ambetter.™ FROM coordinated care™

Provider Manual

Effective January 1, 2015

Ambetter.CoordinatedCareHealth.com

AMB14-WA-C-00129

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WELCOME

Welcome to Ambetter from Coordinated Care ("Ambetter"). Thank you for participating in our network of participating physicians, hospitals and other healthcare professionals.

Ambetter is a Qualified Health Plan (QHP) as defined in the Affordable Care Act. Ambetter will be offered to consumers through the Washington Healthplanfinder powered by the Washington Health Benefit Exchange. The Health Benefit Exchange makes buying health insurance easier and is the only place where eligible consumers can receive federal subsidy.

The Affordable Care Act is the law that has changed healthcare. The goals of the act are:

- to help more Americans get health insurance and stay healthy; and
- to offer consumers a choice of coverage leading to increased health care engagement and empowerment.

HOW TO USE THIS PROVIDER MANUAL

Coordinated Care is committed to assisting its provider community by supporting their efforts to deliver well-coordinated and appropriate health care to our members. Coordinated Care is also committed to disseminating comprehensive and timely information to its provider through this Provider Manual ("Manual") regarding Coordinated Care's operations, policies and procedures. Updates to this Manual will be posted on our website at Ambetter.CoordinatedCareHealth.com Additionally, providers may be notified via bulletins and notices posted on the website and potentially on Explanation of Payment notices. Providers may contact our Provider Services Department at 1-877-687-1197 to request that a copy of this Manual be mailed to you. In accordance with the Participating Provider Agreement, providers are required to comply with the provisions of this Manual. Coordinated Care routinely monitors compliance with the various requirements in this Manual and may initiate corrective action, including denial or reduction in payment, suspension or termination, if there is a failure to comply with any requirements of this Manual.

KEY CONTACTS AND IMPORTANT PHONE NUMBERS

The following table includes several important telephone and fax numbers available to providers and their office staff. When calling, it is helpful to have the following information available.

1. The provider's NPI number
2. The practice Tax ID Number
3. The member's ID number

HEALTH PLAN INFORMATION		
Website	Ambetter.CoordinatedCareHealth.com	
Health Plan address	Coordinated Care 1145 Broadway, Suite 300 Tacoma, WA 98402	
Phone Numbers	**Phone**	**TTY/TDD**
Coordinated Care	1-877-687-1197	1-877-941-9238
Department	**Phone**	**Fax**
Provider Services	1-877-687-1197	
Member Services	1-877-687-1197	
Medical Management Inpatient and Outpatient Prior Authorization	1-877-687-1197	1-855-218-0592

HEALTH PLAN INFORMATION		
Concurrent Review/Clinical Information	1-877-687-1197	1-855-218-0587
Admissions/Census Reports/Facesheets	1-877-687-1197	1-855-218-0585
Care Management	1-877-687-1197	1-855-218-0586
Behavioral Health Prior Authorization	1-877-687-1197	1-855-283-9862
24/7 Nurse Advice Line	1-877-687-1197	
U.S. Script	1-877-687-1197	1-855-218-0592
Advanced Imaging (MRI, CT, PET) (NIA)	1-877-687-1197	
Cardiac Imaging (NIA)	1-877-687-1197	
OptiCare (Vision)	1-877-687-1197	
Interpreter Services – Voiance	1-87-687-1197	
To report suspected fraud, waste and abuse	1-866-685-8664	
EDI Claims assistance	800-225-2573 ext. 25525	e-mail: EDIBA@centene.com

SECURE WEB PORTAL

Coordinated Care offers a robust Secure Web Portal with functionality that will be critical to serving members and to ease administration for the Ambetter product for providers. Each participating provider's dedicated Provider Relations Specialist will be able to assist and provide education regarding this functionality. The Portal can be accessed at Ambetter.CoordinatedCareHealth.com.

Functionality

All users of the Secure Web Portal must complete a registration process. If you are already a registered user on the Coordinated Care Portal, a separate registration is not needed.

- Once registered, providers may:
  - check eligibility;
  - view the specific benefits for a member;
  - view benefit details including member cost share amounts for medical, pharmacy, dental, and vision services
  - view the status of recent claims that have been submitted;
  - view providers associated with the Tax Identification Number ("TIN") that was utilized during the registration process;
  - view demographic information for the providers associated with the registered TIN such as: office location, office hours and associated practitioners;
  - update demographic information (address, office hours, etc.);
  - view and print patient lists (primary care providers). This patient list will indicate the member's name, member ID number, date of birth and the product in which they are enrolled;
  - submit authorizations and view the status of authorizations that have been submitted for members;
  - view claims and the claim status;
  - submit individual claims, batch claims or batch claims via an 837 file;

- view and download Explanations of Payment (EOP);
- view a member's health record including visits (physician, outpatient hospital, therapy, etc.); medications, and immunizations;
- view gaps in care specific to a Member including preventive care or services needed for chronic conditions; and
- send secure messages to Coordinated Care staff.

PROVIDER ADMINISTRATION AND ROLE OF THE PROVIDER

Credentialing and Re-credentialing

The credentialing and re-credentialing process exists to verify that participating practitioners and providers meet the criteria established by Coordinated Care, as well as applicable government regulations and standards of accrediting agencies.

If a practitioner/provider already participates with Coordinated Care in the Medicaid product with Coordinated Care, the practitioner/provider will NOT be separately credentialed for the Ambetter product.

Notice: In order to maintain a current practitioner/provider profile, practitioners/providers are required to notify Coordinated Care of any relevant changes to their credentialing information in a timely manner but in no event later than 10 days from the date of the change.

Whether a state utilizes a standardized credentialing form or a practitioner has registered their credentialing information on the Council for Affordable Quality Health (CAQH) website, the following information must be on file:

- signed attestation as to correctness and completeness, history of license, clinical privileges, disciplinary actions, and felony convictions, lack of current illegal substance use and alcohol abuse, mental and physical competence; and ability to perform essential functions with or without accommodation;
- completed Ownership and Control Disclosure Form;
- current malpractice insurance policy face sheet which includes insured dates and the amounts of coverage;
- current Controlled Substance registration certificate, if applicable;
- current Drug Enforcement Administration (DEA) registration certificate for each state in which the practitioner will see Ambetter members;
- completed and signed W-9 form;
- current Educational Commission for Foreign Medical Graduates (ECFMG) certificate, if applicable;
- current unrestricted medical license to practice or other license in the State of Washington;
- current specialty board certification certificate, if applicable;
- curriculum vitae listing, at minimum, a five (5) year work history if work history is not completed on the application with no unexplained gaps of employment over six months for initial applicants;
- signed and dated release of information form not older than 120 days; and
- current Clinical Laboratory Improvement Amendments (CLIA) certificate, if applicable.

Coordinated Care will primary source verify the following information submitted for credentialing and re-credentialing:

- license through appropriate licensing agency;

- Board certification, or residency training, or professional education, where applicable;
- malpractice claims and license agency actions through the National Practitioner Data Bank (NPDB);
- hospital privileges in good standing or alternate admitting arrangements, where applicable; and
- Federal sanction activity including Medicare/Medicaid services (OIG-Office of Inspector General).

For providers (hospitals and ancillary facilities), a completed Facility/Provider – Initial and Re-credentialing Application and all supporting documentation as identified in the application must be received with the signed, completed application.

Once the application is completed, the Credentialing Committee will usually render a decision on acceptance following its next regularly scheduled meeting.

Practitioners/Providers must be credentialed prior to accepting or treating members. Primary care practitioners cannot accept member assignments until they are fully credentialed.

Credentialing Committee

The Credentialing Committee including the Medical Director or his/her physician designee has the responsibility to establish and adopt necessary criteria for participation, termination, and direction of the credentialing procedures, including participation, denial, and termination. Committee meetings are held at least quarterly and more often as deemed necessary.

Failure of an applicant to adequately respond to a request for missing or expired information may result in termination of the application process prior to committee decision.

Site reviews are performed at provider offices and facilities when the member complaint threshold was met. A site review evaluates:

- physical accessibility;
- physical appearance;
- adequacy of waiting and examining room space; and
- adequacy of medical/treatment record keeping.

Re-credentialing

Coordinated Care conducts practitioner/provider re-credentialing at least every 36 months from the date of the initial credentialing decision and most recent re-credentialing decision. The purpose of this process is to identify any changes in the practitioner's/provider's licensure, sanctions, certification, competence, or health status which may affect the practitioner's/provider's ability to perform services under the contract. This process includes all practitioners, facilities and ancillary providers previously credentialed and currently participating in the network.

In between credentialing cycles, Coordinated Care conducts provider performance monitoring activities on all network practitioners/providers. This includes an inquiry to the appropriate State Licensing Agency for a review of newly disciplined practitioners/providers and practitioners/providers with a negative change in their current licensure status. This monthly inquiry is designed to verify that practitioners/providers are maintaining a current, active, unrestricted license to practice in between credentialing cycles. Additionally, Coordinated Care reviews monthly reports released by the Office of Inspector General to identify any network practitioners/providers who have been newly sanctioned or excluded from participation in Medicare or Medicaid.

A provider's agreement may be terminated if at any time it is determined by the Coordinated Care Credentialing Committee that credentialing requirements or standards are no longer being met.

Practitioner Right to Review and Correct Information

All practitioners participating within the network have the right to review information obtained by Coordinated Care to evaluate their credentialing and/or re-credentialing application. This includes

information obtained from any outside primary source such as the National Practitioner Data Bank Healthcare Integrity and Protection Data Bank, CAQH, malpractice insurance carriers and state licensing agencies. This does not allow a provider to review references, personal recommendations, or other information that is peer review protected.

Practitioners have the right to correct any erroneous information submitted by another party (other than references, personal recommendations, or other information that is peer review protected) in the event the provider believes any of the information used in the credentialing or re-credentialing process to be erroneous, or should any information gathered as part of the primary source verification process differ from that submitted by the practitioner. To request release of such information, a written request must be submitted to the Credentialing Department. Upon receipt of this information, the practitioner will have the following timeframe to provide a written explanation detailing the error or the difference in information to the Credentialing Committee within thirty (30) days of the initial notification.

The Credentialing Committee will then include this information as part of the credentialing or re-credentialing process.

Practitioner Right to Be Informed of Application Status

All practitioners who have submitted an application to join have the right to be informed of the status of their application upon request. To obtain application status, the practitioner should contact the Provider Services Department at 1-877-687-1197.

Practitioner Right to Appeal Adverse Re-credentialing Determinations

Applicants who are existing providers and who are declined continued participation due to adverse re-credentialing determinations (for reasons such as appropriateness of care or liability claims issues) have the right to request an appeal of the decision. Requests for an appeal must be made in writing within thirty (30) days of the date of the notice.

New applicants who are declined participation may request a reconsideration within thirty (30) days from the date of the notice. All written requests should include additional supporting documentation in favor of the applicant's appeal or reconsideration for participation in the network. Reconsiderations will be reviewed by the Credentialing Committee at the next regularly scheduled meeting and/or no later than sixty (60) days form the receipt of the additional documentation.

Provider Types That May Serve As PCPs

Providers who may serve as Primary Care Providers include Family Practice, Internal Medicine, General Practice, Nurse Practitioners, Physician Assistants and OB-GYN.

The PCP may practice in a solo or group setting or at a Federally Qualified Health Center (FQHC), Rural Health Center (RHC), Department of Health Clinic, or similar outpatient clinic.

Member Panel Capacity

All PCPs have the right to state the number of members they are willing to accept into their panel. Coordinated Care does not and is not permitted to guarantee that any provider will receive a certain number of members.

The PCP to member ratio shall not exceed the following limits:

Practitioner Type	Ratio
General/Family Practitioners	1 per 2,500 members
Pediatricians	1 per 2,500 members
Internists	1 per 2,500 members

If a PCP has reached the capacity limit for his/her practice and wants to make a change to their open panel status, the PCP must notify Provider Services Department by calling 1-877-687-1197. A PCP must not refuse new members for addition to his/her panel unless the PCP has reached his/her specified capacity limit.

PCPs must notify Coordinated Care in writing, within thirty (30) days in advance of their inability to accept additional members.

In no event will any established patient who becomes a member be considered a new patient. Providers must not intentionally segregate members from fair treatment and covered services provided to other non-members.

Member Selection or Assignment of PCP

Ambetter members will be directed to select a participating Primary Care Provider at the time of enrollment. In the event an Ambetter member does not make a PCP choice, Coordinated Care will usually select a PCP based on:

1. **A previous relationship with a PCP based on claims history.** If a member has not designated a PCP within the first 90 to 120 days of being enrolled in Ambetter, Coordinated Care will review claims history to determine if a PCP visit has occurred and assign the member to that PCP.
2. **Geographic proximity of PCP to member residence.** The auto-assignment logic is designed to select a PCP for whom the members will not travel more than the required access standards.
3. **Appropriate PCP type.** The algorithm will use age, and gender, and other criteria to identify an appropriate match, such as children assigned to pediatricians.

Pregnant women should be encouraged to select a pediatrician or other appropriate PCP for their newborn baby before the beginning of the last trimester of pregnancy. In the event the pregnant member does not select a PCP, Coordinated Care will auto-assign one for her newborn.

The member may change his or her PCP at any time with the change becoming effective on the next business day, if the selected provider's caseload permits. Members are advised to contact the Member Services Department at 1-877-687-1197 for further information.

Withdrawing from Caring for a Member

Providers may withdraw from caring for a member. Upon reasonable notice and after stabilization of the member's condition, the provider must send a certified letter to Coordinated Care Member Services detailing the intent to withdraw care. The letter must include information on the transfer of medical records as well as emergency and interim care.

PCP Coordination of Care to Specialists

When medically necessary care is needed beyond the scope of what the PCP can provide, PCPs are encouraged to initiate and coordinate the care members receive from specialist providers. ***Paper referrals are not required.***

In accordance with federal and state law, providers are prohibited from making referrals for designated health services to healthcare providers with which the provider, the member, or a member of the provider's family, or the member's family has a financial relationship.

Specialist Provider Responsibilities

Specialist providers must communicate with the PCP regarding a member's treatment plan and referrals to other specialists. This allows the PCP to better coordinate the member's care and ensures that the PCP is aware of the additional service request.

To ensure continuity and coordination of care for the member, every specialist provider must:

- maintain contact and open communication with the member's referring PCP;
- obtain authorization from the Medical Management Department, if applicable, before providing services;
- coordinate the member's care with the referring PCP;
- provide the referring PCP with consultation reports and other appropriate patient records within five (5) business days of receipt of such reports or test results;
- be available for or provide on-call coverage through another source twenty-four (24) hours a day for management of member care;
- maintain the confidentiality of patient medical information; and
- actively participate in and cooperate with all quality initiatives and programs.

Appointment Availability and Wait Times

Coordinated Care follows the accessibility and appointment wait time requirements set forth by applicable regulatory and accrediting agencies. Coordinated Care monitors participating provider compliance with these standards at least annually and will use the results of appointment standards monitoring to ensure adequate appointment availability and access to care and to reduce inappropriate emergency room utilization. The table below depicts the appointment availability and wait time standards for members:

Appointment Type	Access Standard
PCP – Preventive Visits	30 calendar days
PCPs – Routine Visits	10 calendar days
PCPs – Urgent Care Visits	48 hours
Specialty Providers	30 calendar days
Emergency Providers	Immediately, 24 hours a day, 7 days a week and without prior authorization
Initial Visit – Pregnant Women	14 calendar days
Behavioral Health non-life threatening emergency	Within 6 hours
Behavioral Health Urgent Care	48 hours
Behavioral Health routine office visits	10 business days

Wait Time Standards for all Provider Types

It is recommended that office wait times do not exceed 30 minutes before an Ambetter member is taken to the exam room.

Travel Distance and Access Standards

Coordinated Care offers a comprehensive network of PCPs, Specialist Physicians, Hospitals, Behavioral Health Care Providers, Diagnostic and Ancillary Services Providers to ensure every member has access to Covered Services. Below are the travel distance and access standards that Coordinated Care utilizes to monitor its network adequacy:

Physician:

- PCP Access Standards:

- Urban: 2 PCPs within 10 miles of the beneficiary's residence
- Rural: 1 PCP within 25 miles of the beneficiary's residence

- High Volume Specialist Access Standards:
  - Urban: 1 specialist within 30 miles of the beneficiary's residence for at least 90% of the beneficiaries
  - Rural: 1 specialist within 90 miles of the beneficiary's residence for all beneficiaries

Behavioral Health Service Standards:

- Urban: 1 MD and 1 non-MD behavioral health provider within 30 miles for 90% of beneficiaries; 1 behavioral health acute care hospital and 1 CMHC within 30 miles for 90% of beneficiaries; or State/CMC standards
- Rural: 1 MD and 1 non-MD behavioral health provider within 60 miles; 1 behavioral health acute care hospitals and 1 CMHC within 60 miles for all beneficiaries; or State/CMS standards

Providers must offer and provide Ambetter members appointments and wait times comparable to that offered and provided to other commercial members. Coordinated Care routinely monitors compliance with this requirement and may initiate corrective action, including suspension or termination, if there is a failure to comply with this requirement.

Covering Providers

PCPs and specialist providers must arrange for coverage with another provider during scheduled or unscheduled time off. In the event of unscheduled time off, the provider must notify the Provider Relations Department of coverage arrangements as soon as possible. For scheduled time off, the provider must notify the Provider Relations Department prior to the scheduled time off. The provider whom engaged the covering provider must ensure that the covering physician has agreed to be compensated in accordance with the Ambetter fee schedule in such provider's agreement.

Provider Phone Call Protocol

PCPs and specialist providers must:

- answer the member's telephone inquiries on a timely basis;
- schedule appointments in accordance with and appointment standards and guidelines set forth in this Manual;
- schedule a series of appointments and follow-up appointments as appropriate for the member and in accordance with accepted practices for timely occurrence of follow-up appointments for all patients;
- identify and, when possible, reschedule cancelled and no-show appointments;
- identify special member needs while scheduling an appointment (e.g., wheelchair and interpretive linguistic needs, non-compliant individuals, or persons with cognitive impairments);
- adhere to the following response times for telephone call-back wait times:
  - after hours for non-emergent, symptomatic issues: within 30 minutes;
  - same day for all other calls during normal office hours;
- schedule continuous availability and accessibility of professional, allied, and supportive personnel to provide covered services within normal office hours;
- have protocols in place to provide coverage in the event of a provider's absence; and
- document after-hour calls in a written format in either in the member's medical record or an after-hour call log and then transferred to the member's medical record.

Note: If after-hours urgent or emergent care is needed, the PCP, specialist provider or his/her designee should contact the urgent care center or emergency department in order to notify the facility of the patient's impending arrival. Coordinated Care does not require prior-authorization for emergent care.

Coordinated Care will monitor appointment and after-hours availability on an on-going basis through its Quality Improvement Program (QIP).

24-Hour Access to Providers

PCPs and specialist providers are required to maintain sufficient access to needed health care services on an ongoing basis and must ensure that such services are accessible to members as needed 24 hours a day, 365 days a year as follows:

- a provider's office phone must be answered during normal business hours; and
- a member must be able to access their provider after normal business hours and on weekends. This may be accomplished through the following:
  - a covering physician;
  - an answering service;
  - a triage service or voicemail message that provides a second phone number that is answered; or
  - if the provider's practice includes a high population of Spanish speaking members, it is recommended that the message be recorded in both English and Spanish

Examples of unacceptable after-hours coverage include, but are not limited to:

- calls received after-hours are answered by a recording telling callers to leave a message;
- calls received after-hours are answered by a recording directing patients to go to an Emergency Room for any services needed; or
- not returning calls or responding to messages left by patients after-hours within thirty minutes.

The selected method of 24-hour coverage chosen by the provider must connect the caller to someone who can render a clinical decision or reach the PCP or specialist provider for a clinical decision. Whenever possible, PCP, specialist providers, or covering professional must return the call within 30 minutes of the initial contact. After-hours coverage must be accessible using the medical office's daytime telephone number.

Coordinated Care will monitor provider's compliance with this provision through scheduled and unscheduled visits and audits conducted by Coordinated Care staff.

Hospital Responsibilities

Coordinated Care has established a comprehensive network of hospitals to provide services to members. Hospital services and hospital-based providers must be qualified to provide services under the program. All services must be provided in accordance with applicable state and federal laws and regulations and adhere to the requirements set forth by accrediting agencies, if any, and Coordinated Care.

Hospitals must:

- notify the PCP immediately or no later than the close of the next business day after the member's emergency room visit;
- obtain authorizations for all inpatient and selected outpatient services listed on the current prior authorization list, except for emergency stabilization services;

- notify the Medical Management Department by either calling or sending an electronic file of the ER admission within one business day. The information required includes the member's name, member ID, presenting symptoms/diagnosis, date of service, and member's phone number;
- notify the Medical Management Department of all admissions via the ER within one business day; and
- notify the Medical Management Department of all newborn deliveries within one day of the delivery. Notification may occur by our secure web portal, fax, or by phone.

AMBETTER BENEFITS

Overview

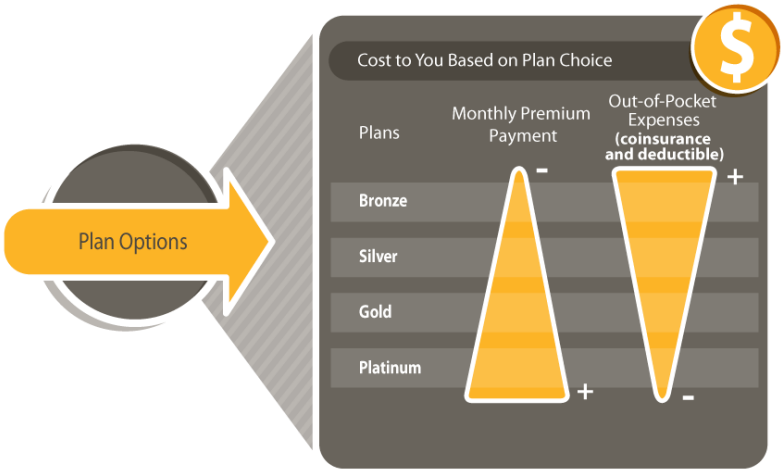
There are many factors that determine which plan an Ambetter member will be enrolled. The plans vary based on the individual liability limits or cost share expenses to the member. The phrase "Metal Tiers" is used to categorize these limits.

Under the Affordable Care Act (ACA) the Metal Tiers include Platinum, Gold, Silver, and Bronze. Essential Health Benefits (EHBs) are the same with every plan. This means that every health plan will cover the minimum, comprehensive benefits as outlined in the Affordable Care Act as modified by the State.

The EHBs outlined in the Affordable Care Act are as follows:

- Preventive and Wellness Services
- Maternity and Newborn Care
- Pediatric Services including Pediatric Vision
- Ambulatory Patient Services
- Laboratory Services
- Rehabilitative and Habilitative Services and Devices
- Hospitalization
- Emergency Services
- Mental Health and Substance Use Services, both inpatient and outpatient
- Prescription Drugs

Each plan offered on the Health Insurance Marketplace (or Exchange) will be categorized within one of these "Metal Tiers". The tiers are based on the amount of member liability. For instance, at a gold level, a member will pay higher premiums, but will have lower out-of-pocket costs, like copays. Below is a basic depiction of how the cost levels are determined within each plan.



Our products are marketed under the following names:

Metal Tier	Marketing Name
Gold	Ambetter Gold and Ambetter Secure Care
Silver	Ambetter Silver and Ambetter Balanced Care
Bronze	Ambetter Bronze and Ambetter Essential Care

Additional Benefit Information

HMO Benefit Plans

Ambetter plans are HMO Benefit plans. Members who are enrolled with Ambetter must utilize in-network participating providers. Members and Providers can identify other participating providers by visiting our website at Ambetter.CoordinatedCareHealth.com and clicking on Find A Provider. If an out-of-network provider is utilized, except in the case of emergency services, the Member will be 100% responsible for all charges. Depending on the benefit plan and any subsidies that the Member receives, most benefit plans contain copays, coinsurance and deductibles (cost shares). As stated elsewhere in this Provider Manual, cost shares may be collected at the time of service.

Preventive Services

In accordance with the Affordable Care Act, all preventive services are covered at 100%. That is, there is no member cost share (copay, coinsurance, or deductible) applied to preventive health services. For a listing of services that are covered at 100% and associated benefits, please visit Ambetter.CoordinatedCareHealth.com.

Free Visits

There are certain benefit plans where three (3) free visits are offered. That is, these visits will not be subject to member cost shares (copay, coinsurance or deductible).

- These three (3) free visits only apply to the evaluation and management (E and M) code provided by a Primary Care Provider
- Preventive care visits are not included in the free visits. As mentioned above, in accordance with the ACA, preventive care is covered at 100% by Ambetter, separately from the free visits
- The secure provider portal at Ambetter.CoordinatedCareHealth.com has functionality to "accumulate or count" free visits. It is imperative that providers always verify eligibility and benefits.
- The following CPT codes will be associated with the free visit benefit when billed by a PCP: 99201-99205, 99211-99215, 99324-99328, 99334-99337, 99339-99345, 99347-99350, 99366, S0220-S0221, S0257

Integrated Deductible Products

Some Ambetter plans contain an integrated deductible meaning that the medical and Rx deductible are combined. In such plans,

- a member will reach the deductible first, then pay coinsurance until they reach the maximum out of pocket for their particular plan;
- copays will be collected before the deductible for services that are not subject to the deductible;
- other copays are subject to the deductible and the copay will be collected only after the deductible is met;

- services counting towards the integrated deductible include: Medical costs, physician services, and hospital services, essential health benefit covered services including pediatric vision and mental health services, and pharmacy benefits; and
- claims information including the accumulators will be displayed on the Provider Secure Portal.

Maximum Out of Pocket Expenses

All Ambetter benefit plans contain a maximum out of pocket expense. Maximum out of pocket is the highest or total amount that must be paid by the member toward the cost of their health care (excluding premium payments). Below are some rules regarding maximum out of pocket expenses.

- A member will reach the deductible first, then pay coinsurance until they reach the maximum out of pocket for their Ambetter benefit plan.
- Copays will be collected before and after the deductible.
- Only medical costs/claims are applied towards the deductible.
- All out of pocket costs, including copays, apply to the maximum out of pocket. (As mentioned previously, this excludes premium payments).

Adding a Newborn or an Adopted Child

Coverage will be provided for a newborn child of an Ambetter member or a member's covered family member for up to 21 days following its birth. Coverage of the child will terminate 21 days after its birth unless the Plan receives both: (A) written notice of the child's birth; and (B) the required premium within 90 days of the child's birth.

Adopted children will be covered from the date of placement until the 60th days after placement. If notification of placement has not been submitted to the plan within 60 days following placement of the child, the coverage will terminate.

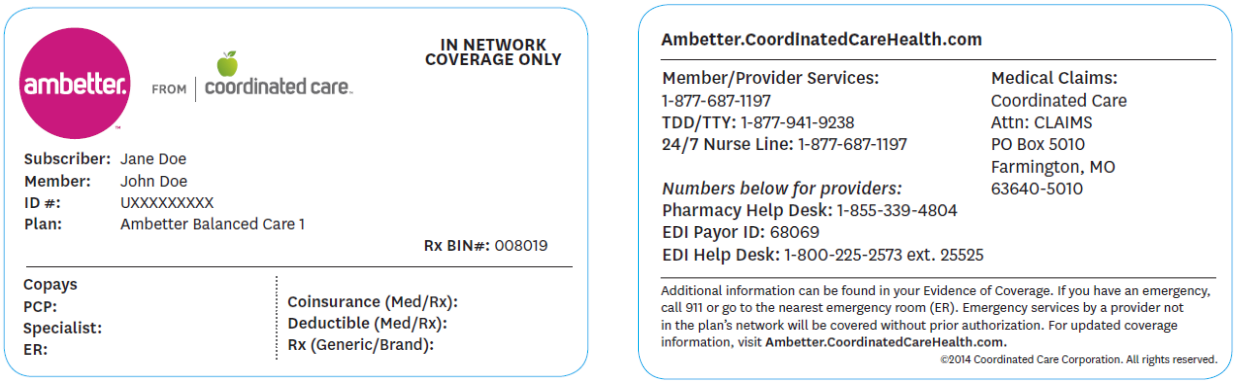
VERIFYING MEMBER BENEFITS, ELIGIBILITY, and COST SHARES

It is imperative that providers verify benefits, eligibility, and cost shares each time an Ambetter member is scheduled to receive services.

All members will receive an Ambetter member identification card.

Member Identification Card

Below is a sample member identification card. Please keep in mind that the ID card may vary due to the features of the plan selected by the member.



(The above is a reasonable facsimile of the Member Identification Card)

NOTE: Presentation of a member ID card is not a guarantee of eligibility. Providers must always verify eligibility on the same day services are required.

Preferred Method to Verify Benefits, Eligibility, and Cost Shares

To verify member benefits, eligibility, and cost share information, the preferred method is the Coordinated Care secure web portal found at Ambetter.CoordinatedCareHealth.com. Using the Portal, any registered provider can quickly check member eligibility, benefits and cost share information. Eligibility and cost share information loaded onto this website is obtained from and reflective of all changes made within the last 24 hours. The eligibility search can be performed using the date of service, member name and date of birth or the member ID number and date of birth.

Other Methods to Verify Benefits, Eligibility and Cost Shares

24/7 Toll Fee Interactive Voice Response (IVR) Line at 1-877-687-1197	The automated system will prompt you to enter the member ID number and the month of service to check eligibility.
Provider Services at 1-877-687-1197	If you cannot confirm a member's eligibility using the secure portal or the 24/7 IVR line, call Provider Services. Follow the menu prompts to speak to a Provider Services Representative to verify eligibility before rendering services. Provider Services will require the member name or member ID number and date of birth to verify eligibility.

Importance of Verifying Benefits, Eligibility, and Cost Shares

Benefit Design

As mentioned previously in the Benefits section of this Manual, there are variations on the product benefits and design. In order to accurately collect member cost shares (coinsurance, copays and deductibles); you must know the benefit design. The Secure Provider Portal found at Ambetter.CoordinatedCareHealth.com will provide the information needed.

Premium Grace Period for Members Receiving APTCs

A provision of the Affordable Care Act requires that Coordinated Care allow members receiving APTCs a three month grace period to pay premiums before coverage is terminated.

When providers are verifying eligibility through the Secure Web Portal during the first month of non-payment of premium, the provider will not receive a message related to the nonpayment of premium due to the fact that claims may be submitted and paid during the first month. During months two and three of the non-payment of premium period, the provider will receive a message that the member is in a suspended status. More discussion regarding the three month grace period for non-payment of premium may be found in the Claims section of this Manual.

MEDICAL MANAGEMENT

The components of the Ambetter Medical Management program are: Utilization Management, Care Management and Concurrent Review, Health Management and Behavioral Health. These components will be discussed in detail below.

Utilization Management

The Ambetter Utilization Management initiatives are focused on optimizing each member's health status, sense of well-being, productivity, and access to appropriate health care while at the same time actively managing cost trends. The Utilization Management Program's goals are to provide covered services that are medically necessary, appropriate to the member's condition, rendered in the appropriate setting and meet professionally recognized standards of care.

Prior authorization is the request to the Utilization Management Department for approval of certain services before the service is rendered. Authorization must be obtained prior to the delivery of certain elective and scheduled services.

Timeframes for Prior Authorization Requests and Notifications

The following timeframes are required for prior authorization and notification:

Service Type	Timeframe
Elective/scheduled admissions	Prior authorization **required** five (5) business days prior to the scheduled admission date
Emergent inpatient admissions	Notification required within one (1) business day
Emergency room and post stabilization, urgent care and crisis intervention	Notification requested within one (1) business day
Maternity admissions	Notification requested within one (1) business day
Newborn admissions	Notification requested within one (1) business day
Neonatal Intensive Care Unit (NICU) admissions	Notification required within one (1) business day
Outpatient Dialysis	Notification requested within one (1) business day

Services Requiring Prior Authorization

The following list is not all-inclusive. Please visit the Ambetter website at Ambetter.CoordinatedCareHealth.com and use the Pre-Screen Tool or call the Authorization Department with questions. Failure to obtain the required prior authorization or pre-certification may result in a denied claim or reduction in payment. ***Note: All out of network services require prior authorization excluding emergency room services.***

Procedures/Services	Inpatient Authorizations	Ancillary Services
• Potentially Cosmetic • High Tech Imaging (i.e., CT, MRI, PET) • Infertility • Obstetrical Ultrasound - 2 allowed in 9 month period, any additional will require authorization except those rendered by Maternal Fetal Medicine specialists. For urgent/emergent ultrasounds, treat using best clinical judgment and it will be reviewed retrospectively	• All elective/scheduled admission notifications requested at least 5 days prior to the scheduled date of admit including but not limited to: • All services performed in out-of-network facilities • Medical Admissions • Surgical Admissions • Hospice Care • Rehabilitation facilities • Behavioral Health/Substance Use Disorder • Transplants, including evaluations • Observation	• Air Ambulance Transport (non-emergent fixed wing plane) • DME • Home health care services including home infusion, skilled nursing and therapy - Home Health Services - Adult Medical Day Care - Hospice - Furnished Medical Supplies and DME • Orthotics/Prosthetics • Hearing Aid devices

Procedures/Services	Inpatient Authorizations	Ancillary Services
• Pain Management (unless performed on the same date as a surgery)	- Observation stays 23 hours or less require Notification Observation stays exceeding 23 hours require Inpatient Authorization/Concurrent Review - Notification is required within 1 business day if admitted • Urgent/Emergent Admissions - Within 1 business day following the date of admission • Newborn Deliveries must include birth outcomes • Behavioral Health Admissions - All behavioral health admissions require authorization within 24 hours of admission via a phone call to the utilization management department • Partial Inpatient, PRTF, and/or Intensive Outpatient Programs	including cochlear implants (cochlear replacement batteries do not require prior auth) • Genetic Testing • Quantitative Urine Drug Screen except Urgent Care, ER and Inpatient place of service

Procedure for Requesting Prior Authorizations

Medical

The preferred method for submitting authorizations is through the Secure Web Portal at Ambetter.CoordinatedCareHealth.com. The provider must be a registered user on the Secure Web Portal. (If a provider is already registered for the Secure Web Portal for one of our other products, that registration will grant the provider access to Ambetter). If the provider is not already a registered user on the Secure Web Portal and needs assistance or training on submitting prior authorizations, the provider should contact his or her dedicated Provider Relations Specialist.

Other methods of submitting the prior authorization requests are as follows:

- Phone the Medical Management Department at 1-877-687-1197. Our 24/7 Nurse Advice line can assist with authorizations after normal business hours
- fax prior authorization request utilizing the Prior Authorization fax forms posted on the Ambetter website at Ambetter.CoordinatedCareHealth.com. Please note: faxes will not be monitored after hours and will be responded to on the next business day. Please contact our 23/7 Nurse Advice Line at 1-877-687-1197 for after hour urgent admissions, inpatient notifications or requests; or

Behavioral

The required method for prior authorization of inpatient admissions is to contact the health plan telephonically. Outpatient authorizations may be submitted via the secure web portal or by fax.

Medical and Behavioral

The requesting or rendering provider must provide the following information to request authorization (regardless of the method utilized):

- member's name, date of birth and ID number;
- provider's NPI number, taxonomy code, name and telephone number;
- facility name, if the request is for an inpatient admission or outpatient facility services;
- provider location if the request is for an ambulatory or office procedure;
- **the procedure code(s).** ***Note:*** *If the procedure codes submitted at the time of authorization differ from the services actually performed, it is recommended that within 72 hours or prior to the time the claim is submitted that you phone Medical Management at 1-877-687-1197 to update the authorization otherwise, this may result in claim denials;*
- relevant clinical information (e.g. past/proposed treatment plan, surgical procedure, and diagnostic procedures to support the appropriateness and level of service proposed);
- admission date or proposed surgery date, if the request is for a surgical procedure;
- discharge plans; and
- for obstetrical admissions, the date and method of delivery, estimated date of confinement and information related to the newborn or neonate.

Advanced Imaging

As part of a continued commitment to further improve advanced imaging and radiology services, Coordinated Care is using National Imaging Associates (NIA) to provide prior authorization services and utilization management for advanced imaging and radiology services. NIA focuses on radiation awareness designed to assist providers in managing imaging services in the safest and most effective way possible.

Prior authorization is required for the following outpatient radiology procedures:

- CT /CTA/CCTA;
- MRI/MRA; and
- PET.

Key Provisions:

- emergency room, observation and inpatient imaging procedures do not require authorization;
- it is the responsibility of the ***ordering*** physician to obtain authorization; and
- providers rendering the above services should verify that the necessary authorization has been obtained. Failure to do so may result in denial of all or a portion of the claim.

Cardiac Imaging

Coordinated Care utilizes NIA to assist with the management of cardiac imaging benefits including cardiac imaging, assessment, and interventional procedures.

National Imaging Associates Authorizations

NIA provides an interactive website (www.RadMD.com) which should be used to obtain on-line authorizations. For urgent authorization requests please call 1-877-687-1197 and follow the prompt for radiology authorizations. For more information call our Provider Services department.

Behavioral Health Services

Coordinated Care has delegated the management of covered mental health and substance use disorder services to Cenpatico. Please refer to your contract with Cenpatico for specific information related to covered services and authorization requirements. Additional information regarding Behavioral Health services can be found in other sections of this Manual as applicable.

Pharmacy

The pharmacy benefits for Ambetter members vary based on the plan benefits. Information regarding the member's pharmacy coverage can be best found via our secure Provider Portal. Additional resources available on the website include the Ambetter Preferred Drug List, the US Script (Pharmacy Benefit Manager) Provider Manual and Medication Request/Exception Request forms.

The Ambetter Preferred Drug List (PDL) is designed to assist contracted healthcare prescribers with selecting the most clinically and cost-effective medications available. The PDL provides instruction on the following:

- Which drugs are covered, including restrictions and limitations;
- The Pharmacy Management Program requirements and procedures;
- An explanation of limits and quotas;
- How prescribing providers can make an exception request; and
- How Ambetter conducts generic substitution, therapeutic interchange and step-therapy.

The Ambetter PDL does not:

- Require or prohibit the prescribing or dispensing of any medication;
- Substitute for the professional judgment of the physician or pharmacist; and
- Relieve the physician or pharmacist of any obligation to the member.

The Ambetter PDL will be approved initially by the Ambetter Pharmacy and Therapeutics Committee (P & T), led by the Pharmacist and Medical Director, with support from community based primary care providers and specialists. Once established, the Preferred Drug List will be maintained by the P & T Committee, using quarterly meetings, to ensure that Ambetter members receive the most appropriate medications. The Ambetter PDL contains those medications that the P & T Committee has chosen based on their safety and effectiveness. If a physician feels that a certain medication merits addition to the list, the PDL Change Request policy can be used as a method to address the request. The Ambetter P & T Committee would review the request, along with supporting clinical data, to determine if the drug meets the safety and efficacy standards established by the Committee. Copies of the PDL are available on our website, Ambetter.CoordinatedCareHealth.com. Providers may also call Provider Services for hard copies of the PDL.

Second Opinion

Members or a healthcare professional with the member's consent may request and receive a second opinion from a qualified professional within the Ambetter network. If there is not an appropriate provider to render the second opinion within the network, the member may obtain the second opinion from an out of network provider only upon receiving a prior authorization from the Coordinated Care Utilization Management Department.

Women's Health Care

Coordinated Care is committed to the promotion of the lifelong benefits of preventive care. Female members may see a network provider, who is contracted with Ambetter to provide women's health care services directly, without prior authorization for:

- medically necessary maternity care;

- covered reproductive health services;
- preventive care (well care) and general examinations particular to women;
- gynecological care; and
- follow-up visits for the above services.

If the member's women's health care provider diagnoses a condition that requires a prior authorization to other specialists or hospitalization, prior authorization must be obtained in accordance with Ambetter's prior authorization requirements.

Abortion Services

When abortion services are Covered Services, an abortion consent form must be submitted with the claim. The abortion consent form may be found on our website.

Utilization Determination Timeframes

Utilization management decision making is based on appropriateness of care and service and the covered benefits of the plan. Coordinated Care does not reward providers or other individuals for issuing denials of authorization.

Authorization decisions are made as expeditiously as possible. Below are the specific timeframes utilized by Coordinated Care. In some cases it may be necessary for an extension to extend the timeframe below. You will be notified if an extension is necessary. Please contact Coordinated Care if you would like a copy of the policy for UM timeframes.

Type	Timeframe
Prospective/Urgent	Forty-eight (48) hours
Prospective/Non-Urgent	Five (5) calendar days
Concurrent/Urgent	Twenty-four (24) hours (1 calendar day)
Concurrent/Non-Urgent	Five (5) calendar days
Retrospective	Thirty (30) calendar days

Retrospective Review

Retrospective review is an initial review of services after services have been provided to a member. This may occur when authorization or timely notification to Coordinated Care was not obtained due to extenuating circumstances (i.e. member was unconscious at presentation, member did not have their Ambetter ID card or otherwise indicated other coverage, services authorized by another payer who subsequently determined member was not eligible at the time of service). Requests for retrospective review must be submitted promptly.

Medically Necessary

Medically Necessary means appropriate and clinically necessary health care services or supplies which are provided to a member for the diagnosis, care or treatment of an illness or injury and which meet all of the standards set forth below:

- Are not solely for the convenience of the member, his/her family or the provider of the services or supplies;
- Are the most appropriate level of service or supply which can be safely provided to the member;
- Are for the diagnosis or treatment of an actual or existing illness or injury unless being provided under the preventive services benefits;
- Are not for recreational, life-enhancing, relaxation or palliative therapy, except for treatment of terminal conditions;

- Are appropriate and consistent with the diagnosis and which, in accordance with accepted medical standards in the State of Washington, could not have been omitted without adversely affecting the member's condition or the quality of health services rendered;
- As to inpatient care, could not have been provided in a provider's office, the outpatient department of a hospital or non-residential facility without affecting the member's condition or quality of health services rendered;
- Are not primarily for research and data accumulation; and
- Are not experimental or investigational.

The fact that a physician may prescribe, authorize, or direct a service does not itself make it medically necessary or covered by the contract. Medical necessity criteria for covered services will be furnished to a member or provider within 30 days of a request to do so.

Medical necessity determinations will be made in a timely manner by thorough review from Coordinated Care clinical staff. Determinations will be made utilizing guidelines based care, appropriate utilization management policies, and by applying clinical judgment and experience. Medical policies are developed through periodic review of generally accepted standards of medical practice and updated at least on an annual basis. Current medical policies are available on our website.

In the event that a member may not agree with the medical necessity determination, a member has the opportunity to appeal the decision. Please refer to the "Grievance Process" section of the contract.

Emergency Medical Condition

Emergency medical condition means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson who possesses and average knowledge could reasonable expect the absence of immediate medical attention to result in:

- Placing the health of the member (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy:
- Serious impairment to bodily functions; or
- Serious dysfunction of any bodily organ or part.

Utilization Review Criteria

Coordinated Care has adopted the following utilization review criteria to determine whether services are medically necessary services for purposes of plan benefits:

Medical Services	InterQual® Adult and Pediatric Guidelines
Behavioral Health Services	InterQual® Adult and Pediatric Guidelines
High Tech Imaging	Internally developed criteria by National Imaging Associates (NIA). Criteria developed by representatives in the disciplines of radiology, internal medicine, nursing and cardiology. The criteria are available at Ambetter.CoordinatedCareHealth.com
Substance Use Disorder Services	Based upon the American Society for Addiction Medicine (ASAM) Patient Placement Criteria. The criteria are available at www.asam.org

Coordinated Care's Medical Director reviews, or other health care professionals that have appropriate clinical expertise in treating the member's condition or disease review, all potential adverse determinations and will make a decision in accordance with currently accepted medical or health care practices, taking into account special circumstances of each case that may require deviation from InterQual® Ambetter.CoordinatedCareHealth.com. Providers may obtain the criteria used to make a specific adverse determination by contacting the Medical Management department at 1-877-687-1197.

Providers have the opportunity to discuss any adverse decisions with a Coordinated Care physician or other appropriate reviewer at the time of the notification to the requesting provider of an adverse determination. The Medical Director may be contacted by calling Coordinated Care at 1-877-687-1197 and asking for the Medical Director. A Coordinated Care Care Manager may also coordinate communication between the Medical Director and the requesting provider.

Utilization management decision making is based on appropriateness of care and service and the existence of coverage. Coordinated Care does not reward providers or other individuals for issuing denials of authorizations.

Care Management and Concurrent Review

Concurrent Review

The Coordinated Care Medical Management Department will concurrently review the treatment and status of all members who are inpatient through contact with the hospital's Utilization and Discharge Planning Departments and when necessary, the member's attending physician. An inpatient stay will be reviewed as indicated by the member's diagnosis and response to treatment. The review will include evaluation of the member's current status, proposed plan of care, discharge plans, and any subsequent diagnostic testing or procedures.

Care Management

Medical Care Management is a collaborative process which assesses plans, implements, coordinates, monitors and evaluates options and services to meet an individual's health needs, using communication and available resources to promote quality, cost effective outcomes. Service/Care Coordination and Care Management is member-centered, goal-oriented, culturally relevant and logically managed processes to help ensure that a member receives needed services in a supportive, effective, efficient, timely and cost-effective manner.

Coordinated Care's Care Management teams support physicians by tracking compliance with the Care Management plan, and facilitating communication between the PCP, member, managing physician, and the Care Management team. The Care Manager also facilitates referrals and links to community Providers, such as local health departments and school-based clinics. The managing physician maintains responsibility for the member's ongoing care needs. The Coordinated Care Manager will contact the PCP, and/or, managing physician if the member is not following the plan of care or requires additional services.

Coordinated Care will provide individual Care Management services for members who have high risk, high-cost, complex or catastrophic conditions. The Coordinated Care Manager will work with all involved Providers to coordinate care, provide referral assistance and other care coordination, as required. The Coordinated Care Manager may also assist with a member's transition to other care, as indicated, when Ambetter benefits end.

Start Smart for Your Baby® (Start Smart) is a Care Management program available to women who are pregnant or have just had a baby. Start Smart is a comprehensive program that covers all phases of the pregnancy, postpartum and newborn periods. The program includes mailed educational materials for newly identified pregnant members and new mothers after delivery.

Telephonic Care Management by Registered Nurses and Social Services Specialists, as well as Marketplace coordinators, is available. Coordinated Care's Care Managers work with the member to create a customizable plan of care in order to promote care as well as adhere to Care Management plans. Care Managers will coordinate with physicians, as needed, in order to develop and maintain a plan of care to meet the needs of all involved.

All Ambetter members with identified needs are assessed for Care Management enrollment.

Members with needs may be identified via clinical rounds, referrals from other Coordinated Care staff members, via hospital census, via direct referral from Providers, via self-referral or referral from other Providers.

Care Management Process

Coordinated Care's Care Management for high risk, complex or catastrophic conditions contains the following key elements:

- Health Risk Screenings to identify members who potentially meet the criteria for Care Management.
- Assess the member's risk factors to determine the need for Care Management.
- Notify the member and their PCP of the member's enrollment in Coordinated Care's Care Management program.
- Develop and implement a treatment plan that accommodates the specific cultural and linguistic needs of the member.
- Establish treatment objectives and monitor outcomes.
- Refer and assist the member in enduring timely access to Providers.
- Coordinate medical, residential, social and other support services.
- Monitor care/services.
- Revise the treatment plan as necessary.
- Assess the member's satisfaction with Complex Care Management services.
- Track plan outcomes.
- Follow-up post discharge from Care Management.
- Referring a member to Coordinated Care Care Management: Providers are asked to contact a Coordinated Care Care Manager to refer a member identified in need of Care Management intervention.

Health Management

Health Management is the concept of reducing health care costs and improving quality of life for individuals with a chronic condition through ongoing integrated care. Health management supports the physician or practitioner/patient relationship and plan of care; emphasizes prevention of exacerbations and complications using evidence-based practice guidelines and patient empowerment strategies, and evaluates clinical, humanistic and economic outcomes on an ongoing basis with the goal of improving overall health. Due to their proven success and expertise, Coordinated Care partners with Nurtur and Cenpatico for health management programs for our members.

Nurtur

Nurtur's programs promote a coordinated, proactive, disease-specific approach to management that will improve members' self-management of their condition; improve clinical outcomes; and control high costs associated with chronic medical conditions. Programs include but are not limited to:

- Adult and Pediatric Asthma
- Coronary Artery Disease (CAD)
- Adult and Pediatric Diabetes
- High Blood Pressure and High Cholesterol Management
- Low Back Pain
- Tobacco Cessation
- Depression

Cenpatico

Cenpatico offers a health management program to Ambetter members with depression in order to provide a coordinated approach in managing the disease and improve the health status of the member. This is accomplished by identifying and providing the most effective and efficient resources, enhancing collaboration between medical and behavioral health providers and ongoing monitoring of outcomes of treatment. Each of Cenpatico's health management programs are based on clinical practice guidelines and include research evidence-based practices. Multiple communication strategies are used in the depression health management program to include written materials, telephonic outreach, web-based information, outreach through care managers, and participation in community events.

It is worth noting that diagnosis of a certain condition, such as diabetes, does not mean automatic enrollment in a health management program. Members with selected disease states will be stratified into risk groups that will determine need and the level of intervention most appropriate for each case. High-risk members with co-morbid or complex conditions will be referred for care management or disease management program evaluation.

To refer a member for Health Management call:

Care Management
1-877-687-1197

Ambetter's Health Risk Assessment

Members are requested to complete a Health Risk Assessment upon enrollment with Ambetter. Coordinated Care utilizes the information to better understand the member's health care needs in order to provide customized, educational information and services specific to the member's needs. The Health Risk Assessment form can be found at Ambetter.CoordinatedCareHealth.com and completed online by the Member.

Ambetter's My Health Pays Member Incentive Program

Coordinated Care encourages our members to receive annual preventive services through our unique rewards program. Members can earn rewards for doing the following:

- Completing a Member Welcome Survey which verifies demographic information and health information;
- Receiving their annual wellness exam; and
- Receiving their flu shot.

The rewards are sent out automatically to the member. The rewards are loaded on to a reloadable health restricted debit card. Members may utilize the debit card to pay for cost sharing (copays, coinsurance, or deductibles) or to help pay their premium payment.

Ambetter's Gym Membership Program

Ambetter promotes healthy lifestyle choices, like using a gym or health club on a regular basis. To help make it more affordable for our members who want to stay healthy and active, Ambetter offers discounted Gym memberships through our participating Gym network. Additionally, Ambetter will reimburse members that use their health club or gym regularly. The reimbursement dollars will be added to the My Health Pays card.

CLAIMS

Clean Claim Definition

Clean claim means a claim that has no defect or impropriety, including any lack of any required substantiating documentation, or particular circumstances requiring special treatment that prevents timely payments from being made on the claim.

Non-Clean Claim Definition

A non-clean claim is where there is substantial evidence of fraud or misrepresentation by providers, facilities or covered persons, or instances where the carrier has not been granted reasonable access to information under the provider's or facility's control.

Timely Filing

Participating providers must submit first time claims within 180 days of the date of service. Claims received outside of this timeframe will be denied for untimely submission.

Non-participating providers must submit first time claims within 90 days of the date of service. Claims received outside of this timeframe will be denied for untimely submission.

All corrected claims, requests for reconsideration or claim disputes from participating providers must be received within 24 months from the date of explanation of payment or denial is issued or 30 months for reconsiderations related to coordination of benefits (from the date the claim was denied or payment intended to satisfy the claim was made).

Corrected claims, requests for reconsideration or claim disputes from non-participating providers must be received within 24 months from the date of explanation of payment or denial is issued or 30 months for reconsiderations related to coordination of benefits (from the date the claim was denied or payment intended to satisfy the claim was made).

Who Can File Claims?

All providers who have rendered services for Ambetter members can file claims. It is important that providers ensure Coordinated Care has accurate and complete information on file. Please confirm with the Provider Services department or your dedicated Provider Relations Specialist that the following information is current in our files:

- Provider Name (as noted on current W-9 form)
- National Provider Identifier (NPI)
- Tax Identification Number (TIN)
- Taxonomy code (This is a REQUIRED field when submitting a claim)
- Physical location address (as noted on current W-9 form)
- Billing name and address

We recommend that providers notify Coordinated Care as soon as possible, but no later than 30 days in advance of changes pertaining to billing information. Please submit this information with a W-9 form. Changes to a Provider’s TIN and/or address are NOT acceptable when conveyed via a claim form.

How to File a Paper Claim

Providers must file claims using standard claims forms (UB-04 for hospitals and facilities; CMS 1500 for physicians or practitioners).

- Enter the provider's NPI number in the "Rendering Provider ID#" section of the CMS 1500 form (see box 24J).
- Providers must include their taxonomy code (ex. 207Q00000X for Family Practice) in this section for correct processing of claims.
- Black and white UB-04 or CMS-1500 forms copied/downloaded or handwritten red forms will be rejected.
- Providers billing CLIA services on a CMS 1500 paper form must enter the CLIA number in Box 23 of the CMS 1500 form. For EDI claims, the CLIA number must appear in X12N 837 (HIPAA version) loop 2300, REF02. REF01 = X4 when a single claim is submitted for laboratory services or in X12N 837 (HIPAA version) loop 2400, REF02. REF01 = X4 when there are laboratory and non-laboratory services on the claim. If the CLIA number is not present on the claim the claims will be rejected.
- All paper claim forms should be typed or printed with either 10 or 12 Times New Roman font. Do not use highlights, italics, bold text or staples for multiple page submissions.

Claims missing the necessary requirements are not considered "clean claims" and will be returned to providers with a written notice describing the reason for return.

Initial Paper Claims may be submitted to:

Ambetter from Coordinated Care
PO Box 5010
Farmington, MO 63640-5010

Coordinated Care will accept claims from providers in multiple, HIPAA compliant methods. We support all HIPAA EDI (Electronic Data Interchange) transaction formats, including HIPAA 837 Institutional and Professional transactions and HIPAA compliant NCPDP format for pharmacies. Providers may submit EDI using our preferred claims clearinghouses or submit HIPAA 837 claims to us directly via our secure web based Provider Portal. Providers may enter claims directly online in HIPAA Direct Data Entry (DDE) compliant fashion via our online claims entry feature – another secure component of our Provider Portal. Finally, providers may also mail CMS 1500 or UB-04 standard paper claims to us.

Claims eligible for payment must meet the requirements as stipulated in the Billing Manual which can be found at Ambetter.CoordinatedCareHealth.com.

Electronic Claims Submission

We encourage all providers to submit clean claims and encounter data electronically. Coordinated Care can receive an ANSI X12N 837 professional, institution, or encounter transaction. In addition, we can generate an ANSI X12N 835 electronic remittance advice known as an Explanation of Payment (EOP) and deliver it securely to providers electronically or in paper format, dependent on provider preference. For more information on electronic claims and encounter data filing and the clearinghouses Coordinated Care has partnered with, contact:

Ambetter from Coordinated Care
c/o Centene EDI Department
1-800-225-2573, extension 25525
or by e-mail at: EDIBA@centene.com

Providers that bill electronically are responsible for filing claims within the same timely filing requirements as providers filing paper claims. Providers that bill electronically must monitor their error reports and evidence of payments to ensure all submitted claims and encounters appear on the reports. Providers are responsible for correcting any errors and resubmitting the affiliated claims and encounter information.

The Ambetter Payer ID is 68069. For a list of the clearinghouses that we currently work with, please visit our website at Ambetter.CoordinatedCareHealth.com.

Corrected Claims, Requests for Reconsideration or Claim Disputes/Appeals

All requests for corrected claims, reconsiderations or claim disputes/appeals must be received within 24 months from the date of explanation of payment or denial is issued or 30 months for reconsiderations related to coordination of benefits (from the date the claim was denied or payment intended to satisfy the claim was made). Prior processing will be upheld for corrected claims or provider claim requests for reconsideration or disputes/appeals received outside of the 24 months or 30 months for COB, unless a qualifying circumstance is offered and appropriate documentation is provided to support the qualifying circumstance. Qualifying circumstances include:

1. A catastrophic event that substantially interferes with normal business operation of the provider, or damage or destruction of the provider's business office or records by a natural disaster, mechanical, administrative delays or errors by Coordinated Care or the Federal and/or State regulatory body.
2. The member was eligible; however the provider was unaware that the member was eligible for services at the time services were rendered. Consideration is granted in this situation only if all of the following conditions are met:
    - The provider's records document that the member refused or was physically unable to provide his or her ID Card or information;
    - The provider can substantiate that he or she continually pursued reimbursement from the patient until eligibility was discovered; and
    - The provider has not filed a claim for this member prior to the filing of the claim under review.

Below are relevant definitions.

1. Corrected claim – A provider is CHANGING the original claim
2. Request for Reconsideration – A Provider disagrees with the original claim outcome (payment amount, denial reason, etc.)
3. Claim Dispute/Appeal – A Provider disagrees with the outcome of the Request for Reconsideration

Corrected Claims

Corrected claims must clearly indicate they are corrected in one of the following ways:

1. Submit a corrected claim via the secure Provider Portal - Follow the instructions on the portal for submitting a correction.
2. Submit a corrected claim electronically via a Clearinghouse
    - Institutional Claims (UB): Field CLM05-3=7 and Ref*8 = Original Claim Number
    - Professional Claims (CMS): Field CLM05-3=7 and REF*8 = Original Claim Number
3. Submit a corrected paper claim to:

Ambetter from Coordinated Care
PO Box 5010
Farmington, MO 63640-5010

Upon submission of a corrected paper claim, the original claim number must be **typed** in field 22 (CMS 1500) and in field 64 (UB-04) with the corresponding frequency codes in field 22 of the CMS 1500 and in field 64 of the UB-04 form.

- Corrected claims must be submitted on standard red and white forms. Handwritten corrected claims will be upfront rejected.
- The original Explanation of Payment (EOP) must be submitted along with the standard red and white form. Failure to submit the original EOP may result in the claim being denied as a duplicate, a delay in the reprocessing or denial for exceeding the timely filing limit.

Request for Reconsideration

A request for reconsideration is a communication from the provider about a disagreement with the manner in which a claim was processed. Generally, medical records are not required for a request for reconsideration. However, if the request for reconsideration is related to a code audit, code edit or authorization denial, medical records **must accompany** the request for reconsideration. If the medical records are not received, the original denial will be upheld.

Reconsiderations may be submitted in the following ways:

1. Phone call to Provider Services.
    - This method may be utilized for requests for reconsideration that do not require submission of supporting or additional information. An example of this would be when a provider may believe a particular service should be reimbursed at a particular rate but the payment amount did not reflect that particular rate.
2. Providers may utilize the Request for Reconsideration form found on our website (preferred method).
3. Providers may send a written letter that includes a detailed description of the reason for the request. In order to ensure timely processing, the letter must include sufficient identifying information which includes, at a minimum, the member name, member ID number, date of service, total charges, provider name, original EOP, and/or original claim number found in box 22 on a CMS 1500 form or field 64 on a UB-04 form.

Written requests for reconsideration and any applicable attachments must be mailed to:

Ambetter from Coordinated Care
PO Box 5010
Farmington, MO 63640-5010

When the request for reconsideration results in an overturn of the original decision, the provider will receive a revised EOP. If the original decision is upheld, the provider will receive a revised EOP or a letter detailing the decision and steps to submit a Claim Dispute/Appeal.

Claim Dispute/Appeal

A claim dispute/appeal should be used only when a provider has received an unsatisfactory response to a request for reconsideration.

A claim dispute/appeal must be submitted on a Claim Dispute/Appeal form found on our website. The Claim Dispute/Appeal form must be completed in its entirety. The completed Claim Dispute/Appeal form may be mailed to:

Ambetter from Coordinated Care
PO Box 5000
Farmington, MO 63640-5000

A Claim Dispute/Appeal will be resolved within 30 calendar days. A provider will receive a written letter detailing the decision to overturn or uphold the original decision. If the original decision is upheld, the letter will include the rationale for upholding the decision.

Electronic Funds Transfers (EFT) and Electronic Remittance Advices (ERA)

Coordinated Care provides an innovative web-based solution for Electronic Funds Transfers (EFTs) and Electronic Remittance Advices (ERAs). Through this service, providers can take advantage of EFTs and ERAs to settle claims electronically. As a participating provider, you can gain the following benefits from using EFT and ERA:

- *Reduce accounting expenses* – Electronic remittance advices can be imported directly into practice management or patient accounting systems, eliminating the need for manual re-keying
- *Improve cash flow* – Electronic payments mean faster payments, leading to improvements in cash flow
- *Maintain control over bank accounts* – You keep TOTAL control over the destination of claim payment funds and multiple practices and accounts are supported
- *Match payments to advices quickly* – You can associate electronic payments with electronic remittance advices quickly and easily

For more information, please visit our provider home page on our website at Ambetter.CoordinatedCareHealth.com. If further assistance is needed, please contact our Provider Services Department at 1-877-687-1187.

Third Party Liability

Third party liability refers to any other health insurance plan or carrier (e.g., individual, group, employer-related, self-insured or self-funded, or commercial carrier, automobile insurance and worker's compensation) or program that is or may be liable to pay all or part of the health care expenses of the member.

If third party liability coverage is determined after services are rendered, Coordinated Care will coordinate with the provider to pay any claims that may have been denied for payment due to third party liability.

Risk Adjustment and Correct Coding

Risk adjustment is a critical element of the Affordable Care Act (ACA) that will help ensure the long-term success of the Health Insurance Marketplace. Accurate calculation of risk adjustment requires accuracy and specificity in diagnostic coding. Providers should, at all times, document and code according to CMS regulations and follow all applicable coding guidelines for ICD-9 CM and after October 1, 2015, ICD-10-CM, CPT, and HCPCs code sets. Providers should note the following guidelines:

- code all diagnoses to the highest level of specificity which means assigning the most precise ICD code that most fully explains the narrative description in the medical chart of the symptom or diagnosis;
- code all documented conditions that co-exist at the time of the encounter/visit, and require or affect patient care, treatment, or management;
- ensure that medical record documentation is clear, concise, consistent, complete and legible and meets CMS signature guidelines (each encounter must stand alone);
- submit claims and encounter information in a timely manner;
- alert Coordinated Care of any erroneous data submitted and follow Coordinated Care's policies to correct errors in a timely manner; and

- provide ongoing training to their staff regarding appropriate use of ICD coding for reporting diagnoses.

Accurate and thorough diagnosis coding is imperative to Coordinated Care's ability to manage members, comply with Risk Adjustment Data Validation audit requirements and effectively offer a Marketplace product. Claims submitted with inaccurate or incomplete data will often require retrospective chart review.

BILLING THE MEMBER

Covered Services

Ambetter providers are prohibited from billing the member for any covered services except for copayments, coinsurance and deductibles.

- Copayments, coinsurance and any unpaid portion of a deductible may be collected from the member at the time of service.
- If the amount collected from the member is higher than the actual amount owed upon claim adjudication, the provider must reimburse the member the overpaid amount within forty-five (45) days.

For members who are in a suspended status and seeking services from providers:

1. Providers may advise the member that services may not be delivered due to the fact that the member is in a suspended status. (Status must be verified through our Secure Web Portal or by calling Provider Services. Providers should follow their internal policies and procedures regarding this situation.
2. Should a provider make the decision to render services, the provider may collect from the member. Providers must submit a claim to Ambetter.
    - If the member subsequently pays their premium and is removed from a suspended status, claims will be adjudicated by Ambetter. The provider would then be responsible to reconcile the payment received from the member and the payment received from Ambetter. The provider may then bill the member for any underpayment or return to the member any overpayment.
    - If the member does not pay their premium and is terminated from their Ambetter plan, providers may bill the member for their full billed charges.

Non-Covered Services

Contracted providers may only bill Ambetter members for non-covered services if the member and provider both sign an agreement outlining the member's responsibility to pay prior to the services being rendered. The agreement must be specific to the services being rendered and clearly state:

- the specific service(s) to be provided;
- a statement that the service is not covered by Ambetter;
- a statement that the member chooses to receive and pay for the specific service; and
- the member is not obligated to pay for the service if it is later found that service was covered by Ambetter at the time it was provided, even if Coordinated Care did not pay the provider for the service because the provider did not comply with Ambetter requirements.

Billing for "No-Shows"

Providers may bill the member a reasonable and customary fee for missing an appointment when the member does not call in advance to cancel the appointment. The "no show" appointment must be documented in the medical record.

Premium Grace Period for Members receiving Advanced Premium Tax Credits (APTCs)

For purposes of this discussion, please note the following:

1. Premiums are billed and paid at the subscriber level; therefore, the grace period is applied at the subscriber level.
2. All members associated with the subscriber will inherit the enrollment status of the subscriber.
    - After the initial premium is paid, a grace period of 3 months from the premium due date is given for the payment of premium.
    - Coverage will remain in force during the grace period.
    - If payment of premium is not received within the grace period, coverage will be terminated as of the last day of the first month during the grace period.
    - During months two and three of the grace period, claims will be pended. The EX Code on the Explanation of Payment will state: "LZ – Pend: Non-Payment of Premium. During the month one, claims may be submitted and paid.

Premium Grace Period for Members NOT receiving Advanced Premium Tax Credits (APTCs)

1. Premium payments are due in advance on a calendar month basis.
2. Monthly payments are due on or before the first day of each month for coverage effective during such month.
3. There is a 1 month grace period. If any required premium is not paid before the date it is due, it may be paid during the grace period.
4. During the grace period, coverage will remain in force.

Failure to Obtain Authorization

Providers may NOT bill members for services when the provider fails to obtain an authorization and the claim is denied by Ambetter.

No Balance Billing

Payments made by Coordinated Care to providers less any copays, coinsurance or deductibles which are the financial responsibility of the member, will be considered payment in full. That is, providers may not seek payment from Ambetter members for the difference between the billed charges and the contracted rate paid by Ambetter.

MEMBER RIGHTS AND RESPONSIBILITIES

Member Rights

Providers must comply with the rights of members as set forth below.

1. To participate with providers in making decisions about his/her health care. This includes working on any treatment plans and making care decisions. The member should know any possible risks, problems related to recovery, and the likelihood of success. The member shall not have any

treatment without consent freely given by the member or the member's legally authorized surrogate decision-maker. The member must be informed of their care options

2. To know who is approving and who is performing the procedures or treatment. All likely treatments and the nature of the problem should be explained clearly
3. To receive the benefits for which the member has coverage
4. To be treated with respect and dignity
5. To privacy of their personal health information, consistent with state and federal laws, and Coordinated Care policies
6. To receive information or make recommendations, including changes, about Coordinated Care's organization and services, the Ambetter network of providers, and member rights and responsibilities
7. To candidly discuss with their providers appropriate and medically necessary care for their condition, including new uses of technology, regardless of cost or benefit coverage. This includes information from the member's primary care physician about what might be wrong (to the level known), treatment and any known likely results. The provider must tell the member about treatments that may or may not be covered by the plan, regardless of the cost. The member has a right to know about any costs they will need to pay. This should be told to the member in a way that the member can understand. When it is not appropriate to give the member information for medical reasons, the information can be given to a legally authorized person. The provider will ask for the member's approval for treatment unless there is an emergency and the member's life and health are in serious danger
8. To make recommendations regarding the Ambetter member's rights, responsibilities and policies
9. To voice complaints or appeals about: Ambetter, any benefit or coverage decisions Ambetter makes, Ambetter coverage, or the care provided
10. To refuse treatment for any condition, illness or disease without jeopardizing future treatment, and be informed by the provider(s) of the medical consequences
11. To see their medical records
12. To be kept informed of covered and non-covered services, program changes, how to access services, primary care physician assignment, providers, advance directive information, referrals and authorizations, benefit denials, member rights and responsibilities, and other Ambetter rules and guidelines. Coordinated Care will notify members at least 60 days before the effective date of the modifications. Such notices shall include the following:
    - Any changes in clinical review criteria
    - A statement of the effect of such changes on the personal liability of the member for the cost of any such changes
13. To have access to a current list of network providers. Additionally, a member may access information on network providers' education, training, and practice
14. To select a health plan or switch health plans, within the guidelines, without any threats or harassment
15. To adequate access to qualified medical practitioners and treatment or services regardless of age, race, creed, sex, sexual preference, national origin or religion
16. To access medically necessary urgent and emergency services 24 hours a day and seven days a week
17. To receive information in a different format in compliance with the Americans with Disabilities Act, if the member has a disability

18. To refuse treatment to the extent the law allows. The member is responsible for their actions if treatment is refused or if the provider's instructions are not followed. The member should discuss all concerns about treatment with their primary care physician or other provider. The primary care physician or other provider must discuss different treatment plans with the member. The member must make the final decision
19. To select a primary care physician within the network. The member has the right to change their primary care physician or request information on network providers close to their home or work.
20. To know the name and job title of people providing care to the member. The member also has the right to know which physician is their primary care physician
21. To have access to an interpreter when the member does not speak or understand the language of the area
22. To a second opinion by a network physician, at no cost to the member, if the member believes that the network provider is not authorizing the requested care, or if the member wants more information about their treatment
23. To execute an advance directive for health care decisions. An advance directive will assist the primary care provider and other providers to understand the member's wishes about the member's health care. The advance directive will not take away the member's right to make their own decisions. Examples of advance directives include:

    - Living Will
    - Health Care Power of Attorney
    - "Do Not Resuscitate" Orders

    Members also have the right to refuse to make advance directives. Members may not be discriminated against for not having an advance directive

Member Responsibilities

1. To read their Ambetter contract in its entirety
2. To treat all health care professionals and staff with courtesy and respect
3. To give accurate and complete information about present conditions, past illnesses, hospitalizations, medications, and other matters about their health. The member should make it known whether they clearly understand their care and what is expected of them. The member needs to ask questions of their provider so they understand the care they are receiving
4. To review and understand the information they receive about Ambetter. The member needs to know the proper use of covered services
5. To show their I.D. card and keep scheduled appointments with their provider, and call the provider's office during office hours whenever possible if the member has a delay or cancellation
6. To know the name of their assigned primary care physician. The member should establish a relationship with their primary care physician. The member may change their primary care physician verbally or in writing by contacting the Coordinated Care Member Services Department
7. To read and understand to the best of their ability all materials concerning their health benefits or to ask for assistance if they need it
8. To understand their health problems and participate, along with their health care providers in developing mutually agreed upon treatment goals to the degree possible
9. To supply, to the extent possible, information that Coordinated Care and/or their providers need in order to provide care

10. To follow the treatment plans and instructions for care that they have agreed on with their health care providers
11. To understand their health problems and tell their health care providers if they do not understand their treatment plan or what is expected of them. The member should work with their primary care physician to develop mutually agreed upon treatment goals. If the member does not follow the treatment plan, the member has the right to be advised of the likely results of their decision
12. To follow all health benefit plan guidelines, provisions, policies and procedures
13. To use any emergency room only when they think they have a medical emergency. For all other care, the member should call their primary care physician
14. To, give all information about any other medical coverage they have at the time of enrollment. If, at any time, the member gains other medical coverage besides Ambetter coverage, the member must provide this information to Coordinated Care
15. To pay their monthly premium, all deductible amounts, copayment amounts, or cost-sharing percentages at the time of service

PROVIDER RIGHTS AND RESPONSIBILITIES

Provider Rights

1. To be treated by their patients, who are Ambetter members, and other healthcare workers with dignity and respect
2. To receive accurate and complete information and medical histories for members' care
3. To have their patients, who are Ambetter members, act in a way that supports the care given to other patients and that helps keep the doctor's office, hospital, or other offices running smoothly
4. To expect other network providers to act as partners in members' treatment plans
5. To expect members to follow their health care instructions and directions, such as taking the right amount of medication at the right times
6. To make a complaint or file an appeal against Coordinated Care and/or a member
7. To file a grievance on behalf of a member, with the member's consent
8. To have access to information about Coordinated Care quality improvement programs, including program goals, processes, and outcomes that relate to member care and services
9. To contact Provider Services with any questions, comments, or problems
10. To collaborate with other health care professionals who are involved in the care of members
11. To not be excluded, penalized, or terminated from participating with Ambetter for having developed or accumulated a substantial number of patients in Ambetter with high cost medical conditions
12. To collect member copays, coinsurance, and deductibles at the time of the service

Provider Responsibilities

Providers must comply with each of the items listed below.

1. To help or advocate for members to make decisions within their scope of practice about their relevant and/or medically necessary care and treatment, including the right to:
    - Recommend new or experimental treatments
    - Provide information regarding the nature of treatment options

- Provide information about the availability of alternative treatment options, therapies, consultations, or tests, including those that may be self-administered
- Be informed of risks and consequences associated with each treatment option or choosing to forego treatment as well as the benefits of such treatment options

2. To treat members with fairness, dignity, and respect
3. To not discriminate against members on the basis of race, color, national origin, limited language proficiency, religion, age, health status, existence of a pre-existing mental or physical disability/condition including pregnancy and/or hospitalization, the expectation for frequent or high cost care
4. To maintain the confidentiality of members' personal health information, including medical records and histories, and adhere to state and federal laws and regulations regarding confidentiality
5. To give members a notice that clearly explains their privacy rights and responsibilities as it relates to the provider's practice and scope of service
6. To provide members with an accounting of the use and disclosure of their personal health information in accordance with HIPAA
7. To allow members to request restriction on the use and disclosure of their personal health information
8. To provide members, upon request, access to inspect and receive a copy of their personal health information, including medical records
9. To provide clear and complete information to members - in a language they can understand - about their health condition and treatment, regardless of cost or benefit coverage, and allow member participation in the decision-making process
10. To tell a member if the proposed medical care or treatment is part of a research experiment and give the member the right to refuse experimental treatment
11. To allow a member who refuses or requests to stop treatment the right to do so, as long as the member understands that by refusing or stopping treatment the condition may worsen or be fatal
12. To respect members' advance directives and include these documents in the their medical record
13. To allow members to appoint a parent/guardian, family member, or other representative if they can't fully participate in their treatment decisions
14. To allow members to obtain a second opinion, and answer members' questions about how to access health care services appropriately
15. To follow all state and federal laws and regulations related to patient care and rights
16. To participate in Coordinated Care data collection initiatives, such as HEDIS and other contractual or regulatory programs
17. To review clinical practice guidelines distributed by Coordinated Care
18. To comply with the Ambetter Medical Management program as outlined herein
19. To disclose overpayments or improper payments to Ambetter
20. To provide members, upon request, with information regarding the provider's professional qualifications, such as specialty, education, residency, and board certification status
21. To obtain and report to Coordinated Care information regarding other insurance coverage the member has or may have
22. To give Coordinated Care timely, written notice if provider is leaving/closing a practice
23. To contact Coordinated Care to verify member eligibility and benefits, if appropriate

24. To invite member participation in understanding any medical or behavioral health problems that the member may have and to develop mutually agreed upon treatment goals, to the extent possible
25. To provide members with information regarding office location, hours of operation, accessibility, and translation services
26. To object to providing relevant or medically necessary services on the basis of the provider's moral or religious beliefs or other similar grounds
27. To provide hours of operation to Ambetter members which are no less than those offered to other commercial members

CULTURAL COMPETENCY

Coordinated Care views Cultural Competency as the measure of a person or organization's willingness and ability to learn about, understand and provide excellent customer service across all segments of the population. It is the active implementation of a system wide philosophy that values differences among individuals and is responsive to diversity at all levels in the community and within an organization and at all service levels the organization engages in outside of the organization. A sincere and successful Cultural Competency program is evolutionary and ever-changing to address the continual changes occurring within communities and families. In the context of health care delivery, Cultural Competency is the promotion of sensitivity to the needs of patients who are members of various racial, religious, age, gender and/or ethnic groups and accommodating the patient's culturally-based attitudes, beliefs and needs within the framework of access to health care services and the development of diagnostic and treatment plans and communication methods in order to fully support the delivery of competent care to the patient. It is also the development and continued promotion of skills and practices important in clinical practice, cross-cultural interactions and systems practices among providers and staff to ensure that services are delivered in a culturally competent manner.

Coordinated Care is committed to the development, strengthening and sustaining of healthy provider/member relationships. Members are entitled to dignified, appropriate care. When healthcare services are delivered without regard for cultural differences, members are at risk for sub-optimal care. Members may be unable or unwilling to communicate their healthcare needs in an insensitive environment, reducing effectiveness of the entire healthcare process.

As part of Coordinated Care's Cultural Competency Program, providers must ensure that:

- members understand that they have access to medical interpreters, signers, and TDD/TTY services to facilitate communication without cost to them;
- medical care is provided with consideration of the members' primary language, race and/or ethnicity as it relates to the members' health or illness;
- office staff routinely interacting with members has been given the opportunity to participate in, and have participated in, cultural competency training;
- office staff responsible for data collection makes reasonable attempts to collect race and language specific information for each member. Staff will also explain race categories to a member in order assist the member in accurately identifying their race or ethnicity;
- treatment plans are developed with consideration of the member's race, country of origin, native language, social class, religion, mental or physical abilities, heritage, acculturation, age, gender, sexual orientation, and other characteristics that may influence the member's perspective on health care;
- office sites have posted and printed materials in English and Spanish or any other non-English language which may be prevalent in the applicable geographic area; and

- an appropriate mechanism is established to fulfill the provider's obligations under the Americans with Disabilities Act including that all facilities providing services to members must be accessible to persons with disabilities. Additionally, no member with a disability may be excluded from participation in or be denied the benefits of services, programs or activities of a public facility, or be subjected to discrimination by any such facility.

Coordinated Care considers mainstreaming of members an important component of the delivery of care and expects providers to treat members without regard to race, color, creed, sex, religion, age, national origin ancestry, marital status, sexual preference, health status, income status, program membership, physical or behavioral disabilities except where medically indicated. Examples of prohibited practices include:

- denying a member a covered service or availability of a facility; and
- providing an Ambetter member a covered service that is different or in a different manner, or at a different time or at a different location than to other "public" or private pay members (examples: separate waiting rooms, delayed appointment times).

COMPLAINT PROCESS

Provider Complaint/Grievance and Appeal Process

Claim Complaints must follow the Dispute Process and then then Complaint Process below. Medical necessity and authorization denial complaints are handled in the Appeals Process below. Please note that claim payments are not appealable. These must be handled via the Claim Dispute and Complaint Process. Claim Disputes may be mailed to:

Ambetter from Coordinated Care
PO Box 5000
Farmington, MO 63640-5000

Complaint/Grievance

A Complaint/Grievance is a verbal or written expression by a provider which indicates dissatisfaction or dispute with Coordinated Care's policies, procedure, or any aspect of Coordinated Care's functions. Coordinated Care logs and tracks all complaints/grievances whether received verbally or in writing. A provider has thirty (30) calendar days from the date of the incident, such as the original Explanation of Payment date, to file a complaint/grievance. After a complete review of the complaint/grievance, Coordinated Care shall provide a written notice to the provider within thirty (30) calendar days from the received date of Coordinated Care's decision. If the complaint/grievance is related to claims payment, the provider must follow the process for claim reconsideration or claim dispute as noted in the Claims section of this Provider Manual prior to filing a Complaint.

Authorization and Coverage Complaints

Authorization and Coverage Complaints must follow the Appeal process below.

An Appeal is the mechanism which allows providers the right to appeal actions of Coordinated Care such as a prior authorization denial, or if the provider is aggrieved by any rule, policy or procedure or decision made by Coordinated Care. A provider has thirty (30) calendar days from Coordinated Care's notice of action to file the appeal. Coordinated Care shall acknowledge receipt of each appeal within ten (10) business days after receiving an appeal. Coordinated Care shall resolve each appeal and provide written notice of the appeal resolution, as expeditiously as the member's health condition requires, but shall not exceed thirty (30) calendar days from the date Coordinated Care receives the appeal. Coordinated Care may extend the timeframe for resolution of the appeal up to fourteen (14) calendar days if the member requests the extension or Coordinated Care demonstrates that there is need for additional information and how the delay is in the member's best interest. For any extension not requested by the member, Coordinated Care shall provide written notice to the member for the delay.

Expedited appeals may be filed with Coordinated Care if the member's provider determines that the time expended in a standard resolution could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function. No punitive action will be taken against a provider that requests an expedited resolution or supports a member's appeal. In instances where the member's request for an expedited appeal is denied, the appeal must be transferred to the timeframe for standard resolution of appeals.

Decisions for expedited appeals are issued as expeditiously as the member's health condition requires, not exceeding seventy-two (72) hours from the initial receipt of the appeal. Coordinated Care may extend this timeframe by up to an additional fourteen (14) calendar days if the member requests the extension or if Coordinated Care provides evidence satisfactory evidence that a delay in rendering the decision is in the member's best interest.

Providers may also invoke any remedies as determined in the Participating Provider Agreement.

Member Complaint/Grievance and Appeal Process

To ensure that Ambetter member's rights are protected, all Ambetter members are entitled to a Complaint/Grievance and Appeals process. The procedures for filing a Complaint/Grievance or Appeal are outlined in the Ambetter member's Evidence of Coverage. Additionally, information regarding the Complaint/Grievance and Appeal process can be found on our website at Ambetter.CoordinatedCareHealth.com or by calling Coordinated Care at 1-877-687-1197.

If a member is displeased with any aspect of services rendered:

1. The member should contact our Member Services department at 1-877-687-1197. The Member Services representative will assist the member.
2. If the member continues to be dissatisfied, they may file a formal complaint/grievance. Again, our Member Services department is available to assist with this process. Information regarding this process can be found at Ambetter.CoordinatedCareHealth.com.
3. Depending on the nature of the complaint/grievance, the member will be offered the right to appeal our decision. At the conclusion of this formalized process, the member will receive written confirmation of the determination. Coordinated Care will complete the appeal process in the timeframes as specified in rules and regulation.
4. The member has the right to appeal to an external independent review organization.
5. A member may designate in writing to Coordinated Care that a provider is acting on behalf of the member regarding the complaint/grievance and appeal process.

Mailing Address

The mailing address for non-claim related Member and Provider Complaints/Grievances and Appeals is:

Ambetter from Coordinated Care
1145 Broadway, Suite 300
Tacoma, WA 98402

QUALITY IMPROVEMENT PLAN

Overview

Coordinated Care's culture, systems and processes are structured around its mission to improve the health of all enrolled members. The Quality Assessment and Performance Improvement (QAPI) Program utilizes a systematic approach to quality improvement initiatives using reliable and valid methods of monitoring, analysis, evaluation and improvement in the delivery of healthcare provided to all members,

including those with special needs. This system provides a continuous cycle for assessing the level of care and service among plan initiatives including preventive health, acute and chronic care, behavioral health, over- and under-utilization, continuity and coordination of care, patient safety, and administrative and network services. This includes the implementation of appropriate interventions and designation of adequate resources to support the interventions. Coordinated Care requires all practitioners and providers to cooperate with all QI activities, as well as allow Coordinated Care to use practitioner and/or provider performance data to ensure success of the QI program.

Coordinated Care intends to arrange for the delivery of appropriate care with the primary goal being to improve the health status of its members. Where the member's condition is not amenable to improvement, Coordinated Care will implement measures to prevent any further decline in condition or deterioration of health status or provide for comfort measures as appropriate and requested by the member. This will include the identification of members at risk of developing conditions, the implementation of appropriate interventions and designation of adequate resources to support the interventions. Whenever possible, the Coordinated Care QAPI Program supports these processes and activities that are designed to achieve demonstrable and sustainable improvement in the health status of its members.

QAPI Program Structure

The Coordinated Care Board of Directors (BOD) has the ultimate oversight for the care and service provided to members. The Board of Directors oversees the QAPI Program and has established various committees and ad-hoc committees to monitor and support the QAPI Program.

The Quality Assessment and Performance Improvement Committee (QAPIC) is a senior management committee with physician representation that is directly accountable to the BOD. The purpose of the QAPIC is:

- enhance and improve quality of care;
- provide oversight and direction regarding policies, procedures, and protocols for member care and services; and
- offer guidelines based on recommendations for appropriateness of care and services.

This is accomplished through a comprehensive, plan-wide system of ongoing, objective, and systematic monitoring; the identification, evaluation, and resolution of process problems; the identification of opportunities to improve member outcomes; and the education of members, providers and staff regarding the QI, UM, and Credentialing and Re-credentialing programs.

The following sub-committees report directly to the Quality Assessment and Performance Improvement Committee (QAPIC):

- Credentialing Committee
- Grievance and Appeals Committee
- Utilization Management Committee
- Cultural Competency Committee
- Performance Improvement Team
- Member, Provider and Community Advisory Committees
- Joint Operations Committees
- Peer review Committee (Ad Hoc Committee)

Practitioner Involvement

Coordinated Care recognizes the integral role that practitioner involvement plays in the success of its QAPI Program. Practitioner involvement in various levels of the process is highly encouraged through

provider representation. Coordinated Care encourages PCP, behavioral health, specialty, and OB/GYN representation on key quality committees such as, but not limited to, the QIC, Credentialing Committee, and select ad-hoc committees.

Quality Assessment and Performance Improvement Program Scope and Goals

The scope of the QAPI Program is comprehensive and addresses both the level of clinical care and the level of service provided to Ambetter members. The Coordinated Care QAPI Program incorporates all demographic groups and ages, benefit packages, care settings, providers, and services in quality improvement activities. This includes services for the following: preventive care, primary care, specialty care, acute care, short-term care, long-term care, ancillary services, and operations, among others.

Coordinated Care's primary QAPI Program goal is to improve members' health status through a variety of meaningful quality improvement activities implemented across all care settings and aimed at improving the care and services delivered.

To that end, the Coordinated Care QAPI Program monitors the following:

- Acute and chronic care management
- Behavioral health care
- Compliance with member confidentiality laws and regulations
- Compliance with preventive health guidelines and practice guidelines
- Continuity and coordination of care
- Delegated entity oversight
- Department entity oversight
- Department performance and service
- Employee and provider cultural competency
- Fraud and abuse detection and prevention
- Information management
- Marketing practices
- Member enrollment and disenrollment
- Member grievance system
- Member satisfaction
- Member services
- Network performance
- Organizational structure
- Patient safety (including hospitals, ambulatory care centers and office-based surgery sites to endorse and adopt procedures for verifying correct patient, the correct procedure, and the correct surgical site that meets or exceeds those set forth in the Universal Protocol TM developed by The Joint Commission)
- Primary care provider changes
- Pharmacy
- Provider and plan accessibility
- Provider availability
- Provider complaint system

- Provider network adequacy and capacity
- Provider satisfaction
- Provider services
- Quality management
- Records management
- Selection and retention of providers (credentialing and re-credentialing)
- Utilization management, including under and over utilization

Practice Guidelines

Coordinated Care approves, adopts, and promotes Practice Guidelines to providers in an effort to improve health care quality and reduce unnecessary variation in care for its enrolled membership. These evidence-based guidelines are known to be effective in improving health outcomes and are adopted from recognized sources. The following are Coordinated Care's QIC approved Practice Guidelines:

- Guidelines for Diagnosis and Management of Asthma
- Guidelines for Antepartum Care
- Practice Guidelines for Preventive Health Maintenance of Sickle Cell Disease Patients
- Practice Guidelines for Lead Toxicity Screening
- Practice Guidelines for General Diabetes Care
- Guidelines for the Prevention for Childhood Obesity
- Practice Guidelines for Diagnosing and Treating with Child for Attention Deficit/Hyperactivity Disorder
- Practice Guidelines for Treatment of Patients with Major Depressive Disorder
- Practice Guidelines for Treatment of Bipolar Disorder
- Adult Preventive Services Guidelines
- Practice Guidelines for the Diagnosis and Management of Pharyngitis
- Disease Management Practice Guidelines for Coronary Artery Disease
- Disease Management Practice Guidelines for Chronic Respiratory Disease (CRD), including Asthma and COPD
- Disease Management Practice Guidelines for Heart Failure

Copies of these guidelines are available on our website at Ambetter.CoordinatedCareHealth.com.

All guidelines are reviewed annually for updating and/or when new scientific evidence or national standards are published.

Coordinated Care's QAPI program assures that Practice Guidelines meet the following:

- Adopted guidelines are approved by Coordinated Care's QIC bi-annually
- Adopted guidelines are evidence-based and include preventive health services
- Guidelines are reviewed on an annual basis and updated accordingly, but no less than bi-annually.
- Guidelines are disseminated to Providers in a timely manner via the following appropriate communication settings:
- Provider orientations and other group sessions

- Provider e-newsletters
- Online via the HEDIS Resource Page
- Online via the Provider Portal
- Targeted mailings

Guidelines are posted on Ambetter's website or paper copies are available upon request by contacting Coordinated Care's QI Department.

Patient Safety and Level of Care

Patient Safety is a key focus of the Ambetter QAPI Program. Monitoring and promoting patient safety is integrated throughout many activities across the plan but primarily through identification of potential and/or actual level of care events. A potential level of care issue is any alleged act or behavior that may be detrimental to the level or safety of patient care, is not compliant with evidence-based standard practices of care or that signals a potential sentinel event, up to and including death of a member. Coordinated Care employees (including medical management staff, member services staff, provider services, complaint coordinators, etc.), panel practitioners, facilities or ancillary providers, members or member representatives, Medical Directors or the BOD may advise the Quality Improvement (QI) Department of potential level of care issues. Adverse events may also be identified through claims based reporting and analyses. Potential level of care issues require investigation of the factors surrounding the event in order to make a determination of their severity and need for corrective action up to and including review by the Peer Review Committee as indicated. Potential level of care issues received in the QI department are tracked and monitored for trends in occurrence, regardless of their outcome or severity level.

Performance Improvement Process

The Coordinated Care QAPIC reviews and adopts an annual QAPI Program and Work Plan based on managed care appropriate industry standards. The QIC adopts traditional quality/risk/utilization management approaches to identify problems, issues and trends with the objective of developing improvement opportunities. Most often, initiatives are selected based on data that indicates the need for improvement in a particular clinical or non-clinical area, and includes targeted interventions that have the greatest potential for improving health outcomes or service standards.

Performance improvement projects, focus studies and other QI initiatives are designed and implemented in accordance with principles of sound research design and appropriate statistical analysis. Results of these studies are used to evaluate the appropriateness and level of care and services delivered against established standards and guidelines for the provision of that care or service. Each QI initiative is also designed to allow Coordinated Care to monitor improvement over time.

Annually, Coordinated Care develops a QAPI Work Plan for the upcoming year. The QAPI Work Plan serves as a working document to guide quality improvement efforts on a continuous basis. The Work Plan integrates QAPIC activities, reporting and studies from all areas of the organization (clinical and service) and includes timelines for completion and reporting to the QIC as well as requirements for external reporting. Studies and other performance measurement activities and issues to be tracked over time are scheduled in the QAPI Work Plan.

Coordinated Care communicates activities and outcomes of its QAPI Program to both members and providers through avenues such as the member newsletter, provider newsletter and the Ambetter website at Ambetter.CoordinatedCareHealth.com.

At any time, Ambetter providers may request additional information on the health plan programs including a description of the QAPI Program and a report on Coordinated Care's progress in meeting the QAPI Program goals by contacting the Quality Improvement department.

Quality Review System

Healthcare Effectiveness Data and Information Set (HEDIS)

HEDIS is a set of standardized performance measures developed by the National Committee for Quality Assurance (NCQA) which allows comparison across health plans. HEDIS gives purchasers and consumers the ability to distinguish between health plans based on comparative quality instead of simply cost differences.

As Federal and State governments move toward a health care industry that is driven by quality, HEDIS rates are becoming more and more important, not only to the health plan, but to the individual provider. Purchasers of health care may use the aggregated HEDIS rates to evaluate the effectiveness of a health insurance company's ability to demonstrate the clinical management of its members. Physician specific scores are being used as evidence of preventive care from primary care office practices.

HEDIS Rate Calculations

HEDIS rates can be calculated in two ways: administrative data or hybrid data. Administrative data consists of claim and encounter data submitted to the health plan. Measures typically calculated using administrative data include: annual mammogram, annual chlamydia screening, appropriate treatment of asthma, cholesterol management, antidepressant medication management, access to PCP services, and utilization of acute and mental health services.

Hybrid data consists of both administrative data and a sample of medical record data. Hybrid data requires review of a random sample of medical records to extract data regarding services rendered but not reported to the health plan through claims or encounter data. Accurate and timely claims and encounter data and submission using appropriate CPT, ICD-9 (ICD-10 effective October 1, 2014) and HCPCS codes can reduce the necessity of medical record reviews (see the Ambetter website and HEDIS brochure (posted on the Ambetter website) for more information on reducing HEDIS medical record reviews). HEDIS measures typically requiring medical record review include: childhood immunizations, well child visits, diabetic HbA1c, LDL, eye exam and nephropathy, controlling high-blood pressure, cervical cancer screening, and prenatal care and postpartum care.

Who Conducts Medical Record Reviews (MRR) for HEDIS/Risk Adjustment?

Coordinated Care may contract with an independent national MRR vendor to conduct the HEDIS/Risk Adjustment MRR on its behalf. Medical record review audits for HEDIS are conducted on an ongoing basis with a particular focus from January-May each year. At that time, if any of your patient's medical records are selected for review, you will receive a call and/or a letter from a medical record review representative. Your prompt cooperation with the representative is greatly needed and appreciated.

As a reminder, sharing of protected health information (PHI) that is used or disclosed for purposes of treatment, payment or health care operations is permitted by HIPAA Privacy Rules (45 CFR 164.506) and does not require consent or authorization from the member. The MRR vendor will sign a HIPAA compliant Business Associate Agreement with Coordinated Care which allows them to collect PHI on our behalf.

How can providers improve their HEDIS scores?

- ***Understand the specifications*** established for each HEDIS measure.
- ***Submit claims and encounter data for each and every service rendered.*** All providers must bill (or submit encounter data) for services delivered, regardless of their contract status with Coordinated Care. Claims and encounter data is the most clean and efficient way to report HEDIS.
- ***Submit claims and encounter data correctly, accurately, and on time.*** If services rendered are not filed or billed accurately, then they cannot be captured and included in the scoring calculation. Accurate and timely submission of claims and encounter data will reduce the number of medical record reviews required for HEDIS rate calculation.

- ***Ensure chart documentation reflects all services provided.*** Keep accurate chart/medical record documentation of each member service and document conversation/services.
- ***Submit claims and encounter data using CPT codes related to HEDIS*** measures such as diabetes, eye exam, and blood pressure.

If you have any questions, comments, or concerns related to the annual HEDIS project or the medical record reviews, please contact the Quality Improvement department at 1-877-687-1197.

Provider Satisfaction Survey

Coordinated Care conducts an annual provider satisfaction survey which includes questions to evaluate provider satisfaction with our services such as claims, communications, utilization management, and provider services. Behavioral health providers receive a provider survey specific to the provision of behavioral health services in the Ambetter network. The survey is conducted by an external vendor. Participants are randomly selected by the vendor, meeting specific requirements outlined by Coordinated Care, and the participants are kept anonymous. We encourage you to respond timely to the survey as the results of the survey are analyzed and used as a basis for forming provider related quality improvement initiatives.

Qualified Health Plan (QHP) Enrollee Survey

The QHP Enrollee survey is a member satisfaction survey that is included to support CMS' administration of the Health Insurance Marketplace as well to support HEDIS and NCQA accreditation. It is a standardized survey administered annually to members by an NCQA certified survey vendor. The survey provides information on the experiences of members with health plan and practitioner services and gives a general indication of how well the plan is meeting the members' expectations. Member responses to the survey are used in various aspects of the quality program including monitoring of practitioner access and availability. This survey is similar to CAHPS (Consumer Assessment of Healthcare Provider Systems) Members receiving behavioral health services have the opportunity to respond to the Experience of Care Health Outcomes (ECHO) survey to provide feedback and input into the quality oversight of the behavioral health program.

Provider Performance Monitoring and Incentive Programs

Over the past several years, it has been nationally recognized that pay-for-performance (P4P) programs, which include provider profiling, have emerged as a promising strategy to improve the level and cost-effectiveness of care. Coordinated Care will manage a provider performance monitoring program to capture data relating to healthcare access, costs, and level of care that Ambetter members receive.

The Coordinated Care Provider Profiling Program is designed to analyze utilization data to identify provider utilization and care issues. Coordinated Care will use Provider Profiling data to identify opportunities to improve communications to providers regarding Clinical Practice Guidelines. Provider Profiling is a highly effective tool that compares individual provider practices to normative data, so that providers can improve their practice patterns, processes, and level of care in alignment with evidence-based clinical practice guidelines. The Coordinated Care Program and Provider Overview Reports will increase provider awareness of performance, identify opportunities for improvement, and facilitate plan-provider collaboration in the development of clinical improvement initiatives. Coordinated Care's Profiling Program incorporates the latest advances in this evolving area.

REGULATORY MATTERS

Medical Records

Ambetter providers must keep accurate and complete patient medical records which are consistent with 42 CFR §456 and National Committee for Quality Assurance (NCQA) standards, and financial and other records pertinent to Ambetter members. Such records will enable providers to render the most appropriate level of health care service to members. They will also enable Coordinated Care to review the level and appropriateness of the services rendered. To ensure the member's privacy, medical records

should be kept in a secure location. Coordinated Care requires providers to maintain all records for members for at least ten (10) years after the final date of service, unless a longer period is required by applicable state law.

Required Information

To be considered a complete and comprehensive medical record, the member's medical record (file) should include, at a minimum: provider notes regarding examinations, office visits, referrals made, tests ordered, and results of diagnostic tests ordered (i.e. x-rays, laboratory tests). Medical records should be accessible at the site of the member's participating primary care physician or provider. All medical services received by the member, including inpatient, ambulatory, ancillary, and emergency care, should be documented and prepared in accordance with all applicable state rules and regulations, and signed by the medical professional rendering the services.

Providers must maintain complete medical records for members in accordance with the standards set forth below.

- Member's name, and/or medical record number must be on all chart pages.
- Personal/biographical data is present (i.e., employer, home telephone number, spouse, next of kin, legal guardianship, primary language, etc.).
- Prominent notation of any spoken language translation or communication assistance must be included.
- All entries must be legible and maintained in detail.
- All entries must be dated and signed, or dictated by the provider rendering the care.
- Significant illnesses and/or medical conditions are documented on the problem list and all past and current diagnoses.
- Medication, allergies, and adverse reactions are prominently documented in a uniform location in the medical record; if no known allergies, NKA or NKDA are documented.
- An up-to-date immunization record is established for pediatric members or an appropriate history is made in chart for adults.
- Evidence that preventive screening and services are offered in accordance with Coordinated Care practice guidelines.
- Appropriate subjective and objective information pertinent to the member's presenting complaints is documented in the history and physical.
- Past medical history (for members seen three or more times) is easily identified and includes any serious accidents, operations and/or illnesses, discharge summaries, and ER encounters; for children and adolescents (18 years and younger) past medical history relating to prenatal care, birth, any operations and/or childhood illnesses.
- Working diagnosis is consistent with findings.
- Treatment plan is appropriate for diagnosis.
- Documented treatment prescribed, therapy prescribed and drug administered or dispensed including instructions to the member.
- Documentation of prenatal risk assessment for pregnant women or infant risk assessment for newborns.
- Signed and dated required consent forms are included.
- Unresolved problems from previous visits are addressed in subsequent visits.
- Laboratory and other studies ordered as appropriate are documented.

- Abnormal lab and imaging study results have explicit notations in the record for follow up plans; all entries should be initialed by the primary care provider (PCP) to signify review.
- Referrals to specialists and ancillary providers are documented including follow up of outcomes and summaries of treatment rendered elsewhere including family planning services, preventive services and services for the treatment of sexually transmitted diseases.
- Health teaching and/or counseling is documented.
- For members 10 years and over, appropriate notations concerning use of tobacco, alcohol and substance use (for members seen three or more times substance abuse history should be queried).
- Documentation of failure to keep an appointment.
- Encounter forms or notes have a notation, when indicated, regarding follow-up care calls or visits. The specific time of return should be noted as weeks, months or as needed.
- Evidence that the member is not placed at inappropriate risk by a diagnostic or therapeutic problem.
- Confidentiality of member information and records are protected.
- Evidence that an advance directive has been offered to adults 18 years of age and older.

Medical Records Release

All member medical records are confidential and must not be released without the written authorization of the member or their parent/legal guardian, in accordance with state and federal law and regulation. When the release of medical records is appropriate, the extent of that release should be based upon medical necessity or on a need to know basis.

All release of specific clinical or medical records for Substance Use Disorders must meet Federal guidelines at 42 CFR Part 2 and any applicable State Laws.

Medical Records Transfer for New Members

All PCPs are required to document in the member's medical record attempts to obtain historical medical records for all newly assigned Ambetter members. If the member or member's parent/legal guardian is unable to remember where they obtained medical care, or they are unable to provide addresses of the previous providers, then this should also be noted in the medical record.

Medical Records Audits

Coordinated Care will conduct random medical record audits as part of its QAPI Program to monitor compliance with the medical record documentation standards noted above. The coordination of care and services provided to members, including over/under utilization of services, as well as the outcome of such services, is also subject to review and assessment during a medical record audit. Coordinated Care will provide written notice prior to conducting a medical record review.

FEDERAL AND STATE LAWS GOVERNING THE RELEASE OF INFORMATION

The release of certain information is governed by a myriad of Federal and/or State laws.

These laws often place restrictions on how specific types of information may be disclosed, including, but not limited to, mental health, alcohol /substance abuse treatment and communicable disease records.

For example, the federal Health Insurance Portability and Accountability Act (HIPAA) requires that covered entities, such as health plans and providers, release protected health information only when permitted under the law, such as for treatment, payment and operations activities, including care management and coordination.

However, a different set of federal rules place more stringent restrictions on the use and disclosure of alcohol and substance abuse treatment records (42 CFR Part 2 or "Part 2"). These records generally may not be released without consent from the individual whose information is subject to the release.

Still other laws at the State level place further restrictions on the release of certain information, such as mental health, communicable disease, etc.

For more information about any of these laws, refer to the following:

- HIPAA - please visit the Centers for Medicare & Medicaid Services (CMS) website at: www.cms.hhs.gov and then select "Regulations and Guidance" and "HIPAA – General Information";
- 42 CFR Part 2 regulations - please visit the Substance Abuse and Mental Health Services Administration (within the U.S. Department of Health and Human Services) at: www.samhsa.gov
- State laws - consult applicable statutes to determine how they may impact the release of information on patients whose care you provide.

Contracted providers within the Ambetter network are independently obligated to know, understand and comply with these laws.

Coordinated Care takes privacy and confidentiality seriously. We have established processes, policies and procedures to comply with HIPAA and other applicable federal and/or State confidentiality and privacy laws.

Please contact the Coordinated Care Compliance Officer by phone at 1-877-687-1197 or in writing (refer to address below) with any questions about our privacy practices.

Ambetter from Coordinated Care
1145 Broadway, Suite 300
Tacoma, WA 98402

WASTE, ABUSE, AND FRAUD

Coordinated Care takes the detection, investigation, and prosecution of fraud and abuse very seriously, and has a waste, abuse and fraud (WAF) program that complies with the federal and state laws. Coordinated Care, in conjunction with its parent company, Centene, operates a waste, abuse and fraud unit. Coordinated Care routinely conducts audits to ensure compliance with billing regulations. Our sophisticated code editing software performs systematic audits during the claims payment process. To better understand this system, please review the Billing and Claims section of this Manual. The Centene Special Investigation Unit (SIU) performs retrospective audits which, in some cases, may result in taking actions against providers who commit waste, abuse, and/or fraud. These actions include but are not limited to:

- remedial education and training to prevent the billing irregularity;
- more stringent utilization review;
- recoupment of previously paid monies;
- termination of provider agreement or other contractual arrangement;
- civil and/or criminal prosecution; and
- any other remedies available to rectify

Some of the most common WAF practices include:

- unbundling of codes;
- up-coding services;
- add-on codes billed without primary CPT;

- diagnosis and/or procedure code not consistent with the member's age/gender;
- use of exclusion codes;
- excessive use of units;
- misuse of benefits; and
- claims for services not rendered.

If you suspect or witness a provider inappropriately billing or a member receiving inappropriate services, please call our anonymous and confidential WAF hotline at 1-866-685-8664. Coordinated Care takes all reports of potential waste, abuse or fraud very seriously and investigates all reported issues.

WAF Program Compliance Authority and Responsibility

The Coordinated Care Vice President of Compliance and Regulatory Affairs has overall responsibility and authority for carrying out the provisions of the compliance program. Coordinated Care is committed to identifying, investigating, sanctioning and prosecuting suspected waste, abuse and fraud.

The Ambetter provider network must cooperate fully in making personnel and/or subcontractor personnel available in person for interviews, consultation, grand jury proceedings, pre-trial conferences, hearings, trials and in any other process, including investigations.

False Claims Act

The False Claims Act establishes liability when any person or entity improperly receives from or avoids payment to the Federal government. The Act prohibits:

1. knowingly presenting, or causing to be presented a false claim for payment or approval;
2. knowingly making, using, or causing to be made or used, a false record or statement material to a false or fraudulent claim;
3. conspiring to commit any violation of the False Claims Act;
4. falsely certifying the type or amount of property to be used by the Government;
5. certifying receipt of property on a document without completely knowing that the information is true;
6. knowingly buying Government property from an unauthorized officer of the Government; and
7. knowingly making, using, or causing to be made or used a false record to avoid, or decrease an obligation to pay or transmit property to the Government

For more information regarding the False Claims act, please visit www.cms.hhs.gov.

Physician Incentive Programs

On an annual basis and in accordance with Federal Regulations, Coordinated Care must disclose to the Centers for Medicare and Medicaid Services, any Physician Incentive Programs that could potentially influence a physician's care decisions. The information that must be disclosed includes the following:

- effective date of the Physician Incentive Program;
- type of Incentive Arrangement;
- amount and type of stoploss protection;
- patient panel size;
- description of the pooling method, if applicable;

- for capitation arrangements, provide the amount of the capitation payment that is broken down by percentage for primary care, referral and other services;
- the calculation of substantial financial risk (SFR);
- whether Coordinated Care does or does not have a Physician Incentive Program; and
- the name, address and other contact information of the person at Coordinated Care who may be contacted with questions regarding Physician Incentive Programs

Physician Incentive Programs may not include any direct or indirect payments to providers/provider groups that create inducements to limit or reduce the provision of necessary services. In addition, Physician Incentive Programs that place providers/provider groups at SFR may not operate unless there is adequate stoploss protection, member satisfaction surveys and satisfaction of disclosure requirements satisfying the Physician Incentive Program regulations.

Substantial financial risk occurs when the incentive arrangement places the provider/provider group at risk beyond the risk threshold which is the maximum risk if the risk is based upon the use or cost of referral services. The risk threshold is set at 25% and does not include amounts based solely on factors other than a provider/provider group's referral levels. Bonuses, capitation, and referrals may be considered incentive arrangements that result in SFR.

If you have questions regarding the Physician Incentive Program Regulations, please contact your Provider Relations Specialist.