COMMUNITY FIRST
HEALTH PLANS

2022 Medicare Advantage and D-SNP Plan

Provider Manual

H5447_0920M000115_C

COMMUNITY FIRST
HEALTH PLANS

Provider Manual

For Physicians, Hospitals, and Health care Providers

Overview of Community First Health Plans

Community First Health Plans, Inc. was established in 1995 by University Health System, to begin providing health care coverage to the citizens of Bexar and the surrounding seven counties. As the only locally owned and managed non-profit health plan in the area, our commitment to our Members is to provide great health care benefits backed by outstanding service and delivered by people who live right here in South Texas. Our goal is to provide San Antonio with opportunities for successful health outcomes by putting the community first.

For over 25 years, Community First has been providing affordable health coverage for families, children, expectant mothers, and children with special health care needs. In keeping with our commitment to our community, we are adding a Medicare Advantage Benefit Program for Members in our service area.

This manual furnishes all participating Providers and office staff with important information concerning Community First's Medicare Advantage Plans (Managed Medicare and Dual Special Needs Plans), policies and procedures, claims submission and adjudication requirements, and guidelines used to administer the health plans. Other policies and procedures are posted online. State-specific Medicaid Provider Manuals are also available and may contain additional information. This manual replaces and supersedes any and all other previous versions and is located on our website. A paper copy may be obtained at any time upon written request to Community First. Any capitalized terms not otherwise defined herein shall have the meaning as outlined in the agreement.

Except as may otherwise be set forth in the agreement, Providers are contractually required to comply with all provisions contained in this manual. However, in the event of a conflict between the obligations, terms, conditions of the participation agreement and this manual, the obligations, terms, and conditions in the agreement shall take precedence.

Variations in applicable laws, regulations, and governmental agency guidance including, but not limited to, state or federal laws, regulations and/or changes to such laws, regulations, or guidance may create certain requirements related to the content in this manual that are not expressly set forth in this manual. Revisions to this manual constitute revisions to Community First's policies and procedures. Any requirements under applicable law, regulation, or guidance that are not expressly set forth in this manual's content are incorporated herein by this reference and shall apply to Providers.

NOTE: State laws and/or regulations do not affect the adjudication of claims for Medicare Advantage Members.

Community First may deny payment for any services or supplies for which a Provider failed to comply with Community First's policies and procedures.

Responsibility for Provision of Medical Services: Providers are independent contractors and are solely responsible to Members to provide health services and the quality of those services. This means Providers and Community First do not have an employer-employee, principal-agent, partnership, joint venture, or similar arrangement. It also means that Providers have a duty to exercise independent medical judgment to make independent health care treatment decisions, regardless of whether a health service is determined to be a covered service. Nothing in the agreement or this manual is intended to create any right for Community First to intervene in the Provider's medical decision-making regarding a Member.

Additionally, Providers are responsible for any costs, damages, claims, or liabilities that arise out of their own actions. Community First does not endorse or control the clinical judgment or treatment recommendations made by Providers.

Community First requires preauthorization with respect to certain services and procedures. Community First's preauthorization determination relates solely to administering its plans and is not, nor should it be construed to be a medical decision. In consultation with the Member, the Provider decides whether the services or procedures should be provided.

Medical Directors: Medical directors serve as the major interface between health care organizations and participating Providers and other health care Providers in the community. The medical director is not engaged in the practice of medicine while acting in the medical director role. This role is invaluable in establishing a Provider network, as well as facilitating Provider participation and cooperation. The medical director's responsibilities include, but are not limited to, oversight of:

- Quality management programs required by federal or state law or accrediting agencies
- Community First health programs
- Credentialing
- Utilization management (UM)/health services

Questions or comments: Suggestions, questions, or comments about this manual should be directed to:

Community First Health Plans
Network Management
12238 Silicon Drive, Suite 100
San Antonio, TX 78249

or via email to:
NMCFHP@CFHP.com

Online Provider Portal

Providers can log into the Provider Portal (registration required) to access a secure portal. Transactional features include, but not limited to: validate Member eligibility; check claim status; submit a preauthorization request; and upload clinical information.

Community First Medicare Website

Providers can visit our public Provider site at communityfirstmedicare.com (registration not required) to find important information. This site provides a variety of informational resources including, but not limited to, Community First's drug list and links to clinical practice guidelines. Please see the following list for additional resources available online.

- **Clinical and Healthcare Resources:** Quickly locate details about Clinical Practice Guidelines, patient health education, clinical services and innovation, transplant services, bariatric services, and disease management programs.
- **Preauthorization List:** The Community First Authorization List provides a comprehensive list of services and medications outlining which services and plans require preauthorization or notification.
- **Provider Appeal Process:** Provides an explanation of the appeals process for physicians and other health care Providers.
- **Credentialing Services:** Council for Affordable Quality Healthcare (CAQH) – Provides a link to the CAQH Universal Credentialing Data source.
- **Provider Onboarding and Support Materials:** Provides a link to educational tools that are available on demand.
- **Claims Payment Procedures:** Procedures are defined in this Provider Manual, see *Claims Submissions and Processing* section.
- **Provider Newsletters:** Access quarterly communications that contain important updates and information for network Providers.

Contact us

Community First can assist in the following areas:

Member Services: Call **1-833-434-2347** or the number listed on the back of the patient's ID card for assistance with questions regarding:

- Benefits
- Claims
- Copayments
- Eligibility
- Appeals and/or grievances
- Provider Directory concerns

Member Eligibility Inquiries:

- Visit the Provider Portal at Provider Portal
- Telephone:
  Medicare Advantage/Medicaid Members
  call **1-833-434-2347**.

NOTE: A copy of the Medicare enrollment form can serve as verification of eligibility for Medicare Members who have not received their Member ID card at the time of service. Members may not be denied covered, medically necessary services.

Community First's verification does not guarantee payment. If Community First subsequently learns that the Member was ineligible on the verification date, no payment will be made. Therefore, it is important that Providers always ask a patient for his/her most current insurance status.

Preauthorization Submissions and Inquiries:

- Access the Provider Portal at Provider Portal.
- Telephone: **1-833-434-2347**
- The list of services requiring authorization can be found at Prior Authorization List.

Case Management: Refer to the Population Health Management section for more detailed information.

Provider Relations: Call Network Management: **1-833-434-2347**, 8 a.m. to 5 p.m. Central time.

Fraud, Waste, and Abuse: 1-833-434-2347

Claims procedures

Checking Member Eligibility

Web:

Access the Provider Portal at Provider Portal

Phone:

- Call Community First Member Services at **1-833-434-2347** or the number listed on the back of the patient's ID card.
- Provide the subscriber's identification number and other authentication information.

Member Identification (ID) Card

The member identification (ID) card is issued to Members upon enrollment and contains information regarding benefit coverage, copayments, and telephone numbers for questions regarding benefits. Members have been issued unique member identification (UMID) numbers assigned by Community First. Key information is identified on the sample identification card below.

NOTE: To avoid potential problems with identity theft or fraud, ask the patient for a separate form of identification such as a driver's license, along with the Member ID card.

COMMUNITY FIRST HEALTH PLANS
MEDICARE ADVANTAGE ALAMO PLAN

Name: John M. Doe
Member ID: AD000000000000
Group No: A0012345678
Policy Effective Date: 01/01/2021
Primary Care Physician: Provider Name MD
PCP Phone Number: 001-234-5678
PCP Effective Date: 01/01/2021

RxBIN: 610602
RxPCN: NVTD
RxGRP: CFD001

SAMPLE

Navitus Health Solutions
H5447_1020D00031_C
MedicareRx Prescription Drug Coverage

COMMUNITY FIRST HEALTH PLANS

H5447-002
MEDICARE ADVANTAGE D-SNP

Name: John M. Doe
Member ID: 0000-000-0000
Group No: A0012345678
Policy Effective Date: 01/01/2021
Primary Care Physician: Provider Name MD
PCP Phone Number: 001-234-5678
PCP Effective Date: 01/01/2021

RxBIN: 610602
RxPCN: NVTD
RxGRP: CFD002

SAMPLE

Navitus Health Solutions
H5447_1020D00031_C

MedicareRx
Prescription Drug Coverage

Providers should have a timely process in place to refund patients any difference between their copayment and the allowable amount for the office visit (in instances when the allowed amount is less than the copay collected) when Community First processes the claim. For assistance, call the number listed on the back of the Member ID card.

Claims Submission and Processing

Claims Submission: Unless applicable law provides that submissions can be in paper format, Providers must submit all claims, encounters, and clinical data to Community First by electronic means. Those electronic means accepted as industry standard may include claims clearinghouses or electronic data interface companies. Providers using electronic submission must submit all claims to Community First or its designee, as applicable, using the Health Insurance Portability and Accountability Act (HIPAA)-compliant EDI 837 electronic format. When the 837 standard electronic format requires the submission of a taxonomy code from one or more Providers, a taxonomy code must be submitted for each Provider. The taxonomy code must be the code most appropriate for that Provider and the services provided.

NOTE: No claim is complete for a covered service and/or no reimbursement is due for a covered service unless Provider's performance of that covered service is fully and accurately documented in the Member's medical record prior to the claim's initial submission.

Prompt Payment of Claims: A claim is deemed to have been promptly adjudicated if it has been paid, pended for review (when applicable under state guidelines), or denied within the time established by the applicable state or federal prompt payment statutes and/or regulations. To ensure that a claim is processed promptly and within a timely manner, the following criteria must be satisfied upon the claim's submission to Community First:

- The claim must be submitted either electronically or by paper if permitted by applicable law.
- The claim must be "complete" and must qualify as a "clean claim."
  - Complete – the information provided in the claim must be sufficient to substantiate the services rendered to the covered patient.
  - Clean claim – the claim must satisfy the description set forth in state or federal law, as applicable, based on the type of plan.
- A Member's original signature or a "signature on file" (or "assignment on file") stamp is required for payments made directly to the Provider.

NOTE: The Provider must maintain a valid written assignment of benefits from the Member on file. This will serve as evidence that the Provider is entitled to all payments for service. Community First reserves the right to review the original, signed assignment document at any time.

- Separate charges must be itemized on separate lines. Medical record documentation must validate the scope of services provided and billed.

The time frame for submitting claims is listed below, if not otherwise specified by the agreement or applicable state or federal law:

- Initial Submission of Claim: 120 days from the date of service
- 1st Level Appeal: 60 days from Explanation of Payment (EOP)
- 2nd Level Appeal: 60 days from initial appeal Explanation of Payment (EOP)

Medicare Appeals Process

To appeal, Provider must include substantive information for the claim appeal.

NOTE: If an authorization number is not obtained prior to the delivery of services, the claim may be rejected. The Member may not be billed for the balance for this type of rejected claim.

Requests for Review of Denied Claims: Providers may request a review of claim payment denials by the plan(s). To obtain a review, Providers must submit

the request via the Provider Portal. For additional information, see the Provider Claim Appeals Process section of this manual.

Claims Processing Procedures: Community First will process accurate and complete Provider claims in accordance with Community First's normal claims processing procedures, including, but not limited to, claims processing edits, claims payment policies, and applicable state and/or federal laws, rules and regulations.

Such claims processing procedures include a review of the interaction of a number of factors. The result of Community First's claims processing procedures will be dependent upon the factors reported on each claim. Accordingly, it is not feasible to provide an exhaustive description of the claims processing procedures. Examples of the most commonly used procedures, including, but not limited to, are:

- The complexity of a service
- Whether a service is one of multiple same-day services such that the cost of the service to the Provider is less than if the service had been provided on a different day. For example:
  - Two or more surgeries performed the same day
  - Two or more therapy services performed the same day
- Whether an assistant surgeon, surgical assistant, or any other Provider who is independently billing is involved
- When a charge includes more than one claim line, whether any service is part of, or incidental to, the primary service that was provided or if these services cannot be performed together
- Whether the service is reasonably expected to be provided for the diagnosis reported
- Whether a service was performed specifically for the Member
- Whether services can be billed as a complete set of services under one billing code

Community First develops claims processing procedures based on a review of one or more of the following sources, including, but not limited to:

- Medicare laws, regulations, manuals, and other related guidance
- Federal and state laws, rules and regulations, including instructions published in the Federal Register
- National Uniform Billing Committee (NUBC) guidance, including the UB-04 Data Specifications Manual
- American Medical Association's (AMA) Current Procedural Terminology (CPT®) and associated AMA publications and services
- The Centers for Medicare & Medicaid Services' (CMS) Healthcare Common Procedure Coding System (HCPCS) and associated CMS publications and services
- International Classification of Diseases (ICD)
- American Hospital Association's (AHA) Coding Clinic Guidelines
- Uniform Billing Editor
- American Psychiatric Association's (APA) Diagnostic and Statistical Manual of Mental Disorders (DSM) and associated APA publications and services
- Food and Drug Administration (FDA) guidance
- Medical and surgical specialty societies and associations
- Industry-standard utilization management criteria and/or care guidelines
- Our medical and pharmacy coverage policies
- Generally accepted standards of medical, behavioral health, and dental practice based on credible scientific evidence recognized in published, peer-reviewed literature

Changes to any one of the sources may lead Community First to modify current or adopt new claims processing procedures.

These claims processing procedures may result in an adjustment or denial of reimbursement, a request for the submission of relevant medical records prior to or after payment, or the recoupment or refund request of a previous reimbursement. Providers may access additional information on Community First's website at communityfirstmedicare.com.

An adjustment in reimbursement as a result of claims processing procedures is not an indication that the service provided is a non-covered service. Providers may submit an appeal request of any adjustment produced by these claims processing procedures by submitting a timely request to Community First. For additional information, see the *Provider Claim Appeals, Member Appeal/Grievances,* and *Provider Termination Appeal Processes* sections of this manual.

Pass-through Billing: Community First prohibits pass-through billing. Pass-through billing occurs when a Provider bills for a service not performed by that Provider or any individual under that Provider's direct employment. Pass-through billing services will not be eligible for reimbursement from Community First. The Provider shall not bill, charge, seek payment, or have any recourse against Members for any amounts related to the pass-through billing provision.

Reimbursement

Payment terms are defined in the agreement. Additionally, the amount of payment for services provided may be affected by one or more of the following factors, including, but not limited, to:

- A Member's eligibility at the time of service
- Whether services provided are covered by the Member's plan
- Whether services provided are medically necessary, as required by the Member's plan
- Whether services provided require prior approval by the Member's plan
- The amount of the Provider's billed charges
- Member copayments, coinsurance, deductibles, and other cost-share amounts due from the Member
- Coordination of benefits with third-party payers as applicable
- Adjustment of payments based on claims processing procedures described in Claims Submission and Processing section of this manual
- Adjustments of payments based on Provider payment integrity policies, can be found at communityfirstmedicare.com.

A Provider who receives reimbursement for services rendered to a Community First Medicare Advantage-covered patient must comply with all federal laws, rules, and regulations applicable to individuals and entities receiving federal funds, including without limitation Title VI of the Civil Rights Act of 1964, Rehabilitation Act of 1973, Age Discrimination Act of 1975, and the Americans with Disabilities Act of 1990.

Nothing contained in the agreement or this manual is intended by Community First to be a financial incentive or payment that directly or indirectly acts as an inducement for Providers to limit medically necessary services.

Electronic Claims Payment: For information about electronic claims payment, including electronic remittance advice and electronic fund transfer (ERA/EFT), visit PaySpan. When you enroll in ERA/EFT you will need to register with PaySpan to view your payment information, Community First claims payments are deposited directly into the bank account(s) of your choice. You can access your ERA through your clearinghouse or PaySpan.

Request for Claims Appeal: If a Provider disagrees with how Community First has adjudicated a claim, the Provider should follow the procedures set forth in the Provider Claims Appeal Process section of this manual or any applicable state laws. See the Providers' section of Community First's claims payment policy on claim appeals.

Balance Billing: Providers must accept as payment-in-full from Community First payment for covered services provided to health plan Members in accordance with the reimbursement terms outlined in the agreement. Members are responsible for applicable copayment, coinsurance, and deductible amounts. For covered services, Providers may not balance-bill Members for an amount other than their applicable copayment, coinsurance, and/or deductible responsibilities.

Subject to the limitation for services provided to a Medicare Advantage plan Member discussed below, a Provider is not prohibited by the agreement from collecting from health plan Members for a service not covered under the terms of the applicable Member plan. A reduction in payment due to claims processing procedures is not an indication that the service provided is a non-covered service.

NOTE: For plan Members, a Provider may only collect for a service not covered under the terms of the applicable Member plan if the Provider followed the procedures outlined in the *Utilization Management/ Preauthorization (Prior Authorization)* section of this manual. To verify covered services, please review the following plan materials:

- Advantage Plan Summary of Benefits
- D-SNP Summary of Benefits

Services That Are Not Medically Necessary: When Community First determines that rendered services covered under the terms of the applicable Member plan were not medically necessary, the Provider shall not bill, charge, seek payment, or have any recourse

against the Member for such services.

Physician or Other Healthcare Professional Surgical Payments: Professional reimbursement for surgical services includes charges for preoperative evaluation and care, surgical procedures, and postoperative care. The following claims processing procedures apply to surgical procedures and related services; this is not an all-inclusive list. See the Providers' section of communityfirstmedicare.com for a more detailed explanation of claims payment policies and/or code edit notifications.

Overpayments: Community First Special Investigative Unit

Overview: Community First Special Investigative Unit (SIU) reviews Community First's claims payments for accuracy and requests refunds if claims are overpaid or paid in error.

Contacts, General Inquiries, and Escalation Process: For more information on how to resolve recoupment concerns, such as overpayments, payment integrity reviews, disputes, and medical record requests, please review the SIU Audit Plan, available upon request by contacting the SIU Manager at **210-510-2455** or SIURequests@cfhp.com.

Special Investigative Unit Medical Record Review Process: Community First operates a review program to detect, prevent, and correct fraud, waste, and abuse and facilitate accurate claim payment. For more information, please review the SIU Audit Plan, available upon request by contacting the SIU Manager at **210-510-2455** or SIURequests@cfhp.com.

Population Health Management (PHM)

Utilization Management

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

Preauthorization

Preauthorization is defined as a process through which the physician or other health care Provider is required to obtain advance approval from the plan as to whether an item, drug, or service will be covered.

You can review the services and medications that require preauthorization on the Prior Authorization List. You also can call Customer Service at **1-833-434-2347** to request a hard copy of the list. Please note, the preauthorization list is subject to change.

Requests for preauthorization should be made as soon as possible, but at least 14 days in advance of the service date.

NOTE: Emergent/urgent care does not require preauthorization. However, Providers should notify Community First within 24 hours of hospital admission and provide supporting documentation within 48 hours of admission.

If preauthorization is required and not obtained, it may result in a reduction or denial of payment.

How to Request a Preauthorization: To initiate pre-authorization or a notification request, a Provider may:

- Enter information online through the Provider Portal (registration required). For many services that require preauthorization, you can answer a series of questions when requesting the preauthorization. You must also attach relevant clinical information to the request. You will be notified when preauthorization is approved.
- Call the number for precertification on the back of the patient's Community First ID card.

Information Required: Information required for a preauthorization request or notification may include, but is not limited to:

- Member's ID number, name, and date of birth
- Relationship to the subscriber
- Date of actual service or hospital admission
- Type of service
- Place of service
- Service quantity
- Procedure codes
- Date of the proposed procedure, if applicable
- ICD 10 Diagnosis codes (primary and secondary), up to a maximum of six per authorization request
- Service location
  - Inpatient
    - Acute hospital
    - Skilled nursing
    - Hospice
  - Outpatient
    - Telehealth
    - Office
    - Home
    - Ambulatory surgery center
- Type of authorization – inpatient or outpatient
- Referral
- Type of authorization - inpatient or outpatient
- Tax ID number and National Provider Identifier (NPI) number of requesting Provider
- Tax ID number and NPI of treatment facility where service is being rendered
- Tax ID number and NPI of the Provider performing the service
- Name and telephone number of all Providers indicated
- Attending physician's telephone number
- Relevant clinical information
- Discharge plans

Submitting all relevant clinical information at the time of the request will facilitate a quicker determination. If additional clinical information is required, a Community First representative will request the specific information needed to complete the authorization process.

For Medicare Advantage (MA) plans – Advanced Coverage Determinations (ACD)/Predeterminations and Advanced Beneficiary Notice (ABNs)

CMS does not permit any Provider to use the Advanced Beneficiary Notice (ABN) for a Medicare Advantage plan enrollee. However, as with Original Medicare, if a Provider thinks a specific service might not be covered, CMS expects that Provider to share that information with the patient before providing the service. Note that for contracted Providers particularly, CMS has established very specific requirements for such services. Before providing a service that might not be covered, you should call Community First to request an ACD/predetermination, unless the Member's plan certificate clearly indicates that the service is never covered.

For procedures or services that are investigational, experimental, or may have limited benefit coverage, or if you have questions regarding whether Community First will pay for any service, you can request an ACD on behalf of the patient prior to providing the service. You may be contacted if additional information is needed.

ACDs for medical services can be submitted in writing, by fax, or by telephone.

- Send written requests to the following address:

  Community First Health Plans
Attn: PHM
12238 Silicon Drive Suite 100
San Antonio, TX 78249
- Submit by fax: **210-358-6408**
- Submit by telephone: **1-833-434-2347**

ACDs for medications on the list can be submitted by telephone:

- Submit by telephone: **1-833-434-2347**

Inpatient Coordination of Care/Concurrent Review

Concurrent review is the process that determines coverage during the inpatient stay, including, but not limited to, acute inpatient facility, skilled nursing facility (SNF), long-term acute care hospital (LTAC), inpatient rehabilitation facility, and behavioral health partial hospital/residential treatment facilities. Each admission will be reviewed for medical necessity and compliance with contractual requirements. Community First will contact the Provider if an additional clinical

review is required.

In addition to the initial admission information, Providers should indicate any complicating factors that prevent discharge. Providers also must contact Community First with the discharge date and discharge disposition upon patient discharge.

For certain plans, in the event coverage guidelines for an inpatient stay are not met and/or the Member's certificate does not provide the benefit, a licensed medical professional from Community First will consult with the Primary Care Physician (PCP) and/or facility utilization management and discharge planning staff. If necessary, the licensed medical professional will refer the case to a health plan medical director for review and possible consultation with the attending physician. If the medical director determines that coverage guidelines for continued hospitalization are no longer are valid, the patient, attending physician, hospital, and the patient's primary care office, as appropriate, will be notified in writing that benefits will not be payable if the patient remains in the hospital on or after the effective date of the non-approval.

Discharge Planning

The Community First Case Management (CM) team collaborates with the Community First-covered patient and his/her family or guardian, the hospital's CM and discharge planning departments, and the patient's attending physician/PCP to facilitate the discharge plan, including identifying the most appropriate post-discharge level of care.

Clinical Review Guidelines

Community First uses nationally accepted clinical guidelines to determine the medical necessity of services. The review guidelines are used as a screening guide to approve services during the utilization management process.

For Medicare Advantage plans, Community First also applies national coverage determinations (NCDs) and local coverage determinations (LCDs). Community First also develops internal clinical policies based on peer-reviewed literature. Community First's internal clinical policies or InterQual utilized to make a medical necessity determination can be made available by request to the PHM Department.

A licensed, board-certified medical director reviews all available clinical documentation to evaluate if guidelines are met. The medical director renders a decision in accordance with clinical review guidelines and currently accepted medical standards of care, taking into account the individual circumstances of each case. Providers may obtain the guidelines used to make a specific adverse determination by contacting Community First.

Peer-to-Peer Review

Prior to or at the time an adverse determination is communicated, the practitioner ordering services may be given an opportunity to discuss the services being requested for the Member and the clinical basis for treatment with a medical director or another appropriate reviewer.

For Community First Medicare Advantage plans, the discussion must be completed prior to the adverse determination being rendered. Once an adverse determination has been made, participating Providers are given the opportunity to submit a Provider Appeal. A participating Provider may submit an appeal prior to submitting a claim under the following circumstances:

- Physician/Provider is contracted with Community First.
- Community First's adverse determination was based on a lack of medical necessity for an authorization request that was retrospective (retro) or concurrent to the service.

Physicians/Providers have five calendar days from notification of the denied authorization to request the pre-claim appeal.

As part of this pre-claim appeal, Providers can request a peer-to-peer conversation if one did not occur prior to the adverse determination. Participating Providers also can submit claim appeals. See the *Provider Claim Appeals* section of this manual.

Second Medical Opinions

A Member has the right to a second medical opinion in any instance in which the Member questions the reasonableness, necessity, or lack of necessity for the following:

- Surgical procedures
- Treatment for a serious injury or illness
  - Other situations in which the Member feels that he/she is not responding to the current treatment plan in a satisfactory manner

Special Requirements for Hospitals – Medicare Advantage (MA) plan Members

Hospital Discharge Rights for Medicare Advantage Members: The CMS requires that hospitals deliver the Important Message from Medicare (IM), CMS-R-193, to all Medicare beneficiaries, including Medicare Advantage (MA) plan Members who are hospital inpatients. Hospitals are required to provide the IM to the MA Member upon admission and at least two days prior to the anticipated last covered date. The notice must be given on the standardized CMS IM form. The form and instructions regarding the IM are on the CMS website at https://www.cms.gov/Medicare/Medicare-GeneralInformation/BNI/HospitalDischargeAppealNotices.

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

Guidelines for Important Message from Medicare (IM) notification by telephone: If the hospital staff is unable to personally deliver the IM to the patient or his/her representative, then the hospital staff should telephone the patient or representative to advise him/her of a Member's rights as a hospital patient, including the right to appeal a discharge decision. At a minimum, the telephone notification should include:

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

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

The hospital is required to:

- Confirm the telephone contact by written notice mailed to the Member's authorized representative on that same date.
- Place a dated copy of the notice in the Member's medical file and document the telephone contact with either the Member or his/her representative on either the notice itself or in a separate entry in the Member's file.
- Ensure that the documentation indicates that the staff person told the Member or representative the planned discharge date, the date that the beneficiary's financial liability begins, the beneficiary's appeal rights, and how and when to initiate an appeal.
- Ensure that the documentation includes the name of the staff person initiating the contact, the name of the Member or representative contacted by phone, the date and time of telephone contact, and the telephone number called.

When direct phone contact with a Member or a Member's representative cannot be made, the hospital must:

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

Right to appeal a hospital discharge: When Members choose to appeal a discharge decision, the hospital or their Medicare health plan must provide them with the Detailed Notice of Discharge (DND). These

requirements were published in a final rule, CMS-4105-F: Notification of Hospital Discharge Appeal Rights, which became effective July 2, 2007.

When the QIO notifies the hospital and Community First of an appeal, Community First will provide the hospital with a DND. The hospital is responsible for delivering the DND as soon as possible to the Member or his/her authorized representative on behalf of Community First, but no later than noon local time of the day after the QIO notifies Community First or the hospital of the appeal. The facility must fax a copy of the DND to the QIO and to Community First.

If the Member misses the time frame to request an immediate review from the QIO and remains in the hospital, he/she can request an expedited reconsideration (appeal) through Community First's appeals department. For more information about notification of termination requirements, practitioners can visit the CMS website at https://www.cms.gov/ Medicare/ Medicare-General-Information/BNI/HospitalDischargeAppealNotices.

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

Important information:

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

Additional information about the MOON can be found on the CMS Medicare Learning Network site (MLN Matters No. 9935) at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9935.pdf.

Special Requirements for Skilled Nursing Facilities (SNFs), Home Health Agencies (HHA), and Comprehensive Outpatient Rehabilitation Facilities (CORFs) – Medicare Advantage (MA) Plan Members

Notice of Medicare Non-Coverage (NOMNC): The Centers for Medicare & Medicaid Services (CMS) requires that physicians and other health care Providers give the Notice of Medicare Non-Coverage (NOMNC) to Medicare Advantage (MA) health plan Members at least two days prior to termination of skilled nursing facility (SNF), home health agency (HHA), or comprehensive outpatient rehabilitation facility (CORF) services. Additionally, if the Member's SNF services are expected to be fewer than two calendar days, the NOMNC should be delivered at the time of admission. For HHA or CORF services, the notice needs to be given no later than the next-to-the-last time services are furnished. The NOMNC informs Members how to request an expedited determination from their QIO if they disagree with the termination.

The form and instructions regarding the NOMNC are available on the CMS website at https://www.cms.gov/Medicare/Medicare-General-Information/BNI/MAEDNotices.html.

Practitioners also can contact their QIO for forms or additional information. Forms also can be obtained from Community First's Population Health Management . No modification of the text on the CMS NOMNC is allowed. For the NOMNC to be valid:

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

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

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

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

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

A dated copy of the annotated NOMNC must be placed in the Member's medical file, mailed to the representative the same day as the telephone contact, and faxed to Community First's Population Health Management department.

Right to appeal a NOMNC (Fast-track Appeal): CMS offers fast-track appeal procedures to Medicare enrollees, including MA Members, when coverage of their SNF, HHA, or CORF services will soon end. CMS contracts with QIOs to conduct these fast-track appeals. When notified by Community First or the QIO that the Member has requested a fast-track appeal, SNFs, HHAs, and CORFs must:

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

If a Member misses the time frame to request an appeal from the QIO, the Member can still appeal through Community First's appeals department.

For more information about notification of termination requirements, practitioners can visit the CMS website at: https://www.cms.gov/Medicare/Medicare-General-Information/BNI/MAEDNotices.html.

Office Procedures

This section provides policies and procedures that pertain to the daily operations of a Provider office.

Office Appointment and Wait Times

Providers should implement procedures and make reasonable efforts to ensure that:

- A clinician sees patients within 15 minutes of the patient's appointment time.
- Routine and follow-up appointments are made within 30 calendar days.
- Urgent appointments are made within 24 hours, seven days per week.
- Urgently needed services are provided immediately for Medicare Members.
- Emergent appointments are made immediately (arrange for on-call or after-hours coverage), 24 hours per day, seven days per week.
- The standards consider the enrollee's need and common waiting times for comparable services in the community. Examples of reasonable standards for primary care services are: (1) urgently needed services or emergency – immediately; (2) services that are not emergency or urgently needed, but in need of medical attention – within one week; and (3) routine and preventive care – within 30 days.

Address Change or Other Practice Information

For Community First to maintain accurate participating Provider directories and for reimbursement purposes, Providers are contractually required to report all changes of address or other practice information electronically or in writing as soon as possible. Notices of any changes must adhere to the time frames outlined in the agreement.

If a Provider's agreement with Community First is through a Management Services Organization (MSO), Independent Practice Association (IPA), or Provider medical group, these changes can be communicated to Community First through the entity rather than by the individual Provider. Please note, changes can be completed much quicker when contacting Community First directly.

Changes that require notice to Community First may include, but are not limited to, the following:

- Provider demographic information
- Tax identification number*
- National Provider Indicator (NPI)
- Address
- Office hours
- Phone number
- Practice name
- Adding a Provider – Provider joining practice/group**
- Provider deletions – Provider no longer participating with the practice/group
- Patient restrictions (age, gender, etc.)
- Accepting new patients
- Medicare numbers
- Hospital privileges
- Languages spoken

**Changes in practice name, legal entity, or tax ID numbers might require an amendment, assignment, or new agreement depending on the reason for the change. Check with the Provider representative in the local Community First office for specific information.*

***If adding a Provider, the new Provider must first be credentialed before rendering treatment to any plan Member.*

Community First requires that changes such as those outlined above be submitted at least 30 days prior to the change's effective date to facilitate accurate directory information and claims payment.

When physicians and other health care professionals need to update their demographic information (e.g., correct a Provider practice name or address, add physicians to a practice, update facility hours of operation, notify that the practice is accepting new patients, etc.), they are required to contact Community First by email at NMCFHP@CFHP.com. Submitting these updates to the correct contact will help Community First quickly update its Provider Directory, which means Community First Members can easily locate the correct information.

If you need a template format on which to submit demographic information, please use the preferred standard roster template available at Community First Medicare Provider Roster. You can submit the template by emailing Community First at NMCFHP@CFHP.com.

Physicians and other health care professionals can view their practice or facility information in Community First's Provider Directory at Provider Directory.

Medical Records

Community First Provider representatives must be permitted access to the Provider's office records and operations. This access allows Community First to monitor compliance with regulatory requirements. Each Provider office will maintain complete and accurate medical records for all Community First-covered patients receiving medical services in a format and for time periods as required by the following:

- Applicable state and federal laws
- Licensing, accreditation, and reimbursement rules and regulations to which Community First is subject
- Accepted medical practices and standards
- Community First's policies and procedures

The Provider's medical records must be available for utilization, risk management, peer review studies, customer service inquiries, appeals and grievances processing, claim appeals, quality compliance audits, and other initiatives Community First might be required to conduct. To comply with accreditation and regulatory requirements, Community First may periodically perform a documentation audit of some Provider medical records.

The participating Provider must respond to the Community First Member appeals and grievances unit expeditiously with the submission of required medical records to comply with time frames established by CMS and/or the state department of insurance for processing appeals and grievances. Only those records for the time period designated on the request should be sent. A copy of the request letter should be submitted with a copy of the record. The submission should include test results, office notes, referrals, telephone logs, and consultation reports. Medical records should not be faxed to the local Community First market office unless the Provider can ensure confidentiality of those medical records.

To be compliant with HIPAA, Providers should make reasonable efforts to restrict access and limit routine disclosure of Protected Health Information (PHI) to the minimum necessary to accomplish the intended purpose of disclosing patient information.

If a Community First-covered patient changes his/her PCP for any reason, the Provider must transfer a copy of the patient's medical record to the patient's new PCP at the plan or patient's request. The agreement states whether the original or a copy of the medical record must be sent. If a Provider terminates, the Provider is responsible for transferring the patients' medical records.

Charges for copying medical records are considered a part of office overhead and are to be provided at no cost to Community First-covered patients and Community First unless state regulations or the agreement stipulate otherwise.

Provider Claim Appeals, Member Appeals/Grievances, and Provider Termination Appeal Processes

Provider Claim Appeals Process

If Providers disagree with Community First's payment denial or nonpayment of a claim, they can request an appeal/reopening of the issue by calling or writing to Community First using the contact information on the back of the patient's ID card. If the Provider does not have this information, he/she can contact Community First at:

- Phone: **1-833-433-2347**
- Address:

  Community First Health Plans
  12238 Silicon Dr. Suite 100
  San Antonio, TX 78249

When submitting a request for an appeal/reopening in writing, Providers should include all of the following information:

- Provider name
- Tax ID
- Member name and identification number
- Date of service
- Relationship of the Member to the patient
- Claim number
- Charge amount
- Payment amount
- Proposed correct payment amount
- Difference between the amount paid and the proposed correct payment amount
- Brief description of the basis for the request
- Relevant supporting documentation (medical re-

cords, copy of the invoice, etc.)

Community First must receive claim appeals within 60 calendar days from the date of the notice of the initial determination or the claim will not be reopened.

See the Providers' section of communityfirstmedicare.com for claims payment policies and further information about claims appeals.

NOTE: The above provisions of this section are to be considered separate and distinct from the arbitration provisions set forth in the Provider agreement.

Member Appeals/Grievances Process

The appeals/grievances process applies to Medicare Advantage Members who are dissatisfied with the health care services received or any aspect of the plan, or who have received an adverse determination.

A Medicare plan grievance can be filed by a current or former Member or his/her representative (upon completion of an Appointment of Representation (AoR) form). Enrollees must submit a verbal or written grievance no later than 60 days after the incident that precipitates the grievance, or Community First may dismiss the grievance. If an enrollee files a quality of care grievance with BFCC-QIO and Community First, Community First must cooperate with the BFCC-QIO and comply with requirements at 42 CFR Part 476 regarding timely submission of requested information to the BFCC-QIO.

A plan Member, representative, or physician can appeal preservice denials as long as the Member is notified. A nonparticipating Provider can appeal claim denials for Medicare Members only with a waiver of liability form for the following:

- Full claim denials
- Claims paying zero dollars
- Claims denied for medical necessity
- Claims denied for non-covered benefits

Community First will accept expedited/urgent appeals from the Member, representative, or physician. The Member's treating physician has the right to file a standard preservice appeal request on behalf of the Member as long as they are notified. An AoR is not required for MA plan Members.

If the initial appeal is upheld, the resolution letter will provide next-level rights as applicable.

Medicare Appeals Definition of Terms

Authorized Representative: Under Part C, as defined in §422.561, an individual appointed by a Member or other party, or authorized under state or other applicable law, to act on behalf of a Member or other party involved in a grievance, organization determination, or appeal. Under Part D, as defined in §423.560 as "appointed representative", an individual either appointed by a Member or authorized under state or other applicable law to act on behalf of the Member in filing a grievance, obtaining a coverage determination, or in dealing with any of the levels of the appeals process. For both Part C & Part D, the representative will have all of the rights and responsibilities of a Member or other party, as applicable.

Expedited/Urgent Appeal: A verbal or written request for a fast review of a preservice denial, termination of care, or a reduction in the level of care. Expedited/urgent appeals are applicable if the time frame for a standard appeal could seriously jeopardize the Member's life or health or the Member's ability to regain maximum function. They also are applicable for care or treatment that, if not rendered, could subject the Member to severe pain that cannot be adequately managed, based on the opinion of a practitioner with knowledge of the Member's medical condition. Expedited appeals exclude requests for payments for services already provided.

Independent Review Entity (IRE): An independent entity contracted by CMS to review adverse level 1 appeal decisions. Under Part C, an IRE can review plan dismissals.

Reconsideration (MA appeal): Under Part C, the first level in the appeals process after an adverse organization determination by a Medicare plan, the findings upon which it was based, and any other evidence submitted by a party to the organization determination, the MA plan, or CMS.

Redetermination (Prescription appeal): The first level of the appeal process involves a Part D plan re-evaluating an adverse coverage determination, the findings upon which it was based, and any other evidence submitted or obtained.

Medicare Grievances Definition of Terms

Beneficiary and Family Centered Care Quality Improvement Organization (BFCC-QIO): Organizations comprised of practicing doctors and other health care

experts under contract to the federal government to monitor and improve the care given to Medicare enrollees. The BFCC-QIOs review enrollee complaints about the quality of care provided by physicians, inpatient hospitals, hospital outpatient departments, hospital emergency rooms, skilled nursing facilities (SNFs), home health agencies (HHAs), Medicare managed care plans, Medicare Part D prescription drug plans, and ambulatory surgical centers.

Enrollee: An eligible individual who has elected a Medicare Advantage, Prescription Drug, cost plan, or health care prepayment plan (HCPP).

Grievance: An expression of dissatisfaction with any aspect of the operations, activities, or behavior of a plan or its delegated entity in the provision of health care or prescription drug services or benefits, regardless of whether remedial action is requested or can be taken. (A grievance does not include, and is distinct from: a dispute of the appeal of an organization determination or coverage determination or a Late Enrollment Penalty (LEP) determination.) Decisions made under the grievance process are not subject to appeal.

Quality of Care Grievance: A type of grievance, verbal or written, related to whether the quality of covered services provided by a plan or Provider meets professionally recognized standards of health care, including whether appropriate health care services have been provided or have been provided in appropriate settings.

Representative: Under Part C, as defined in §422.561, an individual appointed by an enrollee or other party, or authorized under state or other applicable law, to act on behalf of an enrollee or other party involved in a grievance, organization determination, or appeal. Under Part D, as defined in §423.560 as "appointed representative", an individual either appointed by an enrollee or authorized under state or other applicable law to act on behalf of the enrollee in filing a grievance, obtaining a coverage determination, or in dealing with any of the levels of the appeals process. For both Part C and Part D, the representative will have all of the rights and responsibilities of an enrollee or other party, as applicable.

Medicare Appeals Process

A Member, their Provider, or an authorized representative may express orally or in writing dissatisfaction or disagreement regarding an Adverse Benefit Determination. Community First regards any expression of dissatisfaction or disagreement as a request to appeal the Adverse Benefit Determination, within 60 days from the date of the denial notification letter. Community First may accept a request for a standard or expedited level 1 appeal after the 60-day timeframe if a filing party shows good cause. Community First will accept and process any additional evidence or allegations of law and fact related to the disputed issue.

Community First will identify and remove any communication barrier that might impede Members or representatives from effectively making appeals, and facilitate the request to file an appeal for a Member who has a communication challenge affecting his/her ability to communicate or read through the following means:

- A TTY line for the hearing impaired
- A translation service for Members unable to speak English
- Additional accommodations for any Member with special needs who is unable to follow the standard process

We will provide a full and fair review of the appeal, including specialty review for clinical appeals. Appeals must be submitted within 60 calendar days from the date of the adverse determination notice unless the Member can demonstrate good cause.

Medicare Advantage Plans: Notification of the decision will be issued within the following time frames from the date the request is received (with the exception of Medicare Part B drugs):

- Expedited – As expeditiously as the Member's health condition requires, but no later than 72 hours
- Preservice – As expeditiously as required based on the Member's health, but no later than 30 calendar days
- Payment – 60 calendar days from the receipt of the request

The time frames for Medicare Part B drugs are:

- Expedited – No later than 24 hours (no extensions permitted)
- Standard Preservice – No later than seven days (no extensions permitted)

Time frames for decisions might be extended for

expedited and preservice appeals up to 14 calendar days if the:

- Member requests the extension
- Community First justifies the necessity for additional information and documents, in the best interest of the Member

The extension notification to the Member must occur prior to the expiration of the decision time frame and must include the right to file an expedited appeal if the Member disagrees with the extension.

NOTE: If the initial determination is upheld during the appeal process, the resolution letter from Community First will provide information on next-level appeals.

Provider Termination and Appeal Process

Termination without Cause: As required by law, Community First will notify a Provider in advance of terminating his/her agreement. The notification time frames are defined in the agreement and/or applicable state and federal regulations. Community First has the right to terminate any individual Provider, Provider location, or line of business within the time frames specified in the agreement's termination process, unless otherwise mandated by state or federal law.

Should a Provider, IPA, or Physician-Hospital Organization (PHO) elect to terminate network participation, a notice of the pending termination must be forwarded to Community First in accordance with the terms of the agreement and applicable state and federal regulations.

Community First has an established policy and procedures to notify Members in advance of an impending termination of any Provider. Advance notice is required to comply with all federal and state laws, rules and regulations, and accreditation agencies regarding the notification to all Members affected by a Provider's termination.

Community First reviews the Department of Health and Human Services' opt-out list, the CMS preclusion list, System for Award Management list, and the Office of Inspector General's (OIG) sanction list as often as required by federal regulations. Should a Provider's name appear on a current OIG/CMS excluded-provider listing, Community First will take immediate action to terminate the Provider's network participation and, if applicable, take appropriate corrective actions. Other sanctions (e.g., loss of professional license) also are grounds for immediate termination.

The termination appeal process is to be considered in conjunction with the termination rights set forth in the Provider's agreement and, where applicable, state and federal law and regulations.

Medicare Advantage: In accordance with Medicare regulations found at 42 C.F.R. §422. 202, physicians have the right to a review of a termination decision by a physician review panel. The physician must submit a written request for this panel review within 30 calendar days of the date of notice of termination, or the physician's rights to this review will be waived.

The request must be addressed to the party identified in the termination notice letter and must be sent by either registered or certified mail. The request should include any relevant written information to be considered by the physician review panel. However, the physician review panel will consider only the written information submitted. The review will take place prior to the effective date of this termination unless immediate termination is required. The physician review panel will present a written decision to the physician via certified or registered mail.

Covered Services

A service must be medically necessary and covered by the Member's contract to be paid by the plan. The plan determines whether services are medically necessary as defined either by the Member's summary plan description, certificate of insurance, or evidence of coverage. To verify covered or excluded services, vist the Provider Portal, call Community First Customer Service, or review the following plan documents:

- Advantage Plan Summary of Benefits
- D-SNP Summary of Benefits

All services may be subject to applicable copayments, deductibles, and coinsurance.

Community First uses the current, nationally approved criteria for any medical necessity reviews required.

Community First makes coverage determinations, including medical necessity determinations, based on its Member's summary plan description, certificate of insurance, or evidence of coverage. However, Community First is not a provider of medical services, and it does not control the clinical judgment or treatment recommendations made by the Providers in its networks or otherwise be selected by Members. Providers make independent health care treatment decisions.

Compliance/Ethics

Liability Insurance

Upon request, all Providers must provide Community First with evidence of insurance coverage in accordance with their agreement's requirements.

Compliance and Fraud, Waste, and Abuse Requirements

Contracted Providers and those they employ and/or contract to support a contract with Community First are responsible for complying with all applicable laws, regulations, and Community First's policies and procedures. Those who provide services for Community First's Medicare and/or Medicaid-eligible Members, as well as those they employ or contract, also must comply with requirements outlined (see below).

Medicare

Medicare Marketing and Communication Activities: For purposes of this manual, the term "Medicare marketing and communication" includes any information, whether oral or in writing, that is intended to promote or educate prospective or current Community First Medicare Advantage or prescription drug plan Members about Community First or its Medicare plans, products, or services. This includes, but is not limited to, any and all promotional materials used at Provider-sponsored activities, such as open houses, health fairs, and grand openings. Examples of promotional materials include letters, advertisements, invitations, and announcements that use Community First's name.

Medicare marketing and communication must be approved through the Community First corporate review process before a Provider conducts any Medicare marketing and communication activity. The Community First corporate review process includes review by legal and regulatory compliance and filing through Community First's Medicare product compliance department and CMS (as applicable), in accordance with CMS guidelines.

To obtain approved Medicare marketing or communication materials or arrange for a Provider-sponsored activity, contact the Medicare sales director in your local Community First market office, sales and marketing support executive, or physician marketing contact. Any joint (Provider and plan) communication or marketing activity must also comply with Community First policies and procedures, as well as federal and state regulations. Community First applicable policies will be provided upon request. Any misrepresentation of a Medicare product or service, intentional or not, is a serious violation of Community First's agreements with CMS.

Medicare Advantage Liability: If a Medicare Advantage Member disenrolls from a Medicare Advantage plan while in an SNF, costs for SNF services are covered by a new health plan or Medicare as of the effective date of the disenrollment. If a Community First Medicare Advantage Member's effective date of disenrollment occurs while the Member is hospitalized (including, but not limited to, hospitalization in a rehabilitation hospital or long-term care facility), Community First is responsible for paying the contracted rate through the date of discharge, unless otherwise specified in the agreement.

As long as the Medicare Advantage Member resides in the service area, he/she is covered for services until

the effective date of disenrollment. When a Member is temporarily out of the service area (for up to six months), coverage is limited to urgently needed emergency care, post-stabilization services following an emergency, and renal dialysis until the Member returns to the service area or the effective date of disenrollment.

Medicare Disenrollment for Cause: CMS guidelines allow a PCP to request a Member's disenrollment "for cause" only if the Member's behavior is disruptive, unruly, abusive, threatening, or uncooperative to the extent that his/her continued membership would substantially impair the Provider's ability to provide health services to that particular Member or other patients. A Member also may be disenrolled for other reasons including, but not limited to, if he/she fails to qualify for Medicare benefits or fraudulently permits others to use his/her Member ID card for services.

A Member cannot be disenrolled based on the Member's utilization (or lack of use) of services or because of mental or cognitive conditions (including mental illness and developmental disabilities), disagreement with a Provider regarding treatment decisions, or as retaliation for a Member's complaint, appeal, or grievance. Before initiating a request to disenroll a Member for cause, the Provider and Community First must make a serious effort to resolve the problems, such as encouraging the Member to change his/her behavior and must document the result of this action. If the behavioral problems are not resolved, the Provider may initiate a request to disenroll the Member by submitting the Request for Disenrollment for Cause form to the local Community First market office. The form is available by contacting the Network Management Department at **1-833-434-2347.**

CMS requires Community First to notify a Medicare Member that the consequences of continued disruptive behavior could include disenrollment from the plan.

NOTE: The health plan and Provider must reasonably demonstrate that the Member's behavior is not related to the use of prescribed medications, mental illness, or cognitive conditions (including mental illness and developmental disabilities), treatment for a medical condition, or use (or lack of use) of the Provider's medical services.

Procedure for Requesting Disenrollment: A written Request for Disenrollment for Cause letter must be sent to the local Community First market office, along with supporting documentation as follows:

- Description of the Member's age, diagnosis, mental status, functional status, and social support systems
- A complete and detailed description of the Member's behavior
- Efforts taken to resolve any problems and modify behavior
- Any extenuating circumstances
- Summary of the case and reason for disenrollment
- Copy of medical records
- Statements, as applicable, from other Providers, office staff, Members, or law enforcement agencies describing their experiences with the Member

Upon receipt, a letter confirming receipt of the disenrollment request is sent to the PCP. The information is reviewed for completeness and compliance with the Medicare Member's evidence of coverage or the commercial Member's certificate of coverage. If the issues are resolved, the request may be withdrawn.

If the request is deemed to have merit, it is forwarded to a health plan medical director for review and a decision. The Provider is notified of the decision and can appeal the decision by resubmitting the request along with additional supporting documentation for a subsequent review.

If the Member is a Medicare Member, CMS requires the plan to notify the Member of its intent to request CMS permission to disenroll the Member and the plan's grievance procedures. The plan then notifies CMS, and CMS makes the final decision on whether to allow disenrollment of the Member for cause.

Member's Right to Report a Grievance: The Member may request a review of the disenrollment decision by filing a grievance in writing.

Member Disenrollment: The disenrollment is effective the first day of the calendar month after the month in which the health plan gives the Member written notice of the disenrollment, or as provided by CMS. The Member remains the responsibility of the PCP until the Member's effective date of disenrollment.

Specific Medicare Advantage Plan Requirements: Providers must remain neutral when assisting with enrollment decisions.

Providers may not:

- Accept/collect the scope of appointment forms
- Accept Medicare enrollment applications
- Make phone calls or direct, urge, or attempt to persuade beneficiaries to enroll in a specific plan based on financial or any other interests of the Provider
- Mail marketing materials on behalf of plan sponsors
- Offer anything of value to induce plan enrollees to select them as their Provider
- Offer inducements to persuade beneficiaries to enroll in a particular plan or organization
- Conduct health screenings as a marketing activity
- Distribute marketing materials/applications in areas where care is being delivered
- Accept compensation from the plan for any marketing or enrollment activities

Providers may:

- Distribute unaltered, printed materials created by CMS, such as reports from Medicare Plan Finder, the "Medicare & You" handbook, or "Medicare Options Compare" (from www.Medicare.gov), including in areas where care is delivered.
- Provide the names of plan sponsors with which they contract and/or participate.
- Provide information and assistance in applying for the low-income subsidy.
- Answer questions or discuss the merits of a plan or plans, including cost-sharing and benefits information (these discussions may occur in areas where care is delivered).
- Make available, distribute, and display communication materials, including in areas where care is being delivered.
- Provide or make available plan marketing materials and enrollment forms outside of the areas where care is delivered, such as common entryways; vestibules; hospital or nursing home cafeterias; and community, recreation, or conference rooms.
- Refer patients to other sources of information, such as State Health Insurance Assistance Programs (SHIPs), plan marketing representatives, their state Medicaid office, local Social Security office, CMS' website (www.Medicare.gov) or 1-800-MEDICARE.

Community First is responsible for including certain CMS Medicare Advantage-related provisions in the policies and procedures distributed to the Providers that constitute Community First's health services delivery network. The table on the following page summarizes these provisions, which can be accessed online by viewing the Code of Federal Regulations on the U.S. Government Printing Office website (ecfr.gov):

Summary of CMS Requirements	CFR42 (Section)
Safeguard privacy and maintain records accurately and timely	422.118
Permanent “out of area” Members to receive benefits in continuation area	422.54(b)
Prohibition against discrimination based on health status	422.110(a)
Pay for emergency and urgently needed services	422.100(b)
Pay for renal dialysis for those temporarily out of a service area	422.100(b)(1)(iv)
Direct access to mammography and influenza vaccinations	422.100(g)(1)
No copay for influenza and pneumococcal vaccines	422.100(g)(2)
Agreements with Providers to demonstrate “adequate” access	422.112(a)(1)
Direct access to women’s specialists for routine and preventive services	422.112(a)(3)
Services available 24 hours a day, seven days a week	422.112(a)(7)
Adhere to CMS marketing provisions	422.80(a), (b), (c)
Ensure services are provided in a culturally competent manner	422.112(a)(8)
Maintain procedures to inform Members of follow-up care or provide training in self-care as necessary	422.112(b)(5)
Document in a prominent place in the medical record if the individual has executed an advance directive	422.128(b)(1)(ii)(E)
Provide services in a manner consistent with professionally recognized standards of care	422.504(a)(3)(iii)
Continuation of benefits provisions (may be met in several ways, including contract provision)	422.504(g)(2)(i); 422.504(g)(2)(ii); 422.504(g)(3)
Payment and incentive arrangements specified	422.208
Subject to applicable federal laws	422.504(h)
Disclose to CMS all information necessary to (1) administer and evaluate the program, (2) establish and facilitate a process for current and prospective beneficiaries to exercise choice in obtaining Medicare services	422.64(a): 422.504(a)(4) 422.504(f)(2)
Must make a good faith effort to notify all affected Members of the termination of a Provider contract 30 calendar days before the termination by plan or Provider	422.111(e)
Submit data and medical records and certify completeness and truthfulness	422.310(d)(3)-(4), 422.310(e), 422.504(d)-(e), 422.504(i)(3)-(4), 422.504(l)(3)
Comply with medical policy, quality improvement, and medical management	422.202(b); 422.504(a)(5)
Disclose to CMS quality and performance indicators for plan benefits (i.e., disenrollment rates for beneficiaries enrolled in the plan for the previous two years)	422.504(f)(2)(iv)(A)
Disclose to CMS quality and performance indicators for the benefits under the plan regarding enrollee satisfaction	422.504(f)(2)(iv)(B)
Disclose to CMS quality and performance indicators for the benefits under the plan regarding health outcomes	422.504(f)(2)(iv)(C)
Notify Providers in writing for the reason of denial, suspension, and/or termination	422.202(d)(1)
Provide 60-day notice (terminating a contract without cause)	422.202(d)(4)
Comply with federal laws and regulations including, but not limited to, federal criminal law, the False Claims Act (31 U.S.C. et Seq.), and the anti-kickback statute (section 1128B(b) of the act)	422.504(h)(1)
Prohibition of use of excluded practitioners	422.752(a)(8)
Adhere to appeals/grievance procedures	422.562(a)