Nascentia Health

TOMORROW'S HEALTHCARE TODAY

2021 Provider Manual
Nascentia Health Plus

Important Contact Information

Our Website: www.nascentiahealthplus.org

Compliance/Anti-Fraud	
Telephone	**(855) 252-7606**
Online	**www.hotline-services.com**
Grievance and Appeals	
Telephone	**(888) 477-4663**
Fax	**(315) 870-7788**
Member Services	
Telephone	**(888) 477-4663**
Provider Relations (contracts, credentialing)	
Telephone	**(315) 477-9280**
Utilization/Medical Management (referrals, authorization)	
Telephone	**(888) 477-4663**
Fax	**(315) 870-7788**
Claims Customer Service (claims payment and reconsideration)	
Telephone	**(315) 477-9509**

Nascentia Health Plus is a health plan contracted with both Medicare and New York State Medicaid to provide benefits and coordination of care for both programs to enrollees.

This Provider Manual serves as a supplement to the Nascentia Health Provider Services Agreement concerning the management and care of Nascentia Health Plus members. The information contained within this manual is a reference tool that contains eligibility, benefits, policies, procedures and contact information for services provided and administered through Nascentia Health Plus.

The Provider Manual is reviewed, evaluated and updated as needed and at least annually. The most up-to-date information is available by accessing the Provider page at www.nascentiahealthplus.org.

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Introduction

About Nascentia Health Plus
Nascentia Health's roots date back to 1890 as one of the first providers of home and community-based care in New York State. For almost 130 years, our clinicians have worked alongside individuals and their caregivers and families to improve their health and quality of life. Today, we bring that same commitment to the members of our health plans. With offices strategically located across the state, Nascentia Health Plus is positioned to assist our providers and members.

Our Mission
Nascentia Health strives to offer Medicare and Medicaid managed care products that provide the highest standard of excellence in the delivery of exceptional care and service. Throught the development of a network of high-quality physicians and clinical partners we will consistently improve the health of the communities we serve.

Our Vision
Using evidence-based approaches, Nascentia Health Plus applies best practices to medical care to keep our members healthy. This means we:

- Collaborate with our network providers and our members to learn which actions get the best results;
- Try innovative delivery models to get health care to our members;
- Partner with education, government, and other community organizations to multiply the resources for and the effectiveness of our work.

Contact Us - Phone Numbers and Links

Claims Customer Service:

(315) 477-9509

Claim Appeals

(315) 477-9365

General Inquiries

(888) 477-4663

Member Eligibility Inquiries:

(888) 477-4663

Preauthorization and Notification:

(888) 477-4663
Fax: (315) 870-7788

Provider Representatives and Relations:

(315) 477-9280

Grievances and Appeals:

(888) 477-4663
Fax: (315) 870-7788

Pharmacy Provider Helpline-Envision Rx (24/7):

(833) 459-4424 or elixirsolutions.com

Provider Portal

Contracted providers may request access to the Nascentia Health Plus secured provider portal. The URL is available from the Provider page at www.nascentiahealthplus.org. The secured portal can be used to verify eligibility and check status claims.

Member Eligibility

Prior to providing services provider must verify the member's current eligibility by either contacting Member Services or via the portal link located on the Provider page of our website at www.nascentiahealthplus.org. We strongly encourage providers to ask patients for their most up-to-date insurance status before rendering service(s). Failure to verify eligibility at the time of service may result in denial of payment for services rendered. If it is determined that a member was not eligible on the date of service, payment for services will not be made.

Billing Requirements

Provider agrees to follow applicable CMS/NYSDOH and Nascentia Health billing guidelines. For services not covered by Nascentia Health a provider may bill a member only when the service is performed with the expressed written acknowledgment that payment is the responsibility of the member.

If a member requests a service not covered by Nascentia Health Plus, the member must sign a release form indicating they understand the service is not covered and the member is financially responsible for all applicable charges. Do not bill a member for a non-covered service unless you have informed the member in advance that the service is not covered, and the member has agreed in writing to pay for the services if they are not covered.

* All MA Providers –not only those that accept Medicaid–must not charge individuals enrolled in the QMB program for Medicare cost-sharing. Federal law prohibits providers from billing QMB individuals for all Medicare deductibles, coinsurance or copayments. All Medicare and Medicaid payments received by the provider for services delivered to a QMB individual are considered payment in full. Providers that bill a QMB individual for amounts above the sum total of all Medicare and Medicaid payments (even when Medicaid pays nothing) may be subject to sanctions. Note: Individuals enrolled in QMB cannot elect to pay Medicare deductibles, coinsurance, and copays.

Provider Reimbursements

In order for claims to be paid promptly the claim must be submitted electronically or on paper, and the claim must not involve investigations for coordination of benefits (COB), pre-existing conditions, member eligibility, or subrogation (i.e., a “clean claim”).

The time frame for claims submissions, if not otherwise specified within the provider agreement or applicable state or federal law is as follows:

- 90 days from the date of service for all provider types;
- Reconsideration requests must be submitted in writing within 60 days of the date on the last Nascentia Health Plus claim determination notice or remittance advice.

Providers are reimbursed in accordance with the payment model outlined in the provider agreement. Contact Provider Relations at (315) 477-9280 for questions or clarifications.

Terms of payment are outlined in the provider agreement. Payment is not only subject to the terms within the agreement, but to additional variables such as:

- Member's eligibility on the date of service
- If the service is a covered benefit
- If the services are deemed medically necessary
- If prior approval was obtained as applicable to the service provided
- Member's cost-share amounts due and/or coordination of benefits from another payer
- Payment adjustments based on coding edits

Claim Submission

Paper Claims:

Nascentia Health Plus
PO Box 1479
Fort Washington, PA 19034

Electronic Submission: Payor ID 45529

Remitance/Payment

Providers are able to receive payment and remittance either electronically or on paper. EFT/Electronic RA enrollment is necessary, the appropriate form is available on the Provider page of our website at www.nascentiahealthplus.org.

Specialist Providers

Reimbursement for specialist services is dependent upon authorization, when applicable, and corresponding documentation. All specialist claims must include an authorization number, when applicable, or an inpatient authorization number which must be shown in box 23 of the CMS-1500 or box 64 of the CMS UB-04 form. If the authorization number is not on the claim, the claim may be rejected.

Provider Preventable Conditions

Nascentia Health will not pay a claim for a Provider Preventable Conditions including a Health Care Acquired Condition. These conditions include those that could have been prevented by utilizing best practices. Nascentia Health will identify and report on Provider Preventable Conditions. Providers shall not restrict access to care for members relating to treatment for a Provider Preventable Condition.

Medical Management/Utilization Management

The purpose of the Nascentia Health Plus Medical Management/Utilization Management Program is to determine if medical services are:

- Covered under the member's benefit plan;
- Clinically necessary and appropriate;
- Performed at the most appropriate setting.

Advance Notification/Prior Authorization

Advance notification provides Nascentia Health Plus information about planned medical services and helps support the pre-service clinical review and care coordination. Advance Notification is helpful to assist members from pre-service planning to discharge planning.

After a provider notifies Nascentia Health Plus of a planned service requiring Advance Notification/Prior Authorization, the plan will advise if a clinical coverage review is required as part of our prior authorization process, and what additional information is needed to proceed. Nascentia Health Plus will notify the provider of the plan's coverage decision within the time required by law.

Be aware, that although Nascentia Health Plus may require notification/authorization for a service, this does not mean it is covered. Coverage is determined by the member's benefit plan and eligibility hat the time services are rendered.

Requirements
Physicians, health care professionals and ancillary care providers are responsible for:

- Providing advance notification or requesting prior authorization for services as indicated under Prior Authorization Requirements.
- Directing members to use care providers within their network. Members may be required to obtain prior authorization for out-of-network services.

Facilities are responsible for:

- Confirming coverage approval is on file prior to the date of service.
- Providing admission notification for inpatient services even if coverage approval is on file.

Admission Notification Requirement
Facilities are responsible for Admission Notification for the following inpatient admissions:

- Planned/elective admissions for acute care
- Unplanned admissions for acute care
- Skilled Nursing Facility (SNF) admissions
- Admissions following outpatient surgery
- Admissions following observation

For Weekday Admissions, Nascentia Health Plus must be notified within 24 hours, unless otherwise indicated. Weekend and Holiday Admissions, Nascentia Health Plus must be notified by 5 pm on the next business day.

Emergency Admissions (when a member is unstable and not capable of providing coverage information), providers must:

- Notify us by phone or fax with 24 hours, or the next business day if on a weekend/holiday, from the time coverage information is known;
- When notifying us, you must communicate the extenuating circumstances.

Coverage and Utilization Management Decisions

Nascentia Health Plus coverage decisions, including medical necessity decisions, are based on:

- Member's benefits
- State and federal requirements
- Medicare guidelines including National Coverage Determination (NCD) and Local Coverage Determination (LCD) guidelines
- Medicare Benefit Policy Guide
- Medical and drug policies, and coverage determination guidelines and summaries

Nascentia Health Plus employees, contractors, and delegates do not receive financial incentives for issuing non-coverage decisions or denials. Nascentia Health Plus and delegates do not offer incentives for underutilization of care/services or for barriers to care/service. Nascentia Health Plus does not hire, promote or terminate employees or contractors based on whether they deny benefits.

Nascentia Health Plus uses tools (such as medical policies, drug policies, and coverage determination guidelines (CDGs)) and third party resources (such as InterQual Care Guidelines and other guidelines), to assist in administering health benefits and determining coverage. Nascentia Health Plus also uses tools and third party resources to assist clinicians in making informed decisions.

These tools and guidelines are intended to be used in connection with the independent professional medical judgment of a qualified health care provider and are not equivalent to the practice of medicine or medical advice.

Denials/Adverse Determinations

Nascentia Health Plus may issue denials/adverse determinations when:

- The service, item, or drug is not medically necessary
- The service, item, or drug is not covered
- No supporting (or incomplete) information is received

If you disagree with our determination, you may appeal on behalf of the member. Our medical reviewers are able to discuss the denial with the treating or attending care provider.

Authorization determinations are communicated in a manner based on the nature of the member's medical condition and following state and federal law. Decisions are based on sound clinical evidence. Thisincludes:

- Medical records review
- Consultation with the treating care providers
- Review of nationally recognized criteria

Preauthorization and Notification (Utilization Management)

Nascentia Health Plus requires either an authorization or notification before certain services may be rendered to a Nascentia Health Plus member. Providers are encouraged to review the Nascentia Health Plus prior authorization list, found in the Prior Authorization Requirements section of this manual as well as on the Provider page of our website at www.nascentiahealthplus.org.

The Nascentia Health Plus list of services requiring prior authorization and notification is subject to change. Changes to the prior authorization list are communicated through provider notices.

Providers need to be prepared to offer the following information when requesting an authorization or notification:

- Member's name and date of birth
- Member's ID number
- Actual date of service or hospital admission
- Date of proposed procedure as applicable
- Corresponding procedure codes
- Bed type: inpatient or outpatient
- TIN of treatment of facility (where service is being rendered)
- TIN of servicing provider (provider performing service)
- Applicable ICD diagnosis code
- Caller's telephone number

- Attending physician's telephone number

Authorization/Notification is not a guarantee of payment. Billed services remain subject to the review for medical necessity, appropriate setting, billing and coding, plan limitation, and eligibility at the time of service.

To request prior authorization, please submit your request via fax or phone:
Referrals and Authorization Department at (888) 477-4663
Outpatient Authorizations Fax: (315) 870-7788
Inpatient Admissions Fax: (315) 870-7788

Prior Authorization Request Forms are available at www.nascentiahealthplus.org.

Prior Authorization Requirements

Prior authorization is not required for emergency or urgent care.

To request prior authorization, please submit your request via fax or phone:

Referrals and Authorization Department: (888) 477-4663
Outpatient Authorizations Fax: (315) 870-7788
Inpatient Admissions Fax: (315) 870-7788

A Prior Authorization is not a guarantee of payment; Payment is subject to member eligibility and benefits at the time of service.

The Medical Management Department will notify you of their decision by secure email, mail or phone.

Benefit	Details	Nascentia Skilled Nursing Facility	Nascentia Dual Advantage
		I-SNP	D-SNP
		Is Auth required?	
Inpatient Hospital Acute	Includes Substance Abuse and Rehabilitation Services	Y For elective and scheduled admissions only	Y For elective and scheduled admissions only
Inpatient Psychiatric		N	N
Skilled Nursing Facility	Zero hospital day required prior to SNF admission	Y	Y
Cardiac & Pulmonary Rehabilitation Therapy		N	N
Partial Hospitalization	Partial hospitalization program is a structured program of active outpatient psychiatric treatment that is more intense than the care received in a doctor's or therapist's office and is an alternative to inpatient hospitalization	N	N

Home Health Services	• Includes medically necessary intermittent skilled nursing care, home health aide services, and rehabilitation services	Y	Y
Chiropractic Services		N Routine care visits Not covered	N 12 Routine care visits covered
Occupational Therapy		N	N
Physician Specialist Services		Y	N *Authorization is required for all out of network Physician specialists
Mental Health Specialty Services		N	N
Podiatry Services	Routine care not covered, Medicare covered podiatry services only	N	N
Other Health Care Professional		N	N
Psychiatric Services		N	N
PT & SP Services		N	N
Telehealth Services	May include Additional telehealth benefits for: • Primary Care Physician • Physician Specialist Services • Individual Sessions for Psychiatric services	Y	Y
Opioid treatment Program Services		N	N
Outpatient Diagnostic Procedures/tests/Lab services		Y For MRI, Functional MRI, Pharmokinetic Testing, MRA, & PET Scans Only	Y For MRI, Functional MRI, Pharmokinetic Testing, MRA, & PET Scans Only

Outpatient Diagnostic Procedures/Radiation		Y For MRI, Functional MRI, Pharmokinetic Testing, MRA, & PET Scans Only	Y For MRI, Functional MRI, Pharmokinetic Testing, MRA, & PET Scans Only
Outpatient Hospital Services		Y For Hyperbaric Oxygen Therapy only	Y For Hyperbaric Oxygen Therapy only
Ambulatory Surgery Center Services		Y	Y
Outpatient substance abuse		N	N
Outpatient blood services		N	N
Ambulance Services (non emergent)	Medicare covered Ambulance Services	N	N
Transportation (non-emergent)		N/A	Y 8 one-way plan-approved transports via taxi or medical transport
Durable Medical Equipment	For Customized equipment, motorized & manual wheelchairs, scooters, hospital beds & support surfaces, apnea monitors, continuous positive airway pressure, bi-level positive airway, pressure devices (CPAP/BIPAP), external infusion pumps, infusion supplies, lymphedema pumps, osteogenesis stimulators, oxygen therapy, parenteral/enteral nutrition, seat lift mechanisms, specialty wound care, wound care supplies/dressings (i.e. alginate & collagen dressings)	Y	Y
Prosthetics/Medical Supplies		Y For customized & other prosthetics/	Y For customized & other prosthetics/

		Medical supplies	medical supplies
Diabetic Supplies & Service		N	N
Dialysis		N	N
Medicare Zero Dollar Preventative Services		N	N
Kidney Disease Education		N	N
Other Medicare Covered Preventative Services	• Glaucoma Screenings • Diabetes Self-management • Barium enemas • Digital rectal Exams • EKG following welcome visit	N	N
Medicare Part B Prescription Drugs		Y For Medicare Part B chemotherapy drugs and other Part B drugs	Y For Medicare Part B chemotherapy drugs and other Part B drugs
Remote Access Technology	24 hour Nursing/MD hotline	N	N
Home Bathroom Safety Devices	For DSNP Plan Only	N/A	N $300/yr
In home Safety Assessment	For DSNP Plan only	N/A	N $200/yr
Post Discharge In Home Medication Reconciliation	For DSNP plan only	N/A	N $200/yr
Preventative Dental		N/A	N $1000 max benefit annually
Comprehensive Dental		N Medicare covered benefits only	N $1000 max benefit annually
Eye Exam		N	N

Eyewear		N $355 upgrade yearly	N $355 upgrade yearly
Hearing Exam		N/A	N
Hearing Aids		N $1200 max benefit every year	N $1200 max benefit every year

Authorization Decision Timeframes

The following timeframe for decision requirements apply to service authorization requests:

Standard Authorization Decisions

For standard authorization decisions, Nascentia Health Plus shall provide the decision notice as expeditiously as the member's health condition requires, not to exceed fourteen (14) calendar days following receipt of the request for service, with a possible extension of up to fourteen (14) additional calendar days if:

- The member or the provider requests extension; or
- Nascentia Health Plus justifies to CMS upon request that the need for additional information is in the member's interest.

Expedited Authorization Decisions

For cases in which a provider indicates, or Nascentia Health Plus determines, that following the standard timeframe could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function, Nascentia Health Plus will make an expedited authorization decision and provide notice as expeditiously as the member's health condition requires and no later than three (3) working days after receipt of the request for service.

Nascentia Health Plus may extend the three (3) business day turnaround time frame by up to fourteen (14) calendar days if the member requests an extension or Nascentia Health Plus justifies to CMS a need for additional information and how the extension is in the member's interest.

Inpatient Services

Nascentia Health Plus requires prior authorization for services provided in an inpatient setting. Understanding that emergent admissions are possible, Nascentia Health Plus requires immediate notification of any inpatient status for Medicare Advantage members. Providers can obtain an inpatient authorization by calling Utilization Management at (888) 477-4663.

Radiological Services

For services above routine X-rays, prior authorization is required and can be obtained by calling Utilization Management at (888) 477-4663.

Advanced Beneficiary Notice (ABNs)

Nascentia Health Plus members must be notified in advance when a provider believes there is a strong possibility that a specific service will not be covered by Nascentia Health Plus. The notification may either be verbal or written; however, Nascentia Health Plus encourages all providers to document the discussion and code claims appropriately. The CMS approved Advanced Beneficiary Notice (ABN) may serve as their appropriate documentation.

Advanced Coverage Determinations (ACDs)

For procedures or services that may be experimental, investigational or have a limited benefit coverage, Nascentia Health Plus encourages providers request an advanced coverage determination on the member's behalf prior to providing service. The member may be contacted if additional information is needed. ACDs for members may be initiated by submitting a written request to:

Nascentia Health Plus
Attention: Medical Management Department
1050 West Genesee St.
Syracuse, NY 13204

Referrals

The Primary Care Physician (PCP) is responsible for referring Medicare Advantage members to in-network providers. There is not a referral requirement for services provided by in-network providers. Providers and members alike need to be aware that there is no benefit for services provided by out-of-network providers with the exception of specific service types.

Members may be referred to an out-of-network specialist with prior authorization from Nascentia Health Plus in the following circumstances:

- Nascentia Health Plus's contracted providers are unable to provide the specialty service required for the member's medical care;

- Nascentia Health Plus does not have a provider in the network with appropriate training or experience;
- To avoid interruption of care for services authorized by another health plan or Medicare prior to enrollment with Nascentia Health Plus.

Members need to understand that if they elect certain services to be provided by out-of-network providers, they will likely be financially responsible for covering the out-of-network provider's invoice.

Office Procedures

This section details the expectations of policies and procedures as it pertains to provider office operations.

Medical Records

Participating physicians are required to maintain adequate medical records and documentation relating to the care and services provided to Nascentia Health Plus Medicare Advantage members. All communications and records pertaining to our member's health care must be treated as confidential. No records may be released without the written consent of the member or their designated caregiver.

The medical record is the mechanism that maintains and ensures the continuity, accuracy and integrity of clinical data. The medical record serves as the primary resource for information related to patient treatment, not only for the participating physician, but also for other health professionals who assist in patient care. At a minimum, participating physicians are expected to have office policies and procedures for medical record documentation and maintenance, which follow NCQA standards and ensure that medical records are:

- Accurate and legible;
- Safeguarded against loss, destruction or unauthorized use;
- Maintained in an organized fashion for all members receiving care and services, and accessible for review and audit by CMS or contracted External Quality Review Organizations;
- Readily available for Nascentia Health Plus's Medical Management staff with adequate clinical data to support utilization management activities;
- Comprehensive with adequate information to allow record transfer procedures to provide continuity of care when members are treated by more than one provider.

Nascentia Health Plus has established standards for medical record documentation and maintenance. These standards address medical record content, organization, confidentiality and maintenance. Nascentia Health Plus requires medical records to be maintained by all affiliated practitioner offices and/or medical center locations in a manner that is current, detailed and organized, and which permits effective and confidential patient care and quality review. Medical record standards have been established to facilitate communication, coordination, and continuity of care and to promote efficient and effective treatment.

Note: Nascentia Health Plus applies federal and state guidelines as they relate to medical record documentation.

Nascentia Health Plus requires that the provider's medical records be accessible for grievance and appeal processing, claims reconsideration, customer service inquiries, peer review studies, risk management review, utilization, and other initiatives.

Participating providers must expeditiously comply with Nascentia Health Plus's grievance and appeal request for medical record documentation due to the stringent time frames established by CMS and/or the state agency for insurance processing. Nascentia Health Plus only requires medical documentation for the specific time period in question. The submitted medical documentation must include at a minimum: office notes, lab/test results, referral documents, telephone records, and any consultation reports as applicable. Faxed medical records should be submitted with sensitivity and confidence that it is being sent to the intended recipient.

Fees for producing medical records are considered part of the office administration overhead and are to be provided to members and Nascentia Health Plus at no cost, unless state regulations or the agreement stipulates otherwise.

Provider Claims Reconsideration

If a provider disagrees with the coverage/payment determination made by Nascentia Health Plus upon receipt of the paper or automated remittance advice, providers may contact Nascentia Health Plus via written correspondence to dispute the determination. Nascentia Health Plus requires that providers submit the request using the claims reconsideration form found at www.nascentiahealthplus.org, within the Provider section, and recommends including all applicable documentation required to properly consider reprocessing the claim.

Reconsideration requests should be mailed to Nascentia Health Plus at:

Nascentia Health Plus
Attention: Claim Appeals
1050 West Genesee St.
Syracuse, NY 13204

Provider Termination

Nascentia Health may terminate a provider's participation in the network upon the occurrence of any of the following: (a) Plan is notified of a situation in which Provider may cause imminent harm to an Enrollee or has caused harm to an Enrollee; (b) there has been a determination that Provider has committed fraud or abusive billing; or (c) there has been a determination by a Governmental Authority that impairs Provider's ability to render services, as outlined in the provider agreement.

Providers have the right to review the termination decision in accordance with the Medicare regulations found at 42 C.F.R. §422.202. Nascentia Health Plus requires that the provider submit in writing a request for the panel review within 30 days of the date of termination notice. If the provider fails to submit the request within the allotted timeframe, the provider's right to appeal is waived.

Nascentia Health Plus requests that the provider address the letter to the group identified in the termination notice letter, and the request should include any relevant written information to be considered by the Network Development Committee. Only written information submitted will be considered. The Network Development Committee will review the appeal prior to the effective date of the termination date referenced in the letter. The Committee will provide a written decision to the provider upon conclusion of the review.

The appeal process is considered aligned with the termination rights set forth in the Provider's Agreement, and/or where applicable within State and Federal law and regulation.

Member Grievances

This section applies to members of Nascentia Health Plus's Medicare Advantage plans who are not satisfied with the health plan's performance, or the services received from a provider. A plan grievance may be filed by a current or former member or his/her authorized representative.

Nascentia Health Plus will accept requests from Medicare Advantage members and/or providers for urgent appeals, and from prescribing physicians if the member is a Medicare Part D plan member. The physician or the member must request this appeal within 60 calendar days from the date of our decision. If the member or provider would like to file an expedited appeal, Nascentia Health Plus can be reached by phone or fax.

For an Expedited or Standard Appeal, phone or fax:
Grievances and Appeals Phone Number: (888) 477-4663
Grievances and Appeals Fax Number: (315) 870-7788
Grievances and Appeals Mailing Address:

Nascentia Health Plus
Attn: Grievance & Appeals
1050 West Genesee St.
Syracuse, NY 13204

Covered Services

For Nascentia Health Plus to consider payment, a service must be medically necessary and covered by the member's plan contract. The health plan identifies whether services are deemed medically necessary.

A Provider can verify coverage and excluded services by calling Nascentia Health Plus Member Services department at the number listed on the back of the Member's ID card. Please note that all services may be subject to applicable co-payments, deductibles, and co-insurance.

Nascentia Health Plus is not a provider of clinical judgement; therefore, does not control treatment recommendations made by the providers in its network. A provider's clinical judgement is independent of Nascentia Health Plus.

Compliance / Ethics

Liability Insurance

Nascentia Health Plus requires all providers possess and provide evidence of insurance coverage in accordance with the Provider's Agreement upon request.

Compliance and Fraud, Waste and Abuse Requirements

The Program Integrity department was established to support Nascentia Health Plus commitment to the highest standards of conduct, honesty, integrity and reliability in our business practices. Program Integrity is about **"Doing the right thing"** for the right reasons.

The Program Integrity department is designed to assist the organization to uphold our continued commitment in making proper and ethical decisions. The compliance and integrity program maintains a comprehensive plan, which addresses how Nascentia Health will uphold and follow state and federal statutes and regulations pertaining to fraud, waste, and abuse. The program applies to officers, directors, employees and affiliated associates such as providers, vendors, and subcontractors. It consists of the following: policies and procedures, Code of Conduct, compliance oversight, education and training, monitoring and auditing, enforcement and discipline, and detection and prevention of fraud, waste, and abuse.

If you have questions or concerns related to:

- Potential Fraud, Waste, or Abuse;
- Standards of Professional conduct;
- Confidentiality;
- Notice of Privacy Practices;
- Potential Conflicts of Interest;
- Or other regulatory requirements or laws, such as Sarbanes-Oxley and Stark Law

Call the Compliance Helpline: (855) 252-7606, 24 hours a day, 7 days a week or submit questions and concers online at www.hotlines-services.com. You may remain anonymous.

Definitions

- **Fraud:** Knowingly and willfully executing, or attempting to execute, a scheme or artifice to defraud any health care benefit program or to obtain (by means of false or fraudulent pretenses, representations, or promises) any of the money or property owned by, or under the custody or control of, any health care benefit program. 18 U.S.C. § 1347.
- **Waste:** Overutilization of services, or other practices that, directly or indirectly, result in unnecessary costs to the Medicare program. Waste is generally not considered to be caused by criminally negligent actions but rather the misuse of resources.
- **Abuse:** Actions that may, directly or indirectly, result in: unnecessary costs to the Medicare Program, improper payment, payment for services that fail to meet

professionally recognized standards of care, or services that are medically unnecessary. Abuse involves payment for items or services when there is no legal entitlement to that payment and the provider has not knowingly and/or intentionally misrepresented facts to obtain payment. Abuse cannot be differentiated categorically from fraud, because the distinction between "fraud" and "abuse" depends on specific facts and circumstances, intent and prior knowledge, and available evidence, among other factors.

Corporate Compliance and Integrity Plan

Nascentia Health Plus is committed to establishing, adopting, and implementing - through education of officers, directors, employees and affiliated professionals of Nascentia Health Plus - a culture and collective attitude that will promote the prevention and detection of conduct that does not conform to federal and state laws and federal and state health care program requirements. Nascentia Health Plus maintains a policy of "zero tolerance" for fraud, waste, and abuse in every aspect of our business.

Federal False Claims Act - The False Claims Act is a federal statute that covers fraud involving any federally funded contract or program, including the Medicare and Medicaid programs. The act establishes liability for any person who knowingly presents or causes to be presented a false or fraudulent claim to the U.S. government for payment.

The term "knowing" is defined to mean that a person with respect to information:

- Has actual knowledge of falsity of information in the claim;
- Acts in deliberate ignorance of the truth or falsity of the information in a claim; or
- Acts in reckless disregard of the truth or falsity of the information in a claim.

The act does not require proof of a specific intent to defraud the U.S. government. Instead, health care providers can be prosecuted for a wide variety of conduct that leads to the submission of fraudulent claims to the government, such as knowingly making false statements, falsifying records, double-billing for items or services, submitting bills for services never performed or items never furnished or otherwise causing a false claim to be submitted.

Deficit Reduction Act - The Deficit Reduction Act (DRA) aims to cut fraud, waste and abuse from the Medicare and Medicaid programs. Health care entities like Nascentia Health Plus who receive or pay out at least five million dollars in Medicaid funds per year must comply with the DRA. As a contractor doing business with Nascentia Health Plus, providers and their staff have the same obligation to report any actual or suspected violation of Medicare or Medicaid funds by fraud, waste or abuse.

Entities must have written policies that inform employees, contractors, and agents of the following:

- The Federal False Claims Act and state laws pertaining to submitting false claims;

- How providers will detect and prevent fraud, waste, and abuse; and
- Employee protection rights as whistleblowers.

The Federal False Claims Act and State Medicaid False Claims Acts have Qui Tam language commonly referred to as "whistleblower" provisions. These provisions encourage employees (current or former) and others to report instances of fraud, waste or abuse to the government. The government may then proceed to file a lawsuit against the organization/individual accused of violating the False Claims Acts. The whistleblower may also file a lawsuit independently. Cases found in favor of the government will result in the whistleblower receiving a portion of the amount awarded to the government.

Whistleblower protections state that employees who have been discharged, demoted, suspended, threatened, harassed or otherwise discriminated against due to their role in furthering a false claim are entitled to all relief necessary to make the employee whole including:

- Employment reinstatement at the same level of seniority;
- Two (2) times the amount of back pay plus interest; and
- Compensation for special damages incurred by the employee as a result of the employer's inappropriate actions.

Affected entities who fail to comply with the law will be at risk of forfeiting all payments until compliance is met. Nascentia Health Plus will take steps to monitor contracted providers to ensure compliance with the law.

Anti-Kickback Statute - Provides criminal penalties for individuals or entities that knowingly and willfully offer, pay, solicit, or receive remuneration in order to induce or reward business payable or reimbursable under the Medicare or other federal health care programs.

Stark Statute - Similar to the Anti-Kickback Statute, but more narrowly defined and applied. It applies specifically to Medicare and Medicaid services provided only by physicians, rather than by all health care practitioners.

Sarbanes-Oxley Act of 2002 - Requires certification of financial statements by both the Chief Executive Officer and the Chief Financial Officer. The Act states that a corporation must assess the effectiveness of its internal controls and report this assessment annually to the Securities and Exchange Commission.

Examples of Fraud, Waste and Abuse by a Provider

The types of questionable provider schemes investigated by Nascentia Health Plus include, but are not limited to the following:

- Altering claim forms, electronic claim forms, and/or medical record documentation in order to get a higher level of reimbursement;
- Improper billing a Medicare and/or Medicaid member for Medicare and/or Medicaid covered services. This includes asking the member to pay the difference between the discounted and negotiated fees, and the provider's usual and customary fees;

- Billing and providing for services to members that are not medically necessary;
- Billing for services, procedures and/or supplies that have not been rendered;
- Billing under an invalid place of service in order to receive or maximize reimbursement;
- Completing certificates of Medical Necessity for members not personally and professionally known by the provider;
- Concealing a member's misuse of a Nascentia Health Plus identification card;
- False coding in order to receive or maximize reimbursement;
- Inappropriate billing of modifiers in order to receive or maximize reimbursement;
- Inappropriately billing of a procedure that does not match the diagnosis in order to receive or maximize reimbursement;
- Knowingly and willfully referring patients to health care facilities in which or with which the physician has a financial relationship for designated health services (The Stark Law);
- Knowingly and willfully soliciting or receiving payment of kickbacks or bribes in exchange for referring patients;
- Not following incident to billing guidelines in order to receive or maximize reimbursement;
- Overutilization;
- Questionable prescribing practices;
- Unbundling services in order to get more reimbursement, which involves separating a procedure into parts and charging for each part rather than using a single global code;
- Underutilization, which means failing to provide services that are medically necessary;
- Upcoding, which is when a provider does not bill the correct code for the service rendered, and instead uses a code for a like services that costs more;
- Using the adjustment payment process to generate fraudulent payments.

Prepayment Fraud, Waste and Abuse Detection Activities
Through implementation of claims edits, Nascentia Health Plus claims payment system is designed to audit claims concurrently, in order to detect and prevent paying claims that are inappropriate.

Post-payment Recovery Activities
Provider will provide Nascentia Health Plus, governmental agencies and their representatives or agents, access to examine, audit, and copy any and all records deemed by Nascentia Health Plus, necessary to determine compliance with the terms of the Provider Agreement, including for the purpose of investigating potential fraud, waste and abuse. Documents and records must be readily accessible at the location where provider provides services to any Nascentia Health Plus members. Auditable documents and records include, but are not limited to, medical charts; patient charts; billing records; and coordination of benefits information. Production of auditable documents and records must be provided in a timely manner, as requested by Nascentia Health Plus and without charge to Nascentia Health Plus. In the event the plan identifies fraud, waste or abuse, provider agrees to repay funds or Nascentia Health may seek recoupment.

If a Nascentia Health Plus auditor is denied access to provider's records, all of the claims for which provider received payment from Nascentia Health Plus is immediately due and owing. If

provider fails to provide all requested documentation for any claim, the entire amount of the paid claim is immediately due and owing. Nascentia Health Plus may offset such amounts against any amounts owed by Nascentia Health Plus to provider. Provider must comply with all requests for documentation and records timely (as reasonably requested) and without charge. Claims for which provider fails to furnish supporting documentation during the audit process are not reimbursable and are subject to chargeback.

Provider acknowledges that HIPAA specifically permits a covered entity, such as provider, to disclose protected health information for its own payment purposes (see 45 CFR 164.502 and 45 CFR 154.501). Provider further acknowledges that in order to receive payment from Nascentia Health Plus, provider is required to allow Nascentia Health Plus to conduct audits of its pertinent records to verify the services performed and the payment claimed, and that such audits are permitted as a payment activity of provider under HIPAA and other applicable privacy laws.

Reporting Fraud, Waste and Abuse

If you suspect cases of fraud, waste or abuse, you must notify Nascentia Health Plus Compliance Department. You have the right to report your concerns anonymously without fear of retaliation. Information reported to Compliance will remain confidential to the extent possible as allowed by law.
When reporting an issue, please provide as much information as possible. The more information provided, the better the chances the situation will be successfully reviewed and resolved. Information that should be reported includes:

- Allegation – A complete description of the allegation, including the type of fraud, waste, or abuse (e.g., improper billing, falsification of information, billing for services not rendered).
- Suspect's Identity – The names, including any aliases or alternative names, of individuals and/or entity involved in suspected fraud and/or abuse including address, telephone number, email address, Medicare and/or Medicaid ID number and any other identifying information.
- Dates of Occurrence – When did the fraud, waste, or abuse happen? Provide dates and times.

Product / Plan Overview

Health Maintenance Organization (HMO)

Nascentia Health Plus's Medicare Advantage products are CMS-approved Health Maintenance Organizations ("HMOs"), which require members to select a Primary Care Provider (PCP) to coordinate their care. Generally, a PCP is from one of the three disciplines:

- Family Physician – A physician who specializes in the care of all members of a family regardless of age.
- Internist – A physician who specializes in internal medicine and gives non-surgical treatment of medical conditions.
- An OBGYN may also qualify as a PCP in some states.

Contracted HMO PCPs agree to accept health plan members as referenced in the Provider Agreement. The health plan insists that the provider must not refuse new members until he/she can reasonably demonstrate his/her panel size has reached its maximum capacity for adding new members. If a PCP requests that his/her panel be closed to new members, the PCP must request that his/her panel be closed to all third-party payers with whom the PCP contracts. Validation and proof may be requested regarding the size and adequacy of the physician panel.

Role of Primary Care Provider (PCP)

As a Primary Care Physician (PCP), you are the manager of your patients' total healthcare needs. PCPs provide routine and preventive medical services, authorize covered services for members, and coordinate all care that is given by Nascentia Health Plus specialists, Nascentia Health Plus participating facilities, or any other medical facility where your patients might seek care (e.g., Emergency Services). The coordination provided by PCPs may include direct provision of primary care, referrals for specialty care and referrals to other programs including Disease Management and educational programs, public health agencies and community resource.

PCPs are generally Physicians of Internal Medicine, Family Practice, General Practice, Geriatrics, OB/GYNs, physicians that specialize in infectious disease, and Nurse Practitioners in Adult Medicine, Gerontology Family Medicine, or Gynecology.

Access to Care

In an effort to comply with CMS requirements, accrediting and regulatory agencies, Nascentia Health Plus has established specific standards for participating physicians that are summarized below. These standards were developed to ensure that Nascentia Health Plus's Medicare Advantage members have access to health services.

Medicare Providers Access Standards:

Nascentia Health Plus insists that all covered services be geographically accessible and consistent with local patterns of care while ensuring that no Medicare Advantage member residing within the service area travel an unreasonsonable distance to obtain covered services. Nascentia Health Plus requires that the following services be available within the applicable serving area:

- Access to medical coverage 24 a hours a day, 7 days a week.
- Urgent and nonemergent appointments within 24 hours.
- Urgently needed services must be provided to Medicare members.
- Nonurgent, but attention needed, appointments within one week.
- Routine and preventive care or well-child appointments within 30 days.

Nascentia Health Plus recommends that all physicians adopt the standards referenced below:

- Respond to urgent calls within 15 minutes; respond to routine calls within the same business day.
- Respond to after-hours urgent calls within 15 minutes; non-urgent calls within 30 minutes.
- Specialty care within 21 business days.

Note: If state regulations are more stringent, they take precedence over these standards.

Member/Provider Incompatibility

Nascentia Health Plus recognizes that the physician-patient relationship is a personal one and may become unsatisfactory to either party. Nascentia Health Plus has established procedures that allow for the smooth and orderly transfer and re-assignment of members and PCPs.

- All member transfer requests, whether from the member or the PCP, will be reviewed by Nascentia Health Plus to determine the appropriateness of the request. Member transfer requests that involve quality-of-care issues will be forwarded to our Medical Director for review.
- Decisions regarding member transfer requests will be made effective the 1st day of the following month. The member, the provider, and the Interdisciplinary Care Team (ICT) will receive written notification of PCP transfers. The notification will include the effective date of the transfer.
- The new PCP is responsible for contacting the member's former PCP to arrange for the transfer of any medical records, Plan of Care (POC) and to inform the ICT of the change in order to ensure continuity of care.

At Member's Request:

Members have the right to change their PCP with or without cause. Members must contact Nascentia Health Plus's Member Services department to initiate the change. Member Services staff will identify and document the reason for a Primary Care Physician change. We will monitor changes to identify possible trends to be addressed through our Quality Program.

At the PCP's Request:

Primary Care Providers have the right to request that a member be transferred to another participating PCP. Requests for member transfers may be initiated by telephone, but must also be submitted in writing to Nascentia Health Plus's Provider Services department and should include the reason(s) for the request.

All decisions regarding such transfers shall be made and become effective as soon as administratively feasible, but in any event decisions shall be made within (60) days from the date of the request. In the event that a PCP wishes to dismiss a patient from their panel, the provider is still responsible for providing that member with Primary Care Services, participating in the ICT, and facilitating the POC until the transfer to another PCP has taken place. In addition, the Primary Care Physician is required to share with the new Primary Care Physician or other provider any and all Medical Records related to the member's care.

Credentialing

Credentialing and Re-credentialing Program Description Overview

The Credentialing Program of Nascentia Health Plus is comprehensive to ensure that its practitioners and providers meet the standards of professional licensure and certification. The process enables Nascentia Health Plus to recruit and retain a quality network of practitioners and providers to serve its members and ensure ongoing access to care. It consistently and periodically assesses and evaluates a practitioner's or provider's ability to deliver quality care between credentialing and re-credentialing cycles, and it emphasizes and supports a practitioner's and provider's ability to successfully manage the health care of network members in a cost-effective manner.

Nascentia Health Plus Board of Directors (the "Board") has ultimate authority, accountability and responsibility for the Credentialing evaluation process (the "Credentialing Program"). The Board has delegated full oversight of the Credentialing Program to the Credentialing Committee. The Credentialing Committee accepts the responsibility of administering the Credentialing Program, having oversight of operational activities, which includes, but is not limited to, making the final approval or denial decision on all practitioners and providers, as applicable.

Credentialing Committee Structure and Activities

The Medical Director or designee is responsible for the oversight and operation of the Credentialing Committee, and serves as Chairperson or may appoint a Chairperson, with equal qualifications. The Credentialing Committee is a peer-reviewed body that includes representation from a range of participating practitioners including primary care (i.e., family practice, internal medicine, general medicine, obstetrics and gynecology) and specialty practice. Allied health representatives include mental health, rehabilitation, etc., and may be appointed to serve as non-voting members, on an ad-hoc basis. Committee Members may be appointed or requested to attend the meeting representing Nascentia Health Plus's internal staff.

- Receive and review the credentials of all practitioners being credentialed or re-credentialed who do not meet the organization's established criteria, and to offer advice which the organization considers. This includes evaluating practitioner files that have been identified as problematic (e.g., malpractice cases, licensure issues, quality concerns, missing documentation, etc.).
- Review practitioner credentials and give thoughtful consideration to the credentialing elements before making recommendations about a practitioner's ability to deliver care.
- Establish, implement, monitor, and revise policies and procedures for Nascentia Health Plus credentialing and re-credentialing.
- Report to the Medical Advisory Group and other proper authorities, as required.
- Annual Review of the credentialing program description, and other related objectives.

Process and Requirements

Nascentia Health Plus credentials all practitioners prior to being admitted into the Nascentia Health Plus Medicare Network. The intent of the process is to validate and/or confirm credentials information related to a prospective or participating practitioner by contacting the primary source of the issuing credential directly.

Each practitioner must submit a legible and completed application, a consent form that is signed and dated, a confidentiality form that is signed and dated, and any other required documentation. Practitioners may also submit their applications and/or information to the Center for Affordable Quality Healthcare (CAQH). Upon notification from the prospective practitioner that his/her application is filed with CAQH, Nascentia Health Plus's credentialing staff will promptly download the application to initiate the credentialing process.

The following information is obtained and verified according to the standards and using the sources listed under Initial Credentialing:

- Completed Nascentia Health Plus application
- Copy of the unrestricted *(no limitations)*, current and valid license or license number for the participating practitioner
- Copy of the unrestricted *(no limitations)*, current DEA Certificate, if applicable
- Copy of the medical malpractice policy face sheet
- Copy of the board certificate or highest level of education; proof of education, training and competency
- Copy of the current Curriculum Vitae, which must include work history *(gaps or interruptions in work history 6 months or greater must be explained)*
- Primary Source Verification of associated credentialing documentation
- The Office of the Inspector General and the CMS Exclusions List will be checked monthly to ensure practitioners meet the specifications of CMS and are eligible for participation.
- The Credentialing Committee's final decision *(The practitioner shall be notified within 60 calendar days of the Committee's decision)*

Primary Source Verification

The Nascentia Health Plus credentialing staff will conduct primary source verification as required by the most current and applicable Nascentia Health Plus, CMS, and/or NCQA guidelines. Nascentia Health Plus will contact the appropriate sources for verification of the various elements of the applicant's application. These verifications may be completed in the form of documented phone calls, faxes and/or Internet website print outs.

Termination without Cause

Per regulatory guidelines, Nascentia Health Plus will notify a provider in advance of terminating his/her agreement. Please refer to the timeframes specified in the Provider Agreement.

Nascentia Health Plus withholds the right to terminate any individual provider or provider location within the timeframe referenced in the termination process of the Provider Agreement, unless state or federal law specifies otherwise.

Nascentia Health Plus requires that a provider electing to terminate participation with Nascentia Health Plus products, provide a written notice of the pending termination in accordance with the terms specified in the Provider Agreement.

Note: Nascentia Health Plus has developed a process to notify Members of an impending termination of any provider. Nascentia Health Plus requires advanced notice in order to effectively comply with federal and state law, and accrediting agencies.

Note: Nascentia Health Plus reviews the Department of Human Services and OIG exclusion frequently as defined by federal and state law. Should a provider appear on the current OIG list of excluded, Nascentia Health Plus will take immediate action to remove the provider from participating in the Nascentia Health Plus network, and take any corrective actions as applicable. Other sanctions such as loss of licensure are also grounds for immediate dismissal from participating with Nascentia Health Plus.

Measurement of Clinical and Service Quality

Nascentia Health Plus offers a variety of Quality Management programs and initiatives. Providers interested in additional information are encouraged to reach out to the Provider Services department for more information.

Providers that participate agree to assist Nascentia Health Plus with the operationalizing of its quality programs:

Disease Management

Nascentia Health Plus offers disease-specific programs as additional support to members and their physicians. These programs are designed to complement a physician's treatment regimen and empower the member through education and support. Physicians can identify those they believe are viable candidates to participate in disease management programs by contacting the Medical Management department at (888) 477-4663, Monday through Friday, 8:00 am to 5:00 pm EST. All programs are coordinated with the member's care manager as part of the Interdisciplinary Care Team (ICT).

Nascentia Health Plus monitors and evaluates the quality of care and services provided to members through the following mechanisms:

- Healthcare Effectiveness Data and Information Set (HEDIS®);
- Consumer Assessment of Providers and Systems (CAHPS®);
- Health Outcomes Survey (HOS);
- Provider Satisfaction Survey;
- Medical Record Audits; and
- Effectiveness of Quality Improvement Initiatives.

1. **Healthcare Effectiveness Data and Information Set (HEDIS®)** – Nascentia Health Plus utilizes the NCQA HEDIS® as a measurement tool to provide a fair and accurate assessment of specific aspects of managed care organization performance. HEDIS® is an annual activity conducted in the spring. The data comes from on-site medical record review and available administrative data. All reported measures must follow rigorous specifications and are externally audited to assure continuity and comparability of results. The HEDIS® measurement set currently includes a variety of health care aspects including immunizations, women's health screening, diabetes care, well check-ups, medication use and cardiovascular disease.

   HEDIS® results are used in a variety of ways. They are the measurement standard for many of Nascentia Health's clinical quality improvement activities and health

improvement programs. The standards are based on established clinical guidelines and protocols, providing a firm foundation to measure the success of these programs.

Selected HEDIS® results are provided to regulatory and accreditation agencies as part of our contracts with these agencies. The data are also used to compare to established health plan performance benchmarks.

2. **Consumer Assessment of Healthcare Providers and Systems (CAHPS®)** - CAHPS® is the tool used by Nascentia Health Plus to summarize member satisfaction with the health care and service they receive. CAHPS® examines specific measures, including getting needed care, getting care quickly, how well doctors communicate, coordination of care, customer service, rating of health care and getting needed prescription drugs. The CAHPS® survey is administered annually in the spring to randomly selected members by a NCQA certified vendor.

   CAHPS® results are used in much the same way as HEDIS® results, only the focus is on the service aspect of care rather than clinical activities. They form the basis for several of Nascentia Health's quality improvement activities and are used by external agencies to help ascertain the quality of services being delivered.

3. **Medicare Health Outcomes Survey (HOS)** - The HOS measures Medicare members' physical and mental health status over a two (2) year period and categorizes the two (2) year change scores as better, same, or worse than expected. The goal of the HOS is to gather valid, reliable, clinically meaningful data that can be used to target quality improvement activities and resources, monitor health plan performance and reward top performing health plans. Additionally, the HOS is used to inform beneficiaries of their health care choices, advance the science of functional health outcomes measurement, and for quality improvement interventions and strategies.

4. **Provider Satisfaction Survey** - Recognizing that HEDIS® and CAHPS® both focus on member experience with health care providers and health plans, Nascentia Health Plus conducts a Provider Satisfaction Survey annually. The results from this survey are very important to us, as this is one of the primary methods used to identify improvement areas pertaining to the Nascentia Health Plus Provider Network. The survey results have helped establish improvement activities relating to our specialty network, inter-provider communications, and pharmacy authorizations. This survey is fielded to a random sample of providers each year. If your office is selected to participate, please take a few minutes to complete and return the survey.

5. **Medical Record Audits**- Nascentia Health Plus conducts medical record audits to meet the requirements of accrediting agencies and state and federal law. Nascentia Health Plus is not responsible for ensuring the accuracy or completeness of records. Medical record documentation provides the plan for your patients' care. This includes continuity and coordination of care with other physicians, facilities and health care professionals.

Complete and accurate documentation in the medical record reflects the care you gave to your patient. It also serves as both a risk management and patient safety tool.

6. **Effectiveness of Quality Improvement Initiatives** – Nascentia Health Plus monitors the effectiveness of clinical and service activities through metrics selected to demonstrate clinical outcomes and service levels. The plan's performance is compared to that of available national benchmarks indicating "best practices." The evaluation includes an assessment of clinical and service improvements on an ongoing basis. Results of these measurements guide activities for the successive periods. Contracted providers and Facilities must allow Nascentia Health Plus to use its performance data collected in accordance with the provider's or facility's contract. The use of performance data may include, but is not limited to, the following:

    a) development of quality improvement activities;
    b) public reporting to consumers;
    c) preferred status designation in the network;
    d) and/or reduced member cost sharing.

Medicare Star Ratings - The Affordable Care Act

With the passage of the Affordable Care Act, the health care industry will be subject to greater scrutiny wherever taxpayer dollars are involved. One method of oversight is Medicare "Star Ratings." Star ratings are not new, but in the current regulatory climate, value-based payment will be receiving more focus.

Star Ratings are a system of measurements CMS uses to determine how well physicians and health plans are providing care to Medicare members. This system is based on nationally-recognized quality goals such as "The Triple Aim" and the Institute of Medicine's "Six Aims," which focus on improving the health and care of your patients, safe and effective care, as well as making care affordable. These aims are realized through specific measures.

Preventive Health:

- Annual wellness/physical exams
- Glaucoma Screening
- Mammograms
- Osteoporosis testing and management
- Influenza and Pneumonia Immunizations

Chronic Care Management:

- Diabetes management screenings
- Cardiovascular and hypertension management screenings
- Medication adherence for chronic conditions
- Rheumatoid arthritis management

Member Satisfaction Survey Questions:

- "…rate your satisfaction with your personal doctor"
- "…rate your satisfaction with getting needed appointments"

What Can Providers Do?

- Ensure patients are up-to-date with their annual physical exam and preventive health screenings, including related lab orders and referrals to specialists, such as ophthalmology;

- Review the HEDIS® preventive care listing of measures for each patient to determine if anything applicable to your patients' age and/or condition has been missed;

- Check that staff is properly coding all services provided; and

- Be sure patients understand what they need to do.

Care Management

Care Management:

Nascentia Health Plus offers an intensive Integrated Case Management Program to assist the most vulnerable members. The ICT (Interdisciplinary Care Team) works closely with the member, family, caregiver, PCP, ICT and Medicare plan to coordinate health care services across the continuum of care. Care Managers may also intervene when members demonstrate non-adherence to their treatment plan. Circumstances that warrant referral to the Care Management Team may include but are not limited to:

- Presence of progressive, chronic, or life-threatening illness
- Need for inpatient or outpatient rehabilitation
- Terminal illness
- High-risk pregnancies
- Acute/traumatic injury, or an acute exacerbation of a chronic illness
- Complex social factors
- Multiple hospitalizations or emergency room visits

Nascentia Health Plus Care Managers are registered nurses. They engage the appropriate internal, external or community-based resources to support the member's needs. All members are assigned a care manager who serves as an active member of the ICT to develop a person-centered service plan based on member goals and care coordination needs.

As the primary coordinator of care, the Care Manager's responsibilities include:

- Authorization and implementation of covered services outlined in the Member's service plan,
- Monitoring of all services for quality and effectiveness,
- Integration of feedback, observations, and recommendations of other professionals involved in managing the care to the Member, including network Providers, PCP's, Specialists, and Providers of uncovered services,
- Coordination of discharge planning from hospital or nursing home stays.

Rights and Responsibilities

Physician/Practitioner Rights and Responsibilities

Nascentia Health Plus has adopted specific policies for participating providers that are summarized below. Please note that this is not considered an all-inclusive list. There are additional responsibilities and rights referenced throughout this manual and in the Provider Agreement.

Providers Must:

- Meet all Nascentia Health Plus credentialing and recredentialing requirements as defined by Nascentia Health Plus and accrediting agencies.
- Must possess a professional degree and a unrestricted license to practice medicine in New York and bordering states.
- Be able to clearly define and provide documented experience, background, abilities, any malpractice information as requested, disciplinary sanctions or actions, and the physical and mental health status.
- Possess an unrestricted Drug Enforcement Administration (DEA) certificate, or if applicable a state Controlled Dangerous Substance (CDS) certificate.
- Posses a Clinical Laboratory Improvement Amendment (CLIA) as applicable.
- Be a clinical staff member in good standing with partnered hospital network systems, and must not have privileges revoked.
- Provide in writing to Nascentia Health Plus within 24 hours of any revocation or suspension of DEA, CLIA, professional licensures, or hospital systems privileges.
- Not discriminate against members based on payment, age, race, color, national origin, religion, sex, sexual preference, or health status.
- Not discriminate against Nascentia Health Plus members and non-members.
- Provide physician accessibility to members 24 hours a day, 7 days a week.
- Provide an on-call and after-hours service by a participating and credentialed Nascentia Health Plus provider.

Practitioner Rights

- **Right to Application Status:** Each provider has the right to check the status of his/her application, correct erroneous information, and the right to review any information obtained during the credentialing process, at any time.
- **Right to Confidentiality of Information**: Credentialing information is considered highly confidential; therefore, information obtained from NPDB, OIG, DHP, AMA, etc. may not be provided via telephone.
- **Right to Appeal Adverse Quality Decisions:** If a provider is denied network participation due to quality issues, the provider has the right to appeal that denial. Please be aware that quality denials may need to be reported to the appropriate authorities.

- **Right to a Nondiscriminatory Process:** Nascentia Health Plus's credentialing process is nondiscriminatory. It is the plan's policy to not discriminate based solely on an applicant's race, ethnic/national identity, gender, age, sexual orientation or the types of procedures performed or patients treated. Please be aware that this does not preclude the plan from including in its network practitioners who meet certain demographic or specialty needs. It does not preclude the plan from denying participation to a provider, if the network is adequate.
- **Right to be informed of Credentialing Outcomes:** Credentialing decisions will be communicated to providers, in writing, within 60 calendar days from the plan's final decision.
- **Right to a Timely Application Process:** Applications will be processed with in accreditation and/or regulatory guidelines. The Plan will make every attempt to process applications within 90 calendar days of receipt in the Credentialing Department.

Member Rights and Responsibilities

Nascentia Health Plus members have the right to:

- Timely access to their PCP and referrals to specialists when medically necessary or as needed and timely access to all covered services, both clinical and non-clinical.
- Not be balance billed by any provider for any reason for covered services or flexible benefits.
- Not be discriminated against due to; medical conditions, including physical and mental illness, claims experience, receipt of health care and medical history.
- Treatment with quality care, respect and dignity - regardless of their race, physical or mental ability, ethnicity, gender, sexual orientation, creed, age, religion or their national origin, cultural or educational background, economic or health status, English proficiency, reading skills or source of payment for their care.
- Have health care services twenty-four (24) hours a day, three hundred and sixty-five (365) days a year, including urgent, emergency and post-stabilization services.
- Choose their personal Nascentia Health Plus doctor/Primary Care Physician (PCP).
- Change their personal Nascentia Health Plus doctor and choose another one from Nascentia Health Plus's Provider Directory (included in the enrollment/membership package).
- Make their own doctor/PCP appointments to be seen in their private office at their convenience.
- Not to be treated against their will.
- To see their doctor/PCP, get covered services; get their prescriptions filled within a reasonable period of time. They should not be afraid to ask their doctor/PCP questions.
- Call Member Services to file a complaint/grievance about Nascentia Health Plus or to file an appeal if they are not happy with the answer to their inquiry (question), complaint/grievance, or care given.
- To privacy and to have their medical records and personal health information kept private unless they sign a permission form.

- Have timely access to their medical records in accordance with applicable State and Federal laws. They may be required to sign for release of those records.
- Participate with their doctor in making decisions about their health care, give their consent for all care, and make decisions to accept or refuse medical care to the extent permitted by law and be made aware of the medical consequences of such action.
- Have their doctor tell them about all treatment options and alternatives, presented in a manner that can be easily understood, regardless of the cost or benefit coverage. They can also receive a second opinion from Nascentia Health Plus's network of providers.
- Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation, as specified in Federal regulations on the use of restraints and seclusion.
- Free exercise of rights and the exercise of those rights that does not adversely affect the way Nascentia Health Plus and its providers treat their members.
- Receive information about Nascentia Health Plus, its services, costs, providers, network pharmacies, drugs, and Members' Rights and Responsibilities.
- To know the names and qualifications of the physicians and health care professionals involved in their medical treatment.
- Make suggestions regarding Nascentia Health Plus's Member Rights and Responsibilities statement, which are found in the member handbook.
- To reasonable accommodations
- To use Advance Directives (such as a Living Will or a Power of Attorney).
- Nascentia Health Plus will provide information to members about advance directives and any chages made in state law as soon as possible.
- A copy of the Privacy Notice annually or when requested.

Supplemental Member Rights

Nascentia Health Plus members also have the right to:

- See an in-network doctor in a timely manner based on the access standards listed in this document under the section called: Access to Health Care Standards.
- Get emergency care and family planning services in- or out-of-network without prior authorization. Family planning services, preventive services, and basic prenatal care do not need preauthorization, but the member should get care from an in-network doctor/provider.
- Obtain care from a doctor/provider acting within the lawful scope of practice. Nascentia Health Plus may not prohibit, or otherwise restrict, a member's doctor/provider from advising or advocating on behalf of a member who is his/her patient related to the member's health condition, medical care or treatment choices, including any other treatment that may be self-administered.
- Have the doctor's medical record indicate whether or not the member has completed an advance directive.
- Not have the doctor/provider condition the delivery of care or discriminate against a member based on whether he/she has completed an advance directive form.

- Contact Nascentia Health Plus staff that have been trained on advance directives and ask questions, if needed.
- File any type of grievance, including those related to advance directives, with Nascentia Health Plus by calling the toll free line at (877) 739-1370, the Center for Medicare Services, the Bureau of Insurance and the Department of Health.
- Give female members direct access (no referral needed) to a woman's health doctor/provider in the network for covered routine and preventive care services. This is in addition to the member's assigned primary care doctor/provider if that person is not a women's health doctor/provider.
- Have his/her health care needs and information discussed and given to the doctors/providers they want. The member is advised to sign a release form with their current provider in order to have the information released.
- Confidentiality when coordinating care including medical records, member information and appointment records for the treatment of sexually transmitted diseases.
- Be held harmless (not responsible for the bill or extra costs) if out-of-network services are given to a member for emergency care or care that has been preauthorized.
- See in-network doctors/providers with the same office hours as those for other patients who may not have Medicaid like private commercial insurance members and or other types of Medicaid members (fee-for-service), if the doctor/provider sees only Medicaid members.
- See a doctor of his/her choice based on language and/or race and one who is sensitive to the member's cultural needs, including those who cannot speak English well and those with different cultural and racial backgrounds.
- Obtain information in different formats (i.e., large print, braille, etc.), if needed and in an easy form that takes into consideration the special needs of those who may have problems seeing or reading.
- Have any service that has been stopped, reactivated, if a member's location is known.

Member Responsibilities (Nascentia Health Plus Members….)

- Choose a Nascentia Health Plus Primary Care Physician (PCP) from the provider directory. Work with their PCP to help establish a proper patient/physician relationship.
- Get their health care from a participating PCP, hospital or other health care provider.
- Keep their doctor appointments or call to cancel them at least twenty-four (24) hours ahead of time.
- Carry their member ID card with them at all times.
- Inform Nascentia Health Plus if they have other health insurance coverage.
- Tell the doctor that they are a member of Nascentia Health Plus at the time that they speak with their doctor's office.
- Give their PCP and other providers honest and complete information they need about their health to care for them.
- Learn the difference between emergency and urgent care.
    - Know what an emergency is

    - How to keep one from happening
    - What to do if one happens
- Follow plans and instructions for care given by their physician.
- Understand their health problems and discuss and/or agree upon a treatment plan with their physician.
- Advise their PCP of visits to other doctors so that he can be kept informed about the care that they are receiving.
- Act in a way that supports the care given to other patients and helps the efficient operation of their doctor's office, hospitals and other offices.
- Let Nascentia Health Plus know if they have any problems, concerns or suggestions on how we can work better for them.
- Take into advisement the recommendations of the Case Managers and other health care professionals at Nascentia Health Plus.

Members' rights regarding their protected health information

- **Right to Inspect and Copy** – Patients have the right to inspect and copy medical information that may be used to make decisions about their benefits. However, this does not include behavioral health management notes.
- **Right to Amend** – Patients have the right to amend medical information about them that they feel is incorrect or incomplete. The request should be in writing and provide a reason that supports the request to amend.
- **Right to an Accounting of Disclosures** – Patients have the right to request a list of disclosures made by the provider of medical information about them. The request should be in writing and specify the time period in question of the disclosures.
- **Right to Request Restrictions** – Patients can request a restriction or limit on the medical information used or disclosed about their treatment, payment or health care operations. This restriction or limit includes information disclosed to someone who is involved in the patient's care, like a family member or friend. The provider does not have to agree to any restrictions or limits to information.
- **Right to Request Confidential Communications** – Patients have the right to request that a provider communicate with them about medical matters in a certain way or at a certain location. For example a patient may request that communication to them only be made at work or by mail.
- **Right to be notified of a Breach** – Patients have the right to be notified in the event the provider or their business associate discovers a breach of unsecured protected health information.
- **Privacy Right to a Paper Copy of the Notice of Practices** – Patients have the right to receive a paper copy of the provider's Notice of Privacy Practices.

Patient Self-Determination

Nascentia Health Plus requires that participating providers comply with the requirements of the Patient Self-Determination Act (Section 4751 of the Omnibus Reconciliation Act of 1990). The Patient Self-Determination Act protects an adult patient's right to participate in health care

decisions to the maximum extent of his/her ability and to prevent discrimination based on whether the patient has executed an Advance Directive for health care.

All members must be informed of their right to make choices about their medical treatment, including the right to accept or refuse medical or surgical treatment and the right to formulate an Advance Directive. An Advance Directive is a member's written instructions, recognized under State law, relating to the provision of health care when the member is not competent to make health care decisions as determined under State law. Examples of Advance Directives are living wills and durable powers of attorney for health care.

Providers must inform a member of his or her medical condition and all available treatment options, including treatments, which may not be a covered service under the member's Nascentia Health Plus Evidence of Coverage or Member Handbook. In addition, members must be informed of the risks and benefits of each treatment option. The adult member's medical record must have documentation indicating whether or not the patient has executed an Advance Directive. The Advance Directive document must be signed by the member and witnessed. Providers may not make treatment conditional or otherwise discriminate on the basis of whether an individual has executed an Advance Directive.

Medicare law gives members the right to file a complaint with the state survey and certification agency if the member is dissatisfied with the organization's handling of Advance Directives and/or if a provider fails to comply with Advance Directive instructions. If so, the member may write the NY State Department of Health.

Delegation

Nascentia Health Plus may enter into a delegated arrangement with select providers. Delegation is a process by which the health plan grants the required permissions and authority to complete specific functions on its behalf, such as credentialing, utilization management, and claims payment. Such functions may be completely or partially delegated.

Full delegation is defined as allowing all activities of a specific function to be completed by the delegate. Partial allows some activities of a specific function to be delegated. Decisions and expectations of the delegated functions is determined by the provider type and the terms within the agreement. Please contact Nascentia Health Plus's Provider Services Team for additional information on delegation at (888) 477-4663.

Providers that have entered into a delegated arrangement with Nascentia Health Plus must comply with the expectations outlined in this Manual and the Delegated Services arrangement.

Model of Care

The Model of Care (MOC) is a specific outline of care management processes designed and regulated to provide the best possible care and services for members participating in a designated program. The MOC consists of:

- Specific target populations
- Measurable goals
- Interdisciplinary Care Team (ICT)
- Provider network with expertise and use of clinical practice guidelines
- Health risk assessment
- Individualized care plans
- Communication of network
- Care management of the most vulnerable subpopulations
- Performance and health outcomes measures

Specific Target Populations

Nascentia Health Plus Dual Plan is a Medicare Advantage Special Needs Plan, serving members who are dually eligible for Medicare and Medicaid within Nascentia Health Plus' servicing area. Nascentia Health Plus' members have demonstrated the eligibility requirements and have been enrolled in Medicare Part A, Part B and Medicaid benefits. Members may be enrolled in the Nascentia Health Options' (MLTSS) Plan as their Medicaid benefit.

To better understand the MOC, it is imperative to identify the specific target population covered under Nascentia Health Plus. Dual Eligible Special Needs (D-SNP) members are those who have diagnoses or clinical conditions that place these individuals at high risk for poor health outcomes. These individuals have an increased risk due to a combination of risk factors such as being elderly with two or more health conditions, being socially isolated, having limited access to food or transportation, and being at increased risk for making poor health choices. Nascentia Health Plus identifies the following groups as the most vulnerable members who will be in the D-SNP:

- Individuals with cognitive or memory problems (e.g., dementia and traumatic brain injury)
- Individuals with physical or sensory disabilities
- Individuals requiring skilled nursing facilities
- Individuals with serious and persistent mental illnesses
- Individuals with complex or multiple chronic conditions
- Individuals who are frail/elderly or end of life

Measurable Goals

The purpose of the MOC is to improve the care and services provided to members. The MOC works to ensure:

- Access to essential medical, behavioral, and social services
- Access to affordable care
- Coordination of care through an identified primary point of contact
- Seamless transitions of care across health care settings, providers, and health services
- Access to preventive health services
- Improvement of member health outcomes
- Appropriate utilization of services

Interdisciplinary Care Team (ICT)

The ICT is a group of individuals that participates in the development and implementation of a person-centered care plan that includes appropriate interventions that assist members with achieving their self-identified health goals. The ICT may include, but not be limited to:

- Member**
- Family member(s), caregiver, or legal representative**
- Care Manager**
- Primary Care Physician**
- Social Worker
- Disease Management
- Health Educator
- Specialist
- Targeted Case Management (for members with behavioral health needs)
- Pharmacy
- Medical Directors

**Core composition of the ICT team for all members
The frequency of these ICT meetings are contingent upon the member's health needs and preferences. The Care Manager will arrange for ICT meetings at the member's and/or their representative's availability and supply ICT participants. ICT meetings will occur telephonically and participants will have access to the ICP and pertinent health information with permission from the member or his/her representative.

Clinical Practice Guidelines

Nascentia Health Plus conducts a welcome call with each new member to initiate a health risk assessment tool (HRAT). The HRAT determines the medical, psychological and environmental needs of the member. This assessment is also used to determine the level of care management the member will require and serve as the foundation for developing the Individual Care Plan (ICP).

Care Manager

A registered nurse who has demonstrated the appropriate level of education and experience to provide care management services for the D-SNP population. The Care Manager conducts a comprehensive assessment of the member's health and psychosocial needs in collaboration with the member, family, providers, social agents, and other participants of the care team.

Care Managers will:

- Conduct in-depth assessments to determine the services the member will need.
- Convene and lead the interdisciplinary care team (ICT).
- Employ a person-centered approach based on each member's strengths, needs and preferences through involvement of the member, their family, their caregiver(s), and members of the Nascentia Health Plus care team and a network of community-based supports in the care planning and care delivery process.
- Develop an individualized care plan (ICP) with the member, their family and caregivers coordinated by the Interdisciplinary Care Team (ICT) to fully address and adhere to the member's strengths, needs and preferences.
- Utilize community-based resources as available to help support the member's needs and preferences.
- Coordinate with the member's Medicare plan to ensure appropriate utilization.
- Promote the member's ability to actively exercise their rights and responsibilities.
- Provide ancillary program referrals such as disease management services for individuals with chronic conditions to obtain disease-specific education and support.
- Educate members regarding the importance of self-care, prevention, and health maintenance.

Health Risk Assessment Tool (HRAT)

The Health Risk Assessment Tool (HRAT) is an assessment conducted to evaluate a member's physical condition, cognitive functioning, behavioral health, frailty and functional needs. This assessment is administered within the first ninety (90) days of enrollment to the plan. Once the initial HRAT has been completed, the assessment will then occur on an annual basis. The Member Engagement Representative (MERs) are primarily responsible for conducting the HRAT with the member and/or his/her caregiver. The HRAT identifies the potential need for specific case/disease management and potential care management needs based on medical or psychosocial issues.

The HRAT assesses the following:

- Member's perception of health status
- History of hospital and ER utilization
- Substance use
- Caregiver supports
- Pain level
- Chronic medical and/or behavioral health conditions
- Number of medications taken

- Fall screening and mobility limitations
- Special care needs such as Durable Medical Equipment (DME)
- Weight gain/loss patterns.
- Behavioral health screenings

Individualized Care Plan (ICP)

The ICP is a person-centered, comprehensive plan designed to address the member's strengths, specific needs and preferences that includes but is not limited to:

- Prioritized goals based on member and/or caregiver needs and preferences
- Time frame for evaluation of the goals, interventions and resolution of problems
- Resources to be utilized
- Transition/continuity of care
- Collaborative approaches
- Medication management
- Self-management plan
- Outcomes measures
- Social/community service needs
- End of life needs
- Advance care planning (such as advance directives)
- Condition-specific educational needs
- Integrated elements of other care plans (such as home health or targeted case management)

The initial step in developing the ICP is completion of the HRAT with the member and/or caregiver. The Care Manager then engages the member and/or their caregiver along with the ICT in developing the ICP. The ICP is a working document and may have updates as the member completes goals or wishes to add additional goals/preferences to the plan. Additionally, if a member experiences a triggering event such as a change in their health condition or hospitalization, the ICP will be updated to include these changes by the Care Manager, member, and ICT.

Communication of Network

The MOC must include effective, and in some cases enhanced and technologically advanced, communication methods. Nascentia Health Plus utilizes many different methods when communicating with members and providers.

Member Communication

- Member Services Call Center
- Newsletters
- Brochures
- Reminder Mailings

- Website
- Member Meetings
- Focus Groups

Provider Communication

- Provider Visits
- Provider Training
- Peer Review Committees
- Provider Meetings
- Provider Services Call Center
- Newsletters
- Website
- Personalized faxes
- Face-to-face meetings

Performance and Health Outcome Measures

Centers for Medicare & Medicaid Services (CMS) Star Rating system is a primary component to the measurement of Nascentia Health Plus. Utilizing star measures allows Nascentia Health Plus to observe and report changes year over year. This also allows Nascentia Health Plus to understand the quality of care delivered to the members and the care model's effectiveness.

Glossary

Abuse -The use of health services by recipients which is inconsistent with sound fiscal or medical practices and that results in unnecessary costs to the New York State Medical program or in reimbursement for a level of use or pattern of services that is not medically necessary, or provider practices which are inconsistent with sound fiscal or medical practices and that result in (a) unnecessary costs to the New York State Medicaid program, or (b) reimbursement for a level of use or a pattern of services that is not medically necessary or that fails to meet professionally recognized standards for health care.

Appeal - A request from a member, attending physician, provider or facility to reconsider a decision made by Nascentia Health Plus to reduce or deny covered services.

Authorization - The process of obtaining prior approval from the health plan before rendering specified services or procedures to a member.

Centers for Medicare & Medicaid (CMS) - The federal agency of the United States Department of Health and Human Services that is responsible for the administration of Title XIX and Title XXI of the Social Security Act. CMS provides program oversight for Medicaid Managed Care.

Claim - An itemized statement of services rendered by health care providers (such as hospitals, physicians, dentists, etc.) billed electronically or on HCFA 1500 or UB 04.

Clean Claim - A claim that has no defect or impropriety (including any lack of any required substantiating documentation) or particular circumstance requiring special treatment that prevents timely payments from being made on the claim under this title 1816 (c)(2)(b) and 1842(c)(2)(B) of the Social Security Act.

Complaint - Any oral or written communication made by or on behalf of a member expressing dissatisfaction with any aspect of the Health Plan's, providers, or State's operation, activities or behavior regardless of whether a remedial action is requested.

Co-payment - The member's portion of the payment due at the time of service.

D-SNP -"D-SNP" stands for "Dual Eligible Special Needs Plan." It's a program for people who are on both Medicare and Medicaid.

Emergency -A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent lay-person who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairment to body functions, or serious dysfunction of any bodily organ or part.

Enrollment Broker -An independent broker who enrolls recipients in the Medicaid HMO plans, and who is responsible for the operation and documentation of a toll free recipient service helpline. The responsibilities of the enrollment broker include, but are not limited to, recipient education and enrollment and may include recipient marketing and outreach.

Fee-for-Service -The traditional health care payment system in which physicians and other providers receive a payment for each unit of service they provide. This payment is contrasted with capitation, which pays per person, not per service.

Fraud -Intentional deception or misrepresentation made by a person or entity with the knowledge that the deception could result in payment of an unauthorized benefit.

Grievance -Any Complaint or dispute, other than one that constitutes an organization determination under 42 C.F.R. § 422.566, expressing dissatisfaction with any aspect of the Contractor's or Provider's operations, activities, or behavior, regardless of whether remedial action is requested pursuant to 42 C.F.R. § 422.561. Possible subjects for Grievances include, but are not limited to, quality of care or services provided, aspects of interpersonal relationships such as rudeness of a Primary Care Provider or employee of the Contractor, or failure to respect the Member's rights, as provided for in 42 C.F.R. § 438.400. Grievances are overseen by the Nascentia Health Plus Medical Advisory Committee and are related to the availability, delivery or quality of health care services including the utilization review decisions that are adverse to the member or the payment or reimbursement of health care service claims.

Health Risk Assessment(HRA)- A comprehensive assessment of a Member's medical, psychosocial, cognitive, and functional status in order to determine their medical, behavioral health, LTSS and social needs.

HMO -Health Maintenance Organization (HMO). A medical care organization to deliver and finance health care services to its members for a fixed prepaid premium. A primary care physician must provide or authorize all services provided to members. Members must use in-network physicians.

Interdisciplinary Care Team (ICT) -A team of professionals that collaborate, either in person or through
other means, with the member to develop and implement a Plan of Care that meets their medical, behavioral, long-term care and supports and social needs. ICTs may include physicians, physician assistants, long-term care providers, nurses, specialists, pharmacists, behavior health specialists, and/or social workers appropriate for the member's medical diagnoses and health condition, co-morbidities, and community support needs. ICTs employ both medical and social models of care.

LDSS - Local Department of Social Services.

Managed Care -Use of a planned and coordinated approach to provide health care with the

goal of quality care at a lower cost. Usually emphasizes preventive care and often associated with an HMO.

Medical Necessity -Services sufficient in amount, duration, scope and environment to improve health status.

Medicare -Title XVIII of the Social Security Act, the federal health insurance program for people age 65 or older, people under 65 with certain disabilities, and people with End Stage Renal Disease (ESRD) or Amyotrophic Lateral Sclerosis. Medicare Part A provides coverage of inpatient hospital services and services of other institutional providers, such as skilled nursing facilities and home health agencies. Medicare Part B provides supplementary medical insurance that covers physician services, outpatient services, some home health care, durable medical equipment, and laboratory services and supplies, generally for the diagnosis and treatment of illness or injury. Medicare Part C provides Medicare member's with the option of receiving Part A and Part B services through a private health plan. Medicare Part D provides outpatient prescription drug benefits.

Member -An individual who is eligible for Medicare/Medicaid and who is currently enrolled with Nascentia Health Plus. All members are assigned a PCP to provide and/or coordinate all health care services.

Minimum Data Set- Part of the federally-mandated process for assessing individuals receiving care in certified skilled nursing facilities in order to record their overall health status regardless of payer source. The process provides a comprehensive assessment of individuals' current health conditions, treatments, abilities and plans for discharge. The MDS is administered to all residents upon admission, quarterly, yearly and whenever there is a significant change in an individual's condition.

Model of Care (MOC)- The Model of Care is a specific outline of care management processes designed and regulated to provide the best possible care and services for members participating in a designated program.

NCQA National Committee on Quality Assurance – a not-for-profit organization performing accreditation review of managed care plans.

Network Provider -The health care entity or health care professional that has a contract with Nascentia Health Plus or its subcontractor to render covered services to members.

Non-participating Provider – a health care entity or health care provider who is not contracted with Nascentia Health Plus to provide services to members. Often referred to as an "out-of-network" provider.

NYSDOH - New York State Department of Health administers a number of programs in the State to assist low income state residents.

PCP Primary Care Physician (PCP) – a generalist trained physician in Internal Medicine, Family Practice, Pediatrics or OB/GYN, who is responsible for providing the majority of care to individuals and providing case management when additional services are required.

Plan of Care A plan, primarily directed by the member, and family members of **(POC)** the Member as appropriate, with the assistance of the Member's Interdisciplinary Care Team to meet the medical, behavioral, long-term care and supports and social needs of the Member.

Urgent Care A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of medical attention within twenty-four hours (24) could reasonably be expected to result in:

- Placing the patient's health in serious jeopardy
- Serious impairment to bodily function; or
- Serious dysfunction of any bodily organ or part.

Nascentia Health Plus is an HMO SNP organization with a Medicare contract and coordination agreement with New York State Medicaid. Enrollment in any Nascentia Health Plus plan depends on contract renewal.

This information is not a complete description of benefits. Contact the plan for more information. Limitations, co-payments, and restrictions may apply. Benefits, premiums and/or co-payments/co-insurance may change on January 1 of each year.

The formulary, pharmacy network, and/or provider network may change at any time. Notice will be provided when necessary.

Member Services is available at (888) 477-4663, TTY 711, 8:00 am to 8:00 pm, 7 days a week, from October 1 to March 31. On weekends and certain holidays from April 1 to September 30, your call may be handled by our automated phone system.