



PruittHealth
PREMIER



Provider Manual

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PruittHealth Premier HMO SNP

Institutional Special Needs Plan

PruittHealth Premier HMO SNP (“health plan” or “Plan”) is a Medicare Advantage Institutional Special Needs Plan designed to improve the care for the residents of PruittHealth, Inc. Nursing Facilities in Georgia. PruittHealth Premier’s target population is an institutionalized Medicare beneficiary who resides or is expected to reside in a PruittHealth Premier contracted long-term care (LTC) facility for 90 days or longer.

Dual Eligible Special Needs Plan

PruittHealth Premier also operates a Dual Eligible Special Needs Plan (DSNP) in Clarke County, Georgia. The DSNP is designed to improve the care of community-based residents who reside in Clarke County and who are eligible for Medicare and receive Medicaid in the state of Georgia.

Model of Care – ISNP

PruittHealth Premier’s Model of Care organizes best practices and industry innovations such as the PCP/NFist-Nurse Practitioner care team providing onsite, facility-based primary health care support; a risk-assessment tool designed for a geriatric, nursing home patient population; a comprehensive history and physical assessment that drives an Individualized Care Plan (ICP); a care management platform that helps identify needed preventive health/HEDIS services, ensures the use of evidence based guidelines, and facilitates care team communications for care coordination; and frequent face-to-face member and caregiver/family member interactions that identify member care preferences and allow time for important care decision discussions and counseling.

The Model of Care facilitates the early assessment and identification of health risks and major changes in the health status of members with complex care needs, and the coordination of care to improve members overall health. PruittHealth Premier’s Institutional Special Needs Plan (I-SNP) Model of Care has the following goals:

- Improve access to medical, mental health, and social services;
- Improve access to affordable care;
- Improve coordination of care through an identified point of contact;
- Improve transitions of care across healthcare settings and providers;
- Improve access to preventive health services;
- Assure appropriate utilization of services; and
- Improve member health outcomes.

Importantly, the Model of Care focuses on the individual I-SNP member. I-SNP members receive a comprehensive health risk assessment initially and annually thereafter. Based on this assessment, an individualized care plan is developed, based on evidenced-based clinical protocols. An interdisciplinary care team, which includes practitioners of various disciplines and specialties based on the needs of the member, is responsible for care management. The member may participate in this process, as may all of their healthcare providers. The individual care plan is stored centrally so that it can be shared with all members of the interdisciplinary care team, as indicated. All providers are encouraged to participate in the I-SNP Model of Care and interdisciplinary care teams.

PruittHealth Premier uses a data-driven process for identifying the frail/disabled, multiple chronic illnesses and those at the end of life. Risk stratification and protocols for intervention around care coordination, barriers to care, primary care givers, education, early detection, and symptom management are also components of the Model of Care. Based on the needs of Plan members, a specialized provider network is available to assure appropriate access to care, complementing each member's primary care provider.

The NFist is an important and unique part of PruittHealth Premier's provider network. A NFist is a physician who is (1) contracted with PruittHealth Premier, (2) licensed to practice allopathic (MD) or osteopathic (DO) medicine, and (3) is responsible for providing primary care services for PruittHealth Premier members in the Nursing Facility (NF) or Skilled Nursing Facility (SNF) setting, including coordination and management of the delivery of all covered services.

The PruittHealth Premier NFist model ensures that every member has direct access to primary care services onsite in the nursing facility and that the member's primary care physician (PCP)/NFist has experience understanding the special needs of nursing facility residents. NFists provide regular patient care services in the nursing home facilities, working to streamline care and minimize the need for transfers out of the facility for ambulatory services. They work directly with the PruittHealth Premier Nurse Practitioners to provide and oversee all aspects of member care including evaluating, recommending or providing treatments to optimize health status. When possible and clinically appropriate, NFists may decide to treat some acute exacerbations or conditions in place in the nursing facility rather than transferring the member to an external site of care, such as an acute care hospital or emergency room.

PruittHealth Premier uses a gatekeeper model, meaning that all specialist referrals and certain diagnostic tests require a referral to be obtained from a PCP/NFist prior to engaging the specialist or performing the diagnostic test.

All members are required to choose or designate a PCP/NFist at enrollment. PruittHealth Premier members are able to choose their PCP/NFist from the list of contracted NFists maintained and published by PruittHealth Premier. Members are able to change their PCP/NFist at any time. Physicians contracted as NFists and available to be chosen as a primary care physician with PruittHealth Premier are clearly identified in PruittHealth Premier's member materials, including the Provider Directory as credentialed at time of publication.

PruittHealth Premier's evidenced-based Model of Care includes the following components:

- The clinical team provides integrated health care management with a strong primary and preventive care focus to treat acute and chronic conditions.
- All members receive a comprehensive history and physical exam and care plan within 90 days of enrollment and comprehensive visits at least once a month, thereafter.
- Nurse Practitioners utilize a health risk assessment tool that rates each member's medical condition as low, moderate, or high.
- Risk scores dictate the Nurse Practitioner's clinical visit/monitoring schedule.
- A risk score framework is used at each clinical visit/monitoring and tracked over time.
- An individualized plan of care having goals and measurable outcomes specific to the targeted special needs of each member is developed.
- An interdisciplinary care team is formed for each member.

- Access to a specialized provider network having expertise pertinent to the targeted special needs of the member population.
- A medication therapy management program.
- Demonstrated cultural competency among staff and providers.
- Members and their caregivers/families engaged in decision making at all times.
- Member and caregiver/family participation in Plan policy and operations through surveys and formal feedback.

Execution of the I-SNP Model of Care is supported by systems and processes to share information between the health plan, healthcare providers and the member. The I-SNP Model of Care includes periodic analysis of effectiveness, and all activities are supported by the Quality Improvement Program.

Model of Care – DSNP

PruittHealth Premier’s care model offers the potential to decrease the fragmentation in service delivery for its enrolled dually-eligible beneficiaries who are frail, vulnerable and have complex needs, by addressing and integrating the full range of medical, functional and behavioral needs in a coordinated and member-centric manner. This means putting the Member’s preferences at the center of the care planning process and leveraging provider resources to ensure every Member receives the services necessary to achieve their short- and long-term goals. Implementation of this integrated care model will enable PruittHealth Premier to meet the varying and complex needs of the institutional dual beneficiary population; offer seamless delivery of the full range of medical, functional and behavioral services in a coordinated and member-centric manner; and streamline administrative functions for both Members and providers.

PruittHealth Premier’s model organizes best practices such as the PCP and Plan Case Manager (RN) care team providing clinical care and support through: a risk-assessment tool designed for the long-term care patient population; a comprehensive history and physical assessment that drives an Individualized Care Plan (ICP); a care management platform that helps identify needed preventive health/HEDIS services, ensures the use of evidence based guidelines, and depending on where the member lives, either the facilitates care team or community based case manager for care coordination. Additionally, there will be frequent face-to-face Member and caregiver/family member interactions that identify Member care preferences and allow time for important care decision discussions and counseling.

Specific goals of the Plan will include:

- Ensuring Members receive the highest quality of care and services
- Ensuring Members have full access to care and availability of primary care physicians and specialists
- Improved coordination / continuity of care and access to essential services across all healthcare settings, providers and health services
- Improved communication between providers/stakeholders involved in Members’ care
- Improved health outcomes
- Improved access to preventive health services
- Improved medication compliance and regimens
- Improved care transitions
- Preventing avoidable emergency room and inpatient admissions
- Avoiding service duplication and reducing unnecessary services
- Preventing fraud and abuse within the system

- Ensuring caregivers receive necessary support to continue their ability to care for the member

Onsite Primary Care Services: PCP Role

The PCP will be an important—and unique—part of the Plan’s provider network. For the purposes of the PruittHealth Premier Model of Care, a PCP is a physician who is (1) contracted with the Plan, (2) licensed to practice allopathic (MD) or osteopathic (DO) medicine, and (3) is responsible for providing primary care services for Plan-enrolled Members. The PCP will work alongside of the Plan Case Manager who will be responsible for the coordination and management of other covered services that occur in alternative care settings, like the hospital.

The Plan will contract with PCPs who are engaged in general practice, family practice, or internal medicine. In some cases, the Plan may contract with internal medicine physicians who also hold a subspecialty board certification in a specialty relevant to the Plan’s Member population, including pulmonology and cardiology.

The Plan PCP model will ensure that every Member has direct access to primary care services with a physician who has experience understanding the special needs of long-term care patients.

PCPs will provide regular patient care services to members, working to streamline care and minimize the need for transfers to acute and post-acute settings, when avoidable. They will work directly with Plan Case Manager to provide and oversee all aspects of Member care including evaluating, recommending or providing treatments to optimize health status. When possible and clinically appropriate, PCPs may decide to treat some acute exacerbations or conditions in place rather than transferring the Member to an external site of care, such as an acute care hospital or emergency room.

All Members will be required to choose or designate a primary care physician on enrollment. Plan Members will be able to choose their primary care physician from the list of contracted PCPs maintained and published by the Plan. Members will be able to change their primary care physician at any time. Physicians contracted and available to be designated as a primary care physician with the Plan will be clearly identified in the Plan’s Member materials. In the event that a Member does not designate the primary care physician on their CMS-approved Plan enrollment form, the Plan will assign a PCP to the Member as their designated primary care physician. PCPs will be assigned based on geographic location and provider availability within the service area.

PCPs will be required to provide routine and preventive visits for all Plan Members, regardless of risk level, at least annually. Urgent and emergent issues will be addressed immediately. Emergent or urgent issues requiring services or expertise not available, will be addressed with transfer of the Member to an acute care hospital or emergency room able to provide the needed care.

The expectation and the Plan’s contracting strategy will be to work with PCPs whose practice primarily focuses on long-term care patients, meaning that most PCPs are aware of the ongoing needs of the membership, making them more willing to be accessible for Members, Members’ caregivers/families, and the ICT as a whole.

In the Plan’s MOC, the PCP will be providing the routine medical care for members and the Plan Case Manager, in conjunction with the ICT, will assure the requisite clinical services will be provided in the appropriate setting and in compliance with the ICP. Working as a team, the ICT PruittHealth Premier (HMO SNP Plan)

will participate in the ICP process and work closely with the Member, and/or their caregiver, as appropriate, to discuss needed services, provide follow-up to ensure services have been received, and to discuss conditions that might require additional services.

MEMBER INFORMATION

Member Identification & Eligibility

All participating providers are responsible for verifying a member's eligibility at each and every visit. Please note that membership data is subject to change. The Centers for Medicare and Medicaid Services (CMS) retroactively terminates members for various reasons. When this occurs, the PruittHealth Premier claim recovery unit will request a refund from the provider. The provider must then contact CMS Eligibility to determine the member's actual benefit coverage for the date of service in question.

Each member is provided with an individual membership identification card. Noted on the ID card is the member's identification number, plan code, name of PCP, co-payment, and effective date. If the member does not have an ID card, you must verify eligibility either telephonically or through the Provider Web Portal (see below).

Providers should always verify member eligibility prior to the appointment. PruittHealth Premier should have the most current eligibility information. You can verify member eligibility through the following ways:

- Member ID Card: Note that changes do occur and the card alone does not guarantee member eligibility.
- Provider Web Portal: The PruittHealth Premier web portal allows providers to verify eligibility online 24/7 at www.pruitthealthpremier.com.
- Telephonically: Please call the Member Services Department at (844) 224-3659.

Maximum Out-of-Pocket (MOOP)

PruittHealth Premier members have a Maximum Out-of-Pocket (MOOP) benefit--a limit on the amount they will be required to pay out-of-pocket each year for medical services which are covered under Medicare Part A and Part B. Once this maximum out-of-pocket expense has been reached, the member is no longer responsible for any out-of-pocket expenses, including any cost shares, for the remainder of the year for covered Part A and Part B services (excluding the members' Medicare Part B premium and PruittHealth Premier Plan premium).

Member Hold Harmless

Participating providers are prohibited from balance billing PruittHealth Premier members including, but not limited to, situations involving non-payment by PruittHealth Premier, insolvency of PruittHealth Premier, or PruittHealth Premier's breach of its Agreement. Providers shall not bill, charge, collect a deposit from, seek compensation or reimbursement from, or have any recourse against members or persons, other than PruittHealth Premier, acting on behalf of members for Covered Services provided pursuant to the participating Provider's Agreement. The provider is not, however, prohibited from collecting co-payments, co-insurances or deductibles for covered services in accordance with the terms of the applicable member's Benefit Plan.

Member Confidentiality & Privacy

PruittHealth Premier (HMO SNP Plan)

At PruittHealth Premier, we know our members' privacy is extremely important to them and we respect their right to privacy when it comes to their personal information and health care. PruittHealth Premier is committed to protecting our members' personal information. PruittHealth Premier does not disclose member information to anyone without obtaining consent from an authorized person(s), unless we are permitted to do so by law. As a valued provider to PruittHealth Premier, we want you to know the steps we have taken to protect the privacy of our members including how we gather and use their personal information. PruittHealth Premier's privacy practices apply to all of PruittHealth Premier past, present, and future members.

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

PruittHealth Premier's members have additional rights over their health information. They have the right to:

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

As a Covered Entity under HIPAA, providers are required to comply with the HIPAA Privacy Rule and other applicable laws in order to protect member PHI.

Member Rights and Responsibilities

PruittHealth Premier Member Rights

The right to be treated with dignity and respect

Members have the right to be treated with dignity, respect and fairness at all times.

PruittHealth Premier must obey laws against discrimination that protect members from unfair treatment. These laws say that PruittHealth Premier cannot discriminate against members because of a person's race, disability, religion, gender, sexual orientation, health, ethnicity, creed, age, or national origin. If members need help with communication, such as a language interpreter, they should be directed to call the Member Services Department. The Member Services Department can also help members in filing complaints about access to facilities (such as wheel chair access). Members can also call the Office for Civil Rights at 1-800-368-1019 or TTY/TDD 1-800-537-7697, or the Office for Civil Rights in their area for assistance.

The right to the privacy of medical records and personal health information

There are federal and state laws that protect the privacy of member medical records and personal health information. PruittHealth Premier keeps members' personal health information private as required under these laws. Any personal information that a member gives PruittHealth Premier is protected. PruittHealth Premier staff will ensure that unauthorized people do not see or change member records. Generally, we will get written permission from the member (or the member's designated representative or power of attorney) before we can give member health information to anyone who is not providing the member's medical care. There are exceptions allowed or required by law, such as the release of health information to government agencies that are checking on the quality of care. The laws that protect member privacy give members rights related to getting information and controlling how their health information is used. PruittHealth Premier is required to provide members with a notice that tells them about these rights and explains how PruittHealth Premier protects the privacy of their health information. For example, members have the right to look at their medical records (there may be a fee charged for making copies). Members also have the right to ask plan providers to make additions or corrections to their medical records (if members ask plan providers to do this, they will review member requests and determine if the changes are appropriate). Members have the right to know how their health information has been given out and used for routine and non-routine purposes. If members have questions or concerns about the privacy of their personal information and medical records, they should be directed to call Member Services. PruittHealth Premier will release a member's information, including prescription drug event data, to Medicare, which may release it for research and other purposes that follow all applicable Federal statutes and regulations.

The right to see participating providers, get covered services, and get prescriptions filled in a timely manner

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

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

Members have the right to get full information from their providers when they receive medical care, and the right to participate fully in treatment planning and decisions about their health care. PruittHealth Premier's providers must explain things in a way that members can understand. Members have the right to know about all of the treatment choices that are recommended for their condition, including all appropriate and medically necessary treatment options, no matter what their cost or whether they are covered by PruittHealth Premier. This includes the right to know about the different Medication Management Treatment Programs PruittHealth Premier offers and those in which members may participate. Members have the right to be told about any risks involved in their care. Members must be told in advance if a proposed medical care or treatment is part of a research experiment and be given the choice of refusing experimental treatments.

Members have the right to receive a detailed explanation from PruittHealth Premier if they believe that a plan provider has denied care that they believe they are entitled to receive or care they believe they should continue to receive. In these cases, members must request an initial decision. Initial decisions are discussed in members' EOC.

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

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

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

If members decide that they want to have an advance directive, there are several ways to get this type of legal form. Members can get a form from their lawyer, from a social worker or from PruittHealth Premier. Forms may also be available from office supply stores or from organizations that give people information about Medicare. Regardless of where the form comes from it is a legal document. Members should consider having their lawyer help them prepare it. It is important to sign the form and keep a copy. Members should also give a signed copy of the form to their doctor, the facility and to the person they name on the form as the person to make decisions for them if they cannot. Members may want to give copies to family members and close friends as well. If members know in advance they are going to be hospitalized they should take a copy to the hospital. If members are admitted to the hospital, the hospital will ask them whether they have signed an advance directive form and whether they have it with them. If members have not signed an advance directive or do not have a signed copy with them during the admission, the hospital will have forms available and will ask if the member wants to sign one.

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

The right to make complaints

Members have the right to file a complaint if they have concerns or problems related to their care or coverage. Members or an appointed/authorized representative may file appeals or grievances regarding care or coverage determinations. If members make a complaint or file an appeal determination, PruittHealth Premier must treat them fairly and not discriminate against them because they made a complaint or filed an appeal or coverage determination. To obtain information relative to appeals, grievances or concerns and/or coverage determinations, members should be directed to call the Member Services Department.

The right to get information about their health care coverage and cost

The EOC tells members what medical services are covered, and what the member has to pay for. If members need more information, they should be directed to call the Member Services Department. Members have the right to an explanation from PruittHealth Premier about any medical services not covered by PruittHealth Premier. PruittHealth Premier must tell members in writing why PruittHealth Premier will not pay for or allow them to get a service and how they can file for an appeal to ask PruittHealth Premier to change the decision. If asked, staff should inform members on how to file an appeal and should direct members to review their EOC for more information about filing an appeal.

The right to get information about PruittHealth Premier, plan providers, drug coverage, and costs

Members have the right to get information about the PruittHealth Premier Plan and operations. This includes information about the Plan's financial condition, the services provided, and PruittHealth Premier's health care providers and their qualifications. Members have the right to find out from the Plan how doctors are paid. Members should be directed to call the Member Services Department for information. Member also have the right to get information from PruittHealth Premier about their Part D prescription coverage and the network pharmacies. Staff should instruct members to call the Member Services Department.

The right to obtain more information about members' rights

Members have the right to receive information about their rights and responsibilities. If members have questions or concerns about their rights and protections, they should be directed to call the Member Services Department. Members can also get free help and information from their State Health Insurance Assistance Program (SHIP). In addition, the Medicare program has written a booklet titled *Members Medicare Rights and Protections*. To get a free copy, members should be directed to call **1-800-MEDICARE (1-800-633-4227)**. TTY users should call **1-877-486-2048**. Members can call 24 hours a day, 7 days a week. Or members can visit www.medicare.gov on the web to order the booklet or print it directly from their computer.

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

If members think that they have been treated unfairly or their rights have not been respected, there are options.

- If members think they have been treated unfairly due to their race, color, national origin, disability, age, or religion, members should be encouraged to let PruittHealth Premier know immediately by calling the Member Services Department. They can also call the Office for Civil Rights in their area.
- For any other kind of concern or problem related to their Medicare rights and protections described in this section, members should be encouraged to call the Member Services Department. Members also can get help from their State Health Insurance Assistance Program (SHIP).

PruittHealth Premier Member Responsibilities

Along with certain rights, members of PruittHealth Premier also have responsibilities. Members are responsible for the following:

- To become familiar with their PruittHealth Premier coverage and the rules they must follow to get care as a member. Members can use their PruittHealth Premier EOC and other information provided to them to learn about their coverage, what PruittHealth Premier has to pay, and what rules they need to follow. Members should be encouraged to call the Member Services Department if they have questions or complaints.
- To advise PruittHealth Premier if they have other insurance coverage.
- To notify providers when seeking care that they are enrolled with PruittHealth Premier and to present their plan enrollment card to providers unless it is an emergency.
- To give their doctors and other providers the information they need to provide care for them and to follow the treatment plans and instructions that they and their doctors agree upon. Members must be encouraged to ask questions of their doctors and other providers whenever the member has them.
- To act in a way that supports the care given to other patients and helps the smooth running of their doctor's office, hospitals, and other offices.
- To pay their plan premiums and any other co-payments or coinsurance they may have for the Covered Services they receive. Members must also meet their other financial responsibilities that are described in their EOC.
- To let PruittHealth Premier know if they have any questions, concerns, problems, or suggestions regarding their rights, responsibilities, coverage and/or PruittHealth Premier operations.
- To notify PruittHealth Premier and their providers of any address and/or phone number changes as soon as possible.
- To use their PruittHealth Premier Plan only to access services, medications and other benefits for themselves.

Advance Medical Directives

The Federal Patient Self-Determination Act ensures the patient's right to participate in health care decision-making, including decisions about withholding resuscitative services or declining/withdrawing life sustaining treatment. In accordance with guidelines established by CMS, HEDIS requirements, and the Plan's own policies and procedures, PruittHealth Premier

requires all participating providers to have a process in place pursuant to the intent of the Patient Self Determination Act. All providers contracted directly or indirectly with PruittHealth Premier may be informed by the member that the member has executed, changed, or revoked an advance directive. At the time a service is provided, the provider should ask the member to provide a copy of the advance directive to be included in his/her medical record. If the PCP/NFist and/or treating provider cannot as a matter of conscience fulfill the member's written advance directive, he/she must advise the member and PruittHealth Premier. PruittHealth Premier and the PCP/NFist and/or treating provider will arrange for a transfer of care.

Participating providers may not condition the provision of care or otherwise discriminate against an individual based on whether the individual has executed an advance directive. However, nothing in the Patient Self-Determination Act precludes the right under state law of a provider to refuse to comply with an advance directive as a matter of conscience. To ensure providers maintain the required processes to advance directives, PruittHealth Premier conducts periodic patient medical record reviews to confirm that required documentation exists.

Benefits and Services

All PruittHealth Premier members receive benefits and services as defined in their EOC.

PruittHealth Premier encourages its members to call their PCP to schedule appointments. However, if a PruittHealth Premier member calls or comes to a provider's office for an unscheduled non-emergent appointment, please attempt to accommodate the member and explain to them your office policy regarding appointments. If this problem persists, please contact PruittHealth Premier.

Emergent and Urgent Services

PruittHealth Premier follows the Medicare definitions of "emergency medical condition", "emergency services," and "urgently-needed services" as defined in the Medicare Managed Care Manual Chapter 4 Section 20.2:

- Emergency medical condition: "a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:
 - Serious jeopardy to the health of the individual or, in the case of a pregnant woman, the health of the woman or her unborn child;
 - Serious impairment to bodily functions; or
 - Serious dysfunction of any bodily organ or part."
- Emergency services: "covered inpatient and outpatient services that are furnished by a provider qualified to furnish emergency services; and needed to evaluate or treat an emergency medical condition."
- Urgently-needed services: "covered services that are not emergency services as defined above but are medically necessary and immediately required as a result of an unforeseen illness, injury, or condition; are provided when the member is temporarily absent from the plan's service area; or under unusual and extraordinary circumstances, when the member is in the service area and the network is temporarily unavailable or inaccessible; and it was not reasonable given the circumstances to wait to obtain the services through the Plan network."

The PruittHealth Premier network includes multiple hospitals, emergency rooms, and providers able to treat the emergent and urgent conditions of PruittHealth Premier members twenty-four (24) hours a day, seven (7) days a week. For urgent and emergent issues that occur onsite in the member's nursing home or in the community service area, the PCP is responsible for providing, directing, or authorizing a member's urgent or emergent care—including urgent or emergent services provided onsite in the nursing facility ("treatment in place.") The PCP or his/her designee must be available 24 hours a day, 7 days a week to assist members needing emergent or urgent services.

Emergent or urgent issues requiring services or expertise not available onsite in the member's nursing home will be addressed with transfer of the member to an acute care hospital or emergency room able to provide the needed care. The PCP, working with the Plan Nurse Practitioner (ISNP) or Case Manager within the DSNP, is responsible for coordinating the transition of the member to the hospital or emergency room, including communicating with the hospital or emergency room about the Member. Members have a co-payment responsibility for outpatient emergency visits unless an admission results.

While most members remain in the service area, PruittHealth Premier members may receive emergency services and urgently needed services from any provider, regardless of whether services are obtained within or outside the PruittHealth Premier authorized service area and/or network and regardless of whether there is prior authorization for the services. For emergency services outside the service area, PruittHealth Premier will pay reasonable charges for emergency services received from non-participating providers, if a member is injured or becomes ill while temporarily outside the service area. Members may be responsible for a co-payment for each incident of outpatient emergency services at a hospital's emergency room or urgent care facility.

PruittHealth Premier's network includes contracts with ambulance transport services when an ambulance is required for member safety. In cases where ambulance services are dispatched through 911 or a local equivalent and the ambulance provider is not contracted with PruittHealth Premier, the Plan follows Medicare rules on coverage for ambulance services as set forth in 42 CFR 410.40.

Continuing or Follow-Up Treatment

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

Excluded Services

In addition to any exclusions or limitations described in the members' EOC, the following items and services are not covered under the Original Medicare Plan or by PruittHealth Premier:

- Services that are not reasonable and necessary, according to the standards of the Original Medicare Plan, unless these services are otherwise listed by PruittHealth Premier as a covered service.

- Experimental or investigational medical and surgical procedures, equipment, and medications, unless covered by the Original Medicare Plan or unless, for certain services, the procedures are covered.
- Orthopedic shoes, unless they are part of a leg brace and included in the cost of the brace (exception: orthopedic or therapeutic shoes are covered for people with diabetic foot disease).
- Supportive devices for the feet (exception: orthopedic or therapeutic shoes are covered for people with diabetic foot disease).
- Hearing aids and routine hearing examinations unless otherwise specified in the EOC.
- Eyeglasses, with the exception of after cataract surgery, routine eye examinations, radial keratotomy, LASIK surgery, vision therapy, and other low vision aids and services, unless otherwise specified in the EOC.
- Self-administered prescription medication for the treatment of sexual dysfunction, including erectile dysfunction, impotence, and anorgasmia or hyporgasmia unless otherwise included in the member's Part D benefit. Please see the formulary for details.
- Reversal of sterilization measures, sex change operations, and non-prescription contraceptive supplies.
- Acupuncture.
- Naturopathic services.
- Services provided to veterans in Veterans Affairs (VA) facilities. However, in the case of emergency situations received at a VA hospital, if the VA cost sharing is more than the cost sharing required under the Plan, the Plan will reimburse veterans for the difference. Members are still responsible for the Plan cost-sharing amount.
- Any of the services listed above that are not covered will remain not covered even if received at an emergency facility. For example, non-authorized, routine conditions that do not appear to a reasonable person to be based on a medical emergency are not covered if received at an emergency facility.

Grievance & Appeal Process

All telephone complaints received by PruittHealth Premier's the Member Services Department will be resolved on an informal basis, except for complaints that involve "appealable" issues. These appealable issues will be placed in either the expedited or standard appeals process. In situations where a member remains dissatisfied with the informal resolution, the member must submit, in writing, a request for reconsideration of the informal resolution. All other written letters of complaint received by PruittHealth Premier will be logged in the Plan's tracking system

and automatically placed within either the appeal or grievance process, whichever is appropriate.

Members of PruittHealth Premier have the right to file a complaint, also called a grievance, about problems they observe or experience with the health plan. Situations for which a grievance may be filed include but are not limited to:

- Complaints about services in an optional Supplementary Benefit package
- Complaints regarding issues such as waiting times, physician behavior or demeanor, and adequacy of facilities and other similar member concerns
- Involuntary disenrollment situations
- Complaints concerning the quality of services a member receives

Members of PruittHealth Premier have the right to appeal any decision about PruittHealth Premier's failure to provide what they believe are benefits contained in the basic benefit package.

These include:

- Reimbursement for urgently needed care outside the service area or Emergency Services worldwide
- A denied claim for any other health services furnished by a non-participating provider or supplier they believe should have been provided, arranged for, or reimbursed by PruittHealth Premier
- Services they have not received, but believe are the responsibility of PruittHealth Premier to pay for
- A reduction in or termination of service a member feels are medically necessary

In addition, a member may appeal any decision to discharge them from the hospital. In this case, a notice will be given to the member with information about how to appeal and the member will remain in the hospital while the decision is reviewed. The member will not be held liable for charges incurred during this period regardless of the outcome of the review. Please refer to the PruittHealth Premier EOC for additional information.

Continuity of Care

PruittHealth Premier's policy is to provide for continuity and coordination of care with medical practitioners treating the same patient, and coordination between medical and behavioral health services. When a practitioner leaves PruittHealth Premier's network and a member is in an active course of treatment, PruittHealth Premier will attempt to minimize any disruption in care by potentially offering continuity of care services with the current provider for a reasonable period of time. In addition, members undergoing active treatment for a chronic or acute medical condition will have access to the exiting provider through the current period of active treatment or a maximum of 90 calendar days, whichever is shorter. If the Plan terminates a participating provider, PruittHealth Premier will work to transition a member into care with a Participating Physician or other provider within PruittHealth Premier's network. PruittHealth Premier is not responsible for the health care services provided by the terminated provider following the date of termination under such circumstances. PruittHealth Premier also recognizes that new members join the health plan and may have already begun treatment with a provider who is not in PruittHealth Premier's network. Under these circumstances, PruittHealth Premier will work to

coordinate care with the provider by identifying the course of treatment already ordered and offering the member a transition period of up to 90 calendar days to complete the current course of treatment.

PruittHealth Premier will honor plans of care (including prescriptions, DME, medical supplies, prosthetic and orthotic appliances, and any other on-going services) initiated prior to a new member's enrollment for a period of up to 90 calendar days or until the responsible party evaluates the member and establishes a new plan of care.

PROVIDER INFORMATION - ISNP

PruittHealth Premier provides a PCP/NFist-driven care model engaging dedicated medical providers physically located at the contracted nursing facilities to enhance and provide bedside care management and coordination. A NFist is a physician who is (1) contracted with PruittHealth Premier, (2) licensed to practice allopathic (MD) or osteopathic (DO) medicine, and (3) is responsible for providing primary care services for PruittHealth Premier enrolled members in the nursing home or SNF setting, including coordination and management of the delivery of all covered services.

The PCP/NFist is supported by Nurse Practitioners with appropriate certification and qualifications for the population to be managed.

Providers Designated as Primary Care Physicians (PCPs or NFists)

Each PruittHealth Premier member must select a PruittHealth Premier participating primary care physician (PCP or NFist) at the time of enrollment. PruittHealth Premier members will be able to choose their primary care physician from the list of contracted physicians maintained and published by PruittHealth Premier. Members will be able to change their primary care physician at any time. Physicians contracted as PCP/NFists and available to be chosen as a primary care physician with PruittHealth Premier will be clearly identified in PruittHealth Premier's member materials, including the Provider Directory.

PruittHealth Premier will contract for PCP/NFist services with physicians who are engaged in general practice, family practice, or internal medicine. In some cases, PruittHealth Premier may contract with internal medicine physicians who also hold a subspecialty board certification in a specialty relevant to PruittHealth Premier's member population, including pulmonology and cardiology.

The PruittHealth Premier PCP/NFist model will ensure that every member has direct access to primary care services onsite in the nursing facility and that the member's primary care physician has experience understanding the special needs of nursing facility residents.

The Role of the Primary Care Physician (PCP) / NFist

PCP/NFists will provide regular patient care services in the nursing home facilities, working to streamline care and minimize the need for transfers out of the facility for ambulatory services. They will work directly with the PruittHealth Premier Nurse Practitioners to provide and oversee all aspects of member care including evaluating, recommending or providing treatments to optimize members' health status. When possible and clinically appropriate, PCP/NFists may decide to treat some acute exacerbations or conditions in place in the nursing facility rather

than transferring the member to an external site of care, such as an acute care hospital or emergency room.

PCP/NFists will be key participants in the member's interdisciplinary care team, directly supervise Plan mid-level care, and be accountable for all care decisions for members assigned to them. Additionally, all PCP/NFists will be required to participate in quarterly caregiver/family meetings with members. The PCP/NFist is responsible for managing all of the health care needs of a PruittHealth Premier member as follows:

- Manage the health care needs of PruittHealth Premier members who have chosen the physician as their PCP/NFist
- Ensure that members receive treatment as frequently as is necessary based on the member's condition
- Develop an individual treatment plan for each member
- Submit accurate and timely claims and encounter information for clinical care coordination
- Comply with PruittHealth Premier's prior authorization and referral procedures
- Refer members to appropriate PruittHealth Premier participating providers
- Comply with PruittHealth Premier's Quality Management and Utilization Management programs
- Participate in PruittHealth Premier's Comprehensive Geriatric Exam and Health Risk Assessment
- Use appropriate designated ancillary services
- Comply with emergency care procedures
- Comply with PruittHealth Premier access and availability standards as outlined in this manual, including after-hours care
- Submit claims to PruittHealth Premier on the CMS 1500 claim form or electronically in accordance with PruittHealth Premier billing procedures
- Ensure that, when submitting claims for services provided, coding is specific enough to capture the acuity and complexity of a member's condition and ensure that the codes submitted are supported by proper documentation in the medical record
- Comply with Preventive Screening and Clinical Guidelines
- Adhere to PruittHealth Premier's medical record standards as outlined in this manual

The Role of the Nurse Practitioner

The Certified Nurse Practitioner (Nurse Practitioner), in collaboration and consultation with PCP/NFists, physicians, staff RN's and other health care professionals, provides holistic, compassionate care to members and families and provides care coordination and care management activities on behalf of PruittHealth Premier. The Nurse Practitioner practices within the context of collaborative management with a physician(s) in diagnosing, managing, and preventing acute and chronic illness and disease, and promoting wellness. Nurse Practitioners have an advanced nursing practice that includes independent nursing functions based on nursing standards of care and a role in medical management working within a collaborative agreement with a physician(s). The Nurse Practitioner's role includes:

- On-site primary care support
- Assessment, care planning, and communication
- Medication review and monitoring

- Early identification and treatment of symptoms

PruittHealth Premier’s Nurse Practitioners offer:

- Coordinated care and more personal attention
- One point of contact for communication with the member, their caregiver/family, the doctors, and nursing staff
- Clinician visits based on need—at least once a month, but may be weekly, depending on member need
- Frequent visits to help avoid unnecessary and often unwanted trips to the hospital
- Completion of tests and treatments in the nursing home that are normally done in the hospital. For example, Nurse Practitioners will help avoid sometimes-traumatic hospitalizations because they can provide clinical oversight in the nursing home for treatments often done in the hospital (like IV diuretic therapy for congestive heart failure patients)

The Nurse Practitioner will function as an in-the-field case manager and provide protocol driven primary care medicine. Upon member enrollment into the Plan, the Nurse Practitioner will conduct a comprehensive face-to-face history and physical, develop a plan of care with interventions based on the member’s acuity at that point in time, and direct the Interdisciplinary Care Team (ICT). A regular presence in the nursing facility, the Nurse Practitioner, supported by the PCP/NFist and ICT, will actively monitor the member’s condition and proactively treat chronic conditions

The Nurse Practitioner will work with the member to assure that the member has access to the following services as needed:

- Range of Choices - The Nurse Practitioner will be instrumental in ensuring access to a range of choices for members by helping the member identify formal as well as informal supports and services, and ensuring that the services are culturally appropriate as well as accessible. Interpreter services, if needed, will be available for all enrolled members.
- Coordination with the PCP/NFist and Specialists - The Nurse Practitioner will work with the member and PCP/NFist in accessing appropriate specialty care. The Nurse Practitioner also will facilitate periodic preventive care and alert the PCP/NFist to changes in the member’s health status or concerns as appropriate. The Nurse Practitioner will facilitate communication and collaboration between primary care, specialists and mental health/substance abuse in support of a comprehensive and unified individualized care plan.
- Assessment for Understanding of Treatment Plan and Medications – The Nurse Practitioner will assess the member’s ability to understand their medications and ability to follow their prescribed plan. If issues are identified, the Nurse Practitioner will assess the barrier and facilitate care and communication.
- Identification of Special Needs and Referrals to Specialists - The Nurse Practitioner will help the member identify medical issues and functional problems such as poly- pharmacy issues, lack of social supports and high-risk health conditions and assist the member in obtaining necessary services to meet identified needs.
- Coordination of Transitions between Care Settings - The Nurse Practitioner will be an integral connection when the member moves from one care setting to another. This function will be essential to providing a smooth and safe transition.

PROVIDER INFORMATION - DSNP

PruittHealth Premier provides primary care that will be provided by the Plan's PCPs and Plan Case Manager in close coordination with other key clinical staff. Specialty physicians will provide services in the most appropriate setting which may include the nursing facility or home when possible, with the Plan coordinating safe transport with handicap accessible transportation or, if required, by ambulance, for specialty services like dialysis.

Provider Network

The Plan's network of medical providers will be capable of providing the full scope of covered services needed for the Plan's enrolled Member population. In particular, the Plan's network will be prepared to address the special needs of members meeting the dual-eligible requirements including members with multiple chronic conditions and on complicated medication regimens, and Members identified as high risk for hospitalization.

The Plan will have contracts in place for the following health care and specialty services to meet the needs of its enrolled Member population:

- Primary care providers (PCPs)
- Mid-level practitioners (NPs) to support primary care
- Registered Nurses (RNs)
- Acute care hospitals
- Skilled and Long-Term Care Nursing Facilities (SNF and NF)
- Key specialists with expertise in treating chronic conditions of the SNP population, including but not limited to:
 - Cardiologists
 - Pulmonologists
 - Endocrinologists
 - Nephrologists
 - Oncologists
 - Neurologists
 - Gastroenterologists
 - Psychiatrists
 - Psychologists
 - Rheumatologists
 - Urologists
 - Podiatrists
 - Orthopedists
 - Surgeons including general, vascular, cardio-thoracic, and orthopedic
 - Pharmacies
 - Pharmacists (including on-site pharmacy support from the Plan pharmacists)
 - Rehabilitation therapy specialists (physical therapists, occupational therapists, and speech therapists)
 - Hospice providers
 - Laboratory services
 - Radiography facilities
 - Home Health providers
 - Durable medical equipment providers

In addition to those providers directly contracted with the Plan, services will continue to be provided by the Community Based Care Providers and Nursing Facility staff (when appropriate) including social workers, therapists, and nursing professionals who engage in Member care and serve as part of the Integrated Care Team (ICT).

Providers Designated as Primary Care Physicians (PCPs)

Each PruittHealth Premier member must select a PruittHealth Premier participating primary care physician at the time of enrollment. PruittHealth Premier members will be able to choose their primary care physician from the list of contracted physicians maintained and published by PruittHealth Premier. Members will be able to change their primary care physician at any time. Physicians contracted as a PCP and available to be chosen as a primary care physician with PruittHealth Premier will be clearly identified in PruittHealth Premier's member materials, including the Provider Directory.

The Role of the Primary Care Physician (PCP) / NFist

The PCP will be an important—and unique—part of the Plan's provider network. For the purposes of the PruittHealth Premier Model of Care, a PCP is a physician who is (1) contracted with the Plan, (2) licensed to practice allopathic (MD) or osteopathic (DO) medicine, and (3) is responsible for providing primary care services for Plan-enrolled Members. The PCP will work alongside of the Plan Case Manager who will be responsible for the coordination and management of other covered services that occur in alternative care settings, like the hospital.

The Plan will contract with PCPs who are engaged in general practice, family practice, or internal medicine. In some cases, the Plan may contract with internal medicine physicians who also hold a subspecialty board certification in a specialty relevant to the Plan's Member population, including pulmonology and cardiology.

The Plan PCP model will ensure that every Member has direct access to primary care services with a physician who has experience understanding the special needs of long-term care patients.

PCPs will provide regular patient care services to members, working to streamline care and minimize the need for transfers to acute and post-acute settings, when avoidable. They will work directly with Plan Case Manager to provide and oversee all aspects of Member care including evaluating, recommending or providing treatments to optimize health status. When possible and clinically appropriate, PCPs may decide to treat some acute exacerbations or conditions in place rather than transferring the Member to an external site of care, such as an acute care hospital or emergency room.

All Members will be required to choose or designate a primary care physician on enrollment. Plan Members will be able to choose their primary care physician from the list of contracted PCPs maintained and published by the Plan. Members will be able to change their primary care physician at any time. Physicians contracted and available to be designated as a primary care physician with the Plan will be clearly identified in the Plan's Member materials. In the event that a Member does not designate the primary care physician on their CMS-approved Plan enrollment form, the Plan will assign a PCP to the Member as their designated primary care physician. PCPs will be assigned based on geographic location and provider availability within the service area.

PCPs will be required to provide routine and preventive visits for all Plan Members, regardless of risk level, at least annually. Urgent and emergent issues will be addressed

immediately. Emergent or urgent issues requiring services or expertise not available, will be addressed with transfer of the Member to an acute care hospital or emergency room able to provide the needed care.

The expectation and the Plan's contracting strategy will be to work with PCPs whose practice primarily focuses on long-term care patients, meaning that most PCPs are aware of the ongoing needs of the membership, making them more willing to be accessible for Members, Members' caregivers/families, and the ICT as a whole.

In the Plan's MOC, the PCP will be providing the routine medical care for members and the Plan Case Manager, in conjunction with the ICT, will assure the requisite clinical services will be provided in the appropriate setting and in compliance with the ICP. Working as a team, the ICT will participate in the ICP process and work closely with the Member, and/or their caregiver, as appropriate, to discuss needed services, provide follow-up to ensure services have been received, and to discuss conditions that might require additional services.

The Role of the Case Manager

The Plan Case Manager in collaboration with the PCP, will be responsible for developing a comprehensive ICP for the Member. The Plan Case Manager will collaborate with the ICT, Plan team and nursing facility staff (if applicable) as needed in the ICP development process. The Plan Case Manager's role will include:

- On-site primary care and social support
- Assessment, care planning, and communication
- Coordination of medication review and monitoring
- Early identification and treatment of symptoms or changes in condition

The Plan Case Manager will offer:

- Coordinated care and personal attention
- Primary point of contact for communication with the Member, their caregiver/family, the ICT
- Preventive visits to help avoid unnecessary and often unwanted trips to the hospital; preventive visits are based on risk level and include a minimum monthly contact and as frequently as once a week.
- As needed visits and contacts in follow up to acute exacerbations, change in condition, and other triggering events
- Care transition coordination

The Plan Case Manager will provide protocol driven primary care coordination. Upon beneficiary enrollment, the Plan Case Manager will conduct the initial health risk assessment, develop a plan of care with interventions based on the Member's acuity at that point in time, and coordinate the ICT. A regular presence in the life of the member, the Plan Case Manager will actively monitor the Member's condition and proactively work to ensure compliance with the treatment of chronic conditions.

The Plan Case Manager will work with the Member to assure that the Member has access to the following services as needed:

- Range of Choices - The Plan Case Manager will be instrumental in ensuring access to a range of choices for Members by helping the Member identify formal as well as informal supports and services, and ensuring that the services are culturally appropriate as well as accessible. Interpreter services, if needed, will be available for all enrolled Members.

- Coordination with the PCP and Specialists – The Plan Case Manager will work with the Member and PCP in accessing appropriate specialty care. The Plan Case Manager will also facilitate preventive care and alert the PCP and ICT to changes in the Member’s health status or concerns as appropriate. The Plan Case Manager will facilitate communication and collaboration between primary care, specialists and mental health/substance abuse in support of a comprehensive and unified individualized care plan.
- Assessment for Understanding of Treatment Plan and Medications – The Plan Case Manager will assess the Member’s ability to understand their medications and ability to follow their prescribed plan. If issues are identified, the Plan Case Manager will assess the barrier and facilitate care and communication.
- Identification of Special Needs and Referrals to Specialists - The Plan Case Manager will help the Member identify medical issues and functional problems such as poly-pharmacy issues, lack of social supports and high-risk health conditions and assist the Member in obtaining necessary services to meet identified needs and interventions.
- Coordination of Transition between Care Settings - The Plan Case Manager will be an integral connection when the Member moves from one care setting to another. This function will be essential to providing a smooth and safe transition between care settings.

The Plan Case Manager will help break down barriers that exist within a special needs population including but not limited to:

- Communication barriers
- Medical system barriers
- Cultural barriers
- Social and habilitation barriers

Communication Amongst Providers

- The PCP should provide the Specialist Physician with relevant clinical information regarding the member’s care.
- The Specialist Physician must provide the PCP with information about his/her visit with the member in a timely manner.
- The PCP must document in the member’s medical record his/her review of any reports, labs, or diagnostic tests received from a Specialist Physician.

GENERAL PROVIDER INFORMATION

All information contained below applies to all PruittHealth Premier providers, unless otherwise specified.

Provider Marketing Guidelines

The below is a general guideline to assist PruittHealth Premier providers, who have contracted with multiple Medicare Advantage plans and are accepting Medicare fee-for-service patients, in determining what marketing and patient outreach activities are permissible under the CMS guidelines. CMS has advised Medicare Advantage plans to prohibit providers from steering, or attempting to steer an undecided potential enrollee toward a specific plan, or limited number of plans, offered either by the plan sponsor or another sponsor, based on the financial interest of the provider or agent. Providers should remain neutral parties in assisting plans to market to beneficiaries or assisting in enrollment decisions.

Providers Can:

- Mail/call their patient panel to invite patients to general PruittHealth Premier sponsored educational events to learn about the Medicare and/or Medicare Advantage program. This is not a sales/ marketing meeting. No sales representative or plan materials can be distributed. Sales representative cards can be provided upon request.
- Mail a PruittHealth Premier affiliation letter one time to patients listing only PruittHealth Premier.
- Have additional mailings (unlimited) to patients about participation status but must list all participating Medicare Advantage plans and cannot steer towards a specific plan. This letter may not quote specific plan benefits without prior CMS approval and the agreement of all plans listed.
- Notify patients, in a letter, of a decision to participate in a PruittHealth Premier sponsored program.
- Utilize a physician/patient newsletter to communicate information to patients on a variety of subjects. This newsletter can have a PruittHealth Premier area to advise patients of PruittHealth Premier information.
- Provide objective information to patients on specific plan formularies, based on a patient's medications and health care needs.
- Refer patients to other sources of information, such as the State Health Insurance Assistance Programs, PruittHealth Premier marketing representatives, State Medicaid, or 1-800-Medicare to assist the patient in learning about the plan and making a healthcare enrollment decision.
- Display and distribute in provider offices PruittHealth Premier marketing materials, excluding application forms. The office must display or offer to display materials for all participating Medicare Advantage plans.
- Notify patients of a physician's decision to participate exclusively with PruittHealth Premier for Medicare Advantage or to close panel to original Medicare fee-for-service patients if appropriate.
- Record messages on PruittHealth Premier's auto dialer to existing PruittHealth Premier members as long as the message is not sales related or could be construed as steerage. The script must be reviewed by PruittHealth Premier Legal /Government Programs.
- Have staff dressed in clothing with the PruittHealth Premier logo.
- Display promotional items with the PruittHealth Premier logo.
- Allow PruittHealth Premier to have a room/space in provider offices completely separate from where patients receive health care services, to provide Medicare beneficiaries with access to a PruittHealth Premier sales representative.

Providers Cannot:

- Quote specific health plan benefits or cost share in patient discussions.
- Urge or steer towards any specific plan or limited set of plans.
- Collect enrollment applications in physician offices or at other functions.
- Offer inducements to persuade beneficiaries to enroll in a particular plan or organization.
- Health Screen potential enrollees when distributing information to patients, health screening is prohibited.
- Expect compensation directly or indirectly from the plan for beneficiary enrollment activity.
- Call members who are disenrolling from the health plan to encourage re-enrollment in a

health plan.

- Mail notifications of health plan sales meetings to patients.
- Call patients to invite patients to sales and marketing activity of a health plan.
- Advertise using PruittHealth Premier's name without PruittHealth Premier's prior consent and potentially CMS approval depending upon the content of the advertisement.

Member Assignment to New PCP

PruittHealth Premier PCPs have a limited right to request a member be assigned to a new PCP. A provider may request to have a member moved to the care of another provider due to the following behaviors:

- Fraudulent use of services or benefits.
- The member is disruptive, unruly, threatening or uncooperative to the extent that his/her membership seriously impairs PruittHealth Premier's or the provider's ability to provide services to the member or to obtain new members and the aforementioned behavior is not caused by a physical or behavioral health condition.
- Threats of physical harm to a provider and/or his/her office staff.
- Non-payment of required copayment for services rendered.
- Receipt of prescription medications or health services in a quantity or manner which is not medically beneficial or not medically necessary.
- Repeated refusal to comply with office procedures essential to the functioning of the provider's practice or to accessing benefits under the managed care plan.
- The member is steadfastly refusing to comply with managed care restrictions (e.g., repeatedly using the emergency room in combination with refusing to allow the managed care organization to coordinate treatment of the underlying medical condition).

The provider should make reasonable efforts to address the member's behavior which has an adverse impact on the patient/physician relationship, through education and counseling, and if medically indicated, referral to appropriate specialists.

If the member's behavior cannot be remedied through reasonable efforts, and the PCP feels the relationship has been irreparably harmed, the PCP should complete the Member Transfer Request form and submit it to PruittHealth Premier. PruittHealth Premier will research the concern and decide if the situation warrants requesting a new PCP assignment. If so, PruittHealth Premier will document all actions taken by the provider and PruittHealth Premier to cure the situation. This may include member education and counseling. A PruittHealth Premier PCP cannot request a disenrollment based on an adverse change in a member's health status or utilization of services medically necessary for treatment of a member's condition.

A member also may request a change in PCP for any reason. The PCP change that is requested by the member will be effective the first (1st) of the month following the receipt of the request, unless circumstances require an immediate change.

Provider Participation

Providers must be contracted with and credentialed by PruittHealth Premier or the entity under contract to perform credentialing services. PruittHealth Premier's Credentialing Program is compliant with all guidelines from the National Committee for Quality Assurance (NCQA), CMS

and State regulations as applicable. PruittHealth Premier takes ultimate responsibility for all services provided by contracted entities, terms of the contract, and fulfillment of all terms and conditions of its contract. PruittHealth Premier may agree to delegate credentialing to a provider organization so long as a) a Delegation Agreement is signed by both parties, and b) a delegation audit is conducted and found to be satisfactory.

Plan Notification Requirements for Providers

Participating providers must provide written notice to PruittHealth Premier no less than 10 days in advance of any changes to their practice or, if advance notice is not possible, as soon as possible thereafter.

The following is a list of changes that must be reported to PruittHealth Premier by contacting your Network Services Representative:

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

By providing this information in a timely manner, you will ensure that your practice is listed correctly in the Provider Directory. Please note, failure to provide up to date and correct information regarding your practice and the physicians that participate may result in the denial of claims for you and your physicians.

Closing Patient Panels

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

Access and Availability Standards for Providers

PruittHealth Premier has established written standards to ensure timeliness of access to care that meet or exceed the standards established by CMS, to ensure that all standards are

communicated to providers, to continuously monitor compliance with the standards, and to take corrective action as needed. Additionally, PruittHealth Premier requires that all providers offer standard hours of operation that (1) do not discriminate against Medicare enrollees and (2) are convenient for PruittHealth Premier members, the facilities where members reside, and facility staff who aid in member care (i.e. primary care physicians are expected to NOT provide routine visits at times that coincide with regular facility meal times, that may interfere with expected member sleep patterns by occurring before 8 am or after 8 pm, or that occur during nursing staff shift changes).

Timeliness of Access to Care

PruittHealth Premier members have access to care 24 hours a day, 7 days a week as medically necessary. PruittHealth Premier has the additional policies in place to make sure members have timely access to routine, preventive, and urgent care services.

- Primary care physicians—referred to by PruittHealth Premier as NFists (ISNP only)—are required to provide
 - Routine, preventive care and monitoring visits for their assigned members on-site at the member’s nursing facility residence every 60 days for all members and more frequently (every 30 days) for members identified as moderate or high risk.
 - Routine visits for non-urgent new onset symptoms or conditions or condition exacerbations within 1 week (7 days) on-site at member’s nursing facility residence.
 - Immediate urgent and emergent care on-site at member’s nursing facility residence or in the physician’s office or telephonically in coordination with the Nurse Practitioner.
 - 24 hours a day, 7 days a week telephonic access for medically necessary member care, with approved and contracted physician coverage during time off (call coverage), with emergency care calls, both weekdays or after-hours, responded to immediately; urgent care calls, weekdays and after-hours, responded to within 30 minutes; and routine care calls returned by the end of the day.
- Specialists are required to be available for a consult or new patient appointment within 21 days of initial request and to be immediately available to primary care physicians for an urgent or emergent consult regarding a member.
- Telephone Access (applicable to all contracted providers regarding calls from members, members’ caregivers, PruittHealth Premier Nurse Practitioners (ISNP), PruittHealth Premier Case Managers (DSNP) PruittHealth Premier Medical Director and Utilization Management staff, and nursing home facility staff):
 - Emergency care calls, both weekdays and after-hours calls, will be dealt with immediately.
 - Urgent care calls, both weekdays and after-hours calls, will be returned within 30 minutes.
 - Routine care calls, both weekdays and after-hours calls, will be returned by the end of the day or the following morning.
 - All calls are answered promptly by the provider, provider staff and/or a reliable paging service or answering service.

Network Access Monitoring and Compliance

Using valid methodology, PruittHealth Premier will collect and perform regular analyses of

provider data to measure performance against the Plan's written standards. Examples of measurement tools include:

- PCP visit frequency report: Utilizes claims data to monitor frequency of PCP routine visits for members.
- Medical specialty appointment access: Utilizes the third next available appointment methodology to survey selected high-volume specialists like cardiology, endocrinology, neurology, ophthalmology, pulmonology, and urology for availability of consult or new patient appointment within 21 calendar days.
- Member satisfaction survey: Annual survey includes questions related to accessibility and availability of network services.

In addition to regularly scheduled performance measurement, PruittHealth Premier will review monthly utilization reports to track utilization trends and identify significant changes in utilization that may indicate an accessibility issue. Complaints related to access of care (provider or after hours) are collected through the PruittHealth Premier the Member Services Department line or through submissions to the Quality Improvement Committee. Access complaints are analyzed quarterly and reported through the Quality Improvement Committee with immediate action taken to rectify situations where access may cause harm to a member.

Practitioners or sites identified for access improvement opportunities are contacted in a timely manner regarding survey or measurement results, and follow-up inquiries and measurements may be scheduled. All contracted providers are informed of this policy in the Provider Manual. The policy is also included on the PruittHealth Premier website.

Performance consistently falling outside of written standards, with failure to make progress in corrective actions, may result in the recommendation to close primary care panels; contracting with additional practitioners or providers if needed; and adverse credentialing or contracting decisions in cases of persistent failure to make progress towards meeting standards.

Provider Rights and Responsibilities

Provider Rights

PruittHealth Premier encourages your feedback and suggestions on how service may be improved within the organization.

If an acceptable patient-physician relationship cannot be established with a PruittHealth Premier member who has selected you as his/her primary care physician, you may request that PruittHealth Premier have that member removed from your care.

You may appeal any claims submissions you feel have not been paid according to medical policy or in keeping with the level of care rendered.

You may request to discuss any referral request with the Plan Medical Director at various times in the review process, before a decision is rendered or after a decision is rendered.

Provider Responsibilities

Primary Care Physicians are responsible for the coordination of routine preventative care alone with any ancillary services that need to be rendered with authorization.

All providers are required to code to the highest level of specificity necessary to fully describe a member's acuity level. All coding should be conducted in accordance with CMS guidelines and all applicable state and federal laws.

Specialists must provide specialty services upon referral from the Primary Care Physician and work closely with the referring physician regarding the treatment the member is to receive. Specialists must also provide continuous 24 hours, 7 days a week access to care for PruittHealth Premier members. For the INSP and whenever possible, PruittHealth Premier urges specialists to provide member visits in the member's nursing facility for safety and comfort issues for the member.

Provider Responsibilities - ISNP

All Primary Care Physicians must provide continuous 24 hours, 7 days a week access to care for PruittHealth Premier members. During periods of unavailability or absence from the practice, you must arrange coverage for your PruittHealth Premier members and notify PruittHealth Premier of the physician who is providing coverage for your practice.

Primary Care Physicians (NFists) shall provide patient care to new members within sixty (60) days of enrollment with PruittHealth Premier. In general, PruittHealth Premier expects PCP visits to be provided onsite at the member's nursing facility.

Provider Information

Specialists are required to coordinate the referral process (i.e. obtain authorizations) for the further care they recommend. This responsibility does not revert back to the Primary Care Physician while the care of the member is under the direction of the Specialist.

In the event a provider is temporarily unavailable or unable to provide patient care or referral services to a PruittHealth Premier member, he/she must arrange for another physician to provide such services on his/her behalf. This coverage cannot be provided by an Emergency Room.

Each provider has agreed to treat PruittHealth Premier members the same as all other patients in his/her practice, regardless of the amount of reimbursement.

Each provider has agreed to provide continuing care to participating members.

Each provider has agreed to utilize PruittHealth Premier's participating physicians/facilities when services are available and can meet the patient's needs. Approval prior to referring outside of the contracted network of providers may be required.

Each provider has agreed to participate in PruittHealth Premier's peer review activities as they relate to the Quality Management/Utilization Review program.

A provider may not balance bill a member for providing services that are covered by PruittHealth Premier. This excludes the collection of standard co-pays. A provider may bill a member for a procedure that is not a covered benefit, if the provider has followed the appropriate procedures outlined in the Claims section of this manual.

Application Process

1. Submit a completed State Mandated Credentialing application, CAQH Universal Credentialing Application form or CAQH ID, or the Plan's application with a current signed and dated Attestation and Consent and Release form that is less than 90 days old.
2. If any of the Professional Disclosure questions are answered yes on the application, supply sufficient additional information and explanations.
3. Provide appropriate clinical detail for all malpractice cases that are pending, or resulted in a settlement or other financial payment.
4. Submit copies of the following:
 - All current and active State Medical Licenses, DEA certificate(s) and state controlled substance certificate as applicable.
 - Evidence of current malpractice insurance that includes the effective and expiration dates of the policy and term limits.
 - Five years of work history documented in a month/year format either on the application or on a current curriculum vitae. Explanations are required for any gaps exceeding six (6) months.
 - If a physician, current and complete hospital affiliation information on the application. If no hospital privileges and the specialty warrants hospital privileges, a letter detailing the alternate coverage arrangement(s) or the name of the alternate admitting physician should be provided.

Credentialing and Recredentialing Process

Once a Practitioner has submitted an application for initial consideration, PruittHealth Premier's Credentialing Department will conduct primary source verification of the applicant's licensure, education and/or board certification, privileges, lack of sanctions or other disciplinary action, and malpractice history by querying the National Practitioner Data Bank.

The credentialing process generally takes up to ninety (90) days to complete, but can in some instances take longer. Once credentialing has been completed and the applicant has been approved, the Practitioner will be notified in writing of their participation effective date. To maintain participating status, all practitioners are required to recredential at least every three (3) years. Information obtained during the initial credentialing process will be updated and re-verified as required. Practitioners will be notified of the need to submit recredentialing information at least 4 months in advance of their three-year anniversary date. Three (3) separate attempts will be made to obtain the required information via mail, fax, email or telephonic request. Practitioners who fail to return recredentialing information prior to their recredentialing due date will be notified in writing of their termination from the network.

Office Site Evaluations

Office site surveys and medical record keeping practice reviews may be required when it is deemed necessary as a result of a patient complaint, quality of care issue and/or as otherwise mandated by state regulations. Practitioner offices will be evaluated in the following categories:

1. Physical Appearance and Accessibility
2. Patient Safety and Risk Management
3. Medical Record Management and Security of Information

4. Appointment Availability

Providers who fail to pass the area of the site visit specific to the complaint or who score less than 90% on the site evaluation overall will be required to submit a corrective action plan and make corrections to meet the minimum compliance score. A follow up site evaluation will be done within sixty (60) days of the initial site visit, if necessary, to ensure that the corrective action has been implemented.

Practitioner Rights

- Review information obtained from any outside source to evaluate their credentialing application with the exception of references, recommendations or other peer-review protected information. The provider may submit a written request to review his/her file information at least thirty days in advance at which time the Plan will establish a time for the provider to view the information at the Plan's offices.
- Right to correct erroneous information when information obtained during the credentialing process varies substantially from that submitted by the practitioner. In instances where there is a substantial discrepancy in the information, Credentialing will notify the provider in writing of the discrepancy within thirty (30) days of receipt of the information. The provider must submit a written response and any supporting documentation to the Credentialing Department to either correct or dispute the alleged variation in their application information within thirty (30) days of notification.
- Right to be informed of the status of their application upon request. A provider may request the status of the application either telephonically or in writing. The Plan will respond within two business days and may provide information on any of the following: application receipt date, any outstanding information or verifications needed to complete the credentialing process, anticipated committee review date, and approval status.

Organizational Provider Selection Criteria

When assessing organizational providers, PruittHealth Premier utilizes the following criteria:

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

Organizational Provider Application and Requirements

1. A completed Ancillary/Facility Credentialing Application with a signed and dated attestation.
2. If responded "Yes" to any disclosure question in the application, an appropriate explanation with sufficient details/information is required.
3. Copies of all applicable state and federal licenses (i.e. facility license, DEA, Pharmacy license, etc.).
4. Proof of current professional and general liability insurance as applicable.
5. Proof of Medicare participation.
6. If accredited, proof of current accreditation. Note: Current accreditation status is required

- for DME, Prosthetic/Orthotics, and non-hospital based high-tech radiology providers who perform MRIs, CTs and/or Nuclear/PET studies.
7. If not accredited, a copy of any state or CMS site survey that has occurred within the last three years including evidence that the organization successfully remediated any deficiencies identified during the survey.

Organizational Site Surveys

As part of the initial assessment, an on-site review will be required on all hospitals, skilled nursing facilities, free-standing surgical centers, home health agencies and inpatient, residential or ambulatory mental health or substance abuse centers that do not hold acceptable accreditation status or cannot provide evidence of successful completion of a recent state or CMS site survey. Any organizational provider may also be subject to a site survey as warranted subsequent to the receipt of a complaint.

Organizational providers who are required to undergo a site visit must score a minimum of 85% on the site survey tool. Providers who fall below acceptable limits will be required to submit a written Corrective Action Plan (CAP) within thirty (30) days and may be re-audited, at a minimum within sixty (60) days, to verify specific corrective action items as needed. Providers who fail to provide an appropriate CAP or who are unable to meet minimum standards, even after re-auditing, will not be eligible for participation.

Credentialing Committee / Peer Review Process

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

Non-Discrimination in the Decision-Making Process

PruittHealth Premier's Credentialing Program is compliant with all guidelines from NCQA, CMS and State regulations as applicable. Through the universal application of specific assessment criteria, PruittHealth Premier ensures fair and impartial decision-making in the credentialing process. No provider shall be denied participation based solely on race, gender, age, religion, ethnic origin, sexual orientation, type of population served or for specializing in certain types of procedures.

Provider Notification

All initial applicants who successfully complete the credentialing process are notified in writing of their plan effective date. Providers are advised to not see PruittHealth Premier members until the notification of successful credentialing is received. Applicants who are denied by the Credentialing Committee will be notified via a certified letter within sixty (60) days of the decision outcome detailing the reasons for the denial/term and any appeal rights to which the PruittHealth Premier (HMO SNP Plan)

provider may be entitled.

Appeals Process & Notification of Authorities

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

Confidentiality of Credentialing Information

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

Ongoing Monitoring

PruittHealth Premier conducts routine, ongoing monitoring of license sanctions, Medicare/Medicaid sanctions and the CMS Opt Out list between credentialing cycles. Participating providers who are identified as having been sanctioned are subject to review by the Plan Medical Director or the Credentialing Committee who may elect to limit, restrict or terminate participation. Any provider whose license has been revoked or has been excluded, suspended and/or disqualified from participating in any Medicare, Medicaid or any other government health related program or who has opted out of Medicare will be automatically terminated from the Plan.

Provider Directory

To be included in Provider Directories or any other member information, providers must be fully credentialed and approved. Directory specialty designations must be commensurate with the education, training, board certification and specialty(s) verified and approved via the credentialing process. Any requests for changes or updates to the specialty information in the directory may only be approved by Credentialing and Recredentialing Process of the Plan.

CLAIMS

Claims Submission

PruittHealth Premier strongly encourages providers to submit claims electronically and to check the status of claims electronically. While PruittHealth Premier prefers electronic submission of claims, both electronic and paper claims are accepted. The benefits of electronic claims submission and status inquiry include the following:

1. Less staff time spent on phone calls;
2. Increased ability to conduct targeted follow-up; and
3. More accurate and efficient processing and payment of claims.

Providers will need to sign up to submit claims electronically and for electronic remittance. Once enrolled, providers can submit claims directly through our clearinghouse or through their current system and receive payments electronically. Providers can contact customer support at 1-888-635-0009, choose option 2 or visit the Exchange EDI website via the website address below to access the enrollment form and instructions.

Website address: <http://exchangeedi.com/quick-links>

Prior registration is required before using the web service. Complete the EDI Enrollment Form needed to setup the web service connection. Information is also available on the Providers & Partners page of the PruittHealth Premier website at www.pruithhealthpremier.com.

For those providers submitting paper claims, all completed claims forms should be forwarded to the address noted below:

PruittHealth Premier
PO Box 908
Addison, TX 75001-0908

Timely Filing

As a PruittHealth Premier participating provider, you have agreed to submit all claims within twelve months from the date of service.

Claim Format Standards

Standard CMS required data elements must be present for a claim to be considered a clean claim and can be found in the CMS Claims Processing Manuals. The link to the CMS Claims Processing Manuals is: <https://www.cms.gov/manuals/downloads/clm104c12.pdf>.

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

Physicians in the same group practice who are in the same specialty must bill and be paid as though they were a single physician. If more than one service is provided on the same day to the same patient by the same physician or more than one physician in the same specialty in the same group, they must bill and be paid as though they were a single physician. For example, only one evaluation and management service may be reported unless the evaluation and management services are for unrelated diagnoses. Instead of billing separately, the physicians should select a level of service representative of the combined visits and submit the appropriate code for that level.

Physicians in the same group practice, but who are in different specialties may bill and be paid without regard to their membership in the same group.

Claim Payment

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

Pricing

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

PruittHealth Premier will apply correct coding edits, MPPRs as outlined by CMS in the RVU table. PruittHealth Premier will also follow guidelines put forth by the AMA CPT, and CMS HCPC coding guidelines. Bundling, multiple procedure reductions, or payment modifiers may impact contracted allowances. All editing applied by PruittHealth Premier is subject to the grievance, appeals, and clinical review policies and procedures outlined in this manual.

New or Non-Listed Codes

From time to time, providers may submit codes for that are not recognized by the claims system. This can happen when new codes are developed/added for new and newly approved services or procedures or if existing codes are changed.

PruittHealth Premier follows Original Medicare coverage guidelines for new services and procedures. If Original Medicare approves a new service, procedure, or code, PruittHealth Premier shall make every effort to load the new code with approved pricing set at 100% of the current published Medicare rates, subject to all applicable copayments, deductibles, and cost-sharing amounts, as quickly as possible.

In the event a provider submits a code and the PruittHealth Premier claims system does not recognize it as a payable code, or does not have a contracted allowance, the following process will occur:

1. PruittHealth Premier maintains the right to review and/or deny any claim with CPT/HCPC codes that are not recognized by the system. Supporting documentation may be requested to substantiate services, determine allowance basis, and to make a

2. coverage determination. This would include, but is not limited to, new CPT/HCPC codes, not otherwise classified codes, and codes designated as Carrier Defined by CMS;
3. Provider may then appeal the denial, attaching the Medicare coverage guidelines or proof of payment for the service/code (EOB) from Original Medicare; and
4. PruittHealth Premier shall pay for any such services that include proof of payment by Original Medicare within the past six (6) months at 100% of the current Medicare rates less all applicable copayments, deductibles, and cost-sharing.

Providers may submit documentation of payment for new services/codes with original claims to prevent the need for an initial denial and subsequent appeal and re-adjudication process.

All codes/services submitted for payment and not recognized by the claims system shall be subject to verification of medical necessity. Providers should always call for pre-certification of any procedure/service/or code for which they have concerns about coverage.

Claims Encounter Data

Providers who are being paid under capitation must submit claims within the same timely filing limit required for fee-for-service or non-capitated claims in order to capture encounter data as required per your PruittHealth Premier Provider Agreement.

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

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

Non- Payment / Claim Denial

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

Obtaining pre-services review will reduce denials and the need for post service clinical review with possible denials.

Processing of Hospice Claims

When a Medicare Advantage (MA) member has been certified as hospice AND the premium PruittHealth Premier receives from CMS is adjusted to hospice status, the financial responsibility for that member shifts from PruittHealth Premier to Original Medicare. While these two

conditions exist, Original Medicare covers all Medicare–covered services rendered. The only services PruittHealth Premier is financially responsible for during this time include any benefits PruittHealth Premier offers above Original Medicare benefits that are non-hospice related, non-Medicare covered services such as vision (eyewear allowable), prescription drug claims, medical visit transportation, etc.).

Until both conditions listed above have been met, PruittHealth Premier remains financially responsible for the member. Example: If a member is certified hospice on the 8th of the month, PruittHealth Premier continues to be financially responsible for that member until the end of that month. The financial responsibility shifts to Original Medicare on the 1st day of the following month; the date the CMS premium to PruittHealth Premier has been adjusted to hospice status for that member. These rules apply for both professional and facility charges.

Coordination of Benefits and Subrogation Guidelines

General Definitions

Coordination of Benefits (COB): Benefits that a person is entitled to under multiple plan coverage. Coordinating payment of these plans will provide benefit coverage up to but not exceeding one hundred (100) percent of the allowable amount. The respective primary and secondary payment obligations of the two coverages are determined by the Order of Benefits Determination Rule contained in the National Association of Insurance Commissioners (NAIC) COB Model Regulations Guidelines.

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

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

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

Allowable Expense: Any expense customary or necessary for health care services provided as well as covered by the member’s Health Care Plan.

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

Basic NAIC Rules for COB

Birthday Rule: The primary coverage is determined by the birthday that falls earliest in the year,

understanding both spouses are employed and have coverage. Only the day and month are taken into consideration. If both members have the same date of birth, the plan which covered the member the longest is considered primary

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

If the Member/ Beneficiary....	The Below Conditions Exists	Then the Below Program Pays First	The Below Program Pays Secondary
Is age 65 or older, and is covered by a Group Health Plan (GHP) through current employment or a family members current employment	The employer has more than 20 employees, or at least one employer is a multi-employer group that employs 20 or more employees	GHP pays primary	PruittHealth Premier/Medicare pays secondary
Is age 65 or older and is covered a GHP through current employment or a family members current employment	The employer has less than 20 employees	PruittHealth Premier /Medicare pays primary	GHP pays secondary
Is entitled based on disability and is covered by a Large Group Health Plan (LGHP) through his/her current employment or through a family members current employment	The employer has 100 or more employees or at least one employer is a multi-employer group that employs 100 or more employees	LGHP pays primary	PruittHealth Premier /Medicare pays secondary
Is entitled based on disability and is covered by a LGHP through his/her current employment or through a family members current employment	The employer employs less than 100 employees	PruittHealth Premier /Medicare pays primary	LGHP pays secondary
Is age 65 or older or entitled based on disability and has retirement insurance only	Does not matter the number of employees	PruittHealth Premier /Medicare pays primary	Retirement Insurance pays secondary
Is age 65 or older or is entitled based on disability and has COBRA coverage	Does not matter the number of employees	PruittHealth Premier/Medicare pays primary	COBRA pays secondary
Becomes dually entitled based	Had insurance prior to becoming dually	GHP pays primary for the first 30 months	PruittHealth Premier/Medicare pays

If the Member/ Beneficiary....	The Below Conditions Exists	Then the Below Program Pays First	The Below Program Pays Secondary
on age/ESRD	entitled with ESRD as in block one above		secondary (after 30 months PruittHealth Premier pays primary)
Becomes dually entitled based on age/ESRD but then retires and keeps retirement insurance	Had insurance prior to becoming dually entitled with ESRD as in block one above and then retired	The Retirement Insurance pays primary for the first 30 months	PruittHealth Premier/Medicare pays secondary (after 30 months PruittHealth Premier pays primary)
Becomes dually entitled based on age/ESRD but then obtains COBRA insurance through employer	Had insurance prior to becoming dually entitled with ESRD as in block one above and picks up COBRA coverage	COBRA insurance would pay primary for the first 30 months (or until the member drops the COBRA coverage	PruittHealth Premier/Medicare pays secondary (after 30 months PruittHealth Premier pays primary)
Becomes dually entitled based on disability/ESRD	Had insurance prior to becoming dually entitled with ESRD as in block three above	LGHP pays primary	PruittHealth Premier/Medicare pays secondary (after 30 months PruittHealth Premier pays primary)
Becomes dually entitled based on disability/ESRD but then obtains COBRA insurance through employer	Had insurance prior to becoming dually entitled with ESRD as in block three above and picks up the COBRA coverage	COBRA insurance would pay primary for the first 30 months or until the member drops the COBRA coverage	PruittHealth Premier/Medicare pays secondary (after 30 months PruittHealth Premier pays primary) 30 months PruittHealth Premier pays primary)

Basic Processing Guidelines for COB

For PruittHealth Premier to be responsible as either the primary or secondary carrier, the member must follow all HMO rules (i.e. pay co-pays and follow appropriate referral process).

When PruittHealth Premier is the secondary insurance carrier:

- All PruittHealth Premier guidelines must be met in order to reimburse the provider (i.e. precertification, referral forms, etc.).
- The provider collects only the co-payments required.
- Be sure to have the member sign the “assignment of benefits” sections of the claim form.
- Once payment and/or EOB are received from the other carriers, submit another copy of the claim with the EOB of PruittHealth Premier for reimbursement. Be sure to note all authorization numbers on the claims and attach a copy of the referral form if applicable.

When PruittHealth Premier is the primary insurance carrier:

- The provider collects the co-payment required under the member’s PruittHealth

- Premier Plan.
- Submit the claim to PruittHealth Premier first.
- Be sure to have the member sign the “assignment of benefits” sections of the claim form.
- Once payment and/or remittance advise (RA) has been received from PruittHealth Premier, submit a copy of the claim with the RA to the secondary carrier for adjudication.

Please note that PruittHealth Premier is a total replacement for Medicare. Medicare cannot be secondary when members have PruittHealth Premier.

Worker’s Compensation

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

Subrogation

Subrogation is the coordination of benefits between a health insurer and a third-party insurer (i.e. property and casualty insurer, automobile insurer, or worker’s compensation carrier), not two health insurers.

Claims involving Subrogation or Third-Party Recovery (TPR) will be processed internally by the PruittHealth Premier Claims Department. COB protocol, as mentioned above, would still apply in the filing of the claim.

Members who may be covered by third party liability insurance should only be charged the required co-payment. The bill can be submitted to the liability insurer. The provider should submit the claim to PruittHealth Premier with any information regarding the third-party carrier. All claims will be processed per the usual claims procedures.

For claims related questions, please contact your local PruittHealth Premier Network Operations Department at: (844) 224-3659. A Network Services Representative will gladly provide assistance.

Appeals

An appeal is a reconsideration of a previous decision not to approve or pay for a service, including a level of care decision (includes not just outright denials, but also “partial” ones). Your appeal will receive an independent review (made by someone not involved in the initial decision). Requesting an appeal does not guarantee that your request will be approved or your claim paid. The appeal decision may still be to uphold the original decision.

An appeal must be submitted to the address/fax listed below within 60 days from the original decision or the time frame specified in your contract of the receipt of the decision. You must include with your appeal request a copy of your denial, any medical records that would support

why the service is needed, and if for a hospital stay, a copy of the insurance verification done at time of admission.

Part C Appeals Phone and Fax Number: Phone (844) 224-3659 Fax (800) 489-9518.

HEALTHCARE EFFECTIVENESS DATA AND INFORMATION SET (HEDIS®)

HEDIS (a standardized data set) is developed and maintained by NCQA, an accrediting body for managed care organizations. The HEDIS measurements enable comparison of performance among managed care plans. The sources of HEDIS data include administrative data (claims/encounters) and medical record review data. HEDIS measurements include measures such as Comprehensive Diabetes Care, Adult Access to Ambulatory and Preventive Care, Controlling High Blood Pressure, Breast Cancer Screening, and Colorectal Cancer Screening.

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

All records are handled in accordance with PruittHealth Premier's privacy policies and in compliance with the Health Insurance Portability and Accountability Act (HIPAA) Privacy rules. Only the minimum necessary amount of information, which will be used solely for the purpose of this HEDIS initiative, will be requested. HEDIS is considered a quality-related health care operation activity and is permitted by the HIPAA Privacy Rule [see 45 CFR 164.501 and 506]. PruittHealth Premier's HEDIS results are available upon request. Contact the health plan's Quality Improvement Department to request information regarding those results. HEDIS® is a registered trademark of NCQA.

BEHAVIORAL HEALTH

PruittHealth Premier provides comprehensive mental health and substance abuse services to its members. Its goal is to treat the member in the most appropriate, least restrictive level of care possible, and to maintain and/or increase functionality. PruittHealth Premier's network is comprised of mental health and substance abuse services and providers who identify and treat members with behavioral health care needs.

Integration and communication among behavioral health and physical health providers is most important. PruittHealth Premier encourages and facilitates the exchange of information between and among physical and behavioral health providers. Member follow-up is essential. High risk members are evaluated and encouraged to participate in PruittHealth Premier's behavioral health focused Case Management Program where education, care coordination, and support is provided to increase member's knowledge and encourage compliance with treatment and medications. PruittHealth Premier works with its providers to become part of the strategy and the solution to provide quality behavioral health services.

Behavioral Health Services

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

- Access to PruittHealth Premier's Member Services Department for orientation and guidance
- Routine outpatient services to include psychiatrist, addictionologist, licensed psychologist and LCSWs, and psychiatric nurse practitioners. PCPs may provide behavioral health services within his/her scope of practice
- Initial evaluation and assessment
- Individual and group therapy
- Psychological testing according to established guidelines and needs
- In-patient hospitalization
- Inpatient and out-patient detoxification treatment
- Medication management
- Partial hospitalization programs

Responsibilities of Behavioral Health Providers:

PruittHealth Premier encourages behavioral health providers to become part of its network. Their responsibilities include but are not limited to:

- Provide treatment in accordance with accepted standards of care
- Provide treatment in the least restrictive level of care possible
- Communicate on a regular basis with other medical and behavioral health practitioners who are treating or need to treat the member

Responsibilities of the Primary Care Physician:

The PCP can participate in the identification and treatment of their member's behavioral health needs. His/her responsibilities include:

- Screening and early identification of mental health and substance abuse issues
- Treating members with behavioral health care needs within the scope of his/her practice and according to established clinical guidelines. These can be members with co-morbid physical and minor behavioral health problems or those members refusing to access a mental health or substance abuse provider, but requiring treatment
- Consultation and/or referral of complex behavioral health patients or those not responding to treatment
- Communication with other physical and behavioral health providers on a regular basis

Access to Care:

Members may access behavioral health services as needed:

- Members may self-refer to any in-network behavioral health provider for initial assessment and evaluation, and ongoing outpatient treatment.

- Members may access their PCP and discuss their behavioral health care needs or concerns and receive treatment that is within their PCP's scope of practice. They may request a referral to a behavioral health practitioner. Referrals however, are not required to receive most in-network mental health or substance abuse services
- Members and providers may call Customer Service to receive orientation on how to access behavioral health services, provider information, and prior authorizations at (844) 224-3659.

Medical Record Documentation:

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

Continuity of Care:

Continuity of Care is essential to maintain member stability. As a part of the care transition process, the Nurse Practitioner (ISNP) and Case Manager (DSNP) will be the primary advocate in ensuring the member's well-being across multiple care settings and across the health spectrum. The Nurse Practitioner/Case Manager will work with the PCP to ensure that the highest quality of health care will be delivered to the member in each of the health care settings.

The PruittHealth Premier Nurse Practitioners (ISNP) and Case Managers (DSNP) understand how coordinated health care improves the care of this vulnerable membership, and will work to ensure coordinated care by:

- Providing members and caregivers/families one accountable point of contact – the assigned Nurse Practitioner or Case Manager
- Following members across care settings during transitions (i.e. admission to a hospital)
- Educating members and caregivers/families on member diagnoses
- Setting goals that promote coordinated care
- Making and keeping specific tasks/appointments, follow up items with members
- Coordinating care within and across treatment settings between external and internal stakeholders
- Creating a process through which health care providers can communicate with one another about the member's care
- Making member preferences known and accessible to all health care providers

UTILIZATION MANAGEMENT

PruittHealth Premier's Utilization Management Department coordinates health care services to ensure appropriate utilization of health care resources. This coordination assures promotion of the delivery of services in a quality-oriented, timely, clinically-appropriate, and cost-effective manner for the members.

PruittHealth Premier Utilization Management staff base their utilization-related decisions on the clinical needs of members, the Member's Benefit Plan, Milliman Guidelines, the appropriateness of care, Medicare National Coverage Guidelines, health care objectives, and scientifically-based

clinical criteria and treatment guidelines in the context of provider and/or member-supplied clinical information and other such relevant information.

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

Goals:

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

Departmental Functions:

- Prior Authorization
- Referral Management
- Concurrent Review
- Discharge Planning
- Continuity of Care

Prior Authorization

The PCP or Specialist is responsible for requesting prior authorization of all scheduled admissions or services/procedures, for referring a member for an elective admission, and outpatient service. PruittHealth Premier recommends calling at least five (5) days in advance of the admission, procedure, or service. Requests for prior authorization are prioritized according to level of medical necessity. For prior authorizations, providers should call: (844) 224-3659.

You may also submit your request via our online portal 24 hours per day, 7 days per week at: www.pruitthealthpremier.com.

Services requiring prior authorization are listed on PruittHealth Premier's website. The presence or absence of a service or procedure on the list does not determine coverage or benefits. Call the Member Services Department to verify benefits, coverage, and member eligibility.

The Utilization Management Department, under the direction of licensed nurses and medical

directors, documents and evaluates requests for authorization, including:

- Verification that the member is enrolled with PruittHealth Premier at the time of the request for authorization and on each date of service.
- Verification that the requested service is a covered benefit under the member's benefit package.
- Determination of the appropriateness of the services (medical necessity).
- Verification that the service is being provided by the appropriate provider and in the appropriate setting.
- Verification of other insurance for coordination of benefits.

The Utilization Management Department documents and evaluates requests utilizing CMS guidelines as well as nationally accepted criteria, processes the authorization determination, and notifies the provider of the determination. Examples of information required for a determination include, but are not limited to:

- Member name and identification number
- Location of service (e.g., hospital or outpatient surgical center setting)
- Primary Care Physician name
- Servicing/Attending physician name
- Date of service
- Diagnosis
- Service/Procedure/Surgery description and CPT or HCPCS code
- Clinical information supporting the need for the service to be rendered

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

If a member appears at an emergency room for care which is non-emergent, the PCP should be contacted for direction. The member may be financially responsible for payment if the care rendered is non-emergent. PruittHealth Premier also utilizes urgent care facilities to treat conditions that are non-emergent but require immediate treatment.

PruittHealth Premier must be notified of emergency admissions within twenty-four (24) hours of admission. Please be prepared to discuss the member's condition and treatment plan with PruittHealth Premier's nurse coordinator.

Decisions and Time Frames

Emergency - Authorization is not required

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

- Serious jeopardy to the health of the individual or, in the case of a pregnant woman, the

- health of the woman or her unborn child;
- Serious impairment to bodily functions; or
- Serious dysfunction of any bodily organ or part

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

Routine –If all information is submitted at the time of the request, CMS mandates a health plan determination within 14 calendar days.

Once the Utilization Management Department receives the request for authorization, PruittHealth Premier will review the request using nationally recognized industry standards or local coverage determination criteria. If the request for authorization is approved, PruittHealth Premier will assign an authorization number and enter the information in the Plan’s medical management system. This authorization number can be used to reference the admission, service or procedure.

The requesting provider has the responsibility of notifying the member that services are approved and documenting the communication in the medical record.

Retrospective Review

Retrospective review is the process of determining coverage for clinical services by applying guidelines/criteria to support the claim adjudication process after the opportunity for prior authorization or concurrent review timeframe has passed. After confirming the member’s eligibility and the availability of benefits at the time the service was rendered, providers should submit all supporting clinical documentation with the request for review and subsequent reimbursement to: (844) 224-3659.

The requesting provider has the responsibility of notifying the member that services are approved and documenting the communication in the medical record.

Concurrent Review

Concurrent Review is the process of initial assessment and continual reassessment of the medical necessity and appropriateness of inpatient care during an acute care hospital admission, rehabilitation admission or SNF or other inpatient admission in order to ensure:

- Covered services are being provided at the appropriate level of care; and
- Services are being administered according to the individual facility contract.

PruittHealth Premier requires admission notification for the following:

- Elective Admissions
- ER and Urgent Admissions
- Transfers to Acute Rehabilitation, LTAC, and Non-Referring Skilled Nursing Facilities
- Admissions following outpatient procedures or observation status

- Observation Status

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

PruittHealth Premier's Utilization Management Department complies with individual facility contract requirements for concurrent review decisions and timeframes. PruittHealth Premier's nurses, utilizing CMS guidelines and Milliman Care Guidelines (MCG) review criteria, will conduct medical necessity review. PruittHealth Premier is responsible for final authorization.

PruittHealth Premier's preferred method for concurrent review is a live dialogue between our Utilization Management nursing staff and the facility UM staff within 24 hours of notification or on the last covered day. If clinical information is not received within 72 hours of admission or last covered day, the case will be reviewed for medical necessity with the information PruittHealth Premier has available. If it is not feasible for the facility to contact PruittHealth Premier via phone, facilities may fax the member's clinical information within 24 hours of notification to (800) 489-9518.

Specific to the ISNP: Review is not required for readmission to the referring SNF (the member's primary nursing facility); however, if the patient is transitioning to an alternate or out-of-network SNF reviews should be faxed to (800) 489-9518. For these SNF admission requests, a recent physical medicine and rehabilitation (PM&R) or physical, occupational and/or speech therapy consult is requested along with the most recent notes for therapy(ies) or recent medical status and expected skilled treatment and service requirements. Following an initial determination, the Utilization Management nurse will request additional updates from the facility on a case-by-case basis. PruittHealth Premier will render a determination within 24 hours of receipt of complete clinical information. The Utilization Management nurse will make every attempt to collaborate with the facility's utilization or case management staff and request additional clinical information in order to provide a favorable determination. Clinical update information should be received 24 hours prior to the next review date.

A PruittHealth Premier Medical Director reviews all acute, rehab, long-term acute care (LTAC) and SNF confinements that do not meet medical necessity criteria and issues a determination. If the PruittHealth Premier Medical Director deems that the inpatient or SNF confinement does not meet medical necessity criteria, the Medical Director will issue an adverse determination (a denial). The Utilization Management nurse or designee will notify the provider(s) e.g. facility, attending/ordering provider verbally and in writing. The criteria used for the determination is available to the practitioner/facility upon request. To request a copy of the criteria on which a decision is made please contact (844) 224-3659.

In those instances where the attending provider does not agree with the determination, the provider is encouraged to contact PruittHealth Premier's Medical Director for Peer-to-Peer PruittHealth Premier (HMO SNP Plan)

discussion. The telephone number to contact our Medical Director for the discussion is (844) 224-3659. Following the Peer-to-Peer discussion, the Medical Director will either reverse the original determination and authorize the confinement or uphold the adverse determination.

For members receiving hospital care and for those who transfer to a non-referring SNF or Acute Inpatient Rehabilitation Care, PruittHealth Premier will approve the request or issue a denial if the request is not medically necessary. PruittHealth Premier will also issue a denial if a member who is already receiving care in an Acute Inpatient Rehabilitation Facility has been determined to no longer require further treatment at that level of care. This document will include information on the members' or their authorized representatives' right to file an expedited appeal, as well as instructions on how to do so if the member or member's physician does not believe the denial is appropriate.

PruittHealth Premier also issues written Notice of Medicare Non-Coverage (NOMNC) determinations in accordance with CMS guidelines. This notice will be sent by fax to the SNF for all ISNP members and to the respective Home Health agency for DSNP members. The facility (ISNP) or provider (DSNP) is responsible for delivering the notice to the member or their authorized representative/power of attorney (POA) and for having the member, authorized representative or POA sign the notice within the written time frame listed in the Adverse Determination section of the provider manual. The facility is requested and expected to fax a copy of the signed NOMNC back to Utilization Management Department at the number provided. The NOMNC includes information on members' rights to file a fast track appeal.

Discharge Planning/Acute Care Management - ISNP

Discharge Planning is a critical component of the process that begins with an early assessment of the member's potential discharge care needs in order to facilitate transition from the acute setting to the next level of care. Such planning includes preparation of the member and his/her family for any discharge needs along with initiation and coordination of arrangements for placement and/or services required after acute care discharge. PruittHealth Premier utilizes assigned Nurse Practitioners to coordinate with the facility discharge planning team to assist in establishing a safe and effective discharge plan. All contracted Hospitals, Nursing Homes, Rehab Hospitals, LTACHs, and other inpatient facilities are obligated to allow PruittHealth Premier Care Managers (usually the Nurse Practitioner) access to PruittHealth Premier members for purposes of case management and utilization management activities for PruittHealth Premier members.

The Nurse Practitioner

Each Member will be assigned a Nurse Practitioner (NP) who will be responsible for facilitating safe transitions. The PruittHealth Premier Nurse Practitioners understand how coordinated health care improves the care of this vulnerable Membership, and will work to ensure coordinated care by:

- Giving Members and families one accountable point of contact – the assigned Nurse Practitioner
- Educating Members and caregivers on Member diagnoses
- Setting goals that promote coordinated care
- Making and keeping specific tasks/appointments, follow up items with Members
- Coordinating care within and across treatment settings between external and internal

stakeholders

- Creating a process through which health care providers can communicate with one another about the Member's care
- Making Member preferences known and accessible to all health care providers

As a part of the care transition process, the Nurse Practitioner will be the primary advocate in ensuring the member's well-being across multiple care settings and across the health spectrum. The Nurse Practitioner will ensure that the highest quality of health care will be delivered to the member in each of the health care settings. PruittHealth Premier is committed to ensuring a safe care transition process and our Nurse Practitioners will have the following focus:

- Member-Centered Care:
 - The Nurse Practitioner as the single point of contact for communication with the member, their family, the doctors, and nursing staff. Transitions occurring with the member's and/or caregiver and family's input and understanding to the extent possible. The member, caregiver and family engaged and educated as to the reason(s) for the transition, nature and severity of the condition(s) and goals.
 - Transitions consistent with the member's care goals and advance care directives.
 - Transitions including appropriate member and caregiver education.
- Communication
 - Peer to peer communication will be established across sites of care, including the exchange of reliable contact information, for problem-solving and optimization of care to meet the member's specific needs.
 - Information about the member, including medication and care plans, will be collected prior, during and post care transition; for example, prior to admission into the hospital, during the length of stay, and at discharge.
- Safety
 - Safe transitions will rely on:
 - Appropriate assessment of the member prior to transition.
 - Prompt and consistent medication reconciliation at every transition point, as well as proper planning to ensure no discrepancies in administration of medication.
 - Safety will require accurate and timely transition of key information including but not limited to the following:
 - Member's functional and cognitive status
 - Plan of care and advance care directives
 - Current problem list
 - Current treatment regimen, including all necessary equipment needed
 - Allergies
 - Meal consistencies and preferences
 - Recent labs, consultations, and diagnostic testing results

The Nurse Practitioner will ensure that exchange of the member's Individualized Care Plan (ICP) and other relevant information occurs across the care sites. The Nurse Practitioner will send the member's existing ICP within 24 hours of the transitional episode to the receiving care setting.

The ICP will contain information about the member that facilitates communication, collaboration, and continuity of care across the care sites. The Nurse Practitioner, in collaboration with the PCP/NFist, will be the primary point of contact responsible for

coordinating the care transition process; ensuring transition of care protocols are followed; and communicating with the member, their caregiver/family, the doctors, and nursing facility staff during the care transition.

The Nurse Practitioner will establish a discharge plan, including setting a discharge date and discharge planning goals that best suit the member's needs.

Case Management Services

The PruittHealth Premier Case Management Program is an administrative and clinically proactive process that focuses on coordination of services for members with multiple comorbidities, complex care needs and/or short-term requirements for care. The Program is designed to work as a partnership between members, providers, and other care management staff. The goal is to provide the best clinical outcomes for members. The central concept is early identification and assignment of a designated Nurse Practitioner (ISNP) or Case Manager (DSNP) who provides education and measurement of compliance with standards of care. The assigned Nurse Practitioner or Case Manager strives to enhance the member's quality of life, facilitates provision of services in the appropriate setting, and promotes quality cost effective outcomes. The assigned Nurse Practitioner or Case Manager has specific clinical expertise and provides support services and coordination of care in conjunction with the treating provider and other members of the medical support team.

Case Management Approach

PruittHealth Premier strives to promote continuity and coordination of care, remove barriers to care, prevent complications and improve member quality of life. It is important to note that PruittHealth Premier treats disease management as a component of the case management continuum, as opposed to a separate and distinct activity. In doing so, PruittHealth Premier is able to seamlessly manage cases across the care continuum using integrated staffing, content, data resources, risk identification algorithms, and computer applications.

When a member enrolls with PruittHealth Premier, they are assigned a Nurse Practitioner (ISNP) or Case Manager (DSNP). The Nurse Practitioner/Case Manager meets with the member and/or their caregiver face to face and establishes themselves as the member's primary point of contact for all of their healthcare needs, including development of the Individualized Care Plan and coordinating all transitions in care.

Assigned Nurse Practitioners or Case Managers will utilize a Health Risk Assessment Tool (HRAT) that is comprehensive, specialized for institutional patients, and administered in person as part of a Comprehensive Geriatric Exam.

The Comprehensive Geriatric Exam (CGE) includes a full history and physical (H&P), the CMS required elements of an Annual Wellness Visit (AWV) for Hierarchical Condition Category (HCC) coding, and administration of the HRAT and occurs within 60 days of enrollment. Based on the results of the comprehensive assessment, the member will be assigned a total risk score and stratified as low, moderate, or high risk.

Results from health risk assessment surveys, eligibility data, retrospective claims data, and diagnostic values are combined using proprietary rules, and used to identify and stratify members for case management intervention. The plan uses a streamlined operational approach to identify and prioritize member outreach, and focuses on working closely with members and PruittHealth Premier (HMO SNP Plan)

family/caregivers to close key gaps in education, self-management, and available resources. Personalized case management is combined with medical necessity review, ongoing delivery of care monitoring, and continuous quality improvement activities to manage target member groups.

Members continue to receive case management support while enrolled in the PruittHealth Premier Plan.

Coordination with Network Providers

PruittHealth Premier offers members access to a contracted network of facilities, primary care and specialty care physicians, behavioral health, mental health, and alcohol and substance abuse specialists, as well as an ancillary care network. Each member receives a Provider Directory annually giving in-depth information about how to find network providers in their area (by zip code and by specialty), how to select a PCP, conditions under which out-of-area and out-of-network providers may be seen, and procedures for when the member's provider leaves the network. A toll-free Member Services Department telephone number is provided, and members with questions are asked to reach out to the Plan. Members also have access to a series of web-based provider materials.

The provider is a key member of the Interdisciplinary Care Team (ICT). Our assigned Nurse Practitioners (ISNP) and Case Managers (DSNP) will work with you and your staff to meet the unique needs of each member. Assigned Nurse Practitioners or Case Managers work with members and providers to schedule and prepare for member visits, to make sure that identified care gaps are addressed and prescriptions are filled, and to mitigate any non-clinical barriers to care. In cases where provider referrals are necessitated, the Nurse Practitioner or Case Manager will work closely with members to identify appropriate providers, obtain referrals, schedule visits, and secure transportation.

Communications

PruittHealth Premier provides multiple communication channels to members. The Plan maintains a full-service inbound call program that allows members to inquire about all aspects of their relationship with the Plan. Outbound member services and care management calls are also made regularly to members to encourage them to participate in clinical programs and assessment activities provided as part of their health care benefit. In addition to telephonic touch points, the Plan regularly provides educational materials to members in response to identified care gaps and changes in health status.

Program Evaluation

PruittHealth Premier continually monitors its Quality Program, and makes changes as needed to its structure, content, methods, and staffing. Changes to the Program are made under two conditions: (1) changes must benefit members; and (2) changes must be in compliance with applicable regulations and guidance. Changes to the Program are accompanied by policy and procedure revisions and staff training as required. The Program operates under the umbrella of the plan's Quality Improvement Committee which reports to the Joint Board of Directors. It is reviewed and updated annually in collaboration with the Quality Improvement Department.

Confidentiality

PruittHealth Premier is committed to preserving the confidentiality of its members and practitioners. Written policies and procedures are in place to ensure the confidentiality of member information. Patient data gathered during the care management process are available for the purposes of review only and are maintained in a confidential manner. Employees receive confidentiality training that includes appropriate storage and disposal of confidential information. Employees also sign a confidentiality agreement at the time of their initial company orientation.

Continuity of Care

PruittHealth Premier's policy is to provide for continuity and coordination of care with medical practitioners treating the same patient, and coordination between medical and behavioral health services. When a practitioner leaves PruittHealth Premier's network and a member is in an active course of treatment, our Utilization Management staff will attempt to minimize any disruption in care by potentially offering continuity of care services with the current provider for a reasonable period of time.

In addition, members undergoing active treatment for a chronic or acute medical condition will have access to the exiting provider through the current period of active treatment or a maximum of 90 calendar days, whichever is shorter.

If the Plan terminates a participating provider, PruittHealth Premier will work to transition a member into care with a Participating Physician or other provider within PruittHealth Premier's network. PruittHealth Premier is not responsible for the health care services provided by the terminated provider following the date of termination under such circumstances.

PruittHealth Premier also recognizes that new members join our health plan and may have already begun treatment with a provider who is not in PruittHealth Premier's network. Under these circumstances, PruittHealth Premier will work to coordinate care with the provider by identifying the course of treatment already ordered and offering the member a transition period of up to 90 calendar days to complete the current course of treatment.

PruittHealth Premier will honor plans of care (including prescriptions, DME, medical supplies, prosthetic and orthotic appliances, specialist referrals, and any other on-going services) initiated prior to a new member's enrollment for a period of up to 90 calendar days or until the Primary Care Physician evaluates the member and establishes a new plan of care. For additional information about continuity of care or to request authorization for such services, please contact our Prior Authorization Department at (844) 224-3659.

Adverse Determinations

Rendering of Adverse Determinations (Denials)

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

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

PruittHealth Premier employees are not compensated for denial of services. The PCP or Attending Physician may contact the Medical Director by telephone to discuss adverse determinations.

Notification of Adverse Determinations (Denials)

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

- For non-urgent pre-service decisions – within 14 calendar days of the request.
- For urgent pre-service decisions - *within 72 hours or three calendar days of the request.
- For urgent concurrent decisions –*within 24 hours of the request.
- For post-service decisions – within 30 calendar days of the request.

**denotes initial oral notification of the denial decision is provided with electronic or written notification given no later than 3 calendar days after the oral notification*

Peer-to-Peer information is provided.

PruittHealth Premier complies with CMS requirements for written notifications to members, including rights to appeal and grievances. For urgent care requests, PruittHealth Premier notifies the provider(s) only of the decision since the treating or attending practitioner is acting as the member's representative. If the denial is either concurrent or post service (retrospective) and the member is not at financial risk, the member is not routinely notified.

Clinical Practice Guidelines & Reference Material

PruittHealth Premier has adopted evidence based clinical practice guidelines as roadmaps for healthcare decision-making targeting specific clinical circumstances. PruittHealth Premier promotes the use of clinical practice guidelines to:

- define clear goals of care based on the best available scientific evidence
- reduce variation in care and outcomes
- provide a more rational basis for clinical management of some conditions
- comply with accreditation standards and regulatory expectations

PruittHealth Premier developed and maintains a Clinical Practice Guidelines policy, including, PruittHealth Premier (HMO SNP Plan)

but not limited to, the following adopted and implemented guidelines:

- Preventive Care:
 - HEDIS and Best Practices recommendations
 - Adults – Institute for Clinical Systems Improvement (ICSI) guidelines for preventive services (most current)
- Cardiovascular:
 - American College of Cardiology Foundation/American Heart Association (ACCF/AHA) guidelines (most current)
 - Journal of the American Medical Association (JAMA) 2014 Evidence-Based Guidelines for the Management of High Blood Pressure in Adults
 - Secondary Prevention of Atherosclerotic Cardiovascular Disease in Older Adults: A Scientific Statement from the American Heart Association.
- COPD:
 - Global Initiative for Chronic Obstructive Lung Disease, 2014
 - National Committee on Quality Assurance. HEDIS 2014 Measures
 - National Quality Forum. NQF-Endorsed Quality Measures for COPD
- Depression:
 - Institute for Clinical Systems Improvement (ICSI) guidelines for treating depression in adults (most current)
- Dementia:
 - Current Pharmacology Treatment of Dementia: A Clinical Practice Guideline from the American College of Physicians and the American Academy of Family Physicians
 - APA Practice Guidelines: Practice Guideline for the Treatment of Patients with Alzheimer’s disease and Other Dementias. Work Group on Alzheimer’s disease and Other Dementias.
- Diabetes:
 - American Diabetes Association (ADA) Clinical Practice Guidelines
 - Clinical Practice Guidelines. Diabetes Care, January 2014
 - National Quality Forum. NQF-Endorsed Quality Measures for Diabetes
- Treating Tobacco Use and Dependence:
 - Agency for Healthcare Research and Quality (AHRQ) Treating Tobacco Use and Dependence Clinical Practice Guideline
- Chemical Dependency:
 - American Psychiatric Association (APA) guidelines

PruittHealth Premier’s guidelines have been adopted based on valid and reliable clinical evidence from available peer-reviewed, evidence-based standards. PruittHealth Premier will review, revise, and approve these guidelines on an annual basis, using nationally-recognized, evidenced-based literature.

This information is provided for general reference and not intended to address every clinical situation associated with the conditions and diseases addressed by these guidelines. Physicians and health care professionals must exercise clinical discretion in interpreting and applying this information to individual patients. We hope you will consider this information and use it, when it is appropriate for your eligible patients.

Quality Improvement Program Overview

The purpose of the Quality Improvement Program (QIP) at PruittHealth Premier is to continually take a proactive approach to assure and improve the way the Plan provides care and engages with its members, partners, and other stakeholders so that the Plan may fully realize its vision, mission and commitment to member care. In the implementation of the QIP, PruittHealth Premier will be an agent of change, promoting innovations throughout its health plan organization, sites of care, and in the utilization of resources, including technology, to deliver health care services to meet the health needs of its target population. The QIP is designed to objectively, systematically monitor and evaluate the quality, appropriateness and outcome of care/services delivered to PruittHealth Premier's members. In addition, to provide mechanisms that continuously pursue opportunities for improvement and problem resolution.

Quality improvement activities include the following:

- Monitoring/review of provider accessibility and availability
- Monitoring/review of member satisfaction/grievances
- Monitoring/review of member safety
- Monitoring/review of continuity and coordination of care
- Clinical measurement and improvement monitoring of the SNP Model of Care and all QI activities
- Documentation, analysis, re-measurement and improvement monitoring of member health outcomes utilizing the Align360 care management platform.
- Chronic Care Improvement Program (CCIP)
- QI Projects
- Collection and reporting of Healthcare Effectiveness data and Information Sets (HEDIS)
- Collection and reporting of Structure and Process measures
- Participation and analysis of the Health Outcomes Survey (HOS)
- Participation and analysis of the CAHPS Survey
- Credentialing and re-credentialing
- Provider peer review oversight
- Clinical practice guidelines
- Monitoring and analysis of under and over utilization
- Monitoring and analysis of adverse outcomes/sentinel events
- Collection and reporting of Part C Reporting Elements (HPMS)
- Collection and reporting of Part D Medication Management data (Pharmacy Department)

Clinical Guidelines Committee

The Clinical Guidelines Committee will monitor provisions of care, identify problems, recommend corrective action, and guide the education of providers to improve health care outcomes and quality of service. The Clinical Guidelines Committee also will conduct peer reviews, assign severity levels and make recommendations for corrective actions, as needed.

Continuous Quality Improvement Process

The Continuous Quality Improvement (CQI) process will be utilized when an opportunity for improvement is identified through monitoring of either quality of care or quality of service indicators. The steps in the CQI process will be documented; and results and action plans for improvement will be presented to the Quality Improvement Committee (QIC) for review and approval. These steps will include:

- Determination of the relevance of the issue to the population;
- Evaluation of baseline measure(s);
- Analysis to identify an opportunity for improvement;
- Analysis to identify possible root cause or barriers;
- Planning and implementation of actions to eliminate possible root causes or barriers;
- Evaluation of performance and effectiveness of the interventions by re-measurement after implementing actions;
- Analysis to determine how actions impacted performance; and
- Continued re-measurement to determine whether improvements are sustained.

Proposed Action Plans will be approved by the QIC allowing the impacted departments to move forward with implementation. Subsequent to committee review, an improvement action plan such as a Quality or Process Improvement Project will be developed and implemented. This improvement action plan will contain a description of necessary corrective actions as well as timeframes for implementing the actions and evaluating the outcomes. Specific corrective actions and established timeframes for correction will depend on the type of data or process being addressed.

Quality Improvement Projects

PruittHealth Premier will conduct and/or participate in at least two (2) Quality Improvement Projects each year. In addition to plan-specific Quality Improvement Projects, PruittHealth Premier will also consider collaborative Quality Improvement Projects with CMS, through the QIO, and other health plans in a statewide collaborative.

All Quality Improvement Projects will:

- Focus on significant aspects of clinical care and non-clinical services including:
 - Measurement of performance
 - System interventions, including revising practice guidelines
 - Improving performance
 - Systematic and periodic follow-up on the impact of the interventions
- Assess performance under the Plan using quality indicators:
 - Objective, clearly and unambiguously defined, and based on current clinical knowledge or health services research
 - Capable of measuring outcomes such as changes in health status, functional status and member satisfaction, or valid proxies of those outcomes
- Include performance assessment on selected indicators based on systematic ongoing collection and analysis of valid and reliable data.
- Include interventions which achieve demonstrable improvement.
- Allow status and result reports to be reportable to CMS.

Quality of Care Issues

Quality of Care issues include Clinical Quality Indicators and Quality of Care Complaints. Quality Indicators are those issues that are usually identified by the Utilization Management staff and referred to the Quality Improvement Department staff. They may be defined as an adverse outcome occurring in the inpatient or ambulatory care setting that could be indicative of potential inappropriate or incomplete medical care. Quality of Care Complaints are those concerns reported by members, families, or providers that could indicate a potential problem in the provision of quality care and services.

The purpose of identifying these issues is for tracking concerns related to the provision of clinical care and service, evaluating member satisfaction, and trending specific provider involvement with potential quality of care issues. Clinical Quality Indicators include the following:

- Unplanned readmission to the hospital (within 30 days)
- Inpatient hospitalization following outpatient surgery (within 48 hours)
- Post-op complications (including unplanned return to the Operating Room)
- Unplanned removal, injury, or repair of organ or structure during procedure (excludes incidental appendectomy)
- Mortality review (in cases where death was not an expected outcome)
- Primary Care medical record documentation
- Ambulatory follow-up after hospitalization for selected behavioral health diagnosis (HEDIS results)

Quality complaints are categorized as:

- Access to care
- Availability of services
- Clinical quality concerns
- Provider/staff concerns

All Quality of Care issues are reviewed and investigated. Quality often requests records from providers and facilities as part of the investigation. Quality of care issues are reviewed by the QIC. Any action taken is documented in the provider's record and reviewed by the Credentialing Committee at the time of recredentialing. Quality of Care issues are highly confidential and outcomes cannot be shared with the member or provider. All quality of care/service issues may be faxed to the QI Department at (844) 224-3659.

Utilization Reporting and Monitoring

Risk-based compensation methods may create incentive for PruittHealth Premier providers and practitioners to limit approval of needed care. Over-utilization may indicate inadequate coordination of care or inappropriate utilization of services. Both under- and over-utilization may be harmful to the patient. Utilizing data from provider and practitioner sites, individual product lines, and the system as a whole, PruittHealth Premier monitors for under- and over-utilization, analyzes data to identify the causes, and takes action to correct any issues identified. PruittHealth Premier then implements appropriate interventions whenever potential problems are identified and will further monitor the effect of these interventions. PruittHealth Premier also carefully ensures that its financial incentives are aligned to encourage appropriate decisions on the delivery of care to members. PruittHealth Premier unequivocally promises members, providers, and employees that it does not employ incentives to encourage barriers to care and

service.

CORPORATE COMPLIANCE PROGRAM

Overview

The purpose of PruittHealth Premier's Corporate Compliance Program is to articulate PruittHealth Premier's commitment to compliance. It also serves to encourage our employees, contractors, and other interested parties to develop a better understanding of the laws and regulations that govern PruittHealth Premier's operations. Further, PruittHealth Premier's Corporate Compliance Program also ensures that all practices and programs are conducted in compliance with those applicable laws and regulations.

PruittHealth Premier and its subsidiaries are committed to full compliance with federal and state regulatory requirements applicable to our Medicare Advantage and Medicare Part D lines of business. Non-compliance with regulatory standards undermines PruittHealth Premier's business reputation and credibility with the federal and state governments, subcontractors, pharmacies, providers, and most importantly, its members. PruittHealth Premier and its employees are also committed to meeting all contractual obligations set forth in PruittHealth Premier's contracts with the CMS. These contracts allow PruittHealth Premier to offer Medicare Advantage and Medicare Part D products and services to Medicare beneficiaries.

The Corporate Compliance Program is designed to prevent violations of federal and state laws governing PruittHealth Premier's lines of business, including but not limited to, health care fraud and abuse laws. In the event such violations occur, the Corporate Compliance Program will promote early and accurate detection, prompt resolution, and, when necessary, disclosure to the appropriate governmental authorities.

PruittHealth Premier has in place, policies and procedures for coordinating and cooperating with MEDIC (Medicare Drug Integrity Contractor), CMS, State Regulatory Agencies, Congressional Offices, and law enforcement. PruittHealth Premier also has policies that delineate that PruittHealth Premier will cooperate with any audits conducted by CMS, MEDIC or law enforcement or their designees.

Call the PruittHealth Premier Compliance Hotline toll-free at (844) 317-9059.

Fraud, Waste, and Abuse

PruittHealth Premier has policies and procedures to identify fraud, waste, and abuse in its network, as well as other processes to identify overpayments within its network and to properly recover such overpayments. These procedures allow the Plan to report potential fraud or misconduct related to the Medicare program to the appropriate government authority as specified at 42 U.S.C. § 1395w-104 and 42 C.F.R. § 423.504(b)(4)(vi)(H), and PruittHealth Premier has policies and procedures in place for cooperating with CMS and law enforcement entities.

The evaluation and detection of fraudulent and abusive practices by PruittHealth Premier encompasses all aspects of PruittHealth Premier's business and its business relationship with third parties, including health care providers and members. All employees, contractors, and other parties are required to report compliance concerns and suspected or actual misconduct

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without fear of retaliation for reports made in good faith. The Compliance Officer may be contacted in the following manner:

- Anonymously by calling the toll-free Compliance Hotline at (844) 317-9059. The Compliance Hotline is a completely confidential resource that can be used by employees, contractors, agents, members, or other parties to voice concerns about any issue that may affect PruittHealth Premier's ability to meet legal or contractual requirements and/or to report misconduct that could give rise to legal liability if not corrected.
- By email at compliance@pruithhealthpremier.com.
- By mail at Corporate Compliance Officer, P.O. Box 2190, Glen Allen, VA 23058-2190.
- Directly by phone at (804) 396-6412 x117.

All such communications will be kept as confidential as possible, but there may be times when the reporting individual's identity may become known or need to be disclosed to meet requirements of any governmental review actions. Any employee, contractor, or other party that reports compliance concerns in good faith can do so without fear of retaliation.

In addition, as part of an ongoing effort to improve the delivery and affordability of health care to our members, PruittHealth Premier conducts periodic analysis of all levels of Current Procedural Terminology (CPT), ICD-9/ICD-10 and HCPCS codes billed by our providers. The analysis allows PruittHealth Premier to comply with its regulatory requirements for the prevention of fraud, waste, and abuse (FWA), and to supply our providers with useful information to meet their own compliance needs in this area. PruittHealth Premier will review your coding and may review medical records of providers who continue to show significant variance from their peers. PruittHealth Premier endeavors to ensure compliance and enhance the quality of claims data, a benefit to both PruittHealth Premier's medical management efforts and our provider community. As a result, you may be contacted by PruittHealth Premier's contracted partners to provide medical records to conduct reviews to substantiate coding and billing.

In order to meet your FWA obligations, please take the following steps:

- Review and revise your coding policies and procedures for compliance and adherence to CMS guidelines necessary to ensure they are consistent with official coding standards.
- Complete the mandatory online training at www.pruithhealthpremier.com

You may request a copy of the PruittHealth Premier Compliance Program document by contacting PruittHealth Premier Network Operations at (844) 224-3659; or call the PruittHealth Premier Compliance Officer at (804) 396-6412 x 117 or via email at eric.messick@allyalign.com.

MEDICARE ADVANTAGE PROGRAM REQUIREMENTS

The terms and conditions herein are included to meet federal statutory and regulatory requirements of the federal Medicare Advantage Program under Part C of Title XVIII of the Social Security Act ("Medicare Advantage Program"). Provider understands that the specific terms as set forth herein are subject to amendment in accordance with federal statutory and regulatory changes to the Medicare Advantage Program. Such amendment shall not require the consent of provider or PruittHealth Premier and will be effective immediately on the effective

date thereof.

1. **Books and Records; Governmental Audits and Inspections.** Provider shall permit the Department of Health and Human Services (“HHS”), the Comptroller General, or their designees to inspect, evaluate and audit all books, records, contracts, documents, papers and accounts relating to provider’s performance of the Agreement and transactions related to the CMS Contract (collectively, “Records”). The right of HHS, the Comptroller General or their designees to inspect, evaluate and audit provider’s Records for any particular contract period under the CMS Contract shall exist for a period of ten (10) years from the later to occur of (i) the final date of the contract period for the CMS Contract or (ii) the date of completion of the immediately preceding audit (if any) (the “Audit Period”). Provider shall keep and maintain accurate and complete Records throughout the term of the Agreement and the Audit Period.
2. **Privacy and Confidentiality Safeguards.** Provider shall safeguard the privacy and confidentiality of members and shall ensure the accuracy of the health records of members. Provider shall comply with all state and federal laws and regulations and administrative guidelines issued by CMS pertaining to the confidentiality, privacy, data security, data accuracy and/or transmission of personal, health, enrollment, financial and consumer information and/or medical records (including prescription records) of members, including, but not limited, to the Standards for Privacy of Individually Identifiable Information promulgated pursuant to the Health Insurance Portability and Accountability Act.
3. **Member Hold Harmless.** Provider shall not, in any event (including, without limitation, non-payment by PruittHealth Premier or breach of the Agreement), bill, charge, collect a deposit from, seek compensation or remuneration or reimbursement from or hold responsible, in any respect, any member for any amount(s) that PruittHealth Premier may owe to provider for services performed by provider under the Agreement. This provision shall not prohibit provider from collecting supplemental charges, co-payments or deductibles specified in the Benefit Plans. Provider agrees that this provision shall be construed for the benefit of the member and shall survive expiration, non-renewal or termination of the Agreement regardless of the cause for termination.
4. **Delegation of Activities or Responsibilities.** To the extent activities or responsibilities under a CMS Contract are delegated to provider pursuant to the Agreement (“Delegated Activities”), provider agrees that (i) the performance of the Delegated Activities and responsibilities thereof shall be subject to monitoring on an ongoing basis by PruittHealth Premier; and (ii) in the event that the PruittHealth Premier or CMS determine that provider has not satisfactorily performed any Delegated Activity or responsibility thereof in accordance with the CMS Contract, applicable State and/or Federal laws and regulations and CMS instructions, then PruittHealth Premier shall have the right, at any time, to revoke the Delegated Activities by terminating the Agreement in whole or in part, and shall have the right to institute corrective action plans or seek other remedies or curative measures as contemplated by the Agreement. Provider shall not further delegate any activities or requirements without the prior written consent of PruittHealth Premier. To the extent that the Delegated Activities include professional credentialing services, provider agrees that the credentials of medical professionals affiliated or contracted with provider will either be (i) directly reviewed by PruittHealth Premier, or (ii) provider’s credentialing process will be reviewed and approved by PruittHealth Premier and PruittHealth Premier shall audit provider’s credentialing

- process on an ongoing basis. Provider acknowledges that PruittHealth Premier retains the right to approve, suspend or terminate any medical professionals, as well as any arrangement regarding the credentialing of medical professionals. In addition, provider understands and agrees that PruittHealth Premier maintains ultimate accountability under its Medicare Advantage contract with CMS. Nothing in this Agreement shall be construed to in any way limit PruittHealth Premier's authority or responsibility to
5. **Prompt Payment.** PruittHealth Premier agrees to pay provider in compliance with applicable state or federal law following its receipt of a "clean claim" for services provided to PruittHealth Premier members. For purposes of this provision, a clean claim shall mean a claim for provider services that has no defect or impropriety requiring special treatment that prevents timely payment by PruittHealth Premier.
 6. **Compliance with PruittHealth Premier's Obligations, Provider Manual, Policies and Procedures.** Provider shall perform all services under the Agreement in a manner that is consistent and compliant with PruittHealth Premier's contract(s) with CMS (the "CMS Contract"). Additionally, provider agrees to comply with the PruittHealth Premier Provider Manual and all policies and procedures relating to the Benefit Plans.
 7. **Subcontracting.** PruittHealth Premier maintains ultimate accountability for adhering to and otherwise fully complying with all terms and conditions of its contract with CMS. Provider shall not subcontract for the performance of Covered Services under this Agreement without the prior written consent of PruittHealth Premier. Every subcontract between provider and a subcontractor shall (i) be in writing and comply with all applicable local, State and federal laws and regulations; (ii) be consistent with the terms and conditions of this Agreement; (iii) contain PruittHealth Premier and member hold harmless language as set forth in Section 3 hereof; (iv) contain a provision allowing PruittHealth Premier and/or its designee access to such subcontractor's books and records as necessary to verify the nature and extent of the Covered Services furnished and the payment provided by provider to subcontractor under such subcontract; and (v) be terminable with respect to members or Benefit Plans upon request of PruittHealth Premier.
 8. **Compliance with Laws.** Provider shall comply with all State and Federal laws, regulations and instructions applicable to provider's performance of services under the Agreement. Provider shall maintain all licenses, permits and qualifications required under applicable laws and regulations for provider to perform the services under the Agreement. Without limiting the above, provider shall comply with Federal laws designed to prevent or ameliorate fraud, waste and abuse, including but not limited to applicable provisions of Federal criminal law, the False Claims Act (31 U.S.C. 3729 et. seq.) and the anti-kickback statute (section 1128B(b) of the Social Security Act).
 9. **Program Integrity.** Provider represents and warrants that provider (or any of its staff) is not and has not been (i) sanctioned under or listed as debarred, excluded or otherwise ineligible for participation in the Medicare program or any Federal program involving the provision of health care or prescription drug services, or (ii) criminally convicted or has a civil judgment entered against it for fraudulent activities. Provider shall notify PruittHealth Premier immediately if, at any time during the term of the Agreement, provider (or any of its staff) is (i) sanctioned under or listed as debarred, excluded or otherwise ineligible for participation in the Medicare program or any Federal program involving the provision of health care or prescription drug services, or (ii) criminally convicted or has a civil judgment entered against it for fraudulent activities. Provider acknowledges that provider's participation in PruittHealth Premier shall be terminated if

provider (or any of its staff) is debarred, excluded or otherwise ineligible for participation in the Medicare program or any Federal program involving the provision of health care or prescription drug services.

10. **Continuation of Benefits.** Provider shall continue to provide services under the Agreement to members in the event of (i) PruittHealth Premier's insolvency, (ii) PruittHealth Premier's discontinuation of operations or (iii) termination of the CMS Contract, throughout the period for which CMS payments have been made to PruittHealth Premier, and, to the extent applicable, for members who are hospitalized, until such time as the member is appropriately discharged.
11. **Incorporation of Other Legal Requirements.** Any provisions now or hereafter required to be included in the Agreement by applicable Federal and/or State laws and regulations or by CMS shall be binding upon and enforceable against the parties to the Agreement and be deemed incorporated herein, irrespective of whether or not such provisions are expressly set forth in this Manual or elsewhere in your Agreement.
12. **Conflicts.** In the event of a conflict between any specific provision of your Agreement and any specific provision of the Manual, the specific provisions of this Manual shall control.

DISPUTE RESOLUTION

Any controversy, dispute or claim arising out of or relating to your Provider Agreement ("Agreement") or the breach thereof, including any question regarding its interpretation, existence, validity or termination, that cannot be resolved informally, shall be resolved by arbitration in accordance with this Section, provided however that a legal proceeding brought by a third party against PruittHealth Premier, an Affiliate, provider, or any provider ("Defendant"), any cross-claim or third party claim by such Defendant against PruittHealth Premier, an Affiliate, provider, or any provider Facility shall not be subject to arbitration. In the event arbitration becomes necessary, such arbitration shall be initiated by either Party making a written demand for arbitration on the other Party. The arbitration shall be conducted in the county where the majority of the services are performed, in accordance with the Commercial Arbitration Rules of the American Arbitration Association, as they are in effect when the arbitration is conducted, and by an arbitrator knowledgeable in the health care industry. The Parties agree to be bound by the decision of the arbitrator. The Parties further agree that the costs, fees and expenses of arbitration will be borne by the non-prevailing party.

Notwithstanding this Agreement to arbitrate, PruittHealth Premier, an Affiliate, provider, or any provider Facility may seek interim and/or permanent injunctive relief pursuant to this Agreement in the county where the majority of the services are performed in any court of competent jurisdiction. With respect to disputes arising during the life of this Agreement, this Section shall survive the termination or expiration of the Agreement.

HEALTH SERVICES NUMBER

(844) 224-3659