https://hhs.texas.gov/laws-regulations/forms/advance-directives

Patients have the following responsibilities:
Along with certain rights, there are also responsibilities associated with being a patient of the IPA. Patients are responsible for the following:

- To become familiar with their IPA's coverage provider.
- To give their doctors and other providers the information they need to provide care for them and to follow the treatment plans and instructions that they and their doctors agree upon. Patients must be encouraged to ask questions of their doctors and other providers whenever the patient has them.
- To act in a way that supports the care given to other patients and helps the smooth running of their doctor's office, hospitals, and other offices.
- To pay their health plan premiums and any copayments or coinsurances they may have for the Covered Services they receive. Patients must also meet their other financial responsibilities that are described in their Evidence of Coverage.
- To let IPA know if they have any questions, concerns, problems, or suggestions regarding their rights, responsibilities, coverage, and/or IPA's operations.
- To notify Customer Service and their providers of any address and/or phone number changes as soon as possible.
- To use their IPA only to access services, medications and other benefits for themselves.

Benefits and Services

All patients receive benefits and services as defined in their Evidence of Coverage (EOC). Each month, the IPA makes available to each participating Primary Care Physician a list of their active patients. Along with the patient's demographic information, the list includes the name of the health plan in which the patient enrolled. Please be aware that recently terminated patients may appear on the list. (See "Eligibility Verification" section of this manual).

- The IPA encourages its patients to call their Primary Care Physician and the rules they must follow to get care as a patient. Patients can use their Evidence of Coverage and other information that we provide them to learn about their coverage, what we have to pay, and the rules they need to follow. Patients should always be encouraged to call Patient Services if they have any questions or complaints.
- To advise IPA if they have other insurance coverage.
- To notify providers when seeking care (unless it is an emergency) that they are enrolled with IPA and present their health plan enrollment card to schedule appointments. However, if an IPA's patient calls or comes to your office for an unscheduled non-emergent appointment, please attempt to accommodate the patient and explain to them your office policy regarding appointments. If this problem persists, please contact IPA.

Emergency Services and Care after Hours

Emergency Services

An emergency is defined as the sudden onset of a medical condition with acute symptoms. A patient may reasonably believe that the lack of immediate medical attention could result in:

- Permanently placing the patient's health in jeopardy
- Causing serious impairments to body functions
- Causing serious or permanent dysfunction of any body organ or part

In the event of a perceived emergency, patients have been instructed to first contact their Primary Care Physician for medical advice. However, if the situation is of such a nature that it is life threatening, or if they are unsure of the condition's severity, patients have been instructed to go immediately to the nearest emergency room facility. Patients who are unable to contact their PCP prior to receiving emergency treatment have been instructed to contact their PCP as soon as is medically possible or within forty-eight (48) hours after receiving care. The PCP will be responsible for providing and arranging any necessary follow-up services.

For emergency services within the service area, the PCP is responsible for providing, directing, or authorizing a patient's emergency care. The PCP or his/her designee must be available twenty-four (24) hours a day, seven (7) days a week to assist patients needing emergency services. The hospital may attempt to contact the PCP for direction. Patients have a copayment responsibility for outpatient emergency visits unless an admission results.

For emergency services outside the service area, IPA will pay reasonable charges for emergency services received from non-participating providers if a patient is injured or becomes ill while temporarily outside the service area. Patients may be responsible for a copayment for each incident of outpatient emergency services at a hospital's emergency room or urgent care facility.

Urgent Care Services
Urgent Care services are for the treatment of symptoms that are non-life threatening but that require immediate attention. The patient must first attempt to receive care from his/her PCP. IPA will cover treatment at a participating Urgent Care Center without a referral.

Continue or Follow-up Treatment
Continuing or follow-up treatment, except by the PCP, whether in or out of service area, is not covered by IPA unless specifically authorized or approved by IPA. Payment for covered benefits outside the service area is limited to medically necessary treatment required before the patient can reasonably be transported to a participating hospital or returned to the care of the PCP.

Excluded Services

In addition to any exclusion or limitations described in the patient's EOC, the following items and services are not covered under the health plan:

- Services that are not reasonable and necessary
- Experimental or investigational medical and surgical procedures, equipment, and medications, unless covered by the Original Medicare Plan or unless, for certain services, the procedures are covered under an approved clinical trial. The Centers for Medicare & Medicaid Services (CMS) will continue to pay through Original Medicare for clinical trial items and services covered under the September 2000 National Coverage Determination that are provided to health plan patients. Experimental procedures and items are those items and procedures determined the Original Medicare Plan to not be generally accepted by the medical community.
- Private room in a hospital, unless medically necessary.

- Private duty nurses.
- Personal convenience items, such as a telephone or television in a patient's room at a hospital or skilled nursing facility.
- Nursing care on a full-time basis in a patient's home.
- Custodial care unless it is provided in conjunction with covered skilled nursing care and/or skilled rehabilitation services. This includes care that helps
- people with activities of daily living like walking, getting in and out of bed, bathing, dressing, eating, using the bathroom, preparation of special diets, and supervision of medication that is usually self-administered.
- Homemaker services.
- Charges imposed by immediate relatives or patients of the patient's household.
- Meals delivered to the patient's home.
- Elective or voluntary enhancement procedures, services, supplies, and medications including but not limited to: weight loss, hair growth, sexual performance, athletic performance, cosmetic purposes, anti-aging, and mental performance unless medically necessary.
- Cosmetic surgery or procedures, unless needed because of accidental injury or to improve the function of a malformed part of the body. All stages of reconstruction are covered for a breast after a mastectomy, as well as for the unaffected breast to produce a symmetrical appearance.
- Routine dental care (i.e. cleanings, fillings, or dentures) or other dental services unless otherwise specified in the EOC. However, non-routine dental services received at a hospital may be covered.
- Chiropractic care is generally not covered under the health plan with the exception of manual manipulation of the spine and is limited according to Medicare guidelines.
- Routine foot care is generally not covered under the health plan and is limited according to Medicare guidelines.
- Orthopedic shoes unless they are part of a leg brace and included in the cost of the brace. Exception: orthopedic or therapeutic shoes are covered for people with diabetic foot disease.
- Supportive devices for the feet. Exception: orthopedic or therapeutic shoes are covered for people with diabetic foot disease.
- Hearing aids and routine hearing examinations unless otherwise specified in the EOC.
- Eyeglasses, with the exception of after cataract surgery, routine eye examinations, radical keratotomy, LASIK surgery, vision therapy, and other low vision aids and services unless otherwise specified in the EOC.
- Self-administered prescription medication for the treatment of sexual dysfunction, including erectile dysfunction, impotence, and anorgasmy or hyporgasmy unless otherwise included in the patient's Part D benefit. Please see the formulary for details.
- Reversal of sterilization measures, sex change operations, and non-prescription contraceptive supplies.
- Acupuncture
- Naturopath services

- Services provided to veterans in Veterans Affairs (VA) facilities. However, in the case of emergency situations received at a VA hospital, if the VA cost-sharing is more than the cost-sharing required under the health plan, the health plan will reimburse veterans for the difference.
- Patients are still responsible for our health plan cost- sharing amount if applicable

Any of the services listed above that are not covered will remain not covered even if received at an emergency facility. For example, non-authorized, routine conditions that do not appear to a reasonable person to be based on a medical emergency are not covered if received at an emergency facility.

Grievance and Appeal Process

All telephonic inquiries received by the health plan's Customer Service Department will be resolved on an informal basis, except for inquiries that involve "appealable" issues.

Appealable issues will be routed through either the standard or expedited appeal process. In situations where a patient is not in agreement with the informal resolution, the patient must submit a written request for reconsideration. All other written correspondence received by IPA will be documented and routed through the appropriate appeal or grievance channels.

Patients have the right to file a complaint, also referred to as a grievance, regarding any problems they observe or experience with the health plan. Situations for which a grievance may be filed include but are not limited to:

- Complaints about services in an optional Supplementary Benefit package.
- Dissatisfaction with the office experience such as excessive wait times, physician behavior or demeanor, or inadequacy of facilities.
- Involuntary disenrollment situations.
- Poor quality of care or service received.

Patients have the right to appeal any decision about IPA's failure to provide what they believe are benefits contained in the basic benefit package. These include:

- Reimbursement for urgently needed care outside of the service area or Emergency Services worldwide.
- A denied claim for any health services furnished by a non-participating provider or supplier they believe should have been provided, arranged for, or reimbursed by IPA.
- Services not received, but believed to be the responsibility of IPA.
- A reduction or termination of a service a patient feels medically necessary.

In addition, a patient may appeal any decision related to a hospital discharge. In this case, a notice will be given to the patient with instructions for filing an appeal.

QUALITY GUIDANCE

The Centers for Medicare & Medicaid Services (CMS) uses the Five-Star Quality Rating System to determine how much to compensate Medicare Advantage plans and educate consumers on health plan quality. The Star Ratings system consists of over 50 measures from five different rating systems. The cumulative results of these measures make up the Star rating assigned to each health plan.

Star Ratings have a significant impact on the financial outcome of Medicare Advantage health plans by directly influencing the bonus payments and rebate percentages received. CMS will award quality-based bonus payments to high performing health plans based on their Star Ratings performance. For health plans with a four star or more rating, a bonus payment is paid in the form of a percentage (maximum of five percent) added to the county benchmark. (A county benchmark is the amount CMS expects it to cost to provide hospital and medical insurance in the state and county.) After 2015, any health plans with Star Ratings below four will no longer receive bonus payments.

Star Rating Components

The Star Rating is comprised of over 50 different measures from six different rating systems:

- **HEDIS**-The Health Care Effectiveness Data and Information Set is a set of performance measures developed for the managed care industry. All claims are processed regularly to extract the NCQA (National Committee for Quality Assurance) defined measures. For example, this allows the health plan and CMS to determine how many enrollees have been screened for high blood pressure.
- **CAHPS**- Consumer Assessment of Health Care Providers and Systems is a series of patient surveys rating health care experiences performed on behalf of CMS by an approved vendor.
- **CMS**- Centers for Medicare & Medicaid Services rates each plan on administrative type metrics, such as, beneficiary access, complaints, call center hold times, and percentage of patients choosing to leave a plan.
- **PDE**- Prescription Drug Events is data collected on various medications related events, such as high-risk medications, adherence for chronic conditions, and pricing.
- **HOS**- Health Outcomes Survey is a survey that uses patient-reported outcomes over a 2.5-year time span to measure health plan performance. Each spring a random sample of Medicare beneficiaries is drawn from each participating Medicare Advantage Organization (MAO) that has a minimum of 500 enrollees and is surveyed. Two years later, these same respondents are surveyed again (i.e., follow up measurement).
- **IRE**- Medicare Advantage plans are required to submit all denied enrollee appeals (Reconsiderations) to an Independent Review Entity (MAXIMUS Federal Services).

These systems rate the plans based on six domains:

1. Staying healthy: screenings, tests and vaccines
2. Managing chronic (long term) conditions

3. Patient experience with health plan
4. Patient complaints, problems getting services, and improvement in the health plan's performance
5. Health plan customer service
6. Data used to calculate the ratings comes from surveys, observation, claims, data and medical records

CMS continues to evolve the Star Ratings system by adding, removing and adjusting various measures on a yearly basis. CMS weights each measure between one and three points. A three-point measure, or triple weighted measure, are measures that CMS finds most important and should be a focus for health plans. The composition of all rating systems is indicated below.

Health Reform

The Patient Protection and Affordable Care Act (PPACA) requires that Medicare Advantage (MA) plans be awarded quality-based bonus payments beginning in 2012, as measured by the Star Ratings system. Bonus payments are provided to MA plans that receive four or more stars. CMS assigns a benchmark amount to each county within a state, which is the maximum amount CMS will pay to provide hospital and medical benefits. All MA plans submit a bid, which is the projected cost to operate MA within the county. The spread between the bid and original benchmark is called the rebate. A bonus payment is the percentage added to the county benchmark, which increases the spread and the amount of revenue received by the health plan.

Healthcare Plan Effectiveness Data Information Set (HEDIS®)

HEDIS (a standardized data set) is developed and maintained by the National Committee for Quality Assurance (NCQA), an accrediting body for managed care organizations. The HEDIS measurements enable comparison of performance among managed care plans. The sources of HEDIS data include administrative data (claims/encounters) and medical record review data.

HEDIS measurements include measures such as Comprehensive Diabetes Care, Adult Access to Ambulatory and Preventive Care, Glaucoma Screening for Older Adults, Controlling High Blood Pressure, Breast Cancer Screening, and Colorectal Cancer Screening.

Plan-wide HEDIS measures are reported annually and represent a mandated activity for health plans contracting with the Centers for Medicare & Medicaid Services (CMS). Each spring, the Participating Plan Representatives will be required to collect from practitioner offices copies of medical records to establish HEDIS scores. Selected practitioner offices will be contacted and requested to assist in these medical record collections.

All records are handled in accordance with Participating Plan's privacy policies and in compliance with the Health Insurance Portability and Accountability Act (HIPAA) Privacy rules. Only the minimum necessary amount of information, which will be used solely for the purpose of this HEDIS initiative, will be requested. HEDIS is considered a quality-related health care operation activity and is permitted by the HIPAA Privacy Rule [see 45 CFR 164.501 and 506].

Participating Plan's HEDIS results are available upon request. Contact the Health Plan's Quality Improvement Department to request information regarding those results.

HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

Star Measure Weighting

Individual Star measures can be single-weighted, 1.5-weighted or triple-weighted, with higher weight being given to those measures that CMS deems most important by which to measure plan quality. Triple-weighted measures are typically outcomes measures that measure a health plan's ability to manage chronic illnesses and keep patients healthy. Certain disease states appear in multiple measures. For example, diabetes directly impacts 7 measures and cardiovascular conditions directly impact 4 measures.

Following is a summary of the weighting of all Star measures:

Part C Star Rating Measure	Weight
Breast Cancer Screening (HEDIS)	1
Colorectal Cancer Screening (HEDIS)	1
Annual Flu Vaccine (CAHPS)	1
Improving/Maintaining Physical Health (HOS)	3
Special Needs Plan (SNP) Care Management	1
Monitoring Physical Activity (HOS)	1
Adult BMI Assessment (HEDIS)	1
Care For Older Adults -- Medication Review (HEDIS)	1
Care For Older Adults -- Pain Screening (HEDIS)	1
Care For Older Adults -- Functional Status (HEDIS	1
Osteoporosis Management in Women who had a Fracture	1
Comprehensive Diabetes Care -- Eye Exam (HEDIS)	1
Comprehensive Diabetes Care -- Kidney Disease	Expected to Retire
Comprehensive Diabetes Care – Blood Sugar Controlled	3
Controlling Blood Pressure (HEDIS)	3
Rheumatoid Arthritis Management (HEDIS)	Retired
Reducing Risk Of Falling (HOS)	1
Managing Urinary Incontinence	1
Statin Therapy for Patients with Cardiovascular Disease	1
Plan All Cause Readmissions (HEDIS)	3
Medication Reconciliation Post Discharge (HEDIS)	1
Getting Needed Care Without Delays (CAHPS)	4
Getting Appointments And Care Quickly (CAHPS)	4

Customer Service (CAHPS)	4
Overall Rating Of Health Care Quality (CAHPS)	4
Overall Rating Of Plan (CAHPS)	4
Care Coordination (CAHPS)	4
Complaints About The Health Plan (CTM)	4
Beneficiary Access And Performance Problems (CMS)	1.5
Members Choosing To Leave The Plan (CMS)	4
Health Plan Quality Improvement (CMS)	5
Plan Makes Timely Decisions About Appeals (IRE)	4
Reviewing Appeals Decisions (IRE)	4

Part D Star Rating Measure	**Weight**
Foreign language interpreter & TTY/TDD Availability (Call Center)	4
Follow-up after Emergency Department Visit for Patients with Multiple Chronic Conditions	TBD
Transitions of Care – Medication Reconciliation Post-Discharge	0.5
Transitions of Care – Notification of Inpatient Admission	0
Transitions of Care – Patient Engagement After Inpatient Discharge	0.5
Transitions of Care – Receipt of Discharge Information	0
Transition of Care – Average	1
Controlling Blood Pressure	3
Kidney Health Evaluation for Patients with Diabetes	Display
Plan All-Cause Readmissions	1
Appeals Auto forward (IRE)	1.5
Appeals Upheld (IRE)	1.5
Complaints About The Health Plan (CTM)	4
Beneficiary Access And Performance Problems (CMS)	1.5
Members Choosing To Leave The Plan (CMS)	4
Drug Plan Quality Improvement (CMS)	5
Rating Of Drug Plan (CAHPS)	4
Getting Needed Prescription Drugs (CAHPS)	4
MPF Pricing Accuracy (PDE)	1
High Risk Medications (PDE)	3
Diabetes Treatment (PDE)	3
Medication Adherence For Diabetes Medications (PDE)	3
Medication Adherence For Hypertension (PDE)	3
Medication Adherence For Cholesterol (PDE)	3
MTM Program Completion Rate for CMR	1
Statin Use in Persons with Diabetes (SUPD)	1

POPULATION HEALTH TECHNOLOGY AND INTEGRATION

Information Protection Requirements and Guidance
IPA follows all applicable laws, rules, and regulations regarding the electronic transmittal and reception of Patient and Provider information. As such, if an electronic connection is made to facilitate such data transfer, all applicable laws must be followed. At all times, a provider must be able to track disclosures, provide details of data protections, and respond to requests made by IPA regarding information protection.

When an electronic connection is needed, relevant connection details will be provided to a patient by the IT Operations team who will engage with provider's staff to appropriately implement the connection. Any files placed for receipt by provider staff must be downloaded in 24 hours, as all data is deleted on a fixed schedule. If the files are unable to be downloaded, then alternate arrangements for retransmission must be made. The provider and provider's staff will work collaboratively with IPA to ensure information is adequately protected and secure during transmission.

Experience the Ease of HSConnect
- View patient eligibility
- Request precertification
- Search authorizations
- Search claims

Need More Help? Contact the HSConnect Help Line: **1-866-952-7596, Option 2** or e-mail **HSConnectHelp@hsconnectonline.com**
To register for HSConnect, visit: **www.hsconnectonline.com**

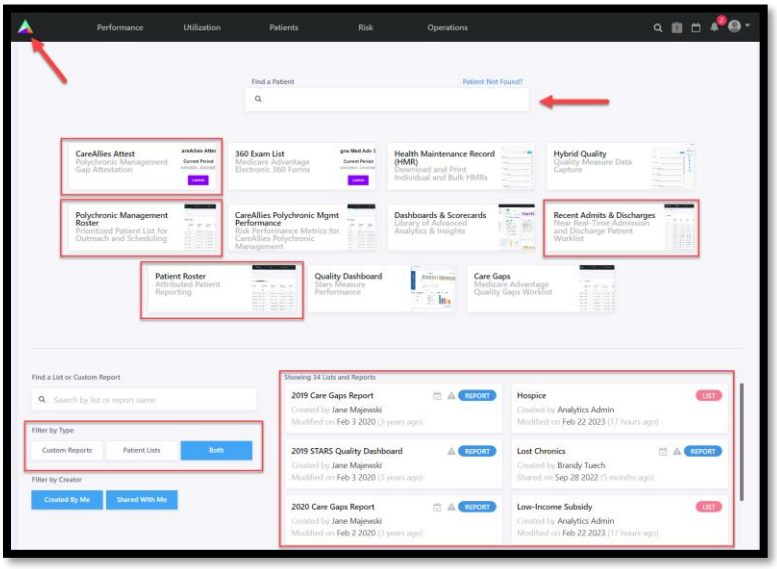
ARCADIA

Arcadia is a population health management company, specializing in data aggregation, analytics, and workflow software for value-based care. Arcadia assists its customers by focusing on creating the highest quality data asset, pushing expertly derived insights to the point of care, and supporting administrative staff with data when and where they need it with applications, including care management.

Home Page

The Home Page is the centralized location of the Arcadia platform where many essential components can be easily accessed. Returning to the Home Page can be easily done by selecting the Arcadia logo in the upper left corner from anywhere in the core platform. From this page the end user can quickly navigate to the following:

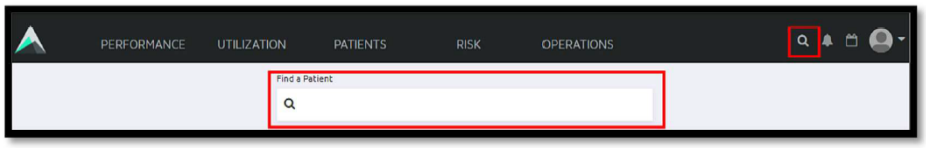
- **Search Bar**: allows users to find a specific patient by searching based on name, member ID or date of birth
- **Custom Chips**: globally filtered reports and lists that allow quick access to the Polychronic Management Roster, CareAllies Attest, Recent Admits and Discharges report and the Patient Roster.
- **Custom Reports and Lists**: administrative or user created reports and lists customized to adapt to specific population needs



Patient Search

Users may search for a specific patient in the **Search Bar** near the top of the homepage or with the **Search Icon** in the upper right corner using the following:

- **Name** (Last Name, First Name)
- **Member Number**
- **Date of Birth (MM-DD-YYYY** or **YYYY-MM-DD)**

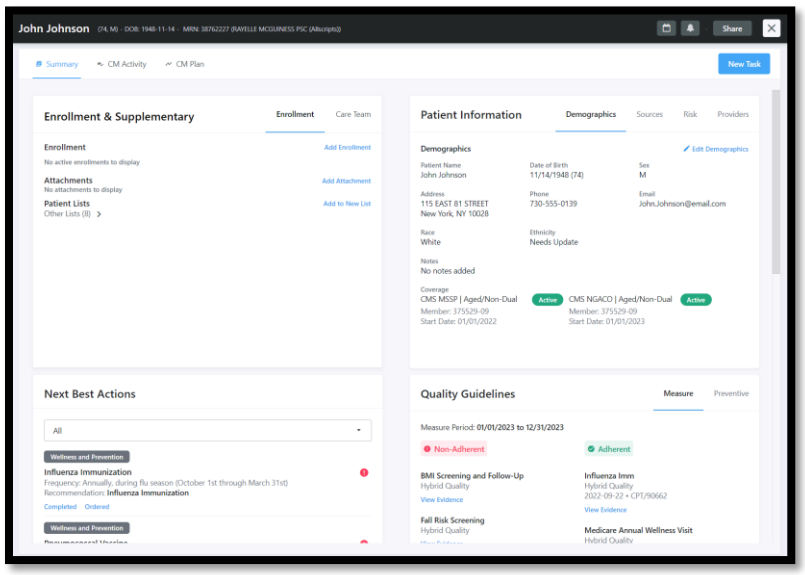


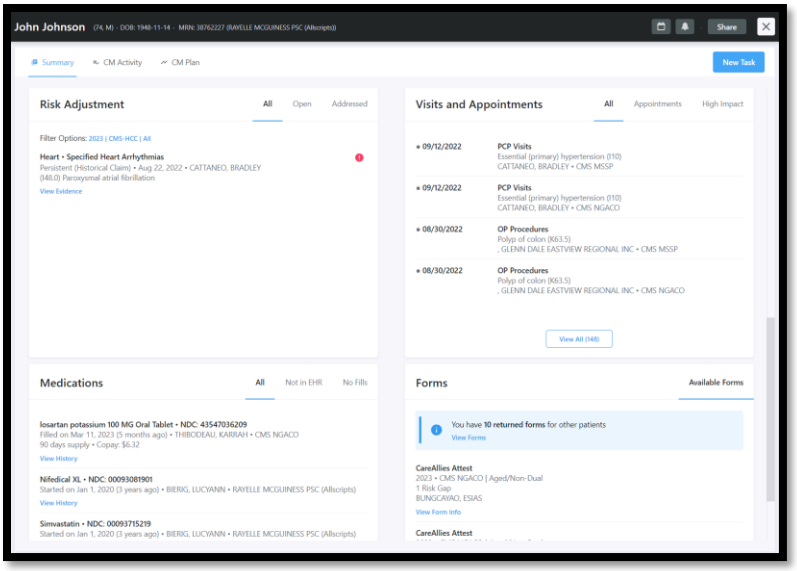
HELPFUL HINT!
The most accurate search results come from using the exact member number or full name.

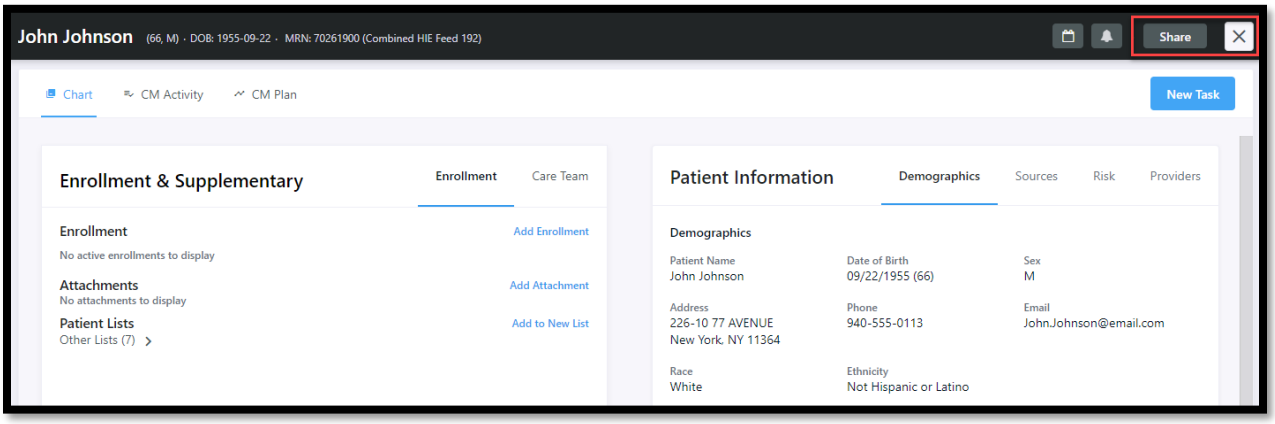
Patient Chart

The **Patient Chart** is the **longitudinal health record of the patient.**
Access to the Patient Chart may be done through a patient search or selecting a specific patient hyperlink within an Arcadia report. This chart will help orient the clinician to the following information:

- Enrollment and Supplementary
- Patient demographics
- Next Best Actions
- Quality Guidelines
- Risk Adjustment
- Visits and Appointments
- Medications
- Forms (360 & Attest)



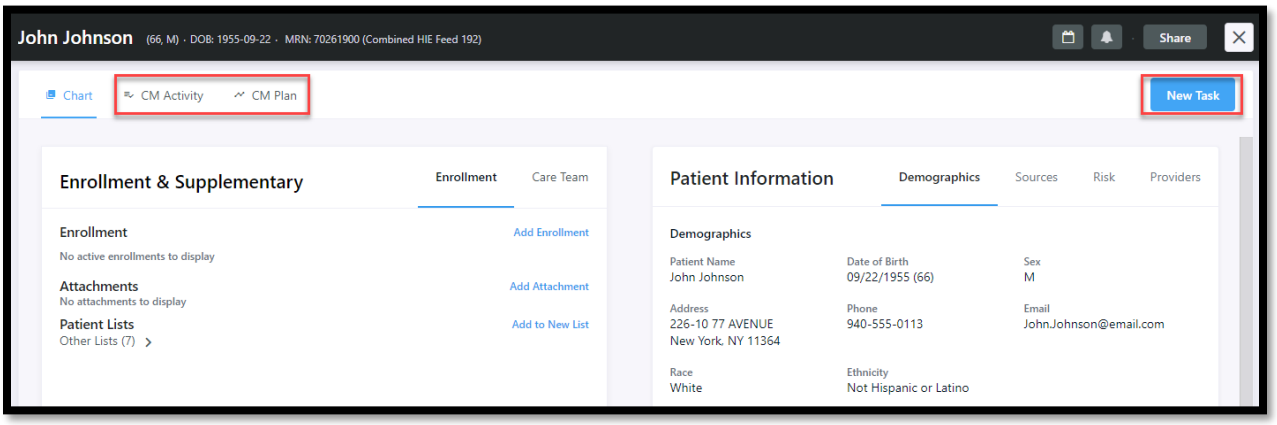




From the Patient Chart, end users will have access to the following buttons and functionality (based on individual user access rights):

- The **Share** button allows the patient chart to be **printed or downloaded as a PDF**
- The **Back** button returns the user to the **previous report or list**

Patient Chart: Care Management User



In addition, end users that leverage **care management** functionality, will have access to the following tabs and buttons:

- The **CM Activity** tab displays a **scorecard view** of scheduled tasks, activities and associated detail
- The **CM Plan** tab shows information around a **set of care plan goals and actionable interventions** to achieve those goals
- The **New Task** button allows the user to **schedule various different tasks**
- The **Back to Dashboard** button returns the user to the **CM Dashboard**

Contacting Production Support

Customer Portal: "Report Issue" button in the Web Application
Email: analyticssupport@arcadia.io
Phone: 888.853.8095
Please remember to never send personal or patient sensitive information via unencrypted email. If you must provide PHI or Pl, please use the customer portal or call the Production Support team for instructions on the best way to communicate sensitive information. Depending on how you created your request, you will receive an acknowledgement with a request number and possibly an estimated time of resolution for your request. Please make a note of and refer to this request number in future communications if you are not using the customer portal.

HEALTH SERVICES

Overview

The Health Services Department coordinates health care services to ensure appropriate utilization of health care resources. This coordination assures promotion of the delivery of services in a quality-oriented, timely, clinically appropriate, and cost-effective manner for the patients.

Services will provide a full range of customary utilization review and care management services and, except in the case of an emergency medical condition, provide prior authorization for those services if required by the patient's benefit plan, including hospital inpatient stays or confinement. You are responsible to participate in and comply with the utilization management program requirements and, to the extent applicable, the delegated utilization management agent's utilization management program, and provide medical records and other information, including access to electronic medical records (EMRs), as requested.

The Utilization Management staff base their utilization-related decisions on the clinical needs of patients, the patient's Benefit Plan, well-established clinical decision-making support tools, the appropriateness of care, CMS Guidelines, health care objectives, and scientifically based clinical criteria and treatment guidelines in the context of provider and/or patient-supplied clinical information and other such relevant information.

The IPA in no way rewards or incentivizes, either financially or otherwise, providers, utilization reviewers, clinical care managers, physician advisers, or other individuals involved in conducting utilization review, for issuing denials of coverage or service, or inappropriately restricting care.

Goals

- To ensure that services are authorized at the appropriate level of care and are covered under the patient's health plan benefits.
- To monitor utilization practice patterns of IPA's contracted physicians, hospitals, ancillary services, and specialty providers.
- To provide a system to identify high-risk patients and ensuring that appropriate care is accessed.
- To provide utilization management data for use in the process of re-credentialing providers.
- To educate patients, physicians, contracted hospitals, ancillary services, and specialty providers about IPA's goals for providing quality, value-enhanced managed health care.
- To improve utilization of IPA's resources by identifying patterns of over- and under-utilization that have opportunities for improvement.

Prior Authorization Department

The IPA requires authorization of certain services, medications, procedures, and/or equipment

prior to performing or providing the service to prevent unnecessary utilization while safeguarding beneficiary access to the most appropriate medically necessary care. The authorization is typically obtained by the ordering provider, but may also be requested by the rendering provider.

Participating providers are responsible for requesting prior authorization on behalf of the patient, when required, at least 14 business days in advance of the admission, procedure, or service when possible.

Requests must include all pertinent clinical information to support the medical necessity of the services requested. The patient may also request a determination prior to delivery of services. In this event, the utilization management agent will contact you for clinical information to support the request.

If prior authorization cannot be obtained in a timely manner, the utilization management agent and the appropriate participating provider must be notified, as applicable, as soon as possible, but no later than 24 hours after providing or ordering the covered services, or on the next working day.
Please refer to the current Prior Authorization Requirements located here:
medicareproviders.cigna.com

If you are uncertain about the precertification requirement for a specific procedure, you may reach out to the Provider Patient Service Department at **1-800-230-6138**, 7 a.m. - 6 p.m. CST.

Prior Authorization is a determination of medical necessity and is not a guarantee of claims payment. Claim reimbursement may be impacted by various factors including eligibility, participating status and benefits at the time the service is rendered.

The presence or absence of a service or procedure on the list does not determine coverage or benefits.

Departmental Functions

- Prior authorization
- Concurrent review
- Discharge planning
- Case management and disease management
- Continuity of care

Requests for Prior Authorization

Upon submission of the request, please be prepared with all necessary information noted below inclusive of accurate diagnosis, CPT/HCPCS coding, and rendering provider information.
Information required for a determination may include, but is not limited to:
Examples of information required for a determination include, but are not limited to:
Patient name and identification number
Date of service

Location of service (e.g., hospital or surgical center setting)
Accurate diagnosis
Service/procedure/surgery description and CPT or HCPCS code(s)
Clinical information supporting the need for the service to be rendered
Primary Care Physician name along with Tax Identification Number (TIN) or Provider Identification Number (PIN)
Servicing/attending physician name, including NPI

As necessary, service requests will be forwarded to clinically licensed staff to complete a review to ensure benefit coverage, medical necessity, appropriateness of provider and place of service. Requests that cannot be approved utilizing CMS and nationally recognized, evidence-based criteria will be forwarded to a Pharmacist or Medical Director for review.

Approval notification may be delivered electronically, orally, or in writing.

Denials for medical necessity are issued only by appropriately licensed personnel such as a Medical Director or Pharmacist depending on the type of service request.

He/she may also make a decision based on administrative guidelines. The Medical Director or Pharmacist, in making the decision, may suggest alternative covered services to the requesting provider. If the Medical Director makes a determination to deny or limit an admission, procedure, service or extension of stay, The health plan notifies the facility or providers office of the denial. Such notice is issued to the patient and the provider when appropriate, documenting the original request that was denied, the rationale for the decision, the alternative approved service if applicable, and the process for appeal.

Denial rationale will include the specific clinical criteria or benefits provision used in the determination of the denial. Written notifications are sent in accordance with CMS and National Committee for Quality Assurance (NCQA) requirements to the provider and/or patient. Upon request, the provider or patient may receive a copy of the clinical criteria used in the decision. To request clinical criteria, call **800.230.6138**, Monday-Friday, 8:00 a.m.-5:00 p.m. CT.
The health plan gives providers the opportunity to discuss adverse determinations with the Medical Director who made the decision.

After a decision is rendered, a peer-to-peer conversation can occur with the purpose of allowing the provider to receive additional clinical information that may be helpful prior to initiating a formal appeal. The health plan will advise the treating provider of the availability of this process when notification of the prior authorization denial is given.
Prior authorization decisions cannot be altered with the peer-to-peer process.

How to Request Prior Authorization

For prior authorizations, providers should fax request to **1-832-553-3420** or may submit requests via our online portal 24 hours per day, 7 days per week at: www.hsconnectonline.com. You can

also contact the Precertification department via phone at **1-800-511-6932**.

The Prior Authorization Department, under the direction of licensed nurses, clinical pharmacists, and medical directors, documents and evaluates requests for authorization, including:

- Confirmation that the patient is eligible for IPA health plan coverage at the initial start of care
- Verification that the requested service is a covered benefit under the patient's benefit package.
- Determination of the appropriateness of the services (medical necessity).
- Validation that the service is being provided by the appropriate provider and in the appropriate setting.

The Prior Authorization Department documents and evaluates requests utilizing CMS guidelines and nationally recognized accepted criteria, to make a determination of coverage. The provider may be notified electronically, orally, or in writing within the regulated CMS time frames.

It is essential to submit clinical information at the time of the request. The Prior Authorization Department may outreach to you for information needed to make a determination. Requests received without supporting documentation may experience delays in processing up to the regulatory time frames, as CMS rules require that appropriate information be requested before decisions are rendered. See the Prior authorization request and time frames section for details regarding decision and notification time frames.

For patients who go to an emergency room for treatment, an attempt should be made in advance to contact the PCP unless it is not medically feasible due to a serious condition that warrants immediate treatment.

If a patient appears at an emergency room for care, which is non-emergent, the PCP should be contacted for direction. The patient may be financially responsible for payment if the care rendered is non-emergent. The IPA also utilizes urgent care facilities to treat conditions that are non-emergent but require immediate treatment. Prior Authorization is a determination of medical necessity and is not a guarantee of claims payment. Claim reimbursement may be impacted by various factors including eligibility, participating status, and benefits at the time the service is rendered.

Prior Authorization Forms

To access the prior authorization forms, go to MedicareProviders.Cigna.com > Find a Form > Prior Authorization Request Forms. It is important to use the forms when faxing a prior authorization request (along with the supporting clinical information) to help assure we have all the information needed to make a determination.

Prior authorization requirements are updated on a quarterly basis to align with program or CPT and HCPCS code changes. Therefore, it is important to check the prior authorization requirements before delivering planned services.

Prior Authorization Requests and Time Frames

Emergency

An Emergency Medical Condition is a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

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

Expedited:

An expedited request can be requested when you as a physician believe that waiting for a decision under the routine time frame could place the patient's life, health, or ability to regain maximum function in serious jeopardy. Expedited requests will be determined within 72 hours or as soon as the patient's health requires.

To help us meet our patient's urgent care needs, it is recommended that requests be reserved for services meeting the above criteria and not utilized as a convenience due to a scheduled service.

Routine:

A routine or standard Prior Authorization request will be determined as expeditiously as the health condition requires, but no later than 14 calendar days after receipt of the request.

Medical Necessity Hierarchy

The hierarchy of decision includes that the service must be:

- A covered benefit in the patient's Evidence of Coverage,
- A benefit that is not otherwise excluded, and
- Appropriate and medically necessary.

The hierarchy of references includes:

- Laws – Title 18 of the Social Security Act
- Regulations – Title 42 Code of the Federal Regulations [CFR])
- National coverage determinations
- Medicare Benefit Policy Manual – Internet Only Manual (IOM) 100-02
- Local coverage determinations
- CMS coverage guidelines in interpretive manuals and IOM sub-manuals
  - Pub 100-04 Medicare Claims Processing
  - Pub 100-08 Medicare Program Integrity
  - Pub 100-10 Quality Improvement Organization
  - Pub 100-16 Medicare Managed Care Manual
- Durable Medical Equipment Medicare Administrative Contractor
- Program Safeguard Contractor for local coverage determinations

- coverage policies
  - Coverage Policy Unit
  - co-branded
  - Drug and biologic coverage policies (Express Scripts)
- Vendor partner guidelines
- NCCN Clinical Practice Guidelines
- Part B drug and biologic coverage parity and step therapy policies
- Standards and guidelines and medical necessity criteria for behavioral health
- MCG (most recent edition)
- Supplemental benefits and limitations as outlined in the patient's Evidence of Coverage
- U.S. Food & Drug Administration (FDA)-approved indications for medications not outlined in specific local coverage determinations
- Other major payer policy and peer-reviewed literature
- Utilization management policies and procedures (such as for network adequacy, continuity of care, and transition of care)
- Additional Medical Director resources:
  - Hayes
  - Wolters Kluwer Clinical Drug Information Lexi-Drugs (up to date)
  - Medical inquiry database

Discharge Planning and Acute Care Management

Discharge Planning is a critical component of the process that begins with an early assessment of the patient's potential discharge care needs in order to facilitate transition from the acute setting to the next level of care. Such planning includes preparation of the patient and his/her family for any discharge needs along with initiation and coordination of arrangements for placement and/or services required after acute care discharge. The Concurrent Review staff will coordinate with the facility's discharge planning team to assist in establishing a safe and effective discharge plan.

Inpatient Coordination of Care and Concurrent Review

Concurrent Review is the process of initial assessment and continual reassessment of the medical necessity and appropriateness of inpatient care during observation, inpatient (acute, long-term acute care, rehabilitation), and skilled nursing facility admissions to ensure:

- Reasonable and necessary covered services or supplies are being provided at the appropriate level of care by a physician, hospital, or other health care provider licensed by the appropriate state or federal agency, or as otherwise approved by concurrent review staff
- Services are not experimental or investigational and are consistent with the symptoms or diagnosis of the patient's condition, disease, ailment, or injury.
- Services are not primarily for the personal comfort or convenience of the patient or their family, physician, hospital, or other health care provider.
- Services are the most appropriate supply or level of services that can safely be provided to the patient consistent with standards of good medical practice.
- Services are being administered according to the individual facility contract.

The health plan requires admission notification for the following:

- Elective admissions
- Emergency room, urgent observation, and acute admissions
- Intent to transfer to acute rehabilitation, long-term acute care, or a skilled nursing facility, as these admissions require prior authorization
- Observation and acute admissions following outpatient procedures

Emergent or urgent admission notification must be received within twenty-four (24) hours of admission or next business day, whichever is later, even when the admission was prescheduled. If the patient's condition is unstable and the facility is unable to determine coverage information, the Health plan requests notification as soon as it is determined, including an explanation of the extenuating circumstances. Timely receipt of clinical information supports the care coordination process to evaluate and communicate vital information to hospital professionals and discharge planners. Failure to comply with notification timelines or failure to provide timely clinical documentation to support admission or continued stay could result in an adverse determination.

The Health plan's preferred method for concurrent review is EMR access. We can also receive concurrent review documentation via fax. We encourage live dialogue between our Concurrent Review nursing staff and the facility's UM staff to assist with discharge planning and needs. We should receive admission notification and clinical information within 24 hours of admission or observation status.

If clinical information is not received within 72 hours of admission or last covered day, the case will be reviewed for medical necessity with the information health plan has available.

Facilities may submit the patient's clinical information within 24 hours of notification using the appropriate contact information below.

Area	Portal	Phone	Fax
Inpatient	N/A	888.454.0013	866.234.7230
Texas CareAllies Inpatient	N/A	844.359.7301	888.205.9577
eviCore healthcare *(preferred method)*	www.eviCore.com/ep360	Post-acute care: 800.298.4806 Home health: 800.298.4806 Durable medical equipment: 866.686.4452	Post-acute care: 800.575.4429 Home health: 855.826.3724 Durable medical equipment: 866.663.7740

Following an initial determination, the concurrent review nurse will request additional updates from the facility on a case-by-case basis. The health plan will render a determination within 24 hours of receipt of complete clinical information. The participating plan's nurse will make every attempt to collaborate with the facility's utilization or case management staff and request additional clinical information in order to provide a favorable determination. Clinical update information should be received 24 hours prior to the next review date.

The health plan's Medical Director reviews all acute, confinements that do not meet medical necessity criteria and issues a determination. If the health plan's Medical Director deems that the confinement does not meet medical necessity criteria, the Medical Director will issue an adverse determination (a denial). The Concurrent Review nurse or designee will notify the provider(s) verbally and in writing of the adverse determination via notice of denial.-

The Health Services department complies with individual facility contract requirements for concurrent review decisions and time frames. The Health Services nurses, utilizing CMS guidelines and nationally accepted, evidence based review criteria, will conduct the medical necessity review. The Health plan is responsible for final prior authorization.

Adverse Determinations – Concurrent Review

Rendering of Adverse Determinations (Denials)

The Utilization Management staff is authorized to render an administrative denial decision to participating providers based only on contractual terms, benefits, or eligibility. Every effort is made to obtain all necessary information, including pertinent clinical information and original documentation from the treating provider to allow the Medical Director to make appropriate determinations.

Only the Medical Director may render an adverse determination (denial) based on medical necessity but he/she may also make a decision based on administrative guidelines. The Medical Director, in making the initial decision, may suggest an alternative Covered Service to the requesting provider. If the Medical Director makes a determination to deny or limit an admission, procedure, service, or extension of stay, the IPA notifies the facility or provider's office of the denial of service. Such notice is issued to the provider and the patient, when applicable, documenting the original request that was denied and the alternative approved service, along with the process for appeal.

If the Medical Director makes a determination to deny an admission, the Health plan notifies the requesting provider and the patient of the denial of service, documenting the denial rationale and the process for appeal. Providers are given the opportunity to discuss adverse determinations with the Medical Director who made the decision.

The purpose of the peer-to-peer conversation is to give the ordering or treating provider an opportunity to discuss the case directly with the reviewer and provide additional clinical information that may be helpful prior to initiating a formal appeal. The Health plan will advise

the treating provider of the availability of this process when notification of the prior authorization denial is given.

While the health plan generally does not allow an adverse decision to be overturned in the absence of an appeal, there is an opportunity to overturn concurrent review denials via the peer-to-peer process for acute inpatient stays at contracted facilities.

The provider may initiate the peer-to-peer discussion by calling the number listed on the denial notification. The provider has three business days following discharge to initiate a peer-to-peer review. We will make the peer-to-peer conversation available after receiving a timely request. If the physician who issued the denial is unavailable, another physician reviewer will be available to discuss the case.

If the peer-to-peer conversation or review of additional information results in an approval, the physician reviewer informs the provider of the approval. If the conversation does not result in an approval, the physician reviewer informs the provider of the right to initiate an appeal and explains the procedure.

Adverse determinations are not based on financial factors. The PCP or attending physician may contact the Medical Director by telephone to discuss adverse determinations.

Notification of Adverse Determinations (Denials)

The reason for each denial, including the specific utilization review criteria with pertinent subset/information or benefits provision used in the determination of the denial, is included in the written notification and sent to the provider and/or patient as applicable. Written notifications are sent in accordance with CMS and NCQA requirements to the provider and/or patient as follows:

- **For urgent concurrent decisions** – within 72 hours of the request.
- **For post-service decisions** – within 30 calendar days of the request.

Retrospective Review

Retrospective review is the process of determining coverage for clinical services by applying guidelines and criteria to support the claim adjudication process after the prior authorization or concurrent review time frame has passed. Listed below are the only scenarios in which retrospective requests can be accepted.

- Prior authorizations for claims billed to an incorrect payer.
  - If you have not submitted the claim to IPA yet and received a denial, you can request a retrospective prior authorization from Health Services within two business days of receiving the remittance advice from the incorrect payer.
  - If you have already submitted the claim to IPA and received a denial, you cannot request a retrospective prior authorization; however, you can request an appeal (you must follow the guidelines for submitting an appeal).
- The IPA will retrospectively review any medically necessary services provided to IPA patients after hours, holidays, or weekends. The retrospective prior authorization request and applicable clinical information must be submitted to the Health Services department within one business day of the start of care.

In accordance with IPA's policy, retrospective requests for prior authorizations not meeting the

scenarios listed above will not be accepted and claims may be denied for payment.

Readmission

The Health Services Department will review all readmissions occurring within 30 days following discharge from the same facility, according to established processes, to assure services are medically reasonable and necessary, with the goal of high-quality, cost-effective health care services for health plan patients.

The Health Services Utilization Management (UM) staff will review acute inpatient and observation readmissions. If admissions are determined to be related, they may follow the established processes to combine the two confinements.

Readmissions that occur on the same day are subject to being combined concurrently.

Readmission Quality Program

The Readmission Quality Program applies to readmissions that occur as an acute inpatient admission for a same or similar diagnosis at a facility under the same Taxpayer Identification Number (TIN) or contract.

Patient engagement and follow-up during the 30-day period following discharge can help reduce readmissions, which is a national goal that the Centers for Medicare & Medicaid Services (CMS) supports to improve the quality of care of Medicare Beneficiaries. In accordance with your contract, you may not bill the patient for covered services that are denied.

The Health plan will reimburse for readmissions for the same or similar diagnosis at a facility under the same Taxpayer Identification Number (TIN) as follows (the Health plan complies with CMS requirements for written notifications to patients, including rights to appeal and grievances):

1. **Readmissions within 48 hours from the date of discharge from the original acute inpatient admission (referred to as the index admission):**

   The facility will *not* be reimbursed for the readmission regardless of the readmission length of stay. The CMS generally considers a short-term readmission for the same or similar diagnosis to be the result of a process failure in discharge planning or the patient not being clinically stable at the time of the original discharge. Medical directors will not conduct medical necessity reviews of admissions within 48 hours from the date of discharge from the original acute inpatient admission. A Medical Director will review the readmission to determine if a same or similar diagnosis is present.

2. **Readmissions within 3-31 days from the date of discharge from original acute inpatient admission (referred to as the index admission):**
   The facility will receive one DRG payment for both confinements, which will be the higher weighted of the two DRG admissions. The days, diagnoses, procedures and all associated

billed items or services from each stay will be accounted for in the single DRG payment. A Medical Director will conduct medical necessity reviews of admissions within 3-31 days from the date of discharge and evaluate whether a same or similar diagnosis is present as well as a modifiable cause.

For per diem: 100% per day of first admission, 85% per day of the readmission.

If there is a second or more readmission(s) that occur within the original 31 day window from the original index admission discharge, then this will likewise bundle into the original admission, if the above parameters are met. A new index readmission is not set until a full 31 days has elapsed.

Program exclusions include:

- Initial admission that occurs in observation. Readmissions that occur in an observational (outpatient) setting are exempt from this program and are reimbursed according to the facility agreement.
- Readmissions for patients undergoing active chemotherapy treatment or who are in the immediate post-transplant period (31 days) are excluded from this program.
- Planned and approved elective admissions that occur within 31 days of acute inpatient discharge are reimbursed according to the facility agreement.
- Transfers from out-of-network to in-network facilities.
- Transfers of patients to receive care not available at the first facility.
- Admissions with a discharge status of “left against medical advice.”
- Behavioral Health, Long Term Acute Care and Inpatient Rehab admissions.

All acute admissions are subject to this program unless the applicable contract specifies differently.

Notice of Medicare Non-Coverage

A utilization management agent reviews all ongoing skilled nursing services that do not meet medical necessity criteria and issues a determination. If the Medical Director deems that a continued stay is not medically necessary, the Medical Director will issue an adverse determination (a denial).

The utilization management agent will issue a Notice of Medicare Non-Coverage (NOMNC) to the skilled nursing facility with adverse organization determinations or denials when it is determined that services will end, and discharge is anticipated in accordance with CMS guidelines. The skilled nursing provider is responsible for delivering the notice to the patient or their authorized representative or power of attorney at least two calendar days prior to the end date of the currently approved authorization.

A NOMNC must be delivered even if the patient agrees with the termination of services. The provider is responsible for ensuring that the patient, authorized representative, or power of attorney signs the notice within the specified time frame. The NOMNC includes information on a patient's rights to file a fast-track appeal.

Appeals

An appeal is a request for the IPA to review a previously made decision related to medical necessity, clinical guidelines, or prior authorization and referral requirements. You must receive a notice of denial, or remittance advice before you can submit an appeal. Please do not submit your initial claim in the form of an appeal.

You may appeal a health services or Utilization Management denial of a service not yet provided, on behalf of a patient. The patient must be aware that you are appealing on his or her behalf. Patient appeals are processed according to Medicare guidelines.

An appeal must be submitted within 60 days of the original decision unless otherwise stated in your provider agreement With your appeal request, you must include a copy of your denial, any medical records that would support the medical necessity for the service, hospital stay, or office visit, and a copy of the insurance verification completed on the date of service.

You may appeal a previous decision not to pay for a service. For example, claims denied for no authorization or no referral, including a decision to pay for a different level of care; this includes both complete and partial denials. Examples of partial denials include denials of certain levels of care, isolated claim line items, or a decreased quantity of office or therapy visits. Total and partial denials of payment may be appealed using the same appeal process. Your appeal will receive an independent review by the Health Services representative not involved with the initial decision. Requesting an appeal does not guarantee that your request will be approved or that the initial decision will be overturned. The appeal determination may fully or partially uphold the original decision.

Appeals can take up to 60 days for review and determination. Timely filing requirements are not affected or changed by the appeal process or by the appeal outcome. If an appeal decision results in approval of payment contingent upon the filing of a corrected claim, the time frame is not automatically extended and will remain consistent with the timely filing provision in the IPA's agreement.

You should submit your appeal using the "Request for Appeal or Reconsideration" form and medical records. There are several ways to submit your appeal to the IPA. You may the appeal request form attached.

Part C Appeals Address and Fax Number:

Renaissance Physicians
Attn: Appeals Unit PO Box 2888
Houston, TX 77252-2888

Phone: 1-832-553-3300
Fax: 1-832-553-3418

Medicare Appeals and Reconsideration Form

APPEALS AND RECONSIDERATION REQUEST FORM

Complete the top section of this form completely and legibly. Check the box that most closely describes your appeal or reconsideration reason. Be sure to include any supporting documentation, as indicated below. Requests received without required information cannot be processed.

Request for appeal or reconsideration

Customer first name: MI: Customer last name:
Customer ID #: Customer date of birth (MM/DD/YYYY):
Claim #: Date of service (MM/DD/YYYY):
Provider name/contact name: Provider NPI:
Provider phone #: Provider's contact email address:

Appeals

Reason for appeal:
__Medical necessity
__Notification/precertification
• Include precertification/prior authorization number
__Referral denial
__Payer policy

Submit Appeals to:
Renaissance Physicians
Attn: Appeals Unit
PO Box 2888
Houston, TX 77252-2888
Phone: 1-832-553-3300
Fax: 1-832-553-3418

Reconsiderations

Reason for reconsideration:
__Payment issue
__Duplicate claim
__Retraction of payment
__Request for medical records
• Include copy of letter/request received
__Request for additional information
• Include copy of letter/request received
• Provide missing or incomplete information
• Coding dispute
• Timely filing
• Remittance Advice (RA), Explanation of Benefits (EOB), or other documentation of filing original claim
__Coordination of Benefits

Submit reconsiderations to:
Renaissance Physicians
Attn: Reconsiderations
PO Box 2888
Houston, TX 77252-2888
Fax: 1-832-553-3418

Note: If you have multiple reconsideration requests for the same health care professional and payment issue, please indicate this in the notes below and include a list of the following: Customer ID #, Claim #, and date of service. If the issue requires supporting documentation as noted above, it must be included for each individual claim. If no additional documentations required for your appeal or reconsideration request, fax in only this completed coversheet. You may use the space below to briefly describe your reason for appeal or reconsideration.

Definitions

Payment issue: Was not paid in accordance with the negotiated terms
Coordination of benefits: Could not fully be processed until information from another insurer has been received
Duplicate claim: The original reason for denial was due to a duplicate claim
Medical necessity: Medical clinical review
Pre-certification/notification of prior-authorization or reduced payment: Failure to notify or pre-authorize services or exceeding authorized limits
Payer policy clinical: Incorrectly reimbursed because of the payers payment policy
Referral denial: Invalid or missing primary care physician (PCP) referral
Request for additional information: Missing or incomplete information *reply via sender*
Request for medical records: Please include copy of letter/request received
Retraction of payment: Retraction of full or partial payment
Timely filing: The claim whose original reason for denial was untimely filing

IPA CARE COORDINATION

The Primary Care Physician (PCP) is the patient's primary point of entry into the health care delivery system for all outpatient specialist care.
The PCP is required to obtain a referral for most outpatient specialist visits for IPA's patients. Referrals can be requested through several methods, such as:

- HSConnect
- Phone

Likewise, the specialist is required to ensure that a referral is in place prior to scheduling a visit (except urgent/emergent visits, which do not require referral). The specialist is also required to communicate to the PCP via consultation reports any significant findings, recommendations for treatment and the need for any ongoing care.

Electronic submission/retrieval of referrals through HSConnect helps to ensure accurate and timely processing of referrals.

All referrals must be obtained prior to services being rendered. No retro-authorizations of referrals will be accepted. Please note that CareAllies value the PCP's role in taking care of our IPA's patients and that the PCP has a very important role in directing the patient to the appropriate specialist based on your knowledge of the patient's condition and health history. It is also absolutely essential that patients are directed to participating providers only. In order to ensure this, please refer to our online directory or contact Customer Service for assistance.

Remember: An authorization number does not guarantee payment – services must be a covered benefit. Please verify benefits before providing services.

Referral Guidelines

- PCPs should refer only to IPA's participating specialists for outpatient visits.
- Non-participating specialist's visits require prior authorization by IPA.
- Referrals must be obtained PRIOR to specialist services being rendered.
- PCPs should not issue retroactive referrals.
- Most referrals are valid for 180 days starting from the issue date.
- All requests for referrals must include the following information:
    - Patient Name, Date of Birth, patient ID
    - PCP Name
    - Specialist Name
    - Date of Referral
    - Number of visits requested

If a patient is in an active course of treatment with a specialist at the time of enrollment, The IPA will evaluate requests for continuity of care. A PCP referral is not required, but an authorization must be obtained from IPA's Prior Authorization Department. For

further details, please refer to the Continuity of Care section in Health Services.
Please note: A specialist may not refer the patient directly to another specialist unless within scope of treatment. If a patient needs care from another specialist, he/she must obtain the referral from his/her PCP.

Self-Referrals

Patients have open access to certain specialists, known as self-referred visits/services; these include but are not limited to:

- Emergency medicine (emergency care as defined in the provider contract)
- Obstetric and Gynecological care (routine care, family planning)

Please refer to IPA's website to view the current provider directory for Participating Specialists. If a patient has a preference, the PCP should accommodate this request if possible. The only exceptions where the patient may self-refer are:

- To a Participating Gynecologist for annual gynecological exam except for infertility and to see a non-participating OB/GYN. The PCP may perform the annual exam if agreed upon by the patient.

Primary Care Physician's Referral Responsibilities

A PCP is responsible for ensuring a patient has a referral prior to the appointment with the specialist. There are two ways a PCP can obtain referral to specialists:

- Log in to HSConnect.
- Submit all referrals through HSConnect
- Submit requests via Fax to **1-832-553-3420.**
- Call in to the Referral Department:
  If the referral is an emergency, or you simply would like to speak with a referral department representative, you may obtain a referral by phone by calling Precert:
  - Local: **1-713-437-3060**
  - Toll Free Fax: **1-855-700-2928** Local Fax: **1-832-553-3420**

Specialist Physician's Referral Responsibilities

Specialists must have a referral from a PCP prior to seeing a patient if the patient's health plan requires a referral. Claims will be denied if a specialist sees a patient without a referral when the health plan requires a referral. The IPA is unable to make exceptions to this requirement. If a referral is not in place, specialists must contact the patient's PCP before the office visit. In order to verify that a referral has been made, the specialist may log in to HSConnect or the specialist may call to verify.

Instructions for a Specialist to Obtain Referrals:
The specialist can obtain referrals directly for the patient to another specialist with the following limits:

- The PCP referred the patient to the specialist
- The following five (5) conditions must be met:

1. Diagnosis must be related to the specialty and/or service to be obtained;

2. Diagnosis must be related to reason PCP referred to referring specialist;
3. Must be a covered benefit of the health plan;
4. The patient must be currently under the care of the referring specialist;
5. And, referral must be made to a participating provider.

- The specialist provides follow-up documentation to the PCP for all referrals obtained for further specialty care.
- Referrals for the following specialty care are excluded from this process and must be referred back to the PCP to obtain referral: Non-participating providers, Chiropractor, Dermatology, Otolaryngology, Maxillofacial Surgeon, Podiatry, Optometry, Transplant Specialist, and Reconstructive (Plastic) Surgeon with the exception of breast reconstruction.
- The referral must be obtained prior to the services being rendered.

Note: If all elements within the limits above cannot be met, the specialist must defer back to the PCP for further services.

The specialist may obtain referrals via HSConnect or telephone.

HSCONNECT

HSConnect

2024

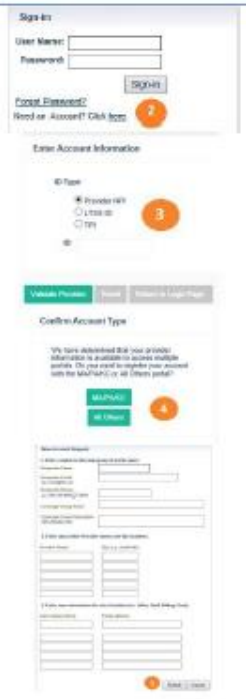
Welcome to HSConnect!

From the HSConnect Provider Portal you're able to:

- Submit Authorizations
- View Authorizations
- Check Member Eligibility & Copay Info
- Check Claim Status

Creating an Account:

1. Access HSConnect: https://www.hsconnectonline.com/login.aspx
2. In the "Sign in" Box click: "Need a new account click here"
3. Enter the requested provider information to correctly process the request.
4. If prompted, select the regional portal to access.
5. Enter the requested information and click submit.



Account Creation Definitions:

Requestor Name
Individual completing request. Preferrably office manager / administrator.

Requestor Email
Individual requestor email address.

Requestor Phone Number
Including area code & extension (if applicable).

Coverage Group Name
Operating name and/or name used with general public.

Coverage Group Description
The provider type of the requesting group. Enter practitioner, facility or ancillary.

Providers
At least one provider is required (up to 5 can be entered in the initial request). Please supply both first and last name. NPI provided should be NPI used on claim submissions.
*Note - both name and NPI are required

Cigna.

PHARMACY QUALITY IMPROVEMENT

Pharmacy Quality Improvement

The plan's Medicare Advantage Pharmacy Quality Department maintains clinical programs that meet or exceed CMS and NCQA standards, drive improvements in CMS Star ratings and Healthcare Effectiveness Data and Information Set (HEDIS®[7]) metrics, and continually strive to improve quality of pharmacy care and prevent under- or overutilization of medication therapy among our patients. These programs include, but are not limited to:

- Medication therapy management
- Opioid drug management
- Case management pharmacy referral
- Clinic-based pharmacists
- Population health: pharmacy and medical integration
- Drug utilization review
- Pharmacy Stars support

A description of each program is included below.

Medication Therapy Management Program
The Medication Therapy Management program is designed to help improve medication therapy outcomes by identifying gaps in care, addressing medication adherence, and recognizing potential cost savings opportunities. The program is designed for patients that satisfy certain CMS criteria.

Eligible patients are automatically enrolled into the program and sent a welcome letter encouraging them to call to complete their **comprehensive medication review** (**CMR**) before their annual wellness visit. Patients who call speak with a clinical pharmacist who will review with them their prescriptions, over-the-counter medications, herbal therapies, and dietary supplements. Any potential **drug therapy problems** (**DTPs**) identified during the call will be sent to the prescribing provider and/or PCP by mail or fax, along with an updated list of the patient's medication history through the previous four months. The patient will also receive an individualized letter that includes their personal medication record of all medications discussed and a medication action plan.

In addition to this review, patients may also receive quarterly **targeted medication reviews** (**TMRs**). These reviews are generated using the medication therapy management software to review for specific drug therapy problems. If any drug therapy programs are identified, a letter may be mailed or faxed to the prescribing provider and/or PCP.

There is no additional cost for participation in the medication therapy management program. The Medication Therapy Management Program Comprehensive Medication Review completion rate is a Part D Star rating based off the percentage of patients who meet eligibility criteria for a medication therapy management program and who receive a comprehensive medication review.

If you have patients with Cigna Medicare Advantage plans who are eligible for the medication therapy management program, please refer them by calling **800.625.9432** so that they may complete their annual comprehensive medication review. For more information, go to Cigna.com > For Medicare > Member Resources: Overview > Manage Medications: Medication Therapy Management

Opioid Drug Management Program (DMP)
The Opioid Drug Management Program is designed to identify patterns of inappropriate opioid utilization with the goal to enhance patient safety through improved medication use. Quarterly reports are generated using an algorithm with CMS criteria that identifies patients at risk of potential opioid overutilization based on their number of prescribers, number of pharmacies, and calculated morphine milligram equivalent (MME) per day. Individuals who have active cancer-related pain or sickle cell disease, are receiving hospice or palliative care, or are a resident of a long-term care facility are excluded from the program. Clinical staff review claims data of all identified patients who meet the established criteria and determine whether further investigation with prescribers is warranted. If intervention is deemed appropriate, clinical staff will send written notification by fax to the prescribers involved in the patient's care requesting information pertaining to the medical necessity and safety of the current opioid regimen. Health Services will reach out to discuss the case with the patient's opioid prescriber(s) in an attempt to reach a consensus regarding the patient's opioid regimen. If clinical staff is able to engage with prescribers, then action will be taken based on an agreed upon plan. In the most severe cases, clinical staff may collaborate with the prescriber(s) to implement patient-specific limitations to assist with control of inappropriate utilization or overutilization of opioid medications. The limitations may require patients to use only selected pharmacies or prescribers for opioid medications or limit the amount of opioid medication covered by the health plan. If Health Services does not receive a response from the prescribers, despite multiple outreach attempts, then limitations may be invoked based on the decision of an internal, multi-disciplinary team according to CMS requirements. As part of the health plan's ongoing partnership with providers to reduce unnecessary use and diversion of controlled substances, prescribers and pharmacists are encouraged to fully utilize their state's prescription drug monitoring program (PDMP). You can locate your state's program by going to PDMPassist.org/state.

Case Management Pharmacy Referral Programs
The Pharmacy Quality Improvement team works collaboratively with the Case Management department to provide comprehensive medications reviews for high-risk patients, including patients recently discharged from inpatient care, and/or patients with potential medication-related issues or concerns. The program is designed to help optimize medication treatment, improve medication adherence and management, and assist with medication affordability.
The team's clinical pharmacists partner with case managers to provide recommendations for the patients. Recommendations to resolve potential drug therapy problems are also communicated to the patient's provider(s) via faxed letter.

These programs support CMS requirements for a SNP Model of Care (MOC) and NCQA standard practices for accreditation.

Clinic-Based Pharmacist Program
The clinic-based pharmacist team partner with provider groups and IPAs that have a high

volume of patients to provide patient-facing care. They drive initiatives to improve patient and plan outcomes for Cigna Medicare Advantage, and collaborate with patients and their health care team to provide support and care in a variety of environments, including face-to-face, telephonic, and virtual.
The clinic-based pharmacists support other pharmacy quality programs described in this manual, as well as additional initiatives, all of which are provided specifically for the clinic-based pharmacist's assigned patient population.

Population health: Pharmacy and Medical Integration Program
The Population Health Pharmacy team develops and coordinates initiatives to reduce medical and pharmacy costs, improve patient health outcomes, and increase pharmacy-related quality ratings. The team employs strategies to reduce access barriers associated with medication use, and provides pertinent pharmacy benefits and services education to internal and external stakeholders, including health systems, providers, and providers' office support staff.

Drug Utilization Review
Drug utilization review is a structured, ongoing review of prescribing, dispensing and use of medication to identify potential drug therapy problems that could result in adverse drug events. Retrospective drug utilization review evaluates prescription drug claims data (after the medications have been dispensed to the patient).
Concurrent drug utilization review is typically performed at the point-of-sale, or point of distribution, by automated checks that are integrated into the pharmacy claims processing system (before the medications have been dispensed to the patient).

Clinical staff tracks and trends all drug utilization review data on a monthly or quarterly basis. The types of drug therapy problems that are identified and addressed include, but are not limited to:
- Underutilization or failure to refill prescribed medications
- Drug-to-drug and drug-to-disease interactions
- Overutilization or duplicate therapy
- Narcotic safety, including potential abuse or misuse
- Use of medications classified as high risk for use in the older population

The retrospective drug utilization review is conducted through various channels. Clinical staff will alert prescribers of drug therapy problems through mail, fax, or EHR integrated messaging solution (where available).

The concurrent drug utilization program aligns with CMS requirements for opioid safety edits. Safety controls will be implemented at the point of sale, including "soft" and "hard" concurrent drug utilization edits, which will reject opioid claims that meet certain utilization criteria. The dispensing pharmacy may override a "soft" rejection by entering the appropriate pharmacy professional service (PPS) codes upon consulting the prescriber and/or determining the safe and appropriate use of the medication. "Hard" rejections may not be overridden at the point of sale; to request coverage of the medication(s), a coverage determination must be initiated.

The current opioid concurrent drug utilization safety edits are listed below. They align with CMS guidance on required and recommended utilization management of opioid prescriptions.

- Opioid prescriptions will be limited to a maximum of a one-month supply OR a seven-day supply in opioid naïve patients. The health plan defines "opioid naïve" as patients who have not had an opioid medication filled within the past 108 days. This is a "hard" cDUR edit and will require a coverage determination for coverage under the beneficiary's Part D plan if a day supply exceeding these limits is needed. However, if the patient meets a specific exemption (including not being truly opioid-naïve, is in palliative care, has cancer, is in long-term care, or has sickle cell anemia), the dispensing pharmacist may use PPS codes to override this "hard" rejection.
- Opioid prescriptions for patients who have claims exceeding a total of 90 MME per day AND have two or more opioid prescribers will receive a "soft" rejection at point-of-sale. A coordination of care between the prescriber and dispensing pharmacist is encouraged. Upon consulting the prescriber and receiving approval, the dispensing pharmacist may use pharmacy professional service (PPS) codes to override the "soft" rejection.
- Opioid prescriptions will "soft" reject at point-of-sale if an interaction with a benzodiazepine is detected. The dispensing pharmacist may override the denial with PPS codes if the pharmacist consults with the prescriber, provides patient counseling, and/or determines that it is safe to dispense the medication(s).
- Opioid prescriptions for long-acting opioid medications will "soft" reject at point-of-sale if a duplication of therapy is detected between two or more long-acting opioid medications. The dispensing pharmacist may override the denial with PPS codes if the pharmacist consults with the prescriber, provides patient counseling and/or determines that it is safe to dispense the opioid medication(s).

Pharmacy Stars Support Programs

There are multiple programs to specifically support pharmacy-related Medicare Part C and D Star measures:

- Statin use in persons with diabetes
- Statin therapy for patients with cardiovascular disease
- Medication adherence for diabetes medications
- Medication adherence for hypertension (RAS antagonists)
- Medication adherence for cholesterol (statins)
- Medication therapy management program completion rate for comprehensive medical review

Low-Income Subsidy Program

Overview

The federal Medicare Extra Help (or Low-Income Subsidy) program provides extra assistance with Medicare prescription drug costs for individuals who have limited income and resources. Although most patients who are eligible for Extra Help benefits will automatically qualify for this program, there are many others who may qualify by applying for this valuable benefit. As a result, many individuals may not even know they are eligible. The Extra Help program has many benefits for qualified individuals including:

- Low or no monthly Part D premiums

- Low or no initial Part D deductible
- Coverage in the donut hole or coverage gap
- Greatly reduced costs for prescription drugs that are covered by the Medicare Part D plan and/or 90-day supply of Medicare Part D covered drugs for the same cost as a 30-day supply (applies to most but not all patients who quality for Extra Help)

Eligibility
To be eligible for the Extra Help program, individuals must reside in one of the 50 states or the District of Columbia and meet certain income and resource limits. Resources include items like savings, stocks, and money in checking and savings accounts, but will not include an individual's home or car. Income limits set by the federal government are used to determine eligibility for the Extra Help program and are based on the federal poverty level (FPL) published by HHS.

Applying for Extra Help
Individuals with limited income and resources may qualify for Extra Help to reduce their out-of-pocket costs. Applying for Extra Help is easy. Patients can choose from the following options:

- Call the Social Security Administration (SSA): **800.772.1213** or **800.325.0778** (TTY); apply over the phone or request a paper application
- Apply online: SSA.gov > Medicare > Apply for Part D Extra Help
- Call PremiumAssist (provided by Human Arc): **877.236.4471**
- Visit the Centauri Health Solutions website CentauriHS.com) > Members & Patients > Eligibility & Enrollment Services: CLICK HERE to see if you qualify

If an individual does not qualify for Extra Help, state programs may be available to help pay for prescription drug costs. All patients are encouraged to inquire about these federal and state programs.

Pharmacy Networks

The health plan provides access to more than 63,000 network pharmacies throughout the country. This extensive network gives our patients convenient access to many pharmacies in their area to choose for their unique needs. Options range from large chain pharmacies to locally owned, independent retail pharmacies. Long-term care, home infusion, and mail order/home delivery pharmacy options are also available.

Preferred pharmacy network
There are also a large number of pharmacies in Cigna's preferred pharmacy network, including over 29,000 retail pharmacies across the United States, that offer lower copayments on most prescriptions. Large national and regional chains in this network include Walgreens, Walmart, and many grocery store pharmacies. The network also includes numerous local and independent pharmacies options.

To view the most up-to-date list of preferred pharmacies, visit Cigna.com > For Medicare > Member Resources > Overview > Pharmacy Networks. You can also link to the provider and pharmacy directories (by region). Preferred pharmacies are identified with a grey-shaded box. Patients can choose to use a pharmacy in the standard or preferred network according to their

needs, but only preferred pharmacies can offer reduced cost sharing on prescription drugs. This can often result in significant total savings over the course of a year, especially for patients who take multiple prescription medications.

Home delivery
One of the most important ways to improve the health of your patients is to make sure they receive and take their medications as you prescribe.
Your patients can receive a three-month supply of their medications through mail order, making it easier for them to fill their prescriptions. Using preferred mail order pharmacy services may lower patient prescription costs and medication adherence – which can lead to lower health care utilization and total health care costs. Medication adherence is also associated with better health outcomes and decreased risk of hospitalization.

Express Scripts
Express Scripts® Pharmacy, a Cigna company, is the preferred home delivery pharmacy. Cigna Medicare Advantage patients should first set up an account with Express Scripts to get their current prescriptions filled through home delivery. They can do this by calling Express Scripts at **877.860.0982** or registering online at Express-Scripts.com > Register. Express Scripts will outreach to the provider for the prescriptions.
A complete listing of home delivery pharmacies can be found (MedicareProviders.Cigna.com) > Other Resources: Pharmacy Resources > Medication Adherence (select a state).

To request participation in the Express Scripts Pharmacy network, please go to ESIProvider.com.

Specialty pharmacies

Accredo
Accredo®, a Cigna specialty pharmacy, is Cigna's preferred specialty pharmacy. Accredo has a team of specialty-trained pharmacists and nurses who are available 24 hours a day, 365 days a year to help patients with questions about their specialty medications. Accredo is ready to work with you and the patient to help them receive the best possible care. To get started, call an Accredo Patient Care Advocate at **877.860.0982**.

Medication Adherence Tracker Initiative

Overview
The Medication Adherence Tracker (MAT) quality improvement initiative represents a bi-weekly cycle that uses a target list in order to intervene on patients that may be non-adherent to their medications. Each bi-weekly cycle corresponds to one MAT target list. The target list focuses on patients that are late to fill medications within specific pharmaceutical classes that correspond to the Part D adherence quality measures. These pharmaceutical classes include ACE/ARBs for the hypertension adherence measure, statins for the cholesterol adherence measure, and all diabetes classes, except insulin, for the diabetes adherence measure. These measures are triple-weighted, and they have a significant impact on the overall STAR quality rating.

Successful implementation of the MAT initiative involves close collaboration between the PCP, PCP office staff, and CareAllies. The role of the PCP is to prioritize this process with the office staff and highlight its importance to Part D quality success. The PCP office staff is responsible for implementing the MAT process (see MAT Best Practices Section), which reduces gaps in pharmaceutical care. The CareAllies pharmacy team collects MAT data and monitors MAT performance throughout the year. Furthermore, the pharmacy team fields questions about the report that our CareAllies' partners may not be able to answer. If a concerning decline in MAT performance is assessed during the year, the pharmacist can coordinate a meeting with the office and work together to identify any issues and formulate solutions to improve the MAT process.

There are two important metrics that are tracked throughout the year: MAT Participation and Gap Closure Rate (GCR). MAT participation is simply the percentage of completed MAT target lists that an office staff has returned to the CareAllies team. For example, if 15 MAT target lists were distributed to a PCP office during the year, and 13 of these were returned after each corresponding 2 week cycle, the participation rate would be 87% (13/15). Ideally, the goal is to be at 100% participation for the year. The GCR metric is the percentage of patients on the target list that refilled their medications after intervention from the PCP office. This metric gives insight into the effectiveness of the MAT process within a specific clinic. It is not uncommon to see an office with high MAT participation and a low GCR, and this is indicative of a need to review the MAT process within the clinic. The goal GCR is 60%, because historically, offices achieving this GCR have a high likelihood of attaining a 4 STAR rating or above on the Part D quality measures.

This improvement initiative has been studied in Texas and has shown positive outcomes. In a study published in the Journal of Managed Care Pharmacy, provider outreach using the MAT was associated with a higher likelihood of paid prescription claims and greater year-end adherence.[1] Our internal data also show that offices with higher participation in this process are more likely to attain a higher Part D STAR rating at the end of the year. Therefore, implementation of this process is an important tool to maximize Part D, and consequently, overall STARs Quality Ratings for our value-based physician offices.

Best Practices

Medication adherence is a challenging issue with no perfect solution, although we can make efforts to improve adherence through quality initiatives. The Medication Adherence Tracker (MAT) initiative is an evidence-based process that can help improve medication adherence, and there are best practices for working this initiative that can maximize gap closure rates (GCR). Each clinic is unique, with different workloads and workflows that affect day-to-day activities. Because of this, the process for working the MAT initiative within each office is expected to differ. However, there are key actions that are part of this process which could maximize success, if incorporated. The following steps are best practices for working the MAT initiative. They were formulated based on feedback from offices that have achieved high GCRs.

<u>Step 1 – Review Patient Electronic Medical Record</u>

The purpose of this step is to be sure that the patient is truly non-adherent to the medication listed on the MAT list. It is possible that the physician has discontinued the medication on the list, and calling the pharmacy and patient to coordinate a refill would be inappropriate. It is

important to remember that when a medication is discontinued by a physician, this does not automatically void a prescription at the pharmacy. If the patient has refills on a discontinued medication, and the pharmacy has not been notified of discontinuation, the patient can continue to fill it. This happens commonly with patients who are not sure of what they are taking and tell the pharmacy to "just refill everything I have."

Step 2 – Organize Patients by Pharmacy

This step is meant to organize patients by pharmacy to make the upcoming phone calls more efficient. If this step is skipped, it is very likely that PCP office staff will make multiple calls to the same pharmacy for different patients. If patients are grouped by pharmacy before phone calls are initiated, one phone call to a pharmacy can be used to address multiple patients. This is a time-saver for the clinic and the pharmacy.

Step 3 – Call Pharmacies

The purpose of calling the patients' pharmacies is to ask if the medication in question has already been picked up. It is possible that a few days have passed between the creation of the MAT list and the call to the pharmacy. During this time, the patient could have picked up the medication on their own. If this has occurred, then this patient no longer needs to be addressed. Another thing to note is that patients aren't always forthcoming with their suboptimal medication adherence. Calling the pharmacy first will confirm late-to-fill status before calling the patient. If the patient has not picked up the medication, the office staff member making the phone call should ask the pharmacy to fill the medication. The pharmacy should also be informed that the patient will receive a phone call by the PCP office to pick up the medication as soon as possible. Some PCP offices have refill authorization protocols that allow certain office members to authorize refills. If the patient is out of refills, this would be a time to address the issue.

Step 4 – Call the Patient

This is a crucial step in the process. The patient should be contacted and informed that they are late to fill their medication. This is an opportunity to educate the patient about the importance of medication adherence in relation to their disease state. Furthermore, the patient should be informed that the PCP office has already taken the step of calling the pharmacy, and that the medication will be ready for pickup soon.

Step 5 – Wait 2 Days and Follow-Up with Pharmacy

Follow-up phone calls to the pharmacy and patient are also key steps in this process, because they have the potential to close gaps that otherwise would have stayed open. If the pharmacy informs the PCP office staff that the patient has still not picked up medication, move to the last step.

Step 6 – Follow-up With Patient

If the pharmacy confirms that the patient has not picked up their medication, a follow-up call to the patient is needed. Many times, this follow-up call is a signal to the patient that the PCP office is being vigilant, and they are likely to pick up their medication after a second call. Furthermore, this call can be used to identify any barriers to picking up the medication (cost, no transportation, etc.).

In summary, for many offices that have seen success with the MAT initiative, these steps are at the core of what they do. The CareAllies pharmacy team highly encourages implementation of these steps within the PCP office workflow in order to increase the likelihood of success. As mentioned before, every office is different, and this process may need to be modified based on individual office factors. The CareAllies pharmacy team is available to help with any questions about this process.

PHARMACY

Pharmacy Prescription Benefit Part D Drug Formulary

For detailed information regarding Part D drugs, their utilization management requirements (prior authorization, step therapy, quantity limits), non-extended day supply limitations, any plan year negative changes, and most recent plan formularies, go to MedicareProviders.Cigna.com > Pharmacy Resources.

The Health plan utilizes the USP classification system defined by the Pharmacy and Therapeutics Committee to develop Part D drug formularies that include drug categories and classes covering a variety of disease states. Each category must include at least two drugs, unless only one drug is available for a particular category or class. The health plan includes all, or substantially all, drugs in protected classes, as defined by CMS. All formularies are reviewed for clinical appropriateness by the health plan's Pharmacy and Therapeutics (P&T) Committee, including the utilization management edits placed on formulary products. Health plan submits all formulary changes to CMS according to the timelines designated by CMS.

A Part D drug is a drug that meets the following criteria:
Dispensed only by prescription
Approved by the FDA
Used and sold in the U.S.
Used for a medically accepted indication. Medically accepted indication is defined as both the uses approved by the FDA and off-label uses supported by the CMS recognized compendia, Micromedex, and American Hospital Formulary Service Drug Information (AHFS-DI). On their own, uses described by clinical guidelines or peer-reviewed literature are insufficient to establish a medically accepted indication. NCCN, Clinical Pharmacology, and Lexicomp, as well as peer-reviewed literature are also used to determine medically accepted indications for drugs or biologicals used off-label in an anti-cancer chemotherapeutic regimen.
Includes prescription drugs, biologic products, vaccines that are reasonable and necessary for the prevention of illness, insulin, and medical supplies associated with insulin that are not covered under Parts A or B (syringes, needles, alcohol, swabs, gauze, and insulin delivery systems not otherwise covered under Medicare Part B).
Drugs excluded under Part D include the following:

- Drugs for which payment - as so prescribed or administered to an individual - is available for that individual under Part A or Part B
- Drugs or classes of drugs, or their medical uses, which are excluded from coverage or otherwise restricted under Medicare (with the exception of smoking-cessation products)
- Drugs for anorexia, weight loss, or weight gain
- Drugs to promote fertility

Drugs for cosmetic purposes and hair growth
Drugs for symptomatic relief of coughs and colds
Vitamins and minerals (except for prenatal vitamins and fluoride preparations)

- Nonprescription drugs
- Outpatient prescriptions for which manufacturers require the purchase of associated tests or monitoring services as a condition for getting the prescription (manufacturer tying arrangements)
- Agents used for treatment of sexual or erectile dysfunction (except when prescribed for other FDA approved indications, such as pulmonary hypertension)

Part D Utilization Management

Cigna formularies include utilization management requirements such as prior authorization, step therapy, and quantity limits. To access the Cigna Medicare Advantage Part D utilization management requirements, go to MedicareProviders.Cigna.com > Pharmacy Resources.

Prior authorization

For certain prescription drugs, patients or their provider are required to obtain prior authorization before the prescription will be covered. This is needed to determine if a drug should be covered under the patient's Medicare Part B or Part D benefit. Another common reason prior authorization may be required is to ensure that a drug is being used for a medically accepted or Part D-allowed indication, as defined above. Some drugs may have more detailed prior authorization criteria and require submission of medical information such as lab results and current and/or past medication history.

Providers can submit prior authorization requests electronically via their electronic health record (EHR) using CoverMyMeds or Surescripts®, or by using the Surescripts website (registration required) or online forms available on the Cigna website . Go to Cigna.com > For Medicare > Member Resources > Patient Forms. If unable to use the electronic prior authorization function, Cigna Medicare Advantage Provider Patient Service can be reached by phone, fax, or mail.

Coverage determination filing

A coverage determination (CD) is any decision made by or on behalf of a Part D plan sponsor (such as Cigna) regarding payment or benefits to which a patient believes they are entitled. A coverage determination may be received orally or in writing from the patient (or appointed representative) or the patient's prescribing physician.

Coverage Determination Outcome Notification Time Frames

Request type	Outcome notification method	Time frame
Standard	Phone, fax, or U.S. mail	No later than 72 hours after the initial request was received or receipt of the supporting statement
Urgent	Phone, fax, or U.S. mail	No later than 24 hours after the initial request was received or receipt of the supporting statement

Note that if the request is regarding payment for a prescription drug the patient already received, an expedited request is not permitted; patients can submit an Enrollee Prescription Drug Claim Form to request reimbursement. A decision and written coverage determination notice will be provided no later than 14 calendar days from the date the request was received.

Information Provided for Denied and Approved Coverage Determinations

Coverage determination	Information provided
Denied	• The specific reason for the denial, taking into account the patient's medical condition, disabilities, and special language requirements, if any • Information regarding the right to appoint a representative to file an appeal on the patient's behalf • A description of both the standard and expedited redetermination processes and time frames, including conditions for obtaining an expedited redetermination and the appeals process
Approved	• The duration of an approval • Limitations associated with an approval and any coverage rules applicable to subsequent refills.

Redetermination or Appeal Filing

A Part D appeal, or redetermination, must be filed within 60 calendar days from the date that appears on the coverage determination denial letter. The health plan can receive it orally or in writing from a patient, a patient's representative, or a patient's prescribing physician or other physician.

Part D appeal outcome notification time frames

Appeal type	Outcome notification method	Time frame
Standard	Phone, fax, or U.S. mail	No later than seven calendar days after the appeal was received
Expedited	Phone, fax, or U.S. mail	No later than 72 hours after the appeal was received

Expedited appeals may be requested in situations where applying the standard time frame could seriously jeopardize the patient's life, health, or ability to regain maximum function. The Request for Redetermination of Medicare Prescription Drug Denial form is available at Cigna.com > For Medicare > Member Resources > Patient Forms > Redetermination Request Forms > Medicare Part D Prescription Plans: Redetermination Form [PDF].
Note that if the request is regarding payment for a prescription drug the patient already received, an expedited appeal is not permitted and patients can submit an Enrollee Prescription Drug Claim Form to request reimbursement. Such requests must be received in writing.

A decision and written coverage determination notice will be provided no later than 14 calendar days from the date the request was received.

Part D appeals contact information:

- Phone: 866.845.6962
- Fax: 866.593.4482

Step therapy
For a select group of drugs, the patient is required to first try and fail certain drugs or drug classes to treat their medical condition before covering another drug for that condition.

Quantity limits

For a select group of drugs, the amount of the drug that will be covered without prior approval is limited.

Fraud, Waste, and Abuse

In order to protect Medicare trust funds from fraud, waste and abuse, to ensure Part D drugs are prescribed only by qualified suppliers, and to follow the recommendations from the Office of Inspector General (OIG); the Centers for Medicare & Medicaid Services (CMS) proposed changes to the Medicare participation requirements related to Drug Enforcement Administration (DEA) certification of registration.

QUALITY CARE MANAGEMENT PROGRAM

Mission Statement

IPA is dedicated to improving the health of the community we serve by delivering the highest quality and greatest value in health care benefits and services.

Values:

- Integrity – We always conduct ourselves in a professional and ethical manner.
- Respect – We all have value and will treat others with dignity and esteem.
- Communications – We encourage the free exchange of thoughts and ideas.
- Excellence – We continuously strive to exceed our patients' expectations.

Quality Principles

The IPA shall apply the guiding values described above to its oversight and operation of its system and:

- Provide services that are clinically driven, cost effective and outcome oriented.
- Provide services that are culturally informed, sensitive and responsive.
- Provide services that enable patients to live in the least restrictive, most integrated community setting appropriate to meet their health care needs.
- Ensure that guidelines and criteria are based on professional standards and evidence-based practices that are adapted to account for regional, rural and urban differences.
- Foster an environment of quality of care and service within the IPAand through our provider partners.
- Promote patient safety as an over-riding consideration in decision-making.

The Quality Improvement program provides guidance for the management and coordination of all quality improvement and quality management activities throughout the IPA and its affiliates. The program describes the processes and resources to continuously monitor, evaluate and improve the clinical care and service provided to enrollees for their physical health. The program also defines the methodology for identifying improvement opportunities and for developing and implementing initiatives to impact opportunities identified:

- All aspects of physical care including accessibility, availability, level of care, continuity, appropriateness, timeliness and clinical effectiveness of care and services provided through IPA and contracted providers and organization.
- All aspects of provider performance relating to access to care, quality of care including provider credentialing, confidentiality, medical record keeping and fiscal and billing activities.
- All services covered.
- All professional and institutional care in all settings including hospitals, skilled nursing facilities, outpatient and home health.
- All providers and any delegated or subcontracted providers.

- Aspects of IPA's internal administrative processes which are related to service and quality of care including credentialing, quality improvement, pharmacy, health education, health risk assessments,
- clinical guidelines, utilization management, patient safety, case management, disease management,
- special needs, complaints, grievances and appeals, patient service, provider network, provider education, medical records, patient outreach, claims payment and information systems

Quality Management Program Goals

The primary objective of the Quality Improvement program is to promote and build quality into the organizational structure and processes to meet the organization's mission of improving the health of the community we serve by delivering the highest quality and greatest value in health care benefits and services.
The goals the organization has established to meet this objective are:

- Maintain an effective quality committee structure that:
    - Fosters communication across the enterprise;
    - Collaboratively works towards achievement of established goals;
    - Monitors progress of improvement efforts to established goals;
    - Provides the necessary oversight and leadership reporting.
- Ensure patient care and service is provided according to established goals and metrics.
- Ensure identification and analysis of opportunities for improvement with implementation of actions and follow- up as needed.
- Promote consistency in quality program activities.
- Ensure the QI program is sufficiently organizationally separate from the fiscal and administrative management to ensure that fiscal and administrative management does not unduly influence decision-making regarding organizational determinations and/or appeals of adverse determinations of covered benefits.
- Ensure timely access to and availability of safe and appropriate physical health services for the population served by IPA.
- Ensure services are provided by qualified individuals and organizations including those with the qualifications and experience appropriate to service patients with special needs.
- Promote the use of evidence-based practices and care guidelines.
- Improve the ability of all IPA's staff to apply quality methodology through a program of education, training, and mentoring.
- Establish a rigorous delegation oversight process.
- Ensure adequate infrastructure and resources to support the Quality Improvement program.
- Ensure provider involvement in maintaining and improving the health of IPA's patients, through a comprehensive provider partnership.

Embedded Care Coordination

The CareAllies Embedded Care Coordination (ECC) Program provides practice support to assist Physicians in providing quality care and achieving better clinical outcomes. The Embedded Care Coordinator (ECC) is typically an RN or LVN. The ECC is a dedicated resource assigned to a

Physician's office.

10 FIVE-STAR STRATEGIES

Recommendations from Embedded Care Coordinators

Embedded Care Coordinators (ECCs) are nurses employed by the plan. ECCs are embedded in physician offices to help improve or maintain a physician's Part C and D Star ratings by helping to identify and close Star gaps. ECCs have identified 10 strategies PCPs can take to help improve our Drive To Five Star Quality Rating initiatives.

STRATEGY	TACTICS	OUTCOMES
1. Practice Coordinator (PC)	Appoint a PC to work with ECC staff on Stars tasks such as: delivering and reviewing discharge reports, discussing opportunities to improve medication adherence, and important documentation such as referral forms, list of covered Rheumatoid Arthritis (RA) approved medications with RA Trigger target lists, list of covered statin medications to address the Statin Use in Diabetes (SUPD) target lists, etc.	Helps ensure that Stars metrics are fully addressed.
2. Strategy sessions	Schedule planning sessions with PC, ECC and staffers to establish strategies to be executed throughout the year.	Helps meet short- and long-term goals, establish priorities and meet deadlines.
3. Empower PC	Empower PC to delegate certain Stars tasks to staffers.	Helps prioritize focus of the PC, meet deadlines and engage staff in fulfilling Stars tasks.
4. Individual education	Enable ECC to schedule regular 1:1 educational encounters to review best practices with all staff members.	Helps maintain workflow if a staff member is out, reduce discrepancies by establishing best practices and helps staff members feel important.
5. Tools and resources	Develop Stars related workflows, guides, and cheat sheets for current and new staff to reference.	Helps ensure all steps are followed to reach gap closure.
6. Timeliness	Establish deadlines that align with the ECC's routine needs and encourage staff to prioritize their work week to meet common goals.	Helps ECC provide progress updates and helps staff prioritize weekly goals.
7. Relatability	Increase PCP face-time with ECC and staffers by scheduling monthly 30-minute conversations to review reports and address outcomes.	In addition to improved outcomes, monthly face-time meetings make PCPs more relatable and help staffers stay present and engaged.
8. Communication technology	Empower ECC to send direct messages to PCP via EMR.	Helps reduce the amount of time it takes to close a gap.
9. Organization	Create an organization system to keep Star reports and important documents in a convenient place that can be easily accessed, reviewed and updated.	Helps create reminders of pending tasks and notation of completed tasks.
10. Proactive Engagement	Be proactive and engaged by moving through tasks early. For example, some offices schedule all labs and EE-focused appointments in Q4 to be completed in Q1.	Strong forward momentum and early resolutions are important in our Drive to 5 Stars Quality Initiatives.

WHAT IS LONESTAR CIN?

Renaissance Physicians Organization Clinically Integrated Network d/b/a Lonestar State Physician Alliance

What is the Lone Star State Physician Alliance Clinically Integrated Network?
Lonestar CIN is a network of health care providers who seek to coordinate patient care to improve health outcomes and reduce medical costs. A CIN is able to negotiate contracts with payors on behalf of all CIN participating providers, which may result in rates that are higher than what providers would receive individually.

How do I join the Lonestar CIN?
To join the Lonestar CIN, you, or your provider group, if applicable, must complete the Clinically Integrated Program Participant Agreement ("Participant Agreement"), as well as the Agreement's accompanying exhibits, which include: the Joinder Agreement (Exhibit D); the Business Association Agreement (Exhibit E); and the Physician Clinical Integration Acknowledgement (Exhibit F) referenced in the Lonestar CIN Provider Manual. You must also be approved by the CIN Program Committee and pay the CIN participation fee.

Does every provider in my group need to sign the Participant Agreement?
No, the Participant Agreement may be signed at the group level, provided that each individual provider signs the Joinder Agreement (Exhibit D), and the Physician Clinical Integration Acknowledgement (Exhibit F). Refer to the Lonestar CIN Provider Manual for details.

What requirements must I meet to remain in Lonestar CIN?
You must actively participate in and adhere to the CIN Program's clinical programs, evidence-based guidelines, quality standards and care coordination programs, performance measurement and reporting procedures, as well as adhere to any requirements that contribute to the core goals of the CIN Program. CIN Participants must also maintain connectivity with the CIN to share electronic clinical data, and meet all credentialing guidelines as determined by the CIN or appropriate committee. Finally, CIN Participants will be held accountable via the CIN Program's Performance Improvement Policy, which encompasses performance monitoring, evaluation and remediation process, inclusive of peer-to-peer counseling, economic incentives and potential sanctions up to and including termination from participation in the CIN Program.

Which health plans does Lonestar CIN currently have contracts with?
Lonestar CIN has an agreement with:

- Aetna MA HMO & PPO
- Blue Cross MA HMO
- Cigna CAC
- Cigna MA PPO
- Devoted Health MA
- Humana MA PPO
- Oscar MA
- Oscar IFP

Does the Lonestar CIN contract affect my current IPA contract?
No, the Lonestar CIN contract is a separate agreement apart from your IPA contract. The Lonestar CIN contract only applies to the health plans listed above.

If I join the Lonestar CIN, how does that affect my current direct health plan contracts?
If you elect to participate with the Lonestar CIN for a given line of business, your fee-for-service reimbursement rate and accompanying terms will now be based on the Lonestar CIN contract with that health plan payer.

Will CIN Providers be required to accept all future CIN lines of business?
No, providers will have the opportunity to opt-in to CIN lines of business they would like to participate with.

Please refer to the entire Lonestar CIN Provider Manual for information specific to Lonestar CIN Participating Providers.

HEALTH PLANS

CIGNA

- Cigna-Medicare Advantage (Cigna MA)
- Cigna Collaborative Accountable Care Legacy
- Clinically Integrated Network (CIN) Cigna Collaborative Accountable Care
- Cigna HMO (City of Houston)

Cigna Medicare Advantage (Cigna MA)

Transportation Benefit
Patients may schedule transportation with Access2Care 24 hours a day, seven days a week by calling toll-free **1-866-214-5126**.

1. **To schedule transportation TO a doctor's visit:**
   Patient should call **Access2Care**:
   - By 4:00 pm, 24 hours in advance, to schedule a trip.
   - 72 hours in advance to schedule trip to health plan's Patient Orientation Meeting.
   - If someone will accompany them (limited to one adult).
   - If they will be using a wheelchair.

   Important: Patient must be ready for pick-up at **LEAST** one hour before their medical appointment. Driver will arrive at patient's residence up to one hour before scheduled medical appointment.

   To **cancel**, patient must call AT LEAST three hours before scheduled pick-up time.

2. **To schedule transportation FROM a doctor's visit** Patient should call the phone number on the card that driver gives them upon arrival at appointment
   - Call when they are ready for their return trip.
   - Driver will arrive within one hour of the call.
   - Do not call Access2Care.

3. **To a PHARMACY on the way home**
   Patient should call Access2Care:
   - Before the driver picks up patient for the return trip
   - Pharmacy trips are allowed after a medical appointment or hospital discharge
   - Pharmacy trips are not allowed as a stand-alone trip

Please note:

- Each trip is limited to 70 miles one way from patient's residence or Adult Day Care to health care professional's office.

- Transportation to health care professional's office and transportation to return home (round trip) is considered two trips.
- Patient must check their benefits to determine eligibility and number of trips available per benefit year.

Case Management Services

Participating Plan's case management program is an administrative and clinically proactive process that focuses on coordination of services for patients with multiple comorbidities, complex care needs and/or short-term requirements for care. The program is designed to work as a partnership between patients, providers, and other health services staff. The goal is to provide the best clinical outcomes for patients. The central concept is early identification, education, and measurement of compliance with standards of care. The case management staff strives to enhance the patient's quality of life, facilitates provision of services in the appropriate setting, and promotes quality cost effective outcomes. Staff patients with specific clinical expertise provide support services and coordination of care in conjunction with the treating provider.

Case Management Program Goals

The Health plan has published and actively maintains a detailed set of program objectives available upon request in our case management program description. These objectives are clearly stated, measurable, and have associated internal and external benchmarks against which progress is assessed and evaluated throughout the year. Health plan demographic and epidemiologic data, and survey data are used to select program objectives, activities, and evaluations.

Case Management Approach

The Participating Plans have multiple programs in place to promote continuity and coordination of care, remove barriers to care, prevent complications and improve patient quality of life. It is important to note that the Health plan treats disease management as a component of the case management continuum, as opposed to a separate and distinct activity.

In so doing, we are able to seamlessly manage cases across the care continuum using integrated staffing, content, data resources, risk identification algorithms, and computer applications.

The Health plan employs a segmented and individualized case management approach that focuses on identifying, prioritizing, and triaging cases effectively and efficiently.

Our aim is to assess the needs of individual patients, to secure their agreement to participate, and to match the scope and intensity of our services to their needs. Results from health risk and diagnostic values are combined using proprietary rules, and used to identify and stratify patients for case management intervention. The plan uses a streamlined operational approach to identify and prioritize patient outreach, and focuses on working closely with patients and family/caregivers to close key gaps in education, self-management, and available resources. Personalized case management is combined with medical necessity review, ongoing delivery of care monitoring, and continuous quality improvement activities to manage target patient groups.

Patients are discharged from active case management under specific circumstances, which many include stabilization of symptoms or a plateau in disease processes, the completed course of therapy, patient specific goals obtained; or the patient has been referred to Hospice. A patient's case may be re-initiated based on the identification of a transition in care, a change in risk score, or through a referral to case management.

How to Use Services

Patients that may benefit from case management are identified in multiple ways, including but not limited to: utilization management activities, predictive modeling, and direct referrals from a provider. If you would like to refer a patient for case management services, please call **1-888-501-1116**. In addition, our patients have access to information regarding the program via a brochure and website and may self-refer. Our case management staff contacts patients by telephone or face-to-face encounter. The patient has the right to opt out of the program. If the patient opts in, a letter will be sent to the patient and you as the provider. Once enrolled, an assessment is completed with the patient and a plan of care with goals, interventions, and needs is established.

Special Needs Plan

In 2008, CMS issued the final regulation "Medicare Improvements for Patients and Providers Act of 2008," known as "MIPPA." This regulation mandated that all Special Needs Plans have a filed and approved Model of Care by January 1, 2010. The Patient Protection and Affordable Care Act reinforced the importance of the SNP Model of Care as a fundamental component by requiring NCQA review and approval.

Special Needs Plan Eligibility Criteria

Special Needs Plans (SNPs) are designed for specific groups of customers with special health care needs. Only customers meeting the following criteria may join the SNP plan. CMS defined these SNP types as follows.

The three SNP specific groups are:

- Dual eligible SNP (D-SNP): (for individuals who eligible for Medicaid and Medicare)
- Chronic conditions SNP (C-SNP): for individuals with chronic conditions that are substantially disabling or life- threatening
- Institutional SNP (I-SNP): for individuals who reside in a long-term care facility

CMS mandates that each SNP type have a **Model of Care (MOC)**. The MOC is an evidenced-based care management program which facilitates the early and on-going assessments, the identification of health risks and major changes in the health status of SNP customers. The SNP MOC provides structure and describes the coordination of care and benefits and services targeted to improve the overall health of our SNP customers. The MOC also serves as also serves to ensure that the unique needs of our SNP customers are identified and appropriately addressed.

The SNP MOC identifies four key care management components:

- **SNP population** – provides a description of the unique characteristics of our overall and most vulnerable SNP customers.
- **Care coordination** – describes our SNP staff structure, the **Health Risk Assessment (HRA), Individualized Care plan (ICP), Interdisciplinary Care Team (ICT)** and Care Transition process, all of which identify the services and benefits offered through this plan and are available to our SNP customers. The wide range of services is targeted to help our SNP customers achieve their optimal health and improve the connection to care.
- **Provider Network** – describes the Specialized Expertise providers who participate in our SNP program, Clinical Practices guidelines, and Care Transition protocols. The SNP MOC Training is also addressed this section.
- **MOC Quality Measurement and Performance Improvement** – this section describes the quality improvement plan and identifies goals for the SNP population; this section of the MOC includes clinical and customer satisfaction goals, as well as on-going performance evaluation of the SNP MOC.

SNP MOC Process

The SNP MOC care management process focuses on the unique needs of our SNP customers. The MOC includes key program components, including conducting an initial and/or annual HRA, the development of an ICP by the ICT team and with a change in the health status, performing Care Transition coordination. These benefits and services are provided to ensure appropriate care coordination and care management. The IPA also utilizes risk stratification methodology to identify our most vulnerable SNP customers. These members include those who are frail/disabled, customers with multiple chronic illnesses and those at the end of life. The risk stratification process includes input from the provider, customer, and data analysis. The goal is to identify interventions, care coordination and care transitions needs, barriers to care, education, early detection, and symptom management.

- **Health Risk Assessment (HRA)** – Health plan will conduct an HRA to identify care needs. SNP customers will have a Health Risk Assessment (HRA) completed within 90 days of enrollment and then annually, within 365 days of the last HRA.
- **Individualized Care Plan (ICP)** – HRA results and evidence-based clinical protocols are utilized to develop an ICP. The Interdisciplinary Care Team is responsible for the development of an ICP.
- **Interdisciplinary Care Team** – An ICT is composed of key stakeholders, including the PCP and case managers. The ICT help to develop the ICP.

    - Primary Care Providers (PCPs) who treat SNP customers are core participants of the Interdisciplinary Care Team (ICT) as they are the primary care giver. However, ICT participants can also include practitioners of various disciplines and specialties, based on the customer's individual needs. The customer may participate in the ICT meetings, as may health care providers.
- **Care Transition** – a change in health status could result in new care management needs. As a result, our case management teams provide support to address the specific needs of our SNP population.

As a provider, your participation is required for the coordination of care, care plan management and in identifying additional health care needs for our Special Needs program patients.

PCP – Your Participation is Needed at the ICT Meetings.

The IPA case manager will invite you to participate in an ICT meeting when your SNP customer requires care management. We encourage you to participate in the ICT meeting and to collaborate in the care planning and identification of care plan goals for your SNP customer. SNP programs are geared support our customers and you by providing the benefits and services required and by supporting care management and customer goal self-management. Additionally, care transitions, whether planned or unplanned, are monitored, and PCPs are informed accordingly. PCP communication to promote continuity of care and ICT involvement is a critical aspect of care transitions protocols.

Implementation of the SNP Model of Care is supported through feedback from you, as well as systems and information sharing between the health plan, health care providers and the customer. The SNP Model of Care includes periodic analysis of effectiveness, and all activities are supported by the Stars & Quality department.

SNP Contact Information:

When a SNP customer completes a Health Risk Assessment (HRA), a care plan is generated. A copy of the HRA can be obtained by calling: our Health Risk Assessment department at **1-800-331-6769** based on the HRA responses. The customer and assigned PCP will receive a copy of the customer's care plan. A copy of the HRA can be obtained by calling: our Health Risk Assessment department at **1-800-331-6769.** To discuss and/or request a copy of the care plan, refer an SNP customer for an Interdisciplinary Care Team meeting or to participate in an Interdisciplinary Care Team meeting at **1-888-501-1116**.

BEHAVIORAL HEALTH SERVICES

Behavioral health services are available and provided for the early detection, prevention, treatment, and maintenance of the patient's behavioral health care needs. Behavioral health services are interdisciplinary and multidisciplinary: a patient may need one or multiple types of behavioral health providers, and the exchange of information among these providers is essential. Behavioral health and substance use treatment benefits cover the continuum of care from the least restrictive outpatient levels of care to the most restrictive inpatient levels of care.

Behavioral Health services include:

- Access to Participating Plan's patient Service for orientation and guidance.
- Routine outpatient services to include psychiatrist, addicitionologist, licensed psychologist and LCSWs, and psychiatric nurse practitioners. PCPs may provide behavioral health services within his/her scope of practice.
- Initial evaluation and assessment.
- Individual and group therapy.
- Psychological testing according to established guidelines and needs.
- Inpatient hospitalization.
- Medication management.
- Partial hospitalization programs.

Responsibilities of Behavioral Health Providers

PCPs can participate in the identification and treatment of their patient's behavioral health needs. PCPs' responsibilities include:

- Screening and early identification of behavioral health and substance use disorders.
- Treating patients with behavioral health care needs within the scope of their practice and according to established clinical practice guidelines. These can be patients with comorbid physical and minor behavioral health problems, or those who require treatment but refuse to access a behavioral health or substance use disorder provider.
- Consulting with and/or making referrals for patients with complex behavioral health needs, or those not responding to treatment.
- Communicating with other physical and behavioral health providers on a regular basis.
- Submitting claims with appropriate medical and behavioral health diagnosis codes. If you have questions, go to MedicareProviders.Cigna.com > Provider Education > Documentation and Coding Resources.
- Coordinating care with the patient's behavioral health practitioner when the patient first enters treatment, as well as sending subsequent updates when there is a clinical indication and when the patient completes treatment.

Access to Care

Patients may access behavioral health services as needed.

- Patients may self-refer to any network-participating behavioral health provider for initial assessment and evaluation, and ongoing outpatient treatment.
- Patients may access their PCP to discuss their behavioral health care needs or concerns, receive treatment that is within their PCP's scope of practice, and request a referral to a behavioral health practitioner. Referrals,

however, are not required to receive most network-participating behavioral health or substance use disorder services.

- Patients and providers can call Cigna Medicare Advantage Behavioral Health to receive orientation on how to access behavioral health services, provider information, and prior authorizations at **866.780.8546**.

Medical Record Documentation

When requesting prior authorization for specific services or billing for services provided, behavioral health providers must use the DSM-IV multi-axial classification system and document a complete diagnosis. The provision of behavioral health services require progress note documentation that correspond with day of treatment, the development of a treatment plan, and discharge plan as applicable for each patient in treatment.

Continuity of Care for Behavioral Health

Continuity of Care is essential to maintain patient stability. Behavioral health practitioners and PCPs, as applicable, are required to:

- Evaluate patient if he/she was hospitalized for a behavioral health condition within 7 days post-discharge.
- Provide patients receiving care with contact information for any emergency or urgent matter arising that necessitates communication between the patient and the provider.
- Evaluate patient needs when the patient is in acute distress.
- Communicate with the patient's other health care providers.
- Identify those patients necessitating follow-up and refer to Participating Plan's behavioral health focused case management program as necessary.
- Discuss cases as needed with a peer reviewer.
- Request prior authorization for a patient in an active course of treatment with a nonparticipating practitioner.

The health plan monitors the continuity and coordination of care for behavioral health patients annually through use of the following:

- Provider coordination-of-care survey – measures communication between behavioral health and PCPs, including accuracy, sufficiency, timeliness, clarity, and frequency
- Antidepressant medication-compliance rates
- Appropriate use of psychotropic medications
- Diabetes monitoring for people with diabetes and schizophrenia
- Diabetes and cardiovascular disease screening
- Monitoring for people with schizophrenia or bipolar disorder who use antipsychotic medications (individuals with serious mental illness who use antipsychotics are at increased risk of cardiovascular diseases and diabetes).

Utilization Management for Behavioral Health

The Clinical Operations department is staffed by licensed health care providers and board-certified behavioral health physicians coordinate behavioral health care services to ensure appropriate utilization of behavioral health and substance use treatment resources. This coordination assures promotion of the delivery of services in a quality-oriented, timely, clinically appropriate, and cost-effective manner for the patients.

The Participating Plan's Utilization Management staff base their utilization-related decisions on the clinical needs of patients, the patient's Benefit Plan, well established clinical decision-making support tools, the appropriateness of care, CMS guidelines, health care objectives, and scientifically-based clinical criteria and treatment guidelines in the context of provider and/or patient-supplied clinical information and other relevant information. For requests for behavioral health services that require authorization, the health plan will approve the request or issue a notice of denial if the request is not medically necessary.

BEHAVIORAL HEALTH SERVICES QUICK FACTS AND PHONE GUIDE

Cigna Medicare Advantage is committed to providing our customers with the highest quality and greatest value in healthcare benefits and services. Managing the behavioral health benefits of our customers allows Cigna Medicare Advantage the opportunity to demonstrate this commitment by recognizing overall needs and providing better care.

Cigna Medicare Advantage will continue to offer the outpatient services listed below without the requirement of a prior authorization. Any service not listed will continue to utilize the standard authorization process.

Services Requiring No Authorization by Participating Provider

CPT Code	DESCRIPTION	Report with Psychotherapy Add-On Codes
90791	Psychiatric diagnostic evaluation (no medical services)	
90792 (or New Patient E & M codes)	Psychiatric diagnostic evaluation with medical services	
Outpatient 99201-99205 99211-99215	New Patient Visit (10-60 min) Established Patient (5-25 min)	Psychotherapy Add On Codes: (when appropriate)
Nursing Facility 9304-99306 99307-99310	New Patient Visit (10-45 min) Established Patient (10-35 min)	90833-30 min 90836-45 min 90838-60 min
90832	Psychotherapy (30 min)	
90834	Psychotherapy (45 min)	
90837	Psychotherapy (60 min)	
90846	Family Psychotherapy (without patient present)	
90847	Family Psychotherapy (with patient present)	
90853	Group Psychotherapy (other than of a multiple–family group) *Physicians Office Only ~ Facilities Require Prior Authorization.*	
Q3014	Telehealth	

FUNCTION	PHONE/ADDRESS	DESCRIPTION OF SERVICES
Customer Eligibility/Benefits	800-230-6138	Verification of coverage and benefits; for facility admissions and other facility services, consult the Common Working File if customer does present ID card.
Authorization Line	866-780-8546 Fax: 866-949-4846	Prior authorization is required for services not listed above.
Inpatient Admissions	866-780-8546 Fax: 866-949-4846	Notification is required within 24 hours of admissions; clinical staff available 24 hrs a day/7 days a week to assist with notifications and precertification.
Claims Submission (paper)	Cigna MA Claims Department P.O. Box 981706 El Paso, TX 79998-1706	
Claims Submission (electronic)	**Emdeon** Payer ID: 63092 or 52192 **SSIGroup** Payer ID: 63092 **Availity** Payer ID: 63092 or 52192 **Proxymed** Payer ID: 63092	
	Medassets Payer ID: 63092 **Zirmed Payer ID: 63092** **OfficeAlly Payer ID: 63092** **GatewayEDI Payer ID: 63092** **Relay Health Professional claims CPID: 2795 or 3839** **Institutional claims CPID: 1556 or 1978**	
Claim Status Inquires	**800-230-6138**	

HSConnect	**www.hsconnectonline.com**	Access to on-line provider portal for verification of member eligibility, authorization, and claim payment review. Select Providers tab, then HSConnect to access portal.
Demographic Updates	**provider.evernorth.com**	If the provider does not have web access, they may contact Cigna Behavioral Health (CBH) Provider Services at 1-800-926- 2273
Medical Management Program (formerly referred to as: Provider Manual)	**provider.evernorth.com**	If the provider does not have web access, they may contact Cigna Behavioral Health (CBH) Provider Services at 1-800-926-2273
Contract Questions	**provider.evernorth.com**	If the provider does not have web access, they may contact Cigna Behavioral Health (CBH) Provider Services at 1-800-926-2273
Interested in Joining Cigna Behavioral Health Network	**provider.evernorth.com**	Follow: Join the Cigna Network > Behavioral > Cigna Behavioral Health Provider Application

Cigna Commercial

Cigna Local Access Plus

Access Standards

A physician group (hereinafter collectively "Provider") entering into a Collaborative Accountable Care (CAC) relationship with Cigna with their Local Access Plus product must meet the following, minimum standards when providing care:

- Daily acute care: Provider shall extend daily hours as needed until last urgent care patient is seen. Urgent care services may be delivered in an alternate facility, but Provider will use best efforts to ensure care is delivered in a Provider facility;
- Telephonic triage: Provider shall provide clinically capable evening and weekend telephonic consultation and triage service;
- Evening and weekend acute care: Provider shall provide evening and weekend office hours, which may be provided on a regional basis or other reasonable limited location basis;
- Access to care: Provider shall ensure that Cigna Participants receive physician access equal to or better than that of any other payer.

Assignment of Aligned CAC Participants

Aligned CAC Participants will be identified at minimum every three (3) months using the methodology described below. A Participant becomes an Aligned CAC Participant once the Participant is listed on the Aligned CAC Participant list, except for purposes of determining Provider's TMC and the Market's TMC or TMC Performance Index, in which case when a

Participant becomes an Aligned CAC Participant, the Participant is considered an Aligned CAC Participant for the entire Measurement Period or for the time during the Measurement Period in which the Aligned CAC Participant was a Participant, whichever is longer. Participants with Cigna Connect, Cigna Focus or Cigna SureFit networks, and Shared Administration, Strategic Alliances, patients under a capitation arrangement Payer Solutions, and Cigna International plans will not be included as CAC Participants. Also, excluded are Participants in Benefit Plans which have elected to not participate in the CAC program and when the Benefit Plan that is insured or administered by Cigna is not primary.

- Cigna uses twenty-four (24) months of retrospective medical claim data.
- Records are selected for a specific market(s); claim records are assigned a market based on the servicing physician's zip code.

The alignment uses records where:

- Servicing physician is a primary care physician (PCP) (specialty of Family Practice - FP, General Practice - GP, Internal medicine - IM, pediatrics – PD, Adolescent Medicine – AM, Geriatric Medicine - GE*)
- 29 evaluation and management (E&M) codes are used for alignment:
  - Office Visit E&M, New & Established (99201 – 99205; 99211 – 99215)
  - Office Visit Preventive, New & Established (99381 – 99387; 99391 – 99397)
  - Office Consult (99241 – 99245)
- Alignment – Step 1 (most recent twelve (12) months)
  - Services for the 29 established E&M codes and totaled by Participant and PCP (sorted by Participant and number of visits).
  - Participant is assigned to the PCP with the most visits.
  - If there is a tie for the number of visits (to multiple PCPs), assignment is to the PCP with the most recent visit.

- Alignment – Step 2 (prior twelve (12) months)
  - For Participants NOT aligned for the most recent 12 months (no PCP visit), services for the 29 E&M codes for the prior 12 months (sorted by service date).
  - Participant is assigned to the PCP with the most recent visit.
  - If Participant is no longer an active Participant with Cigna in the most recent 12 months, they will be excluded.

- Claim Assignment (most recent twelve (12) months)
  - All Participant claim activity occurring nationwide over the most recent 12 month period attributed to the aligned PCP.
  - If a Participant's zip code is greater than 100 miles from the aligned PCP, Participant is aligned to the "next best" aligned PCP within 100 miles. If there is no other service to an aligned PCP within 100 miles, the Participant is not aligned.

*Alignment to OB/GYN's, Nurse Practitioners (NP), and Physician Assistants (PA) will occur when Participants do not have a visit with one of the physician specialties described

above. In order for this to occur, OB/GYNs, NPs, and PAs must be included in the CAC roster, and NPs and PAs must be credentialed to provide primary care services.

Patient Level Actionable Reports

The following reports will be provided to the group:

- Monthly Report: A combined report that includes Previse, Well Informed Gaps in Care and Monthly Closed Case Referral reports. It also includes pharmacy and other pertinent patient detail information helpful in managing high risk patients. Please refer to the below descriptions for more detail on each section.
  - PreVise: a Cigna developed predictive model, which measures the likelihood of an individual incurring high health care expenditures in a twelve-month period. The data utilized in this model includes information from medical claims, pharmacy claims, demographic data, lab results, gap scores, and episode treatment groups (ETGs).This model looks at hundreds of variables to project a risk level for every Participant.
  - Well Informed Gaps in Care (Gaps in Care): This report identifies Aligned CAC Participants who may need additional services based on past claims history. Gaps are identified at a patient level on a monthly basis using clinical rule-based software. The software evaluates all the medical, pharmacy, and lab data to first identify whether or not a patient has a condition. It then identifies if there is a potential gap in care.
  - Monthly Closed Case Referral Report: This is a summary of all Aligned CAC Participants in which a case management case was closed during the past month.
- Daily Report: The daily report is a combined report that includes the inpatient daily census and case management referral report. It provides real time hospital admission information on Aligned CAC Participants to facilitate transition of care activities. It includes all reported admissions, at all types of inpatient facilities and provides discharge dates contingent on Cigna obtaining that information. The case management portion of the report provides the information on all Aligned CAC Participants referred into a case management program in the prior 24 hours.

Participant Communications

Cigna expects the Provider to issue the following communications to Aligned CAC Participants:

- Initial communication with Aligned CAC Participants describing the CAC Program, data that will be exchanged and that Provider will reach out to them periodically regarding the CAC Program and its services, and periodic communications to Aligned CAC Participants.
- The availability of comprehensive, coordinated care with the Provider every six months or as otherwise mutually agreed to.
- Furthermore, Provider will communicate information regarding availability of their services at the time of each visit.
- Provider will encourage Aligned CAC Participants to enroll in Cigna disease management and other programs where there is a likely benefit to the Aligned CAC Participant.
- Provider will implement annual patient satisfaction surveys and share results with Cigna. If patient satisfaction results deteriorate, Provider will develop and share improvement plans with Cigna.

Performance Reports

Cigna may provide the following reports on a quarterly basis:

- Advanced Imaging Summary
- Alignment Summary
- Episode Treatment Group Cost Summary
- Inpatient Facility Summary
- Out of Network Activities Summary
- Outpatient Emergency Department/Urgent Care Performance
- Pharmacy Utilization
- Provider Drilldown Report
- Quality Provider Drilldown Report
- Quality Summary
- Specialty Care Utilization Cost Summary
- Total Medical Cost Summary
- Trend Summary

The types of reports may change from time to time and Cigna will provide notice of any material changes to Provider. For additional information on the purpose and specifications of these reports, please contact your Cigna contracting representatives.

Quality Multiplier Definitions

Aligned National Participant(s) means a Participant(s) who resides in the United States and its territories that is aligned to a primary care physician using the same alignment process outlined in the section entitled "Assignment of Aligned CAC Participants".

Aligned Pharmacy Participant(s) means an Aligned CAC Participant(s) who has Prescription Drug Benefits under a Cigna insured or administered Benefit Plan at any time during the Measurement Period.

Generic Drug means each single source or multisource drug or supply generally accepted as therapeutically equivalent and/or interchangeable with drugs having identical amount of the same active ingredient and as further defined by the Aligned Pharmacy Participant's Benefit Plan.

Market EBM Rules Performance means the result of the sum of the successes divided by the number of opportunities incurred during that Measurement Period for every Market Aligned Participant as identified and calculated by Evidence- based medicine Connect using claims that were submitted and paid within or sixty (60) days after the Measurement Period, For purposes, of determining Market Performance, the Provider's opportunities and successes are excluded. Market Pharmacy Participant(s) means Aligned Market Participant(s) who have Prescription Drug Benefits under a Cigna insured or administered Benefit Plan.

Market Pharmacy Performance means the result when 1) for each therapeutic class, the number of days supply during the Measurement Period for which Generic Drug claims were submitted and paid within or sixty (60) days after the Measurement Period for Market Pharmacy Participants divided by the number of days supply during the Measurement Period for all prescription drugs for which claims were submitted and paid within or sixty (60) days after the Measurement Period

for Market Pharmacy Participants (Therapeutic Class generic dispensing rate GDR) and 2) the Therapeutic Class GDR is then multiplied by Provider's Weight for each class and summed across all therapeutic classes. The Provider's Weight is determined by number of days supply for which claims were submitted for each therapeutic class divided by total number of days supply for which claims were submitted for all the therapeutic classes. For purposes of determining Market Pharmacy Performance, the Provider's experience is excluded.

National EBM Rules Performance means the result of the sum of the successes divided by the number of opportunities incurred during a Measurement Period for every Aligned National Participant as identified and calculated by EBM Connect using claims that were submitted and paid within or sixty (60) days after the Measurement Period.

National Pharmacy Participant(s) means Aligned National Participant(s) who have Prescription Drug Benefits under Cigna insured or administered Benefit Plan.

National Pharmacy Performance means the result when 1) for each therapeutic class, the number of days supply during the Measurement Period for which Generic Drug claims were submitted and paid within or sixty (60) days after the Measurement Period for National Pharmacy Participants divided by the number of days supply during the Measurement Period all prescription drugs for which claims were submitted and paid within or sixty (60) days after the Measurement Period for National Pharmacy Participant (Therapeutic Class GDR) and 2) the Therapeutic Class GDR is then multiplied by Provider's Weight for each class and summed across all therapeutic classes. The Provider's Weight is determined by number of days supply for which claims were submitted for each therapeutic class divided by total number of days supply for which claims were submitted for all the therapeutic classes.

Quality Multiplier is determined by the Provider's performance relative to the 15 EBM Rules, the Generic Dispensing Rate, and Patient Experience Questions, collectively referred to as "Program Rules."

Success Rate means the number of times a Provider successfully complied with an EBM Rule divided by the number of opportunities to comply expressed as a percentage.

Program Rules

- EBM Rules: EBM Rules are derived from rules endorsed by the National Quality Forum (NQF), Ambulatory Care Quality Alliance (AQA), Healthcare Effectiveness Data Information Set (HEDIS), or developed by physician organizations. The EBM Rules that will be used in this evaluation are listed in Exhibit A. The opportunities and successes for each EBM Rule are identified using the Optum lnsight (EBM Connect) version that is in use by Cigna at the end of a given Measurement Period, and the parties agree to abide by such calculations.
  Each opportunity and success will be attributed solely to the Represented Provider to which the Aligned CAC Participant is aligned and then included in the Providers results for the CAC program in which the Representative Provider participates.
- Generic Dispensing Rate or GDR. Generic Dispensing Rate or GDR is the number of days supply during the Measurement Period for which Generic Drug claims were

submitted and paid within or sixty (60) days after the Measurement Period for CAC Pharmacy Participants divided by the number of days supply during the Measurement Period using claims that were submitted and paid within or sixty (60) days after the Measurement Period for all prescription drugs for CAC Pharmacy Participants.

- Patient Experience. Each Provider will be asked to respond to the following Patient Experience Questions:
  - Do you measure Patient Experience with at least seventy percent (70%) of physicians?
  - Have you identified three areas of opportunity for improvement of the Patient Experience?
  - Do you have action plan for improvement in the three Patient Experience areas identified in the above question reflected in your Key Focus Action Plan?

Assessment Process

- Earned Points
  - EBM: For each Measurement Period, Provider will earn a maximum of one point for each Program Rule for which the Provider has at least twenty (20) opportunities during the Measurement Period and
    For which its Success Rate is at least ninety percent (90%) or for which the Provider's performance exceeds one or more of the following by four percent (4%):
    - National EBM Rules Performance during the same Measurement Period; or
    - Market EBM Rules Performance during the same Measurement Period; or
    - Provider's EBM Rules Performance for the Prior Measurement Period, or during the initial term of the Addendum, the twelve (12) months of the prior to the Effective Date. The Provider must have twenty (20) opportunities in both the above time periods for this provision to apply.
  - GDR: For each Measurement Period during which the Provider had at least 1500 Aligned Pharmacy Participants the CAC will earn one point if the Provider's performance exceeds one or more of the following by three percent (3%):
    - National Pharmacy GDR Performance during the same Measurement Period, or
    - Market Pharmacy GDR Performance during the same Measurement Period, or
    - Providers GDR during the prior Measurement Period or during the initial term the twelve (12) months prior to the Effective Date of this Addendum.
  - Patient Experience For each Measurement Period, the Provider will earn one point if the Provider responds "yes" to each of the Patient Experience Questions.
- Maximum Points. The Maximum Points will be the sum of all points available for the Program Rules.
- EBM (Provider must have at least twenty (20) opportunities for each Rule to be included in the Maximum Points)
- Generic Dispensing Rate (Provider must have at least fifteen hundred (1500) Aligned Pharmacy Participants)
- Patient Experience.

Study Participation

Cigna encourages Provider to participate with Cigna in pilot studies as they become available. A typical study would have the practice identify a set of activities that constitute "Usual Care," and to that add other workflows that constitute "enhanced care." Cigna then uses rigorous methods to build credible comparison groups under these two options and measure resulting patient outcomes. The intent of these pilots is to support the continuous cycle of innovation in understanding which interventions work as designed and implemented and which must be otherwise modified.

CCF and Performance Results

Provider acknowledges that its CCF and Performance Results may be shared with Cigna Affiliates, agents, subcontractors, and existing or potential Payors, or other patients of Cigna or Cigna Affiliates.

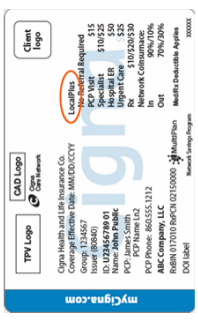
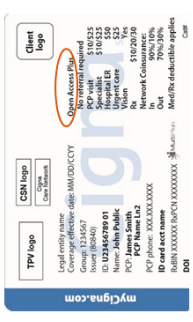
Cigna Commercial Products

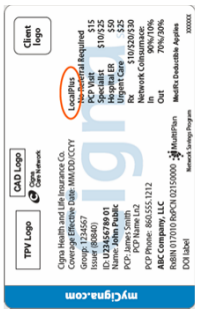
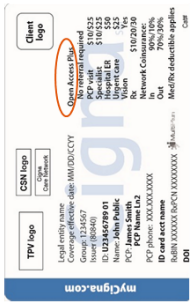
Cigna Products

Renaissance Physician Organization (RPO)

	Plans			
Attributes	**Cigna SureFit®**	**City of Houston**	**Local Plus® & LocalPlus IN**	**Open Access Plus (OAP)**
PCP Selection Criteria	Required	Required	Encouraged	Encouraged
Specialty Care Referral Requirements	Referral required	Referral required	No referral required*	No referral required*
Out-of-Network Benefits	No out-of-network benefits	No out-of-network benefits	Out-of-network available	Out-of-network available
Emergency	In- and out-of-network coverage**	In- and out-of-network coverage**	In- and out-of-network coverage**	In- and out-of-network coverage**
Employer plan	Employer	Client specific network	Employer	Employer
Physician Network Composition	4 separate healthcare organizations: RPO, Kelsey Care, Memorial Hermann and Health Care Alliance of Houston	RPO, Kelsey Care, and Memorial Hermann Physician Network	Narrow physician network. Refer to the health care professional directory on Cigna.com	Open Access Pus network
Hospital Network Composition	All Cigna-contracted hospitals in the service area	All Cigna-contracted hospitals in the service area	Narrow hospital network. Refer to the health care professional directory on Cigna.com	All Cigna-contracted hospitals
Dedicated Phone Numbers	1.800.882.4462	Prior authorization: 1.713.437.3060 All other calls: 1.800.997.1406	1.800.882.4462	1.800.882.4462

Example of Cigna Commercial ID Cards

	Plans			
Attributes	**Cigna SureFit®**	**City of Houston**	**LocalPlus & LocalPlus IN**	**Open Access Plus (OAP)**
eServices Capability Differences	NaviNet not available for precertification	All capabilities available, when applicable	All capabilities available	All capabilities available
Service Area	*Partial counties:* Brazoria, Chambers, Fort Bend, Galveston, Grimes, Harris, Liberty, Montgomery, and Waller	*Full Counties*: Harris, Fort Bend, Galveston, Montgomery - *Partial Counties*: San Jacinto, Waller, Austin, Brazoria, Liberty, Walker, Grimes and Chambers	*Full counties:* Austin, Brazos, Fort Bend, Galveston, Grimes, Harris, Liberty, Montgomery, Waller, Washington *Partial counties:* Brazoria, Chambers, San Jacinto, Walker	Statewide
National Ancillary	Not all national ancillaries are participating. Contact RPO.	Not all national ancillaries are participating. Contact RPO.	All in-network	All in-network
ID Card				

	Plans			
Attributes	**Cigna SureFit®**	**City of Houston**	**LocalPlus & LocalPlus IN**	**Open Access Plus (OAP)**
eServices Capability Differences	NaviNet not available for precertification	All capabilities available, when applicable	All capabilities available	All capabilities available
Service Area	*Partial counties:* Brazoria, Chambers, Fort Bend, Galveston, Grimes, Harris, Liberty, Montgomery, and Waller	*Full Counties*: Harris, Fort Bend, Galveston, Montgomery - *Partial Counties*: San Jacinto, Waller, Austin, Brazoria, Liberty, Walker, Grimes and Chambers	*Full counties:* Austin, Brazos, Fort Bend, Galveston, Grimes, Harris, Liberty, Montgomery, Waller, Washington *Partial counties:* Brazoria, Chambers, San Jacinto, Walker	Statewide
National Ancillary	Not all national ancillaries are participating. Contact RPO.	Not all national ancillaries are participating. Contact RPO.	All in-network	All in-network
ID Card				

CICNA CAC Quality Measures

Cigna Domain	Case Description	Rule Description
At-Risk/Chronic Condition Population	Diabetes Care (NS)	Patient(s) 18-75 years of age that had an annual screening test for diabetic retinopathy.
	Diabetes Care (NS)	Patient(s) 18-75 years of age that had annual screening for nephropathy or evidence of nephropathy.
	Diabetes Care (NS)	Patient(s) 18-75 years of age with lab results that have evidence of poor diabetic control, defined as the most HbA1c result value greater than 9.0%.
	Diabetes Care (NS)	Patient(s) 18-75 years of age with lab results with most recent HbA1c result value less than 8.0%.
	CAD (NS)	Patient(s) currently taking a statin, All males or females that are 18 years or older at end of reporting period. At least 12 months medical benefit and 4 months pharmacy benefit.
	Diabetes Mellitus	Patient(s) complaint with prescribed statin-containing medication (minimum compliance 80%). All males or females that are 18 years or older at end of reporting period. At least 12 months medical benefits and 6 months pharmacy benefit.
Behavioral Health	Depression Med Mgmt (NS)	Patient(s) with a new episode of major depression that remained on an antidepressant medication during the 5 months acute treatment phase.
Child Health	Adolescent Well-Care	Patient(s) 12-21 years of age that had one comprehensive well0care visit with a PCP or an OB/GYN in the last 12 reported months.
	URI (NS)	All children that are 3 months to 18 years with a diagnosis of upper respiratory infection (URI) that did not have a prescription for an antibiotic on or three days after the initiating visit.
	Pharyngitis (NS)	All children that are 2 to 18 years treated with an antibiotic for pharyngitis that had a Group A streptococcus test.
	Well-Child 15 MO (NS)	Patient(s) that had six or more well0child visits with a PCP during the first 15 months of life.
Coordination/ Appropriate Utilization	LBP Imaging (NS)	Patient(s) with uncomplicated low back pain that did not have imaging studies.
	Bronchitis, Acute (NS)	Patient(s) with a diagnosis of acute bronchitis that did not have prescription for antibiotic on or three days after the initiating visit.
	GDR	Generic Dispensing Rate or GDR is the number of days supply during the Measurement Period for which Generic Drug claims were submitted and paid within or sixty (60) days after the Measurement Period for CAC Pharmacy Participants divided by the numbers of days supply during the Measurement Period using claims that were submitted and paid within or sixty (60) days after the Measurement Period for all prescriptions drugs for CAC Pharmacy Participants
Preventive Health	Breast Cancer Screening (NS)	Patient(s) 52-72 years of age that had a screening mammogram in last 27 reported months.
	Chlamydia Screening (NS)	Patient(s) 16-20 years of age that had a chlamydia screening test in the last 12 reported months.
Patient Experience	Patient Experience of Care	Each CAC will be asked to respond to the following Patient Experience Questions: 1. Do you/CAC measure Patient Experience with a least seventy percent (70%) of physicians? 2. Have you identified three areas of opportunity for improvement of the Patient Experience? 3. Do you have action plan for improvement in the three Patient Experience areas identified in the above question reflected in your Key Focus Action Plan?

Appendix

I. IPA Harassment Policy

It is the policy of the IPA that all persons affiliated with the IPA, either as a physician or as an independent contractor or vendor have an unconditional right to work in an environment free from harassment perpetrated by member physicians, independent contractors and/or vendors and their employees.

Harassment
The following conduct constitutes prohibited harassment within the meaning or coverage of this policy.

Sexual Harassment: Prohibited sexual harassment includes any sexual advances, requests for sexual favors, or other verbal or physical conduct of a sexual nature when:

- Submission to such conduct is an explicit or implicit condition of employment;
- Submission to or rejection of such conduct is used as the basis for employment decisions;
- Such conduct has the purpose or effect of unreasonably interfering with an individual's work performance, or creating an intimidating, hostile or offensive work environment; or
- Such conduct otherwise adversely affects an individual's employment opportunities.

Verbal Harassment: Prohibited verbal harassment includes any verbal conduct of a sexual, obscene, vulgar or general nature when such conduct serves to belittle, show hostility, or ridicule an individual because of race, gender, color, religion, national origin, age, or disability, when such conduct:

- Has the purpose or effect of creating an intimidating, hostile or offensive working environment;
- Has the purpose or effect of unreasonably interfering with an individual's work performance; or
- Otherwise adversely affects an individual's employment opportunities.

Other Prohibited Harassment: Other forms of prohibited harassment include any physical conduct that

- Has the purpose or effect of creating an intimidating, hostile or offensive working environment;
- Has the purpose or effect of unreasonably interfering with an individual's work performance; or
- Otherwise adversely affects an individual's employment opportunities.

Reporting Harassment
In the event that you are the victim of any of the behaviors described above, or witness anyone engaging in any such behaviors, you must report the incident ***immediately***. To report violations of this policy, please contact one of the following persons:

- Member of the IPA Board (if such is appropriate)
- Member of the IPA Board (if such is appropriate)
- Legal Counsel
- Vendor Representative (if such is appropriate)

To ensure that The IPA handles each matter with consistency, the Chairman of the IPA Board will be informed of all reports of harassment, unless the circumstances of the complaint require otherwise.

Investigation of Harassment
Reports of harassment will be treated seriously and an investigation will be initiated promptly. To the extent possible, confidentiality will be maintained.

Disciplinary Measures
Where an investigation reveals that the allegations of harassment are true, appropriate remedial action, including discipline, will be taken. All disciplinary measures will be implemented promptly and shall be commensurate with the person's conduct. The remedies vary depending on the entire facts and circumstances found by the investigation. However in the event such conduct is perpetrated by a participating physician such conduct may be the basis for an immediate termination of the physician's contractual relationship with The IPA.

Harassment by Customers and Vendors
The IPA recognizes that harassment can also be perpetrated by a customer, vendor, or employee of a vendor of The IPA. Should this occur, the reporting and investigation procedures discussed above will be followed. Where the investigation reveals that allegations of harassment are true, The IPA will undertake appropriate measures to end such harassment.

Right to Appeal
If, after an investigation is completed or remedial action is recommended, a victim of alleged harassment or the alleged perpetrator may appeal the investigative findings or proposed remedial action to the IPA Board.

Continued Harassment, Nondiscrimination and Retaliation
If, following remedial action, the harassment continues, the victim should report the recurrence of the conduct in accordance with the procedures in this policy, and The IPA will take all additional remedial measures necessary to end the conduct. The IPA does not discriminate or retaliate against any person who reports a violation of this policy or participates in an investigation of a complaint regarding harassment.