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Introduction and Provider Experience

Introduction

Sharp Health Plan is a subsidiary of Sharp HealthCare, the largest provider of comprehensive health care services in San Diego. Sharp Health Plan is a not-for-profit organization that has been serving the health benefit needs of businesses of all sizes in San Diego and southern Riverside Counties since 1992. Sharp Health Plan offers a variety of health insurance options for individuals, families, and businesses that combine affordability and choice, while delivering high-quality health care and personal service.

As of January 1, 2017, Sharp Health Plan will offer five Medicare Advantage products under the name Sharp Advantage (HMO). Three are employer group waiver plans (EGWP) and two Individual plans open to all Medicare-eligible people in San Diego County. All products are Medicare Advantage Prescription Drug plans (MA-PDs), and therefore have Part D Prescription Drug benefits. Formularies and drug tiers are the same for all plans, though copays differ.

All Sharp Health Plan Medicare Advantage products include the full benefits of traditional Medicare (Part A and Part B) as well as Part D Drug Coverage, and supplemental benefits covering health services beyond those offered by traditional fee-for-services Medicare. Additional benefits include vision coverage, hearing aid coverage, gym membership as well as interactive wellness resources. Dental coverage is not included except as required by Medicare. Not all plan configurations are offered the same supplemental benefits. Please review the appropriate Summary of Benefits, the member’s Evidence of Coverage and the formulary documents available at sharpmedicareadvantage.com for more information.

Network Providers

Sharp Advantage is an HMO plan. It has a defined network of physician groups, called Plan Medical Groups (PMGs), from which Members choose a Primary Care Physician (PCP), receive specialty physician care and access to hospitals and other facilities like Urgent Care centers. Members must obtain Covered Benefits through their PCP and providers affiliated with the PCP's PMG. The PCP is responsible for coordinating and directing necessary care to the appropriate Plan Providers.

Service Areas

In 2017, the following are the service areas:

Sharp Advantage (HMO) – Individual and Employer Group Plan:
All of San Diego County
## Claim Submission Addresses

<table>
<thead>
<tr>
<th>Provider</th>
<th>Address</th>
<th>Phone</th>
<th>Fax</th>
</tr>
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<tbody>
<tr>
<td>GTC – Greater Tri-Cities (IPA)</td>
<td>PO Box 5059, Oceanside, CA 92052</td>
<td>760-941-7309, option 3</td>
<td>760-631-7614</td>
</tr>
<tr>
<td>Palomar Health</td>
<td>PO Box 260890, Encino, CA 91426</td>
<td>888-445-0062 or 818-461-5000</td>
<td></td>
</tr>
<tr>
<td>Sharp Community Medical Group (SCMG)</td>
<td>PO Box 939037, San Diego, CA 92193</td>
<td>858-499-2550</td>
<td>858-499-4441</td>
</tr>
<tr>
<td>Sharp Rees-Stealy Medical Group (SRSMG)</td>
<td>PO Box 939035, San Diego, CA 92193</td>
<td>858-499-2410</td>
<td>858-268-4642</td>
</tr>
<tr>
<td>(SHP) Sharp Advantage</td>
<td>8520 Tech Way, Ste 201, San Diego, CA 92123-1450</td>
<td>858-820-2112</td>
<td>858-636-2307 (Provider disputes or reconsiderations only)</td>
</tr>
<tr>
<td>American Specialty Health Plan</td>
<td>PO Box 509002, San Diego, CA 92150</td>
<td>800-972-4226</td>
<td></td>
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<tr>
<td>Vision Service Plan (VSP)</td>
<td>PO Box 997105, Sacramento, CA 95899</td>
<td>800-877-7195</td>
<td></td>
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<tr>
<td>CVS Minute Clinic</td>
<td>See (SHP) Sharp Advantage</td>
<td></td>
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## Provider Experience

We are committed to providing high quality service to both our Members and Providers. Sharp Health Plan attributes much of its success to our network of dedicated Providers, our partners in success. We therefore commit to providing the resources and support Providers need to serve our Members.

Participating Providers have the right to expect the following:
Respect
Confidentiality
Orientation and in-service training
Information about changes in policies, procedures, and Plan benefits
Prompt responses to inquiries
Consideration of your suggestions
Accurate and timely claims processing
Timely resolutions of coverage decisions, Appeals and Grievances
Accurate representation in Sharp Health Plan directories and publications

This Manual is one means of providing the information you need as a participating network Provider. Providers are also apprised of new policies, changes within the Plan, and updates through in-service trainings, fax alerts, and notices on our website. Providers who identify additional educational needs are encouraged to contact the Provider Relations at 858-499-8330 or email: provider.relations@sharp.com.
# Sharp Health Plan Medicare Advantage Quick Reference Guide

<table>
<thead>
<tr>
<th>RESOURCE</th>
<th>INDIVIDUAL</th>
<th>EMPLOYER GROUP WAIVER PLAN (EGWP)</th>
</tr>
</thead>
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<td>Website: <a href="https://www.sharpmedicareadvantage.com/">https://www.sharpmedicareadvantage.com/</a></td>
</tr>
</tbody>
</table>
| **Appeals and Grievances**| Sharp Health Plan  
Attn: Appeal and Grievance Department  
8520 Tech Way, Ste 200  
San Diego, CA 92123 | Sharp Health Plan  
Attn: Appeal and Grievance Department  
8520 Tech Way, Ste 200  
San Diego, CA 92123 |
<p>|                           | Phone: 1-855-562-8853                           | Phone: 1-855-820-2112                         |
|                           | Fax: 858-636-2256                               | Fax: 858-636-2256                             |
| <strong>Capitation</strong>            | Phone: 1-858-499-8113                           | Phone: 1-858-499-8113                         |
|                           | Fax: 858-499-8246                               | Fax: 858-499-8246                             |
|                           | Email: <a href="mailto:provider.relations@sharp.com">provider.relations@sharp.com</a> Or Contracted Medical Group | Email: <a href="mailto:provider.relations@sharp.com">provider.relations@sharp.com</a> Or Contracted Medical Group |</p>
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<tr>
<th>RESOURCE</th>
<th>INDIVIDUAL</th>
<th>EMPLOYER GROUP WAIVER PLAN (EGWP)</th>
</tr>
</thead>
</table>
| Claims (paid by Sharp Health Plan) | Sharp Health Plan  
8520 Tech Way, Ste 200  
San Diego, CA 92123  
Phone: 1-855-562-8853  
Fax: 858-636-2307 (Provider Disputes or Reconsiderations only)  
Email: shp.claimsresearch@sharp.com | Sharp Health Plan  
8520 Tech Way, Ste 200  
San Diego, CA 92123  
Phone: 1-855-820-2112  
Fax: 858-636-2307 (Provider Disputes or Reconsiderations only)  
Email: shp.claimsresearch@sharp.com |
| Claims: Third Party Liability | 8520 Tech Way, Ste 200  
San Diego, CA 92123-1450 | 8520 Tech Way, Ste 200  
San Diego, CA 92123-1450 |
| Claims Pharmacy | MedImpact  
10181 Scripps Gateway Ct  
San Diego, CA 92131 | MedImpact  
10181 Scripps Gateway Ct  
San Diego, CA 92131 |
| Contracts | Phone: 1-855-562-8853  
Fax: 858-499-8244 | Phone: 1-855-820-2112  
Fax: 858-499-8244 |
| Coverage Determination - Pharmacy | MedImpact  
Fax: 858-790-7100 | MedImpact  
Fax: 858-790-7100 |
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<td>Customer Care</td>
<td>8520 Tech Way, Ste 201, San Diego, CA 92123</td>
<td>8520 Tech Way, Ste 201, San Diego, CA 92123</td>
</tr>
<tr>
<td></td>
<td>Phone: 1-855-562-8853</td>
<td>Phone: 1-855-820-2112</td>
</tr>
<tr>
<td></td>
<td>Fax: 619-740-8571</td>
<td>Fax: 619-740-8571</td>
</tr>
<tr>
<td></td>
<td>Email: <a href="mailto:customer.services@sharp.com">customer.services@sharp.com</a></td>
<td>Email: <a href="mailto:customer.services@sharp.com">customer.services@sharp.com</a></td>
</tr>
<tr>
<td></td>
<td>Hours: Oct. 1 - Feb 14: Sun-Sat, 8 a.m. to 8 p.m.</td>
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<td>Feb 15 - Sept 30: M-F, 8 a.m. to 8 p.m.</td>
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<tr>
<td>Eligibility Verification</td>
<td>Phone: 1-858-499-8300, Option 2</td>
<td>Phone: 1-858-499-8300, Option 2</td>
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<tr>
<td>Medical Policies</td>
<td>Go to: <a href="https://www.sharpmedicareadvantage.com/">https://www.sharpmedicareadvantage.com/</a>, then click “Login”</td>
<td>Go to: <a href="https://www.sharpmedicareadvantage.com/">https://www.sharpmedicareadvantage.com/</a>, then click “Login”</td>
</tr>
<tr>
<td>Organization Determination</td>
<td>Fax: 858-636-2426</td>
<td>Fax: 858-636-2426</td>
</tr>
<tr>
<td>- Medical Services only</td>
<td>Phone: 1-888-672-7197</td>
<td>Phone: 1-888-672-7197</td>
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<td>RESOURCE</td>
<td>INDIVIDUAL</td>
<td>EMPLOYER GROUP WAIVER PLAN (EGWP)</td>
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<tr>
<td>Provider Relations</td>
<td><strong>Phone:</strong> 1-858-499-8330</td>
<td><strong>Phone:</strong> 1-858-499-8330</td>
</tr>
<tr>
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<td><strong>Fax:</strong> 858-499-8244</td>
<td><strong>Fax:</strong> 858-499-8244</td>
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<tr>
<td></td>
<td>Email <a href="mailto:provider.relations@sharp.com">provider.relations@sharp.com</a></td>
<td>Email <a href="mailto:provider.relations@sharp.com">provider.relations@sharp.com</a></td>
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<td></td>
<td><strong>Sharp Advantage</strong></td>
<td><strong>Sharp Advantage</strong></td>
</tr>
<tr>
<td></td>
<td>8520 Tech Way, Ste 200</td>
<td>8520 Tech Way, Ste 200</td>
</tr>
<tr>
<td></td>
<td>San Diego, CA 92123-1450</td>
<td>San Diego, CA 92123-1450</td>
</tr>
<tr>
<td></td>
<td><strong>Toll-Free Phone:</strong> 1-855-562-8853</td>
<td><strong>Toll-Free Phone:</strong> 1-855-820-2112</td>
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<td><strong>Fax:</strong> 858-636-2307</td>
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<tr>
<td></td>
<td>Email: <a href="mailto:shp.claimsresearch@sharp.com">shp.claimsresearch@sharp.com</a> or Contracted Plan Medical Group</td>
<td>Email: <a href="mailto:shp.claimsresearch@sharp.com">shp.claimsresearch@sharp.com</a> or Contracted Plan Medical Group</td>
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<tr>
<td></td>
<td><strong>Phone:</strong> 1-858-499-8050</td>
<td><strong>N/A</strong></td>
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<tr>
<td>Legislative and Regulatory Aff airs</td>
<td>Email: <a href="mailto:Government.relations@sharp.com">Government.relations@sharp.com</a></td>
<td>Email: <a href="mailto:Government.relations@sharp.com">Government.relations@sharp.com</a></td>
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<tr>
<td>Website</td>
<td><a href="http://www.sharpmedicareadvantage.com/">www.sharpmedicareadvantage.com</a></td>
<td><a href="http://www.sharpmedicareadvantage.com/">www.sharpmedicareadvantage.com</a></td>
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Medicare Advantage Overview

Sharp Health Plan is a licensed health maintenance organization (HMO). We have contracted with CMS to provide Medicare Advantage Prescription Drug health plans. All network providers are contracted with Sharp Health Plan.

Sharp Health Plan believes hospitals, physicians and other providers are pivotal to successful managed care. In order to establish high quality services standards, Sharp Health Plan seeks to work collaboratively with all its caregivers to maintain a stable provider network. We commit to providing essential information in this manual to benefit you and your staff. As a team, we can strive to be the best integrated system of coordinated and quality care for members.

Employer Group Waiver Plan (EGWP) Basics

The Medicare Modernization Act (MMA) provided employers and unions with a number of options for providing coverage to their Medicare-eligible members. Under the MMA, these options include purchasing benefits from sponsors of prescription drug-only plans (PDPs), making special arrangements with Medicare Advantage Organizations (MAOs) and Section 1876 Cost Plans to purchase customized benefits, including drug benefits, for their members, and directly contracting with CMS to become Part D or MAO plan sponsors themselves. Each of these approaches involves the use of CMS waivers authorized under Sections 1857(i) or 1860D-22(b) of the SSA.

Under this authority, CMS may waive or modify requirements that “hinder the design of, the offering of, or the enrollment in” employer-sponsored group plans. CMS may exercise its waiver authority for PDPs, MAOs and Cost Plan Sponsors that offer employer/union-only group waiver plans (EGWPs). EGWPs are also known as “800 series” plans because of the way they are enumerated in CMS systems in the Plan Benefit Package (PBP).

Employer/union group health plan enrollment in EGWPs is only available to Medicare beneficiaries who are members of an employer/union-sponsored group health plan.

Individual Medicare Advantage Plan Basics

Medicare Advantage Plans sold directly to individuals, and not through an employer/union group health plan EGWP product, must comply with all of the requirements applicable to Medicare Advantage plans under the law.
General Member Enrollment Information

Members have a choice of having their Medicare health services through Original Medicare or through one of the plans we offer. The Centers for Medicare and Medicaid Services (CMS) mails a copy of the “Medicare and You” guide to Medicare beneficiaries describing plan choices every fall by October 1st.

Medicare beneficiaries can enroll in a Medicare Advantage plan like Sharp Advantage during certain time periods. Important time periods for Sharp Advantage are:

- **Annual Election Period (AEP):** The AEP occurs from October 15 through December 7 every year. Medicare beneficiaries can enroll into or disenroll from a Medicare Advantage plan during this time. The effective date of the change is January 1 of the following year.
- **Medicare Advantage Disenrollment Period (MADP):** This election period occurs from January 1 through February 14 of each year. During the MADP, Medicare beneficiaries have the opportunity to disenroll from a Medicare Advantage plan and return to original Medicare. If they choose to return to original Medicare, they have the option of enrolling in a stand-alone prescription drug plan. At this time, Sharp Health Plan does not offer a stand-alone prescription drug plan.
- **Initial Coverage Election Period (ICEP):** When a person first becomes eligible for Medicare Part A and enrolls in Medicare Part B, there is a seven-month period to enroll in a Medicare Advantage plan. This period occurs around the person’s 65th birthday.
- **Initial Enrollment Period for Part D (IEP):** The period when a person is first eligible for a Part D plan. A person is eligible for a Part D plan when they are entitled to Part A or enrolled in Part be and permanently reside in the service area of the plan. IEP enrollment period are the same as the initial enrollment period for Medicare Part B, a seven month period that begins three months before the month of the person meets eligibility requirements for Part B and ends three months after the month of eligibility.
- **Special Election Periods (SEP):** CMS identified time periods, based on certain circumstances, in which a person may change Medicare options outside of the annual or initial enrollment periods. For example: joining or dropping employer/union health or drug coverage.

The Sharp Advantage Plan (EGWP) enrollment periods include an Annual Election Period (AEP) that is determined by each Employer group. Beneficiaries who are eligible can also enroll in the Initial Coverage Election Period (ICEP) when a person first becomes eligible for Medicare Part A and enrolls in Medicare Part B, and Special Election Periods (SEP). Members should contact their Employer Group benefits administrator for more information:

Once CMS confirms a member’s eligibility, Sharp sends the member a letter confirming their enrollment. A new member shall also receive:

- A new identification card
• An Evidence of Coverage (EOC);
• Low Income Subsidy (LIS) Rider
• Comprehensive formulary or abridged formulary, including information on how the beneficiary can obtain a comprehensive formulary
• A hard copy pharmacy directory, or separate notice to alert members where they can find the pharmacy directory online and how they can request a hard copy
• A separate notice to alert members where they can find more information about the provider network

Members selecting a Sharp Health Plan Medicare Advantage plan receive a member identification card containing the member’s name, member number and basic information about the member’s benefits. Plan members should present this card (sample card below) when receiving services rather than the government issued red, white and blue Medicare card.

Please use the Sharp Health Plan Eligibility Interactive Voice Response (IVR), 1-855-562-8853 for Individual members or 1-855-820-2112 for Employer Group members, Option 1 to confirm eligibility.
Sharp Advantage ID Cards

Front of Card

Back of Card
CMS Regulations

Sharp Health Plan (Sharp) is a Medicare Advantage (HMO). Sharp Health Plan has established this section to address compliance with the laws and regulations governing the delivery of health care services as a Medicare Advantage Organization (MAO) as set forth by the Centers for Medicare and Medicaid Services (CMS).

All regulations are required to be communicated to all Providers through policies, standards, and manuals. Providers are responsible for implementing and adhering to all CMS regulations outlined in the manual, policies and contract.

As per the executed provider contract, all providers must abide by the Health Plan’s policies and procedures, and manuals.

Please refer to your contract or call your assigned Provider Services Representative for further requirements and/or information.
42 CFR 422.111(b) (3) and (h) (2) (ii), 422.112, 423.128(d) (2)

Online Provider/Pharmacy Directory Requirements

Sharp Health Plan must post a provider and/or pharmacy directory. The provision of accurate provider/pharmacy information and ensuring adequate access to covered services are essential protections for members. Accurate provider/pharmacy directories are critical to helping members make educated decisions about their Medicare Advantage Prescription Drug plan choices. These directories must contain all the information required in the provider/pharmacy (as applicable) directory models located at [www.cms.gov](http://www.cms.gov). In addition, the online provider directory must contain a special notation to highlight providers that are not accepting new patients.

Sharp Health Plan is expected to update directory information any time they become aware of changes. All updates to the online provider/pharmacy directory are expected to be done in real-time.

Therefore, please contact Provider Relations at 858-499-8330 or [provider.relations@sharp.com](mailto:provider.relations@sharp.com) if any of the following information changes:

- Ability to accept new patients
- Street address
- Phone number
- Office hours
- Any other changes that affect availability to our members

42 CFR §422.64, 422.504(a) (4):422.504(f) (2)

Information About the Medicare Advantage Program

Sharp Health Plan provides, on an annual basis, and in a format using standard terminology specified by CMS, the information necessary to enable CMS to provide to current and potential beneficiaries the information they need to make informed decisions with respect to the available choices for Medicare coverage.

Sharp Health Plan provides this information to all members on an annual basis.

Sharp Health Plan will disclose to CMS all information necessary to (1) Administer & evaluate the program (2) Establish and facilitate a process for current and prospective beneficiaries to exercise choice in obtaining Medicare services
In conducting marketing activities, Sharp Health Plan and the network providers may not:

- Provide cash or other monetary rebates as an inducement for enrollment or otherwise.
- Offer gifts to potential enrollees, unless the gifts are of nominal (as defined in the CMS Marketing Guidelines) value, are offered to all potential members without regard to whether or not the beneficiary enrolls, and are not in the form of cash or other monetary rebates.
- Engage in any discriminatory activity such as, for example, attempts to recruit Medicare beneficiaries from higher income areas without making comparable efforts to enroll Medicare beneficiaries from lower income areas.
- Solicit door-to-door for Medicare beneficiaries or through other unsolicited means of direct contact, including calling a beneficiary without the beneficiary initiating the contact.
- Engage in activities that could mislead or confuse Medicare beneficiaries, or misrepresent the Medicare Advantage organization. Sharp may not claim it is recommended or endorsed by CMS or Medicare or that CMS or Medicare recommends that the beneficiary enroll in Sharp Health Plan. It may, however, explain that the organization is approved for participation in Medicare.
- Market non-health care related products to prospective members during any Medicare Advantage or Part D sales activity or presentation. This is considered cross-selling and is prohibited.
- Market any health care related product during a marketing appointment beyond the scope agreed upon by the beneficiary, and documented by the plan, prior to the appointment (48 hours in advance, when practicable).
- Market additional health related lines of plan business not identified prior to an individual appointment without a separate scope of appointment identifying the additional lines of business to be discussed.
- Distribute marketing materials for which, before expiration of the 45-day period, Sharp Health Plan receives from CMS written notice of disapproval because it is inaccurate or misleading, or misrepresents Sharp Health Plan, its marketing representatives, or CMS.
- Use providers or provider groups to distribute printed information comparing the benefits of different health plans unless the providers, provider groups, or pharmacies accept and display materials from all health plans with which the providers, provider groups, or pharmacies contract. The use of publicly available comparison information is permitted if approved by CMS in accordance with the Medicare marketing guidance.
- Conduct sales presentations or distribute and accept Sharp Health Plan enrollment forms in provider offices or other areas where health care is delivered to individuals, except in the case where such activities are conducted in common
areas in health care settings.

- Conduct sales presentations or distribute and accept plan applications at educational events.
- Employ Sharp Health Plan plan names that suggest that a plan is not available to all Medicare beneficiaries. This prohibition shall not apply to MA plan names in effect on July 31, 2000.
- Display the names and/or logos of co-branded network providers on the organization's member identification card, unless the provider names, and/or logos are related to the member selection of specific provider organizations (for example, physicians, and hospitals). Other marketing materials (as defined in §422.2260) that include names and/or logos of provider co-branding partners must clearly indicate that other providers are available in the network.
- Engage in any other marketing activity prohibited by CMS in its marketing guidance.
- Provide meals for potential enrollees, which is prohibited, regardless of value.
- Use a plan name that does not include the plan type. The plan type should be included at the end of the plan name.

Sharp Health Plan does not distribute any marketing materials or election forms, or make such materials or forms available to individuals eligible to elect an Medicare Advantage plan;

- For at least 45 days (or 10 days if using marketing materials that use, without modification, proposed model language as specified by CMS) following the date on which the Medicare Advantage organization submitted the material or form to CMS for review under CMS guidelines.
  - If the Medicare Advantage plan has file and use certification as submitted to CMS, the Medicare Advantage plan may distribute designated marketing materials 5 days following their submission to CMS.
- Or if CMS disapproves the distribution of the new material or form.

Marketing materials include any informational materials targeted to Medicare beneficiaries which:

- Promote the Medicare Advantage organization, or any Medicare Advantage plan offered by the Medicare Advantage organization;
- Inform Medicare beneficiaries that they may enroll, or remain enrolled in, an Medicare Advantage plan offered by the Medicare Advantage organization;
- Explain the benefits of enrollment in an Medicare Advantage or rules that apply to enrollees;
- Explain how Medicare services are covered under an Medicare Advantage plan, including conditions that apply to such coverage.

Examples of marketing materials include, but are not limited to:
• General audience materials such as general circulation brochures, newspapers, magazines, television, radio, billboards, yellow pages, or the Internet.
• Marketing representative materials such as scripts or outlines for telemarketing or other presentations.
• Presentation materials such as slides and charts.
• Promotional materials such as brochures or leaflets, including materials for circulation by third parties (e.g., physicians or other providers).
• Membership communication materials such as membership rules, subscriber agreements (evidence of coverage), member handbooks, and wallet card instructions to enrollees.
• Letters to members about contractual changes, changes in providers, premiums, benefits, plan procedures, etc.
• Membership or claims processing activities (e.g., materials on rules involving non-payment of premiums, confirmation of enrollment or disenrollment, or annual notification information).

In reviewing marketing material or election forms, CMS determines if the marketing materials:

• Provide, in a format (and, where appropriate, print size) that is, and using standard terminology that may be, specified by CMS, the following information to Medicare beneficiaries interested in enrolling:
  o Adequate written description of rules (including any limitations on the providers from whom services can be obtained), procedures, basic benefits and services, and fees and other charges.
  o Adequate written description of any supplemental benefits and services.
  o Adequate written explanation of the grievance and appeals process, including differences between the two, and when it is appropriate to use each.
  o Any other information necessary to enable beneficiaries to make an informed decision about enrollment.

• Notify the general public of its enrollment period (whether time-limited or continuous) in an appropriate manner, through appropriate media, throughout its service and continuation area.

• Include notice that the Medicare Advantage organization is authorized by law to refuse to renew its contract with CMS, that CMS also may refuse to renew the contract, and that termination or non-renewal may result in termination of the beneficiary's enrollment in the plan.

• Are not materially inaccurate or misleading or otherwise make material misrepresentations.

• For markets with a significant non-English speaking population, provide materials in the language of these individuals.
The Customer Care Department is designed to assist both Members and Providers with all of Sharp Health Plan’s health plan benefit coordination. The Customer Care Department has friendly, knowledgeable, and bilingual representatives available. Our Customer Care Representatives assist Members by answering questions regarding, but not limited to: eligibility, general benefits, PCP assignment, hospital information, and pharmacy locations.

The Customer Care Department can also provide assistance with information about any of the following:

- Status of referrals and Authorizations
- Billing questions
- Pharmacy benefits and coverage
- Grievances and appeals process
- ID card replacements

**Interpreter Services**

Plan Providers may request interpreters for Members whose primary language is not English by calling Sharp Health Plan. The customer care representative will request the following information:

- Member name, identification number, age, sex, language, and country of origin (to determine the appropriate version of the requested language).
- Provider information, including appointment date and time, office location, name, physician’s phone number, and type of appointment (e.g., OB/GYN, well-care, etc.)

For face-to-face interpreting services, requests must be made at least three days prior to the appointment date. However, even with advance notice, face-to-face interpreters for some languages may not be available. In the event that an interpreter is not available for face-to-face interpreting, Sharp Health Plan can make arrangements for telephone interpreting services. Please call Sharp to arrange for timely language assistance services for your patient.

**Member Rights and Responsibilities**

At the time of enrollment, each Member is given an Evidence of Coverage (EOC) that contains a list of Member Rights and Responsibilities, which are also listed. Printable EOC versions (in English and Spanish) suitable for distribution to Members are also available online at www.SharpHealthPlan.com/SharpAdvantage (for Sharp Advantage).
Member Rights

The Sharp Health Plan honors our Members’ rights to:

• Be provided with information in a way that works for them (in Spanish and in large print)
• Be treated with fairness and respect at all times
• Receive timely access to covered services and drugs
• Have the privacy of their personal health information protected
• Be given information about the plan, its network of providers, and their covered services
• Make decisions about their care
• Make complaints, and to ask Sharp Health Plan to reconsider decisions we have made
• Obtain information about what can be done if s/he believes they are being treated unfairly or their rights are not being respected
• Obtain more information about his/her rights

Member Responsibilities

Sharp Health Plan Members have the following responsibilities:

• Provide information that Sharp Health Plan and your doctors and other providers need to offer you the best care.
• Understand your health problems and participate in developing treatment goals.
• Ask questions if you do not understand explanations and instructions.
• Respect provider office policies and ask questions if you do not understand them.
• Follow advice and instructions agreed-upon with your provider.
• Report any changes in your health.
• Keep all appointments and arrive on time. If you are unable to keep an appointment, cancel 24 hours in advance, if possible.
• Notify Sharp Health Plan of any changes in your address or telephone number.
• Let your health care provider or Sharp Health Plan know if you have any suggestions, compliments or complaints.
• Notify Sharp Health Plan of any changes that affect your eligibility, including no longer working or residing in the Plan’s Service Area.

Member Appeals and Grievances

An important part of Sharp Health Plan’s Quality Improvement Program is the mechanism through which Members can ask questions and solve problems. Often,
Members will address their questions directly to their PCP, who can answer many questions without the Plan’s intervention. When the PCP cannot resolve a question or problem, the Member should be advised of his/her right to file a Grievance and instructed to contact Sharp Health Plan Customer Care (see Sharp Quick Reference Guide).

Providers may occasionally receive Grievances directly from Sharp Health Plan’s Members. A Grievance is an indication that a Member is dissatisfied with any perceived aspect of his/her health care and/or the delivery of care. Grievances received by Sharp Health Plan may include complaints about the quality of health care services rendered or Appeals of service denials. Members (or their designees) may call Customer Care or submit their Appeal and/or Grievance in writing, via email or fax:

Sharp Health Plan  
Appeal and Grievance Department  
8520 Tech Way, Suite 201  
San Diego, CA 92123-1450  
Fax: (858)636-2256

**Individual Customer Care 1-855-562-8853**  
**Employer Group Customer Care 1-855-820-2112**

Sharp Health Plan’s Customer Care Representatives answer questions and/or may resolve the grievances during the Member’s telephone call. Sharp Health Plan encourages all Members to first discuss questions and concerns with their PCP or other Plan Providers involved in their care. If Customer Care and the Provider cannot resolve the concern, the matter is forwarded to the Plan’s Appeal/Grievance Department.

Sharp Health Plan will acknowledge receipt of the Grievance and will send the Member a decision letter within 30 days. In most cases, Plan Providers involved in the Member’s care may be contacted by the Plan to request medical records or other information needed to research the Member’s Grievance. **It is important to respond promptly to such requests, in order to ensure that the Appeals and Grievances are resolved within the timelines established by the Centers of Medicare and Medicaid Services (CMS).**

Sharp Health Plan understands that there are two sides to every issue, so it is very important for Plan Providers to respond to inquiries about Member Grievances. Sharp Health Plan uses responses from Providers to identify opportunities to educate Members regarding realistic expectations of access, office wait times, appropriate patient–physician and patient–office staff interaction, etc. The responses also highlight opportunities for Sharp Health Plan to work more closely with Providers on interactions that are perceived to be problematic by Sharp Member(s) and to work together to improve processes.
An appeal is a disagreement to a decision of denial for coverage of health care services or prescription drugs, or payment for services or prescription drugs already received by the Member. An appeal can also be made when a decision for services that are presently being received are stopped. For more information please refer to Section: 42 CFR 423.566-423.578, Coverage Determination and Exception Requests, or call the Appeals and Grievance department for Individual or EGWP listed in the quick reference guide.

Services of noncontracting providers and suppliers:

(1) An MA organization must make timely and reasonable payment to or on behalf of the plan enrollee for the following services obtained from a provider or supplier that does not contract with the MA organization to provide services covered by the MA plan:

   i. Ambulance services dispatched through 911 or its local equivalent as provided in §422.113
   ii. Emergency and urgently needed services as provided in §422.113
   iii. Maintenance and post-stabilization care services as provided in §422.113
   iv. Renal dialysis services provided while the member was temporarily outside the plan's service area
   v. Services for which coverage have been denied by the Medicare Advantage organization and to which the member was found to have been entitled to have furnished, or paid for, by the Medicare Advantage organization

Benefits affecting screening mammography, influenza vaccine, and pneumococcal vaccine

   1. Sharp Health Plan Members may directly access (through self-referral) screening mammography and influenza vaccine
   2. Sharp Health Plan Members may not be charged a cost-sharing for influenza vaccine and pneumococcal vaccine

42 CFR §422.110

Discrimination Against Beneficiaries Prohibited

Except as provided in the following paragraph of this section, Sharp Health Plan does not deny, limit, or condition the coverage or furnishing of benefits to individuals eligible to enroll in an Medicare Advantage plan offered by the organization on the basis of any factor that is related to health status, including, but not limited to the following:

- Medical condition, including mental as well as physical illness
- Claims experience
- Receipt of health care
- Medical history
- Genetic information
• Evidence of insurability, including conditions arising out of acts of domestic violence
• Disability

42 CFR §422.111
Disclosure Requirements

Sharp Health Plan makes a good faith effort to provide notice of a termination of a contracted provider at least 30 calendar days before the termination effective date to all members who are patients seen on a regular basis by the provider whose contract is terminating, irrespective of whether the termination was for cause or without cause. When a contract termination involves a primary care professional, all members who are patients of that primary care professional must be notified.

Sharp Health Plan has this policy and procedure in place. Please contact Provider Relations if you have any questions (858)499-8330 or email to, provider.relations@sharp.com.

42 CFR §422.112
Access to Services

An Medicare Advantage organization that offers an Medicare Advantage coordinated care plan may specify the networks of providers from whom members may obtain services if the Medicare Advantage organization ensures that all covered services, including additional or supplemental services contracted for, by (or on behalf of) the Medicare enrollee, are available and accessible under the plan. To accomplish this, Sharp Health Plan meets the following requirements:

• Maintains and monitors a network of appropriate providers that is supported by written agreements and is sufficient to provide adequate access to covered services to meet the needs of the population served. These providers are typically used in the network as primary care providers (PCPs), specialists, hospitals, skilled nursing facilities, home health agencies, ambulatory clinics, and other providers.

• Establishes the panel of PCPs from which the member may select a PCP. If a Medicare Advantage organization requires its members to obtain a referral in most situations before receiving services from a specialist, the Medicare Advantage organization must either assign a PCP for purposes of making the needed referral or make other arrangements to ensure access to medically necessary specialty care.

• Provides or arranges for necessary specialty care, and in particular give women members the option of direct access to a women's health specialist within the network for women's routine and preventive health care services provided as basic benefits. The Medicare Advantage organization arranges for specialty care
outside of the plan provider network when network providers are unavailable or inadequate to meet an enrollee's medical needs.

- If seeking a service area expansion for a Medicare Advantage plan, demonstrate that the number and type of providers available to plan members are sufficient to meet projected needs of the population to be served.
- Demonstrates to CMS that its providers in a Medicare Advantage plan are credentialed through the process set forth.
- Ensures that:
  - The hours of operation of its Medicare Advantage plan providers are convenient to the population served under the plan and do not discriminate against Medicare enrollees; and
  - Plan services are available 24 hours a day, 7 days a week, when medically necessary.
- Ensures that services are provided in a culturally competent manner to all enrollees, including those with limited English proficiency or reading skills, and from diverse cultural and ethnic backgrounds.
- Provides coverage for ambulance services, emergency and urgently needed care services, and post-stabilization care services.
- Ensures that its contracted provider network have the information required for effective and continuous patient care and quality review, including procedures to ensure that--
  - Sharp Health Plan will make a "best-effort" attempt to conduct an initial assessment of each enrollee’s health care needs, including following up on unsuccessful attempts to contact an enrollee, within 90 days of the effective date of enrollment.
  - Maintain procedures to inform members of follow-up care or provide training in self-care as necessary.
  - Each provider, supplier, and practitioner furnishing services to members maintains an member health record in accordance with standards established by the Medicare Advantage organization, taking into account professional standards; and
  - There is appropriate and confidential exchange of information among provider network components.

42 CFR §422.118

Confidentiality and Accuracy of Member Records

The Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule requires covered entities such as health plans, health care clearinghouses, and most health care providers, including pharmacies, to safeguard the privacy of patient information. Covered entities are required to conduct HIPAA Privacy training on an annual basis and to ensure ongoing organizational compliance with the regulations.

A major goal of the Privacy Rule is to ensure that an individual's personal health
information is properly protected, while still allowing the flow of health information needed to provide and promote high-quality health care, as well as to protect the public’s health and well-being. A covered entity must maintain reasonable and appropriate administrative, technical, and physical safeguards to prevent inappropriate uses and disclosures of Protected Health Information (PHI). The following are examples of appropriate safeguards that Providers should take to protect the security and privacy of PHI:

- Ensure that data files are not saved on public or private computers while accessing corporate email through the Internet
- Ensure that electronic systems for patient mailings are properly programmed in order to prevent documents containing PHI from being sent to the wrong patients.
- Ensure that PHI on all portable devices is encrypted
- Implement security measures to restrict access to PHI based on an individual’s need to access the data
- Perform an internal risk assessment or engage an industry-recognized security expert to conduct an external risk assessment of the organization to identify and address security vulnerabilities
- Shred documents containing PHI before discarding them
- Secure medical records with lock and key or pass code
- Limit access to keys and pass codes
- Lock computer screens when away from your desk/work station.
- Refrain from discussing patient information outside the workplace or in lunchrooms, elevators, or lobbies

Providers who disclose PHI to another entity may be limited in how this information can be shared. Patients have the right to request to see a list of all persons/organizations with whom their personal health information has been shared. For more detailed information regarding these regulations, go to the Department of Health and Human Services website at www.hhs.gov/ocr/privacy.

This information regarding HIPAA privacy compliance is provided as a courtesy to the Plan Providers. While every attempt is made to keep the information as accurate as possible, it is designed for educational purposes only and should not to be used as a substitute for legal or other professional advice.

Sharp Health Plan and the Provider agree to ensure confidentiality, privacy and accuracy for any medical records or other health and enrollment information it maintains with respect to enrollees. Sharp Health Plan has procedures to do the following as well:

- Abide by all Federal and State laws regarding confidentiality and disclosure of medical records, or other health and enrollment information. Sharp Health Plan
and the Provider must safeguard the privacy of any information that identifies a particular member and have procedures that specify:

- For what purposes the information will be used within the organization; and
- To whom and for what purposes it will disclose the information outside the organization.

- Ensure that medical information is released only in accordance with applicable Federal or State law, or pursuant to court orders or subpoenas.
- Maintain the records and information in an accurate and timely manner.
- Ensure timely access by members to the records and information that pertain to them.

**42 CFR §422.128 Information on Advance Directives**

Sharp Health Plan has written policies respecting the implementation of those rights concerning advance directives, including a clear and precise statement of limitation if the Medicare Advantage organization cannot implement an advance directive as a matter of conscience. At a minimum, Providers must do the following:

- Document in a prominent part of the individual's current medical record whether the individual has executed an advance directive.

**42 CFR §422.202, 422.204 Participation Procedures**

Sharp Health Plan has established a formal mechanism to consult with the physicians who have agreed to provide services under the Medicare Advantage plan offered by the organization and agreed to comply with the organization's medical policy, quality improvement programs, and medical management procedures and ensure that the following standards are met:

- Practice guidelines and utilization management guidelines -
  - Are based on reasonable medical evidence or a consensus of health care professionals in the particular field;
  - Consider the needs of the enrolled population;
  - Are developed in consultation with contracting health care professionals; and
  - Are reviewed and updated periodically.
- If Sharp suspends or terminates an agreement under which the physician provides services to Medicare Advantage plan members must give the affected individual written notice of the following requirements:
  - The reasons for the action, including, if relevant, the standards and profiling data used to evaluate the physician and the numbers and mix of physicians needed by the Medicare Advantage organization.
The affected physician's right to appeal the action and the process and timing for requesting a hearing.

- Sharp Health Plan ensures that the majority of the hearing panel members are peers of the affected physician.
- If Sharp Health Plan suspends or terminates a contract with a physician because of deficiencies in the quality of care, Sharp Health Plan provides written notice of that action to licensing or disciplinary bodies or to other appropriate authorities.
- Sharp Health Plan and a contracted provider must provide at least 60 days written notice to each other before terminating the contract without cause.

42 CFR §422.208
Physician Incentive Plans: Requirements and Limitations

The requirements in this section apply to a Medicare Advantage organization and any of its subcontracting arrangements that utilize a physician incentive plan in their payment arrangements with individual physicians or physician groups. Subcontracting arrangements may include an intermediate entity, which includes but is not limited to, an individual practice association that contracts with one or more physician groups or any other organized group.

Any physician incentive plan operated by a Medicare Advantage organization must meet the following requirements:

- The Medicare Advantage organization makes no specific payment, directly or indirectly, to a physician or physician group as an inducement to reduce or limit medically necessary services furnished to any particular enrollee. Indirect payments may include offerings of monetary value (such as stock options or waivers of debt) measured in the present or future.
- If the physician incentive plan places a physician or physician group at substantial financial risk for services that the physician or physician group does not furnish itself, the Medicare Advantage organization must assure that all physicians and physician groups at substantial financial risk have either aggregate or per-patient stop-loss and conduct periodic surveys.
- For all physician incentive plans, the Medicare Advantage organization provides all information requested to CMS.

42 CFR §422.504
Contract Provisions

Sharp Health Plan agrees to comply with all the applicable requirements and conditions set forth in this part and in general instructions. Sharp Health Plan agrees:

- To provide:
  - The basic benefits and, to the extent applicable, supplemental benefits.
  - Access to benefits as required.
In a manner consistent with professionally recognized standards of health care, all benefits covered by Medicare.

- To disclose information to beneficiaries in the manner and the form prescribed by CMS.
- To operate a quality improvement program and have an agreement for external quality review as required.
- To comply with the reporting requirements for submitting encounter data/risk adjustment to CMS.
  - The CEO, CFO, or an individual delegated the authority to sign on behalf of one of these officers, and who reports directly to such officer, must certify that each member for whom the organization is requesting payment is validly enrolled in an Medicare Advantage plan offered by the organization and the information relied upon by CMS in determining payment (based on best knowledge, information, and belief) is accurate, complete, and truthful.
  - The CEO, CFO, or an individual delegated with the authority to sign on behalf of one of these officers, and who reports directly to such officer, must certify (based on best knowledge, information, and belief) that the encounter data it submits are accurate, complete, and truthful.
  - If such encounter data, or risk adjustment data is generated by a related entity, contractor, or subcontractor of an Medicare Advantage organization, such entity, contractor, or subcontractor must similarly certify (based on best knowledge, information, and belief) the accuracy, completeness, and truthfulness of the data.
- To submit to CMS all information necessary for CMS to administer and evaluate the program and to simultaneously establish and facilitate a process for current and prospective beneficiaries to exercise choice in obtaining Medicare services. This information includes, but is not limited to:
  - The benefits covered under the Medicare Advantage plan;
  - The Medicare Advantage monthly basic beneficiary premium and Medicare Advantage monthly supplemental beneficiary premium, if any, for the plan;
  - Medical records and certify completeness and truthfulness;
  - The service area and continuation area, if any, of each plan and the enrollment capacity of each plan;
  - Plan quality and performance indicators for the benefits under the plan including:
    - Disenrollment rates for Medicare members electing to receive benefits through the plan for the previous 2 years;
    - Information on Medicare member satisfaction;
    - Information on health outcomes.
- To comply with:
  - Title VI of the Civil Rights Act of 1964 as implemented by regulations at 45 CFR part 84;
The Age Discrimination Act of 1975 as implemented by regulations at 45 CFR part 91;
- The Rehabilitation Act of 1973;
- The Americans With Disabilities Act;
- Other laws applicable to recipients of Federal funds; and
- All other applicable laws and rules.
- Comply with Federal laws and regulations to include, but not limited to: Federal criminal law, the False Claims Act (31 U.S.C. 3729 et. Seq.) and the anti-kickback statute (section 1128B(b) of the Act)

To comply with:
- All applicable provider requirements, including provider certification requirements, anti-discrimination requirements, provider participation and consultation requirements, the prohibition on interference with provider advice, limits on provider indemnification, rules governing payments to providers, and limits on physician incentive plans; and
- For the arrangements to be specified in the contracts between the MAO, providers, first tier and downstream entities.

42 CFR §422.562
Health Care Fraud, Waste, and Abuse Prevention

Sharp Health Plan is committed to complying with all federal and state statutory, regulatory, and other requirements related to health plan operations. In accordance with state and federal regulations, Sharp Health Plan has a comprehensive plan to detect, correct, and prevent fraud, waste, and abuse.

Fraud, waste, and abuse are defined as:

- **Fraud** – Intentional deception or misrepresentation with the knowledge that the deception could result in some unauthorized benefit to a person or an entity.
- **Waste** – To use or expend carelessly, extravagantly, or to no purpose.
- **Abuse** – Incidents or practices that are inconsistent with accepted and sound business, fiscal, or medical administrative practices. For example, abuse may exist when a Provider fails to appropriately bill new and established patient procedure codes, but instead bills a new patient code on the initial visit and subsequent visits.

The purpose of Sharp Health Plan’s Fraud, Waste, and Abuse Plan is to organize and implement an antifraud strategy to detect, prevent, and control fraud, waste, and abuse in order to reduce the cost caused by fraudulent activities, and to protect Members in the delivery of health care services. The Fraud, Waste, and Abuse Plan is designed to establish methods to identify, investigate, and report incidents of suspected fraud and/or abuse in Sharp Health Plan’s delivery systems.
Sharp Health Plan is committed to working to reduce fraudulent activity. It is the goal of Sharp to improve the detection and investigation of fraud. In pursuit of that goal, we have joined forces with the legal and regulatory community to prosecute those parties attempting to abuse the health care system. Sharp Health Plan monitors, investigates, and corrects possible fraud, waste, and abuse issues.

Help us stop health care fraud. Support in this area helps us all. If you suspect fraud, please contact the Sharp Health Plan Regulatory Affairs Department at 858-499-8237, email government.relations@sharp.com or mail to:

Sharp Health Plan
Fraud and Abuse Investigations
8520 Tech Way, Ste. 200
San Diego, CA 92123

Reporters of suspected fraud have the right to remain anonymous, if so desired. Just tell us why you think fraud is occurring. Give us the name of the Provider or Member, and tell us what you are concerned about. We take your questions and input seriously. You can help us stop health care fraud.

Compliance Program:

Sharp Health Plan has a comprehensive commitment to compliance based on trust, integrity and accountability, which reflects how fundamental components of Sharp Health Plan’s business operations are conducted. Regulatory compliance is not an option, but it is a requirement. Non-compliance with the commitment and all regulatory statutes undermines the Plan’s reputation and credibility with its Members, Providers, employees and the community.

The compliance program addresses all aspects of regulatory compliance including quality of care, business ethics, protected health information, health insurance law and employment practices. Compliance training attendance is a vital component of new employee orientation and required annually thereafter for continued employment.

Sharp Health Plan recognizes that its employees and Providers are the keys to providing quality health care services and is committed to managing its business operations in an ethical manner, in accordance with contractual obligations, and consistent with all applicable state and federal requirements.

Sharp Health Plan requires its first tier and related entities to complete the following CMS requirements and submit a signed, dated attestation within 90 days of contract signature and annually thereafter, attesting to its compliance with these requirements:

- Compliance, Fraud Waste and Abuse, and Specialized Training
- Exclusion List Review
• Code of Conduct and Compliance Policies and Procedures
• Maintain and provide any required documents and other records to substantiate the attestation for at least a period of 10 years following the end of the Agreement or the date of audit completion, whichever is later
• Oversight of its downstream entities with respect to compliance, fraud, waste and abuse and specialized training, Code of Conduct, exclusion list review and record retention

General compliance training and FWA training is required to be completed by all First tier, downstream and related entities (FDR) personnel responsible for the administration or delivery of Medicare Part C and/or D benefits within 90 days of contracting with Sharp, and annually thereafter.


CMS developed web-based compliance training (WBT) to ensure the requirement is met and to reduce the largely duplicative training required of FDRs by the multiple organizations with whom they contract.

This WBT course is designed to provide education on fraud, waste, and abuse in the Medicare Part C and D programs and general compliance concepts. It includes two parts and can be used to satisfy general compliance training requirements and fulfill the annual fraud, waste and abuse training requirement for Medicare Part C and D organizations.

Part 1 of the training provides an overview of fraud, waste, and abuse in the Medicare Part C and D program. Part 1 can be used to fulfill the requirement for annual fraud, waste, and abuse training for Medicare Part C and D organizations, their employees and all individuals who provide health or administrative services to Medicare Part C and D enrollees via first tier, downstream, or related entity arrangements. Medicare providers who are certified are not required to take Part 1.

Part 2 of the training provides an overview of general compliance concepts, and can be used to satisfy general compliance training requirements. FDRs and its employees can complete the general compliance and/or FWA training modules located on the CMS Medicare Learning Network (MLN). Once the individual completes the training, the system will generate a certificate of completion.

FDRs may also download, view or print the content of the CMS standardized training modules from the CMS website to incorporate into their organization’s existing compliance training materials/systems. The CMS training content cannot be modified to ensure the integrity and completeness of the training. However, an
organization can add to the CMS training to cover topics specific to their organization. Training materials are available for downloading at the following path:


The training should take less than 30 minutes and is available free of charge.

General Provision:
Sharp Health Plan has established and maintains:

- A grievance procedure for addressing issues that do not involve organization determinations, as described in §422.564;
- A procedure for making timely organization determinations;
- Appeal procedures that meet the requirements of this subpart for issues that involve organization determinations.

As Sharp Health Plan does not delegate the Part C appeal or grievance function, Sharp Health Plan is ultimately responsible for ensuring compliance with the relevant Appeals and Grievance requirements. Please note that MedImpact is delegated for processing coverage determinations (Part D).

All providers must adhere to the Sharp Health Plan Appeal and Grievance policies and procedures.

42 CFR §422.752
Basis for Imposing Sanctions

For the violation listed below, CMS may impose any of the sanctions on any Medicare Advantage organization that has a contract in effect. The Medicare Advantage organization may also be subject to other applicable remedies available under law if the MAO:

- Employs or contracts with an individual or entity who is excluded from participation in Medicare under section 1128 or 1128A of the Act (or with an entity that employs or contracts with such an individual) for the provision of any of the following:
  - Health care
  - Utilization review
  - Medical social work
  - Administrative services

42 CFR 423.120
Part D Prescription Drug Coverage

Sharp Health Plan offers a comprehensive pharmacy services program including
formulary management, utilization management, and pharmacy network management.

**Formulary**

Sharp Health Plan maintains a list of drugs, also known as formulary, that it covers. The formulary includes a range of brand and generic drugs in a five tiered copay structure. All covered drugs are placed on one of the five tiers. It is important for the Member and Provider to work together to determine which drug is most appropriate.

- Tier 1: Includes lower cost generic drugs
- Tier 2: Includes higher cost generic drugs
- Tier 3: Includes preferred brand drugs
- Tier 4: Includes non-preferred brand drugs
- Tier 5: Includes very high cost and unique drugs

Not all drugs are included in the formulary. In some cases, CMS prohibits coverage of certain types of drugs. Additionally, drug tier placement is subject to change throughout the year. Sharp Health Plan may also add or remove drugs from the formulary. If Sharp Health Plan makes any negative formulary changes, Sharp Health Plan will notify Members at least 60 days before the effective date of the change. However, if a drug has been removed from the formulary due to a safety reason, Sharp Health Plan will not provide a 60-day advance notice before removing the drug from the formulary. Instead, Sharp will removed the drug from the formulary immediately and notify Members about the change as soon as possible.

To get updated information about the drugs covered by Sharp Advantage please contact Customer Care (858)499-8300 or visit sharpmedicareadvantage.com for a printable version of the formulary.

**Utilization Management**

For certain drugs, Sharp Health Plan may have coverage rules or limits to ensure that Members are using these drugs appropriately. Examples of utilization management tools are described below:

A. Prior Authorization: Sharp Health Plan requires Members to get prior authorization for certain drugs. Providers on behalf of Members may request approval from Sharp before the Member fills the prescription. Members must meet specific criteria, as outlines by the P&T Committee, to be authorized by Sharp.

B. Step Therapy: Sharp Health Plan requires Members to first try one drug to treat their medical condition before Sharp covers another drug for that condition. The step therapy program encourages the use of cost-effective, clinically proven, first-line therapies and is designed so that the most therapeutically appropriate and cost-effective agents are used first, before other treatments may be covered. Step therapy protocols are based on current medical findings, FDA-approved drug labeling, and drug costs as reviewed and recommended by the P&T
Providers can find out if the prescribed drug are subject to these additional requirements or limits by looking in the formulary. Prior authorization and step therapy criteria are available on sharpmedicareadvantage.com. If the prescribed drug does have these additional restrictions or limits, Providers can ask Sharp to make an exception to the coverage rules. Please refer to the Coverage Determination/Exception Requests section.

### Network Pharmacy

Sharp Advantage (HMO) Members generally must use network pharmacies to obtain their outpatient prescription drugs. A network pharmacy is a pharmacy that has a contract with Sharp and is part of Sharp’s network. Sharp has a network of pharmacies inside and outside of San Diego County where Members can get their drugs covered.

Members can get up to a 90-day supply of their covered prescription drugs sent directly to them through the network mail order delivery programs, PPSRx Postal Prescription Services. Tier 5 drugs are always limited to a 30-day supply per prescription. Typically, Members can expect to receive their prescription within 5 business days from the time that the mail order pharmacy receives the order. This is a cost-effective and convenient way to fill prescription drugs.

### 42 CFR 423.153(d)

#### Medication Therapy Management Program

Members enrolled in Sharp Advantage may be eligible for the Medication Therapy Management Program (MTMP), in accordance with CMS requirements. The purpose of the program is to provide medication therapy management services to targeted Members. These services are designed to ensure that covered Part D drugs are appropriately used to optimize therapeutic outcomes by improving medication use and reducing the risk of adverse drug. The MTMP is developed in cooperation with licensed and practicing pharmacists.

Individual Members eligible for MTMP services must meet program criteria that include having multiple chronic diseases, taking multiple part D drugs and incurring an annual Part D drug cost specified by CMS. The 2017 MTMP annual cost threshold is $3,919.

Eligible Members are automatically enrolled in the program. A letter and participation form will be mailed to the eligible Members informing them of their enrollment in the program. Participation in the program is voluntary and the program and services are provided at no additional cost to the Member. MTMP services for each enrolled Member include an interactive comprehensive medication review (CMR) by a pharmacist or
other qualified Provider with written summaries, and targeted medication reviews (TMR), which may result in beneficiary and prescriber directed interventions.

42 CFR 423.566 – 423.578
Coverage Determination and Exception Requests

Providers can request an exception to the coverage rules and limits. There are several types of exceptions that Providers can request.

A. Providers can ask Sharp to cover a drug even if it is not on the formulary
B. Providers can ask Sharp to waive coverage restrictions or limits on certain drugs
C. Providers can ask for coverage of a drug requiring prior authorization
D. Providers can ask Sharp to lower the cost-sharing amount for drugs in Tier 2 and Tier 4

Generally, Sharp will only approve the request for an exception if the alternative drug included on the formulary would not be as effective in treating the Member’s condition and/or would cause them to have adverse medical effects.

How to Request and Exception:
1. Fill out the Coverage Determination Request form available on sharpmedicareadvantage.com
2. Include a supporting statement that the exception is medically necessary to treat the Member’s medical condition
3. Fax the form along with the clinical notes and supporting statements to (858)790-7100

A determination will be made no later than seventy-two (72) hours from the date the standard request is received. For urgent requests, a determination will be made no later than twenty-four (24) hours from the date the request is received. The Member and the Member’s Provider will be given notice of the coverage determination. If Sharp approves the exception request, the approval is valid for the remainder of the benefit year, as long as the Provider continues to prescribe the drug and it continues to be safe and effective for treating the Member’s condition.

If the decision is not in the Member’s favor, the notice will include notification of the appeal and grievance processes to be followed if the Member is dissatisfied with the decisions. To request an appeal, fax or mail a written request using the Redetermination Request form available on sharpmedicareadvantage.com within 60 days from the date of the denial notice. The Redetermination Request form may be sent by mail or fax:

Sharp Advantage
Attention: Appeals and Grievance Department
8520 Tech Way, Ste 201
San Diego, CA 92123
Fax: (858)636-2256