Bright HealthCare™ 2022 Provider Manual

Medicare Advantage

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Welcome to Bright HealthCare!

This manual outlines key program requirements for Bright HealthCare's Medicare Advantage Plan. Program requirements are protocols, payment policies, and other administrative regulations that define Bright HealthCare's business requirements for network providers. For a more specific definition of program requirements, please refer to your Network Participation Agreement. Additional program requirements can be found in other Bright HealthCare policy documents provided separately from this manual. For information on Bright HealthCare's Medicare plans, please refer to **Availity.com**. Log in using your credentials provided when you completed registration for Availity.

We're building partnerships

Bright HealthCare strives to partner with providers who share our passion of elevating primary care.

We help your patients improve their health

Our plans encourage preventive care, which leads to healthier, more highly-engaged patients.

We're here to support your community

We know that every community has different needs. That's why we're committed to working with you to develop community-specific healthcare solutions.

We tailor our partnership to fit your needs

Our Vision

Collaborating with Care Partners to make healthcare simpler, personal, and more affordable.

Our Mission

Making healthcare right. Together.

Our Values

Be: Purposeful, Respectful, Authentic, Brave and Positive

Updates and Revisions

This provider manual is a dynamic tool and will evolve with Bright HealthCare. Written communication will accompany any material changes made to this manual.

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Section One:
Provider Roles & Expectations

Provider Rights

Providers have the right to freely communicate with patients about treatment options available to them, including medication treatment options, regardless of benefit coverage limitations.

Provider Roles and Responsibilities

- Confirm member eligibility and benefits prior to rendering services
- Confirm any limitations, exceptions, and/or benefit exclusions applicable to Bright HealthCare members
- Cooperate with Bright HealthCare's Case Management and Utilization Management Program
- Where applicable, obtain prior authorization before rendering services
- Communicate member information to Bright HealthCare, as appropriate under HIPAA
- Maintain confidentiality of medical information in compliance with all state and federal regulatory agencies, including HIPAA
- Maintain legible and comprehensive medical records for each member encounter that conform to documentation standards for ten years
- Provide Bright HealthCare with advance notice of providers joining or leaving their practice, as described in the Network Participation Agreement
- Cooperate with Bright HealthCare to achieve effective and efficient discharge, post-discharge, and follow-up procedures for members
- Cooperate with Bright HealthCare in investigating and resolving member grievances and appeals
- Comply with Bright HealthCare credentialing requirements, including state credentialing application with CAQH
- Follow the billing guidelines provided in the Claims & Provider Reimbursement section for risk delayed or denied payments
- Follow rules for requesting reconsideration of claims payment decisions and for resolution of overpayments and underpayments
- Refer members to Bright HealthCare in-network providers
- Adhere to the applicable standards of care, professional code of conduct, and facility accreditation and quality standards

- Report any potential fraud, waste, and abuse
- Update Bright HealthCare when there are changes to provider demographic and billing information
- Conduct an audit of provider demographic and billing information in accordance with your Network Participation Agreement
- Comply with all state rules and regulations, as well as other applicable regulations

Rights in the Case of Disruptive Member Behavior

If, after reasonable effort, the member's primary care provider (PCP) or any other contracted provider is unable to establish and maintain a satisfactory relationship with a patient and member of Bright HealthCare, the provider may request that the member be discharged from care and transferred to an alternate network provider. The PCP must submit the request in writing to Bright HealthCare Member Services. Please refer to Appendix 1 for contact information. Reasons for discharge may include but are not limited to:

- Disruptive behavior
- Physical threats
- Physical abuse and verbal abuse
- Gross non-compliance with the treatment plan

Note: Physical abuse and other behavior that is a danger to the physician or the member warrants immediate action, which must be documented. Please notify the proper law enforcement authorities and Bright HealthCare Member Services immediately.

Note: The PCP must provide adequate documentation in the member's medical record of the verbal and written warnings. In the absence of an emergency created by abusive member behavior, the provider is obligated to provide care to the member until it is determined that the member is under the care of another physician.

Advanced Directives

The Federal Patient Self-Determination Act grants patients the right to participate in healthcare decision making, including decisions about withholding resuscitative services or declining/withdrawing life sustaining treatment. In accordance with guidelines established by the Centers for Medicare & Medicaid Services (CMS), and our own policies and procedures, Bright HealthCare requires all participating providers to have a process in place pursuant to the intent of the Patient Self Determination Act.

Participating providers must document in a prominent part of the Bright HealthCare member's current medical record whether or not the member has executed an Advance Directive. Advance Directives are written instructions, such as living wills or durable powers of attorney for healthcare, recognized under the law of the state and signed by a patient, that explain the patient's wishes concerning the provision of healthcare if the patient becomes incapacitated and is unable to make those wishes known.

Participating providers are not required to provide care that conflicts with an advance directive. In addition, participating providers shall not, as a condition of treatment, require a member to execute or waive an advance directive.

Participating providers should inform members that any complaints concerning noncompliance with advance directive requirements may be filed with the appropriate state governing body.

Using Availity.com

Bright HealthCare uses **Availity.com**, a multi-payer platform, to facilitate key electronic transactions and share information. Providers can register for an account directly with Availity.

Once registered, log into your account to:

- Verify member eligibility and benefits
- File claims electronically
- Check claims status and electronic remittance
- Access key information and documents from the Bright HealthCare Payer Spaces tab
- Find prior authorization lists, forms, and instructions
- Evidence of Coverage (EOCs) and Summaries of Access Benefits and Coverage (SBCs) resources
- Quick Reference Guide
- A copy of this Provider Manual
- Bright HealthCare news, tools, and resources

Notice of Privacy Practices

Pursuant to regulations under the Health Insurance Portability and Accountability Act (HIPAA), all covered entities, including participating providers, must provide adequate notice of the provider's privacy practices and an individuals' rights with respect to their personal health information. Bright HealthCare, as a health plan, must give notice to you at enrollment, and send reminders of your right to request notice at least once every three years. Bright HealthCare will always give notice to the "name insured" but is not required to give separate notices to spouses and dependents. Participating providers should have such notice available at their office upon request by any member and should post the notice in a clear and prominent location, or take any additional steps as required by HIPAA for their particular type of practice.

Credentialing Process

Bright HealthCare is dedicated to providing our members with access to high-quality, affordable healthcare. Credentialing ensures that our members have access to providers who demonstrate consistent delivery of high-quality care. Credentialing for Bright HealthCare's provider networks is performed by Bright HealthCare personnel or delegated to a provider entity on behalf of Bright HealthCare, as applicable.

Bright HealthCare utilizes the state-mandated Professional Credentials Application for gathering data about providers for initial credentialing, and every 36 months thereafter for recredentialing purposes. Providers should file applications with the Council for Affordable Quality Healthcare (CAQH) to streamline the credentialing process. Bright HealthCare utilizes a Credentialing Verification Organization (CVO) vendor, Aperture Credentialing, LLC, to access CAQH application information and conduct primary source verification of provider credentials. Providers may be contacted by Aperture on behalf of Bright HealthCare.

For more information about Bright HealthCare's credentialing process, please visit **BrightHealthCare.com/provider/resource/credentialing.**

Provider Credentialing

Providers should ensure that their CAQH profile has a current attestation within the last 180 days and that they have authorized Bright HealthCare to access their application. Providers can go to **CAQH.org/solutions/caqh-proview-faqs** for detailed information on how to obtain a CAQH number and how to create or edit their application.

Bright HealthCare credentials providers who are licensed, certified or registered by the state to practice independently without direction or supervision. Per our policy these are **examples** of Providers to be credentialed and re-credentialed under the scope of our policies and URAC requirements.

Medical:

- Allopathic Physician of Medicine and Surgery (MD)
- Osteopathic Physician of Medicine and Surgery (DO)
- Doctor of Dentistry (DDS)
- Doctor of Medical Dentistry (DMD)
- Doctor of Optometry (OD)

Allied Health Professionals:

- Physician Assistant
- Clinical Psychologist (Ph.D.)
- Advanced Practice Registered Nurse (APRN)
- Certified Nurse Midwife (CNM)
- Licensed Professional Counselor (LPC)
- Licensed Clinical Social Worker (LCSW)
- Licensed Marriage Family Therapist (LMFT)
- Physical/Occupational Therapist (PT/OT)

Facility Credentialing

We do not require facilities applying for participation with Bright HealthCare to use CAQH. Instead, facilities should complete and submit Bright HealthCare's Facility Credentialing Application. Please contact Bright HealthCare to obtain the application, which also includes a detailed list of the specific types of facilities that Bright HealthCare credentials. Bright HealthCare collects Facility Credentialing Applications on an individual Tax Identification Number (TIN) level. As part of the application, the facility entity is required to submit copies of the following items:

- Current and valid state license
- Certifications and Accreditation Certificates

  Note: If unaccredited, include a copy of the most recent CMS Survey or State Survey indicating the facility is in substantial compliance (include the Corrective Action Plan and Approval Letter, if applicable)

- Declaration sheet and certificate of insurance
- Current professional malpractice
- Comprehensive general liability insurance policies
- Copy of Medicare Participation Number/CMS Certification Number (CCN)
- Signed and dated complete attestation

A facility only needs to submit one copy of each required attachment for all locations that use the associated TIN, *unless* one of the locations differs (i.e., one location has separate insurance from other locations). For each separate location, include additional state license(s), accreditation(s), and certificates of insurance for each Group NPI associated with the TIN.

If you have any further questions, please contact us at **FacilityCredentialing@BrightHealthGroup.com**

Post-application Collection

For both professional and facility applicants, following successful application collection and primary source verification, Bright HealthCare's Credentialing Committee makes the final determination on whether a provider will be added to Bright HealthCare's network.

Bright HealthCare retains the right to approve, suspend, or terminate individual physicians, healthcare professionals, or where it has delegated credentialing decision making. Submission of a credentialing application and required documentation does not guarantee inclusion in Bright HealthCare's network(s). Each applicant will receive a written response regarding the Credentialing Committee's decision, sent within 10 business days of the Committee review date.

Bright HealthCare conducts regular reviews to verify the credentials of network providers. This process includes monthly monitoring of the Medicare and Medicaid sanctions, state sanctions and limitations on licensure, and complaints. We use the Office of Inspector General (OIG) published sanction lists and National Practitioner Data Bank (NPDB), among other sources.

Bright HealthCare does not make credentialing and recredentialing decisions based on an applicant's race, ethnic/national identity, gender, age, sexual orientation, the types of procedures the applicant performs, or the patients for whom the provider renders services. This does not preclude Bright HealthCare from including providers in our network who meet certain demographic or specialty needs to fulfill the cultural needs of our members.

For More Information

If you are unsure of your credentialing status or have questions about the credentialing process, please contact Bright HealthCare Credentialing at **Credentialing@BrightHealthPlan.com** or **FacilityCredentialing@BrightHealthGroup.com** or refer to Appendix 1 for additional contact information.

For more information about Bright HealthCare's credentialing process, please visit **BrightHealthCare.com/provider/resource/credentialing.**

Credentialing Requirements

Bright HealthCare requires all providers being directly credentialed to submit a fully completed credentialing application. Submit the required documentation listed below to CAQH.

Note: Providers delegated for credentialing by Bright HealthCare will be directly credentialed by their respective delegated entity and should submit applications through that entity's preferred process.

Professional Application Requirements

Professional credentialing applications, whether directly credentialed or delegated by Bright HealthCare, must contain the following elements:

- **State license:** A current, valid, and unrestricted license to practice in the state in which the provider will treat Bright HealthCare members
- **DEA/CDS:** For prescribing providers, a current and unrestricted Drug Enforcement Administration (DEA) registration and/or CDS certification from each state in which the provider treats Bright HealthCare members, if applicable. A copy of the DEA/CDS certificate must include effective and expiration dates
- **Education and training:** Graduation from an accredited medical school or accredited profession training program, internship, residency training program, and any applicable fellowships
- **Board certification:** Board certification is required for all physicians to participate in Bright HealthCare's provider network

  Individual exceptions may apply, if explained and approved
- **Current malpractice insurance**: Malpractice insurance must be current with acceptable minimum amounts. Providers must provide a cover sheet with their name, the effective dates, and covered amounts indicated
- **Malpractice history:** A list of all liability claims history, including details for any claims within the last ten years
- **Hospital affiliations:** A listing of hospital affiliations and privileges, if applicable
- **Work history (N/A for recredentialing):** A chronological, relevant work history for at least the past five years, including month and year
    - All gaps of six months or more must be explained by the provider in writing
    - If the provider has practiced for fewer than five years, professional work history starts at the time of initial licensure
- **History of state and federal sanctions:** A listing of all sanctions or penalties imposed by licensing boards, government entities, and managed care organizations, along with a written explanation for each

- **Additional disclosures:** Disclosure of any physical, mental, or substance abuse problems that could, without reasonable accommodation, impede the provider's ability to provide care according to accepted standards of professional performance or pose a threat to the health or safety of patients
- **Attestations:** Providers must sign and date a statement attesting that the information submitted within the credentialing application is complete and accurate to the provider's knowledge. The provider must additionally sign and authorize Bright HealthCare to collect any information necessary to verify the information within the credentialing or recredentialing application

The application is required for both initial credentialing and recredentialing. It also contains questions regarding:

- Reasons for inability to perform the essential functions of the position
- Lack of present illegal drug use
- History of loss of license
- License sanctions
- Disciplinary actions or felony convictions
- History of loss or limitation of clinical privileges
- Current malpractice insurance

Recredentialing Requirements

The recredentialing process takes place at least every 36 months for both professionals and facilities. For professionals, the provider credentialing application is required each time. A previously completed copy may be submitted with any updates or changes noted but must include an updated attestation. The credentialing requirements listed above are reviewed and verified with each application submission. The Credentialing Committee may also incorporate the following information into the recredentialing decision making process:

- Member grievances
- Provider complaints
- Quality of care concerns
- Monthly monitoring activities
- Provider office site quality issues
- Medical malpractice actions

Ongoing Provider Monitoring

Bright HealthCare monitors, identifies, and when appropriate, acts on important quality and safety issues in a timely manner during the interval between formal credentialing and recredentialing.

For providers that Bright HealthCare directly credentials, Bright HealthCare will review reports monthly regarding:

- Medicare/Medicaid sanctions
- Monitoring of Medicare opt-out
- Sanctions or limitations on licensure
- Provider adverse events
- Member complaints

Substantiated complaints or identified issues will be incorporated in the provider's credentialing file and will be considered at the time of recredentialing.

When Bright HealthCare identifies such issues, we will make a determination if there is evidence of poor quality that could affect the health and safety of members, and depending on the nature of the event, implement appropriate interventions.

If a provider is suspended or terminated due to reasons that qualify as reportable under state and federal regulations, Bright HealthCare will report such actions to the appropriate regulatory body. Bright HealthCare does not report administrative terminations based on failure to meet contractual obligations for participation in the network.

As required in their Network Participation Agreements, network providers must report any of the adverse events described above to Bright HealthCare as soon as reasonably possible, and in any event within the time limits outlined in the Network Participation Agreement.

For provider entities to which credentialing and recredentialing activities are delegated on Bright HealthCare's behalf, the provider entity will provide ongoing monitoring and reporting of such monitoring to Bright HealthCare. Monitoring under this section shall include monitoring of any adverse or formal actions against a provider, including actions by CMS, any state agency, or any licensing or accreditation body. Monitoring under this section shall additionally include monitoring for complaints against a provider, even to the extent that such complaint does not result in formal action against the provider. Monitoring procedures must ensure that any complaint or action against a provider is reviewed within 30 days of its release.

Provider Rights Regarding Credentialing

Each applicant seeking credentialing through Bright HealthCare has the right to:

- Receive the status of their credentialing or recredentialing application upon request
- Request to review information submitted to support their credentialing application
- Correct erroneous information provided for credentialing by phone or in writing (refer to Appendix 1 for contact information)

If any information obtained through the credentialing verification process is found to be significantly disparate from the information provided by the provider, the applicant will be contacted by the Bright HealthCare credentialing team and provided an opportunity to explain the discrepancy, prior to issuance of a negative credentialing decision. The provider may not review references, recommendations, or other information that is peer-review protected, and Bright HealthCare is not required to reveal the source of information if law prohibits disclosure. Upon request, the provider may contact the Credentialing Department to inquire about the status of their application, including the date Bright HealthCare received the application, the date the application went into process, and/or the date that we mailed the determination letter.

Provider rights regarding credentialing are detailed fully in the Bright HealthCare Policy and Procedure Provider Credentialing Guidelines.

Provider Appeal Rights and Fair Hearing Plan

Bright HealthCare makes every effort to ensure providers are treated fairly. Bright HealthCare has a well-defined appeal process regarding provider appeal rights for negative credentialing or recredentialing decisions, and provider appeal rights in the case of suspensions, terminations, or other change in participation in the Bright HealthCare network.

- For initial credentialing determination appeals, send a formal appeal letter to:
  Bright HealthCare Credentialing
  777 NW Blue Pkwy Suite 3350
  Lee's Summit, MO 64086
- All written requests must be received within 30 days of the date notification letters were sent.
- Notification of appeal should include additional supporting documentation in favor of the applicant's reconsideration for network participation.
- Reconsideration/appeals with additional information will be reviewed by Bright HealthCare's Senior Medical Director (or independent participating provider designee) at a Credentialing Committee hearing within 60 calendar days of receipt of written appeal.
- Bright HealthCare will inform the provider of a specific date when the hearing is scheduled.
- We will notify the provider of the decision within 10 days of the reconsideration/appeal decision.
- If the initial decision of denial of participation is upheld, then the provider may not apply for participation in Bright HealthCare's network earlier than 12 months from the final reconsideration/appeal decision date.

These rights are fully detailed in Bright HealthCare's Policy and Procedure for Fair Hearing Plan. You may request a copy of this document by contacting Bright HealthCare Provider Services. Refer to Appendix 1 for contact information.

Provider Directory

The provider directory is available on Bright HealthCare's website, **BrightHealthCare.com**. Bright HealthCare makes every effort to ensure information available through the provider directory is current, accurate, and consistent with information obtained during the credentialing process, as well as through ongoing audits and provider data quality initiatives. Bright HealthCare makes timely updates to the directory as new information is received and validates the information on a regular basis.

Providers are required to supply Bright HealthCare with accurate, complete, and up-to-date information (in a format requested by Bright HealthCare) for inclusion in the provider directory, and to notify Bright HealthCare of changes in demographic data that affect the provider directory. Additionally, Bright HealthCare expects that each provider assists in assuring the accuracy of the information provided by reviewing what is being displayed for themselves and providing notification of any discrepancies or erroneous information as soon as possible. Refer to Appendix 1 for contact information.

Effective Date

Bright HealthCare will confirm that the information provided in member materials and the provider directory is consistent with the information obtained during the independent direct credentialing process or data provided by Bright HealthCare's delegated entities with credentialing authority, as well as through ongoing audits and provider data quality initiatives. Providers will enter the provider directory after credentialing is complete and Bright HealthCare has received the minimum roster data requirements. Bright HealthCare will not pay claims to a provider or add a provider to the directory prior to their effective date of credentialing. Bright HealthCare will provide providers with formal notification of the effective date of passing credentialing.

Covering Physicians

Bright HealthCare's participating providers must arrange for coverage of their practice 24 hours a day, 7 days a week. The covering physician must be a Bright HealthCare participating provider. If the covering physician is not in your group practice, you must notify Bright HealthCare to prevent claims payment issues.

Closed Panels

If a participating provider wishes to close their panel, the request must be made to Bright HealthCare in writing and in advance of such closure, in accordance with your Network Participation Agreement. The participating provider's panel must be closed to all new patients, not only to Bright HealthCare members. Once a panel is closed, it may not be opened to allow only select members to enter.

National Provider Identifier Requirements

As required by the Health Insurance Portability and Accountability Act (HIPAA), rendering, referring, attending, and supervising providers must be identified on electronic claims by their National Provider Identifier (NPI). These providers must be enrolled and their NPI must be on record with the fiscal agent for the billing provider to be paid. Atypical providers are not required to have an NPI.

Regulatory Requirements Addendums

One or more regulatory appendices may be attached to this Provider Manual, setting forth additional provisions included in the Network Participation Agreements in order to satisfy regulatory requirements related to specific types of benefit plans. Such additional provisions are incorporated by reference into this Provider Manual and into the Network Participation Agreement. The parties agree to comply with all such regulatory requirements for those types of benefit plans to which the regulatory requirements apply, and to ensure that their employees, subcontractors, affiliates, and network providers understand and adhere to the regulatory provisions. To the extent that the regulatory requirements are inconsistent with other provisions of the Network Participation Agreement, including those provisions found in other exhibits, appendices, and attachments, the regulatory requirements will prevail for those benefit plans to which the regulatory requirements apply.

Section Two: Member Eligibility

Member Enrollment

Medicare's Open Enrollment Period (OEP) is from October 15 - December 7 of each year.

The 21st Century Cures Act eliminated the Medicare Advantage (MA) disenrollment period that took place from January 1st through February 14th of each year and, effective calendar year 2019, replaced it with a new MA OEP that takes place from January 1st through March 31st annually. The new OEP allows individuals enrolled in an MA plan, including newly MA-eligible individuals, to make a one-time election to enroll in another MA plan or Original Medicare. Individuals using the OEP to make a change may make a coordinating change to add or drop Part D coverage.

Note that members with a chronic condition have a Special Election Period (SEP) to join a Chronic Special Needs Plan (C-SNP) anytime during the year.

Member Eligibility

Bright HealthCare will disclose member eligibility and benefits to both in-network and out-of-network providers who provide the necessary member information in compliance with HIPAA rules and regulations.

Eligibility information will be given to the provider based on date of service and our eligibility records at the time of the request.

Bright HealthCare prefers providers obtain member eligibility information from the Provider Portal, **Availity.com**. The following information is required:

- Requesting provider's NPI
- Member ID
- Member first and last name
- Member date of birth

Providers may also contact Bright HealthCare Provider Services to confirm eligibility (refer to Appendix 1 for contact information). Providers must be able to provide the following information to request member eligibility:

- Member first and last name
- Member ID
- Member date of birth
- Date of service

Section Three:
Member Benefits & Service

Health Plan Benefit Summary

Benefits are limited to covered health services included in the member's specific plan Evidence of Coverage (EOC) document. All covered healthcare services are subject to the limitations and exclusions contained in the Limitations/Exclusions section of the EOC. The EOC and Summary of Benefits for each plan are located on **Availity.com.**

Coverage is only available under the following conditions:

- Unless otherwise specified, services or supplies are medically necessary as defined in the EOC and in Bright HealthCare's medical policies and coverage guidelines
- Covered healthcare services are received while the policy is in effect
- The person who receives covered healthcare services is a covered person and meets all eligibility requirements specified in the EOC

Additionally, most healthcare services should be provided by an in-network provider. Exceptions include emergency services, out-of-area urgently needed services, and any covered out-of-network (OON) benefits as outlined in the EOC.

Bright HealthCare Medicare Advantage plans

Bright HealthCare offers several Medicare Advantage plans in your market. All plans include both medical and prescription drug benefits (MAPD plans). Some plans also include coverage for out-of-network services. For a list of plans specific to your market, please reference the plan lists in Appendix 1 or your Network Participation Agreement. If you have any additional questions, please contact Bright HealthCare Provider Services (refer to Appendix 1 for contact information).

Bright HealthCare HMO plans use a primary care provider (PCP) gatekeeper model, which require referrals for members to access in-network care from specialists. Note: We do not require referrals in Florida.

HMO Plans

Bright HealthCare's Health Maintenance Organization (HMO) plans generally offer the most affordable cost sharing for in-network services and improved maximum out-of-pocket protection for members. Additionally, many Bright HealthCare HMOs include supplemental benefits such as dental, vision, hearing benefits, and transportation services. All markets have a $0 premium HMO plan option available.

PPO Plans (Florida Only)

Bright HealthCare Preferred Provider Organization (PPO) plans offer in-network coverage like our HMO plans. In addition, these plans also offer out-of-network coverage for all Medicare-covered services. Members are responsible for a coinsurance payment (percentage of the total cost) for services received outside of the Bright HealthCare network. Members will generally have fixed copays and get the best value when they receive services within the network.

Low-income Plans

Bright Advantage Assist is the filed name for plans designed for individuals that receive Extra Help or Low-Income Subsidy (LIS) from the Federal Government but do not receive full Medicaid benefits. These plans optimize the application of a member's subsidy to limit the member's out-of-pocket responsibility and to add additional benefits that support a member's access to care.

Special Needs Plans (SNP)

Bright HealthCare offers D-SNP and C-SNP plans.

D-SNP members have $0 cost-share for all Medicare-covered services on this plan and must be held harmless for all associated cost sharing. The state Medicaid program covers eligible cost sharing on behalf of the members. Individuals must be dually eligible for both Medicare and Medicaid to enroll in these plans.

C-SNP members receive competitive cost sharing for most services and rich supplemental benefits, such as $0 transportation and meals. Additionally, members may be able to receive insulin for a $0 copay. To be eligible for the C-SNP, members must be diagnosed with chronic conditions. For more information on these plans, please reference the Evidence of Coverage documents located on **Availity.com.**

Section Four:
Claims & Provider Reimbursement

Timely Filing

Bright HealthCare requests that claims be submitted within 365 days from the date of service in accordance with CMS Guidelines.

Bright HealthCare Responsibilities

Definition of "clean claim": A claim that has no defect, impropriety, lack of any required substantiating documentation, or circumstance requiring special treatment that prevents timely payment, and otherwise conforms to the clean claim requirement for equivalent claims under Original Medicare.

Bright HealthCare has the following responsibilities with respect to the provider:

- Provide information about requirements for filing claims
- Notify providers of changes in standard forms, instructions, or requirements in advance of the change
- Determine whether sufficient information has been submitted to allow proper consideration of a claim and notify providers if additional information is needed
- Provide appropriate explanations for denied claims
- Approve, deny, or settle all clean claims within 30 days of receipt
- Approve, deny, or settle all other claims (except fraudulent claims) within 90 days, or the time period specified in the provider's Network Participation Agreement
- Apply interest and/or penalties to clean claims paid outside of the applicable regulatory time limit under federal law

Bright HealthCare processes claims billed by Participating Providers for covered services with timeliness, accuracy, and the member rights set forth by CMS. If clean claims are not reimbursed within 30 days, then Bright HealthCare agrees to pay interest as set forth by the Department of Treasury pursuant to the federal Prompt Payment Act. The prevailing interest rate can be obtained from the Bureau of the Fiscal Service, at **Fiscal.Treasury.gov**. Unless prohibited by the Network Participation Agreement, Bright HealthCare has the right to pay the lesser of the contract rate or billed charges.

For reimbursement rates tied to original Medicare rates, such as "percentage of Medicare allowable," Bright HealthCare will base the reimbursement on the prevailing rate for Original Medicare in the locality and the date of service in which the member is treated by the provider, unless the Network Participation Agreement specifically requires otherwise.

Unless otherwise stated in your Network Participation Agreement, Bright HealthCare will:

- Apply the prevailing Medicare sequestration reduction imposed by the Budget Control Act of 2011, as amended, for services provided
- Apply the prevailing CMS payment rules for Original Medicare for HACs and Serious 17

Reportable Events

Bright HealthCare will reduce payment for those portions of the claims that are attributable to Hospital-Acquired Conditions (HACs) and Serious Reportable Events in accordance with CMS payment rules under the Deficit Reduction Act of 2005 and Section 3008 of the Affordable Care Act. These actions include:

- Apply multiple procedure payment reductions
- Not apply bonuses, penalties, or other adjustments to reimbursement related to the Merit-based Incentive Payment System, in Alternative Payment Models, or in other CMS performance-based payment programs
- Apply industry standard coding adjustments (such as CMS coding standards and guidelines) to editing, bundling, or re-bundling a primary procedure for those services that are a part of, incidental to, or inclusive of the primary procedure, and make other reasonable and appropriate adjustments to billing or coding consistent with industry standards, including without limitation inappropriate billing or coding
- Apply Bright HealthCare fee schedule for those codes not valued by Medicare
- Update fee schedules to align with the Medicare fee for service updates within 60 days of the effective date of the CMS update. Claims processed before the fee schedule updates are loaded will be paid at the previous rates

Provider Billing Responsibilities

Providers rendering services to Bright HealthCare members have the following responsibilities in relation to billing:

- Verify member eligibility prior to rendering services (except in the case of emergencies)
- Verify that the service is a covered service under the member's benefit plan with reference to the Evidence of Coverage (EOC)
- Ensure they have met appropriate prior authorization requirements
- Ensure they file claims using appropriate coding standards as established by CMS
- Verify place-of-service codes are correct
- Verify diagnosis and/or procedure codes match the service(s) provided

When completing a claim form:

- Complete all required data elements
- Leave non-required data fields blank (do not enter N/A)
- Use only black or dark red ink on any handwritten paper claim
- Use only high-quality toner, typewriter, or printer ribbons/cartridges for paper claims
- Do not use highlighters to mark claims or attachments
- Attach all required documentation to the claim
- If several claims require the same attachment, a photocopy of the attachment must be submitted with each claim
- Submit initial claims within 90 days or as specified in the Network Participation Agreement
- Bill third parties that are primary payers prior to submitting claims to Bright HealthCare.

Providers are required to submit clean claims to Bright HealthCare for all services rendered to Bright HealthCare members.

EDI Clearinghouses

Electronic Data Interface (EDI) for Bright HealthCare is Payer ID: BRGHT. Providers can submit a paper claim or use another clearinghouse, including Availity, Emdeon, Gateway, Relay Health, and other EDI clearinghouses if they so desire. Bright HealthCare accepts claims electronically through clearinghouses or through direct batch file submissions in the HIPAA5010 version of the 837-file format.

Although we prefer EDI, we accept paper claims in current CMS HCFA1500 or UB04/CMS 1450 formats. To process claims in a timely and accurate manner, providers must follow standard billing requirements and the requirements listed above.

Providers may also reference the following resources when completing claims submissions:

- CMS 1500 Physician's Manual

  Medicare Billing: Form CMS-1500 and the 837 Professional
- UB04 Billing Manual

  Medicare Billing: Form CMS-1450 and the 837 Institutional
- ICD-10-CM Code Book

  Medicare Learning Network – Information and Resources for Submitting Correct ICD-10 Codes to Medicare
- Physicians' "Current Procedural Terminology" (CPT)
  AMA – Finding coding resources

Overpayments/Underpayments

Overpayments and Underpayments

Overpayments and underpayments may be identified by the provider or by Bright HealthCare and will follow the time period and other terms defined in the provider's Network Participation Agreement.

For purposes of this manual, a provider's request for a claim adjustment or a claim reconsideration, as described in more detail below, will be defined as a "payment dispute." To initiate a provider payment dispute, providers should follow the steps in this section. While the provider's Network Participation Agreement may contain varying time limits, Bright HealthCare asks that the provider payment dispute be submitted within **180 days of the original explanation of payment (with the contractual time limit ultimately controlling)**. Correspondence related to overpayments/underpayments should be sent to the mailing address located in the contact information in Appendix 1.

If Bright HealthCare notifies the provider of an overpayment, the provider has 60 days (or such longer time limit granted under the Network Participation Agreement) to dispute or reimburse Bright HealthCare for the overpayment. If the provider does not reimburse or dispute the overpayment amount within the required time limit, Bright HealthCare will reconcile overpayments through electronic adjustments in future payment cycles, using industry standard procedures identifying the claim overpayment for which the adjustment will be made, and subject to any applicable regulatory limitations or any restrictions in the provider's Network Participation Agreement.

Provider Payment Dispute Process

Bright HealthCare has established procedures for resolution of provider payment disputes.

Definition of a payment dispute: A written request for review when a provider disputes the amount paid by Bright HealthCare for a service, including issues related to administration denials, bundling, and downcoding of services. The payment dispute form is available on **Availity.com**

The written request must include:

- A statement indicating factual or legal basis for the payment dispute
- Information necessary to identify the claim, including claim number
- Any additional supporting information, clinical records, or documentation relevant to the dispute

Bright HealthCare Payment Integrity

Bright Healthcare Payment Integrity focuses on ensuring claims are paid accurately. Claim controls focus on optimization of claim payment efficiencies, including payment accuracy and shared liability for all business segments and claims platforms. Payment Integrity will request refunds on claims when overpayments are identified.

Reasons for overpayments include, but are not limited to:

- Duplicate payments
- An issue regarding the coordination of member benefits
- Subrogation
- Member plan termination
- Medical record/coding reviews
- Fraud, waste and abuse detection
- Incorrect provider reimbursement
- Industry standard practices

Bright HealthCare, or one of its designees, utilizes but is not limited to, the resources below to conduct its reviews. These are widely acknowledged national guidelines for billing practices and support the concept of uniform billing for all payers. A healthcare provider's order must be present to support all charges, along with clinical documentation to support the diagnosis and services or supplies that were billed:

- Centers for Medicare & Medicaid Services (CMS) guidelines as stated in Medicare manuals
- Medicare Local Coverage Determinations and National Coverage Determinations
- All Bright HealthCare policies, including medical coverage policies, provider manuals, and claims payment policies.
- National Uniform Billing Guidelines from the National Uniform Billing Committee
- American Medical Association Current Procedural Terminology (CPT®) guidelines
- Healthcare Common Procedure Coding System (HCPCS) rules
- ICD-10-CM Official Guidelines for Coding and Reporting
- American Association of Medical Audit Specialists National Health Care Billing Audit Guidelines
- Industry-standard utilization management criteria and/or care guidelines, including MCG care guidelines (formerly Milliman Care Guidelines): Current edition on date of service
- UB-04 Data Specifications Manual
- American Hospital Association Coding Clinic Guidelines
- Social Security Act
- National professional medical societies' guidelines and consensus statements
- Department of Health and Human Services final rules, regulations and instructions published in the Federal Register

Medical Records Review

- Bright HealthCare, or one of our designees, has the right to request and review records related to services rendered to its members. We may request records and/or other billing documents to conduct reviews.
- The Treatment, Payment and Health Care Operations (TPO) exception under the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule (45 CFR 164.506) allows the release of medical records containing protected health information between covered entities without additional authorization for the payment of health care claims. All billed charges must be supported by the clinical documentation to support the diagnosis and services/supplies that are billed.
- In the event Bright HealthCare requests medical records from a participating provider, such provider must honor the request within 30 calendar days (unless the request is otherwise stated or separately defined within the network agreement).
- Under no circumstances will Bright HealthCare reimburse participating providers for the cost of collecting, copying, or delivering requested medical records, except when required by law or separately defined within the network agreement.
- Participating providers, and any subcontractors or third parties who may collect, copy and/or deliver records for such providers, may not bill Bright HealthCare or any Bright HealthCare member for expenses related to a records request from Bright HealthCare unless otherwise stated in the network agreement
- Types of records Bright HealthCare or its designee may request include, but are not limited to, the following:
    - Activities of daily living (ADL) sheet, including flow sheets and/or logs
    - Admission assessments
    - Anesthesia records, including time of anesthesia administration
    - Case management notes
    - Change of Therapy (COT) assessment
    - Chat logs
    - Chemotherapy orders
    - Clinical trial information, including consents and treatment plans
    - Consultation notes
    - Diagnosis notes, including past medical history
    - Discharge/transfer summaries
    - Drawings and photos, when applicable
    - Emergency department reports
    - Evaluations: Any evaluation related to the service provided
    - Face sheets

- Face-to-face encounter documentation
- For durable medical equipment/home infusion/home health: Delivery receipts for supplies or drugs/proof of delivery
- Hospice/end-of-life-care documentation
- Implant detail: Sticker sheet and copies of invoices for implants or high-cost drugs; implant logs with additional information on implants, screws, and plates
- Itemized bill
- Laboratory and pathology reviews: Clinical reviews of pathology claims often require additional information to make determinations. Medical records from the ordering physician, as well as the requisition form and lab results, are necessary to complete a full and fair review of the pathology claim.
- Laboratory reports and X-rays from ordering physician, along with written interpretations of X-rays, tests and/or laboratory results
- Letter/certificate of medical necessity (CMN) for services
- Medication records/medication administration records (MAR), including strength, National Drug Code (NDC) and waste, mixing logs, infusion medication sheet and transfusion/infusion logs
- Nurse or any other healthcare provider's progress, treatment, SOAP (subjective, objective, assessment, plan) notes, dietary notes and daily notes
- Obstetric/newborn services
- Operating reports and records
- Operative reports
- Patient history
- Physical exam
- Physician office records: Complete records, including office visit documentation, demographic/face sheet, patient history, laboratory and procedure results and all correspondence with healthcare providers, including consultation requests and reports
- Physician orders
- Plans of Care (POC), treatment plans (tried and failed conservative treatments) and any related evaluations and updates or recertifications for the time period during which the patient was treated. The POC and recertifications should be signed by a qualified healthcare provider.
- Preanesthetic evaluation
- Preoperative and postoperative notes
- Prescriptions

- Progress notes
- Psychiatric evaluation notes
- Test orders/results/reports including, but not limited to, pathology, radiology and laboratory (include results, when applicable)
- Toxicology reports
- Treatment notes
- Uniform billing form (UB-04)/Health Care Finance Administration Form (HCFA 1500)
- Wound care assessment

Hospital Bill Validation

Bright HealthCare, or one of our designees, may perform focused audits verifying the accuracy of the site of service billed for specific claims based on the level of care acuity, documented clinical information and severity of illness. We will consider reimbursement for services at an outpatient level when hospital services were appropriate but reimbursement at the inpatient level is not appropriate. Discrepancies may result in reimbursement reduction or payment recoupment.

Hospital Charge Audits

Bright HealthCare, or one of our designees, may audit either onsite or perform a desk audit of a facility's claim(s) to assess the accuracy of the inpatient or outpatient facility charges by such provider. Bright HealthCare may sometimes review an itemized bill for an inpatient admission to determine whether supplies, items and services specified on the itemized bill are separately billable. If an itemized bill is not provided when requested or if improper billing is identified during the review of the itemized bill, one of the following outcomes may result:

- Reimbursement reduction
- Payment recoupment
- Denial of specific charges

DRG Audits

Bright HealthCare, or one of our designees, may audit claims to ensure the diagnosis, procedure codes which generate the DRG, and hospital invoice are accurate, valid and sequenced in accordance with nationally correct coding rules and standards.

- A Diagnosis-Related Group (DRG) audit focuses on payment of a claim related to an inpatient hospital stay.
- The intent of a post-payment DRG audit is to ensure that the hospital has applied appropriate care, utilization, and billing practices to code the claim correctly.
- The post-payment DRG audit process requires obtaining the patient's medical record in order to review the underlying and supporting documentation.

Subrogation and Coordination of Benefits

Our benefit plans are subject to subrogation and coordination of benefits rules. Bright HealthCare or one of its designees will review claims data to identify where Bright HealthCare paid as primary but another plan should have. We will identify other responsible payers, verify results, and determine primacy.

- **Subrogation** – Bright HealthCare reserves the right to recover benefits paid for a member's health care services when a third party causes the member's injury or illness to the extent permitted under state and federal law and the member's benefit plan.
- **Coordination of Benefits (COB)** – COB is administered according to the member's benefit plan and in accordance with law.
- **Workers' Compensation** – In cases where an illness or injury is employment-related, workers' compensation is primary. If you receive notification that the workers' compensation carrier has denied a claim for services, submit the claim to Bright HealthCare. It is also helpful to send us the workers' compensation denial statement with the claim.
- **Medicare** – If the care provider accepts Medicare assignment, all COB types coordinate up to Medicare's allowed amount. Medicare Secondary Payer (MSP) rules dictate when Medicare pays secondary. Other coverage is primary over Medicare in the following instances:
    - Aged employees: For members who are entitled to Medicare due to age, commercial is primary over Medicare if the employer group has 20 or more employees.
    - Disabled employees (large group health plan): For members who are entitled to Medicare due to disability, commercial is primary to Medicare if the employer group has 100 or more employees.
    - End-Stage Renal Disease (ESRD): If a member has or develops ESRD while covered under an employer's group benefit plan, the member must use the benefits of the employer's group plan for the first 30 months after becoming eligible for Medicare. After the 30 months, Medicare is the primary payer.

Pre-Payment Reviews

- Bright HealthCare, or its designee, conducts pre-payment reviews related to the services billed to its members and facilitates accurate claims payments.
- The Payment Integrity Prepayment reviews look for overutilization of services or practices that directly or indirectly result in unnecessary costs to the healthcare industry. Examples include, but are not limited to:
    - Excessive billed charges or selection of the wrong code(s) for services or supplies
    - Billing for items or services that should not have been or were not provided based on documentation supplied
    - Unit errors, duplicate charges, and redundant charges
    - Insufficient documentation in the medical record to support the charges billed
    - Experimental and investigational items billed
    - Lack of medical necessity to support services or days billed
    - Uncovered services per the member's benefit plan, Bright HealthCare or CMS policies
    - Lack of objective clinical information in the medical record to support condition for which services were billed
    - Items not separately payable or included in another charge, such as routine nursing, capital equipment charges, reusable items, etc.
    - Consolidated Billing

These reviews also confirm that:

- The most appropriate and cost-effective supplies were provided.
- The records and/or documentation substantiate the setting or level of service that was provided to the patient.
    - Bright HealthCare, or one of its designees, will review records to determine if the services billed are substantiated by the submitted clinical and medical documentation. If the findings do not support the services billed, Bright HealthCare will process the claim accordingly. If there is a dispute of the findings, there is an opportunity to appeal.
    - If the requested records are not returned in the timeframe requested, the claim(s) will result in a technical denial.

Post-Payment Reviews

Bright HealthCare's Payment Integrity Team, or one of its designees, will review claims and claims data on a post-payment basis to detect, prevent and mitigate fraud, waste, abuse, and error.

Bright HealthCare may conduct reviews within 12 months of date of claim payment (or as otherwise designated by state or federal statute(s)).

Health care professionals are asked to send complete copies of medical records within 30 days of receipt of the request (unless otherwise designated). If the requested records are not returned in the timeframe requested, the claim(s) will result in a technical denial and validated overpayment.

If an overpayment is identified, the health care professional will be notified of the findings via an overpayment letter with an explanation of findings. If there is a dispute of the findings, there is an opportunity to appeal.

Technical Denial

A denial of the entire claim amount will occur when services cannot be substantiated due to the healthcare provider's non-response to Bright HealthCare's request for records.

- Initial Request: An initial request for medical records will be made with a due date listed in the letter. The due date is 30 days from the date the letter was sent by Bright HealthCare.
- Second Request: If records are not received by the initial due date, a second request for records will be sent, allowing an additional 14 days for records submission.
- Request for Overpayment Refund: If the records are not received after the second request due date, a technical denial letter will be sent with an overpayment request. The health care provider will have 60 days from the date on the refund letter to submit a refund check before the paid amount of the claims is set to offset future funds owed. If an immediate offset is desired, please include the overpayment notification letter with that instruction. Funds can be offset immediately to satisfy the overpayment amount.

Overpayments

Offsets/Recoupments/Takebacks are various names used for an adjustment made by the carrier to offset the debt of excess/ incorrect payments by withholding payments of future claims of the same patient or other beneficiaries. If we inform you of an overpaid claim that you do not contest, send Bright HealthCare your refund check or recoupment request within 60 calendar days from the date of notification (or as required by law or your Agreement). We may apply/offset/recoup the overpayment against future claim payments unless your Agreement states otherwise or as required by law. If you find we overpaid a claim, please use the Overpayment Refund/Notification Form. Bright HealthCare follows state regulations, provider contract requirements and CMS provisions when processing overpayments and recoupments.

- Call **844-926-4522** with questions related to overpayments or refer to details in the overpayment letter(s) received.
- Send refunds to:
  Bright HealthCare
  P.O. Box 23039
  New York, NY 10087-3039

Please include documentation that shows the overpayment, including member's name, member ID number, date of service and amount paid. If possible, also include a copy of the Explanation of Payment (EOP) that corresponds with our payment. If the refund is owed because of COB with another carrier, please provide a copy of the other carrier's EOB/remittance advice with the refund. If we find a claim was paid incorrectly, we may make a claim adjustment which will be detailed on the EOP.

Post-audit Procedures

Refund Remittance: Following an overpayment request, providers/hospitals should remit the amount of the overpayment within 30 calendar days of receipt of the refund request, or as required by state or federal law.

Audit Findings: If providers/hospitals disagree with the findings, they can submit notification of the disagreement/dispute/appeal within 30 calendar days of receipt of the audit findings, per the terms outlined in the overpayment notification letter. The notification must clearly identify the items with which provider/hospital disagrees and include any relevant documentation to support said position.

Disagreement/Dispute/Appeal Resolution: Bright HealthCare's Appeals and Grievance Team, or one of our designees, will respond to audit findings. Time frame may vary by state. (Refer to Section 5 that provides an overview of the A&G process).

Offsets: When we issue a refund request in connection with an audit, we recoup or offset the identified overpayment and/or disallowed charge amounts after 60 calendar days from the date of the refund request, except when the hospital/provider:

- Has refunded the amount due within the requested timeframe.
- Has provided written notification of its disagreement with the audit findings within the required timeframe.
- Provider/Hospital Agreement, contractual obligations or state law states otherwise.

Requirements of the Written Request

When All Necessary Information is Supplied

For provider payment dispute requests, where all necessary information was supplied, Bright HealthCare will send written confirmation of receipt within 30 days of the dispute resolution request (or shorter time period if required by the Network Participation Agreement). The written confirmation contains:

- A description of Bright HealthCare's dispute resolution procedures and time frames
- The procedures and time frames for the provider to present the rationale for the dispute resolution request
- The date by which Bright HealthCare must resolve the dispute resolution request

Note: In instances where the payment dispute resolution request is resolved in accordance with this section within 30 days, the notice required under the Notice of Determination section below will constitute the notice required by this section.

When All Necessary Information is Not Supplied

In cases where Bright HealthCare does not receive all necessary information, Bright HealthCare will send a written request for additional information within 30 days of receipt of the request (or shorter time period if required by the Network Participation Agreement). The request includes:

- A description of the additional necessary information required to process the request
- The date that additional information must be supplied by the provider
- A statement that failure to supply the requested information within the time limit noted in the request will result in the closure of the request with no further review

When Additional Necessary Information is Requested but Not Supplied

In cases where Bright HealthCare closes the request due to insufficient information, we will notify the provider that the case is closed and that for further consideration, a new written request with all necessary information must be submitted.

Notice of Determination

Bright HealthCare will supply written notification of the determination to the provider. In the event the determination is not in favor of the provider; the written notification will include the principal reasons for the determination. The written notice of determination includes:

- The names and titles of the parties evaluating the payment dispute resolution request and, when the decision was based on a review of medical documentation, the qualifying credentials of the parties evaluating the payment dispute
- A statement of the reviewers' understanding of the basis for the payment dispute
- The reviewers' decision and the rationale for the decision in clear terms
- A reference to the evidence or documentation used as the basis for the decision

Patient Billing

Balance Billing

Balance billing is the practice of billing a Bright HealthCare member for the difference between the provider's billed charges and the amount reimbursed by Bright HealthCare under the Network Participation Agreement. It can also be defined as billing a Bright HealthCare member for denied charges when the denial rationale is due to billing issues.

CMS MA rules govern the payment policies of MA plans. These rules do not permit providers to balance bill members. The Medicare Managed Care Manual, Chapter 4, Section 170-180, states in part, "Medicare Advantage members are responsible for paying only the plan allowed cost sharing for covered services." Therefore, apart from member cost sharing, providers may not bill Bright HealthCare members for outstanding amounts owed on claims under the circumstances described in this section.

Dual Eligible Enrollees

Federal law, section C.F.R. §422.504(g)(1)(iii) prohibits providers from collecting Medicare Part A and Medicare Part B deductibles, coinsurance, or copayments from those enrolled in the Qualified Medicare Beneficiaries (QMB) program; a dual eligible program which exempts individuals from Medicare cost sharing liability. Balance billing prohibitions may also apply to other dual eligible beneficiaries in MA plans if the state Medicaid program holds these individuals harmless for Part A and Part B cost sharing. Providers will (1) accept the MA plan payment as payment in full, or (2) bill the appropriate state source.

Member Self-payment for Non-covered Services

Where a Bright HealthCare member wishes to receive and self-pay for a non-covered service, the member (or the provider on the member's behalf) must first obtain an organization determination from Bright HealthCare denying coverage for the service, subject to the exceptions described below.

Ban on Use of Advanced Beneficiary Notices for Medicare Advantage Plans

Provider organizations should be aware that an Advanced Beneficiary Notice (ABN) of non-coverage is not a valid form of denial notification for a Bright HealthCare Medicare Advantage member. ABNs, sometimes referred to as "waivers," are used in the Original Medicare program. However, ABNs cannot be used for members enrolled in Bright HealthCare's Medicare Advantage plans, as CMS prohibits use of ABNs for members enrolled in a Medicare Advantage plan.

As a Bright HealthCare network provider who has elected to participate in the Medicare program, you should understand which services are covered by Original Medicare and which are not. Bright HealthCare Medicare Advantage plans are required to cover everything that Original Medicare covers and may provide coverage that is more generous than what is covered under Original Medicare. CMS mandates that providers who are contracted with a Medicare Advantage plan, such as Bright HealthCare, are not permitted to hold a Medicare Advantage member financially responsible for payment of a service not covered under the member's Medicare Advantage plan unless the member has received the Bright HealthCare prior authorization Organization Determination notice of denial prior to receiving services.

If Medicare non-covered (or conditionally covered) services are rendered prior to the member receiving a prior authorization organization determination notice of denial from Bright HealthCare, network providers are required to hold the member harmless for the services. However, only when a service is listed as a clear exclusion in the member's plan materials may you hold the member financially responsible without requesting a prior authorization organization determination. The procedure to request a prior authorization organization determination is similar to requesting a prior authorization. Once Bright HealthCare has reviewed the request, the member and requesting provider will be notified of the plan decision along with any applicable member appeal rights. Providers may only bill the member for the service if the member (1) has received the written decision from Bright HealthCare prior to rendering non-covered or conditionally covered services and (2) continues to request the item or service notwithstanding our original decision not to cover the item or service.

Modifiers GA & GX

Modifiers GA and GX should not be used when billing Bright HealthCare Medicare Advantage members.

Modifier GA indicates that an ABN is on file and allows the provider to bill the member if not covered by Medicare. Use of this modifier ensures that upon denial, liability will be assigned to the beneficiary, **Modifier GX** indicates that a voluntary ABN was issued for services that are not covered.

Member Cost Sharing

Bright HealthCare asks that providers submit claims first and obtain a remittance advice with the cost sharing indicated, permitting the provider to bill the member accurately for the cost sharing. This will reduce member overpayments. The member will also receive an Explanation of Benefits (EOB) referencing their cost sharing responsibility. If member cost sharing is taken at the time of service, Bright HealthCare asks that providers use consumer-friendly procedures and do not demand up-front cost sharing as a condition of providing services. In the event that the member has overpaid for cost sharing, a refund of the difference must be provided to the member.

Cost Sharing Waivers and Discounts

Waiving or reducing member cost sharing is prohibited except in the case of financial hardship. Waiving copays, coinsurance, and deductibles for government program beneficiaries implicates the "beneficiary inducement" prohibition in Medicare Advantage. The prohibition on beneficiary inducement prohibits payers, providers, and other healthcare entities that participate in federal healthcare programs, including Medicare Advantage, from offering remuneration to a beneficiary where the remuneration "is likely to influence the beneficiary's selection of a particular provider, practitioner, or supplier of Medicare or Medicaid payable items or services" (OIG Special Advisory Bulletin, 2002). Remuneration is defined as, among other items of value, the waiver of copayments, coinsurance, and deductibles. 42 CFR 1003.101.

Coordination of Benefits

If Bright HealthCare is the "secondary payer," Bright HealthCare is only legally obligated to pay claims subject to the primary payer's payment responsibilities. Coordination of benefits occurs during claims adjudication to ensure payment is made for only that portion of the claim for which Bright HealthCare is responsible. Bright HealthCare actively pursues any identified overpayments resulting from circumstances where a member has other primary healthcare coverage.

Bright HealthCare is not liable for any claims for which the member is entitled to benefits under state or federal workers' compensation law or plan, any no-fault insurance, or any liability insurance policy or plan. Bright HealthCare shall identify claims for which a third party may be liable and make recoveries for those claims. All recovery activities shall be made in accordance with the EOC, applicable laws and CMS instructions.

General Compliance and Fraud, Waste, and Abuse Requirements

As required in their Network Participation Agreements, providers will be asked to cooperate with Bright HealthCare's coordination of benefits procedures.

Contracted providers are responsible for complying with all applicable laws, regulations, and Bright HealthCare's policies and procedures, including Bright HealthCare's Code of Conduct. Bright HealthCare's general compliance and fraud, waste, and abuse (FWA) expectations for contracted providers are outlined in this section and incorporate requirements imposed by CMS for all health plans, such as Bright HealthCare, that administer Medicare Advantage or Prescription Drug Plans. The CMS requirements are detailed in Chapter 21 of the Medicare Managed Care Manual and Chapter 9 of the Prescription Drug Benefit Manual and further apply to any individual or entity that provides healthcare services for health plans that are subject to the CMS requirements. Bright HealthCare's contracted providers are responsible to:

- Be familiar with Bright HealthCare's general compliance and FWA requirements
- Monitor the compliance of your employees and address non-compliance issues in a timely manner
- Monitor and audit the compliance of subcontractors that provide services to you in support of Bright HealthCare's Medicare plans, as applicable
- Obtain approval from Bright HealthCare when seeking relationships with downstream entities (subcontractors).

  In addition, note that Bright HealthCare must notify CMS of any contractor that is located outside of the United States or a territory of the United States that receives, processes, transfers, stores, or accesses Medicare member protected health information (PHI) in verbal, written or electronic form
- Report instances of non-compliance or suspected or actual fraud, waste, and abuse to Bright HealthCare immediately upon discovery
- Develop and implement policies and procedures that describe the procedures for preventing, detecting, correcting, and reporting FWA that include, but are not limited to:
    - Requiring employees and downstream entities to report FWA
    - Screening all individuals and entities against the federal governments exclusion lists prior to hire or contract execution, including the Office of Inspector General's List of Excluded Individuals and Entities and the General Service Administration (GSA) Excluded Parties List System (EPLS). Anyone listed on one or both lists are not eligible to provide services for Bright HealthCare's Medicare Advantage or Prescription Drug plans. Bright HealthCare must be notified immediately if a person or entity is identified as being excluded from either of these lists. Your procedure must include ongoing monthly monitoring of the OIG LEIE and the GSA EPLS lists

- Establishing procedures for conducting general compliance and FWA training for all employees and any individuals or entities that will be providing services to support Bright HealthCare's Medicare plan within 90 days of hire or contracting, including collecting and retaining training records for a period of at least 10 years. The training is to be administered upon new hire or contract execution and annually thereafter
- Publicizing disciplinary standards and taking appropriate action upon discovery on non-compliance or fraud, waste, and abuse
- Safeguarding Bright HealthCare's confidential and proprietary information
- Protecting member health information in accordance with HIPAA Privacy and Security Rules

Fraud, Waste, and Abuse

Bright HealthCare is committed to detecting, preventing, investigating, and reporting potential fraud, waste, and abuse in accordance with federal and state statutory, regulatory, and contractual requirements. Preventing and correcting fraud, waste, and abuse helps keep healthcare affordable. Bright HealthCare encourages members, providers, employees, and other parties to report suspected unethical or illegal conduct or suspected fraud, waste, and abuse.

CMS Definitions of Fraud, Waste, and Abuse

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

Fraud is knowingly and willfully executing, or attempting to execute, a scheme or artifice to defraud any healthcare benefit program or to obtain (by means of false or fraudulent pretenses, representations, or promises) any of the money or property owned by, or under the custody or control of, any healthcare benefit program. 18 U.S.C. § 1347.

Waste is the overutilization of services, or other practices that, directly or indirectly, result in unnecessary costs to the Medicare program. Waste is generally not considered to be caused by criminally negligent actions but rather the misuse of resources.

Examples of provider fraud, waste, and abuse:

- Billing for services not rendered
- Billing for services that were not medically necessary
- Double billing
- Unbundling
- Upcoding

Providers can prevent fraud, waste, and abuse by ensuring the services rendered are medically necessary, accurately documented in the medical records, and billed according to American Medical Association guidelines.

To help prevent fraud, waste, and abuse, providers can educate members about these types of fraud and the penalties levied. Also, spending time with patients and reviewing their records for prescription administration will help minimize drug fraud and abuse.

One of the most important steps to help prevent member fraud is as simple as reviewing the Medicare member ID card. It is the first line of defense against fraud. Examples of member fraud, waste, and abuse:

- Benefit sharing
- Collusion
- Drug trafficking
- Forgery
- Illicit drug seeking
- Impersonation fraud
- Misinformation/misrepresentation
- Subrogation/third-party liability fraud
- Transportation fraud

Important Fraud, Waste, and Abuse Laws

Anti-Kickback Statute

The Anti-Kickback Statute provides penalties for individuals or entities that knowingly and willfully offer, pay, solicit, or receive remuneration to induce or reward business payable (or reimbursable) under the Medicare or other federal healthcare programs. In addition to applicable criminal sanctions, an individual or entity may be excluded from participation in the Medicare and other federal healthcare programs and subject to civil monetary penalties. Civil penalties for violating the Anti-Kickback Statute may include penalties of up to $50,000 per kickback plus three times the amount of kickback. Criminal penalties for violating the Anti-Kickback Statute may include fines, imprisonment, or both.

Health Insurance Portability and Accountability Act

The Health Insurance Portability and Accountability Act (HIPAA) protects the privacy of an individual's identity and medical records. Providers are responsible for implementing procedures to protect member health information in accordance with HIPAA Privacy and Security Rules.

False Claims Act

The False Claims Act (FCA) prohibits knowingly presenting (or causing to be presented) to the federal government a false or fraudulent claim for payment or approval. It also prohibits knowingly using (or causing to be used) a false record or statement to get a false or fraudulent claim paid or approved by the federal government or its agents. The False Claims Act protects individuals from retaliation (demotion, dismissal, suspension, harassment, etc.) for reporting suspected fraud, waste, and abuse. The FCA provides civil penalties of no less than $5,000 but no more than $10,000, plus three times the government's damages, with respect to each false claim.

Physician Self-Referral Law (Stark Law)

The Physician Self-Referral Law, often called the Stark Law, prohibits a physician from making a referral for certain designated health services payable by Medicare or Medicaid to an entity in which the physician (or an immediate family member) has an ownership/investment interest or with which they have a compensation arrangement, unless an exception applies. Penalties for violation of the Stark Law can include overpayment or refund obligation, False Claims Act liability, civil money penalties (CMPs) and program exclusions for knowing violations, with a potential $15,000 CMP for each service, and civil assessment of up to three times the amount claimed.

Reporting Potential Suspicious Activity or Fraud, Waste, and Abuse

Contracted providers, their employees, and related entities are required to notify Bright HealthCare of suspected or actual fraud, waste, and abuse. Federal and state regulatory agencies, law enforcement, and Bright HealthCare investigate all incidents of suspected or actual fraud, waste, and abuse.

If you think that FWA or other suspicious activity has occurred, may be occurring, or is going to occur, please report it to Bright HealthCare immediately. To report suspected FWA or other suspicious activity, please call or email Bright HealthCare Compliance. Refer to Appendix 1 for contact information.

When reporting suspicious or fraudulent activity, be sure to include as much detail as possible in the report for thorough investigation of the issue. Reports can be made anonymously. All reports are treated as confidential and will be investigated. Bright HealthCare will not release personal information unless required to do so; for example, under court rule or subpoena. Bright HealthCare may refer the activity to law enforcement or other appropriate regulatory bodies. Members or providers that are found to be engaging in suspicious activity, fraud, or abuse are subject to termination from the Bright HealthCare network and recovery of any overpayments.

The time limits in this manual and in the Network Participation Agreements that apply to the resolution and collection of overpayments in the normal course of business do not apply in the instance of an investigation and settlement of fraud, waste, and abuse against a network provider. Such investigations and settlement matters are instead subject to Medicare time limits and other statutory or regulatory statute of limitations provisions.

Section Five:
Prescription Drug Coverage

Formulary

Bright HealthCare's Part D formulary is designed to provide access to clinically supported therapies used to aid the delivery of high-quality, cost-effective healthcare for members in conformance with Bright HealthCare's values, covered benefits, and applicable Medicare Part D requirements. The formulary is designed to aid members and providers in the identification of low-cost therapy options, validate medications are used in accordance with Medicare Part D benefit restrictions, and support clinical best practices. Members will typically experience a lower out-of-pocket cost when using medications covered on a lower formulary tier, as compared to comparable medications on a higher tier. An exception to this general rule applies to Tier 6 (Select Care Drugs) which provides low-cost access to a selection of generic medications used to treat cholesterol, hypertension, and diabetes. Medications that are not listed on Bright HealthCare's Medicare Part D Formulary are not covered unless the member is granted a formulary exception.

For coverage, cost sharing, and Utilization Management (UM) protocols, please view the formulary. The formulary is available on Bright HealthCare's website:
BrightHealthCare.com/medicare-advantage/drug-search

For questions about coverage determination please contact **833-726-0667**.

Drug Utilization Management and Pharmacy Coverage Determinations

Certain drugs may be subject to utilization management requirements, such as prior authorization, step therapy, or quantity limits.

Medications subject to coverage determinations require the provider to submit additional clinical information to Bright HealthCare before the medication will be covered. These reviews are considered Medicare Part D coverage determinations and include a review of approved formulary clinical criteria, Medicare coverage guidance, and the member's benefit plan.

Medications subject to step therapy will not be covered unless the member has first attempted treatment with other drugs that are considered first line therapy according to approved formulary criteria. Coverage of medications subject to step therapy will be granted when members have pharmacy claim history of first line drug use. When prior use cannot be confirmed via pharmacy claims, providers will need to seek a step therapy exception for the medication to be covered.

Quantity limits may be instituted to prevent the overuse of medications. Quantity limits may be based on a maximum daily dose, the maximum amount of drug allowed for a period of time, and/or the maximum number of dosage units covered for a period of time.

As required in the Network Participation Agreements, network providers must comply with the above Bright HealthCare drug utilization management procedures, as well as any other applicable drug utilization management procedures.

Transitional Benefits

Bright HealthCare may provide members with a temporary exception to formulary restrictions to ensure that members do not experience a gap in existing therapy. This temporary exception, known as a Transition Benefit Fill, provides members and providers the time to discuss treatment options and determine whether any formulary options are appropriate for the member's individual situation. This process applies to the following groups of beneficiaries:

- New enrollees into prescription drug plans following the annual coordinated election period
- Newly eligible Medicare beneficiaries from other coverage
- Enrollees who switch from one plan to another after the start of a contract year
- Current enrollees affected by negative formulary changes across contract years
- Enrollees residing in long-term care (LTC) facilities, including beneficiaries being admitted to or discharged from an LTC facility
- Bright HealthCare's transitional benefit policy applies to:
- Part D drugs that are not on Bright HealthCare's formulary
- Drugs previously approved for coverage under an exception once the exception expires
- Part D drugs that are on sponsor's formulary but require prior authorization or step therapy, or that have an approved quantity limit lower than the beneficiary's current dose, under a plan's utilization management requirements

Policy

The transition policy provides for at least a one-time, temporary 30-day supply fill, anytime during 1) the first 90 days of the member's enrollment in the plan, beginning on their effective date of coverage, or 2) within the first 90 days of the calendar year when a member experiences a negative formulary change to their existing drug therapy.

After this transition period has expired, members residing in a long-term care facility may be eligible for up to a 31-day emergency supply of Part D eligible medications. Members residing in, being admitted to or discharged from a long-term care facility may be eligible for an additional fill of medication up to a maximum of a 31-day supply.

Provider Responsibility

Bright HealthCare will provide members and prescribers with a written notice within three (3) business days of the applicable temporary transition fill that will include instructions for identifying a formulary alternative (if appropriate) and how to request a formulary exception. Network providers should contact members following a transition fill to determine whether any formulary alternatives may be appropriate given the member's individual circumstances. Timely communication and action by providers are important to prevent subsequent prescription denials for the corresponding medication.

Exceptions Process

Providers may request a formulary exception for a Part D drug that is not included on Bright HealthCare's formulary or may request coverage for a formulary drug at a lower formulary tier. Providers may also request access to a formulary drug without being subject to applicable formulary utilization management criteria (e.g., step therapy, prior authorization, quantity limit). Exceptions may be granted if the provider submits a supporting statement indicating that a non-formulary, restricted, or higher tier drug is necessary for treating a member's condition and other formulary coverage options would be less effective and/or may not be tolerated by the member.

Providers may request a formulary exception by contacting Bright HealthCare Provider Services and selecting options for pharmacy. Refer to Appendix 1 for contact information.

Medicare Medication Therapy Management

The Medication Therapy Management (MTM) program is a component of Bright HealthCare's Medicare Advantage Prescription Drug plans and helps members and providers manage medication utilization. MTM may help identify opportunities to reduce medication risks, provide therapy recommendations based upon proven medical practices, and help members take a more active role in managing their health.

This program is available at no additional cost to members who meet all the following criteria:

- Have three or more of these medical conditions:
    - Osteoporosis
    - Chronic heart failure (CHF)
    - Dyslipidemia
    - Diabetes
    - Depression
    - Asthma
    - Chronic obstructive pulmonary disease (COPD)

- Take at least eight maintenance Part D medications
- Have incurred one-fourth of the specified annual cost threshold in the previous three months. The annual threshold is determined by CMS. For 2022, it has been set at **$4,696** (including amounts paid by both the member and Bright HealthCare)

Within 60 days of becoming eligible for Bright HealthCare's MTM program, members will be automatically enrolled (unless they opt-out of the program) and will receive a welcome packet in the mail from Bright HealthCare. They may also receive an offer to participate by phone.

All MTM eligible members will be offered a Comprehensive Medications Review (CMR). This review includes:

- 30-minute visit between a Healthcare Provider and member over the phone
- Healthcare Provider review of all member medications (including prescription, over-the-counter (OTC) medications, herbal therapies, and dietary supplements) and medical conditions to determine if there are any drug therapy issues
- If needed, the Healthcare Provider will work with the member's doctor to resolve any issues identified as part of the review
- Within 14 days following the Comprehensive Medication Review, the Healthcare Provider will mail the member a Personal Medication List, which summarizes their medication history, and a Medication Action Plan, which summarizes any clinical concerns that were identified. Information may also be mailed to the member's doctor, based upon opportunities for medication therapy improvement

In addition, once every three months, Bright HealthCare will perform a "Targeted Review" of the member's medications. After each review, Bright HealthCare may contact the member's doctor with suggestions about medications that may be safer or a better alternative to the current therapy. As always, medications will not change unless the member and their doctor decide to change them.

The MTM program is available in English and Spanish.

There is no extra cost to the member for the MTM program. The MTM program is a component of Bright HealthCare Medicare Advantage plans and is not considered a Medicare benefit.

Section Six: Utilization & Care Management Programs

Bright HealthCare's Utilization Management Program

Bright HealthCare's Utilization Management (UM) program is designed to ensure the delivery of high-quality, cost-efficient healthcare for members in conformance with our values, covered benefits, and applicable state requirements. The Utilization Management program is dynamic through the care setting, acuity, and product and services continuums, in order to achieve the desired outcomes of the program.

Provider Obligations and Disclaimers

Bright HealthCare requires prior authorizations on select inpatient, outpatient, and ancillary services. The complete lists of services requiring prior authorization can be found on **Availity.com** and **BrightHealthCare.com/provider/utilization-management**. Services requiring prior authorization are subject to change. Please make sure to review the most current list.

Objectives of the Utilization Management Program

The objectives of the Utilization Management program are to promote evidence-based care, cost-effective use of healthcare resources, and to proactively identify and connect members to care management programs. To that end, the program is grounded in applicable federal and state regulations and coverage guidelines, published clinical evidence, and well-established third-party clinical guidelines. Prior authorizations seek to confirm that:

- Providers and facilities are in network
- The requested product or service is a covered benefit
- The requested product or service is medically necessary based on evidence based clinical criteria as discussed in more detail below
- Not all services requiring a prior authorization will require a review of medical necessity

Bright HealthCare Prior Authorization and Utilization Management Determinations

This section outlines how Bright HealthCare makes Utilization Management decisions for specific services subject to UM protocols and for those that require the application of clinical criteria to determine coverage.

A member's Evidence of Coverage (EOC), applicable Medicare Advantage federal and state rules, and coverage guidelines ultimately control the determination of whether a specific health service is covered under that member's benefit plan.

The member's EOC states that covered services must meet the standard for medical necessity, along with meeting other conditions for coverage, including eligibility. Bright HealthCare's medical policies define whether a health service is proven to be effective and medically necessary. Services that are not medically necessary, or that are unproven, investigational, or experimental, are not covered under Bright HealthCare's Medicare Advantage benefit plans.

Bright HealthCare's coverage guidelines determine whether a service falls within a covered benefit category, is an excluded service, or has a limitation. Examples of services determined by coverage guidelines include, without limitation, whether a service is skilled or custodial, whether a service is reconstructive or cosmetic, and whether a service involves a limited number of visits to a provider.

Medical Necessity and Other Medical Coverage Determinations Based on Clinical Criteria

Bright HealthCare makes coverage determinations in accordance with the member's benefit plan, as described in their EOC. Benefits that require coverage determinations must meet at least one of three criteria. The benefit is subject to:

- A medical necessity determination
- A determination whether the service is unproven, investigational, or experimental

Application of Other Clinical Criteria in Order to Determine Coverage

To interpret the terms of an EOC, Bright HealthCare uses:

- Medicare Advantage regulations and other applicable regulatory requirements
- Medicare National Coverage Determination policies and Medicare Local Coverage Determination policies, as well as any other applicable Medicare coverage policies
- Bright HealthCare's medical policies and coverage guidelines
- Third party, nationally recognized clinical care guidelines, such as MCG Care Guidelines

The terms of the EOC prevail in instances where there is a conflict between the EOC and Bright HealthCare's medical policies, Bright HealthCare's coverage guidelines, or third-party guidelines.

Bright HealthCare Prior Authorization Requirements for Medical and Behavioral Services

Bright HealthCare completes a network validation to ensure that the rendering provider and/or facility are contracted with Bright HealthCare (in-network). Services that require only a network validation review are typically reviewed same day. For more information on services requiring only a network validation review, visit **Availity.com**.

In-network providers do not need to submit an authorization for services that require only a network validation review. All providers and facilities not contracted with Bright HealthCare (out-of-network) are required to submit an authorization request for any service and/or procedure performed out-of-network. This includes when an in-network provider renders a service at an out-of-network facility.

In-network Inpatient Admissions

Network providers must admit members to Bright HealthCare contracted facilities. Network providers must obtain prior authorization for non-emergent inpatient admissions, including admissions to:

- Acute, sub-acute, substance abuse facilities
- Inpatient habilitation or rehabilitation facilities
- Skilled nursing facilities (SNF)
- Long-term acute care (LTAC) facilities

In the case of a request to maintain a specific level of care, or to transfer a member to a different level of care, the provider must submit the request with sufficient notice and supporting information for Bright HealthCare to make a determination.

Network facility admitting members for inpatient services must notify Bright HealthCare within 48 hours of admission, or as soon as reasonably possible. All admissions will be reviewed for medical necessity and follow normal concurrent review processes.

Home Health Services

In-network providers are required to submit a prior authorization request for medical necessity review on Day 8 of admission.

Out-of-network Inpatient Medical and Behavior Admissions

Out-of-network providers must notify Bright HealthCare of an admission within 48 hours of admission. Upon stabilization, Bright HealthCare may work with the admitting physician to move the member to the nearest appropriate in-network facility.

Transplant Services

Transplant services are subject to prior authorization procedures. Additionally, Bright HealthCare reserves the right to direct members to receive inpatient care and other medically necessary services related to the transplant at particular facilities identified as meeting the required quality standards of our transplant management programs.

Outpatient Medical and Behavioral Services

Partial hospitalization requires prior authorization. Other outpatient medical and behavioral services requiring network validation review and/or medical necessity please review the prior authorization grid available on **Availity.com**.

"Important Message from Medicare"

Hospitals are required to issue the "Important Message from Medicare" (IM) at or near admission, but no later than two calendar days following the date of the member's admission to the hospital. Hospitals may deliver the initial copy of the notice if the member is seen during a preadmission visit, but no earlier than seven calendar days in advance of admission. If a member receives and signs the initial copy of the IM as part of the preadmission process, the follow-up copy of the notice must be delivered to the member if delivery of the initial copy occurred more than two calendar days prior to the date the coverage of services ends. Please refer to the **Medicare appeals and grievances** section for more information on disputes related to these notices.

Notice of Medicare Non-Coverage (NOMNC)

Skilled nursing facilities, home health agencies, and comprehensive outpatient rehabilitation facilities are responsible for delivering a "Notice of Medicare Non-Coverage" (NOMNC) to Bright HealthCare Medicare members no later than two calendar days before the termination of services. This notice fulfills the CMS advance written notice of termination requirement (42 CFR 422.624(b) (2)). This requirement states, "Prior to any termination of service, the provider of the service must deliver valid written notice to the enrollee of the MA organization's decision to terminate services.

The provider must use a standardized notice, required by the Secretary, in accordance with the following procedures." Please refer to the **Medicare appeals and grievances** section for more information regarding NOMNC.

Bright HealthCare Prior Authorization for Drugs Covered Under the Medical (Part C) Benefit

Some medications may be covered by Medicare Part C, the medical benefit, based on Medicare coverage guidelines and associated clinical criteria. Medications furnished by a provider may be subject to prior authorization. Medications furnished by a pharmacy are typically covered by the Part D benefit. Please refer to **Section Five** of this manual.

Refer to the formulary on **Availity.com** to understand which medications are covered under the pharmacy benefit and subject to Utilization Management edits.

Services that are presumptively considered unproven, investigational, or experimental must receive prior authorization for such services. Providers who have questions about whether a service requires prior authorization as an unproven, investigational, or experimental service, should contact Bright HealthCare to confirm.

Where a member wishes to receive and self-pay for a non-covered service, such as an unproven, investigational, or experimental service, the member (or the provider on the member's behalf) must first obtain an organization determination from Bright HealthCare denying coverage for the service. For more information about the rules regarding a member self-paying for a non-covered service, please refer to the **Patient billing** section of this manual.

Provider Obligations and Disclaimers

Bright HealthCare may enforce other Utilization Management controls in addition to requirements pertaining to prior authorization. These controls are used to validate that coverage of healthcare services are being provided in accordance with Medicare policy, plan benefits, and established clinical guidelines supporting the safe and effective use of healthcare services. Any services that do not meet these conditions will not be approved.

Subject to limitations set forth in a provider's network agreement, denials for failure to seek a prior authorization review will result in the provider being held financially responsible for the claims and therefore, providers may not balance bill Bright HealthCare members for such claims. An approved authorization is not a guarantee of payment. Billed services are subject to additional review for billing and coding issues, plan limits, eligibility at the time of service, and other limitations on coverage.

Concurrent Review

As part of its Utilization Management program, Bright HealthCare will conduct concurrent reviews of inpatient admissions and certain outpatient services for duration of stay, level of care reviews, and other medical necessity reviews. As required in their network participation agreements, network providers will be asked to cooperate with such concurrent reviews and the other Bright HealthCare Utilization Management programs described above.

Submitting Requests for Prior Authorization and Accessing UM Program Staff

A defined list of procedures that require prior authorization, including their procedure codes, can be found on **Availity.com** and **BrightHealthCare.com/provider/utilization-management**.

For information on where to submit an authorization request, please go to **BrightHealthCare.com/provider/utilization-management**. On this site you'll find a list of authorization resources by state.

If you are unsure where or how to submit a prior authorization, utilize Bright HealthCare's Authorization Navigator at **careteam.BrightHealthCare.com/auth-check**. The Authorization Navigator is an online tool to help determine if an authorization is needed and where/how to submit the authorization depending on the location or specialty.

Organization Determination/Coverage Decisions for Medical Care

Requests for authorization may be submitted electronically through Availity for some states and service types. For specific prior authorization resources, go to **BrightHealthCare.com/provider/utilization-management**.

Availability of Criteria

Upon request, Bright HealthCare will provide the criteria that was used to make a coverage decision in the UM program in writing. Bright HealthCare has established policies and procedures for registering and responding to member grievances and appeals if a member or authorized representative is not satisfied with a coverage decision. Refer to the Medicare appeals and grievances section for more information.

Case Management

The purpose of Case Management programs at Bright HealthCare is to identify and engage with members who are at high risk for complex, costly, or long-term healthcare needs. Through logical processes and utilization of the member's network, the case manager will coordinate medically appropriate services in a supportive and cost-effective manner. All case management activities will maintain the member's privacy, confidentiality and safety. The case manager will advocate for the member and adhere to ethical, legal, and accreditation/regulatory standards, while reinforcing the member's rights and responsibilities as noted in the EOC. The desired outcomes of the program are to:

- Improve self-management knowledge and skills regarding disease/condition
- Return the member's health to the maximum potential
- Promote positive health outcomes
- Increase member satisfaction
- Support the primary care physician
- Utilize in-network providers
- Reduce the cost of care
- Reduce unplanned hospital admissions and inappropriate emergency room use Identifying and recommending members to Case Management

Members may be identified by Care Partners, individual care providers, Health Risk Assessment (HRA) responses, administrative data (prior authorization and processed claims data), member services, and utilization review staff. Members may also self-refer to our programs by calling Member Services. Refer to the contact information in Appendix 1. As required in their Network Participation Agreements, network providers will be asked to cooperate with such Case Management programs offered by Bright HealthCare.

If you feel that a Bright HealthCare member would benefit from our Case Management program, please contact Bright HealthCare Provider Services. Refer to the contact information in Appendix 1.

Disease Management

The purpose of Disease Management programs at Bright HealthCare is to identify and engage members who have been diagnosed with a specific condition and are at risk for costly, or chronic healthcare needs. Members may be identified for disease management programs by Health Risk Assessment (HRA) responses, administrative data (prior authorization and processed claims data), and case management staff.

Disease management provides supports for the following conditions:

- Diabetes
- Depression
- Heart Disease
- Asthma/COPD
- High Cholesterol/High Blood Pressure
- Low Back Pain
- High Risk Pregnancy

All disease management activities will maintain the member's privacy, confidentiality and safety. The disease manager will advocate for the member and adhere to ethical, legal, and accreditation/ regulatory standards while reinforcing the member's rights and responsibilities as noted in the EOC.

Medicare Advantage Special Needs Plans (SNPs)

Special Needs Plans (SNPs) are Medicare Advantage plans that focus on certain vulnerable groups of Medicare beneficiaries. SNPs limit membership to individuals with specific conditions or characteristics and tailor their benefits, clinical programs and drug formularies to best meet the specific needs of the members we serve. Bright HealthCare offers two types of SNPs nationally.

Dual Eligible Special Needs Plan (D-SNP): The D-SNP is a plan designed for members who are eligible for both Medicare and Medicaid benefits.

Chronic Condition Special Needs Plan (C-SNP): The C-SNP is a plan designed for members with one or more chronic conditions, (e.g., diabetes mellitus, congestive heart failure, and/or certain cardiovascular diseases).

SNP Model of Care Overview

CMS requires SNPs to operate under a Model of Care (MOC) that has been approved by the National Committee for Quality Assurance (NCQA). The SNP MOC provides the framework for how each SNP will meet the specific needs of its members, including through care management and care coordination processes, clinical programs, a specialized provider network, and/or a comprehensive quality program.

Bright HealthCare designed its MOCs for the C-SNP and D-SNP to assure that member healthcare needs, preferences for healthcare services, choice of providers, and information needs are met across the continuum of care. Upon D-SNP and C-SNP member effective date of enrollment, all members are assigned to a Care Manager. In addition, a comprehensive health risk assessment (HRA) is completed within 90 days of enrollment.

Care Managers elicit a complete picture of each member's functioning, including non-medical factors that compound the risk for avoidable utilization, such as poor social supports, unstable or unsafe housing, and family caregiving responsibilities. The HRA drives development of an individualized care plan (ICP) that includes person-centered, measurable goals to address the member's unique medical and psychosocial needs. The ICP also identifies the member's Interdisciplinary Care Team (ICT); a group of qualified professionals that is chosen based on the member's needs. The ICT typically includes the member's Primary Care Provider (PCP) and other providers, as applicable, depending on the member's needs (e.g., specialists involved in the member's care).

The member's Care Manager is responsible for assisting the member with accessing necessary services, including specialty services, and ensuring their delivery (i.e., ensuring the member gets to the appointment, providing transportation assistance if needed, and/or communicating about barriers with the member). The Care Manager is responsible for ensuring the ICP accurately reflects the needs/wants of the member and keeps ICT participants informed of changes and updates as appropriate. The Care Manager follows up as needed with the member, the ICT, and the member's primary care provider and/or specialty provider(s). As a result of those discussions, the Care Manager adds any updates to the member's ICP and communicate those changes to the ICT. As a result of the comprehensive SNP MOCs, members experience delivery of high-quality health care that is rooted in the best practices of current evidence-based medicine and shared accountability.

Responsibilities of Providers Participating in a D-SNP or C-SNP Network

- Review and provide input to SNP member's ICP, as requested by the member's Care Manager or other SNP staff
- Participate in SNP member's ICT, as requested by the Member's Care Manager or other SNP staff
- Communicate and collaborate with the member's Care Manager and other members of the ICT to help coordinate the member's care
- Complete annual Model of Care training and attestation (see below for additional detail and a link to the training and attestation)

SNP Model of Care Provider Training

CMS requires SNPs to provide annual MOC training to network providers that are contracted to provide health services to SNP members. You are considered a SNP provider if you participate in the Bright HealthCare Medicare Advantage D-SNP or C-SNP network.

Bright HealthCare offers the Model of Care training as a self-guided presentation on the Bright HealthCare website under Provider Resources:

1. Visit Provider Resources **(BrightHealthCare.com)**
2. Scroll down to the SNP Model of Care Training section Click the SNP Training and Attestation link

At the end of the training, there will be a link to an attestation form. Please complete and submit the attestation online so Bright HealthCare has documentation of your completed training.

Dual Eligible Member Benefits and Cost-sharing

Members enrolled in a Bright HealthCare D-SNP receive Medicare benefits through Bright HealthCare. D-SNP members who are eligible for Medicaid benefits not covered by Medicare receive those benefits through a Medicaid managed care plan or Medicaid Fee for Service. Medicare is the primary payer for benefits covered by both Medicare and Medicaid.

Providers must not bill a dual eligible member with Qualified Medicare Beneficiary (QMB) benefits for Medicare cost sharing amounts, including deductibles, coinsurance and copayments. A dual eligible member with QMB benefits has no obligation to make further payment to a provider for Medicare Part A or Part B cost sharing amounts. Providers must accept Bright HealthCare's Medicare reimbursement as payment in full for Medicare services rendered to dual eligible members or bill the appropriate Medicaid agency as applicable for any additional Medicare payments that may be reimbursed by Medicaid. Dual eligible members will be responsible for any applicable Medicaid copayments.

Quality Assurance and Improvement

Where applicable, Bright HealthCare follows state utilization management licensure requirements and URAC accreditation standards. To the extent that utilization management functions are delegated to a third party, Bright HealthCare performs appropriate oversight of the quality of the vendor's performance including, without limitation, monitoring the consistency of approvals, denials, and inpatient admission decisions, turnaround time of utilization management decisions, and oversight of physician review activities performed by medical directors. Telephone services are tracked based on the percentage of calls that go into the hold queue, abandonment rate, and average speed of answer.

The program is under the administrative and clinical direction of Bright HealthCare's senior clinical staff, Utilization Management Subcommittee and Quality Management Council. The Quality Management Council evaluates and approves the Utilization Management Program annually. Updates occur, as required, based on feedback from providers and in consideration of the needs of members.

Bright HealthCare and its delegated utilization management partners receive no financial incentives for issuing denials of coverage.

Section Seven:
Medicare Appeals & Grievances

Medicare (Part C) Medical Appeals Procedure

Providers must follow the organization determination process prior to providing services subject to prior authorization or other pre-service review. Failure to follow the organization determination process will result in denied claims and may be subject to provider liability. Refer to Bright HealthCare's prior authorization list for a list of services requiring prior authorization.

For all provider-liable claim disputes for Medicare members, please follow the provider payment dispute process located in the **Provider payment dispute process** section of this manual.

Reconsideration Review

Network providers should work with members to provide all necessary/required information supporting reconsideration and organization determination requests as early in the review process as possible. Any documentation omissions or delays will likely result in unnecessary denials or delayed decisions.

Reconsideration requests from a member, the authorized representative, or the treating provider, will be considered timely if filed with Bright HealthCare, in writing, within 60 days of the plan action (organization determination).

Reconsideration requests filed more than 60 days from the date of the original decision will not be reviewed unless good cause for late filing exception is granted by Bright HealthCare.

Time Frames for Completing Reconsideration

Claim: The reconsideration decision will be rendered within 60 calendar days.

Standard (non-expedited) pre-service organization determination: The reconsideration decision will be rendered within 30 calendar days, or as expeditiously as the member's condition requires, unless a 14-day extension would benefit the member.

Expedited review of a pre-service organization determination denial (also known as a "fast appeal"): The reconsideration decision will be rendered within 72 hours of receipt (if it meets federal guidelines for expedited handling), unless a 14-day extension would benefit the member.

Any request for reconsideration may be withdrawn, verbally or in writing, at any time during the appeals process by the appellant (the member or their authorized representative). At such time, no further reconsideration review will be completed, and Bright HealthCare will notify the parties that the reconsideration has been withdrawn.

If the member would like to exercise their right to reconsideration at a later date, they may do so as long as the reconsideration request is made within the 60 days of the plan action, unless a good cause for late filing exemption is granted by Bright HealthCare. Bright HealthCare will issue a final decision, in writing, to all parties involved in the reconsideration review.

If there are any questions regarding the reconsideration review (or any subsequent appeal rights), please direct the member, the authorized representative, or treating provider, to Bright HealthCare using the contact information provided on the reconsideration determination letter.

If a claim reconsideration review finds the network provider liable for charges, the network provider may consult the **Provider payment dispute process** section of this manual for next steps regarding filing a separate payment dispute. However, providers must promptly discontinue all collection efforts from the member upon receipt of the Bright HealthCare outcome letter or revised remittance advise. Refusal to discontinue collection efforts following plan direction of provider liability will be considered a breach of the provider's Network Participation Agreement.

Quality Improvement Organization Procedure

Bright HealthCare will provide prompt reviews to all member complaints and appeals in accordance with the Medicare appeals and/or Medicare grievance processes outlined below.

This section addresses the member's **Medicare appeal and grievance** rights.

Providers may act on behalf of the member at the organization determination level and in some reconsiderations. For member appeals beyond those levels, the provider may only act on behalf of the member if they are appointed as an authorized representative. If you are acting on behalf of a member, please refer to the contact information in Appendix 1 when sending correspondence or contacting Bright HealthCare.

There is a special procedure for the local Quality Improvement Organization (QIO) for Hospital Inpatient, Skilled Nursing Facility (SNF), Home Health Agency (HHA), and Comprehensive Outpatient Rehabilitation Facility (CORF) discharge decisions. This procedure is located in the Quality Improvement Organization (QIO) Procedure section of this manual.

Medicare (Part D) Prescription Appeals Procedure

Bright HealthCare Medicare Advantage plan members have the right to appeal an adverse Part D coverage determination. If a member wishes to appeal an adverse coverage determination decision, the process requires a redetermination filing (the first level of the Prescription Appeals procedure) with Bright HealthCare.

- If a member has questions on how to file a Part D redetermination, please contact Bright HealthCare Part D Appeals. Refer to Appendix 1 for contact information
- To exercise the member's rights to a redetermination, a member or authorized representative (or, for prior authorization standard or expedited appeals, the member's prescribing physician) must send a written request to Bright HealthCare Appeals either by fax or mail. Refer to Appendix 1 for contact information

Time Frames for Bright HealthCare to Complete a Redetermination Request

Redeterminations are generally resolved within seven (7) calendar days and notice of the decision will be provided verbally to the member, with written notification forwarded within three (3) days of that phone call.

- If the request is a prior authorization and waiting could seriously jeopardize the life or health of the member, or the member's ability to regain maximum function, an expedited redetermination can be requested. These redetermination requests are handled within 72 hours
- Redetermination requests must be filed within 60 days of the notice of unfavorable Part D coverage determination. Redetermination requests regarding events more than 60 days prior to the date of filing will not be accepted, unless the member can provide good cause for late filing exception
- In the event of an unfavorable redetermination outcome, the member will be provided information in their written notice on how to file a Part D reconsideration with the Independent Review Entity (IRE), if they choose to exercise that right

Medicare Appeals and Grievances

Grievance Overview and Filing

A member, or their authorized representative, may file a grievance either verbally or in writing to Bright HealthCare Appeals & Grievances within 60 days of the event in question.

Grievances regarding events greater than 60 days past will not be accepted unless the member can provide good cause for late filing. Verbal grievances will be resolved verbally unless the member requests a response in writing. All written grievances will be responded to in writing no later than 30 days from receipt of the grievance, unless the member requests a time extension, or Bright HealthCare justifies a need for additional information that could benefit the member. Extensions may be granted for 14 days. If an extension is made, the member will be notified in writing.

If a member disputes Bright HealthCare's refusal to perform an expedited review of a coverage determination or appeal, or the decision to take a 14-day extension, Bright HealthCare will make the grievance decision within 24 hours from the receipt of the member's dispute.

Appeals & Grievances Contact Information

Medical (Part C)

- Mail:

  Bright HealthCare MA – Appeals and Grievances
  P.O. Box 1868
  Portland, ME 04104
- Phone: **844-202-2154**
- Fax: **800-894-7742**

Medical (Part D) appeals

- Mail:

  Med Impact
  10181 Scripps Gateway Court
  San Diego, CA 92131
- Phone: **833-726-0667**
- Fax: **858-790-6060**

Medical (Part D) grievances

- Mail:

  Med Impact
  10181 Scripps Gateway Court
  San Diego, CA 92131
- Phone: **833-726-0667**
- Fax: **858-790-6060**

Appointment of Representation

Background on Member Representation

There are times when a member may request third parties to assist them with various interactions with Bright HealthCare, which are considered "appointments." Bright HealthCare strives to make the appointment process as easy as possible for members within the confines of the law and CMS regulations.

We recognize four levels of appointment: Durable Appointment, PHI Delegate Appointment, Authorized Representative Appointment, and Limited Verbal Appointment.

Bright HealthCare encourages members to call the Member Services number on the back of their member ID card for questions regarding the appointment process or for instructions on how to appoint a representative or delegate.

CMS guidelines regarding the Appointment of Representative Form CMS-1696: "If an enrollee would like to appoint a person to file a grievance, request a coverage determination, or request an appeal on his or her behalf, the enrollee and the person accepting the appointment must fill out Form CMS-1696 (or a written equivalent) and submit it with the request."

Section Eight:
Quality Management & Improvement

Quality Management Program

Bright HealthCare's Quality Management Program is based on a philosophy that emphasizes a systematic, data-driven effort to measure and continuously improve healthcare services and outcomes for members while exceeding member expectations. It applies to all member demographic groups, care settings, and types of services (medical and behavioral health). We maintain a quality program that aims to meet or exceed accreditation requirements, state and federal regulations, statutes, and Bright HealthCare's policy and procedures.

The overall goal of the Quality Management Program is to improve the quality and safety of clinical care and services provided to the members in Bright HealthCare's network of providers. All goals are reviewed annually and revised as needed. All goals will operate in compliance with and responsive to applicable requirements of Medicare Advantage plan sponsors, federal and state regulators, and appropriate accrediting bodies.

As part of its Health Plan Quality Management Program, Bright HealthCare measures and analyzes data to improve performance, process, satisfaction, and outcome in the areas of consumer satisfaction, access and availability, surveys, HEDIS measures calculated from claims, medical record and supplemental data, outcome reports of targeted quality improvement activities, and claims data. Key areas of focus include, but are not limited to:

- Quantitative member and organizational outcomes
- Patient safety
- Confidentiality
- Network adequacy
- Preventive health
- Service utilization
- Disease and case management
- Coordination/continuity of care
- Cultural competency
- Credentialing
- Quality of care/service, including critical incidents
- Appeals and grievances
- Client satisfaction
- Member and provider satisfaction

- Components of operational service
- Reporting requirements

Provider Support

Bright HealthCare's provider network is a key partner in achieving the goals of our Quality Management Program.

Gaps in Care Closure

A gap in care is defined as a discrepancy between recommended best practices and care that is provided. Bright HealthCare obtains health information on our members and shares potential gaps with our provider partners. Opportunities to close gaps in care include, but are not limited to:

- ***Complete and accurate coding and documentation*** is the first step to closing care gaps. By following, documenting, and coding the recommended care, Bright HealthCare will receive the necessary information via claims submissions which automatically closes the gap in care for the member
- ***Direct EMR Access*** allows Bright HealthCare to efficiently close quality gaps and gather required medical records without having to put undue burden on your staff (Bright HealthCare adheres to all HIPAA regulations and only obtains the minimum information necessary to close the care gap)
- ***Supplemental Data*** refers to additional clinical information about a member, beyond administrative claims, received by a health plan. A health system or provider group can submit reports directly from their EMR to Bright HealthCare and is an acceptable way to close gaps in care
- ***Chart Chase*** is the final way to close quality gaps in care. During specific times of year, Bright HealthCare will submit bulk requests for medical records to be abstracted to prove that required care was delivered. This usually takes place as part of HEDIS or Risk Adjustment audits (see below)

Chart Retrieval

Providing contact information for your Medical Records Department or Third-Party Record Retrieval Vendors allows Bright HealthCare to more accurately direct chart requests within your organization, thus reducing the administrative burden on your team. Please provide the following information to our Medical Record Retrieval Department (**medicalrecords@BrightHealthPlan.com**):

- Internal Medical Records Department
- Contact name
- Phone number
- Fax number
- Mailing address
- Third Party Vendor
- Name of the organization

- Established organization workflow for records
- Escalation contact
- ***Health Effectiveness Data and Information Set (HEDIS)*** is a comprehensive set of standardized performance measures designed to ensure that the public has information to compare different health insurance organizations' performance on important dimensions of care and service. A portion of HEDIS reporting relies on providers submitting necessary medical records to prove that certain aspects of care were provided
- Timeline – Annually February through May
- Your office will receive requests directly from Bright HealthCare or through our third-party record retrieval vendor. Specific instructions for the type of information needed will be provided along with directions on where to send the information. Timely submission of records is key to ensuring the care provided is accurately reflected in the published HEDIS rates.

Risk

Risk adjustment is a statistical process developed by the Centers for Medicare and Medicaid Services (CMS) that helps predict healthcare utilization and patient care needs for Medicare Advantage patients. Risk adjustable medical conditions are captured by providers and submitted on claims in order to determine the patient's health status. Risk adjustment chart review is necessary in order to ensure that the risk adjustable conditions documented and submitted are complete and accurate.

- Timeline
- Risk Adjustment Chart Reviews
- Medicare Advantage – annually May to December
    - Your office will receive requests directly from Bright HealthCare or through our third-party record retrieval vendor. Specific instructions for the type of information needed will be provided along with directions on where to send the information. Timely submission of records is key to ensuring the care provided is accurately reflected in the member's risk score

Quality of Care and Patient Safety

Care Partners, clinically integrated networks, health systems, facilities, and medical groups are responsible for monitoring the quality of services provided by providers to members, including without limitation to ensure patient safety.

In addition to any regulatory reporting requirements, providers must provide prompt notice to Bright HealthCare of any member quality issues or other adverse events. Such reporting requirements must include Hospital-Acquired Conditions ("HAC") and Serious Reportable Events (as defined by the National Quality Forum) related to services rendered to a Bright HealthCare member.

Such notifications should be submitted in a HIPAA-compliant communication via one or more of the following formats:

- Certified mail or courier:

  Bright HealthCare
  ATTN: Quality
  8000 Norman Center Drive, Suite 1200
  Minneapolis, MN 55437

- Fax: **877-825-2725**
- Email: **Quality@BrightHealthPlan.com**

Bright HealthCare may also receive Quality of Care Concerns (QOCC) directly from Members or from our internal clinical staff. If that occurs, requests for medical records will be submitted to your office or facility (or third-party vendor, identified). CMS requires that Member initiated concerns be addressed within 30 days, making timely submission of medical records vitally important. We ask that you submit any records requested through our QOCC process as soon as possible but no later than 7 days after the request.

Chronic Care Improvement programs (CCIPs)

These programs focus on activities that address opportunities for error reduction or performance improvement and promotes effective management of chronic disease, improving care and health outcomes for enrollees with chronic conditions, and are conducted over a three-year period.

Bright HealthCare CCIPs relate to key indicators of quality, are member focused, and are designed to improve performance. Bright HealthCare clinical leadership staff members and at least one participating provider provide input for all CCIPs. If you would like to take a more active role in Bright HealthCare's Chronic Care Improvement Programs, please reach out to our Quality Team (**Quality@BrightHealthPlan.com**).

Section Nine: Delegation Oversight

Delegation Oversight

Broad definition of a Delegated Group

Physician organizations, commonly referred to as medical groups or Independent Physicians Organizations (IPA), are paid under a population-based payment model (commonly referred to as capitation). In this model, the Centers for Medicare & Medicaid Services (CMS) makes a payment of premium to health plans. Health plans pay physician groups a defined amount for each enrolled patient for services over a span of time, which is typically a per member, per month payment. When a health plan (Sponsor) contracts with an IPA or medical group and delegates them to perform administrative or healthcare services for enrollees on behalf of the Plan, the entity is considered a delegated (contracted) medical group. Bright HealthCare's Delegation Agreement (Division of Delegated Responsibilities) will specify in detail what functions have been delegated to the Delegated Group.

Responsibilities of Being Delegated

The Sponsor maintains the ultimate responsibility for fulfilling the terms and conditions of its contract with CMS, and for meeting the Medicare program requirements. Therefore, CMS may hold the Sponsor accountable for the failure of its First Tier, Downstream, and Related Entities (FDRs) to comply with Medicare program requirements. Providers contracted directly with Bright HealthCare shall be monitored to ensure compliance with federal and state regulations, Accreditation standards, and Bright HealthCare policies. If the Delegated Group is delegated to perform Utilization Management (UM), Claims, Credentialing, Provider Network Operations (PNO), or any of these specific functions, the delegate is to ensure that their Policy and Procedures (P&Ps) for each area are in alignment with Bright HealthCare policies and requirements.

Ongoing Auditing/Monitoring

Annually, Bright HealthCare will conduct an audit of delegated functions performed by the Delegated Group. If the Delegated Group sub-contracts with a Management Services Organization (MSO) to perform the delegated functions, the MSO performing the functions on behalf of the delegated group is audited. Bright HealthCare's annual audit is a comprehensive review of the delegate's performance, including both compliance with applicable standards and the extent to which the delegate's activities promote the organization's overall goals and objectives for the delegated function. Annual audits will include a comprehensive review of **UM, Claims, Credentialing, and PNO**.

The UM review shall include an extensive review of UM P&Ps, SOD/EOD files, and denials.

The Claims review shall include non-contracted paid/denied claims and denied reports. Credentialing will review the delegate's Credentialing P&Ps and credentialing files utilizing NCQA's "8 and 30 file sampling procedure" to ensure all providers are credentialed and recredentialed.

The review of PNO shall include a request for a full network roster to ensure CMS network adequacy requirements are met. Provider contracts are also reviewed to ensure all required CMS language is in contracts.

In the event problems or deficiencies are identified, a corrective action may be issued and may include procedures for assuring that the corrective action is implemented.

Required Reporting

Delegated Groups shall provide Bright HealthCare with periodic written reports regarding all delegated activities in the formats specified by each business unit. Delegated Groups are to submit complete and accurate ongoing reports for all delegated activities according to the reporting frequencies specified in the Required Reporting Agreement.

Sub-Delegation

All Providers delivering service to Bright HealthCare members will adhere to the guidelines listed below. Delegated Groups shall not further sub-delegate any delegated activities to any other entity or organization without the prior written consent of the Plan.

Revocation

Bright HealthCare may, at its sole discretion or at the discretion of CMS, revoke any or all delegated activities at any time, for any reason.

Appendix 1: Medicare Advantage Contact Information

Provider Services

- Phone: **844-223-8380** for plan year/services 2021 or older
- Phone: **844-926-4522** for plan year/service 2022
- Monday – Sunday, 8 a.m. to 8 p.m. Local time
- April 1 – Sept. 30, Monday – Friday, 8 a.m. to 8 p.m. Local time

Pharmacy Specific Care Services

Pharmacy Help Desk

- Phone: **833-726-0667**
- 24 Hours, Monday – Sunday (except holidays)

Pharmacy Prior Authorization

- Phone: **833-726-0667**
- Fax: **858-790-7100**
- 24 Hours Monday – Sunday (except holidays)
- For medical UM prior authorization, refer to information on **BrightHealthCare.com/provider/utilization-management.**

Appeals, Grievances, and Complaints

- Phone: **844-202-2154**
- Fax: **858-790-6060**
- Bright HealthCare Provider Disputes
  PO Box 1359
  Portland, ME 04104

Medicare Advantage Claims

- **Plan Year 2022 (EDI Payer ID: BRGHT)**
  Bright HealthCare Claims PO Box 211502
  Eagan, MN 55121
- **Plan Year 2021 (EDI Payer ID: BRGHT)**
  Bright HealthCare Medicare Advantage – Claims Operations P.O. Box 853960
  Richardson, TX 75085-3960

Reporting Fraud, Waste, and Abuse or Suspicious Activity

- Phone: **1-855-208-3766**

Appendix 2: Regulatory Addendum

Bright HealthCare Management, Inc., and its affiliates (Bright HealthCare Insurance Company and its other health plan affiliates) are engaged in the business of Medicare Advantage and Part D coverage through a contract with the Center for Medicare & Medicaid Services (CMS) ("MA Plan(s)"). Vendor or Provider provides services to MA Plan Members pursuant to an agreement with MA Plan (Agreement). Accordingly, Vendor or Provider agrees, on behalf of itself and its affiliates performing services to MA Members under the Agreement, to comply with the following provisions.

Any term not defined in this addendum shall have the same meaning as set forth in the Agreement. For purposes of this addendum, "Member" shall mean an individual who is enrolled in Bright HealthCare Plan's MA coverage. In the event of a conflict with the Agreement, the terms of this addendum will take control.

General Compliance Provisions

Delegated Activities and Reporting Requirements

The delegated activities and reporting responsibilities must be specified in the Agreement. 42 CFR § 422.504(i)(4); 42 CFR § 423.505(i)(4).

Compliance with Medicare Laws, Regulations, and CMS guidance

Vendor or Provider agrees to comply with all applicable Medicare laws, regulations, and CMS guidance. 42 CFR § 422.504(i)(4); 42 CFR § 423.505(i)(3).

Compliance with MA Plan's Contract with CMS

Any services or other activity performed in accordance with this Agreement by Vendor or Provider are consistent and comply with the MA Plan's contractual obligations with CMS. 42 C.F.R. § 422.504(i)(3); 42 CFR § 423.505(i)(3); 42 CFR § 423.505(i)(4).

Medicare Compliance Program

Vendor or Provider agrees to develop and maintain an effective MA compliance program that meets CMS requirements and that includes without limitation: (a) an effective system for routine monitoring and auditing to identify compliance risks, (b) procedures and systems for prompt response to compliance issues, (c) written policies, procedures, and standards of conduct that articulate the Vendor or Provider's commitment to comply with all applicable Federal and state standards and describes compliance expectations, (d) designation of a compliance office and compliance committee responsible for oversight of the compliance plan, (e) an effective compliance training program that includes fraud, waste, and abuse training, (f) effective lines of communication between the compliance officer and the MA Plan and the compliance officer and Vendor or Provider employees and contractors, (g) published and enforced disciplinary standards for noncompliance by employees and contractors, up to and including termination.

Vendor or Provider further agrees to provide Medicare Standards of Conduct and policies and procedures to all employees and contractors who perform services pursuant to the Agreement. 42 CFR 422.503(b); 42 CFR § 423.505(i)(3); 42 CFR § 423.505(i)(4).

Report Compliance Concerns

Vendor or Provider agrees to report compliance or fraud, waste, and abuse (FWA) concerns to the MA Plan within five calendar days of discovery of an actual, suspected, or potential compliance concern or FWA concern. If the matter is emergent, either because beneficiary access to care is affected or because of other critical impacts, Vendor or Provider must notify the MA Plan as soon as reasonably possible, and no later than 24 hours from discovery. Vendor or Provider shall coordinate with MA Plan to (a) timely investigate compliance or FWA risk, (b) mitigate the FWA or compliance concern, and (c) implement the appropriate corrective action. 42 CFR § 422.503(b); 42 CFR § 423.504(b)(4)(vi)(D).

Exclusion

Vendor or Provider certifies that no member of its governing bodies and advisory boards, individual employed or contracted practitioners, all other employees and contractors, or affiliated provider organizations has been excluded from participation in federal contracts by (a) U.S. Treasury Office of Foreign Assets Control, (b) Office of Inspector General of the Department of Health and Human Services, or (c) U.S. General Services Administration (GSA).

Vendor or Provider agrees that for each of its employees, independent contractors, volunteers, and members of its governing bodies, and advisory boards, it shall (a) perform a background check prior to hire and (b) monitor the exclusion lists published by the above federal agencies prior to hire and monthly thereafter.

Vendor or Provider shall also require any of its subcontracts to include such checks prior to hire and on a monthly basis thereafter. If any of its employees or other individuals are excluded by such federal agencies, Vendor or Provider agrees to notify the MA Plan and immediately remove the individual from any services performed under the Agreement on behalf of the MA Plan. 42 CFR § 422.503(b); 422.752(a); 423.504(d).

Investigations, Legal Actions, and Arbitrations

Vendor or Provider acknowledges to the best of its knowledge, information and belief, there are no past or pending investigations, legal actions, or matters subject to arbitration involving Vendor or Provider or any of its employees, contractors, governing body members, downstream entities, or any major shareholders (5% or more) on matters relating to payments from governmental entities, both federal and state, for health care and/or prescription drug services.

Convictions and Civil Judgements

Vendor or Provider acknowledges to the best of its knowledge, information, and belief that neither Vendor or Provider, nor any of its employees, contractors, governing body members, downstream entities, or any major shareholders (5% or more) have been criminally convicted nor has a civil judgment been entered against them for fraudulent activities nor are they sanctioned under any federal program involving the provision of healthcare and/or prescription drug services.

Section 1557 of the Patient Protection and Affordable Care Act (ACA)

Vendor or Provider shall comply with the nondiscrimination provisions, meaningful access requirements, language assistance services, and requirements of Section 1557 of the ACA requirements. 45 CFR §§ 92.1 – 92.303.

Certifications to Accuracy, Completeness, and Truthfulness of Data

If Vendor or Provider generates data to determine payment on behalf of MA Plan, then Vendor or Provider must certify (based on best knowledge, information, and belief) the accuracy, completeness, and truthfulness of the data.

Marketing Guidelines

To the extent Vendor or Provider performs services or functions that are governed by the CMS Manual

System, Pub. 100-16 Medicare Managed Care, Chapter 3, Medicare Marketing Guidelines for the Department of Health & Human Services Centers for Medicare & Medicaid Services, as amended, Vendor or Provider agrees to comply with such guidelines.

Records

Record Retention and Audit

Vendor or Provider agrees to retain any books, records, contracts, and other documents related to the MA Plan's MA contract with CMS for a period of 10 years from the final date of the MA contract or the completion of any audit, whichever is later.

Vendor or Provider agrees to comply at no additional charge with any document requests by the MA Plan pursuant to an audit, for purposes of MA Plan oversight, or for any other reason related to the operation of the MA business.

Vendor or Provider agrees to allow HHS, the Comptroller General, or their designees to audit and inspect any books, records, contracts, and other documents related to the MA Plan's MA contract with CMS for a period of 10 years from the final date of the MA contract or the completion of any audit, whichever is later. 42 CFR § 422.504(i)(2); 42 CFR § 423.505(e) (2); 42 CFR § 423.505(i)(2).

Data Privacy and Confidentiality of Records

Vendor or Provider shall establish procedures that comply with the privacy, confidentiality, and accuracy of Member record requirements including without limitation, abiding by all federal and state laws regarding use and disclosure of medical records, or other protected health and enrollment information, and safeguarding the privacy of information that identifies a particular Member.

Vendor or Provider shall have procedures that (1) specify for what purpose the information is used by Vendor or Provider, (2) specify to whom and for what purpose it discloses the information to third parties, (3) ensure that medical information is released only in accordance with applicable federal or state law, or pursuant to court orders or subpoenas, (4) specify that the records and information are maintained in an accurate and timely manner, and (5) ensure timely access by Members to the records and information that pertain to them. 42 C.F.R. § 422.504(a)(13); 42CFR § 422.118; 42 CFR § 423.136.

General contract provisions

Vendor Offshore Services

Vendor agrees that it will not perform offshore administrative services, or any other services on behalf of the MA Plan, or delegate to offshore entities without obtaining written prior approval from the MA Plan. If such approval is granted, Vendor agrees to demonstrate compliance with all laws, rules, and CMS guidance related to offshore services and related to the transmission of electronic data and protected health information offshore. MA Plan has the right to conduct an annual audit of the Vendor to evaluate the practices and procedures, including but not limited to PHI privacy and security controls, of the Vendor and the audit results will be used to evaluate the continuation of the offshore relationship.

Amendments Required by Law

If Medicare laws, regulations, or CMS guidance require a change to the terms of this addendum, this addendum may be modified by the MA Plan to reflect the changed requirements and such modification will become immediately upon written notice by the MA Plan providing the modified addendum to the Vendor or Provider without the need to amend the Agreement.

Monitoring and Termination

The MA Plan will monitor the Vendor or Provider's performance under the Agreement and this addendum on an ongoing basis. The MA plan and CMS have the right to revoke the delegation activities and may terminate the Agreement with Vendor or Provider if the MA Plan or CMS determines that Vendor or Provider has committed a violation of CMS rules, committed FWA, or has not performed satisfactorily under this addendum. 42 CFR § 422.504(i)(4); 42 CFR § 423.505(i)(4).

Flow-down Requirements

Vendor or Provider (where services are delegated) will incorporate these requirements into its agreements with downstream providers, subcontractors, and delegated entities. The MA Plan retains the right to approve, suspend, or terminate Vendor or Provider's agreements with downstream providers, subcontractors, and delegated entities. 42 CFR § 422.504(i)(5); 42 CFR 423.505(i)(3); 42 CFR 423.505(i)(4).

Vendor or Provider shall monitor and audit its downstream providers, subcontractors, and delegated entities ("Downstream Entity(ies)") to ensure that they are in compliance with all applicable laws, regulations, and contractual requirements, including compliance with these Medicare Advantage provisions. If Vendor or Provider determines a Downstream Entity requires corrective action(s), Vendor or Provider shall ensure that such corrective action(s) are taken by its Downstream Entity. Vendor or Provider shall provide information about its Downstream Entity oversight, including any corrective action plans, to MA Plan upon request.

Notwithstanding any relationships that MA Plan may have with first tier, downstream, and related entities, MA Plan maintains ultimate responsibility for adhering to and otherwise fully complying with all terms and conditions of its contract with CMS. Vendor or Provider shall participate in and comply with MA Plan's oversight program, including but not limited to, attending meetings, providing attestations, responding to document requests, FWA and General Compliance Training, policy, and procedure review requests, implementing corrective action plans imposed by MA Plan or CMS, participating in monitoring and reviews, and providing MA Plan with similar information about Vendor's or Provider's Downstream Entities.

Requirements Applicable Only to Providers

Hold Harmless

Provider agrees to accept the MA Plan's MA contracted rate as payment in full and agrees not to hold Members liable for the payment of any fees that are the obligation of the MA Plan. 42 CFR § 422.504(i)(3); 42 CFR § 422.504(g); 42 CFR .§ 423.505(i)(3).

Medicare-Medicaid Enrollees

For Members eligible for both Medicare and Medicaid, Provider agrees not to hold MA Enrollees liable for Medicare Part A and Part B cost sharing amounts where the Members are eligible for Medicare and Medicaid coverage and the state is responsible for paying such amounts. The Provider shall not impose cost sharing that exceeds the amount of cost sharing that would be permitted with respect to the individual under Title XIX if the individual were not enrolled in such a plan. Providers will (1) accept the MA plan payment as payment in full or (2) bill the appropriate State source. 42 CFR § 422.504(i)(3); 42 CFR § 422.504(g)(1)(iii); 42 CFR § 423.505(i)(3).

Credentialing

Where MA Plan has delegated credentialing to Provider for provider organizations and/or individual practitioners, Provider agrees to submit its credentialing process and upon reasonable request, the credentials of individual medical professionals and organizations affiliated with Provider, to the MA Plan for review and approval and Provider agrees that the MA Plan may monitor and audit the credentialing process on an ongoing basis. 42 CFR § 422.504(i)(4(iv).

Termination Rights

MA Plan retains the right to approve, suspend, or terminate the selection of provider organizations and individual practitioners and MA Plan also retains the right to revoke the delegation of credentialing to Provider without triggering a termination of the Agreement. 42 CFR § 422(i)(5); 42 CFR § 423.505.

Prompt Payment

MA Plan agrees to pay clean claims within the time period required by MA regulations. If MA Plan reimburses clean claims outside of the time period required by MA regulations, MA Plan agrees to pay interest as set forth by the Department of Treasury pursuant to the federal Prompt Payment Act. Where Provider is responsible for paying claims on behalf of the MA Plan, Provider agrees to include in its contracts and adhere to all applicable federal and state requirements for the prompt payment of claims with respect to downstream providers. 42 CFR § 520(b)(1) & 504(c).

Stop-loss Protection

Where Provider accepts financial risk in its Agreement with the MA Plan, Provider agrees to comply with all CMS rules for physician incentive plans applicable to the arrangement, including without limitation obtaining stop-loss protection where required. 42 CFR § 422.208.

Non-covered Services

With the exception of an explicitly excluded service in the Member's MA Evidence of Coverage, Providers may not permit a Member to self-pay for a non-covered service unless the Member, or the Provider on the Member's behalf, has first obtained an organization determination from the MA Plan denying coverage for the service. For an explicitly excluded service, Providers may permit the Member to self-pay for the service without an organization determination.

Provider Offshore Services

Provider agrees that it will notify the MA Plan before performing offshore administrative services, or any other services on behalf of the MA Plan. Provider agrees to demonstrate compliance with all laws, rules, and CMS guidance related to offshore services and related to the transmission of electronic data and protected health information offshore. MA Plan has the right to conduct an annual audit of the Provider to evaluate the practices and procedures.