Provider Manual

ConnectiCare Medicare Advantage 2026

Capitalized words or phrases used in this Provider Manual shall have the meaning set forth in the Provider Agreement with ConnectiCare. “ConnectiCare” has the same meaning as “Health Plan” in the Provider Agreement with ConnectiCare. The Provider Manual is customarily updated annually but may be updated more frequently as needed. Providers can access the most current Provider Manual at connecticare.com.

Last Updated: 09/2026

ConnectiCare

Table of contents

1. Product overview 2
2. Contact information 3
3. Provider responsibilities 7
4. Culturally and linguistically appropriate services 18
5. Member rights and responsibilities 24
6. Eligibility and enrollment in Medicare Advantage plans 25
7. Benefit overview 27
8. Health care services 29
9. Behavioral health 55
10. Quality 56
11. Risk adjustment accuracy and completeness 71
12. Compliance 73
13. Claims 102
14. Medicare Member grievances and appeals 119
15. Credentialing and recredentialing 127
16. Delegation 137
17. Medicare Part D 138

1. Product overview

ConnectiCare Choice Dual (HMO-POS D-SNP)

ConnectiCare Choice Plan 2 (HMO-POS)

ConnectiCare Passage Plan 1 (HMO-POS)

ConnectiCare Flex Plan 3 (HMO-POS)

ConnectiCare Choice Plan 3 (HMO-POS)

ConnectiCare Flex Plan 2 (HMO-POS)

ConnectiCare Choice Plan 1 (HMO-POS)

2. Contact information

ConnectiCare
175 Scott Swamp Road
Farmington, CT 06034

Provider services

The ConnectiCare Provider Contact Center handles telephone inquiries from Providers regarding claims, appeals, authorizations, eligibility, and general concerns. ConnectiCare Provider Contact Center representatives are available 8 a.m. to 6 p.m., ET, Monday through Friday, excluding state and federal holidays. Questions can also be submitted through the Secure Messaging feature on the Availity Essentials portal.

Phone: (800) 828-3407
Availity Essentials portal: availity.com/providers

Provider relations

The Provider Relations department manages Provider calls regarding issue resolution, Provider education and training. The department has Provider Relations representatives who serve all of ConnectiCare's Provider network.

Phone: (800) 828-3407

Member services

The ConnectiCare Member Contact Center handles all telephone inquiries regarding, benefits, eligibility/identification, pharmacy inquiries, selecting or changing primary care providers (PCP), Member complaints, and if applicable, offers to assist Members with obtaining Medicaid-covered services, resolving grievances, including requesting authorization of Medicaid services and navigating Medicaid appeals and grievances regardless of whether such coverage is in Medicaid fee-for-service or a Medicaid managed care plan. ConnectiCare Member Contact Center representatives are available from Oct. 1 to March 31, 7 days a week from 8 a.m. to 8 p.m., ET. From April 1 to Sept. 30, Monday through Friday from 8 a.m. to 8 p.m., ET., excluding state and federal holidays.

Phone: (800) 224-2273
Hearing Impaired (TTY/TDD): 711

Claims

For dates of services beginning 01/01/2026: ConnectiCare strongly encourages Participating Providers to submit claims electronically via a clearinghouse or the Availity Essentials portal whenever possible.

- -Availity Essentials portal: availity.com/providers
- EDI Payer ID MLNCT

To verify the status of your claims, please use the Availity Essentials portal. Claim questions can be submitted through the Secure Messaging feature via the Claims Status module on the Availity Essentials portal or by contacting the ConnectiCare Provider Contact Center. For additional information please refer to the **Claims** section of this Provider Manual.

Phone: (800) 828-3407
Hearing Impaired (TTY/TDD): 711

Claims recovery

The Claims Recovery department manages recovery for overpayment and incorrect payment of claims.

Provider disputes	ConnectiCare PO Box 2470 Spokane, WA 99210-2470
Refund checks lockbox	ConnectiCare PO Box 416947 Boston, MA 02241-6947
Phone	(866) 642-8999

Compliance and fraud alertline

Suspected cases of fraud, waste or abuse must be reported to ConnectiCare. You may do so by contacting the ConnectiCare Alertline or by submitting an electronic complaint using the website listed below. For additional information on fraud, waste and abuse please refer to the **Compliance** section of this Provider Manual.

Confidential
Compliance Official
Molina Healthcare, Inc.
200 Oceangate, Suite 100
Long Beach, CA 90802

Phone: (866) 606-3889
Online: molinahealthcare.alertline.com

Credentialing

The Credentialing department verifies all information on the Provider Application prior to contracting and re-verifies this information every three (3) years or sooner, depending on ConnectiCare's credentialing criteria. The information is then presented to the Professional Review Committee to evaluate a Provider's qualifications to participate in

the ConnectiCare network. For additional information please refer to the **Credentialing and Recredentialing** section of this Provider Manual.

Phone: (800) 828-3407

24-hour Nurse Advice Line

This telephone-based nurse advice line is available to all ConnectiCare Members. Members may call anytime they are experiencing symptoms or need health care information. Registered nurses are available 24 hours a day, 7 days a week.

Phone: (833) 957-0169
Hearing Impaired (TTY/TDD): 711)

Health care services

The Heath Care Services (HCS) department conducts concurrent review on inpatient cases and processes prior authorizations/service requests. The HCS department also performs case management for Members who will benefit from case management services. Participating Providers are required to interact with ConnectiCare's HCS department electronically whenever possible. Prior authorization/service requests and status checks can be easily managed electronically. For additional information please refer to the **Health Care Services** section of this Provider Manual.

Managing Prior Authorizations/Service Requests electronically provides many benefits to Providers, such as:

- Easy to access to 24/7 online submission and status checks
- Ensures Health Insurance Portability and Accountability Act (HIPAA) compliance
- Ability to receive real-time authorization status
- Ability to upload medical records
- Increased efficiencies through reduced telephonic interactions
- Reduces costs associated with fax and telephonic interactions

ConnectiCare offers the following electronic prior authorizations/service requests submission options:

- Submit requests directly to ConnectiCare via the Availity Essentials portal.
- Submit requests via 278 transactions.

Mental health and substance use disorder

ConnectiCare's vendor, Optum Behavioral Health, coordinates and manages behavioral health and substance abuse services for Members. Optum Behavioral Health has a Help Line that Members and Providers can access by calling (888) 946-4658. Standard hours of operation are 7 a.m. to 7 p.m., CST. When Members call this number at any time there is an IVR prompt that asks if they have concerns about their own or someone else's safety. If the Member answers YES, they are routed directly to a crisis team *24/7.*

For Clinical Assistance, Providers can contact Optum Behavioral Health at (800) 349-5365 from 7 a.m. to 7 p.m., CST. For higher level of care auth requests ONLY, Providers can call this number 24/7.

For additional information please refer to Optum's website at providerexpress.com.

Claims address:

Optum Behavioral Health
PO Box 30757
Salt Lake City, UT 84130-0757

Pharmacy

The prescription drug benefit is administered through CVS Caremark. A list of in-network pharmacies is available at CVS Caremark.com/pharmacy locator or by contacting ConnectiCare. For additional information please refer to the **Medicare Part D** section of this Provider Manual.

Phone: (800) 665-3086
Part D Fax: (866) 290-1309
J Code Fax: (800) 391-6437

Quality

ConnectiCare maintains a quality department to work with Members and Providers in administering the ConnectiCare Quality Improvement (QI) Program. For additional information please refer to the **Quality** section of this Provider Manual.

Phone: (800) 828-3407

3. Provider responsibilities

Non-discrimination in health care service delivery

Providers must comply with the non-discrimination in health care service delivery requirements as outlined in the **Culturally and Linguistically Appropriate Services** section of this Provider Manual.

Additionally, ConnectiCare requires Providers to deliver services to ConnectiCare Members without regard to the source of payment. Specifically, Providers may not refuse to serve ConnectiCare Members because they receive assistance with cost-sharing from a government-funded program.

Section 1557 investigations

All ConnectiCare Providers shall disclose all investigations conducted pursuant to Section 1557 of the Patient Protection and Affordable Care Act to ConnectiCare's Civil Rights Coordinator.

Molina Healthcare, Inc.
Civil Rights Coordinator
200 Oceangate, Suite 100
Long Beach, CA 90802

Phone: (866) 606-3889
Hearing Impaired: TTY/TDD: 711
Online: molinahealthcare.alertline.com
Email: civil.rights@molinahealthcare.com

For additional information please refer to the Department of Health and Human Services (HHS) website at federalregister.gov/documents/2020/06/19/2020-11758/nondiscrimination-in-health-and-health-education-programs-or-activities-delegation-of-authority.

Facilities, equipment, personnel and administrative services

The Provider's facilities, equipment, personnel and administrative services must be at a level and quality necessary to perform duties and responsibilities to meet all applicable legal requirements including the accessibility requirements of the Americans with Disabilities Act (ADA).

Provider data accuracy and validation

It is important for Providers to ensure ConnectiCare has accurate practice and business information. Accurate information allows us to better support and serve our Members and Provider Network.

Maintaining an accurate and current Provider Directory is a state and federal regulatory requirement, as well as a National Committee for Quality Assurance (NCQA) required element. Invalid information can negatively impact Member access to care, Member/PCP assignments and referrals. Additionally, current information is critical for timely and accurate claims processing.

Please visit our Provider Online Directory to validate your information. Providers must validate the Provider information on file with ConnectiCare at least once every 90 days for correctness and completeness.

Provider information that must be validated includes, but is not limited to:

- Provider or practice name
- Location(s)/address
- Specialty(ies)
- Telephone number, fax number and email
- Digital contact information
- Whether your practice is open to new patients (PCPs only)
- Tax ID and/or National Provider Identifier (NPI)

The information above must be provided as follows:

- Delegated Providers and other Providers that typically submit rosters must submit a full roster that includes the above information to ConnectiCare at CCI-providerfileoperations@molinahealthcare.com.
- All other Providers must log into their Council for Affordable Quality Healthcare, Inc., (CAQH) account to attest to the accuracy of the above information for each health care Provider and/or facility in your practice that is contracted with ConnectiCare. If the information is correct, please select the option to attest that the information is correct. If the information is not correct, Providers can make updates through the CAQH portal. Providers unable to make updates through the CAQH portal should contact their ConnectiCare Provider Relations representative for assistance.

Additionally, in accordance with the terms specified in the Provider Agreement with ConnectiCare, Providers must notify ConnectiCare of any changes, as soon as possible but at a minimum 30 calendar days in advance of any changes in any Provider information on file with ConnectiCare. Changes include, but are not limited to:

- Change in office location(s)/address, office hours, phone, fax or email.
- Addition or closure of office location(s).
- Addition of a Provider (within an existing clinic/practice).
- Change in Provider or practice name, Tax ID and/or National Provider Identifier (NPI).
- Opening or closing your practice to new patients (PCPs only).
- Change in specialty.
- Any other information that may impact Member access to care.

For Provider terminations (within an existing clinic/practice), Providers must notify ConnectiCare in writing in accordance with the terms expressed in the Provider Agreement with ConnectiCare.

Note: Some changes may impact credentialing. Providers are required to notify ConnectiCare of changes to credentialing information in accordance with the requirements outlined in the **Credentialing and Recredentialing** section of this Provider Manual.

ConnectiCare is required to audit and validate our Provider Network data and Provider Directories on a routine basis. As part of our validation efforts, we may reach out to our Network of Providers through various methods, such as letters, phone campaigns, face-to-face contact, fax and fax-back verification, etc. ConnectiCare also may use a vendor to conduct routine outreach to validate data that impacts the Provider Directory or otherwise impacts its membership or ability to coordinate Member care. Providers are required to supply timely responses to such communications.

All ConnectiCare Providers participating in a Medicaid network must be enrolled in the state Medicaid program to be eligible for reimbursement. If a Provider has not had a Medicaid number assigned, the Provider must apply for enrollment with the Connecticut Department of Social Services and meet the Medicaid Provider enrollment requirements set forth in the HUSKY Health Provider Website for fee-for-service Providers of the appropriate provider type.

National Plan and Provider Enumeration System (NPPES) Data Verification

In addition to the above verification requirements, the Centers for Medicare & Medicaid Services (CMS) recommends that Providers routinely verify and attest to the accuracy of their NPPES data.

NPPES allows Providers to attest to the accuracy of their data. If the data is correct, the Provider is able to attest and NPPES will reflect the attestation date. If the information is not correct, the Provider is able to request a change to the record and attest to the changed data, resulting in an updated certification date.

ConnectiCare supports the CMS recommendations around NPPES data verification and encourages our Provider network to verify Provider data via nppes.cms.hhs.gov. Additional information regarding the use of NPPES is available in the Frequently Asked Questions (FAQ) document published at the following link: cms.gov/medicare/health-plans/managedcaremarketing/index.

ConnectiCare electronic solutions requirements

ConnectiCare requires Providers to utilize electronic solutions and tools whenever possible.

ConnectiCare requires all contracted Providers to participate in and comply with ConnectiCare's electronic solution requirements, which include but are not limited to, electronic submission of prior authorization requests, prior authorization status inquiries, health plan access to electronic medical records (EMR), electronic claim submission, electronic fund transfers (EFT), electronic remittance advice (ERA), electronic claim Appeal and registration for and use of the Availity Essentials portal.

Electronic claims include claims submitted via a clearinghouse using the EDI process and claims submitted through the Availity Essentials portal.

Any Provider entering the network as a contracted Provider will be required to comply with ConnectiCare's electronic solution policy by enrolling for EFT/ERA payments and registering for the Availity Essentials portal within 30 days of entering the ConnectiCare network.

ConnectiCare is committed to complying with all HIPAA Transactions, Code Sets and Identifiers (TCI) standards. Providers must comply with all HIPAA requirements when using electronic solutions with ConnectiCare. Providers must obtain a National Provider Identifier (NPI) and use their NPI in HIPAA transactions, including claims submitted to ConnectiCare. Providers may obtain additional information by visiting our website at connecticare.com.

Electronic solutions/tools available to providers

Electronic solutions/tools available to ConnectiCare Providers include:

- Electronic claim submission options
- Electronic payment: EFT with ERA
- Availity Essentials portal: availity.com/providers

Electronic claim submission requirement

ConnectiCare strongly encourages participating Providers to submit claims electronically whenever possible. Electronic claim submission provides significant benefits to the Provider such as:

- Promoting HIPAA compliance
- Helping to reduce operational costs associated with paper claims (printing, postage, etc.)
- Increasing accuracy of data and efficient information delivery
- Reducing claim processing delays as errors can be corrected and resubmitted electronically
- Eliminating mailing time and enabling claims to reach ConnectiCare faster

ConnectiCare offers the following electronic claim submission options:

- Submit claims directly to ConnectiCare via the Availity Essentials portal

- Submit claims to ConnectiCare through your EDI clearinghouse using Payer ID MLNCT.

While both options are embraced by ConnectiCare, submitting claims via the Availity Essentials portal (available to all Providers at no cost) offers a number of additional claim processing benefits beyond the possible cost savings achieved from the reduction of high-cost paper claims.

Availity Essentials portal claim submission includes the ability to:

- Submit claims through direct data entry
- Add attachments to claims
- Submit claims through quick claims entry and saving templates
- Submit corrected claims
- Add attachments to corrected claims
- Add attachments to pending claims
- Easily and quickly void claims
- Check claim status
- Receive timely notification of a change in status for a particular claim
- Ability to save incomplete/un-submitted claims
- Create/manage claim templates

For additional information on EDI claim submission and paper claim submission please refer to the **Claims** section of this Provider Manual.

Electronic payment requirement

Participating Providers are strongly encouraged to enroll in EFT and ERA. Providers enrolled in EFT payments will automatically receive ERAs as well. EFT/ERA services give Providers the ability to reduce paperwork, utilize searchable ERAs and receive payment and ERA access faster than the paper check and remittance advice (RA) processes. There is no cost to the Provider for EFT enrollment and Providers are not required to be in-network to enroll. ConnectiCare uses a vendor to facilitate the HIPAA-compliant EFT payment and ERA delivery processes.

ConnectiCare has partnered with ECHO Health, Inc. (ECHO), for payment delivery and 835 processing. On this platform you may receive your payment via EFT/Automated Clearing House (ACH) or a physical check.

By default, if you have no payment preferences specified on the ECHO platform, your payments will be issued via check.

Once you have enrolled for electronic payments you will receive the associated ERAs from ECHO with the ConnectiCare Payer ID. Please ensure that your practice management system is updated to accept the Payer ID referenced below. All generated ERAs will be accessible to download from the ECHO provider portal at providerpayments.com.

If you have any difficulty with the website or have additional questions, ECHO has a customer services team available to assist with this transition. Additionally, changes to the ERA enrollment or ERA distribution can be made by contacting the ECHO customer services at (888) 834-3511.

As a reminder, ConnectiCare's Payer ID is MLNCT.

Once your account is activated, you will begin receiving all payments through EFT and you will no longer receive a paper EOP (i.e., remittance) through the mail. You will receive 835s (by your selection of routing or via manual download) and can view, print, download and save historical and new ERAs with a two (2)-year lookback.

Availity Essentials portal

Providers and third-party billers can use the no-cost Availity Essentials portal to perform many functions online without the need to call or fax ConnectiCare. Registration can be performed online and once completed the easy-to-use tool offers the following features:

- Verify Member eligibility, covered services, benefit limits, benefit accumulators and view Healthcare Effectiveness Data and Information Set (HEDIS®) needed services (gaps)
- Claims:
  - Submit Professional (CMS-1500) and Institutional (CMS-1450 [UB04]) claims with attached files
  - Correct/void claims
  - Add attachments to previously submitted claims
  - Check claim status
  - View ERA and EOP
  - Create and manage claim templates
  - Submit and manage claim disputes, including formal appeals or reconsideration requests, for finalized claims
  - View, dispute, resolve claim overpayments
- Prior authorizations/service requests
  - Create and submit prior authorization/service requests
  - Check status of prior authorization/service requests
  - Access prior authorization letters directly through the Digital Correspondence Hub functionality in the Availity Essentials portal. Please note: Letters will only be available for prior authorization requests submitted via the Availity Essentials portal.
- Download forms and documents
- Send/receive secure messages to/from ConnectiCare
- Manage Overpayment invoices (Inquire, Dispute and Resolve)

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

Digital Correspondence Hub

The Digital Correspondence Hub lets your organization manage communication preferences in the Availity Essentials portal. Only your designated Administrator can change settings, including opting out of paper letters. For updates, please contact your Administrator.

Users can also choose to receive or decline weekly reminder notifications for unopened digital letters. These reminders are not real-time alerts. Opting out of reminders does not affect your organization's digital correspondence delivery preferences.

Provider Network Management Portal: Enrollment Tool

The **Provider Network Management Portal** is a secure, free tool used to manage Provider enrollment and credentialing requests. All credentialing requests for a Provider to join the network must be submitted electronically through the portal.

Available functions include:

- Adding practitioners to an existing group
- Submitting credentialing requests
- Tracking credentialing and participation status
- Providing additional or missing information for enrollment or credentialing
- Uploading provider rosters
- Adding new facility locations

Access

Office managers, administrative personnel, or Providers who need access to the portal for the first time must submit a registration request directly through the Provider Network Management Portal.

Balance billing

Pursuant to law and CMS guidance, Members who are dually eligible for Medicare and Medicaid and classified as Qualified Medicare Beneficiaries (QMB) shall not be held liable for Medicare Part A and B cost sharing when the state or another payor is responsible for paying such amounts. The Provider is responsible for verifying eligibility and obtaining approval for those services that require prior authorization.

Providers agree that under no circumstance shall a Member be liable to the Provider for any sums that are the legal obligation of ConnectiCare to the Provider. Balance billing a Member for covered services is prohibited, except for the Member's applicable co-payment, co-insurance and deductible amounts.

Member rights and responsibilities

Providers are required to comply with the Member Rights and Responsibilities as outlined in ConnectiCare's Member materials (such as Member Handbooks).

For additional information please refer to the **Member Rights and Responsibilities** section of this Provider Manual.

Member information and marketing

Any written informational or marketing materials directed to ConnectiCare Members must be developed and distributed in a manner compliant with all state and federal laws and regulations and approved by ConnectiCare prior to use.

Please contact ConnectiCare Provider Relations representatives for information and review of proposed materials.

Member eligibility verification

Possession of a ConnectiCare Member ID Card does not guarantee Member eligibility or coverage. Providers should verify the eligibility of ConnectiCare Members prior to rendering services. Payment for services rendered is based on enrollment and benefit eligibility. The contractual agreement between Providers and ConnectiCare places the responsibility for eligibility verification on the Provider of services.

Providers who contract with ConnectiCare may verify a Member's eligibility by checking the following:

- Availity Essentials portal: availity.com/providers
- ConnectiCare Provider Contact Center automated Interactive Voice Response (IVR) system at (800) 828-3407

For additional information please refer to the **Eligibility and Enrollment in Medicare Advantage Plans** section of this Provider Manual.

Member cost share

Providers should verify the ConnectiCare Member's cost share status prior to requiring the Member to pay co-pay, co-insurance, deductible or other cost share that may be applicable to the Member's specific benefit plan. Some plans have a total maximum cost share that frees the Member from any further out-of-pocket charges once reached (during that calendar year).

Health care services (utilization management and case management)

Providers are required to participate in and comply with ConnectiCare's utilization management and case management programs, including all policies and procedures regarding ConnectiCare's facility admission, prior authorization and Medical Necessity review determination and Interdisciplinary Care Team (ICT) procedures. Providers will also cooperate with ConnectiCare in audits to identify, confirm, and/or assess utilization levels of covered services.

Providers are required to participate in and comply with the CMS Model of Care (MOC)

training requirements as applicable. This includes completing ConnectiCare's MOC training and submitting attestation documentation upon completion as required. ConnectiCare's MOC Provider training and attestation documents are found on the ConnectiCare website at connecticare.com.

For additional information, please refer to the **Health Care Services** section of this Provider Manual.

Referrals

A referral may become necessary when a Provider determines medically necessary services are beyond the scope of the PCP's practice or it is necessary to consult or obtain services from other in-network specialty health professionals unless the situation is one involving the delivery of emergency services. Information is to be exchanged between the PCP and Specialist to coordinate care of the patient to ensure continuity of care. Providers need to document, in the patient's medical record, any referrals that are made. Documentation needs to include the specialty, services requested and diagnosis for which the referral is being made.

Providers should direct ConnectiCare Members to health professionals, hospitals, laboratories and other facilities and Providers which are contracted and credentialed (if applicable) with ConnectiCare. In the case of urgent and emergency services, Providers may direct Members to an appropriate service including, but not limited to, primary care, urgent care and hospital emergency room. There may be circumstances in which referrals may require an out-of-network Provider. Prior authorization will be required from ConnectiCare except in the case of emergency services.

For additional information please refer to the **Health Care Services** section of this Provider Manual.

PCPs are able to refer a Member to an in-network specialist for consultation and treatment without a referral request to ConnectiCare.

Treatment alternatives and communication with Members

ConnectiCare endorses open Provider and Member communication regarding appropriate treatment alternatives and any follow up care. ConnectiCare promotes open discussion between Provider and Members regarding medically necessary or appropriate patient care, regardless of covered benefits limitations. Providers are free to communicate all treatment options to Members regardless of benefit coverage limitations. Providers are also encouraged to promote and facilitate training in self-care and other measures Members may take to promote their own health.

Pharmacy program

Providers are required to adhere to ConnectiCare's drug formularies and prescription policies. For additional information please refer to the **Medicare Part D** section of this Provider Manual.

Participation in quality improvement (QI) programs

Providers are expected to participate in ConnectiCare's QI programs and collaborate with ConnectiCare in conducting peer reviews and audits of care rendered by Providers. Such participation includes, but is not limited to:

- Access to care standards
- Site and medical record-keeping practice reviews as applicable
- Delivery of patient care information

For additional information please refer to the **Quality** section of this Provider Manual.

Compliance

Providers must comply with all state and federal laws and regulations related to the care and management of ConnectiCare Members.

Confidentiality of Member health information and HIPAA transactions

ConnectiCare requires that Providers respect the privacy of ConnectiCare Members (including ConnectiCare Members who are not patients of the Provider) and comply with all applicable laws and regulations regarding the privacy of patient and Member protected health information (PHI).

For additional information please refer to the **Compliance** section of this Provider Manual.

Participation in grievance and appeals programs

Providers are required to participate in ConnectiCare's grievance and appeals programs and cooperate with ConnectiCare in identifying, processing and promptly resolving all Member complaints, grievances or inquiries. If a Member has a complaint regarding a Provider, the Provider will participate in the investigation of the grievance. If a Member submits an appeal, the Provider will participate by providing medical records or statements if needed. This includes the maintenance and retention of Member records for a period of not less than 10 years and retained further if the records are under review or audit until such time that the review or audit is complete.

For additional information please refer to the **Medicare Member Grievances and Appeals** section of this Provider Manual.

Participation in credentialing

Providers are required to participate in ConnectiCare's credentialing and re-credentialing process and will satisfy, throughout the term of their contract, all credentialing and re-credentialing criteria established by ConnectiCare and applicable accreditation, state and federal requirements. This includes providing prompt responses to ConnectiCare's requests for information related to the credentialing or re-credentialing process.

For additional information on ConnectiCare's credentialing program please refer to the **Credentialing and Recredentialing** section of this Provider Manual.

Delegation

Delegated entities must comply with the terms and conditions outlined in ConnectiCare's Delegated Services Addendum. For additional information on ConnectiCare's delegation requirements and delegation oversight please refer to the **Delegation** section of this Provider Manual.

Primary care provider responsibilities

PCPs are responsible to:

- Serve as the ongoing source of primary and preventive care for Members
- Assist with coordination of care as appropriate for the Member's health care needs
- Recommend referrals to specialists participating with ConnectiCare
- Triage appropriately
- Notify ConnectiCare of Members who may benefit from case management
- Participate in the development of care management treatment plans
- Complete Special Needs Plan (SNP) MOC training as required
- Participate in all MOC-required activities including coordination of care during transitions

4. Culturally and linguistically appropriate services

Background

ConnectiCare works to ensure all Members receive culturally and linguistically appropriate care across the service continuum to reduce health disparities and improve health outcomes. The Culturally and Linguistically Appropriate Services in Health Care (CLAS) standards published by the U.S. Department of Health and Human Services (HHS), seek to improve the appropriateness and accessibility of health care services by meeting the cultural, linguistic and accessibility related needs of individuals served. ConnectiCare complies with Section 1557 of the Patient Protection and Affordable Care Act, prohibiting discrimination in health programs and activities receiving federal financial assistance on the basis of race, color and national origin, sex, age and disability per Title VI of the Civil Rights Act of 1964, Title IX of the Education Amendments of 1972, the Age Discrimination Act of 1975 and Section 504 of the Rehabilitation Act of 1975 (29 U.S.C. § 794). ConnectiCare complies with applicable portions of the Americans with Disabilities Act of 1990. ConnectiCare also complies with all regulations for the foregoing. Compliance ensures the provision of linguistic access and disability-related access to all Members, including those with Limited English Proficiency (LEP) and Members who are deaf, hard of hearing, non-verbal, have a speech impairment or have an intellectual disability. Policies and procedures address how individuals and systems within the organization will effectively provide services to people of all cultures, races, ethnic backgrounds, sexes, ages and religions as well as those with disabilities in a manner that recognizes values, affirms and respects the worth of the individuals and protects and preserves the dignity of each.

Additional information on culturally and linguistically appropriate services is available on the Availity Essentials portal (Go to Payer spaces, Resources Tab), from local ConnectiCare Provider Relations representatives and by calling the ConnectiCare Provider Contact Center at (800) 828-3407.

Non-discrimination in health care service delivery

ConnectiCare complies with Section 1557 of the Affordable Care Act (ACA). As a Provider participating in ConnectiCare's Provider Network, you and your staff must also comply with the non-discrimination provisions and guidance set forth by the Department of Health and Human Services, Office for Civil Rights (HHS-OCR); state law and federal program rules, including Section 1557 of the ACA.

You are required to do, at a minimum, the following:

1. You **MAY NOT** limit your practice because of a Member's medical (physical or mental) condition or the expectation for the need of frequent or high-cost care.
2. You **MUST** post in a conspicuous location in your office a Nondiscrimination Notice. A sample of the Nondiscrimination Notice that you will post can be found on the Member pages of ConnectiCare's website at connecticare.com/legal/nondiscrimination.

3. You **MUST** post in a conspicuous location in your office a Tagline Document, that explains how to access non-English language services. A sample of the Tagline Document that you will post can be found on the Member pages of ConnectiCare's website at connecticare.com/legal/nondiscrimination.
4. If a ConnectiCare Member is in need of accessibility-related services, you **MUST** provide reasonable accommodations for individuals with disabilities and appropriate auxiliary aids and services.
5. If a ConnectiCare Member is in need of language assistance services while at your office and you are a recipient of federal financial assistance, you **MUST** take reasonable steps to make your services accessible to persons with LEP. You can find resources on meeting your LEP obligations at Limited English Proficiency (LEP) | HHS.gov and Limited English Proficiency Resources for Effective Communication | HHS.gov.
6. If a ConnectiCare Member complains of discrimination you **MUST** provide them with the following information so that they may file a complaint with ConnectiCare's Civil Rights Coordinator or the HHS-OCR:

Civil Rights Coordinator Molina Healthcare, Inc. 200 Oceangate, Suite 100 Long Beach, CA 90802 Phone: (866) 606-3889 (TTY/TDD: 711) Email: civil.rights@molinahealthcare.com	Office of Civil Rights U.S. Department of Health and Human Services 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201 Website: ocrportal.hhs.gov/ocr/portal/lobby.jsf Complaint Form: hhs.gov/ocr/complaints/index.html

If you or a ConnectiCare Member needs additional help or more information call the Office of Civil Rights at (800) 368-1019 or TTY/TDD (800) 537-7697 for persons with hearing impairments.

Culturally and linguistically appropriate services

ConnectiCare is committed to reducing health care disparities and improving health outcomes for all Members. Training employees, Providers and their staff and improving appropriateness and accessibility of services are the cornerstones of assessing, respecting and responding to a wide variety of cultural, linguistic and accessibility needs when providing health care services. ConnectiCare integrates culturally and linguistically appropriate practices training into the overall Provider training and quality-monitoring programs. An integrated quality approach enhances the way people think about our Members, service delivery and program development so that culturally and linguistically appropriate practices become a part of everyday thinking.

Provider and community training

ConnectiCare offers educational opportunities in culturally and linguistically appropriate practices and concepts for Providers and their staff. ConnectiCare conducts Provider training during Provider orientation with annual reinforcement training offered through Provider Services and/or online/web-based training modules. Web-based training modules can be found on the Availity Essentials portal.

Training modules, delivered through a variety of methods, include:

1. Provider written communications and resource materials
2. On-site culturally and linguistically appropriate practices training
3. Online culturally and linguistically appropriate practices Provider training
4. Integration of culturally and linguistically appropriate practices and concepts and non-discrimination of service delivery into Provider communications

Integrated quality improvement

ConnectiCare ensures Member access to language services such as oral interpretation, American Sign Language (ASL), written materials in alternate formats, and written translation. ConnectiCare must also ensure access to programs, aids and services that are congruent with cultural norms. ConnectiCare supports Members with disabilities and assists Members with LEP.

ConnectiCare develops Member materials according to plain language guidelines. Members or Providers may also request written Member materials in alternate languages and formats (i.e., braille, audio, large print), leading to better communication, understanding and Member satisfaction. Online materials found on connecticare.com and information delivered in digital form meet Section 508 accessibility requirements to support Members with visual impairments.

Key Member information, including appeal and grievance forms, is also available in threshold languages on the ConnectiCare Member website.

Access to language services

Providers may request interpreters for Members who speak a language other than English, including American Sign Language, by calling the ConnectiCare Member Contact Center at (800) 224-2273. If ConnectiCare Member Contact Center representatives are unable to interpret in the requested language, the representative will immediately connect you and the Member to a qualified interpreter.

ConnectiCare Providers must support Member access to telephonic interpreter services by offering a telephone with speaker capability or a telephone with a dual headset. Providers may offer ConnectiCare Members interpreter services if the Members do not request them on their own. Please remember it is never permissible to ask a family member, friend or minor to interpret.

All eligible Members with LEP are entitled to receive language services. Pursuant to Title VI of the Civil Rights Act of 1964, services provided for Members with LEP, limited reading proficiency (LRP) or limited hearing or sight are the financial responsibility of the Provider. Under no circumstances are ConnectiCare Members responsible for the cost of such services. Written procedures are to be maintained by each office or facility regarding their process for obtaining such services.

An individual with LEP is an individual whose primary language for communication is not English and who has a limited ability to read, write, speak or understand English well enough to understand and communicate effectively (whether because of language, cognitive or physical limitations). It is possible that an individual with LEP may be able to speak or understand English but still be limited to read or write in English. It is also important to not assume that an individual who speaks some English is proficient in the technical vocabulary of the health care services required.

ConnectiCare Members are entitled to:

- Be provided with effective communications with medical Providers as established by the Americans with Disabilities Act of 1990, the Rehabilitation Act of 1973 and the Civil Rights Act of 1964
- Be given access to care managers trained to work with individuals with cognitive impairments
- Be notified by the medical Provider that interpreter services, including American Sign Language, are available at no cost
- Be given reasonable accommodations, appropriate auxiliary aids and services
- Decide, with the medical Provider, to use an interpreter and receive unbiased interpretation
- Be assured of confidentiality, as follows:
    - Interpreters must adhere to Health and Human Service Commission (HHSC) policies and procedures regarding confidentiality of Member records
    - Interpreters may, with Member written consent, share information from the Member's records only with appropriate medical professionals and agencies working on the Member's behalf
    - Interpreters must ensure that this shared information is similarly safeguarded
- Have interpreters, if needed, during appointments with the Member's Providers and when talking to the health plan

Interpreters include people who can speak the Member's primary language, assist with a disability or help the Member understand the information.

When ConnectiCare Members need an interpreter, limited hearing and/or limited reading services for health care services, the Provider should:

- Verify the Member's eligibility and medical benefits
- Inform the Member that an interpreter, limited hearing, and/or limited reading services are available
- ConnectiCare is available to assist Providers with locating these services if needed:

- Providers needing assistance finding on-site, video remote, or telephonic interpreter services
- Providers needing assistance obtaining written materials in preferred languages
- Providers with Members who cannot hear or have limited hearing ability may use the TTY/TDD relay service at 711
- Providers with Members with limited vision may contact ConnectiCare for documents in large print, braille or audio version
- Providers with Members with LRP: ConnectiCare Member Service representatives will verbally explain the information, up to and including reading the documentation to the Members or offer the documents in audio version.

Documentation

As a contracted ConnectiCare Provider, your responsibilities for documenting Member language services/needs in the Member's medical record are as follows:

- Record the Member's language preference in a prominent location in the medical record. This information is provided to you on the electronic Member lists that are sent to you each month by ConnectiCare.
- Document all Member requests for interpreter services
- Document who provided the interpreter service. This includes the name of ConnectiCare's internal staff or someone from a commercial interpreter service vendor. Information should include the interpreter's name, operator code and vendor.
- Document all counseling and treatment done using interpreter services
- Document if a Member insists on using a family member, friend or minor as an interpreter or refuses the use of interpreter services after notification of their right to have a qualified interpreter at no cost

Members who are deaf or hard of hearing

TTY/TDD connection is accessible by dialing 711. This connection provides access to the ConnectiCare Member and Provider Contact Center, Quality, Health Care Services and all other health plan functions.

ConnectiCare strongly recommends that Provider offices make assistive listening devices available for Members who are deaf or hard of hearing. Assistive listening devices enhance the sound of the Provider's voice to facilitate a better interaction with the Member.

ConnectiCare will provide on-site or video service delivery for ASL to support our Members who are deaf or hard of hearing. Requests should be made at least three (3) business days in advance of an appointment to ensure availability of the service. In most cases, Members will have made this request via the ConnectiCare Member Contact Center.

24-hour Nurse Advice Line

ConnectiCare provides a nurse advice line for Members 24 hours per day, 7 days per week. The 24-hour Nurse Advice Line provides access to 24-hour interpretive services. Members may call ConnectiCare's 24-hour Nurse Advice Line directly at (833) 957-0169 or TTY/TDD: 711. The 24-hour Nurse Advice Line telephone numbers are also printed on ConnectiCare Member ID cards.

Program and policy review guidelines

ConnectiCare conducts assessments at regular intervals of the following information to ensure its programs are most effectively meeting the needs of its Members and Providers:

- Annual collection and analysis of race, ethnicity and language data from:
  - Eligible individuals to identify significant culturally and linguistically diverse populations within a plan's membership
  - Contracted Providers to assess gaps in network demographics
- Revalidate data at least annually
- Local geographic population demographics and trends derived from publicly available sources (Community Health Measures and state Rankings Report)
- Applicable national demographics and trends derived from publicly available sources
- Assessment of Provider network and cultural responsiveness
- Collection of data and reporting for the Race/Ethnicity Description of Membership HEDIS® measure
- Collection of data and reporting for the Language Description of Membership HEDIS® measure
- Annual determination of threshold languages and processes in place to provide Members with vital information in threshold languages
- Identification of specific cultural and linguistic disparities found across the Plan's diverse subpopulations
- Analysis of HEDIS® and Consumer Assessment of Healthcare Providers and Systems (CAHPS®) results for potential cultural and linguistic disparities that prevent Members from obtaining the recommended key chronic and preventive services.

CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

5. Member rights and responsibilities

Providers must comply with the rights and responsibilities of ConnectiCare Members as outlined in the ConnectiCare Evidence of Coverage (EOC). The EOC that is provided to Members annually is hereby incorporated into this Provider Manual. The most current EOC can be found on the Member pages of ConnectiCare's website at connecticare.com/resources/forms-medicare.

State and federal laws require that health care Providers and health care facilities recognize Member rights while the Members are receiving medical care and that Members respect the health care Provider's or health care facility's right to expect certain behavior on the part of the Members.

For additional information, please contact the ConnectiCare Provider Contact Center at (800) 828-3407, 8 a.m. to 6 p.m., ET, Monday through Friday, or TTY/TDD 711 for persons with hearing impairment.

Second opinions

If a Member does not agree with the Provider's plan of care, the Member has the right to request, at no cost, a second opinion from another Provider. Members should call the ConnectiCare Member Contact Center to find out how to get a second opinion. Second opinions may require prior authorization.

6. Eligibility and enrollment in Medicare Advantage plans

Enrollment information

Members who wish to enroll in ConnectiCare Medicare Advantage plans must meet the eligibility criteria as outlined in the ConnectiCare EOC. The most current EOC can be found on the Member pages of ConnectiCare's website at connecticare.com/resources/forms-medicare.

ConnectiCare does not impose any additional eligibility requirements as a condition of enrollment other than those established by CMS in Chapter 2 of the Medicare Managed Care Manual.

Members telephone numbers

Members may call the ConnectiCare Member Contact Center at (800) 224-2273, from Oct. 1 to March 31, 7 days a week from 8 a.m. to 8 p.m., ET, from April 1 to Sept. 30, Monday through Saturday from 8 a.m. to 8 p.m., ET, or TTY/TDD 711 for persons with hearing impairments.

Effective date of coverage

ConnectiCare will determine the effective date of enrollment for all enrollment requests. The effective date of coverage is determined when the complete enrollment is signed and received, following the Member's enrollment election period.

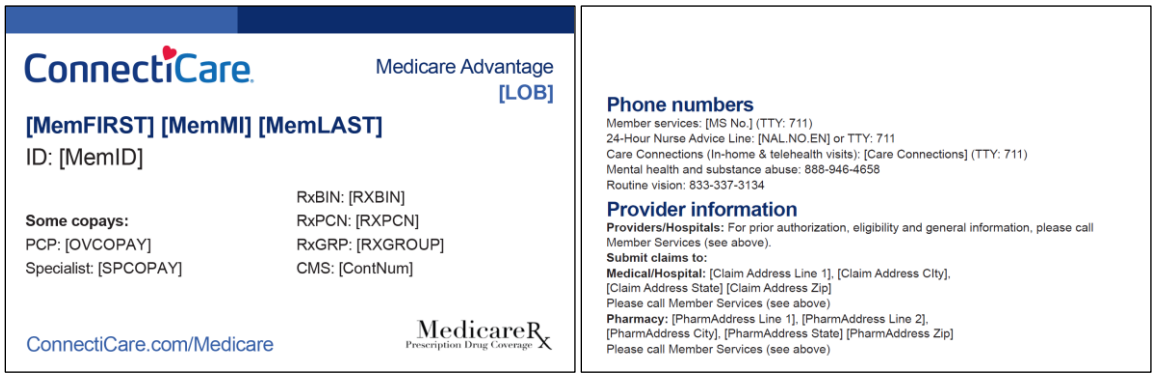
Disenrollment

ConnectiCare staff may never, verbally, in writing or by any other action or inaction, request or encourage a Member to disenroll except as outlined in the ConnectiCare EOC. The most current EOC can be found on the Member pages of ConnectiCare's website at connecticare.com/resources/forms-medicare.

In all circumstances except death, ConnectiCare will provide a written notice to the Member with an explanation of the reason for the disenrollment. All notices will be in compliance with CMS regulations and will be approved by CMS.

In the event of death, a verification of disenrollment will be sent to the deceased Member's estate.

Member identification card sample – medical services



Verifying eligibility

To ensure payment, ConnectiCare strongly encourages Providers to verify eligibility at every visit and especially prior to providing services that require authorization. Possession of a ConnectiCare Member ID card does not guarantee Member eligibility or coverage. It is the responsibility of the Provider to verify the eligibility of the cardholder.

Providers who contract with ConnectiCare may verify a Member's eligibility by checking the following:

- Availity Essentials portal: availity.com/providers
- ConnectiCare Provider Contact Center automated IVR system at (800) 828-3407

D-SNP Members and cost share

ConnectiCare allows Members to enroll who have full Medicaid assistance. These Members may or may not be entitled to cost share assistance and may or may not have Medicaid benefits. Providers can find cost share information on an individual ConnectiCare Member through the Availity Essentials portal or by visiting connecticare.com/resources/forms-medicare.

7. Benefit overview

Questions about ConnectiCare Medicare Advantage benefits

If there are questions as to whether a service is covered or requires prior authorization, please reference the prior authorization tools on the ConnectiCare website and the Availity Essentials portal. You may also contact ConnectiCare's Provider Contact Center at (800) 828-3407, 8 a.m. to 6 p.m., ET, Monday through Friday or TTY/TDD 711 for persons with hearing impairments.

Links to ConnectiCare benefit materials

Member benefit materials including the Summary of Benefits and the Evidence of Coverage documents can be found on ConnectiCare's website at connecticare.com/resources/forms-medicare. Detailed information about benefits and services can be found in the Evidence of Coverage booklets provided to each ConnectiCare Member.

Please note: The Medicare-covered initial preventive and physical examination (IPPE) and the annual wellness visit are covered at zero cost sharing. Our plans cover Medicare-covered preventive services at no cost to the Member.

Obtaining access to certain covered services

Telehealth and telemedicine services

ConnectiCare Members may obtain medical covered services by participating Providers, through the use of telehealth and telemedicine services. Not all participating Providers offer these services. The following additional provisions apply to the use of telehealth and telemedicine services:

- Services must be obtained from a participating Provider
- Members have the option of receiving PCP services through telehealth. If they choose to use this option, the Member must use a Network Provider who offers telehealth.
- Services are a method of accessing covered services and not a separate benefit
- Services are not permitted when the Member and participating Provider are in the same physical location.
- Member cost share may apply based on the applicable Summary of Benefits and the Evidence of Coverage
- Services must be coded in accordance with applicable reimbursement policies and billing guidelines
- Rendering Providers must comply with applicable federal and state guidelines for telehealth service delivery

For additional information on telehealth and telemedicine claims and billing, please refer to the **Claims** section of this Provider Manual.

Supplemental services

ConnectiCare offers supplemental benefits for all ConnectiCare Members. Supplemental benefits can be either mandatory, meaning all Members on the plan are eligible for that supplemental benefit or considered Special Supplemental Benefits for the Chronically Ill, referred to as SSBCI. As per CMS, SSBCIs are only available to Members who meet specific criteria by having certain chronic conditions that qualify them for a specific benefit.

A request for a SSBCI can be sent directly to ConnectiCare's care management department who will verify and validate the Member has the qualifying diagnosis. Verification of qualifying criteria may require confirmation directly with our Providers in which a member of our care management team will reach out to your office. We appreciate your assistance with this process and your support to ensure that all SSBCIs are provided as CMS had intended. Depending on the plan, SSBCI benefits may include food and produce.

A referral from the Member's PCP is not required for mandatory supplemental benefits.

Please refer to the Member Evidence of Coverage for more information – a link is available above under "Links to ConnectiCare Benefit Materials."

ConnectiCare partners with Providers/vendors for certain services. To find an in-network Provider/vendor, please refer to the Provider Online Directory.

Provider education on covered benefits and Member access to care

Providers are educated on the tools and information required to ensure Members understand their benefits and how to access care. This includes but is not limited to:

- How to identify Medicare and Medicaid covered benefits by accessing the appropriate plan or state agency materials (see hyperlinks below)
- How to access Medicaid-covered services including waiver services such as Long-Term Services & Supports (LTSS), In-Home Supportive Services (IHSS) or behavioral services

Medicaid-covered benefits

Medicaid-covered services not covered by ConnectiCare D-SNP can be found on the ConnectiCare Medicaid website at huskyhealthct.org/members/members_benefits.

8. Health care services

Health care services is comprised of utilization management (UM) and care management (CM) departments that work together to achieve an integrated approach to coordinating care. Research and experience show that a higher-touch, Member-centric care environment for at-risk Members supports better health outcomes. ConnectiCare provides CM services to Members to address a broad spectrum of needs, including chronic conditions that require the coordination and provision of health care services.

Utilization management (UM)

The ConnectiCare UM program provides pre-service authorization, inpatient authorization management and concurrent review of inpatient and continuing services. ConnectiCare aims to ensure that services are medically necessary and an appropriate use of resources for the Member. Some of the elements of the UM program are:

- Evaluating the medical necessity and appropriateness of health care services across the continuum of care
- Applying appropriate criteria based on CMS guidelines, third party guidelines, and, when applicable, state requirements
- Providing pre-admission, admission and inpatient hospital and skilled nursing facility (SNF) review
- Ensuring services are available in a timely manner, in appropriate settings
- Ensuring qualified health care professionals are engaged in the UM decision-making process when appropriate
- Ensuring the appropriate application of Member benefit coverage and coverage criteria
- For dual eligible Members: ConnectiCare will coordinate benefits for dual eligible Members, where applicable, in circumstances where the requested services are not covered by Medicare but are covered by their Medicaid benefit.

Medical groups/IPAs and delegated entities who assume responsibility for UM must adhere to ConnectiCare's UM Policies. Their programs, policies and supporting documentation are reviewed by ConnectiCare at least annually.

MCG Cite for Guideline Transparency and MCG Cite AutoAuth

ConnectiCare has partnered with MCG Health to implement Cite for Guideline Transparency. Providers can access this feature through the Availity Essentials portal. With MCG Cite for Guideline Transparency, ConnectiCare can share clinical indications with Providers. The tool operates as a secure extension of ConnectiCare's existing MCG investment and helps meet regulations around transparency for the delivery of care:

- Transparency – Delivers medical determination transparency
- Access – Clinical evidence that payers use to support Member care decisions
- Security – Ensures easy and flexible access via secure web access

MCG Cite for Guideline Transparency does not affect the process for notifying ConnectiCare of admissions or for seeking Prior Authorization approval. To learn more about MCG or Cite for Guideline Transparency, visit MCG's website or call (888) 464-4746.

ConnectiCare has also partnered with MCG Health to extend our Cite AutoAuth self-service method for all lines of business to submit prior authorization requests.

Cite AutoAuth can be accessed via the Availity Essentials portal and is available 24 hours per day/7 days per week. This method of submission must be used as your primary submission route. Clinical information submitted with the prior authorization will be reviewed by ConnectiCare. This system will provide quicker and more efficient processing of your authorization request and the status of the authorization will be available immediately upon completion of your submission.

What is Cite AutoAuth and how does it work?

By attaching the relevant care guideline content to each prior authorization request and sending it directly to ConnectiCare, health care Providers receive an expedited, often immediate, response. Through a customized rules engine, Cite AutoAuth compares ConnectiCare's specific criteria to the clinical information and attached guideline content to the procedure to determine the potential for auto authorization.

For a full list of codes that require prior authorization, refer to the Prior Authorization LookUp Tool at connecticare.com.

Medical necessity review

ConnectiCare only reimburses for services that are medically necessary. Medical necessity review may take place prospectively, as part of the inpatient admission notification/concurrent review or retrospectively. Medical necessity decisions are made by a physician or other appropriate licensed health care personnel with sufficient medical expertise and knowledge of the appropriate coverage criteria. These medical professionals conduct medical necessity reviews in accordance with CMS guidelines (such as national and local coverage determinations) and use nationally recognized evidence based guidelines, third party guidelines, guidelines from recognized professional societies and peer reviewed medical literature, when appropriate. Providers may request to review the criteria used to make the final decision.

Where applicable, ConnectiCare clinical policies can be found on the public website at molinaclinicalpolicy.com. Please note that ConnectiCare follows federal/state-specific criteria, if available, before applying ConnectiCare-specific criteria.

Requesting prior authorization

Contracted Providers are responsible for requesting prior authorization of services when required by ConnectiCare policy, which may change from time to time. Failure to obtain prior authorization before rendering a service may result in a denial with Provider liability

and/or denial of the claim. The Member cannot be billed when a contracted Provider fails to follow the UM requirements for the Plan, including failure to obtain prior authorization before the Member receives the item or service. Obtaining authorization does not guarantee payment. ConnectiCare retains the right to review benefit limitations and exclusions, beneficiary eligibility on the date of service (DOS), correct coding, billing practices and whether the service was provided in the most appropriate and cost-effective setting of care.

ConnectiCare requires prior authorization for specified services. The list of services that require prior authorization is available in narrative form, along with a more detailed list by Current Procedural Technology (CPT®) and HealthCare Common Procedural Coding System (HCPCS) codes. The prior authorization list is customarily updated quarterly, but may be updated more frequently and is posted on the ConnectiCare website at connecticare.com. The Prior Authorization LookUp Tool is also available in the Availity Essentials portal.

CPT® is a registered trademark of the American Medical Association (AMA).

The prior authorization request must include the following information:

- Member demographic information (name, date of birth, ConnectiCare Member ID number, health plan)
- Provider demographic information (ordering Provider, servicing Provider and referring Provider (when appropriate)
- Relevant Member diagnoses and International Classification of Diseases, Tenth Revision (ICD-10) codes
- Requested items and/or services, including all appropriate CPT and HCPCS codes
- Location where services will be performed (when relevant)
- Supporting clinical information demonstrating medical necessity under Medicare guidelines (and/or state guidelines when applicable)

Members and their authorized representatives may also request prior authorization of any item or service they want to receive. In this case, the physician or other appropriate Provider will be contacted to confirm the need for and specific details of the request.

Contracted Providers are expected to cooperate with ConnectiCare UM processes and guidelines, including submission of sufficient clinical information to support the medical necessity, level of care, and/or site of service of the items and/or services requested. Contracted Providers must also respond timely and completely to requests for additional information. If ConnectiCare determines that a contracted Provider failed to follow the terms and conditions of the relevant Provider Agreement with ConnectiCare or the Provider Manual, a denial may be issued with Provider liability. Members cannot be held responsible when the Provider fails to follow the terms and conditions of the relevant Provider Agreement with ConnectiCare or this Provider Manual. For information on the contracted Provider claim appeals process, please refer to the Provider Claim Payment Disputes and Appeal Processes subsection located in the **Claims** section of this Provider Manual.

Availity Essentials portal: ConnectiCare is a Digital First organization for authorization submissions. Participating Providers must use the Availity Essentials portal for prior authorization submissions. All prior authorization submissions must include supporting clinical documentation to ensure timely and accurate review. Instructions for how to submit a prior authorization request are available on the Availity Essentials portal. The benefits of submitting your prior authorization request through the Availity Essentials portal are:

- Create and submit prior authorization requests
- Check status of prior authorization requests
- Receive notification of change in status of prior authorization requests
- Attach medical documentation required for timely medical review and decision-making
- Receive notification of authorization decisions
- Access prior authorization letters directly through the Digital Correspondence Hub functionality in the Availity Essentials portal. Please note: Letters will only be available for prior authorization requests submitted via the Availity Essentials portal.
    - The Digital Correspondence Hub lets your organization manage communication preferences in the Availity Essentials portal. Only your designated Administrator can change settings, including opting out of paper letters. For updates, please contact your Administrator.
    - Users can also choose to receive or decline weekly reminder notifications for unopened digital letters. These reminders are not real-time alerts. Opting out of reminders does not affect your organization's digital correspondence delivery preferences.

Prior authorization requests for Transplants can also be made by calling (855) 714-2415. ConnectiCare's 24-hour Nurse Advice Line is available to Members 24 hours a day, 7 days a week at (833) 957-0169.

Notwithstanding any provision in the Provider Agreement with ConnectiCare that requires Providers to obtain prior authorization directly from ConnectiCare, ConnectiCare may choose to contract with external vendors to help manage prior authorization requests.

For additional information regarding the prior authorization of specialized clinical services, please refer to the Prior Authorization tools located on the connecticare.com website:

- Prior Authorization LookUp Tool
- Prior Authorization Code Matrix

Evolent: Radiology Benefit Management (Advanced Imaging)

ConnectiCare collaborates with Evolent to conduct medical necessity review on certain prior authorization (PA) requests.

PA requests for Participating and non-participating Servicing Providers are to be submitted to Evolent for professional service review and decisions for ConnectiCare adult and pediatric Members.

Evolent conducts reviews for the following professional services:

Advanced Radiology services:

- CT/CTA
- MRI/MRA
- PET Imaging
- Additional advanced imaging CPT codes identified in the RBM code matrix

Please consult the PA LookUp Tool for further guidance on where to submit professional services PA requests.

Evolent: PA request submission

The requesting Provider must complete a PA request using one of the following methods:

- For Providers' convenience, logging into the Evolent online portal is the preferred submission method: Welcome to RadMD.com | RADMD
  - Evolent's online portal functionality offers instant approvals for PA requests
- Evolent telephonic request lines
  - Medicare: (800) 424-6112
  - DSNP-Duals: (866) 642-9702
- Evolent Fax intake: (800) 784-6864

Evolent: peer-to-peer review

Peer-to-peer review will be conducted by Evolent via physician discussions with expanded collaboration to better discuss treatment plans.

Providers are strongly encouraged to take advantage of Evolent's streamlined peer-to-peer process to hold timely conversations related to requested services.

TurningPoint Comprehensive Condition Management: Musculoskeletal Surgical Quality and Safety Management Program

ConnectiCare has contracted with TurningPoint to provide an innovative solution to work collaboratively with providers, facilities, and physicians to reduce treatment variability, promote safety, quality of care improvements, and support for ConnectiCare members. As part of this program, ConnectiCare has delegated its utilization management function to TurningPoint for a limited scope of procedures outlined below:

Orthopedic Surgical Procedures	**Spinal Surgical Procedures**

Including all associated partial, total, and revision surgeries:
• Knee Arthroplasty
• Unicompartmental/Bicompartmental Knee Replacement
• Hip Arthroplasty
• Shoulder Arthroplasty
• Elbow Arthroplasty
• Ankle Arthroplasty
• Wrist Arthroplasty
• Acromioplasty and Rotator Cuff Repair
• Anterior Cruciate Ligament Repair
• Knee Arthroscopy
• Hip Resurfacing
• Meniscal Repair
• Hip Arthroscopy
• Femoroacetabular Arthroscopy
• Ankle Fusion
• Shoulder Fusion
• Wrist Fusion
• Osteochondral Defect Repair
	Including all associated partial, total, and revision surgeries:
	• Spinal Fusion Surgeries
	  ○ Cervical
	  ○ Lumbar
	  ○ Thoracic
	  ○ Sacral
	  ○ Scoliosis
	• Disc Replacement
	• Laminectomy/Discectomy
	• Kyphoplasty/Vertebroplasty
	• Sacroiliac Joint Fusion
	• Implantable Pain Pumps
	• Spinal Cord Neurostimulator
	• Spinal Decompression

Prior Authorization is required for inpatient, outpatient, and doctor's office settings for these procedures. Clinical coding specific to the procedures included in the program may be accessed using the PA LookUp Tool. Please note the coding is subject to regular updates/changes as CPT/HCPCS coding is added or deleted.

TurningPoint: utilization management and precertification contact information

TurningPoint requests a digital-first approach, with case submissions expected to be submitted through the provider portal whenever feasible. TurningPoint's provider portal can be accessed at myturningpoint-healthcare.com.

TurningPoint is available at **(866) 422-0800**, 5 a.m. – 5 p.m. of each normal business day in each time zone where TurningPoint conducts its review activities. In the event a provider needs to contact TurningPoint for prior authorization after hours or on weekends, TurningPoint has medical professionals on-call 24 hours a day, 7 days a week.

TurningPoint: peer-to-peer review

Peer-to-peer reviews are unique in that they are conducted by specialized physicians in accordance with the procedure.

Peer-to-peer reviews are offered but are for educational purposes only per CMS guidelines.

Providers can initiate a peer-to-peer conversation with a TurningPoint Medical Reviewer by contacting TurningPoint's Peer to Peer Department at **(800) 581-3920**.

Evolent: oncology

ConnectiCare collaborates with Evolent (formerly known as New Century Health) to conduct medical necessity review on certain prior authorization (PA) requests.

PA requests for Participating Servicing Providers are to be submitted to Evolent for professional service review and decisions for ConnectiCare adult Members ages 18 and over.

All out-of-network Servicing Provider PA requests and PA requests for ConnectiCare Members under the age of 18 will be reviewed by ConnectiCare.

Please consult the PA LookUp Tool for further guidance on where to submit professional services PA requests.

For inpatient service requests, once approved by Evolent, the inpatient status will be reviewed by ConnectiCare upon notification of the admission. The inpatient admission and length of stay will be determined by Inpatient Utilization Management (Concurrent Review) at the time of hospitalization. Providers are to follow ConnectiCare's inpatient notification process as you do today, and the continued stay will be reviewed for medical necessity and a decision made at that time.

Medical oncology

Cancer Related Diagnoses: C00-D09.0, D37.01-D49.9, D61.810, D61.82, D63.0, D64.0-D64.81, D70.1, D72.822, D75.81, E34.0, Z41.8

Infused, injectable and oral* chemotherapy, hormonal therapeutic treatment, supportive agents, and symptom management medications.

**Pharmacy benefit single oral agent requests are out of scope for Evolent and pre-authorization must be obtained from ConnectiCare or applicable Pharmacy Benefits Manager (PBM). Pharmacy benefits oral agents submitted in a request combined with infused/injectable cancer agents will be reviewed by Evolent for preauthorization.*

Radiation oncology

Cancer Related Diagnoses: C00-D09.0, D37.01-D49.9, D61.810, D61.82, D63.0, D64.0-D64.81, D70.1, D72.822, D75.81, E34.0, Z41.8

- Brachytherapy
- Conformal
- IMRT (Intensity-modulated radiation therapy)
- SBRT (Stereotactic Body Radiation Therapy)

- IGRT (Image-guided radiation therapy)
- 2D, 3D (2 or 3 dimensional)
- SRS (Stereotactic radiosurgery)
- Radiopharmaceuticals
    - Proton and Neutron Beam Therapy

CAR-T

For inpatient CAR-T service requests, the inpatient status will be approved when medical necessity criteria is met, simultaneously with the approval of the CAR-T professional service(s) being reviewed.

The inpatient admission length of stay (where CAR-T is in scope) will be determined by Inpatient Utilization Management (Concurrent Review) at the time of any needed hospitalization. Providers are to follow ConnectiCare's inpatient notification process as you do today, and the continued stay will be reviewed for medical necessity and a decision made at that time. If other services are being performed during the inpatient stay that are unrelated to the CAR-T procedures, a separate authorization will need to be completed through ConnectiCare's standard prior authorization process for medical necessity determination.

PA request submission

The requesting in-network Provider must complete a PA request using one of the following methods:

- For Providers' convenience, logging into the Evolent Provider Web Portal is the preferred submission method: my.newcenturyhealth.com
    - Evolent's Provider Web Portal functionality offers instant approvals for PA requests
- Evolent Tel: (888) 999-7713
    - Option 2 Medical Oncology
    - Option 3 Radiation Oncology

Providers should call the Evolent Network Operations department at (888) 999--7713, Option 6, with questions or for assistance with access/training on the Evolent Provider Web Portal.

Peer-to-peer review

Peer-to-peer review will be conducted by Evolent via physician discussions with expanded collaboration to better discuss treatment plans.

Providers are strongly encouraged to take advantage of Evolent's streamlined peer-to-peer process to hold timely conversations related to requested services.

Affirmative statement about incentives

Health care professionals involved in the UM decision-making process base their decisions on the appropriateness of care and services and the existence of coverage. ConnectiCare does not specifically reward Practitioners or other individuals for issuing denials of coverage or care and does not provide financial incentives or other types of compensation to encourage decisions that result in under-utilization or barriers to care.

Time frames

Prior authorization decisions are made as expeditiously as the Member's health condition requires and within regulatory time frames.

Medicare organization and coverage determination time frames for pre-service requests are:

Expedited (non-Part B, non-Part D drug)	*72 hours – Medicare guidance allows written notice to follow within 3 calendar days after verbal notice to the member
Expedited Part B drug	24 hours
Expedited Part D drug	24 hours
Standard (non-Part B, non-Part D drug)	* 7 calendar days
Standard Part B drug	72 hours
Standard Part D drug	72 hours

**Timeframes for fully integrated plans may vary with regulatory and contractual requirements.*

Extensions may be allowed under specific conditions (with the exception of requests involving a Part B or Part D drug).

A Provider may request that a UM decision be expedited if following the standard timeframe could seriously jeopardize the life or health of the Member or the Member's ability to regain maximum function. Providers must ask that a request be expedited only when this standard is supported by the Member's condition. Vendors are not allowed to expedite without a physician order stating it needs expedited time frame.

Communication of pre-service determinations

Upon approval, the requestor will receive an authorization number. The number may be provided by telephone.

When a prior authorization request is denied with Member liability, the Member is issued a denial notice informing them of the decision and their appeal rights with a copy to the Provider. The Member's appeal rights are discussed further in the **Medicare Member Grievances and Appeals** section of this Provider Manual.

When a prior authorization request is denied with Provider liability, the Provider is issued a denial notice via the Availity Essentials portal informing them of the decision. Additional information on the contracted Provider claims appeal process can be found in

the Provider Claim Payment Disputes and Appeal Processes subsection located in the **Claims** section of this Provider Manual.

Peer-to-peer discussions and re-openings

Contracted Providers may request a peer-to-peer conversation with a ConnectiCare medical director. Once a final adverse decision is made, however, the decision may not be reversed if Member liability is assigned (i.e., the Member is issued a denial notice with Medicare appeal rights) unless the CMS requirements for a reopening are met. CMS allows Medicare Advantage plans to use the reopening process only sparingly. Requirements for a reopening include clear clerical error, the procurement of new and material evidence that was not available or known at the time of the decision that may result in a different conclusion or evidence that was considered in making the decision clearly shows on its face that an obvious error was made at the time of the decision (i.e., the decision was clearly incorrect based on all the evidence presented). Providers may not use the reopening process for the routine submission of additional information. Re-openings are not allowed once an appeal is filed by the Provider or the Member (or their authorized representative). ConnectiCare medical directors are available prior to the time of the decision to discuss any unique circumstances to be considered in the case.

Adverse decisions for which only Provider liability is assigned and that do not involve an adverse determination or liability for the Member may be subject to a peer-to-peer conversation. A peer-to-peer conversation is an opportunity to clarify the clinical information or to provide newly discovered clinical information. ConnectiCare will not allow contracted Providers to use the peer-to-peer process as a vehicle for routine failure to provide sufficient information in the UM process or to avoid the contracted Provider claims appeals process. Contracted Providers are responsible for providing all information to support the request within the required timeframes.

For additional information on the contracted Provider claim appeals process, please refer to the Provider Claim Payment Disputes and Appeal Processes subsection located in the **Claims Compensation** section of this Provider Manual.

Open communication about treatment

ConnectiCare prohibits contracted Providers from limiting Provider or Member communication regarding a Member's health care. Providers may freely communicate with and act as an advocate for their patients. ConnectiCare requires provisions within the Provider Agreement with ConnectiCare that prohibit the solicitation of Members for alternative coverage arrangements for the primary purpose of securing financial gain. No communication regarding treatment options may be represented or construed to expand or revise the scope of benefits under a health plan or insurance contract.

ConnectiCare and its contracted Providers may not enter into contracts that interfere with any ethical responsibility or legal right of Providers to discuss information with a

Member about the Member's health care. This includes, but is not limited to, treatment options, alternative plans or other coverage arrangements.

Utilization management functions performed exclusively by ConnectiCare

The following UM functions are conducted by ConnectiCare and are **never delegated**:

1. **Transplant –** ConnectiCare does not delegate management of transplant cases to the medical group. Providers are required to notify ConnectiCare's UM department (transplant unit) when the need for a transplant evaluation is identified. Contracted Providers must obtain prior authorization from ConnectiCare for transplant evaluations and surgery. Upon notification, ConnectiCare conducts medical necessity review. ConnectiCare selects the facility to be accessed for the evaluation and possible transplant.
2. **Clinical trials –** ConnectiCare does not delegate to Providers the authority to authorize payment for services associated with clinical trials. See Clinical Trials below for additional information.
3. **Experimental and investigational reviews –** ConnectiCare does not delegate to Providers the authority to determine and authorize experimental and investigational (E & I) reviews.

Clinical trials

National Coverage Determination (NCD) 310.1 provides that Medicare covers the routine costs of qualifying clinical trials (as defined in the NCD) as well as reasonable and necessary items and services used to diagnose and treat complications arising from participation in all clinical trials. All other Medicare rules apply. Routine costs of a clinical trial include all items and services that are otherwise generally available to Medicare beneficiaries that are provided in either the experimental or control arm of a clinical trial except:

- The investigational item or service itself unless otherwise covered outside of the clinical trial;
- Items and services provided solely to satisfy data collection and analysis needs and that are not used in the direct management of the patient; and
- Items and services customarily provided by the research sponsors free of charge for any enrollee in the clinical trial.

Routine costs in clinical trials include:

- Items or services that are typically provided absent a clinical trial;
- Items or services required solely for the provision of the investigational item or service, the clinically appropriate monitoring of the effects of the item or service or the prevention of complications; and,
- Items or services needed for reasonable and necessary care arising from the provision of an investigational item or service and in particular, for the diagnosis or treatment of complications.

For non-covered items and services, including items and services for which Medicare payment is statutorily prohibited, Medicare only covers the treatment of complications arising from the delivery of the non-covered item or service and unrelated to reasonable and necessary care. However, if the item or service is not covered by virtue of a national non-coverage policy (i.e., an NCD) and is the focus of a qualifying clinical trial, the routine costs of the clinical trial will be covered by Medicare but the non-covered item or service itself will not.

Clinical trials must meet qualifying requirements. Additional information on these requirements and the qualifying process can be found in NCD 310.1.

If the Member participates in an unapproved study, the Member will be liable for all costs associated with participation in that study. Members can obtain additional information about coverage for the costs associated with clinical trials and Member liability for Medicare cost-sharing amounts in their EOC or Member Handbook.

Delegated utilization management functions

ConnectiCare may delegate UM functions to qualifying Medical Groups/IPAs and delegated entities. These entities are required to perform these functions in compliance with all current ConnectiCare policies and regulatory and certification requirements. For more information about delegated UM functions and the oversight of such delegation please refer to the **Delegation** section of this Provider Manual.

Communication and availability to Members and Providers

HCS staff is available for inbound and outbound calls through an automatic rotating call system triaged by designated staff by calling (800) 562-6833 Monday through Friday (except for state and federal holidays) from 9 a.m. to 5 p.m., ET. All staff members identify themselves by providing their first name, job title and organization.

TTY/TDD services are available for Members who are deaf, hard of hearing or speech impaired. Language assistance is also always available for Members.

Providers must utilize the Availity Essentials portal for UM access.

ConnectiCare's 24-hour Nurse Advice Line is available to Members and Providers 24 hours a day, 7 days a week at (833) 957-0169. ConnectiCare's 24-hour Nurse Advice Line handles urgent and emergent after-hours UM calls.

Emergency services, urgent care and post-stabilization services

ConnectiCare covers emergency services as well as urgently needed services and post-stabilization care for Members in accordance with applicable federal and state law.

Medicare defines emergency services as covered services provided to evaluate or treat an emergency medical condition. 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:

1. 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;
2. Serious impairment to bodily functions; or
3. Serious dysfunction of any bodily organ or part.

Urgently needed services are covered services that:

1. Are not emergency services, but are medically necessary and immediately required as a result of an unforeseen illness, injury condition;
2. Are provided when (a) the Member is temporarily absent from the Plan's service area and therefore, the Member cannot obtain the needed service from a network Provider; or (b) when the Member is in the Plan's service area but the network is temporarily unavailable or inaccessible; and
3. Given the circumstances, it was not reasonable for the Member to wait to obtain the needed services from their regular Plan Provider after returning to the service area or the network becomes available.

Post-stabilization care services are covered services that are:

1. Related to an emergency medical condition;
2. Provided after the Member is stabilized; and
3. Provided to maintain the stabilized condition or under certain circumstances, to improve or resolve the Member's condition.

Providers requesting an inpatient admission as a post-stabilization service must request this type of service by contacting ConnectiCare at (800) 562-6833.

Inpatient admission requests (not including post-stabilization requests) received via the Availity Essentials portal will be processed within standard inpatient regulatory and contractual time frames.

Emergency services and urgently needed services do not require prior authorization, although contracted Provider notification requirements may apply. Please refer to the Emergent Inpatient Admissions subsection below.

ConnectiCare care managers will contact Members over-utilizing the emergency department to provide assistance whenever possible and determine the reason for using emergency services.

Inpatient admission notification and management

Elective inpatient admissions

ConnectiCare requires prior authorization for all elective/scheduled inpatient admissions and procedures to any inpatient facility (i.e., including hospitals, SNFs and other inpatient settings). Contracted SNFs, long-term acute care hospitals (LTACH) and acute

inpatient rehabilitation (AIR) facilities/units must obtain prior authorization before admitting the Member.

Inpatient facilities are also required to notify ConnectiCare of the admission within 24 hours or by the following business day or as otherwise specified in the relevant Provider Agreement with ConnectiCare. Inpatient notifications must be submitted via the Availity Essentials portal.

Continued stay must be supported by clinical documentation supporting the level of care. Failure to obtain prior authorization, to provide timely notice of admission or to support the level of care may result in denial with Provider liability. Members cannot be held liable for the failure of a contracted Provider to follow the terms of the relevant Provider Agreement with ConnectiCare and this Provider Manual.

For additional information on the contracted Provider claims appeal process please refer to the Provider Claim Payment Disputes and Appeal Processes subsection located in the **Claims** section of this Provider Manual.

Emergent inpatient admissions

ConnectiCare requires notification of all emergent inpatient admissions within 24 hours of admission or by the following business day or as otherwise specified in the relevant Provider Agreement with ConnectiCare. Notification of admission is required to verify eligibility, authorize care, including level of care and initiate concurrent review and discharge planning. Notification must include Member demographic information, facility information, date of admission and clinical information supporting the level of care. Notifications must be submitted via the Availity Essentials portal.

Prior authorization is not required for an observation level of care. Once the Member is stabilized and a request for inpatient admission is made or the observation period expires, contracted Providers are responsible for supporting an admission level of care. Failure to provide timely notice of admission or to support an admission level of care may result in a clinical level of care denial with Provider liability. Members cannot be held liable for a contracted Provider's failure to follow the terms of the relevant Provider Agreement with ConnectiCare and this Provider Manual.

For additional information on the contracted Provider claims appeal process, please refer to the Provider Claim Payment Disputes and Appeal Processes subsection located in the **Claims** section of this Provider Manual.

Inpatient at time of termination of coverage

Members hospitalized on the day that the Member in the Plan terminates are usually covered through discharge. Specific Plan rules and Provider Agreement with ConnectiCare provisions may apply.

NOTICE Act

Under the Notice of Observation Treatment and Implication for Care Eligibility Act (NOTICE Act), hospitals (including critical access hospitals) must deliver the Medicare Outpatient Observation Notice (MOON) to any beneficiary (including a Medicare Advantage enrollee) who receives observation services as an outpatient for more than 24 hours. The MOON is issued to inform the beneficiary that they are an outpatient receiving observation services and not a hospital inpatient. The beneficiary is informed that their services are covered under Part B and that Part B cost-sharing amounts apply. Additional information is provided to the beneficiary with regard to how an observation stay may affect their eligibility for a SNF level of care and that Part B does not cover self-administered drugs.

Inpatient concurrent review

ConnectiCare performs concurrent inpatient review to ensure medical necessity of ongoing inpatient services, adequate progress of treatment and development of appropriate discharge plans. Concurrent review is performed for inpatient stays regardless of setting (i.e., including hospital, SNF and other inpatient settings), although the cadence and extent of concurrent review may vary depending on the setting and the member's circumstances. Performing these functions requires timely clinical. ConnectiCare will request updated clinical records from inpatient facilities at regular intervals during a Member's inpatient stay. Requested clinical updates must be received from the inpatient facility within 24 hours of the request or such other time as may be indicated in the request.

Failure to provide timely clinical updates may result in denial of authorization for the remainder of the inpatient admission with provider liability dependent on the circumstances and the terms of the relevant Provider Agreement with ConnectiCare. Members cannot be held liable for a contracted Provider's failure to follow the terms of the relevant Provider Agreement with ConnectiCare or this Provider Manual.

ConnectiCare will authorize hospital care as an inpatient when the clinical record supports the medical necessity of continued hospital stay. An observation level of care should be provided first when appropriate. Upon discharge, the Provider must provide ConnectiCare with a copy of the Member's discharge summary to include demographic information, date of discharge, discharge plan and instructions and disposition.

Discharge planning

The goal of discharge planning is to initiate cost-effective, quality-driven treatment interventions for post-hospital care at the earliest point in the admission. UM staff work communicate with hospital discharge planners to determine the most appropriate discharge setting for our Members. The clinical staff review medical necessity and appropriateness for home health, infusion therapy, durable medical equipment (DME), skilled nursing facility and rehabilitative services.

Readmissions

Readmission review is important to ensure that ConnectiCare Members are receiving hospital care that is compliant with nationally recognized guidelines as well as federal and state regulations.

When a subsequent admission to the same facility with the same or similar diagnosis occurs within 24 hours of discharge, the hospital will be informed that the readmission will be combined with the initial admission and will be processed as a continued stay.

When a subsequent admission to the same facility occurs within 2-30 days of discharge and it is determined that the subsequent readmission is related to the first admission (readmission) and determined to be preventable, then a single payment may be considered as payment in full for both the first and second hospital admissions.

Out-of-network providers and services

ConnectiCare maintains a contracted network of qualified health care professionals who have undergone a comprehensive credentialing process. ConnectiCare requires Members to receive non-emergency medical care within the participating, contracted network of Providers. Services provided by non-contracted Providers must be prior authorized. Exceptions include emergency services and medically necessary dialysis services obtained by the Member when they are outside the service area. Please refer to the subsection on Emergency Services, Urgent Care and Post-stabilization Services above. When no exception applies, ConnectiCare will determine whether there are contracted Providers within the service area willing and able to provide the items or services requested for the Member.

Termination of ongoing services

Termination of inpatient hospital services

Hospitals are required by CMS regulations to deliver the Important Message from Medicare (IM, Form CMS-10065), to all Medicare beneficiaries (including Medicare Advantage enrollees) who are hospital inpatients within two (2) calendar days of admission. This requirement is applicable to all hospitals regardless of payment type or specialty. Delivery must be made to the Member or the Member's authorized representative in accordance with CMS guidelines. A follow-up copy of the IM is delivered no more than two (2) calendar days before the planned discharge date.

The IM informs beneficiaries of their rights as a hospital inpatient, including their right to appeal the decision to discharge. Hospitals must deliver the IM in accordance with CMS guidelines and must obtain the signature of the beneficiary or their representative and provide a copy at that time. When the Member is no longer meeting criteria for continued inpatient stay and the hospital has not initiated discharge planning, ConnectiCare may require that the hospital issue a follow-up copy of the IM and notify the Member of their discharge date or provide additional clinical information supporting an inpatient level of care. Failure to do so may result in the denial of continued hospital services with Provider liability. The Member cannot be held liable for any continued care

(aside from any applicable deductibles or co-payments) without proper notification that includes their appeal rights located within the IM and if the Member exercises their appeal rights, not until noon of the day after the Quality Improvement Organization (QIO) notifies the Member of a determination adverse to the Member.

When the Member exercises their appeal rights with the QIO, the hospital is required to properly complete and deliver the Detailed Notice of Discharge (DND, Form CMS-10066) to the QIO and the Member as soon as possible and no later than noon following the day of the QIO's notification to the hospital of the appeal. The hospital is required to provide all information to the QIO that it requires to make a determination. At the Member's request, the hospital must provide the Member a copy of all information provided to the QIO, including written records of any information provided by telephone. This documentation must be provided to the Member no later than the close of business of the first day the Member makes the request.

The exhaustion of a Member's covered Part A hospital days is not considered to be a discharge for purposes of issuing the IM.

Termination of SNF, CORF and HHA services

The Notice of Medicare Non-coverage (NOMNC, Form CMS-10123) is a statutorily required notice issued to Medicare beneficiaries to inform them of the termination of ongoing services (discharge) by a SNF (including hospital swing beds providing Part A and Part B services), comprehensive outpatient rehabilitation facility (CORF) or home health agency (HHA). The NOMNC also provides the beneficiary with their appeal rights for the termination of services. The NOMNC must be delivered to the Member or the Member's authorized representative in accordance with CMS guidelines and at least two (2) calendar days prior to discharge (or the next to the last time services are furnished in the case of CORF or HHA services).

When ConnectiCare makes a determination that the Member's continued services are no longer skilled and discharge is appropriate, a valid NOMNC is sent to the contracted Provider (SNF & CORF) for delivery with a designation of the last covered day. Contracted Providers are responsible for delivering the NOMNC on behalf of ConnectiCare to the Member or Member representative and for obtaining signature(s) in accordance with CMS guidelines. The contracted Provider must provide ConnectiCare with a copy of the signed NOMNC. If the Member appeals the discharge to the Quality Improvement Organization (QIO), the contracted Provider must also provide the QIO with a signed copy of the NOMNC and all relevant clinical information. The Member cannot be held liable for any care (aside from any applicable deductibles or copayments) without proper notification that includes their appeal rights located in the NOMNC and if the Member exercises their appeal rights, not before the appeal process with the QIO is complete. If the QIO's decision is favorable to the Member, the Member cannot be held liable until a proper NOMNC is issued and the Member is given their appeal rights again. Failure of the contracted Provider to complete the notification timely and in accordance with CMS guidelines or to provide information timely to the QIO may result in the assignment of Provider liability. Members cannot be held responsible for

the contracted Provider's failure to follow the terms of the relevant Provider Agreement with ConnectiCare or the Provider Manual.

A NOMNC is not issued in the following instances:

- When services are reduced (e.g., when a Member is receiving physical therapy and occupational therapy from a home health agency and only the occupational therapy is terminated);
- When the Member moves to a higher level of care (e.g., from home health to SNF);
- When the Member exhausts their Medicare benefit;
- When the Member terminates services on their own initiative;
- When the Member transfers to another Provider at the same level of care (e.g., a move from one SNF to another while remaining in a Medicare-covered stay); or
- When the Provider terminates services for business reasons (e.g., the Member is receiving home health services but has a dangerous animal on the premises).

Coordination of care and services

ConnectiCare HCS staff work with Providers to assist with coordinating referrals, services and benefits for Members who have been identified for ConnectiCare's Integrated Care Management (ICM) program via assessment or referral such as self-referral, Provider referral, etc. In addition, the coordination of care process assists ConnectiCare Members, as necessary, in transitioning to other care when benefits end.

ConnectiCare staff provide an integrated approach to care needs by assisting Members with the identification of resources available such as community programs, national support groups, appropriate specialists and facilities, identifying best practice or new and innovative approaches to care. Care coordination by ConnectiCare staff is done in partnership with Providers, Members and/or their authorized representative(s) to ensure efforts are efficient and non-duplicative.

Providers must offer the opportunity to provide assistance to identified Members through:

- Notification of community resources, local or state-funded agencies
- Education about alternative care
- How to obtain care as appropriate

Continuity of care and transition of Members

It is ConnectiCare's policy to provide Members with advance notice when a Provider they are seeing will no longer be in-network. Members and Providers are encouraged to use this time to transition care to an in-network Provider. The Provider leaving the network shall provide all appropriate information related to the course of treatment, medical treatment, etc., to the Provider(s) assuming care. Under certain circumstances, Members may be able to continue treatment with the out-of-network Provider for a given period of time and provide continued services to Members undergoing a course of

treatment by a Provider that has terminated their contractual agreement if the following conditions exist at the time of termination.

- Acute condition or serious chronic condition – Following termination, the terminated Provider will continue to provide covered services to the Member for 90 days or for as long as the treatment plan requires. The Member will be safely transferred to another Provider by ConnectiCare or its delegated medical group/IPA.
- Pregnancy – The terminated Provider will continue to provide services following termination until post-partum services related to delivery are completed or longer if necessary for a safe transfer.

For additional information regarding continuity of care and transition of Members please contact ConnectiCare at (800) 828-3407.

Continuity and coordination of Provider communication

ConnectiCare stresses the importance of timely communication between Providers involved in a Member's care. This is especially critical between specialists, including behavioral health Providers and the Member's PCP. Information should be shared in such a manner as to facilitate communication of urgent needs or significant findings.

Reporting of suspected abuse and/or neglect

A vulnerable adult is a person who is or receiving or may be in need of receiving community care services by reason of mental or other disability, age or illness; and who is or may be unable to take care of themselves or unable to protect themselves against significant harm or exploitation. When working with children one may encounter situations suggesting abuse, neglect and/or unsafe living environments.

Every person who knows or has reasonable suspicion that a child or adult is being abused or neglected must report the matter immediately. Specific professionals mentioned under the law as mandated reporters are:

- Physicians, dentists, interns, residents or nurses
- Public or private school employees or child caregivers
- Psychologists, social workers, family protection workers or family protection specialists
- Attorneys, ministers or law enforcement officers

Suspected abuse and/or neglect should be reported as follows:

Child abuse

Connecticut State Department of Children and Families (800) 842-2288

Adult abuse

Connecticut State Department of Social Services

Protective Services for the Elderly

- **By Phone:** Toll-free line: **(888) 385-4225.**
  - Staff are available to receive calls between 8 a.m. and 4:30 p.m., Monday through Friday.
  - After business hours or on weekends or state holidays: call the Infoline at **2-1-1**
  - Outside of Connecticut: call the Infoline 24/7 at **(800) 203-1234**
- **By Form:** Complete the Report Form (W-675)
  - Email to psereferrals.dss@ct.gov
  - Fax to: (860) 424-5091
  - Mail to: DSS/PSE, 55 Farmington Avenue, Hartford, CT 06105
- **Online:** Complete an online referral

ConnectiCare's HCS teams will work with PCPs and medical groups/IPA and other delegated entities who are obligated to communicate with each other when there is a concern that a Member is being abused. Final actions are taken by the PCP/medical group/IPA, other delegated entities or other clinical personnel. Under state and federal law, a person participating in good faith in making a report or testifying about alleged abuse, neglect, abandonment, financial exploitation or self-neglect of a vulnerable adult in a judicial or administrative proceeding may be immune from liability resulting from the report or testimony.

ConnectiCare will follow up with Members that are reported to have been abused, exploited or neglected to ensure appropriate measures were taken and follow up on safety issues. ConnectiCare will track, analyze and report aggregate information regarding abuse reporting to the Healthcare Services Committee and the proper state agency.

Primary care providers

ConnectiCare provides a panel of PCPs to care for its Members. Providers in the specialties of Family Medicine, Internal Medicine and Obstetrics and Gynecology are eligible to serve as PCPs. Members may choose a PCP or have one selected for them by ConnectiCare. ConnectiCare's Members are required to see a PCP who is part of the ConnectiCare Network. ConnectiCare's Members may select or change their PCP by contacting ConnectiCare's Member Contact Center.

Specialty providers

ConnectiCare maintains a network of specialty Providers to care for its Members. Some specialty care Providers may require a referral for a Member to receive specialty services; however, no prior authorization is required to see a specialist within the network. Members are allowed to directly access women's health specialists within the network for routine and preventive health without a referral for services.

Referrals to specialty care outside the network require prior authorization from ConnectiCare. ConnectiCare will assist in ensuring access for second opinions from network and out-of-network Providers as well, as applicable.

Health management

The tools and services described here are educational support for ConnectiCare Members and may be changed at any time as necessary to meet the needs of ConnectiCare Members. Level 1 Members can be engaged in the program for up to 90 days depending on Member preferences and the clinical judgement of the Health Management team.

Level 1 Case management (health management)

ConnectiCare offers programs to help our Members and their families manage various health conditions. The programs include telephonic outreach from our clinical staff and health educators that includes condition-specific triage assessment, care plan development and access to tailored educational materials. Members are identified via Health Risk Assessments (HRA) and identification and stratification. You can also directly refer Members who may benefit from these program offerings by contacting ConnectiCare. Members can request to be enrolled or disenrolled in these programs at any time.

ConnectiCare provides health management programs designed to assist Members and their families to better understand their chronic health condition(s) and adopt healthy lifestyle behaviors. The programs include:

- Tobacco cessation
- Weight management
- Nutrition consult

For more information about these programs, please call (833) 269-7830 (main line) or (866) 472-9483 (health lifestyle programs), TTY/TDD: 711 or fax at (800) 642-3691.

Care management (CM)

The Integrated Care Management (ICM) program provides care coordination and health education for disease management, as well as identifies and addresses psychosocial barriers to accessing care with the goal of promoting high quality care that aligns with a Member's individual health care goals. CM focuses on the delivery of quality, cost-effective and appropriate health care services for Members. Members may receive health risk assessments that help identify physical health, behavioral health, medication management problems and social determinants of health to target high-needs Members who would benefit from more intensive support and education from a case manager. Additionally, functional, social support and health literacy deficits are assessed, as well as safety concerns and caregiver needs.

1. **The role of the case manager includes:**

- Coordination of quality and cost-effective services
- Appropriate application of benefits
- Promotion of early, intensive interventions in the least restrictive setting of the Member's choice
- Assistance with transitions between care settings and/or Providers
- Provision of accurate and up-to-date information to Providers regarding completed health assessments and care plans
- Creation of individualized care plan (ICP), updated as the Member's conditions, needs and/or health status change
- Facilitation of ICT meetings as needed
- Promote utilization of multidisciplinary clinical, behavioral and rehabilitative services
- Referral to and coordination of appropriate resources and support services, including but not limited to LTSS
- Attention to Member preference and satisfaction
- Attention to the handling of PHI and maintaining confidentiality
- Provision of ongoing analysis and evaluation of the Member's progress towards ICP adherence
- Protection of Member rights
- Promotion of Member responsibility and self-management

2. **Referral to CM may also be made by the following entities:**

- Member or Member's designated representative(s)
- Member's primary care provider
- Specialists
- Discharge planner
- Hospital staff
- Home health staff
- ConnectiCare staff

Special Needs Plan (SNP) Model of Care (MOC)

The MOC is the framework for ConnectiCare's CM processes and systems that enable coordinated care for our Members in our Special Needs Plans. As defined by CMS, our MOC includes the following areas: description of the SNP population (including health conditions), care coordination, Provider network, quality measurement and performance improvement. We value the partnerships we have with our Providers and want to work with you to coordinate care, help our Members obtain the best possible outcomes and improve the health and well-being of our aging, vulnerable and chronically ill Members. Our MOC program addresses the following areas:

1. **Targeted population** – We operate Medicare Dual Eligible Special Needs Plans (D-SNP) in multiple markets for Members who are eligible for both Medicare and Medicaid. Our population may include full benefit duals that have access to Medicaid benefits and Members who are only eligible to receive assistance with

some or all the Medicare premiums and cost sharing. Our MOC describes our population and includes a description of the medical conditions, co-morbidities, cognitive issues, social and environmental factors our Members experience. We identify the most vulnerable Members as those who may have experienced a change in health status, transition of care setting, a diagnosis that requires extensive use of resources or those who need help navigating the health care system due to social determinants of health.

2. **Care coordination:** This section of the MOC defines our clinical program and includes multiple sections as described below:

   A. Staff structure: Our staff structure has both administrative and clinical teams that directly or indirectly affect the care coordination of our Member and is designed to manage the needs of the SNP enrollees. Our clinical team interact directly with the Member or care givers and/or with the Providers caring for this complex population.

   B. HRA, ICP, ICT, face-to-face encounter and care transitions:

   Our program has multiple care coordination strategies including the following:

   - HRA: Completion of an initial and annual HRA targeted to assess physical, behavioral, cognitive, psychosocial and functional areas. We outreach to our Members in multiple ways to complete the initial assessment within 90 days of the effective date and at a minimum annually thereafter or based on state contract requirements. We also reassess the Member if a significant status change or if a targeted transition in care occurs. Our team may reach out to your office to obtain additional contact information on our unable to reach Members who do not respond to our multiple outreach attempts.
   - ICP: Each Member has an ICP created using the results of the HRA and other data available from multiple areas such as claims, authorizations or other assessments. Feedback from the Member, care givers or Providers may also be included in the ICP. The ICP is a living document updated as needs change and is available to Members of the care team.
   - ICT: Each Member has an ICT developed based on the Member's preferences, complexity and needs as identified during the assessment and care planning process. The Member and/or care giver are encouraged to participate. Our Providers, especially the PCP, are key members of the ICT and our team may reach out to you to provide feedback or participate in the care planning process or address needs identified by our care team. The ICP will be made available for the ICT members to review as needed. Communication with the ICT is coordinated based on the Member's needs and may be a formal or informal discussion or sharing of information using multiple communication strategies.

- Face-to-face encounter: All SNP Members must have a face-to-face encounter annually for the delivery of health care, care management or care coordination services. The encounter must be with a member of the Member's ICT, the plan's case management and coordination staff or contracted plan health care Providers and may be in person or through visual, real-time, interactive telehealth encounters.
- Care transition protocols: Coordination of care and managing transitions is an important part of our SNP program. This population has a substantial risk of experiencing fragmented and unsafe care during transitions. The best way to help Members navigate through the complexities of transitions is a team approach with both our team and Providers caring for the Member working together to coordinate care. To effectively manage the care of a Member that experiences an applicable transition we expect our Providers to notify our care management staff in advance of planned transitions requiring authorization as soon as possible but no later than three (3) business days for unplanned transitions. Our Providers are essential to the successful coordination of care during transitions and should be actively involved in the process. Managing transitions include processes such as assisting with logistical arrangements, providing education on post transition care and self-management, closing care gaps, medication reconciliation, coordination of care, transferring data to the receiving Provider during a transition and making sure the Member has access to their personal health information. Our care team is available to assist during complex transitions in care. Additional details are provided in the previous sections of this Provider Manual on coordination and transition of Members.
    - The point of contact during transitions may be the PCP chosen by the Member to coordinate care or the Provider of care during the transitions
    - Our care manager supports the Member and the Provider during a transition
    - Members also have access to our customer service team at the number listed on the ConnectiCare Member ID card

3. **Provider Network:**

- We have a contracted Provider Network that includes Providers and facilities relevant and necessary to address the unique and/or specialized health care needs of our membership. Our credentialing process validates the licensure and credentials of our network.

  In most situations the Member's PCP is responsible for determining what medical services the Member needs; however, if treatment is primarily through a specialist physician, the specialist may be primarily responsible for determining needed services. Our care team is available to assist our Providers or Members with care coordination. For Members undergoing

transitions in health care settings, facility staff (hospital, SNF, home health, etc.) may also be involved in making recommendations or assisting with access to needed services.

- Clinical Practice Guidelines (CPG): We use nationally recognized, evidence-based clinical practice guidelines. Our Medical Directors will select Clinical Practice Guidelines that are relevant to the SNP population. These Clinical Practice Guidelines will be communicated using the Provider Newsletter and the ConnectiCare website. ConnectiCare will annually measure Provider compliance with important aspects of the Clinical Practice Guidelines and report results to Providers.
- MOC Training - All contracted primary care and key high-volume specialty Providers will be required to complete MOC training as required and provide an attestation confirming completion. Providers will have access to the training via the ConnectiCare website or through web-based or in-person training sessions. Providers will receive notice to participate in the training with instructions on how to complete the attestation.

4. **Quality performance improvement plan:** We have a comprehensive and multi-functional Quality Improvement (QI) program and conduct a wide range of quality improvement activities focusing on the health care and services our Members receive across the health care continuum. Our program includes quality measurement and performance improvement, which is a collaborative process for improving our ability to deliver high-quality health care services and benefits to our Members.

    - Our program includes multiple goals based on our program design and population that focus on structure, process and outcomes. We have a specific set of goals to measure the effectiveness of our program focusing on all aspects of care and health outcomes including but not limited to the following:
        - Improved coordination of care/case management and appropriate delivery of services through the HRA, ICP, and ICT processes.
        - Improved access to preventive health services and management of chronic conditions
        - Appropriate utilization of services for preventive health and chronic conditions
        - Improved beneficiary health outcomes
        - Improved access to behavioral health services
        - Care transitions
    - We use multiple data sources to monitor, analyze and evaluate performance outcomes, according to our work plan and MOC objectives. Based on our results, we will take corrective actions if needed to improve our performance.
    - Our program is evaluated and results are communicated to multiple stakeholders

We want to be your partner and assist in helping to manage and coordinate the complex needs experienced by our Members. To better assist you, we ask the following of all our Providers involved in the care of our SNP Members:

- Complete the MOC Provider training as required.
- Review the HRA results, the ICP and other data we may provide to you. If asked sign and return the ICP.
- Respond to communications you may receive from our team concerning needs identified during our interactions with the Members or requiring assistance in developing the ICP
- Participate in the ICT by providing feedback to communications or inquiries sent by members of the ICT
- Assist in managing transitions in care, sharing important health information between health care settings.
- Assist with coordination of care including coordinating with Medicaid on our Dual Members
- Communicate and collaborate with our care team, the ICT, Members and caregivers. Reach out to our team if you have complex Members, we can assist you with coordinating needed care.
- Encourage the Member to work with your office, the care team, keeping all appointments, completing the HRA and complying with all treatment plans.

9. Behavioral health

ConnectiCare's vendor, Optum Behavioral Health, coordinates and manages behavioral health and substance abuse services for Members. Optum Behavioral Health has a Help Line that Members and Providers can access by calling (888) 946-4658. Standard hours of operation are 7 a.m. to 7 p.m., CST. When Members call this number at any time there is an IVR prompt that asks if they have concerns about their own or someone else's safety. If the Member answers YES, they are routed directly to a crisis team 24/7.

For Clinical Assistance, Providers can contact Optum Behavioral Health at (800) 349-5365 from 7 a.m. to 7 p.m., CST. For higher level of care auth requests ONLY, Providers can call this number 24/7.

For additional information please refer to Optum's website at providerexpress.com.

Claims address:

Optum Behavioral Health
PO Box 30757
Salt Lake City, UT 84130-0757

10. Quality

Maintaining quality improvement processes and programs

ConnectiCare works with Members and Providers to maintain a comprehensive Quality Improvement (QI) program. You can contact the ConnectiCare Quality department at (800) 828-3407.

The address for mail requests is:

ConnectiCare
Quality Department
175 Scott Swamp Road
PO Box 4050
Farmington, CT 06034-4050

This Provider Manual contains excerpts from the ConnectiCare QI program. For a complete copy of ConnectiCare's QI program, you can contact your Provider Relations representative or call the telephone number above to receive a written copy.

ConnectiCare has established a QI program that complies with regulatory requirements and accreditation standards. The QI program provides structure and outlines specific activities designed to improve the care, service and health of our Members. In our quality program description, we describe our program governance, scope, goals, measurable objectives, structure and responsibilities.

ConnectiCare does not delegate quality improvement activities to medical groups/IPAs. However, ConnectiCare requires contracted medical groups/IPAs to comply with the following core elements and standards of care. ConnectiCare medical groups/IPAs must:

- Have a quality improvement program in place
- Comply with and participate in ConnectiCare's QI Program including reporting of access and availability survey and activity results and provision of medical records as part of the HEDIS® review process and during potential quality of care and/or critical incident investigations
- Cooperate with ConnectiCare's quality improvement activities that are designed to improve quality of care and services and Member experience
- Allow ConnectiCare to collect, use and evaluate data related to Provider performance for quality improvement activities, including but not limited to focus areas, such as clinical care, care coordination and management, service and access and availability
- Allow access to ConnectiCare Quality personnel for site and medical record review processes

Patient safety program

ConnectiCare's Patient Safety Program identifies appropriate safety projects and error avoidance for ConnectiCare Members in collaboration with their PCPs. ConnectiCare continues to support safe health practices for our Members through our safety program, pharmaceutical management and case management/health management programs and education. ConnectiCare monitors nationally recognized quality index ratings for facilities including adverse events and hospital-acquired conditions as part of a national strategy to improve health care quality mandated by the Patient Protection and ACA and the Department of Health and Human Services (HHS) to identify areas that have the potential for improving health care quality to reduce the incidence of events.

The Tax Relief and Health Care Act of 2006 mandates that the Office of Inspector General reports to Congress regarding the incidence of "never events" among Medicare beneficiaries, the payment for services in connection with such events and CMS processes to identify events and deny payment.

Quality of care

ConnectiCare has established a systematic process to identify, investigate, review and report any quality of care, adverse event/never event, critical incident (as applicable), and/or service issues affecting Member care. ConnectiCare will research, resolve, track and trend issues. Confirmed adverse events/never events are reportable when related to an error in medical care that is clearly identifiable, preventable and/or found to have caused serious injury or death to a patient. Some examples of never events include:

- Surgery on the wrong body part
- Surgery on the wrong patient
- Wrong surgery on a patient

ConnectiCare is not required to pay for inpatient care related to "never events."

Medical records

ConnectiCare requires that medical records are maintained in a manner that is current, detailed and organized to ensure that care rendered to Members is consistently documented and that necessary information is readily available in the medical record. All entries will be indelibly added to the Member's medical record. PCPs should maintain the following medical record components that include but are not limited to:

- Medical record confidentiality and release of medical records within medical and behavioral health care records
- Medical record content and documentation standards, including preventive health care
- Storage maintenance and disposal processes
- Process for archiving medical records and implementing improvement activities

Medical record-keeping practices

Below is a list of the minimum items that are necessary in the maintenance of the Member's medical records:

- Each patient has a separate medical record
- Medical records are stored away from patient areas and preferably locked
- Medical records are available during each visit and archived records are available within 24 hours
- If hard copy, pages are securely attached in the medical record and records are organized by dividers or color-coded when the thickness of the record dictates
- If electronic, all those with access have individual passwords
- Record keeping is monitored for quality and HIPAA compliance, including privacy of confidential information, such as race, ethnicity, language and sexual orientation and gender identity
- Storage maintenance for the determined timeline and disposal are managed per record management processes
- Process is in place for archiving medical records and implementing improvement activities
- Medical records are kept confidential and there is a process for release of medical records including behavioral health care records

Content

Providers must remain consistent in their practices with ConnectiCare's medical record documentation guidelines. Medical records are maintained and should include, but not limited to the following information. All records should contain:

- The patient's name or ID number on each page in the record
- The patient's name, date of birth, sex, marital status, address, employer, home and work telephone numbers and emergency contact
- Legible signatures and credentials of the Provider and other staff members within a paper chart
- A list of all Providers who participate in the Member's care
- Information about services that are delivered by these Providers
- A problem list that describes the Member's medical and behavioral health conditions
- Presenting complaints, diagnoses and treatment plans, including follow-up visits and referrals to other Providers
- Prescribed medications, including dosages and dates of initial or refill prescriptions
- Medication reconciliation within 30 days of an inpatient discharge with evidence of current and discharge medication reconciliation and the date performed
- Allergies and adverse reactions (or notation that none are known)
- Documentation that shows advance directives, power of attorney and living will have been discussed with Member and a copy of advance directives when in place
- Past medical and surgical history, including physical examinations, treatments, preventive services and risk factors
- Treatment plans that are consistent with diagnosis

- A working diagnosis recorded with the clinical findings
- Pertinent history for the presenting problem
- Pertinent physical exam for the presenting problem
- Lab and other diagnostic tests that are ordered as appropriate by the Provider
- Clear and thorough progress notes that state the intent for all ordered services and treatments
- Notations regarding follow-up care, calls or visits that include the specific time of return noted in weeks, months or as needed, included in the next preventative care visit when appropriate
- Notes from consultants as applicable
- Up-to-date immunization records and documentation of appropriate history
- All staff and Provider notes are signed physically or electronically with either name or initials
- All entries are dated
- All abnormal lab/imaging results show explicit follow up plan(s)
- All ancillary services reports
- Documentation of all emergency care provided in any setting
- Documentation of all hospital admissions and follow-up care, inpatient and outpatient care, including hospital discharge summaries, hospital history and physicals and operative report
- Labor and delivery record for any child seen since birth
- A signed document stating with whom protected health information may be shared

Organization

- The medical record is legible to someone other than the writer
- Each patient has an individual record
- Chart pages are bound, clipped or attached to the file
- Chart sections are easily recognized for retrieval of information
- A release document for each Member authorizing ConnectiCare to release medical information for the facilitation of medical care

Retrieval

- The medical record is available to the Provider at each encounter
- The medical record is available to ConnectiCare for purposes of quality improvement
- The medical record is available to the applicable state and/or federal agency and the external quality review organization upon request
- The medical record is available to the Member upon their request
- A storage system for inactive Member medical records which allows retrieval within 24 hours, is consistent with state and federal requirements and the record is maintained for not less than 10 years from the last date of treatment or for a minor, one (1) year past their 20th birthday but, never less than 10 years
- An established and functional data recovery procedure in the event of data loss

Confidentiality

ConnectiCare Providers shall develop and implement confidentiality procedures to guard Member protected health information, in accordance with HIPAA privacy standards and all other applicable federal and state regulations. This should include and is not limited to, the following:

- Ensure that medical information is released only in accordance with applicable federal or state law in pursuant to court orders or subpoenas
- Maintain records and information in an accurate and timely manner
- Ensure timely access by Members to the records and information that pertain to them
- Abide by all federal and state laws regarding confidentiality and disclosure of medical records or other health and enrollment information
- Protect medical records from unauthorized access
- Restrict access to computerized confidential information
- Take precautions to prevent inadvertent or unnecessary disclosure of protected health information
- Educate and train all staff on handling and maintaining protected health care information
- Ensure that confidential information, such as patient race, ethnicity, preferred language, sexual orientation, gender identity and social determinants of health is protected

Additional information on medical records is available from your local ConnectiCare Quality department. For additional information regarding HIPAA please refer to the **Compliance** section of this Provider Manual.

Advance directives (Patient Self-Determination Act)

ConnectiCare complies with the advance directive requirements of the states in which the organization provides services. Responsibilities include ensuring Members receive information regarding advance directives and that contracted Providers and facilities uphold executed documents.

Advance directives are a written choice for health care. There are two (2) types of advance directives:

- **Appointment of health care representative**: allows an agent to be appointed to carry out health care decisions.
- **Living will**: allows choices about withholding or withdrawing life support and accepting or refusing nutrition and/or hydration.

When there is no advance directive: The Member's family and Provider will work together to decide on the best care for the Member based on information they may know about the Member's end-of-life plans.

Providers must inform adult ConnectiCare Members, 18 years old and up, of their right to make health care decisions and execute advance directives. It is important that Members are informed about advance directives.

Members who would like more information are instructed to contact the ConnectiCare Member Contact Center or are directed to the CaringInfo website at caringinfo.org/planning/advance-directives for forms available to download. Additionally, the ConnectiCare website offers information to both Providers and Members regarding advance directives, with a link to forms that can be downloaded and printed.

PCPs must discuss advance directives with a Member and provide appropriate medical advice if the Member desires guidance or assistance.

ConnectiCare network Providers and facilities are expected to communicate any objections they may have to a Member directive prior to service when possible. Members may select a new PCP if the assigned Provider has an objection to the Member's desired decision. ConnectiCare will facilitate finding a new PCP or specialist as needed.

In no event may any Provider refuse to treat a Member or otherwise discriminate against a Member because the Member has completed an advance directive. CMS regulations give Members the right to file a complaint with ConnectiCare or the state survey and certification agency if the Member is dissatisfied with ConnectiCare's handling of advance directives and/or if a Provider fails to comply with advance directive instructions.

ConnectiCare will notify the Provider of an individual Member's advance directive identified through case management, care coordination or case management. Providers are instructed to document the presence of an advance directive in a prominent location of the medical record. Advance directive forms are state-specific to meet state regulations.

ConnectiCare expects that there will be documented evidence of the discussion between the Provider and the Member during routine medical record reviews.

Access to care

ConnectiCare maintains access to care standards and processes for ongoing monitoring of access to health care provided by contracted PCPs and participating specialists. Providers surveyed include PCPs (family/general practice, internal medicine and pediatric), OB/GYN (high-volume specialists), Oncologists (high-impact specialists) and behavioral health Providers. Providers are required to conform to the access to care appointment standards listed below to ensure that health care services are provided in a timely manner. The PCP or their designee must be available 24 hours a day, 7 days a week to Members.

Appointment access

All Providers who oversee the Member's health care are responsible for providing the following appointments to ConnectiCare Members in the timeframes noted.

Medical appointment

Appointment types	Standard
Primary Care: Routine and Preventive Care	Within 30 business days
Primary Care: Services that are not emergency or urgently needed but require medical attention	Within 7 business days
Urgently needed services or emergency	Immediately
After Hours Care	24 hours/day; 7 day/week availability
Non-urgent ancillary services	Within 15 business days
Non-urgent specialty care	Within 15 business days
Urgent Specialty Care	Within 24 hours

Behavioral health appointment

Appointment types	Standard
Life-threatening Emergency: Urgently needed services or emergency	Immediately
Non-life-threatening Emergency	Within 6 hours
Services that are not emergency or urgently needed but require medical attention	Within 7 business days
Initial Routine Care Visit	Within 10 business days
Follow-up Routine Care Visit	Within 10 business days

Additional information on appointment access standards is available from your local ConnectiCare Quality department.

Office wait time

For scheduled appointments, the wait time in offices should not exceed 30 minutes. All PCPs are required to monitor waiting times and adhere to this standard.

After hours

All Providers must have backup (on-call) coverage after hours or during the Provider's absence or unavailability. ConnectiCare requires Providers to maintain a 24-hour telephone service, 7 days a week. This access may be through an answering service or a recorded message after office hours. The service or recorded message should instruct Members with an emergency to hang up and call 911 or go immediately to the nearest emergency room. Voicemail alone after hours is not acceptable.

Women's health access

ConnectiCare allows Members the option to seek obstetric and gynecological care from an in-network obstetrician or gynecologist or directly from a participating PCP designated by ConnectiCare as providing obstetric and gynecological services. Member access to obstetric and gynecological services is monitored to ensure Members have direct access to participating Providers for obstetric and gynecological services. Gynecological services must be provided when requested regardless of the gender status of the Member.

Additional information on access to care is available from your local ConnectiCare Quality department.

Monitoring access for compliance with standards

Access to care standards are reviewed, revised as necessary and approved by the Quality Improvement and Health Equity Transformation Committee on an annual basis.

Provider network adherence to access standards is monitored via one or more of the following mechanisms:

1. Provider access studies – Provider office assessment of appointment availability, after-hours access, Provider ratios and geographic access.
2. Member complaint data – assessment of Member complaints related to access and availability of care.
3. Member satisfaction survey – evaluation of Members' self-reported satisfaction with appointment and after-hours access.

Analysis of access data includes assessment of performance against established standards, review of trends over time and identification of barriers. Results of analysis are reported to the Quality Improvement and Health Equity Transformation Committee at least annually for review and determination of opportunities for improvement. Corrective actions are initiated when performance goals are not met and for identified Provider-specific and/or organizational trends. Performance goals are reviewed and approved annually by the Quality Improvement and Health Equity Transformation Committee.

Quality of provider office sites

ConnectiCare Providers are to maintain office-site and medical record keeping practice standards. ConnectiCare continually monitors Member appeals and complaints/grievances for all office sites to determine the need for an office site visit and will conduct office site visits as needed. ConnectiCare assesses the quality, safety and accessibility of office sites where care is delivered against standards and thresholds. A standard survey form is completed at the time of each visit. This includes an assessment of:

- Physical accessibility

- Physical appearance
- Adequacy of waiting and examining room space
- Adequacy of medical/treatment record keeping; paper records
- Adequacy of medical/treatment record keeping; electronic records
- Patient safety including adequacy of equipment

Physical accessibility

ConnectiCare evaluates office sites as applicable, to ensure that Members have safe and appropriate access to the office site. This includes, but is not limited to, ease of entry into the building, accessibility of space within the office site and ease of access for patients with physical disabilities.

Physical appearance

The site visits include but are not limited to an evaluation of office site cleanliness, appropriateness of lighting and patient safety as needed.

Adequacy of waiting and examining room space

During the site visit as required, ConnectiCare assesses waiting and examining room spaces to ensure that the office offers appropriate accommodations to Members. The evaluation includes, but is not limited to, appropriate seating in the waiting room areas and availability of exam tables in exam rooms.

Administration and confidentiality of facilities

Facilities contracted with ConnectiCare must demonstrate overall compliance with the guidelines listed below:

- Office appearance demonstrates that housekeeping and maintenance are performed appropriately on a regular basis, the waiting room is well-lit, office hours are posted and the parking area and walkways demonstrate appropriate maintenance.
- Accessible parking is available, the building and exam rooms are accessible with an incline ramp or flat entryway and the restroom is accessible with a bathroom grab bar.
- Adequate seating includes space for an average number of patients in an hour and there is a minimum of two (2) office exam rooms per Provider.
- Basic emergency equipment is located in an easily accessible area. This includes a pocket mask and Epinephrine, plus any other medications appropriate to the practice.
- At least one (1) CPR-certified employee is available.
- Yearly Occupational Safety and Health Administration (OSHA) training (fire, safety, blood-borne pathogens, etc.) is documented for offices with 10 or more employees.
- A container for sharps is located in each room where injections are given.
- Labeled containers, policies, contracts and evidence of a hazardous waste management system in place.

- Patient check-in systems are confidential. Signatures on fee slips, separate forms, stickers or labels are possible alternative methods.
- Confidential information is discussed away from patients. When reception areas are unprotected by sound barriers, scheduling and triage phones are best placed at another location.
- Medical records are stored away from patient areas. Record rooms and/or file cabinets are preferably locked.
- A Clinical Laboratory Improvement Amendment (CLIA) waiver is displayed when the appropriate lab work is run in the office.
- Prescription pads are not kept in exam rooms.
- Narcotics are locked, preferably double-locked. Medication and sample access is restricted.
- System in place to ensure expired sample medications are not dispensed and injectables and emergency medication are checked monthly for outdates.
- Drug refrigerator temperatures are documented daily.

Monitoring for compliance with standards

ConnectiCare monitors compliance with the established performance standards as outlined above at least annually. Performance below ConnectiCare's standards may result in a corrective action plan (CAP) with a request that the Provider submit a written CAP to ConnectiCare within 30 calendar days. Follow-up to ensure resolution is conducted at regular intervals until compliance is achieved. The information and any response made by the Provider are included in the Provider's permanent credentials file. If compliance is not attained at follow-up, an updated CAP will be required. Providers who do not submit a CAP may be terminated from network participation or closed to new Members.

Quality improvement activities and programs

ConnectiCare maintains an active Quality Improvement (QI) Program. The QI Program provides structure and key processes to carry out our ongoing commitment to the improvement of care and service. ConnectiCare focuses on reducing health care disparities through the QI Program. The goals identified are based on an evaluation of programs and services,; regulatory, contractual and accreditation requirements; and strategic planning initiatives.

Health management and case management

The ConnectiCare health management and case management programs provide for the identification, assessment, stratification and implementation of appropriate interventions for Members with chronic diseases.

For additional information please refer to the **Health Care Services** section of this Provider Manual.

Clinical practice guidelines (CPG)

ConnectiCare adopts and disseminates CPGs to reduce inter-Provider variation in diagnosis and treatment. CPG adherence is measured at least annually. All guidelines are based on scientific evidence, review of medical literature and/or appropriately established authority.

ConnectiCare CPGs include the following:

- Acute Stress and Post-Traumatic Stress Disorder (PTSD)
- Anxiety/Panic Disorder
- Asthma
- Attention Deficit Hyperactivity Disorder (ADHD)
- Autism
- Bipolar Disorder
- Children with Special Health Care Needs
- Chronic Kidney Disease
- Chronic Obstructive Pulmonary Disease (COPD)
- Depression
- Diabetes
- Heart Failure in Adults
- Homelessness-Special Health Care Needs
- Hypertension
- Obesity
- Opioid Management
- Perinatal Care
- Pregnancy Management
- Schizophrenia
- Sickle Cell Disease
- Substance Abuse Treatment
- Suicide Risk
- Trauma-Informed Primary Care

All CPGs are updated at least annually and more frequently, as needed when clinical evidence changes and are approved by the Quality Improvement and Health Equity Transformation Committee. A review is conducted at least monthly to identify new additions or modifications. On an annual basis or when changes are made during the year, CPGs are distributed to Providers at connecticare.com and the Provider Manual. Notification of the availability of the CPGs is published in the ConnectiCare Provider Newsletter.

Preventive health guidelines

ConnectiCare provides coverage of diagnostic preventive procedures based on recommendations published by the U.S. Preventive Services Task Force (USPSTF), Bright Futures/American Academy of Pediatrics and the Centers for Disease Control

and Prevention (CDC) in accordance with CMS guidelines. Diagnostic preventive procedures include but are not limited to:

- Adult Preventive Services Recommendations (U.S. Preventive Services Task Force). Links to current recommendations are included on ConnectiCare's website.
- Recommendations for Preventive Pediatric Health Care (Bright Futures/American Academy of Pediatrics). Links to current recommendations are included on ConnectiCare's website.
- Recommended Adult Immunization Schedule for ages 19 Years or Older (United States). These recommendations are revised every year by the CDC. Links to current recommendations are included on ConnectiCare's website.
- Recommended Child and Adolescent Immunization Schedule for ages 18 years or younger (United States). These recommendations are revised every year by the CDC. Links to current recommendations are included on ConnectiCare's website.

All preventive health guidelines are updated at least annually and more frequently as needed when clinical evidence changes and are approved by the Quality Improvement and Health Equity Transformation Committee. A review is conducted at least monthly to identify new additions or modifications. On an annual basis or when changes are made during the year, preventive health guidelines are distributed to Providers at connecticare.com and the Provider Manual. Notification of the availability of the preventive health guidelines is published in the ConnectiCare Provider Newsletter.

Cultural and linguistic appropriate services

ConnectiCare works to ensure all Members receive culturally competent care across the service continuum to reduce health disparities and improve health outcomes. For additional information about ConnectiCare's program and services, please refer to the **Culturally and Linguistically Appropriate Services** section of this Provider Manual.

Measurement of clinical and service quality

ConnectiCare monitors and evaluates the quality of care and services provided to Members through the following mechanisms:

- HEDIS®
- CAHPS®
- Health Outcomes Survey (HOS)
- Provider Satisfaction Survey
- Effectiveness of quality improvement initiatives

ConnectiCare evaluates continuous performance according to or in comparison with objectives, measurable performance standards and benchmarks at the national, regional and/or at the local/health plan level.

Contracted Providers and facilities must allow ConnectiCare to use its performance data collected in accordance with the Provider Agreement with ConnectiCare. The use of performance data may include but is not limited to the following:

1. Development of quality improvement activities
2. Public reporting to consumers
3. Preferred status designation in the network
4. Reduced Member cost sharing

ConnectiCare's most recent results can be obtained from your local ConnectiCare Quality department or by visiting our website at connecticare.com.

HEDIS®

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

HEDIS® results are used in a variety of ways. The results are used to evaluate the effectiveness of multiple quality improvement activities and clinical programs. The standards are based on established clinical guidelines and protocols, providing a firm foundation to measure the effectiveness of these programs.

Selected HEDIS® results are provided to federal and state regulatory agencies and accreditation organizations. The data are also used to compare against established health plan performance benchmarks.

CAHPS®

CAHPS® is the tool used by ConnectiCare to summarize Member satisfaction with Providers, health care and service they receive. CAHPS® examines specific measures, including Getting Needed Care, Getting Care Quickly, How Well Doctors Communicate, Coordination of Care, Customer Service, Rating of Health Care and Getting Needed Prescription Drugs (for Medicare). The CAHPS® survey is administered annually in the spring to randomly selected Members by an NCQA-certified vendor.

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

Medicare Health Outcomes Survey (HOS)

HOS measures Medicare Members' physical and mental health status over a two (2)-year period and categorizes the two (2)-year change scores as better, same or worse than expected. The goal of HOS is to gather valid, reliable, clinically meaningful data that can be used to target quality improvement activities and resources, monitor health

plan performance and reward top-performing health plans. Additionally, HOS is used to inform beneficiaries of their health care choices, advance the science of functional health outcomes measurement and for quality improvement interventions and strategies.

Provider satisfaction survey

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

Effectiveness of quality improvement initiatives

ConnectiCare monitors the effectiveness of clinical and service activities through metrics selected to demonstrate clinical outcomes and service levels. The plan's performance is compared to that of available national benchmarks indicating "best practices." The evaluation includes an assessment of clinical and service improvements on an ongoing basis. Results of these measurements guide activities for the successive periods.

In addition to the methods described above, ConnectiCare also compiles complaint and appeals data as well as requests for out-of-network services to determine opportunities for service improvements.

Medicare star ratings – The Affordable Care Act

Star ratings are a system of measurements CMS uses to determine how well physicians and health plans are providing care to Medicare Members. This system is based on nationally-recognized quality goals which focus on improving the health and care of your patients, safe and effective care, as well as making care affordable. These aims are realized through the collection and reporting of specific measure results.

Preventive health:

- Annual wellness/physical exams
- Mammograms
- Osteoporosis testing and management
- Influenza and Pneumonia immunizations
- Colonoscopies

Chronic care management:

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

Member satisfaction survey questions:

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

What can providers do?

- Ensure patients are up-to-date with their annual physical exam and preventive health screenings, including related lab orders and referrals to specialists, such as ophthalmology.
- Review the HEDIS® preventive care listing of measures for each patient to determine if anything applicable to your patients' age and/or condition has been missed.
- Check that staff are properly coding all services provided.
- Be sure patients understand what *they* need to do.

ConnectiCare has additional resources to assist Providers and their patients. For access to tools that can assist, please visit the Availity Essentials portal. There are a variety of resources, including HEDIS® CPT/CMS-approved diagnostic and procedural code sheets. To obtain a current list of HEDIS® and CAHPS® star ratings measures, contact your local ConnectiCare Quality department.

11. Risk adjustment accuracy and completeness

What is risk adjustment?

CMS defines risk adjustment as a process that helps to accurately measure the health status of a plan's membership based on medical conditions and demographic information.

This process helps ensure health plans receive accurate payment for services provided to ConnectiCare Members and prepares for resources that may be needed in the future to treat Members who have chronic conditions.

Interoperability

The Provider agrees to deliver relevant clinical documents (Clinical Document Architecture (CDA) or Continuity of Care Document (CCD) format) at encounter close for ConnectiCare Members by using one of the automated methods available and supported by the Provider's electronic medical records (EMR), including but not limited to Epic Payer Platform, Direct Protocol, Secure File Transfer Protocol (sFTP), query or Web service interfaces such as Simple Object Access Protocol (External Data Representation) or Representational State Transfer (Fast Healthcare Interoperability Resource).

The CDA or CCD document should include signed clinical notes or conform with the United States Core Data for Interoperability (USCDI) common data set and Health Level 7 (HL7) Consolidated Clinical Data Architecture (CCDA) standard.

The Provider will also enable HL7 v2 Admission/Discharge/Transfer (ADT) feed for all patient events for ConnectiCare Members to the interoperability vendor designated by ConnectiCare.

The Provider will participate in ConnectiCare's program to communicate Clinical Information using the Direct Protocol. Direct Protocol is the HIPAA-compliant mechanism for exchanging healthcare information that is approved by the Office of the National Coordinator for Health Information Technology (ONC).

- If the Provider does not have a Direct Address, the Provider will work with its EMR vendor to set up a Direct Messaging Account, which also supports the CMS requirement of having the Provider's Digital Contact Information added in NPPES
- If the Provider's EMR does not support the Direct Protocol, the Provider will work with ConnectiCare's established interoperability partner to get an account established

Risk adjustment data validation (RADV) audits

As part of the regulatory process, CMS may conduct RADV audits to ensure that the diagnosis data submitted by ConnectiCare is complete and accurate. All

claims/encounters submitted to ConnectiCare are subject to state and/or federal and internal health plan auditing. If ConnectiCare is selected for a RADV audit, Providers will be required to submit medical records in a timely manner to validate the previously submitted data.

Your role as a Provider

As a Provider, complete and accurate documentation in a medical record is critical to a Member's quality of care. We encourage Providers to record all diagnoses to the highest specificity. This will ensure ConnectiCare receives adequate resources to provide quality programs to you and our Members.

For a complete and accurate medical record, all Provider documentation must:

- Address clinical data elements (e.g., diabetic patient needs an eye exam or multiple comorbid conditions) provided by ConnectiCare and reviewed with the Member
- Be compliant with the CMS National Correct Coding Initiative (NCCI)
- Use the correct ICD-10 code by documenting the condition to the highest level of specificity
- Only use diagnosis codes confirmed during a Provider visit with a Member. The visit may be face-to-face or telehealth, depending on state or CMS requirements
- Contain a treatment plan and progress notes
- Contain the Member's name and date of service
- Have the Provider's signature and credentials

Contact information

For questions about ConnectiCare's risk adjustment programs, please contact your ConnectiCare Provider Relations representative.

12. Compliance

Fraud, waste and abuse

Introduction

ConnectiCare is dedicated to the detection, prevention, investigation and reporting of potential health care fraud, waste and abuse. As such, ConnectiCare's Compliance department maintains a comprehensive plan, which addresses how ConnectiCare will uphold and follow state and federal statutes and regulations pertaining to fraud, waste and abuse. ConnectiCare also addresses fraud, waste and abuse prevention, detection and correction along with the education of appropriate employees, vendors, Providers and associates doing business with ConnectiCare.

ConnectiCare's Special Investigation Unit (SIU) supports Compliance in its efforts to prevent, detect and correct fraud, waste and abuse by conducting investigations aimed at identifying suspect activity and reporting these findings to the appropriate regulatory and/or law enforcement agency.

Mission statement

Our mission is to pay claims correctly the first time and that mission begins with the understanding that we need to proactively detect fraud, waste and abuse, correct it and prevent it from reoccurring. Since not all fraud, waste or abuse can be prevented, ConnectiCare employs processes that retrospectively address fraud, waste or abuse that may have already occurred. ConnectiCare strives to detect, prevent, investigate and report suspected health care fraud, waste and abuse in order to reduce health care costs and to promote quality health care.

Regulatory requirements

Federal False Claims Act

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

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

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

The Act does not require proof of a specific intent to defraud the U.S. government. Instead, health care Providers can be prosecuted for a wide variety of conduct that leads to the submission of fraudulent claims to the government, such as knowingly making false statements, falsifying records, double-billing for items or services,

submitting bills for services never performed or items never furnished or otherwise causing a false claim to be submitted.

Deficit Reduction Act (DRA)

The DRA aims to cut fraud, waste and abuse from the Medicare and Medicaid programs.

As a contractor doing business with ConnectiCare, Providers and their staff have the same obligation to report any actual or suspected violation or fraud, waste or abuse. Entities must have written policies that inform employees, contractors and agents of the following:

- The federal False Claims Act and state laws pertaining to submitting false claims
- How Providers will detect and prevent fraud, waste and abuse
- Employee protection rights as whistleblowers
- Administrative remedies for false claims and statements

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

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

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

Affected entities who fail to comply with the law will be at risk of forfeiting all payments until compliance is met. ConnectiCare will take steps to monitor ConnectiCare contracted Providers to ensure compliance with the law. Health care entities (e.g., providers, facilities, delegates and/or vendors) to which ConnectiCare has paid $5 million or more in Medicaid funds during the previous federal fiscal year (October 1-September 30) will be required to submit a signed "Attestation of Compliance with the Deficit Reduction Act of 2005, Section 6032" to ConnectiCare.

Anti-kickback Statute (42 U.S.C. § 1320a-7b(b))

Anti-kickback Statute (AKS) is a criminal law that prohibits the knowing and willful payment of "remuneration" to induce or reward patient referrals or the generation of business involving any item or service payable by the federal health care programs

(e.g., drugs, supplies or health care services for Medicare or Medicaid patients). In some industries, it is acceptable to reward those who refer business to you. However, in the federal health care programs, paying for referrals is a crime. The statute covers the payers of kickbacks-those who offer or pay remuneration- as well as the recipients of kickbacks-those who solicit or receive remuneration.

ConnectiCare conducts all business in compliance with federal and state AKS statutes and regulations and federal and state marketing regulations. Providers are prohibited from engaging in any activities covered under this statute.

AKS statutes and regulations prohibit paying or receiving anything of value to induce or reward patient referrals or the generation of business involving any item or service payable by federal and state health care programs. The phrase "anything of value" can mean cash, discounts, gifts, excessive compensation, contracts not at fair market value, etc. Examples of prohibited AKS actions include a health care Provider who is compensated based on patient volume or a Provider who offers remuneration to patients to influence them to use their services.

Under ConnectiCare's policies, Providers may not offer, solicit an offer, provide or receive items of value of any kind that are intended to induce referrals of federal health care program business. Providers must not, directly or indirectly, make or offer items of value to any third party for the purpose of obtaining, retaining or directing our business. This includes giving, favors, preferential hiring or anything of value to any government official.

Marketing guidelines and requirements

Providers must conduct all marketing activities in accordance with the relevant contractual requirements and marketing statutes and regulations – both state and federal.

Under ConnectiCare's policies, marketing means any communication, to a beneficiary who is not enrolled with ConnectiCare, that can reasonably be interpreted as intended to influence the beneficiary to enroll with ConnectiCare's Medicaid, Marketplace or Medicare products. This also includes communications that can be interpreted to influence a beneficiary to not enroll in or to disenroll from another health plan's products.

Restricted marketing activities vary from state to state but generally relate to the types and forms of communications that health plans, Providers and others can have with Members and prospective Members. Examples of such communications include those related to enrolling Members, Member outreach and other types of communications.

Stark statute

The Physicians Self-Referral Law (Stark Law) prohibits physicians from referring patients to receive "designated health services" payable by Medicare or Medicaid from

entities with which the physician or an immediate family member has a financial relationship unless an exception applies. Financial relationships include both ownership/investment interests and compensation arrangements. The Stark law prohibits the submission or causing the submission of claims in violation of the law's restrictions on referrals. “Designated health services” are identified in the Physician Self-Referral Law (42 U.S.C. § 1395nn).

Sarbanes-Oxley Act of 2002

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

Definitions

Fraud means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to themself or some other person. It includes any act that constitutes fraud under applicable federal or state law (42 CFR § 455.2).

Waste means health care spending that can be eliminated without reducing the quality of care. Quality waste includes overuse, underuse and ineffective use. Inefficiency waste includes redundancy, delays and unnecessary process complexity. An example would be the attempt to obtain reimbursement for items or services where there was no intent to deceive or misrepresent, however the outcome resulted in poor or inefficient billing methods (e.g., coding) causing unnecessary costs to state and federal health care programs.

Abuse means Provider practices that are inconsistent with sound fiscal, business or medical practices and result in unnecessary costs to state and federal health care programs or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes recipient practices that result in unnecessary costs to state and federal health care programs (42 CFR § 455.2).

Examples of fraud, waste and abuse by a Provider

The types of questionable Provider schemes investigated by ConnectiCare include, but are not limited to the following:

- A Provider knowingly and willfully referring a Member to health care facilities in which or with which the Provider has a financial relationship (Stark Law).
- Altering claims and/or medical record documentation in order to get a higher level of reimbursement.
- Balance billing a ConnectiCare Member for covered services. This includes asking the Member to pay the difference between the discounted and negotiated fees and the Provider’s usual and customary fees.

- Billing and providing services to Members that are not medically necessary.
- Billing for services, procedures and/or supplies that have not been rendered.
- Billing under an invalid place of service in order to receive or maximize reimbursement.
- Completing certificates of medical necessity for Members not personally and professionally known by the Provider.
- Concealing a Member's misuse of a ConnectiCare Member ID card.
- Failing to report a Member's forgery or alteration of a prescription or other medical document.
- False coding in order to receive or maximize reimbursement.
- Inappropriate billing of modifiers in order to receive or maximize reimbursement.
- Inappropriately billing of a procedure that does not match the diagnosis in order to receive or maximize reimbursement.
- Knowingly and willfully soliciting or receiving payment of kickbacks or bribes in exchange for referring patients.
- Not following incident-to-billing guidelines in order to receive or maximize reimbursement.
- Overutilization
- Participating in schemes that involve collusion between a Provider and a Member that result in higher costs or charges.
- Questionable prescribing practices.
- Unbundling services in order to get more reimbursement, which involves separating a procedure into parts and charging for each part rather than using a single global code.
- Underutilization, which means failing to provide services that are medically necessary.
- Upcoding, which is when a Provider does not bill the correct code for the service rendered and instead uses a code for a like service that costs more.
- Using the adjustment payment process to generate fraudulent payments.

Examples of fraud, waste and abuse by a Member

The types of questionable Member schemes investigated by ConnectiCare include, but are not limited to, the following:

- Benefit sharing with persons not entitled to the Member's benefits.
- Conspiracy to defraud state and federal health care programs.
- Doctor shopping, which occurs when a Member consults a number of Providers for the purpose of inappropriately obtaining services.
- Falsifying documentation in order to get services approved.
- Forgery related to health care.
- Prescription diversion, which occurs when a Member obtains a prescription from a Provider for a condition that they do not suffer from and the Member sells the medication to someone else.

Review of Provider claims and claim system

ConnectiCare claims examiners are trained to recognize unusual billing practices, which are key in trying to identify fraud, waste and abuse. If the claims examiner suspects fraudulent, abusive or wasteful billing practices, the billing practice is documented and reported to the SIU through our Compliance Alertline/reporting repository.

The claim payment system utilizes system edits and flags to validate those elements of claims are billed in accordance with standardized billing practices, ensure that claims are processed accurately and ensure that payments reflect the service performed as authorized.

ConnectiCare performs auditing to ensure the accuracy of data input into the claim system. The claims department conducts regular audits to identify system issues or errors. If errors are identified, they are corrected and a thorough review of system edits is conducted to detect and locate the source of the errors.

Prepayment of fraud, waste and abuse detection activities

Through the implementation of claim edits, ConnectiCare's claim payment system is designed to audit claims concurrently, in order to detect and prevent paying claims that are inappropriate.

ConnectiCare has a pre-payment claim auditing process that identifies frequent correct coding billing errors ensuring that claims are coded appropriately according to state and federal coding guidelines. Code edit relationships and edits are based on guidelines from specific state Medicaid guidelines, federal CMS guidelines, American Medical Association (AMA) and published specialty-specific coding rules. Code edit rules are based on information received from the National Physician Fee Schedule Relative File (NPFS), the Medically Unlikely Edit (MUE) table, NCCI files, Local Coverage Determination/National Coverage Determination (LCD/NCD)and state-specific policy manuals and guidelines as specified by a defined set of indicators in the Medicare Physician Fee Schedule Data Base (MPFSDB).

Additionally, ConnectiCare may, at the request of a state program or at its own discretion, subject a Provider to prepayment reviews whereupon the Provider is required to submit supporting source documents that justify an amount charged. Where no supporting documents are provided or insufficient information is provided to substantiate a charge, the claim will be denied until such time that the Provider can provide sufficient accurate support.

Post-payment recovery activities

The terms expressed in this section of this Provider Manual are incorporated into the Provider Agreement with ConnectiCare and are intended to supplement, rather than diminish, any and all other rights and remedies that may be available to ConnectiCare under the Provider Agreement with ConnectiCare or at law or equity.

In the event of any inconsistency between the terms expressed here and any terms expressed in the Provider Agreement with ConnectiCare, the parties agree that ConnectiCare shall in its sole discretion exercise the terms that are expressed in the Provider Agreement with ConnectiCare, the terms that are expressed here, its rights under law and equity or some combination thereof.

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

If a ConnectiCare auditor is denied access to the Provider's records, all of the claims for which the Provider received payment from ConnectiCare are immediately due and owing. If the Provider fails to provide all requested documentation for any claim, the entire amount of the paid claim is immediately due and owing. ConnectiCare may offset such amounts against any amounts owed by ConnectiCare to the Provider. The Provider must comply with all requests for documentation and records timely (as reasonably requested by ConnectiCare) and without charge to ConnectiCare. Claims for which the Provider fails to furnish supporting documentation during the audit process are not reimbursable and are subject to chargeback.

The Provider acknowledges that HIPAA specifically permits a covered entity, such as the Provider, to disclose protected health information for its own payment purposes (see 45 CFR 164.502 and 45 CFR 164.501). The Provider further acknowledges that in order to receive payment from ConnectiCare, the Provider is required to allow ConnectiCare to conduct audits of its pertinent records to verify the services performed and the payment claimed and that such audits are permitted as a payment activity of the Provider under HIPAA and other applicable privacy laws.

Claim auditing

ConnectiCare shall use established industry claim adjudication and/or clinical practices, state and federal guidelines and/or ConnectiCare's policies and data to determine the appropriateness of the billing, coding and payment.

The Provider acknowledges ConnectiCare's right to conduct pre and post-payment billing audits. The Provider shall cooperate with ConnectiCare's SIU and audits of claims and payments by providing access at reasonable times to requested claim information, the Provider's charging policies and other related data as deemed relevant

to support the transactions billed. Additionally, Providers are required, by contract and in accordance with the Provider Manual, to submit all supporting medical records/documentation as requested. Failure to do so in a timely manner may result in an audit failure and/or denial resulting in an overpayment.

In reviewing medical records for a procedure, ConnectiCare reserves the right and where unprohibited by regulation, to select a statistically valid random sample or smaller subset of the statistically valid random sample. This gives an estimate of the proportion of claims that ConnectiCare paid in error. The estimated proportion or error rate may be extrapolated across all claims to determine the amount of overpayment.

Provider audits may be telephonic, an on-site visit, internal claims review, client-directed/regulatory investigation and/or compliance reviews and may be vendor-assisted. ConnectiCare asks that you provide ConnectiCare or ConnectiCare's designee, during normal business hours, access to examine, audit, scan and copy any and all records necessary to determine compliance and accuracy of billing.

If ConnectiCare's SIU suspects that there is fraudulent or abusive activity, ConnectiCare may conduct an on-site audit without notice. Should you refuse to allow access to your facilities, ConnectiCare reserves the right to recover the full amount paid or due to you.

Provider education

When ConnectiCare identifies, through an audit or other means, a situation with a Provider (e.g., coding, billing) that is either inappropriate or deficient, ConnectiCare may determine that a Provider education visit is appropriate.

ConnectiCare will notify the Provider of the deficiency and will take steps to educate the Provider, which may include the Provider submitting a CAP to ConnectiCare addressing the issues identified and how it will cure these issues moving forward.

Reporting fraud, waste and abuse

Suspected cases of fraud, waste or abuse must be reported to ConnectiCare by contacting the ConnectiCare Alertline. The ConnectiCare Alertline is an external telephone and web-based reporting system hosted by NAVEX Global, a leading provider of compliance and ethics hotline services. The ConnectiCare Alertline telephone and web-based reporting is available 24 hours a day, 7 days a week, 365 days a year. When a report is made, callers can choose to remain confidential or anonymous. When calling the ConnectiCare Alertline, a trained professional at NAVEX Global will note the caller's concerns and provide them to the ConnectiCare compliance department for follow-up. When electing to use the web-based reporting process, a series of questions will be asked concluding with the submission of the report. Reports to the ConnectiCare Alertline can be made from anywhere within the United States with telephone or internet access.

The ConnectiCare Alertline can be reached at (866) 606-3889 or use the service's website to make a report at any time at molinahealthcare.alertline.com

Fraud, waste or abuse cases may also be reported to ConnectiCare's Compliance department anonymously without fear of retaliation.

ConnectiCare
Attn: Compliance
200 Oceangate, Suite 100
Long Beach, CA 90802

The following information must be included when reporting:

- Nature of complaint.
- The names of individuals and/or entity involved in suspected fraud and/or abuse including address, phone number, ConnectiCare Member ID number and any other identifying information.

Suspected fraud, waste and abuse may also be reported directly to CMS at:

Phone: 1-800-MEDICARE (1-800-633-4227)

or

Office of Inspector General
Attn: OIG Hotline Operations
PO Box 23489
Washington, DC 20026

Phone: (800) 447-8477
TTY/TDD: (800) 377-4950
Fax (10-page max): (800) 223-8164

Online at the Health and Human Services Office of the Inspector General website at oig.hhs.gov/fraud/report-fraud/index.

HIPAA requirements and information

ConnectiCare's commitment to patient privacy

Protecting the privacy of Members' personal health information is a core responsibility that ConnectiCare takes very seriously. ConnectiCare is committed to complying with all federal and state laws regarding the privacy and security of Members' protected health information (PHI).

Provider responsibilities

ConnectiCare expects that its contracted Providers will respect the privacy of ConnectiCare Members (including ConnectiCare Members who are not patients of the Provider) and comply with all applicable laws and regulations regarding the privacy of

patient and Member PHI. ConnectiCare provides its Members with a privacy notice upon their enrollment in our health plan. The privacy notice explains how ConnectiCare uses and discloses their PHI and includes a summary of how ConnectiCare safeguards their PHI.

Telehealth/telemedicine Providers: telehealth transmissions are subject to HIPAA-related requirements outlined under state and federal law, including:

- 42 C.F.R. Part 2 regulations
- Health Information Technology for Economic and Clinical Health Act, (HITECH Act)

Applicable laws

Providers must understand all state and federal health care privacy laws applicable to their practice and organization. Currently, there is no comprehensive regulatory framework that protects all health information in the United States; instead, there is a patchwork of laws that Providers must comply with. In general, most health care Providers are subject to various laws and regulations pertaining to the privacy of health information, including, without limitation, the following:

1. **Federal laws and regulations**
   - HIPAA
   - HITECH
   - 42 C.F.R. Part 2
   - Medicare and Medicaid laws
   - The Affordable Care Act

2. **State medical privacy laws and regulations**

   Providers should be aware that HIPAA provides a floor for patient privacy, but that state laws should be followed in certain situations, especially if the state law is more stringent than HIPAA. Providers should consult with their own legal counsel to address their specific situation.

Artificial intelligence

Provider shall comply with all applicable state and federal laws and regulations related to artificial intelligence and the use of artificial intelligence tools (AI). Artificial Intelligence or AI means a machine-based system that can, with respect to a given set of human-defined objectives, input or prompt, as applicable, make predictions, recommendations, data sets, work product (whether or not eligible for copyright protection), or decisions influencing physical or virtual environments. The Provider is prohibited from using AI for any functions that result in a denial, delay, reduction, or modification of covered services to ConnectiCare Members including, but not limited to utilization management, prior authorizations, complaints, appeals and grievances, and quality of care services, without review of the denial, delay, reduction or modification by a qualified clinician. In addition, the Provider shall not use AI-generated voice technology, including but not limited to AI voice bots, voice cloning, or synthetic speech

systems to initiate or conduct outbound communications to ConnectiCare. The prohibition includes, but is not limited to, communications for billing, eligibility verification, prior authorization, or any other administrative function.

Notwithstanding the foregoing, the Provider shall give advance written notice to your ConnectiCare contract Manager (for any AI used by the Provider that may impact the provision of Covered Services to ConnectiCare Members) that describes (i) Providers' use of the AI tool(s) and (ii) how the Provider oversees, monitors and evaluates the performance and legal compliance of such AI tool(s). If the use of AI is approved by ConnectiCare, the Provider further agrees to (i) allow ConnectiCare to audit Providers' AI use, as requested by ConnectiCare from time to time, and (ii) to cooperate with ConnectiCare with regard to any regulatory inquiries and investigations related to Providers' AI use related to the provision of covered services to ConnectiCare Members.

If you have additional questions, please contact your ConnectiCare contract Manager.

Uses and disclosure of PHI

Member and patient PHI should only be used or disclosed as permitted or required by applicable law. Under HIPAA, a Provider may use and disclose PHI for their own treatment, payment and health care operations activities (TPO) without the consent or authorization of the patient who is the subject of the PHI. Uses and disclosures for TPO apply not only to the Provider's own TPO activities, but also for the TPO of another covered entity[1]. Disclosure of PHI by one covered entity to another covered entity or health care Provider, for the recipient's TPO is specifically permitted under HIPAA in the following situations:

1. A covered entity may disclose PHI to another covered entity or a health care Provider for the payment activities of the recipient. Please note that "payment" is a defined term under the HIPAA Privacy Rule that includes, without limitation, utilization review activities, such as preauthorization of services, concurrent review and retrospective review of "services[2]."

2. A covered entity may disclose PHI to another covered entity for the health care operations activities of the covered entity that receives the PHI, if each covered entity either has or had a relationship with the individual who is the subject of the PHI being requested, the PHI pertains to such relationship and the disclosure is for the following health care operations activities:

    - Quality improvement
    - Disease management
    - Case management and care coordination
    - Training programs

[1] See Sections 164.506(c) (2) & (3) of the HIPAA Privacy Rule.
[2] See the definition of Payment, Section 164.501 of the HIPAA Privacy Rule

- Accreditation, licensing and credentialing

Importantly, this allows Providers to share PHI with ConnectiCare for our health care operations activities, such as HEDIS® and quality improvement.

Confidentiality of substance use disorder patient records

Federal Confidentiality of Substance Use Disorder Patient Records under 42 USC § 290dd-2 and 42 CFR Part 2 (collectively, "42 CFR Part 2") apply to any entity or individual providing federally-assisted alcohol or drug abuse prevention treatment. "SUD Records" means PHI that includes substance use disorder treatment information that is protected under 42 CFR Part 2. Providers that are Part 2 Programs must comply with the requirements of 42 CFR Part 2, as amended from time to time.

SUD Records are confidential and may be disclosed only as permitted by 42 CFR Part 2. Although HIPAA protects substance use disorder information, 42 CFR Part 2 is more restrictive than HIPAA and does not allow disclosure without the patient's written consent except as set forth in 42 CFR Part 2. Any disclosure of SUD Records to ConnectiCare with the written consent of the patient, by a Provider that is a Part 2 Program, must meet the notice requirements of 42 CFR Part 2, specifically Sections 2.31 and 2.32, and shall include a copy of the patient's consent or a clear explanation of the scope of the consent provided.

Providers that are Part 2 Programs pursuant to 42 CFR Part 2 must promptly inform ConnectiCare that they are a Part 2 Program.

Inadvertent disclosures of PHI

ConnectiCare may, on occasion, inadvertently misdirect or disclose PHI pertaining to ConnectiCare Member(s) who are not the patients of the Provider. In such cases, the Provider shall return or securely destroy the PHI of the affected ConnectiCare Members in order to protect their privacy. The Provider agrees to not further use or disclose such PHI and further agrees to provide an attestation of return, destruction and non-disclosure of any such misdirected PHI upon the reasonable request of ConnectiCare.

Written authorizations

Uses and disclosures of PHI that are not permitted or required under applicable law require the valid written authorization of the patient. Authorizations should meet the requirements of HIPAA and applicable state law.

Patient rights

Patients are afforded various rights under HIPAA. ConnectiCare Providers must allow patients to exercise any of the below-listed rights that apply to the Provider's practice:

1. Notice of privacy practices

Providers that are covered under HIPAA and that have a direct treatment relationship with the patient should provide patients with a notice of privacy practices that explains the patient's privacy rights and the process the patient should follow to exercise those rights. The Provider should obtain a written acknowledgment that the patient received the notice of privacy practices.

2. **Requests for restrictions on uses and disclosures of PHI**
   Patients may request that a health care Provider restrict its uses and disclosures of PHI. The Provider is not required to agree to any such request for restrictions.

3. **Requests for confidential communications**
   Patients may request that a health care Provider communicate PHI by alternative means or at alternative locations. Providers must accommodate reasonable requests from the patient.

4. **Requests for patient access to PHI**
   Patients have a right to access their own PHI within a Provider's designated record set. Personal representatives of patients have the right to access the PHI of the subject patient. The designated record set of a Provider includes the patient's medical record, as well as billing and other records used to make decisions about the Member's care or payment for care.

5. **Request to amend PHI**
   Patients have a right to request that the Provider amend information in their designated record set.

6. **Request accounting of PHI disclosures**
   Patients may request an accounting of disclosures of PHI made by the Provider during the preceding six (6) year period. The list of disclosures does not need to include disclosures made for treatment, payment.

HIPAA security

Providers must implement and maintain reasonable and appropriate safeguards to protect the confidentiality, availability and integrity of ConnectiCare Member and patient PHI. As more Providers implement electronic health records, Providers need to ensure that they have implemented and maintain appropriate cybersecurity measures. Providers should recognize that identity theft – both financial and medical -- is a rapidly growing problem and that their patients trust their health care Providers to keep their most sensitive information private and confidential.

Medical identity theft is an emerging threat in the health care industry. Medical identity theft occurs when someone uses a person's name and sometimes other parts of their identity – such as health insurance information – without the person's knowledge or consent to obtain health care services or goods. Medical identity theft frequently results in erroneous entries being put into existing medical records. Providers should be aware of this growing problem and report any suspected fraud to ConnectiCare.

HIPAA transactions and code sets

ConnectiCare strongly supports the use of electronic transactions to streamline health care administrative activities. ConnectiCare Providers are encouraged to submit claims and other transactions to ConnectiCare using electronic formats. Certain electronic transactions in health care are subject to HIPAA's Transactions and Code Sets rule including, but not limited to, the following:

- Claims and encounters
- Member eligibility status inquiries and responses
- Claim status inquiries and responses
- Authorization requests and responses
- Remittance advices

ConnectiCare is committed to complying with all HIPAA transaction and code sets standard requirements. Providers should refer to ConnectiCare's website at connecticare.com for additional information regarding HIPAA standard transactions.

Code sets

HIPAA regulations require that only approved code sets may be used in standard electronic transactions.

National Provider Identifier (NPI)

Providers must comply with the NPI rule promulgated under HIPAA. The Provider must obtain an NPI from NPPES for itself or for any subparts of the Provider. The Provider must report its NPI and any subparts to ConnectiCare and to any other entity that requires it. Any changes in its NPI or subparts information must be reported to NPPES within 30 days and should also be reported to ConnectiCare within 30 days of the change. Providers must use their NPI to identify it on all electronic transactions required under HIPAA and on all claims and encounters submitted to ConnectiCare.

Additional requirements for delegated Providers and atypical Providers

Providers that are delegated for Claims and Utilization Management activities ("Delegated Providers") are the "Business Associates" of ConnectiCare for the delegated functions performed on behalf of ConnectiCare. Providers that provide services to ConnectiCare Members but who are not health care providers under HIPAA ("Atypical Providers") are the Business Associates of ConnectiCare. Under HIPAA, ConnectiCare must obtain contractual assurances from all Business Associates that they will safeguard ConnectiCare Member PHI. Delegated Providers and Atypical Providers must agree to various contractual provisions required under HIPAA's privacy and security rules, including entering into a Business Associate Agreement with ConnectiCare. Delegated Providers and Atypical Providers agree to comply with the following HIPAA Business Associate Agreement requirements.

HIPAA required business associate agreement

Applicability: This HIPAA Required Business Associate Agreement ("BAA") sets forth the requirements with which the Business Associate must comply when it receives or has access to Protected Health Information ("PHI") in the performance of Services under the Agreement(s) and with respect to that PHI.

1. Definitions

Unless otherwise provided for in this BAA, terms used in this BAA shall have the same meanings as set forth in the HIPAA Rules including, but not limited to the following: "Availability," "Confidentiality," "Covered Entity," "Data Aggregation," "Designated Record Set," "Health Care Operations," "Integrity," "Minimum Necessary," "Notice of Privacy Practices," "Required By Law," "Secretary," and "Subcontractor." Specific definitions are as follows:

"Breach" shall have the same meaning as the term "breach" at 45 CFR 164.402.

"Business Associate" shall have the same meaning as the term "business associate" at 45 CFR 160.103 and in reference to the party to this BAA, shall mean the Provider subject to this BAA.

"Compliance Date" shall mean, in each case, the date by which compliance is required under the referenced provision of the HIPAA, the HITECH Act or the HIPAA Rules, as applicable; provided that, in any case for which that date occurs prior to the effective date of this BAA, the Compliance Date shall mean the effective date of this BAA.

"Covered Entity" shall mean ConnectiCare.

"Electronic Protected Health Information" or "Electronic PHI" shall have the same meaning as the term "electronic protected health information" at 45 CFR 160.103.

"HIPAA Rules" shall mean the Privacy, Security, Breach Notification, and Enforcement Rules at 45 CFR Part 160 and Part 164.

"Party or Parties" shall mean Covered Entity and Business Associate who parties to this BAA.

"Protected Health Information" or "PHI" shall have the same meaning as the term "protected health information" at 45 CFR 160.103.

"Privacy Rule" means the Standards for Privacy of Individually Identifiable Health Information, set forth at 45 CFR Parts 160 and 164.

"Security Incident" shall have the same meaning as the term "security incident" at 45 CFR 164.304.

"Security Rule" means the Security Standards for the Protection of Electronic Protected Health Information, set forth at 45 CFR Parts 160 and 164.

"Services" shall mean, to the extent and only to the extent they involve the creation, use, maintenance, transmission, or disclosure of PHI, the services provided by the Business Associate to ConnectiCare under the Agreement(s), including those set forth in this BAA, as amended by written consent of the parties from time to time.

"SUD Records" means PHI that includes substance use disorder treatment information that is protected under 42 USC §290dd-2 and 42 CFR Part 2 (collectively, "42 CFR Part 2").

"Unsecured PHI" shall have the same meaning as the term "unsecured Protected Health Information" at 45 CFR 164.402.

2. General provisions

2.1. Effect. This BAA supersedes any prior business associate agreement between the Parties and those portions of any Agreement between the Parties that involve the disclosure of PHI by ConnectiCare to Business Associate. To the extent any conflict or inconsistency between this BAA and the terms and conditions of any Agreement exists, the terms of this BAA shall prevail.

2.2. Amendment. ConnectiCare may, without Business Associate's consent, amend this BAA to maintain consistency and/or compliance with any state or federal law, policy, directive, regulation, or government sponsored program requirement, upon 45 business days' notice to the Business Associate unless a shorter timeframe is necessary for compliance. ConnectiCare may otherwise materially amend this BAA only after 45 business days prior written notice to the Business Associate and only if mutually agreed to by the Parties as evidenced by the amendment being executed by each Party hereto. If the Parties fail to execute a mutually agreeable amendment within 45 days of the Business Associate's receipt of ConnectiCare's written notice to amend this BAA, ConnectiCare shall have the right to immediately terminate this BAA and any Agreement(s) between the Parties which may require the Business Associate's use or disclosure of PHI in performance of services described in such Agreement(s) on behalf of ConnectiCare.

3. Scope of use and disclosure

3.1. The Business Associate may use or disclose PHI as required to provide Services and satisfy its obligations under the Agreement(s) if such use or disclosure of PHI would not violate the Privacy Rule.

3.2. The Business Associate may not use or further disclose PHI in a manner that would violate the Privacy Rule if done by ConnectiCare, except that the Business Associate may use or disclose PHI as necessary:

a. for the proper management and administration of the Business Associate as provided in Section 3.3; and
b. to provide Data Aggregation services relating to the Health Care Operations of ConnectiCare if required under the Agreement.

3.3. The Business Associate may use or disclose PHI for the proper management and administration of the Business Associate or to carry out the legal responsibilities of the Business Associate. Any disclosures of PHI under this section may be made only if:

a. the disclosures are required by law, or
b. the Business Associate obtains reasonable assurances from the person to whom the PHI is disclosed that the PHI will remain confidential and used or further disclosed only as required by law or for the purposes for which it was disclosed to the person, and the person notifies the Business Associate of any instances of which it is aware in which the confidentiality of the PHI has been breached.

3.4. The Business Associate shall not request, use or release more than the Minimum Necessary amount of PHI required to accomplish the purpose of the use or disclosure and shall comply with 42 U.S.C. § 17935(b) as of its Compliance Date. The Business Associate hereby acknowledges that all PHI created or received from, or on behalf of, ConnectiCare, is as between the Parties, the sole property of ConnectiCare.

3.5. The Business Associate or its agents or Subcontractors shall not perform any work outside the United States of America that involves access to, use of, or disclosure of, PHI without the prior written consent of ConnectiCare in each instance. Further, the Business Associate or its agents or Subcontractors shall not transmit or store PHI outside of the United States of America without ConnectiCare's prior written consent.

3.6. The Business Associate agrees to be fully bound by the requirements of 42 CFR Part 2 upon receipt of any SUD Records disclosed under this Agreement. The Business Associate shall not use or disclose SUD Records except as necessary for the Business Associate to perform Services. The Business Associate shall not redisclose any SUD Records to a third party, except to a contract agent acting on the Business Associate's behalf to provide Services or back to ConnectiCare. The contract agent may only redisclose such information to the Business Associate or ConnectiCare. The Business Associate and any contract agent shall not disclose SUD Records for use in any civil, criminal, administrative or legislative proceeding against the individual who is the subject of the SUD Record and shall immediately notify ConnectiCare of any such request. The Business Associate must ensure that any such contract agent agrees in writing to these same restrictions and obligations set forth in this Section.

4. Obligations of the business associate

The Business Associate shall:

4.1. Not use or disclose PHI other than permitted or required by this BAA or as Required by Law.

4.2. Establish and use appropriate safeguards to prevent the unauthorized use or disclosure of PHI.

4.3. Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the Confidentiality, Integrity, and Availability of the Electronic PHI that it creates, receives, maintains, or transmits on behalf of ConnectiCare. The Business Associate shall, as of the Compliance Date, comply with the applicable standards at Subpart C of 45 CFR Part 164.

4.4. Promptly report to ConnectiCare any unauthorized use or disclosure of PHI, Breach of Unsecured PHI, or Security Incident, within no more than five (5) days, after Business Associate becomes aware of the unauthorized use or disclosure of PHI, Breach of Unsecured PHI or Security Incident. The Business Associate shall take all reasonable steps to mitigate any harmful effects of such unauthorized use or disclosure, Breach of Unsecured PHI, or Security Incident. The Business Associate shall indemnify ConnectiCare against any losses, damages, expenses or other liabilities including reasonable attorney's fees incurred as a result of the Business Associate's or its agent's or Subcontractor's unauthorized use or disclosure of PHI, Breach of Unsecured PHI, or Security Incident, including, but not limited to, the costs of notifying individuals affected by a Breach of Unsecured PHI and the provision of two years of credit monitoring and identity protection services to the affected individuals. Indemnification is subject to an ability to demonstrate that no agency relationship exists between the parties.

4.5. The Business Associate shall, following discovery of a Breach of Unsecured PHI, notify ConnectiCare of such Breach as required at 45 CFR 164.410, without unreasonable delay, and in no event more than 30 days after the discovery of the Breach. The notification by the Business Associate to ConnectiCare shall include: (1) the identification of each individual whose Unsecured PHI was accessed, acquired, used or disclosed during the Breach; and (2) any other available information that ConnectiCare is required to include in its notification to individuals affected by the Breach including, but not limited to, the following:

a. a brief description of what happened, including the date of the Breach and the date of the discovery of the Breach;
b. a description of the types of Unsecured PHI that were involved in the Breach; and
c. a brief description of what the Business Associate is doing to investigate the Breach, to mitigate harm to individuals, and to protect against any further Breaches.

4.6. In accordance with 45 CFR 164.502(e)(1)(ii) and 164.308(b)(2), if applicable, ensure that any Subcontractors or agents that create, receive, maintain, or transmit PHI on behalf of the Business Associate agree to the same restrictions, conditions, and requirements that apply to the Business Associate with respect to such information.

4.7. Within 10 days of receiving a request, make available PHI in a Designated Record Set to ConnectiCare as necessary to satisfy ConnectiCare's obligations under 45 CFR 164.524.

4.8. Within 15 days of receiving a request, make any amendment(s) to PHI in a Designated Record Set as directed or agreed to by ConnectiCare pursuant to 45 CFR 164.526.

4.9. Maintain and make available to ConnectiCare, within 20 days of receiving a request, the information required to provide an accounting of disclosures to the individual as necessary to satisfy ConnectiCare's obligations under 45 CFR 164.528.

4.10. Make its internal practices, books and records relating to the use or disclosure of PHI received from or on behalf of ConnectiCare available to ConnectiCare or the U. S. Secretary of Health and Human Services for purposes of determining compliance with the HIPAA Rules.

4.11. To the extent the Business Associate conducts Standard Transaction(s) (as defined in the HIPAA Rules) on behalf of ConnectiCare, Business Associate shall comply with the HIPAA Rules, "Administrative Requirements," 45 C.F.R. Part 162, by the applicable compliance date(s) and shall not: (a) change the definition, data condition or use of a data element or segment in a standard; (b) add any data elements or segments to the maximum defined data set; (c) use any code or data elements that are either marked "not used" in the standard's implementation specification or are not in the standard's implementation specification(s); or (d) change the meaning or intent of the standard's implementation specifications. The Business Associate shall comply with any applicable certification and compliance requirements (and provide the Secretary with adequate documentation of such compliance) under subsection (h) of Title 42 U.S.C. Section 1320d-2.

4.12. To the extent the Business Associate is to carry out one or more of ConnectiCare's obligation(s) under Subpart E of 45 CFR Part 164, comply with the requirements of Subpart E that apply to ConnectiCare in the performance of such obligation(s).

5. Miscellaneous

5.1. Indemnification. In addition to any indemnities set forth in the Agreement(s), each party will indemnify and defend the other party from and against any and all claims, losses, damages, expenses or other liabilities, including reasonable attorney's fees, incurred as a result of any breach by such party of any representation, warranty, covenant, agreement or other obligation expressly contained herein by such party, its employees, agents, Subcontractors or other representatives.

5.2. Interpretation. Any ambiguity in this BAA shall be interpreted to permit compliance with the HIPAA Rules.

5.3. No Third Party Beneficiaries. Nothing express or implied in this BAA is intended to confer, nor shall anything herein confer, upon any person other than the Parties and the respective successors or assigns of the Parties, any rights, remedies, obligations, or liabilities whatsoever.

5.4. Governing Law and Venue. This BAA shall be governed by Connecticut law notwithstanding any conflicts of law provisions to the contrary. The venue shall be the jurisdiction where the applicable services were received by ConnectiCare.

5.5. Compliance with Confidentiality Laws. The Business Associate acknowledges that it must comply with all applicable laws that may protect the confidentiality of PHI or other personally identifiable information received and will comply with all such laws.

5.6. Notices. Any notices to be given hereunder to ConnectiCare shall be made via certified U.S. Mail or express courier to ConnectiCare's address given below, and/or (other than for the delivery of fees) via email to the email listed below:

Molina Healthcare, Inc.
200 Oceangate Blvd., Suite 100
Long Beach, CA 90802

Attn: Privacy Official
Email: PrivacyOfficial@MolinaHealthcare.com

6. Term and termination of BAA

6.1. Term. The Term of this BAA shall be effective as of the effective date set forth in the first paragraph of this BAA, and shall terminate on date that the last Agreement remaining in force between the parties is terminated or expires, or on the date ConnectiCare terminates for cause as authorized in paragraph 6.2 below, whichever is sooner.

6.2. Termination for Cause. Notwithstanding any other provision of this BAA or the Agreement(s), ConnectiCare may terminate this BAA and any or all Agreement(s) upon five (5) days written notice to Business Associate if ConnectiCare determines, in its sole discretion, that Business Associate has violated a material term of this BAA.

6.3. Obligations of Business Associate Upon Termination. Upon termination of this BAA for any reason, Business Associate shall return to ConnectiCare or, if agreed to by ConnectiCare, destroy all PHI received from ConnectiCare, or created, maintained, or received by Business Associate on behalf of ConnectiCare, that the Business Associate still maintains in any form. If PHI is destroyed, Business Associate agrees to provide ConnectiCare with certification of such destruction. Business Associate shall not retain any copies of PHI except as Required by Law. If return or destruction of all PHI, and all copies of PHI, received from ConnectiCare, or created, maintained, or received by Business Associate on behalf of ConnectiCare, is not feasible, Business Associate shall:

a. Continue to use appropriate safeguards and comply with Subpart C of 45 CFR Part 164 with respect to Electronic PHI to prevent use or disclosure of the PHI, other than as provided for in this Section 6, for as long as Business Associate retains the PHI; and

b. Not use or disclose the PHI retained by Business Associate other than for the purposes for which such PHI was retained and subject to the same conditions set forth in Section 3 above which applied prior to termination.

6.4. Survival. The obligations of Business Associate under this Section shall survive the termination of this BAA and remain in force as long as Business Associate stores or maintains PHI in any form or format (including archival data). Termination of the BAA shall not affect any of the provisions of this BAA that, by wording or nature, are intended to remain effective and to continue in operation.

Reimbursement for copies of PHI

ConnectiCare does not reimburse Providers for copies of PHI related to our Members. These requests may include, although are not limited to, the following purposes:

- Utilization management
- Care coordination and/or complex medical case management services
- Claims review
- Resolution of an appeal and/or grievance
- Anti-fraud program review
- Quality of care issues
- Regulatory audits
- Risk adjustment
- Treatment, payment and/or operation purposes
- Collection of HEDIS® medical records

Information security and cybersecurity

NOTE: This section (Information Security and Cybersecurity) is only applicable to Providers who have been delegated by ConnectiCare to perform a health plan function(s)and in connection with such delegated functions.

1. Definitions:

(a) "ConnectiCare Information" means any information: (i) provided by ConnectiCare to Provider; (ii) accessed by Provider or available to Provider on ConnectiCare's Information Systems; or (iii) any information with respect to ConnectiCare or any of its consumers developed by Provider or other third parties in Provider's possession, including without limitation any ConnectiCare Nonpublic Information.

(b) "Cybersecurity Event" means any actual or reasonably suspected contamination, penetration, unauthorized access or acquisition or other breach of confidentiality, data integrity or security compromise of a

network or server resulting in the known or reasonably suspected accidental, unauthorized or unlawful destruction, loss, alteration, use, disclosure of or access to ConnectiCare Information. For clarity, a Breach or Security Incident as these terms are defined under HIPAA constitute a Cybersecurity Event for the purpose of this section. Unsuccessful security incidents, which are activities such as pings and other broadcast attacks on Provider's firewall, port scans, unsuccessful log-on attempts, denials of service and any combination of the above, do not constitute a Cybersecurity Event under this definition so long as no such incident results in or is reasonably suspected to have resulted in unauthorized access, use, acquisition or disclosure of ConnectiCare Information or sustained interruption of service obligations to ConnectiCare.

(c) "HIPAA" means the Health Insurance Portability and Accountability Act, as may be amended from time to time.

(d) "HITECH" means the Health Information Technology for Economic and Clinical Health Act, as may be amended from time to time.

(e) "Industry Standards" mean as applicable, codes, guidance (from regulatory and advisory bodies, whether mandatory or not), international and national standards, relating to security of network and information systems and security breach and incident reporting requirements, all as amended or updated from time to time and including but not limited to the current standards and benchmarks set forth and maintained by the following, in accordance with the latest revisions and/or amendments:

i. HIPAA and HITECH
ii. HITRUST Common Security Framework
iii. Center for Internet Security
iv. National Institute for Standards and Technology ("NIST") Special Publications 800.53 Rev.5 and 800.171 Rev. 1or as currently revised
v. Federal Information Security Management Act ("FISMA")
vi. ISO/ IEC 27001
vii. Federal Risk and Authorization Management Program ("FedRamp")
viii. NIST Special Publication 800-34 Revision 1 – "Contingency Planning Guide for federal Information Systems."
ix. International Organization for Standardization (ISO) 22301 – "Societal security – Business continuity management systems – Requirements."

(f) "Information Systems" means all computer hardware, databases and data storage systems, computer, data, database and communications networks (other than the Internet), cloud platform, architecture interfaces and firewalls (whether for data, voice, video or other media access, transmission or reception) and other apparatus used to create, store, transmit, exchange or receive information in any form.

(g) "Multi-Factor Authentication" means authentication through verification of at least two of the following types of authentication factors: (1) knowledge factors, such as a password; (2) possession factors, such as a token or text message on a mobile phone; (3) inherence factors, such as a biometric characteristic; or (4) any other industry standard and commercially accepted authentication factors.

(h) "Nonpublic Information" includes:

i. ConnectiCare's proprietary and/or confidential information;

ii. Personally Identifiable Information as defined under applicable state data security laws, including, without, limitation, "nonpublic personal information," "personal data," "personally identifiable information," "personal information" or any other similar term as defined pursuant to any applicable law; and

iii. Protected Health Information as defined under HIPAA and HITECH.

2. Information Security and Cybersecurity Measures. Provider shall implement and at all times maintain, appropriate administrative, technical and physical measures to protect and secure the Information Systems, as well as Nonpublic Information stored thereon and ConnectiCare Information that are accessible to or held by, Provider. Such measures shall conform to generally recognized industry standards and best practices and shall comply with applicable privacy and data security laws, including implementing and maintaining administrative, technical and physical safeguards pursuant to HIPAA, HITECH and other applicable U.S. federal, state and local laws.

(a) Policies, Procedures and Practices. The Provider must have policies, procedures and practices that address its information security and cybersecurity measures, safeguards and standards, including as applicable, a written information security program, which ConnectiCare shall be permitted to audit via written request and which shall include at least the following:

i. Access Controls. Access controls, including Multi-Factor Authentication, to limit access to the Information Systems and ConnectiCare Information accessible to or held by the Provider.

ii. Encryption. Use of encryption to protect ConnectiCare Information, in transit and at rest, accessible to or held by the Provider.

iii. Security. Safeguarding the security of the Information Systems and ConnectiCare Information accessible to or held by the Provider, which shall include hardware and software protections such as network firewall provisioning, intrusion and threat detection controls designed to protect against malicious code and/or activity, regular (three or more annually) third party vulnerability assessments, physical security controls and personnel training programs that include phishing recognition and proper data management hygiene.

iv. Software Maintenance. Software maintenance, support, updates, upgrades, third party software components and bug fixes such that

the software is and remains, secure from vulnerabilities in accordance with the applicable Industry Standards.

(b) Technical Standards. Provider shall comply with the following requirements and technical standards related to network and data security:

i. Network Security. Network security shall conform to generally recognized industry standards and best practices. Generally recognized industry standards include, but are not limited to, the applicable Industry Standards.

ii. Cloud Services Security: If Provider employs cloud technologies, including infrastructure as a service (IaaS), software as a service (SaaS) or platform as a service (PaaS), for any services, Provider shall adopt a "zero-trust architecture" satisfying the requirements described in NIST 800-207 (or any successor cybersecurity framework thereof).

iii. Data Storage. The Provider agrees that any and all ConnectiCare Information will be stored, processed and maintained solely on designated target servers or cloud resources. No ConnectiCare Information at any time will be processed on or transferred to any portable or laptop computing device or any portable storage medium, unless that device or storage medium is in use as part of the Provider's designated backup and recovery processes and is encrypted in accordance with the requirements set forth herein.

iv. Data Encryption. The Provider agrees to store all ConnectiCare Information as part of its designated backup and recovery processes in encrypted form, using a commercially supported encryption solution. The Provider further agrees that any and all ConnectiCare Information stored on any portable or laptop computing device or any portable storage medium be likewise encrypted. Encryption solutions will be deployed with no less than a 128-bit key for symmetric encryption, a 1024 (or larger) bit key length for asymmetric encryption and the federal Information Processing Standard Publication 140-2 ("FIPS PUB 140-2").

v. Data Transmission. Provider agrees that any and all electronic transmission or exchange of system and application data with ConnectiCare and/or any other parties expressly designated by ConnectiCare shall take place via secure means (using HTTPS or SFTP or equivalent) and solely in accordance with FIPS PUB 140-2 and the Data Re-Use requirements set forth herein.

vi. Data Re-Use. The Provider agrees that any and all ConnectiCare Information exchanged shall be used expressly and solely for the purposes enumerated in the Provider Agreement with ConnectiCare and this section. Data shall not be distributed, repurposed or shared across other applications, environments or 1business units of the Provider. Provider further agrees that no ConnectiCare Information or data of any kind shall be transmitted,

exchanged or otherwise passed to other affiliates, contractors or interested parties, except on a case-by-case basis as specifically agreed to in advance and in writing by ConnectiCare.

3. Business Continuity ("BC") and Disaster Recovery ("DR"). The Provider shall have documented procedures in place to ensure continuity of Provider's business operations, including disaster recovery, in the event of an incident that has the potential to impact, degrade or disrupt Provider's delivery of services to ConnectiCare .

   (a) Resilience Questionnaire. Provider shall complete a questionnaire provided by ConnectiCare to establish Provider's resilience capabilities.

   (b) BC/DR Plan.

      i. Provider's procedures addressing continuity of business operations, including disaster recovery, shall be collected and/or summarized in a documented BC and DR plan or plans in written format ("BC/DR Plan"). The BC/DR Plan shall identify the service level agreement(s) established between Provider and ConnectiCare. The BC/DR Plan shall include the following:

         a) Notification, escalation and declaration procedures.
         b) Roles, responsibilities and contact lists.
         c) All Information Systems that support services provided to ConnectiCare.
         d) Detailed recovery procedures in the event of the loss of people, processes, technology and/or third-parties or any combination thereof providing services to ConnectiCare.
         e) Recovery procedures in connection with a Cybersecurity Event, including ransomware.
         f) Detailed list of resources to recover services to ConnectiCare including but not limited to: applications, systems, vital records, locations, personnel, vendor and other dependencies.
         g) Detailed procedures to restore services from a Cybersecurity Event including ransomware.
         h) Documented risk assessment which shall address and evaluate the probability and impact of risks to the organization and services provided to ConnectiCare. Such risk assessment shall evaluate natural, man-made, political and cybersecurity incidents.

      ii. To the extent that ConnectiCare Information is held by the Provider, Provider shall maintain backups of such ConnectiCare Information that are adequately protected from unauthorized alterations or destruction consistent with applicable Industry Standards.

      iii. The Provider shall develop information technology disaster recovery or systems contingency plans consistent with applicable Industry Standards and in accordance with all applicable laws.

(c) Notification. Provider shall notify ConnectiCare's Chief Information Security Officer by telephone and email (provided herein) as promptly as possible, but not to exceed 24 hours, of either of the following:

i. Provider's discovery of any potentially disruptive incident that may impact or interfere with the delivery of services to ConnectiCare or that detrimentally affects Provider's Information Systems or ConnectiCare's Information.

ii. Provider's activation of business continuity plans. The Provider shall provide ConnectiCare with regular updates by telephone or email (provided herein) on the situation and actions taken to resolve the issue, until normal services have been resumed.

(d) BC and DR Testing. For services provided to ConnectiCare, the Provider shall exercise its BC/DR Plan at least once each calendar year. The Provider shall exercise its cybersecurity recovery procedures at least once each calendar year. At the conclusion of the exercise, Provider shall provide ConnectiCare a written report in electronic format upon request. At a minimum, the written report shall include the date of the test(s), objectives, participants, a description of activities performed, results of the activities, corrective actions identified and modifications to plans based on results of the exercise(s).

4. Cybersecurity Events.

(a) The Provider agrees to comply with all applicable data protection and privacy laws and regulations. The Provider will implement best practices for incident management to identify, contain, respond to and resolve Cybersecurity Events.

(b) In the event of a Cybersecurity Event that threatens or affects ConnectiCare's Information Systems (in connection with Provider having access to such Information Systems); Provider's Information Systems; or ConnectiCare Information accessible to or held by Provider, Provider shall notify ConnectiCare's Chief Information Security Officer of such event by telephone and email as provided below (with follow-up notice by mail) as promptly as possible, but in no event later than 24 hours from Provider's discovery of the Cybersecurity Event.

i. In the event that Provider makes a ransom or extortion payment in connection with a Cybersecurity Event that involves or may involve ConnectiCare Information, Provider shall notify ConnectiCare's Chief Information Security Officer (by telephone and email, with follow-up notice by mail) within 24 hours following such payment.

ii. Within 15 days of such a ransom payment that involves or may involve ConnectiCare Information, Provider shall provide a written description of the reasons for which the payment was made, a description of alternatives to payment considered, a description of due diligence undertaken to find alternatives to payment and evidence of all due diligence and sanctions checks performed in

compliance with applicable rules and regulations, including those of the Office of Foreign Assets Control.

(c) Notification to ConnectiCare's Chief Information Security Officer shall be provided to:

ConnectiCare Chief Information Security Officer
Telephone: (844) 821-1942
Email: cyberincidentreporting@molinahealthcare.com

Molina Chief Information Security Officer
Molina Healthcare, Inc.
200 Oceangate Blvd., Suite 100
Long Beach, CA 90802

(d) In the event of a Cybersecurity Event, Provider will, at ConnectiCare's request, (i) fully cooperate with any investigation concerning the Cybersecurity Event by ConnectiCare, (ii) fully cooperate with ConnectiCare to comply with applicable law concerning the Cybersecurity Event, including any notification to consumers and (iii) be liable for any expenses associated with the Cybersecurity Event including without limitation: (a) the cost of any required legal compliance (e.g., notices required by applicable law)and (b) the cost of providing two (2) years of credit monitoring services or other assistance to affected consumers. In no event will Provider serve any notice of or otherwise publicize a Cybersecurity Event involving ConnectiCare Information without the prior written consent of ConnectiCare

(e) Following notification of a Cybersecurity Event, Provider must promptly provide ConnectiCare any documentation requested by ConnectiCare to complete an investigation, or, upon request by ConnectiCare, complete an investigation pursuant to the following requirements:

i. make a determination as to whether a Cybersecurity Event occurred;
ii. assess the nature and scope of the Cybersecurity Event;
iii. identify ConnectiCare's Information that may have been involved in the Cybersecurity Event; and
iv. perform or oversee reasonable measures to restore the security of the Information Systems compromised in the Cybersecurity Event to prevent further unauthorized acquisition, release or use of ConnectiCare Information.

(f) The Provider must provide ConnectiCare the following required information regarding a Cybersecurity Event in electronic form. The Provider shall have a continuing obligation to update and supplement the initial and subsequent notifications to ConnectiCare concerning the Cybersecurity Event. The information provided to ConnectiCare must include at least the following, to the extent known:

i. the date of the Cybersecurity Event;

ii. a description of how the information was exposed, lost, stolen or breached;
iii. how the Cybersecurity Event was discovered;
iv. whether any lost, stolen or breached information has been recovered and if so, how this was done;
v. the identity of the source of the Cybersecurity Event;
vi. whether Provider has filed a police report or has notified any regulatory, governmental or law enforcement agencies and, if so, when such notification was provided;
vii. a description of the specific types of information accessed or acquired without authorization, which means particular data elements including, for example, types of medical information, types of financial information or types of information allowing identification of the consumer;
viii. the period during which the Information System was compromised by the Cybersecurity Event;
ix. the number of total consumers in each state affected by the Cybersecurity Event;
x. the results of any internal review identifying a lapse in either automated controls or internal procedures or confirming that all automated controls or internal procedures were followed;
xi. a description of efforts being undertaken to remediate the situation which permitted the Cybersecurity Event to occur;
xii. a copy of Provider's privacy policy and a statement outlining the steps Provider will take to investigate and if requested by ConnectiCare, the steps that Provider will take to notify consumers affected by the Cybersecurity Event; and
xiii. the name of a contact person who is familiar with the Cybersecurity Event and authorized to act on behalf of the Provider.

(g) The Provider shall maintain records concerning all Cybersecurity Events for a period of at least five (5) years from the date of the Cybersecurity Event or such longer period as required by applicable laws and produce those records upon ConnectiCare's request.

5. Right to Conduct Assessments; Provider Warranty. The Provider agrees to fully cooperate with any security risk assessments performed by ConnectiCare and/or any designated representative or vendor of ConnectiCare. The Provider agrees to promptly provide accurate and complete information with respect to such security risk assessments. If ConnectiCare performs a due diligence/security risk assessment of the Provider, the Provider (i) warrants that the services provided pursuant to the Provider Agreement with ConnectiCare will be in compliance with generally recognized industry standards and as provided in Provider's response to ConnectiCare's due diligence/security risk assessment questionnaire; (ii) agrees to inform ConnectiCare promptly of any material variation in operations from what was provided in Provider's response to ConnectiCare's due diligence/security risk assessment; and (iii) agrees that any material deficiency in

operations from those as described in the Provider's response to ConnectiCare's due diligence/security risk assessment questionnaire may be deemed a material breach of the Provider Agreement with ConnectiCare.

6. Other Provisions. Provider acknowledges that there may be other information security and data protection requirements applicable to Provider in the performance of services which may be addressed in an agreement between ConnectiCare and Provider, but are not contained in this section.

7. Conflicting Provisions. In the event of any conflict between the provisions of this section and any other agreement between ConnectiCare and Provider, the stricter of the conflicting provisions will control.

13. Claims

Payer ID	**MLNCT**
Availity Essentials portal	**availity.com/providers**
Clean Claim Timely Filing	**180 calendar days after the discharge for inpatient services or from the date of services for outpatient services**

Electronic claim submission

For dates of services beginning 01/01/2026: ConnectiCare strongly encourages participating Providers to submit claims electronically, including secondary claims. Electronic claim submission provides significant benefits to the Provider including:

- Helps to reduce operation costs associated with paper claims (printing, postage, etc.)
- Increases accuracy of data and efficient information delivery
- Reduces claim delays since errors can be corrected and resubmitted electronically
- Eliminates mailing time and claims reach ConnectiCare faster

ConnectiCare offers the following electronic claim submission options:

- Submit claims directly to ConnectiCare via the Availity Essentials portal
- Submit claims to ConnectiCare via your regular EDI clearinghouse using Payer ID MLNCT.

Availity Essentials portal

The Availity Essentials portal is a no-cost online platform that offers a number of claim processing features:

- Submit Professional (CMS-1500) and Institutional (CMS-1450 [UB04]) claims with attached files
- Correct/void claims
- Add attachments to previously submitted claims
- Check claim status
- View ERA and EOP
- Create and manage claim templates
- Create and submit a claim appeal with attached files
- View, dispute, resolve claim overpayments

Clearinghouse

ConnectiCare uses The SSI Group as its gateway clearinghouse. The SSI Group has relationships with hundreds of other clearinghouses. Typically, Providers can continue to submit claims to their usual clearinghouse.

If you do not have a Clearinghouse, ConnectiCare offers additional electronic claim submission options as shown by logging on to the Availity Essentials portal.

ConnectiCare accepts EDI transactions through our gateway clearinghouse for claims via the 837P for Professional and 837I for institutional. It is important to track your electronic transmissions using your acknowledgement reports. The reports assure claims are received for processing in a timely manner.

When your claims are filed via a clearinghouse:

- You should receive a 999 acknowledgement from your clearinghouse
- You should also receive 277CA response file with initial status of the claim from your clearinghouse
- You should refer to the ConnectiCare Companion Guide for information on the response format and messages
- You should contact your local clearinghouse representative if you experience any problems with your transmission

EDI claim submission issues

Providers who are experiencing EDI submission issues should work with their clearinghouse to resolve this issue. If the Provider's clearinghouse is unable to resolve, the Provider should contact their Provider Relations representative for additional support.

Timely claim filing

Providers shall promptly submit to ConnectiCare claims for covered services rendered to Members. All claims shall be submitted in a form acceptable to and approved by ConnectiCare and shall include all medical records pertaining to the claim if requested by ConnectiCare or otherwise required by ConnectiCare's policies and procedures. Claims must be submitted by the Provider to ConnectiCare within 180 calendar days after the discharge for inpatient services or the date of service for outpatient services. If ConnectiCare is not the primary payer under coordination of benefits or third-party liability, the Provider must submit claims to ConnectiCare within 180 calendar days after final determination by the primary payer. Except as otherwise provided by law or provided by government program requirements, any claims that are not submitted to ConnectiCare within these timelines shall not be eligible for payment and Provider hereby waives any right to payment.

Claim submission

Participating Providers are required to submit claims to ConnectiCare with appropriate documentation. Providers must follow the appropriate state and CMS Provider billing guidelines as well as any criteria explicitly required in the ConnectiCare Billing and Claims page and any criteria explicitly required in the Claims Submission section. Providers must utilize electronic billing through a clearinghouse or the Availity

Essentials portal whenever possible and use current HIPAA-compliant American National Standards Institute (ANSI) X 12N format (e.g., 837I for institutional claims, 837P for professional Claims and 837D for dental claims) and use electronic Payer ID number MLNCT. For Members assigned to a delegated medical group/IPA that processes its own claims, please verify the claim submission instructions on the ConnectiCare Member ID card.

Providers must bill ConnectiCare for services with the most current CMS-approved diagnostic and procedural coding available as of the date the service was provided or for inpatient facility claims, the date of discharge.

National provider identifier (NPI)

A valid NPI is required on all claim submissions. Providers must report any changes in their NPI or subparts to ConnectiCare as soon as possible, not to exceed 30 calendar days from the change. ConnectiCare supports the CMS recommendations around NPPES data verification and encourages our Provider network to verify Provider data via nppes.cms.hhs.gov. ConnectiCare may validate the NPI submitted in a claim transaction is a valid NPI and is recognized as part of the NPPES data.

Required elements

Electronic submitters should use the Implementation Guide and ConnectiCare Companion Guide for format and code set information when submitting or receiving files directly with ConnectiCare. In addition to the Implementation Guide and Companion Guide, electronic submitters should use the appropriate state-specific Companion Guides and Provider Manuals. These documents are subject to change as new information is available. Please check the ConnectiCare website at connecticare.com for regularly updated information regarding ConnectiCare's companion guide requirements.

Electronic claim submission will adhere to specifications for submitting medical claims data in standardized Accredited Standards Committee (ASC) X12N 837 formats. Electronic claims are validated for compliance with the Strategic National Implementation Process (SNIP) levels 1-7.

The following information must be included on every claim, whether electronic or paper:

- Member name, date of birth and ConnectiCare Member ID number
- Member's gender
- Member's address
- Date(s) of service
- Valid International Classification of Diseases diagnosis and procedure codes
- Valid revenue, CPT or HCPCS for services or items provided
- Valid Diagnosis Pointers
- HIPAA-compliant CPT, HCPCS and modifier code sets
- Total billed charges

- Place and type of service code
- Days or units as applicable (anesthesia claims require minutes)
- Provider tax identification number (TIN)
- 10-digit National Provider Identifier (NPI) or Atypical Provider Identifier (API)
- 10-digit National Provider Identifier (NPI) of the Billing Provider or Group
- Rendering Provider information when different than billing
- Billing/Pay-to Provider name and billing address
- Place of service and type (for facilities)
- Disclosure of any other health benefit plans
- National Drug Code (NDC), NDC Units, Units of Measure and Days or Units for medical injectables
- E-signature
- Service facility location information
- Any other state-required data

Provider and Member data will be verified for accuracy and active status. Be sure to validate this data in advance of claim submission. This validation will apply to all Provider data submitted and also applies to atypical and out-of-state Providers.

Inaccurate, incomplete or untimely submissions and re-submissions may result in denial of the claim.

EDI (clearinghouse) submission

Corrected claim information submitted via EDI submission is required to follow electronic claim standardized ASC X12N 837 formats. Electronic claims are validated for compliance with SNIP levels 1-7. The 837 claim format allows you to submit changes to claims that were not included on the original adjudication.

The 837 Implementation Guides refer to the National Uniform Billing Data Element Specifications Loop 2300 CLM05-3 for explanation and usage. In the 837 formats, the codes are called “claim frequency codes.” Using the appropriate code, you can indicate that the claim is an adjustment of a previously submitted finalized claim. Use the below frequency codes for claims that were previously adjudicated.

Claim frequency code	Description	Action
7	Use to replace an entire claim.	ConnectiCare will adjust the original claim. The corrections submitted represent a complete replacement of the previously processed claim.
8	Use to eliminate a previously submitted claim.	ConnectiCare will void the original claim from records based on request.

When submitting claims noted with claim frequency code 7 or 8, the original claim number must be submitted in Loop 2300 REF02 – Payer Claim Control Number with qualifier F8 in REF01. The original claim number can be obtained from the 835 ERA. Without the original claim number adjustment requests will generate a compliance error and the claim will reject.

Claim corrections submitted without the appropriate frequency code will deny as a duplicate and the original claim number will not be adjusted.

Paper claim submission

Participating Providers should submit claims electronically. If electronic claim submission is not possible, please submit paper claims to the following address:

ConnectiCare Claims
PO Box 36010
Louisville, KY 40233

When submitting paper claims:

- Paper claim submissions are not considered to be “accepted” until received at the appropriate claims PO Box; claims received outside of the designated PO Box will be returned for appropriate submission.
- Paper claims are required to be submitted on original red and white CMS-1500 and CMS-1450 (UB-04) claim forms.
- Paper claims not submitted on the required forms will be rejected and returned. This includes black and white forms, copied forms and any altering to include claims with handwriting.
- Claims must be typed with either 10 or 12-point Times New Roman font, using black ink.
- Link to paper claims submission guidance from CMS: cms.gov/medicare/billing/electronicbillingeditrans/1500

Corrected claim process

Providers may correct any necessary field of the CMS-1500 and CMS-1450 (UB-04) forms.

ConnectiCare strongly encourages participating Providers to submit corrected claims electronically via EDI or the Availity Essentials portal.

All corrected claims:

- Must be free of handwritten or stamped verbiage (paper claims).
- Must be submitted on a standard red and white CMS-1450 (UB-04) or CMS-1500 claim form (paper claims).

- Original claim number must be inserted in field 64 of the CMS-1450 (UB-04) or field 22 of the CMS-1500 of the paper claim or the applicable 837 transaction loop for submitting corrected claims electronically.
- The appropriate frequency code/resubmission code must also be billed in field 4 of the CMS-1450 (UB-04) and 22 of the CMS-1500.

Note: The frequency/resubmission codes can be found in the National Uniform Claim Committee (NUCC) manual for CMS-1500 claim forms or the Uniform Billing (UB) Editor for UB-04 claim forms.

Corrected claims must be sent within 100 additional days from the original submission timely filing limits of the claim.

Corrected claim submission options:

- Submit corrected claims directly to ConnectiCare via the Availity Essentials portal
- Submit corrected claims to ConnectiCare via your regular EDI clearinghouse

Coordination of benefits (COB) and third-party liability (TPL)

Coordination of Benefits (COB) - ConnectiCare shall coordinate payment for covered services in accordance with the terms of a Member's benefit plan, applicable state and federal laws and applicable CMS guidance. If ConnectiCare is the secondary payer due to COB, Providers shall bill primary insurers for items and services they provide to a Member before they submit claims for the same items or services to ConnectiCare for reimbursement. ConnectiCare will adjudicate the claim based upon the primary explanation of benefits (EOB) submitted and pay for covered services up to the secondary liability based upon COB payment guidelines. If services and payment have been rendered prior to establishing third-party liability, an overpayment notification letter will be sent to the Provider requesting a refund including third-party policy information required for billing.

Medicaid coverage for ConnectiCare Medicare Members

There are certain benefits that will not be covered by ConnectiCare Medicare programs but may be covered by **fee-for-service Medicaid**. In this case, the Provider should bill Medicaid with a copy of the ConnectiCare Medicare remittance advice and the associated state agency will process the claim accordingly.

After exhausting all other primary coverage benefits, Providers may submit claims to ConnectiCare Medicare. A copy of the remittance advice from the primary payer must accompany the claim or the claim will be denied. If the primary insurance paid more than ConnectiCare's contracted allowable rate the claim is considered paid in full and zero dollars will be applied to the claim.

Hospital-acquired conditions (HAC) and present on admission (POA) program

The Deficit Reduction Act of 2005 (DRA) mandated that Medicare establish a program that would modify reimbursement for fee-for-service beneficiaries when certain conditions occurred as a direct result of a hospital stay that could have been reasonably prevented by the use of evidence-based guidelines. CMS titled the program “Hospital-Acquired Conditions and Present on Admission Indicator Reporting.”

The following is a list of CMS hospital-acquired conditions. CMS reduces payment for hospitalizations complicated by these categories of conditions that were not present on admission:

1) Foreign Object Retained After Surgery
2) Air Embolism
3) Blood Incompatibility
4) Stage III and IV Pressure Ulcers
5) Falls and Trauma
    a) Fractures
    b) Dislocations
    c) Intracranial Injuries
    d) Crushing Injuries
    e) Burn
    f) Other Injuries
6) Manifestations of Poor Glycemic Control
    a) Diabetic Ketoacidosis
    b) Nonketotic Hyperosmolar Coma
    c) Hypoglycemic Coma
    d) Secondary Diabetes with Ketoacidosis
    e) Secondary Diabetes with Hyperosmolarity
7) Catheter-Associated Urinary Tract Infection (UTI)
8) Vascular Catheter-Associated Infection
9) Surgical Site Infection, Mediastinitis, Following Coronary Artery Bypass Graft (CABG)
10) Surgical Site Infection Following Bariatric Surgery for Obesity
    a) Laparoscopic Gastric Bypass
    b) Gastroenterostomy
    c) Laparoscopic Gastric Restrictive Surgery
11) Surgical Site Infection Following Certain Orthopedic Procedures:
    a) Spine
    b) Neck
    c) Shoulder
    d) Elbow
12) Surgical Site Infection Following Cardiac Implantable Electronic Device (CIED)
13) Deep Vein Thrombosis (DVT)/Pulmonary Embolism (PE) Following Certain Orthopedic Procedures
    a) Total Knee Replacement
    b) Hip Replacement
14) Iatrogenic Pneumothorax with Venous Catheterization

What this means to Providers:

- Acute Inpatient Prospective Payment System (IPPS) hospital claims will be returned with no payment if the POA indicator is coded incorrectly or missing.
- No additional payment will be made on IPPS hospital claims for conditions that are acquired during the patient's hospitalization.

For additional information on the Medicare HAC/POA program, including billing requirements, please refer to the CMS website at cms.hhs.gov/hospitalacqcond.

ConnectiCare coding policies and payment policies

Frequently requested information on ConnectiCare's coding policies and payment policies is available on the connecticare.com website. Questions can be directed to ConnectiCare Provider Relations representatives.

Reimbursement guidance and payment guidelines

Providers are responsible for submission of accurate claims. ConnectiCare requires coding of both diagnoses and procedures for all claims as follows:

- For diagnoses, the required coding schemes are the International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM)
- For procedures:
  - Professional and outpatient claims require the Healthcare Common Procedure Coding System, Current Procedural Terminology Level 1 (CPT codes), Level 2 and 3 (HCPCS codes)
  - Inpatient hospital claims require International Classification of Diseases, 10th Revision, Procedure Coding System (ICD-10-PCS) coding schemes

Furthermore, ConnectiCare requires that all claims be coded in accordance with the HIPAA transaction code set guidelines and follow the guidelines within each code set.

ConnectiCare utilizes a claim adjudication system that encompasses edits and audits that follow federal requirements as well as administers payment rules based on generally accepted principles of correct coding. These payment rules include, but are not limited to, the following:

- Manuals and Relative Value Unit (RVU) files published by CMS, including:
  - NCCI edits, including procedure-to-procedure (PTP) bundling edits and MUE. If a professional organization has a more stringent/restrictive standard than a federal MUE the professional organization standard may be used.
  - Medicare National Coverage Determinations (NCD)
  - Medicare Local Coverage Determinations (LCD)
  - CMS Physician Fee Schedule RVU indicators
- CPT guidance published by the AMA
- ICD-10 guidance published by the National Center for Health Statistics
- Other coding guidelines published by industry-recognized resources

- Payment policies based on professional associations or other industry-recognized guidance for specific services. Such payment policies may be more stringent than federal guidelines.
- ConnectiCare policies based on the appropriateness of health care and medical necessity
- Payment policies published by ConnectiCare

Telehealth claims and billing

Providers must follow CMS guidelines as well as state-level requirements.

All telehealth claims for ConnectiCare Members must be submitted to ConnectiCare with the correct codes for the plan type in accordance with applicable billing guidelines. For guidance, please refer to the resources located at telehealth.hhs.gov/providers.

National Correct Coding Initiative (NCCI)

CMS has directed all federal agencies to implement NCCI as policy in support of Section 6507 of the Patient Affordable Care Act. ConnectiCare uses NCCI standard payment methodologies.

NCCI procedure to procedure edits prevent inappropriate payment of services that should not be bundled or billed together and to promote correct coding practices. Based on the NCCI coding manual and CPT guidelines, some services/procedures performed in conjunction with an evaluation and management (E&M) code will bundle into the procedure when performed by the same physician and separate reimbursement will not be allowed if the sole purpose for the visit is to perform the procedures. NCCI editing also includes MUE which prevent payment for an inappropriate number/quantity of the same service on a single day. An MUE for a HCPCS/CPT code is the maximum number of units of service under most circumstances reportable by the same Provider for the same patient on the same date of service. Providers must correctly report the most comprehensive CPT code that describes the service performed, including the most appropriate modifier when required.

General coding requirements

Correct coding is required to properly process claims. ConnectiCare requires that all claims be coded in accordance with the HIPAA transaction code set guidelines and follow the guidelines within each code set.

CPT and HCPCS codes

Codes must be submitted in accordance with the chapter and code-specific guidelines set forth in the current/applicable version of the AMA CPT and HCPCS codebooks. In order to ensure proper and timely reimbursement, codes must be effective on the date of service for which the procedure or service was rendered and not the date of submission.

Modifiers

Modifiers consist of two (2) alphanumeric characters and are appended to HCPCS/CPT codes to provide additional information about the services rendered. Modifiers may be appended only if the clinical circumstances justify the use of the modifier(s). For example, modifiers may be used to indicate whether a:

- Service or procedure has a professional component
- Service or procedure has a technical component
- Service or procedure was performed by more than one (1) physician
- Unilateral procedure was performed
- Bilateral procedure was performed
- Service or procedure was provided more than once
- Only part of a service was performed

For a complete listing of modifiers and their appropriate use, consult the AMA CPT and the HCPCS code books.

ICD-10-CM/PCS codes

ConnectiCare utilizes ICD-10-CM and ICD-10-PCS billing rules and will deny claims that do not meet ConnectiCare's ICD-10 claim submission guidelines. To ensure proper and timely reimbursement, codes must be effective on the date of service for which the procedure or service was rendered and not the date of submission. Refer to the ICD-10 CM/PCS Official Guidelines for Coding and Reporting on the proper assignment of principal and additional diagnosis codes.

Place of service (POS) codes

POS codes are two (2)-digit codes placed on health care professional claims (CMS-1500) to indicate the setting in which a service was provided. CMS maintains POS codes used throughout the health care industry. The POS code should be indicative of where that specific procedure/service was rendered. If billing multiple lines, each line should indicate the POS code for the procedure/service on that line.

Type of bill

Type of bill is a four (4)-digit alphanumeric code that gives three (3) specific pieces of information after the first digit, a leading zero. The second digit identifies the type of facility. The third classifies the type of care. The fourth indicates the sequence of this bill in this particular episode of care, also referred to as a "frequency" code. For a complete list of codes, reference the National Uniform Billing Committee (NUBC) Official CMS-1450 (UB-04) Data Specifications Manual.

Revenue codes

Revenue codes are four (4)-digit codes used to identify specific accommodation and/or ancillary charges. There are certain revenue codes that require CPT/HCPCS codes to be billed. For a complete list of codes, reference the NUBC's Official CMS-1450 (UB-04) Data Specifications Manual.

Diagnosis related group (DRG)

Facilities contracted to use DRG payment methodology submit claims with DRG coding. Claims submitted for payment by DRG must contain the minimum requirements to ensure accurate claim payment.

ConnectiCare processes DRG claims through DRG software. If the submitted DRG and system-assigned DRG differ, the ConnectiCare-assigned DRG will take precedence. Providers may appeal with medical record documentation to support the ICD-10-CM principal and secondary diagnoses (if applicable) and/or the ICD-10-PCS procedure codes (if applicable). If the claim cannot be grouped due to insufficient information, it will be denied and returned for lack of sufficient information.

National drug code (NDC)

The NDC number must be reported on all professional and outpatient claims when submitted on the CMS-1500 claim form, CMS-1450 (UB-04) or its electronic equivalent.

Providers will need to submit claims with both HCPCS and NDC codes with the exact NDC number that appears on the medication packaging in the 5-4-2 digit format (i.e., xxxxx-xxxx-xx) as well as the NDC units and descriptors. Claims submitted without the NDC number will be denied.

Coding sources

Definitions

CPT – Current Procedural Terminology 4th Edition; an AMA-maintained uniform coding system consisting of descriptive terms and codes that are used primarily to identify medical services and procedures furnished by physicians and other health care professionals. There are three types of CPT codes:

- Category I Code – Procedures/Services
- Category II Code – Performance Measurement
- Category III Code – Emerging Technology

HCPCS – HealthCare Common Procedural Coding System; a CMS maintained uniform coding system consisting of descriptive terms and codes that are used primarily to identify procedure, supply and durable medical equipment codes furnished by physicians and other health care professionals.

ICD-10-CM – International Classification of Diseases, 10th revision, Clinical Modification; maintained by the CDC within the Department of Health and Human Services (HHS).

ICD-10-PCS – International Classification of Diseases, 10th revision, Procedure Coding System; used to report procedures for inpatient hospital services.

Claim auditing

ConnectiCare shall use established industry claims adjudication and/or clinical practices, state and federal guidelines, and/or ConnectiCare's policies and data to determine the appropriateness of the billing, coding and payment.

The Provider acknowledges ConnectiCare's right to conduct pre and post-payment billing audits. The Provider shall cooperate with ConnectiCare's SIU and audits of claims and payments by providing access at reasonable times to requested claims information, the Provider's charging policies and other related data as deemed relevant to support the transactions billed. Additionally, Providers are required, by contract and in accordance with the Provider Manual, to submit all supporting medical records/documentation as requested. Failure to do so in a timely manner may result in an audit failure and/or denial, resulting in an overpayment.

In reviewing medical records for a procedure, ConnectiCare reserves the right, and where unprohibited by regulation, to select a statistically valid random sample or smaller subset of the statistically valid random sample. This gives an estimate of the proportion of claims that ConnectiCare paid in error. The estimated proportion or error rate may be extrapolated across all claims to determine the amount of overpayment.

Provider audits may be telephonic, an on-site visit, internal claims review, client-directed/regulatory investigation and/or compliance reviews and may be vendor-assisted. ConnectiCare asks that you provide us or our designee, during normal business hours, access to examine, audit, scan and copy any and all records necessary to determine compliance and accuracy of billing.

If ConnectiCare's SIU suspects that there is fraudulent or abusive activity, ConnectiCare may conduct an on-site audit without notice. Should you refuse to allow access to your facilities, ConnectiCare reserves the right to recover the full amount paid or due to you.

Timely claim processing

A complete claim is a claim that has no defect, impropriety, lack of any required substantiating documentation as outlined in "Required Elements" above or particular circumstance requiring special treatment that prevents timely payment from being made on the claim. Interest will not be applied to late payments.

Claim processing will be completed for contracted Providers in accordance with the timeliness provisions set forth in the Provider Agreement with ConnectiCare. Unless the

Provider and ConnectiCare or contracted medical group/IPA have agreed in writing to an alternate schedule, ConnectiCare will process the claim for service as follows:

- 95% of the monthly volume of non-contracted “clean” claims are to be adjudicated within 30 calendar days of receipt
- 95% of the monthly volume of contracted claims are to be adjudicated within 60 calendar days of receipt
- 95% of the monthly volume of non-clean non-contracted claims shall be paid or denied within 60 calendar days of receipt

The receipt date of a claim is the date ConnectiCare receives notice of the claim.

Electronic claim payment

Participating Providers are required to enroll for EFT and ERA. Providers who enroll in EFT payments will automatically receive ERAs as well. EFT/ERA services allow Providers to reduce paperwork, provides searchable ERAs and Providers receive payment and ERA access faster than the paper check and RA processes. There is no cost to the Provider for EFT enrollment and Providers are not required to be in-network to enroll. ConnectiCare uses a vendor to facilitate the HIPAA-compliant EFT payment and ERA delivery. Additional information about EFT/ERA is available at connecticare.com or by contacting the ConnectiCare Provider Contact Center.

Overpayments and incorrect payments refund requests

In accordance with 42 CFR 438.608, ConnectiCare requires network Providers to report to ConnectiCare when they have received an overpayment and to return the overpayment to ConnectiCare within 60 calendar days after the date on which the overpayment was identified and notify ConnectiCare in writing of the reason for the overpayment.

If, as a result of retroactive review of claim payment ConnectiCare determines that it has made an overpayment to a Provider for services rendered to a Member, it will make a claim for such overpayment. Providers will receive an overpayment request letter if the overpayment is identified in accordance with state and CMS guidelines. Providers will be given the option to either:

1. Submit a refund to satisfy overpayment,
2. Submit request to offset from future claim payments, or
3. Dispute overpayment findings.

A copy of the overpayment request letter and details are available in the Availity Essentials portal.

In the Overpayment Application section, Providers can make an inquiry, contest an overpayment with supporting documentation, resolve an overpayment or check status. This is ConnectiCare’s preferred method of communication.

Instructions will be provided on the overpayment notice and overpayments will be adjusted and reflected in your remittance advice. The letter timeframes are ConnectiCare standards and may vary depending on applicable state guidelines and contractual terms.

Overpayments related to TPL/COB will contain primary insurer information necessary for rebilling including the policy number, effective date, term date and subscriber information. For Members with Commercial COB, ConnectiCare will provide notice within 270 days from the claim's paid date if the primary insurer is a Commercial plan. A Provider may resubmit the claim with an attached primary EOB after submission to the primary payer for payment. ConnectiCare will adjudicate the claim and pay or deny the claim in accordance with claim processing guidelines.

A Provider shall pay a claim for an overpayment made by ConnectiCare which the Provider does not contest or dispute within the specified number of days on the refund request letter mailed to the Provider. If a Provider does not repay or dispute the overpaid amount within the timeframe allowed ConnectiCare may offset the overpayment amount(s) against future payments made to the Provider.

Payment of a claim for overpayment is considered made on the date payment was received or electronically transferred or otherwise delivered to ConnectiCare or the date that the Provider receives a payment from ConnectiCare that reduces or deducts the overpayment.

Provider claim payment disputes, appeals and inquiries

Provider claim payment disputes

A Provider claim payment dispute is the mechanism that should be used if a Provider disagrees with the denial of payment/partial payment of their claim which does not involve a denial of payment/partial payment related to medical necessity. Examples include, but are not limited to:

- Contractual payment issues
- Disagreements over reduced claims or zero-paid claims not related to medical necessity
- Post-service authorization issues
- Other health insurance denial issues
- Claim code editing issues
- Duplicate claim issues
- Retro-eligibility issues
- Experimental/investigational procedure issues
- Claim data issues
- Timely filing issues*

**Timely filing issues: Connecticare will consider reimbursement of a claim which has been denied due to failure to meet timely filing if you can: 1) provide documentation the claim was submitted within the timely*

filing requirements; or 2) good cause can be demonstrated, which is left to the sole discretion of ConnectiCare to determine.

Provider claim payment disputes must be submitted with a statement of what the provider believes is the issue as well as all necessary documentation to support the dispute, such as coding requirements, contracts, state and/or federal regulations, and payment policies. If incomplete information is supplied, then it will cause the claim payment dispute to be dismissed.

Provider claim payment appeals

Claims that were denied for lack of medical necessity should follow the Provider claim payment appeal process. A Provider claim payment appeal is a formal request for review of a previous ConnectiCare decision where medical necessity was not established, including partial stay denials and level of care. One example of this appeal scenario would be as follows (this is not all encompassing, but serves as a singular example):

- On clinical review, the services related to the prior authorization request were:
  - Deemed not medically necessary, but services were rendered and claim payment was denied.
  - Some days were deemed not medically necessary, but services were rendered and claim payment was denied.

When submitting a Provider claim payment appeal, please include any information that would help ConnectiCare determine why the Provider believe the services were medically necessary including all necessary medical records.

Provider claim payment inquiries

Any inquiry where you believe the claim was paid or denied incorrectly due to minor errors that can be easily remediated, **without** providing supporting documentation. Examples include retro-eligibility issues, coordination of benefit updates, claims denied as duplicates and claims denied for no authorization when authorization was not required or an approved authorization is on file. Supporting documentation cannot be submitted with a claim payment inquiry. This inquiry may result in a claims adjustment or direct you to submit a Corrected Claim or initiate the Claim Payment Dispute/Appeal process.

For the avoidance of doubt, in the event a Provider claim payment inquiry has been filed for a claim it will not toll the time frame for filing a provider claim payment dispute or provider claim payment appeal.

Timeframe for submitting a Provider claim payment dispute or claim payment appeal

Please note, neither a Provider claim payment dispute nor a Provider claim payment appeal can be reviewed without a finalized claim on file.

ConnectiCare accepts disputes and appeals in writing via mail or fax or through our provider website within 90 calendar days from the date on the Explanation of Payment (EOP) unless a different time frame is specified in the Provider Agreement with ConnectiCare. Requests filed beyond these timeframes will be untimely and denied unless good cause can be established, which is left to the sole discretion of ConnectiCare to determine.

ConnectiCare will make every effort to resolve the claims payment disputes and claims payment appeals within 90 calendar days of receipt, unless otherwise specified by the Provider Agreement with ConnectiCare or a different timeframe is required by law.

ConnectiCare will send you our decision in a determination letter when upholding our decision, which will include the reason and rationale for the upheld decision.

If the decision results in a claim adjustment, the payment and Explanation of Payment (EOP) will be sent separately.

For each claim, the Provider is limited to one claim payment dispute or claim payment appeal.

How to submit a Provider claim payment dispute or claim payment appeal or claim payment inquiry

Providers have several options to file a claim payment dispute, claim payment appeal, or claim payment inquiry:

- **Online**: Use the secure Availity Essentials portal to submit a claim payment dispute, claim payment appeal, or claim payment inquiry. Instructions on how to file a claim payment dispute, claim payment appeal, or claim payment inquiry is available on the Availity Payer Spaces Resources tab.
- **Written**: Provider claim payment disputes and Provider claim appeals can also be mailed or faxed to (provider claim payment inquiries **cannot** be used for this method of delivery):
  - **Mail**: PO Box 22816, Long Beach, CA 90801-9977; or
  - **Fax:** (562) 499-0610
- **Phone (for Provider Claim Payment Inquiries only):** (800) 828-3407

In the event you are not satisfied with the resolution of the provider claim payment appeal or provider claim payment dispute, and you have exhausted all levels of a claim payment dispute or claim payment appeal, please refer to your Provider Agreement with ConnectiCare for further information on the claims dispute process, which is the sole remedy available to a Provider through their Provider Agreement with ConnectiCare.

Provider reconsideration of delegated claims – contracted providers

Providers requesting a reconsideration, correction or reprocessing of a claim previously adjudicated by an entity that is delegated for claims payment must submit their request to the delegated entity responsible for payment of the original claim.

Balance billing

Pursuant to law and CMS guidance, Members who are dually eligible for Medicare and Medicaid and classified as Qualified Medicare Beneficiaries (QMB) shall not be held liable for Medicare Part A and B cost sharing when the state or another payor is responsible for paying such amounts. The Provider is responsible for verifying eligibility and obtaining approval for those services that require prior authorization.

Providers agree that under no circumstance shall a Member be liable to the Provider for any sums that are the legal obligation of ConnectiCare to the Provider. Balance billing a Member for covered services is prohibited, except for the Member's applicable copayment, coinsurance and deductible amounts.

Fraud, waste and abuse

Failure to report instances of suspected fraud, waste and abuse is a violation of the law and subject to the penalties provided by law. For additional information please refer to the **Compliance** section of this Provider Manual.

Encounter data

Each Provider, capitated Provider or organization delegated for claims processing is required to submit Encounter data to ConnectiCare for all adjudicated claims. The data is used for many purposes, such as regulatory reporting, rate setting and risk adjustment, hospital rate setting, the QI Program and HEDIS® reporting.

Encounter data must be submitted at least monthly and within 30 days from the date of service in order to meet state and CMS encounter submission threshold and quality measures. Encounter data must be submitted via HIPAA-compliant transactions, including the ANSI X12N 837I–Institutional, 837P–Professional and 837D–Dental. Data must be submitted with claims level detail for all non-institutional services provided.

ConnectiCare has a comprehensive automated and integrated Encounter data system capable of supporting all 837 file formats and proprietary formats if needed.

Providers must correct and resubmit any encounters which are rejected (non-HIPAA-compliant) or denied by ConnectiCare. Encounters must be corrected and resubmitted within 15 days from the rejection/denial.

ConnectiCare has created 837P, 837Iand 837D Companion Guides with the specific submission requirements available to Providers.

When encounters are filed electronically Providers should receive two (2) types of responses:

- First, ConnectiCare will provide a 999 acknowledgement of the transmission.
- Second, ConnectiCare will provide a 277CA response file for each transaction.

14. Medicare Member grievances and appeals

Distinguishing between appeals involving Provider liability and appeals involving Member liability

All Medicare Member liability denials are subject to the Member Appeals terms of this Provider Manual described below. The Member will receive the appropriate denial notice with appeal rights (e.g., Integrated Denial Notice, Notice of Denial of Medicare Prescription Drug Coverage, IM, NOMNC or EOB) indicating there is Member responsibility assigned to a claim processed). When Member liability is assigned, the Member Appeals process must be followed.

Disputes between ConnectiCare and a contracted Provider that do not result in an adverse determination or liability for the Member are subject to the claims appeals provisions of this Provider Manual. Parts C & D Enrollee Grievances, Organization/Coverage Determinations and Appeals Guidance of the Medicare Managed Care Manual specifically states that contracted Providers do not have appeal rights on their own behalf under the Medicare Member appeals process. Contracted Provider disputes involving plan payment denials are governed by the appeals and dispute resolution provisions of the relevant Provider Agreement with ConnectiCare. When ConnectiCare determines that a contracted Provider failed to follow the terms and conditions of the relevant Provider Agreement with ConnectiCare or Provider Manual, either administratively or by not providing the clinical information needed to substantiate the services requested, the contracted Provider is prohibited from billing the Member for the services unless ConnectiCare assigned Member liability and issued the appropriate notice with Member appeal rights. Additional information on the contracted Provider claims appeal process can be found in the Provider Claim Payment Disputes and Appeal Processes subsection located in the **Claims** section of this Provider Manual.

Definition of key terms used in the Medicare Member grievances and appeals process

Appeal: Medicare defines an appeal as the procedures that deal with the review of adverse initial determinations made by the Plan on health care services or benefits under Part C or D that the Member believes they are entitled to receive, including a delay in providing, arranging for or approving the health care services or drug coverage (when a delay would adversely affect the Member's health) or on any amounts the Member must pay for a service or drug. These appeal procedures include a Plan reconsideration or redetermination (also referred to as a level 1 appeal), a reconsideration by an independent review entity (IRE), adjudication by an Administrative Law Judge (ALJ) or attorney adjudicator, review by the Medicare Appeals Council (Council)and judicial review.

Applicable Integrated Plan (AIP): A type of D-SNP in which state policy limits the D-SNP's membership to enrollees whose Medicaid benefits are covered under a Medicaid managed care organization contract between the State and the D-SNP's Medicare

Advantage organization (or another entity related to the D-SNP's Medicare Advantage organization as specified in federal rules) (also known as "exclusive alignment"). AIPs are subject to federal rules providing a unified, integrated process for Appeals and Grievances for the enrollee's Medicare and Medicaid benefits.

Authorized representative: An individual appointed by the Member or authorized under state law to act on behalf of the Member in filing a grievance or appeal. An authorized representative has all of the rights and responsibilities of the Member. For Medicare, an individual may be appointed using the CMS Appointment of Representative Form found at cms.hhs.gov/cmsforms/downloads/cms1696.

Beneficiary and Family Centered Care Quality Improvement Organization (BFCC-QIO or QIO): Organizations comprised of practicing doctors and other health care experts under contract to the federal government to monitor and improve the care given to Medicare enrollees. The BFCC-QIOs review beneficiary complaints about the quality of care provided by physicians, inpatient hospitals, hospital outpatient departments, hospital emergency rooms, SNF, home health agencies (HHA), Medicare managed care plans, Medicare Part D prescription drug plans and ambulatory surgical centers. The BFCC-QIOs also review continued stay denials in acute inpatient hospital facilities as well as coverage terminations in SNFs, HHAs and comprehensive CORF. In some cases, the BFCC-QIO can provide informal dispute resolution between the health care provider (e.g., physician, hospital, etc.) and beneficiary.

Coverage Determination: Any determination made by a Part D plan sponsor, or its delegated entity, with respect to:

- A decision about whether to provide or pay for a drug that a Member believes may be covered by the Plan sponsor, including a decision related to a Part D drug that is: not on the Plan's formulary; determined not to be medically necessary; furnished by an out-of-network pharmacy; or otherwise excluded by law if applied to Medicare Part D.
- A decision on the amount of cost sharing for a drug;
- Failure to provide a Coverage Determination in a timely manner when a delay would adversely affect the Member's health;
- Whether a Member has (or has not) satisfied a prior authorization or other utilization management requirement;
- A decision about a tiering exception; or
- A decision about a formulary exception request.

Dual-Eligible Special Needs Plan (D-SNP): A Medicare Advantage (MA) plan that enrolls individuals who are entitled to both Medicare and Medicaid. D-SNPs coordinate the delivery of the Member's Medicare and Medicaid benefits.

Grievance: An expression of dissatisfaction with any aspect of the operations, activities or behavior of a Medicare Advantage Plan or its delegated entity in the provision of health care items, services or prescription drugs, regardless of whether remedial action is requested or can be taken. A grievance does not include and is distinct from, an

appeal. Examples of a Grievance include but are not limited to the quality of care, aspects of interpersonal relationships such as rudeness of a Provider or Plan employee, waiting times for an appointment, cleanliness of contracted Provider facilities, failure of the Plan or a contracted Provider to respect the Member's rights under the Plan, involuntary disenrollment, Plan benefit design, the Organization or Coverage Determination or Appeals process, the Plan formulary or the availability of contracted Providers.

Organization Determination: Any determination (approval or denial) made by a Medicare Advantage Plan, or its delegated entity, with respect to:

- Payment for temporarily out-of-the-area renal dialysis services, emergency services, post-stabilization care, or urgently needed services (for more information on these services see the Emergency Services, Urgent Care, and Post-Stabilization Services section of this Provider Manual);
- Payment for any other health services furnished by a Provider that the Member believes are covered under Medicare, or if not covered under Medicare, should have been furnished, arranged for, or reimbursed by the Medicare Advantage plan;
- Refusal to authorize, provide, or pay for services, in whole or in part, including the type or level of services, which the Member believes should be furnished or arranged by the Medicare Advantage plan;
- Reduction or premature discontinuation of a previously ongoing course of treatment; or
- Failure of the Medicare Advantage plan to approve, furnish, arrange for, or provide payment for health care services in a timely manner, or to provide timely notice of an adverse determination, such that a delay would adversely affect the Member's health.

Medicare Member liability appeals

How to file an appeal

For expedited appeals: Call the ConnectiCare Member Contact Center at (800) 224-2273.

For standard appeals: Members should mail or fax their written appeal to ConnectiCare at:

ConnectiCare
Attn: Grievance and Appeals
PO Box 22816
Long Beach, CA 90801-9977

Fax: (562) 499-0610

For information on Part D appeals/redeterminations, please refer to the **Medicare Part D** section in this Provider Manual.

Providers assisting their Members with Expedited Appeal requests should call the ConnectiCare Provider Contact Center at (800) 828-3407.

Members and their authorized representatives (and treating Providers acting on their behalf) have 65 days from the date of the denial to file an appeal. This timeframe may be extended for good cause.

What to include with the appeal

Members should include their name, contact information, Member ID number, health plan name, reason for appealing and any evidence the Member wishes to attach. Members may send in supporting medical records, documentation or other information that explains why ConnectiCare should provide or pay for the item or service.

Participating Provider responsibilities in the Medicare Member appeals process

Appeals should include the Member's name, contact information, ConnectiCare Member ID number, health plan name, the reason for appealing and any evidence to support the request.

Providers can request Appeals on behalf of Members; however, if the Appeal is not requested by a treating physician, an Appointment of Representative (AOR) Form may be required. The AOR Form can be found online and downloaded at cms.gov/medicare/cms-forms/cms-forms/downloads/cms1696.pdf.

Please provide all medical records and/or supporting documentation with the appeal request. Please note that if additional information must be requested, processing of the appeal may be delayed.

Expedited appeals should only be requested if waiting for the time frame for a standard appeal could jeopardize the Member's life, health or ability to regain maximum function.

Time frames

Appeal decisions are made as expeditiously as the Member's health condition requires and within regulatory time frames.

Expedited Pre-Service (non-Part B, non-Part D drug)	72 hours
Expedited Pre-Service Part B drug	72 hours
Expedited Pre-Service Part D drug	72 hours
Standard Pre-Service (non-Part B, non-Part D drug)	30 calendar days
Standard Pre-Service Part B drug	7 calendar days
Standard Pre-Service Part D drug	7 calendar days
Standard Post-Service (Part C)	60 calendar days

Standard Post-Service Part D drug	14 calendar days

Extensions may be allowed under specific conditions (except requests involving a Part B or Part D drug).

A Provider may request that a pre-service Appeal be expedited if following the standard timeframe could seriously jeopardize the life or health of the Member or the Member's ability to regain maximum function. Providers must ask that an Appeal be expedited only when this standard is supported by the Member's condition.

Continuation of benefits (aka "Aid Continuing")

Members enrolled in a Plan providing integrated Medicare and Medicaid benefits may be entitled to continue benefits pending appeal if authorization for services is terminated, suspended or reduced prior to the expiration of the authorization period. This typically occurs with Medicaid-covered services such as personal care services but can be applicable to other Medicare or Medicaid services not authorized for a limited, defined benefit period when the services are terminated, suspended, or reduced prior to the expiration of the authorization period. The right to continue benefits is subject to the filing of the Appeal and/or providing a written request for continuation of benefits within 10 calendar days of the date of the notice of suspension, termination, or reduction or the expiration of the authorization, whichever is later. The right to request continuation of benefits typically resides with the member. When Providers are allowed to request continuation of benefits under applicable federal and state regulations, they may be required to have the written consent of the Member to file the Appeal.

If the Member's Appeal is upheld by the Plan, their notice of the Appeal decision will contain any instructions for continuation of benefits pending State Fair Hearing.

Federal and state rules applicable to the specific Plan determine whether recovery of costs applies if the Member receives an adverse decision on Appeal or at State Fair Hearing.

Further appeal rights

If ConnectiCare upholds the initial adverse determination, in whole or in part, for a Part C item or service (including a Part B drug), the Appeal will be forwarded to an Independent Review Entity (IRE). (For Part D upholds, the Member must request a review by the IRE.) The IRE is a CMS contractor independent of ConnectiCare. If the IRE upholds the initial adverse determination and the amount in controversy requirements are met, the Member may continue to an additional level of Appeal with an ALJ or attorney adjudicator. Additional levels of Appeal are available to the Member if the amount in controversy requirements are met, including an appeal to the Medicare Appeals Council (MAC) and federal court.

The Member may have additional appeal rights if they are enrolled in a Plan providing integrated Medicare and Medicaid benefits. In these plans, when the item or service is

or could be covered by Medicaid or by both Medicare and Medicaid (overlap), the Member will be provided with their State Fair Hearing rights and any other state appeal rights to which they are entitled. (For example, the Member may be entitled to additional appeal rights for Medicaid-covered services under the state HMO law.) Additional levels of appeal follow the applicable state rules and requirements.

Hospital discharge appeals

Hospital discharges are subject to an expedited Member appeal process. Members receive their appeal rights through the delivery of the Important Message from Medicare (IM, Form CMS-10065) by the hospital. For additional information on delivery of the IM, refer to the Termination of Inpatient Hospital Services section of this Provider Manual.

Members disputing their discharge decision may request an immediate appeal to the QIO for the service area (Commence Health or Acentra Health). The Member must appeal to the QIO as soon as possible and no later than the planned discharge date and before the Member leaves the hospital. The QIO will typically respond within one (1) day after it receives all necessary information.

If the QIO agrees with the discharge decision, the Member will be responsible for payment for continued care beginning at noon of the calendar day following the day the QIO provides notice of its decision to the Member. The Member may request a reconsideration from the QIO if they remain in the hospital. If the QIO continues to agree with the discharge decision, the Member may appeal to an ALJ or attorney adjudicator.

If the QIO disagrees with the discharge decision, the Member is not responsible for any continued care (aside from any applicable deductibles or copayments) without proper notification that includes their appeal rights located within the IM. The Member will then have an opportunity to appeal that subsequent discharge determination.

If the Member misses the deadline to file an appeal with the QIO and is still in the hospital, the Member (or their Authorized Representative) may request an expedited pre-service Appeal with the Plan. In this case, the Member does not have financial protection during the course of the expedited pre-service Appeal and may be financially liable for the cost of additional hospital days beyond the discharge date if the original decision to discharge is upheld.

SNF, CORF and HHA termination of services appeals

Discharges from care provided by a SNF (including a swing bed in a hospital providing Part A and Part B services), CORF or HHA are subject to an expedited (fast track) Member appeal process. For this purpose, a discharge means the complete termination of services and not the termination of a single service when other services continue (e.g., when the Member is receiving skilled nursing, skilled therapy and home health aide services from an HHA and only the home health aide services are terminated while the other services continue). When a single service is terminated and other services

continue, an Integrated Denial Notice (IDN) with Member appeal rights is issued to the Member. Members receive their discharge appeal rights through the delivery of the NOMNC by the SNF, CORF or HHA. For additional information on delivery of the NOMNC, see the Termination of SNF, CORF and HHA Services section of this Provider Manual.

Members disputing their discharge decision may request an expedited (fast-track) appeal to the QIO for the service area (Commence Health or Acentra Health). The Member must appeal to the QIO by noon of the calendar day after the NOMNC is delivered. The QIO will typically respond by the effective date provided in the NOMNC (the last covered day).

If the QIO agrees with the discharge decision, the Member will be responsible for payment for continued care received beyond the last covered day provided in the NOMNC. The Member has an opportunity to request a reconsideration from the QIO if they remain in the SNF or continue to receive services from the CORF or HHA beyond the last covered day provided in the NOMNC. If the QIO continues to agree with the discharge decision, the Member may appeal to an ALJ or attorney adjudicator.

If the QIO disagrees with the discharge decision, the Member is not responsible for any continued care (aside from any applicable deductibles or copayments) without proper notification that includes their appeal rights located within the NOMNC. The Member will then have an opportunity to appeal that subsequent termination of services (discharge) determination.

If the Member misses the deadline to file an appeal with the QIO and is still in the SNF or continuing to receive services from the CORF or HHA beyond the last covered day provided in the NOMNC, the Member (or their Authorized Representative) may request an appeal with the QIO. In this case, the Member does not have financial protection during the course of the Appeal and may be financially liable for the cost of additional services provided beyond the discharge date (last covered day) if the original decision to discharge is upheld.

Obtaining additional information about the Member appeal process

For additional information about Member appeal rights, call ConnectiCare's Provider Contact Center at (800) 828-3407 or TTY/TDD 711 for persons with hearing impairments. A detailed explanation of the appeal process is also included in the Member's EOC (or Member Handbook), which is available on ConnectiCare's website. If Members have additional questions, please refer them to ConnectiCare's Member Contact Center.

Medicare Member grievances

A Member may file a grievance verbally or in writing within 60 days of the event precipitating the grievance. (Members enrolled in HMO D-SNP plans may file a grievance at any time, except a Part D grievance. Part D grievances must be filed within

60 days of the event precipitating the grievance.) Grievances are typically responded to by the Plan within 30 days . The Plan may also be allowed to take an extension under certain circumstances.

Medicare allows an expedited grievance only if the Plan diverts an expedited request for a coverage decision or appeal to the standard timeframe or if the Plan takes an extension in making a coverage decision or deciding an appeal (when allowed). These expedited grievances are decided within 24 hours.

Members may file a grievance by calling the ConnectiCare Member Contact Center at (800) 224-2273 or by writing to:

ConnectiCare
Attn: Grievance and Appeals
PO Box 22816
Long Beach, CA 90801-9977

FAX: (562) 499-0610

15. Credentialing and recredentialing

The purpose of the Credentialing program is to assure that ConnectiCare's network consists of quality Providers who meet clearly defined criteria and standards. It is the objective of ConnectiCare to provide superior health care to the community. Additional information is available in the Credentialing Policy and Procedure which can be requested by contacting your ConnectiCare Provider Relations representative.

The decision to accept or deny a credentialing applicant is based upon primary source verification, secondary source verification and additional information as required. The information gathered is confidential and disclosure is limited to parties who are legally permitted to have access to the information under state and federal law.

The Credentialing Program has been developed in accordance with state and federal requirements and the standards of the NCQA. The Credentialing Program is reviewed annually, revised and updated as needed.

Non-discriminatory credentialing and recredentialing

ConnectiCare does not make credentialing and recredentialing decisions based on an applicant's race, ethnic/national identity, gender, gender identity, age, sexual orientation, ancestry, religion, marital status, health status or patient types (e.g., Medicaid) in which the practitioner specializes. This does not preclude ConnectiCare from including in its network practitioners who meet certain demographic or specialty needs; for example, to meet the cultural needs of Members.

Types of practitioners credentialed and recredentialed

Practitioners and groups of Practitioners with whom ConnectiCare contracts must be credentialed prior to the contract being implemented. Practitioner types requiring credentialing include but are not limited to:

- Acupuncturists
- Addiction medicine specialists
- Audiologists
- Behavioral health care Practitioners who are licensed, certified or registered by the state to practice independently*
- Chiropractors
- Clinical Social Workers
- Dentists*
- Dieticians/Nutritionists
- Doctoral or master's-level psychologists*
- Licensed/Certified Midwives (Non-Nurse)
- Massage Therapists
- Master's-level clinical social workers*
- Master's-level clinical nurse specialists or psychiatric nurse practitioners*

- Medical Doctors (MD)
- Naturopathic Physicians
- Nurse Midwives
- Nurse Practitioners/Advanced Practice Registered Nurse (APRN)
- Occupational Therapists
- Optometrists*
- Oral Surgeons
- Osteopathic Physicians (DO)
- Pharmacists*
- Physical Therapists
- Physician Assistants
- Podiatrists
- Psychiatrists*
- Speech and Language Pathologists
- Telemedicine Practitioners

**These practitioner types are credentialed through external vendors*

Credentialing turn-around time

ConnectiCare fully enrolls/on-boards initial Practitioners within 60 calendar days. The 60 calendar days is measured from the date ConnectiCare receives a full and complete credentialing application.

Criteria for participation in the ConnectiCare network

ConnectiCare has established criteria and the sources used to verify these criteria for the evaluation and selection of practitioners for participation in the ConnectiCare network. These criteria have been designed to assess a Practitioner's ability to deliver care. This policy defines the criteria that are applied to applicants for initial participation, recredentialing and ongoing participation in the ConnectiCare network. To remain eligible for participation, Practitioners must continue to satisfy all applicable requirements for participation as stated herein and in all other documentation provided by ConnectiCare.

ConnectiCare reserves the right to exercise discretion in applying any criteria and to exclude practitioners who do not meet the criteria. ConnectiCare may, after considering the recommendations of the Professional Review Committee, waive any of the requirements for network participation established pursuant to these policies for good cause if it is determined such waiver is necessary to meet the needs of ConnectiCare and the community it serves. ConnectiCare's refusal to waive any requirement shall not entitle any Practitioner to a hearing or any other right of review.

Providers shall not be eligible to see ConnectiCare Members as participating Providers until notified of their effective date from ConnectiCare.

Additionally, Providers shall not be eligible to treat Members as a participating Provider at a location until both notified of credentialing completion and added to the health plan systems. The Provider will receive a welcome notice from ConnectiCare with the effective date of participation, along with a copy of the fully executed agreement for new contract execution (if applicable). Providers may reach ConnectiCare Provider Relations representatives by calling (800) 828-3407.

Practitioners must meet the following criteria to be eligible to participate in the ConnectiCare network. The Practitioner shall have the burden of producing adequate information to prove they meets all criteria for initial participation and continued participation in the ConnectiCare network. If the Practitioner does not provide this information, the credentialing application will be deemed incomplete and it will result in an administrative denial or administrative termination from the ConnectiCare network. Practitioners who fail to provide this burden of proof do not have the right to submit an appeal.

- **Application** – Practitioners must submit to ConnectiCare a complete credentialing application either from CAQH ProView or other state-mandated practitioner application. The attestation must be signed within 90 days. The application must include all required attachments.
- **License, Certification or Registration** – Practitioners must hold a current and valid license, certification or registration to practice in their specialty in every state in which they will provide care and/or render services for ConnectiCare Members. Telemedicine Practitioners are required to be licensed in the state where they are located and the state the Member is located.
- **Drug Enforcement Agency (DEA) certificate** – Practitioners must hold a current, valid, unrestricted DEA certificate. Practitioners must have a DEA certificate in every state where the Practitioner provides care to ConnectiCare Members. If a Practitioner has a pending DEA certificate and never had any disciplinary action taken related to their DEA certificate or chooses not to have a DEA certificate, the Practitioner must then provide a documented process that allows another Practitioner with a valid DEA certificate to write all prescriptions requiring a DEA number.
- **Controlled Dangerous Substances (CDS) certificate** – Practitioners working from Massachusetts and Rhode Island practice locations must meet CDS requirements in that state.
- **Specialty** – Practitioners must only be credentialed in the specialty in which they have adequate education and training. Practitioners must confine their practice to their credentialed area of practice when providing services to ConnectiCare Members.
- **Education** – Practitioners must have graduated from an accredited school with a degree required to practice in their designated specialty.
- **Residency training** – Practitioners must have satisfactorily completed residency training from an accredited training program in the specialty in which they are practicing. ConnectiCare only recognizes programs that have been accredited by the Accreditation Council of Graduate Medical Education (ACGME) and the American Osteopathic Association (AOA) in the United States or by the College of Family

Physicians of Canada (CFPC), the Royal College of Physicians and Surgeons of Canada. Oral Surgeons must complete a training program in Oral and Maxillofacial Surgery accredited by the Commission on Dental Accreditation (CODA). Training must be successfully completed prior to completing the verification. It is not acceptable to verify completion prior to graduation from the program. As of July 2013, Podiatric residencies are required to be three (3) years in length. If the podiatrist has not completed a three (3)-year residency or is not board-certified, the podiatrist must have five (5) years of work history practicing podiatry.

- **Fellowship training** – Fellowship training is verified when a Practitioner will be advertised in the directory in their fellowship specialty. ConnectiCare only recognizes fellowship programs accredited by ACGME, AOA, CFPC and CODA.
- **Board certification** – Board certification in the specialty in which the Practitioner is practicing is not required. Initial applicants who are not board certified will be considered for participation if they have satisfactorily completed residency training from an accredited training program in the specialty in which they are practicing. ConnectiCare recognizes certification only from the following Boards:
  - American Board of Medical Specialties (ABMS)
  - American Osteopathic Association (AOA)
  - American Board of Foot and Ankle Surgery (ABFAS)
  - American Board of Podiatric Medicine (ABPM)
  - American Board of Oral and Maxillofacial Surgery
  - American Board of Addiction Medicine (ABAM)
  - College of Family Physicians of Canada (CFPC)
  - Royal College of Physicians and Surgeons of Canada (RCPSC)
  - Behavioral Analyst Certification Board (BACB)
  - National Commission on Certification of Physician Assistants (NCCPA)
- **General practitioners** – Practitioners who are not board certified and have not completed training from an accredited program are only eligible to be considered for participation as a General Practitioner in the ConnectiCare network. To be eligible, the practitioner must have maintained a primary care practice in good standing for a minimum of the most recent five (5) years without any gaps in work history. ConnectiCare will consider allowing a practitioner who is/was board certified and/or residency trained in a specialty other than primary care to participate as a General Practitioner if the Practitioner is applying to participate as a Primary Care Physician or as an Urgent Care or Wound Care Practitioner. General Practitioners providing only wound care services do not require five (5) years of work history as a PCP.
- **Nurse Practitioners and Physician Assistants** – In certain circumstances, ConnectiCare may credential a Practitioner who is not licensed to practice independently. In these instances, the Practitioner providing the supervision and/or oversight must also be contracted and credentialed with ConnectiCare.
- **Work history** –Practitioners must supply the most recent five (5)-years of relevant work history on the application or curriculum vitae. Relevant work history includes work as a health professional. If a gap in employment exceeds six (6) months, the Practitioner must clarify the gap verbally or in writing. The organization will document verbal clarification in the Practitioner's credentialing file. If the gap in employment exceeds one (1) year, the Practitioner must clarify the gap in writing.

- **Malpractice history** –Practitioners must supply a history of malpractice and professional liability claims and settlement history in accordance with the application. Documentation of malpractice and professional liability claims and settlement history is requested from the Practitioner on the credentialing application. If there is an affirmative response to the related disclosure questions on the application, a detailed response is required from the Practitioner.
- **State sanctions, restrictions on licensure or limitations on scope of practice** – Practitioners must disclose a full history of all license/certification/registration actions including denials, revocations, terminations, suspension, restrictions, reductions, limitations, sanctions, probations and non-renewals. Practitioners must also disclose any history of voluntarily or involuntarily relinquishing, withdrawing or failure to proceed with an application to avoid an adverse action or to preclude an investigation or while under investigation relating to professional competence or conduct. If there is an affirmative response to the related disclosure questions on the application, a detailed response is required from the Practitioner. At the time of initial application, the Practitioner must not have any pending or open investigations from any state or governmental professional disciplinary body[3]. This would include Statement of Charges, Notice of Proposed Disciplinary Action or the equivalent.
- **Medicare, Medicaid and other sanctions and exclusions** – Practitioners must not be currently sanctioned, excluded, expelled or suspended from any state or federally-funded program including but not limited to the Medicare or Medicaid programs. Practitioners must disclose all Medicare and Medicaid sanctions. If there is an affirmative response to the related disclosure questions on the application, a detailed response is required from the practitioner. Practitioners must disclose all debarments, suspensions, proposals for debarments, exclusions or disqualifications under the non-procurement common rule or when otherwise declared ineligible from receiving federal contracts, certain subcontracts and certain federal assistance and benefits. If there is an affirmative response to the related disclosure questions on the application, a detailed response is required from the Practitioner.
- **Medicare opt out** – Practitioners currently listed on the Medicare Opt-Out Report may not participate in the ConnectiCare network for any Medicare or Duals (Medicare/Medicaid) lines of business.
- **Social Security Administration Death Master File** – Practitioners must provide their Social Security number. That Social Security number should not be listed on the Social Security Administration Death Master File.
- **Medicare Preclusion List** – Practitioners currently listed on the Preclusion List may not participate in the ConnectiCare network for any Medicare or Duals (Medicare/Medicaid) lines of business.

[3] If a practitioner's application is denied solely because a practitioner has a pending Statement of Charges, Notice of Proposed Disciplinary Action, Notice of Agency Action or the equivalent from any state or governmental professional disciplinary body, the practitioner may reapply as soon as practitioner is able to demonstrate that any pending Statement of Charges, Notice of Proposed Disciplinary Action, Notice of Agency Action or the equivalent from any state or governmental professional disciplinary body is resolved, even if the application is received less than one year from the date of original denial.

- **Professional liability insurance** – Practitioners must have and maintain professional malpractice liability insurance with limits that meet ConnectiCare criteria. This coverage shall extend to ConnectiCare Members and the practitioners activities on ConnectiCare's behalf. Practitioners maintaining coverage under federal tort or self-insured policies are not required to include amounts of coverage on their application for professional or medical malpractice insurance.
- **Inability to perform** – Practitioners must disclose any inability to perform essential functions of a practitioner in their area of practice with or without reasonable accommodation. If there is an affirmative response to the related disclosure questions on the application, a detailed response is required from the Practitioner.
- **Lack of present illegal drug use** – Practitioners must disclose if they are currently using any illegal drugs/substances.
- **Criminal convictions** – Practitioners must disclose if they have ever had any of the following:
    - Criminal convictions including any convictions, guilty pleas or adjudicated pretrial diversions for crimes against person such as murder, rape, assault and other similar crimes.
    - Financial crimes such as extortion, embezzlement, income tax evasion, insurance fraud and other similar crimes.
    - Any crime that placed the Medicaid or Medicare program or its beneficiaries at immediate risk, such as a malpractice suit that results in a conviction of criminal neglect or misconduct.
    - Any crime that would result in mandatory exclusion under section 1128 of the Social Security Act.
    - Any crime related to fraud, kickbacks, health care fraud, claims for excessive charges, unnecessary services or services which fail to meet professionally recognized standards of health care, patient abuse or neglect, controlled substances or similar crimes.

  At the time of initial credentialing, Practitioners must not have any pending criminal charges in the categories listed above.
- **Loss or limitations of clinical privileges** – At initial credentialing, Practitioners must disclose all past and present issues regarding loss or limitation of clinical privileges at all facilities or organizations with which the Practitioner has had privileges. If there is an affirmative response to the related disclosure questions on the application, a detailed response is required from the Practitioner. At recredentialing, Practitioners must disclose past and present issues regarding loss or limitation of clinical privileges at all facilities or organizations with which the Practitioner has had privileges since the previous credentialing cycle.
- **Hospital privileges** – Practitioners must list all current hospital privileges on their credentialing application. If the Practitioner has current privileges, they must be in good standing.
- **National Provider Identifier (NPI)** – Practitioners must have an NPI issued by CMS.

Notification of discrepancies in credentialing information & practitioner's right to correct erroneous information

ConnectiCare will notify the Practitioner immediately in writing if credentialing information obtained from other sources varies substantially from that provided by the Practitioner. Examples include but are not limited to actions on a license, malpractice claims history, board certification actions, sanctions or exclusions. ConnectiCare is not required to reveal the source of information if the information is obtained to meet organization credentialing verification requirements or if disclosure is prohibited by law.

Practitioners have the right to correct erroneous information in their credentials file. Practitioner rights are published on the ConnectiCare website and are included in this Provider Manual.

The notification sent to the Practitioner will detail the information in question and will include instructions to the Practitioner indicating:

- Their requirement to submit a written response within 10 calendar days of receiving notification from ConnectiCare.
- In their response, the Practitioner must explain the discrepancy, may correct any erroneous information and may provide any proof that is available.
- The Practitioner's response must be sent to:

  Molina Healthcare, Inc.
  Attention: Credentialing Director
  22522 – 29th Drive SE, #L-210
  PO Box 4004
  Bothell, WA 98041

Upon receipt of notification from the Practitioner, ConnectiCare will document receipt of the information in the Practitioner's credentials file. ConnectiCare will then re-verify the primary source information in dispute. If the primary source information has changed, the corrections will be made immediately to the Practitioner's credentials file. The Practitioner will be notified in writing that the correction has been made to their credentials file. If the primary source information remains inconsistent with the Practitioner's information, the Credentialing department will notify the Practitioner.

If the Practitioner does not respond within 10 calendar days, their application processing will be discontinued and network participation will be administratively denied or terminated.

Practitioner's right to review information submitted to support their credentialing application

Practitioners have the right to review their credentials file at any time. Practitioner rights are published on the ConnectiCare website and are included in this Provider Manual.

The Practitioner must notify the Credentialing department and request an appointment time to review their file and allow up to seven (7) calendar days to coordinate schedules. A medical director and a director responsible for credentialing or the quality improvement director will be present. The Practitioner has the right to review all information in the credentials file except peer references or recommendations protected by law from disclosure.

The only items in the file that may be copied by the Practitioner are documents which the Practitioner sent to ConnectiCare (e.g., the application and any other attachments submitted with the application from the Practitioner. Practitioners may not copy any other documents from the credentialing file.

Practitioner's right to be informed of application status

Practitioners have the right, upon request, to be informed of the status of their application by telephone, email or mail. Practitioner rights are published on the ConnectiCare website and are included in this Provider Manual. ConnectiCare will respond to the request within two (2) working days. ConnectiCare will share with the Practitioner where the application is in the credentialing process to include any missing information or information not yet verified.

Professional review committee (PRC)

ConnectiCare designates a PRC to make recommendations regarding credentialing decisions using a peer review process. ConnectiCare works with the PRC to assure that network Practitioners are competent and qualified to provide continuous quality care to ConnectiCare Members. The PRC reports to the Quality Improvement Committee (QIC). ConnectiCare utilizes information such as, but not limited to credentialing verifications, QOCs and Member complaints to determine continued participation in ConnectiCare's network or if any adverse actions will be taken. Certain PRC decisions may be appealed. To utilize this process, providers should request a fair hearing as outlined below and in ConnectiCare's policy. Please contact ConnectiCare Provider Relations representatives for additional information about fair hearings.

Notification of credentialing decisions

Initial credentialing decisions are communicated to Practitioners via letter or email. This notification is typically sent by the ConnectiCare medical director within two (2) weeks of the decision. Under no circumstance will notification letters be sent to the Practitioners later than 60 calendar days from the decision. Notification of recredentialing approvals is not required.

Recredentialing

ConnectiCare recredentials every Practitioner at least every 36 months.

Excluded Providers

Excluded Provider means an individual Provider or an entity with an officer, director, agent, manager or individual who owns or has a controlling interest in the entity who has been convicted of crimes as specified in section 1128 of the SSA, excluded from participation in the Medicare or Medicaid program, assessed a civil penalty under the provisions of section 1128or has a contractual relationship with an entity convicted of a crime specified in section 1128.

Pursuant to section 1128 of the SSA, ConnectiCare and its Subcontractors may not subcontract with an Excluded Provider/person. ConnectiCare and its Subcontractors shall terminate subcontracts immediately when ConnectiCare and its Subcontractors become aware of such excluded Provider/person or when ConnectiCare and its Subcontractors receive notice. ConnectiCare and its Subcontractors certify that neither it nor its Member/Provider is presently debarred, suspended, proposed for debarment, declared ineligible or voluntarily excluded from participation in this transaction by any federal department or agency. Where ConnectiCare and its Subcontractors are unable to certify any of the statements in this certification, ConnectiCare and its subcontractors shall attach a written explanation to this Agreement.

Ongoing monitoring of sanctions and exclusions

ConnectiCare monitors the following agencies for Practitioner sanctions and exclusions between recredentialing cycles for all Practitioner types and takes appropriate action against Practitioners when instances of poor quality are identified. If a ConnectiCare Practitioner is found to be sanctioned or excluded, the Practitioner's contract will be immediately terminated effective the same date as the sanction or exclusion was implemented.

- **The United States Department of Health and Human Services (HHS), Office of Inspector General (OIG) Fraud Prevention and Detection Exclusions Program** – Monitor for individuals and entities that have been excluded from Medicare and Medicaid programs
- **The OIG High Risk List –** Monitor for individuals or facilities who refused to enter a Corporate Integrity Agreement (CIA) with the federal government on or after October 1, 2018
- **State Medicaid exclusions** – Monitor for state Medicaid exclusions through each state's specific Program Integrity Unit (or equivalent)
- **Medicare Exclusion Database (MED)** – Monitor for Medicare exclusions through CMS MED online application site
- **Medicare Preclusion List** – Monitor for individuals and entities that are reported on the Medicare Preclusion List
- **National Practitioner Database (NPDB)** – ConnectiCare enrolls all credentialed Practitioners with the NPDB continuous query service to monitor for adverse actions on license, DEA, hospital privileges and malpractice history between credentialing cycles

- **System for Award Management (SAM)** – Monitor for Practitioners sanctioned by SAM

ConnectiCare also monitors the following for all Practitioner types between the recredentialing cycles.

- Member complaints/grievances
- Adverse events
- Medicare opt-out
- Social Security Administration Death Master File

ConnectiCare will monitor the timely renewal of healthcare licenses for all Practitioner types. In the event a Practitioner does not renew their state license prior to the expiration date, ConnectiCare may take action up to and including payment suspension for dates of service on or after license expiration or termination from applicable ConnectiCare provider networks.

Provider appeal rights

In cases where the Professional Review Committee suspends or terminates a Practitioner's contract based on quality of care or professional conduct, a certified letter is sent to the Practitioner describing the adverse action taken and the reason for the action, including notification to the Practitioner of the right to a fair hearing when required pursuant to laws or regulations.

16. Delegation

Delegation is a process that gives another entity the ability to perform specific functions on behalf of ConnectiCare. ConnectiCare may delegate:

1. Utilization management
2. Credentialing and recredentialing
3. Claims
4. Complex case management
5. CMS Preclusion List monitoring
6. Other clinical and administrative functions

When ConnectiCare delegates any clinical or administrative functions, ConnectiCare remains responsible to external regulatory agencies and other entities for the performance of the delegated activities, including functions that may be sub-delegated. To become a delegate, the Provider/accountable care organization (ACO)/vendor must be in compliance with ConnectiCare's established delegation criteria and standards. ConnectiCare's Delegation Oversight Committee (DOC)or other designated committee, must approve all delegation and sub-delegation arrangements. To remain a delegate, the Provider/ACO/vendor must maintain compliance with ConnectiCare's standards and best practices.

Delegation reporting requirements

Delegated entities contracted with ConnectiCare must submit monthly and quarterly reports. The function(s) delegated will determine such reports, which will be reviewed by ConnectiCare delegation oversight Staff for compliance with performance expectations within the timeline indicated by ConnectiCare.

Corrective action plan (CAP) and revocation of delegated activities

If it is determined that the delegate is out of compliance with ConnectiCare's guidelines or regulatory requirements, ConnectiCare may require the delegate to develop a CAP designed to bring the delegate into compliance. ConnectiCare may also revoke delegated activities if it is determined that the delegate cannot achieve compliance or if ConnectiCare determines that is the best course of action.

If you have additional questions related to delegated functions, please contact your ConnectiCare contract Manager.

17. Medicare Part D

Coverage determinations

A Part D coverage determination is a decision about whether to provide or pay for a Part D drug, a decision concerning a tiering exception request, a formulary exception request, a decision on the amount of cost sharing for a drug or whether a Member has or has not satisfied a prior authorization or other UM requirement.

Any party to a coverage determination, (e.g., a Member, a Member's representative or a Member's prescriber) may request that the determination be appealed. A Member, a Member's representative or a Provider are the only parties who may request that ConnectiCare expedite a coverage determination or redetermination.

Coverage determinations are either standard or expedited depending on the urgency of the Member's request.

Appeals/redeterminations

When a Member's request for a coverage determination is denied, Members may choose someone (including an attorney, Provider or other authorized representative) to serve as their personal representative to act on their behalf. After the date of the denial, a Member has up to 60 days to request a redetermination. This is the first level of appeal for Part D adverse decisions. Appeal data is confidential.

The redetermination request will be responded to within seven (7) days. If an expedited appeal is required for an emergent situation, then the decision will be made within 72 hours of the request.

At any time during the appeal process, the Member or personal representative may submit written comments, papers or other data about the appeal in person or in writing. If the appeal/reconsideration is denied, the Member has the right to send the appeal to the IRE within 60 days of receipt of the appeal. The IRE has seven (7) days to make a decision for a standard appeal/reconsideration and 72 hours for an expedited request. The IRE will notify ConnectiCare and the Member of the decision. When an expedited review is requested, the IRE will make a decision within 72 hours.

If the IRE changes the ConnectiCare decision, authorization for service must be made within 72 hours for standard appeals and within 24 hours for expedited appeals.

Payment appeals must be paid within 30 days from the date the plan receives notice of the reversal.

If the IRE upholds ConnectiCare's denial, they will inform the Member of their right to a hearing with the ALJ and will describe the procedures that must be followed to obtain an ALJ hearing.

CMS's IRE monitors ConnectiCare's compliance with determinations to decisions that fully or partially reverse an original ConnectiCare denial. The IRE is currently C2C Innovative Solutions, Inc. (C2C).

Part D prescription drug exception policy

CMS defines a coverage determination as the first decision made by a Plan regarding the prescription drug benefits a Member is entitled to receive under the plan, including a decision not to provide or pay for a Part D drug, a decision concerning an exception request and a decision on the amount of cost sharing for a drug.

An exception request is a type of coverage determination request. Through the exceptions process, a Member can request an off-formulary drug, an exception to the Plan's tiered cost sharing structure and an exception to the application of a cost UM tool (e.g., step therapy requirement, dose restriction or prior authorization requirement).

ConnectiCare is committed to providing access to medically necessary prescription drugs to Members of ConnectiCare. If a drug is prescribed that is not on ConnectiCare's formulary, the Member or Member's representative may file for an exception. All exceptions and appeals are handled at the Plan level (on-site) and are not delegated to another entity. Please see below for contact information by Plan for personnel who handle the exceptions. Members or the Member's representatives (who can include Providers and pharmacists) may call, write, fax or e-mail ConnectiCare's exception contact person to request an exception. Procedures and forms to apply for an exception may be obtained from the contact persons.

Part D exceptions and appeals contact information: call ConnectiCare at (800) 665-3086 or fax (866) 290-1309.

The Policy and Procedure for Exceptions and Appeals will be reviewed by a Pharmacy and Therapeutics (P&T) committee on an annual basis at minimum. Exception/prior authorization criteria are also reviewed and approved by a P&T committee.

Understanding Part D Prescription Drug Coverage

1. **Formulary** – A formulary is a list of medications selected by ConnectiCare in consultation with a team of health care Providers, which represents the prescription therapies believed to be a necessary part of a quality treatment program. ConnectiCare will generally cover the drugs listed in our formulary as long as the drug is medically necessary, the prescription is filled at a ConnectiCare network pharmacy, the prescription is being used for a medically accepted indication (i.e., either FDA approved or compendia supported for the diagnosis for which it is being used) and other plan rules are followed.

   Formularies may be different depending on the ConnectiCare plan and will change over time. Current formularies for all products may be downloaded from our website at connecticare.com.

2. **Co-payments for Part D** – The amount a patient pays depends on which drug tier the drug is in under the plan and whether the patient fills the prescription at a preferred network pharmacy.

   - Most Part D services have a co-payment
   - Co-payments cannot be waived by ConnectiCare per CMS
   - Co-payments for ConnectiCare may differ by state and plan

3. **Restrictions on ConnectiCare's Medicare Drug Coverage**

   Some covered drugs may have additional requirements or limits on coverage. These requirements and limits may include:

   - **Prior authorization:** ConnectiCare requires prior authorization for certain drugs, some of which are on the formulary and also drugs that are not on the formulary. Without prior approval, ConnectiCare may not cover the drug.
   - **Quantity limits:** For certain drugs, ConnectiCare limits the amount of the drug that it will cover.
   - **Step therapy:** In some cases, ConnectiCare requires patients to first try certain drugs to treat a medical condition before it will cover another drug for that condition. For example, if Drug A and Drug B both treat a medical condition, ConnectiCare may not cover drug B unless drug A is tried first.
   - **Part B medications:** Certain medications and/or dosage forms listed in this formulary may be available on Medicare Part B coverage depending upon the place of service and method of administration. Newly FDA approved drugs are considered non-formulary and subject to non-formulary policies and other non-formulary utilization criteria until a coverage decision is rendered by the ConnectiCare P&T committee.

4. **Non-covered ConnectiCare Medicare Part D drugs:**

   - Agents when used for anorexia, weight loss or weight gain (no mention of medically necessary)
   - Agents when used to promote fertility
   - Agents used for cosmetic purposes or hair growth
   - Agents used for symptomatic relief of cough or colds
   - Prescription vitamins and minerals, except those used for prenatal care and fluoride preparations
   - Non-prescription drugs, except those medications listed as part of ConnectiCare's over-the-counter (OTC) monthly benefit as applicable and depending on the plan
   - Out-patient drugs for which the manufacturer seeks to require that associated tests or monitoring services be purchased exclusively from the manufacturer or its designee as a condition of sale
   - ConnectiCare Members with Medicaid coverage may have a limited selection of these excluded medications as part of its Medicaid coverage for Members assigned to ConnectiCare Medicaid

- Prescriptions that are not being used for a medically accepted indication (i.e., prescriptions must either be FDA-approved or compendia supported for the diagnosis for which they are being used; the Medicare-approved compendia are American Hospital Formulary Service Drug Information (AHFS) and DRUGDEX® Information System)

5. **There may be differences between the Medicare and Medicaid formularies.** The ConnectiCare formulary includes many injectable drugs not typically found in its Medicaid formularies such as those for the aged, blind and disabled.

6. **Requesting a ConnectiCare Medicare formulary exception –** ConnectiCare Medicare product drug prior authorizations are called exceptions, which are required when your patient needs a drug that is not on the formulary. A Member, a Member's appointed representative or a Member's prescribing Provider are permitted to file an exception. (The process for filing an exception is predominantly a fax based system.) The form for exception requests is available on the ConnectiCare website.

   Requesting a ConnectiCare Medicare formulary redetermination (appeal) – The appeal process involves an adverse determination regarding ConnectiCare issuing a denial for a requested drug or claim payment. If the Member received a Notice of Denial of Medicare Prescription Drug Coverage and disagrees with the decision rendered, they may request a redetermination (appeal) from ConnectiCare by completing the appeal form sent with the Notice of Denial.

   A Member, a Member's appointed representative or a Member's prescribing Provider (for expedited appeals) may complete the appeal form and submit any information which may help ConnectiCare with the processing of the appeal. An appeal must be submitted in writing and filed within 60 calendar days from the date that the determination was rendered.

   - A standard appeal may be submitted to ConnectiCare in writing. The appeal will be reviewed upon receipt and the Member will be notified in writing within seven (7) calendar days from the date the request for re-determination is received.
   - An expedited appeal can be requested by the Member or by a Provider acting on behalf of the Member in writing or can be taken over the phone. An expedited appeal may be requested in situations where applying the standard time frame could seriously jeopardize the Member's life, health or ability to regain maximum function. If a Provider supports the request for an expedited appeal, ConnectiCare will honor this request.
   - If a Member submits an appeal without Provider support, ConnectiCare will review the request to determine if it meets Medicare's criteria for expedited processing. If the plan determines that the request meets the expedited criteria, ConnectiCare will render a decision as expeditiously as the Member's health requires, but not exceeding 72 hours. If the request does not meet the

expedited criteria, ConnectiCare will render a coverage decision within the standard redetermination time frame of seven (7) calendar days.

- To submit a verbal request, please call (800) 665-3086. Written appeals must be mailed or faxed to (866) 290-1309.

7. **Initiating a Part D coverage determination request –** ConnectiCare will accept requests from Providers or a Member's appointed representative on the behalf of the Member either by a written or verbal request. The request may be communicated through the standardized ConnectiCare Medication Prior Authorization Request Form or through telephone via fax and telephone lines. All requests will be determined and communicated to the Member and the Member's prescribing Provider with an approval or denial decision within 72 hours/3 calendar days after ConnectiCare receives the completed request.

   ConnectiCare will request the submission of additional information if a request is deemed incomplete for a determination decision. All requests may be approved by: 1) ConnectiCare Pharmacy Technician under the supervision of a pharmacist; 2) ConnectiCare Pharmacist; or, 3) Chief Medical Officer (CMO) of ConnectiCare. Review criteria will be made available at the request of the Member or their prescribing Provider. ConnectiCare will determine whether a specific off-label use is a medically accepted indication based on the following criteria:

   a. A prescription drug is a Part D drug only if it is for a medically accepted indication, which is supported by one or more citations included or approved for inclusion with the following compendia:
      - American Hospital Formulary Service Drug Information
      - DRUGDEX Information System

   b. Requests for off-label use of medications will need to be accompanied with excerpts from one of the two (2) CMS-required compendia for consideration. The submitted excerpts must cite a favorable recommendation.

   c. Depending upon the prescribed medication, ConnectiCare may request the prescribing Provider to document and justify off-label use in clinical records and provide information such as diagnostic reports, chart notes and medical summaries.

      Denial decisions are only given to the Member or Member's representative by a Pharmacist or CMO of ConnectiCare. The written denial notice to the Member (and the prescriber involved) includes the specific rationale for denial; the explanation of both the standard and expedited appeals process; and an explanation of a Member's right to and conditions for, obtaining an expedited appeals process.

If ConnectiCare denies coverage of the prescribed medication, ConnectiCare will give the Member a written notice within 72 hours explaining the reason for the denial and how to initiate the appeals process. If no written notice is given to the Member within the specified timeframe, ConnectiCare will start the next level of appeal by sending the Coverage Determination request to the IRE within 24 hours.

If a coverage determination is expedited, ConnectiCare will notify the Member of the coverage determination decision within the 24 hour timeframe by telephone and mail the Member a written expedited coverage determination within three (3) calendar days of the oral notification. If ConnectiCare does not give the Member a written notification within the specified time frame, ConnectiCare will start the next level of appeal by sending the coverage determination request to IRE within 24 hours.

8. **Initiating a Part D appeal –** If ConnectiCare's initial coverage determination is unfavorable, a Member may request a first level of appeal or re-determination within 60 calendar days from the date of the notice of the coverage determination. In a standard appeal ConnectiCare has up to seven (7) days to make the re-determination, whether favorable or adverse and notify the Member in writing within seven (7) calendar days from the date the request for re-determination is received. Members or a Member's prescribing Provider may request ConnectiCare to expedite a redetermination if the standard appeal timeframe of seven (7) days may seriously jeopardize the Member's life, health or ability to regain maximum function. ConnectiCare has up to 72 hours to make the re-determination, whether favorable or adverse and notify the Member in writing within 72 hours after receiving the request for re-determination. If additional information is needed for ConnectiCare to make a re-determination, ConnectiCare will request the necessary information within 24 hours of the initial request for an expedited re-determination. ConnectiCare will inform the Member and prescribing Provider of the conditions for submitting the evidence since the timeframe is limited on expedited cases.

9. **The Part D Independent Review Entity (IRE) –** If the re-determination is unfavorable, a Member may request reconsideration by the IRE. The Part D Qualified Independent Contractor is currently C2C, a CMS contractor that provides second level appeals.

   - **Standard appeal:** The IRE has up to seven (7) days to make the decision.
   - **Expedited appeal:** The IRE has up to 72 hours to make the decision.
   - **Administrative Law Judge (ALJ):** If the IRE's reconsideration is unfavorable, a Member may request a hearing with an ALJ if the amount in controversy requirement is satisfied. Note: Regulatory time frame is not applicable on this level of appeal.
   - **Medicare Appeals Council (MAC):** If the ALJ's finding is unfavorable, the Member may appeal to the MAC, an entity within the Department of Health

and Human Services that reviews ALJ's decisions. Note: Regulatory timeframe is not applicable on this level of appeal.

- **Federal District Court (FDC) –** If the MAC's decision is unfavorable, the Member may appeal to a federal district court, if the amount in controversy requirement is satisfied. Note: Regulatory timeframe is not applicable on this level of appeal.

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