



# **2019 Provider Operations Manual for Sharp Direct Advantage**

## **January 2019**

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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.

Sharp Health Plan offers five Medicare Advantage products: three are employer group waiver plans (EGWP) and two Individual plans that are open to all Medicare-eligible individuals residing 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, access to participating gym, as well as interactive wellness resources. Dental coverage is not included except as required by Medicare. **Supplemental benefits vary among different plan configurations.** For more information, please review the appropriate Summary of Benefits, Evidence of Coverage and formulary documents online at [www.sharpmedicareadvantage.com](http://www.sharpmedicareadvantage.com)

### Sharp Health Plan's Provider Experience

At Sharp Health plan, 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](mailto:provider.relations@sharp.com).

## **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(l) 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, 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 First.

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

- Annual Election Period (AEP): The AEP occurs from October 15 through December 7 every year. Medicare beneficiaries can enroll or disenroll into a Medicare Advantage plan during this time. The effective date of the change is January 1 of the following year.
- Medicare Advantage Open Enrollment Period (OEP): This election period occurs from January 1 through March 31 of each year. During the OEP, 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 65<sup>th</sup> 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 B and permanently reside in the service area of the plan. IEP enrollment periods 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 Health 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 Direct 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 Direct Advantage dedicated member Eligibility Phone line 1-855-562-8853 to confirm eligibility.

## **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.sharpmedicareadvantage.com](http://www.sharpmedicareadvantage.com) (for Sharp Direct 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

Sharp Health Plan's Customer Care Representatives answer questions and/or may resolve the grievances during the Member's telephone call. All Plan Members are encouraged to discuss their concerns and questions first with their PCP or other Plan Provider involved in their care. If Customer Care and the Provider cannot resolve the concern, the concern will be forwarded to Sharp Health 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 non-contracting providers and suppliers:

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

Sharp Health Plan Members may not be charged a cost sharing for influenza vaccine and pneumococcal vaccine

## **Network Providers**

Sharp Direct 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.

## **PROVIDER RESPONSIBILITIES**

Sharp Health Plan relies on Plan Providers to provide high-quality health care service and care in the following manner:

- Provide services only as medically necessary in accordance with generally accepted medical, surgical, and scientific practices and community standards.
- Provide and coordinate continuity of care in the Member's best interest.
- Maintain quality standards for all health care services.

- Ensure that office sites where care is provided is physically accessible to patients with disabilities, has adequate parking, restroom facilities, seating and a well-lit waiting area.
- Ensure that office sites where care is provided is maintained is clean and orderly at all times.
- Maintain open physician-patient communication regarding appropriate treatment alternatives or when recommending any procedure which Plan Provider deems medically appropriate. The physician communication does not guarantee coverage, as an authorization of said treatment may be required.
- Effectively communicate with Members regarding their health care needs.
- Encourage Members to be active in decisions about their own treatment.
- Be accessible to Sharp Direct Advantage Members, including emergency access via telephone per the section, 42 CFR 422.122 *Access to Care* regulations below.
- Assist Members who may be dissatisfied with his/her health care and/or the delivery of care to report their grievance to the Plan and to make Grievance Forms available to Members upon request. (Refer to Member Appeals and Grievances, Pages 7-8).
- Maintain licensures and other applicable credentials as required by law and Plan's policy.
- Verify each Member's eligibility prior to rendering services unless it is an emergency. Refer to subsequent page under: Eligibility Verification.
- Cooperate with Sharp Health Plan's Medical Director or designee in the review and supervision of the quality of care administered to Plan Members.
- Respond within the designed amount of time to all requests for information related to potential quality of care issues and/or Peer Reviews.
- Maintain and preserve all records, including but not limited to medical and billing records, as required by law and medical standards.
- Provide medical histories, financial, administrative, and other records of Sharp Direct Advantage Members as requested by Sharp Health Plan or Sharp Health Plan's designee.
- Treat all Members with respect and not differentiate or discriminate based on factors including, but not limited to, race, religion, color, national origin, gender, age, disability, marital status, sexual orientation, or source of payment.

- Actively participate in the Plan's quality and utilization management initiatives.
- Notify Sharp Health Plan within five (5) days of any change in practice, including but not limited to a change of group affiliation, name, address, telephone number, type of practice, willingness to accept new Members, and/or languages spoken.
- Respond within thirty (30) business days to Sharp Health Plan's annual or bi-annual request for affirmative updates, or risk deletion from the Provider Directory.

## ON-CALL PHYSICIANS COVERAGE

The PCP shall provide coverage for Sharp Direct Advantage Members 24 hours a day, 7 days a week and shall make coverage arrangements with another physician (preferably one who is also contracted with Sharp Health Plan) in the event of his/her absence. A PCP contracted directly with Sharp Health Plan shall notify the Plan in advance, or as soon as is reasonably possible, of the use of a non-participating physician in a coverage arrangement.

**It is the responsibility of the PCP to ensure that the covering physician will comply with the Plan's peer review procedures and accept the fee from Sharp Health Plan as payment in full for services delivered to the Member (except applicable Copayments; unless the member is QMB eligible). Capitated Providers must make arrangements directly with the covering physician for payment of all Covered Benefits provided to Sharp Direct Advantage Members. Covering physicians must not bill Sharp Direct Advantage Members for covered benefits.**

## ROLE OF THE PRIMARY CARE PHYSICIAN (PCP)

Primary Care Physicians (PCPs) are responsible for providing certain basic health care services to Sharp Direct Advantage Members. The PCP has primary responsibility for coordinating the Member's overall health care, which may include care planning during the Member's transition of care from one care setting to the next, as well as ensuring the appropriate use of pharmaceutical medications. All Sharp Direct Advantage Members must choose a PCP or clinic at the time of enrollment, or one will be chosen for them.

The PCP provides primary care, including preventive health care, treatment for acute illnesses, minor accidents, and follow-up care for ongoing medical problems. In addition, the PCP manages all of the health care provided to the Member, such as initiating referrals for specialty care and coordinating follow up after inpatient discharge to assure continuity of care. The PCP's responsibilities include the following services:

- Provide Member's primary health care services.
- Provide coverage 24 hours a day, 7 days a week. (Members are instructed to contact the PCP prior to seeking care in all cases except emergencies. Members should be referred to the nearest emergency department for Emergency Services and to the nearest contracted Urgent Care facility for Urgent Care Services that cannot be addressed in the PCP's office. PCPs are not responsible for identifying a contracted Urgent Care facility when a Member is outside the Plan's Service Area.)
- Refer Members to a participating specialist when specialized care is indicated (Women enrolled in Sharp Direct Advantage may self-refer directly to an OB/GYN affiliated with the Member's Plan Medical Group for obstetric and gynecologic services.)
- Request Authorization for referrals, services, procedures, and medications when required by the Plan.
- Review and incorporate the specialist's documentation into the Member's primary medical record.
- Use contracted network laboratories and radiology services.
- Notify Members of test results and document the notification in the medical record.

## ROLE OF THE SPECIALTY AND ANCILLARY PROVIDER

Collaboration between the PCP and specialty providers is crucial to achieve continuity of care. When a Member requires or requests specific services, treatment, or referral for specialty or ancillary services, the PCP is responsible for reviewing the request for medical necessity and referring the Member to the appropriate contracted provider affiliated with the member's PMG as defined by Sharp Health Plan.

**The specialty provider may provide treatment authorized by the referral, which may include ordering appropriate lab tests, imaging services, or**

**therapies. Services must be performed at a contracted facility with appropriate authorization, if required. The specialist is responsible for contacting the PMG or Sharp Health Plan for authorization. The specialist is also responsible for documentation of the services provided, including results of any diagnostic studies or procedures and recommendations for treatment or follow-up. The specialist is also responsible for sharing records with the Member's PCP.**

### **Provider-Initiated Member Dismissal**

Sharp Direct Advantage Network Providers are obligated to provide Medically Necessary care and access to services for as long as the Member requires medical care, or until the relationship is ended appropriately.

Rarely, a Sharp Direct Advantage Network Provider may provide care to a Medicare Advantage Member who is disruptive or excessively difficult and may feel the need to terminate the member from their care. If this is the case, provider must notify their PMG Network Management/Provider Relations Representative for assistance with the process to reassign the member to a different provider. Providers may also contact Customer Care at 858-499-8300 or toll-free at 1-800-359-2002 to request assistance with difficult Members.

Disruptive behavior may include:

- Member is non-compliant with recommended treatment plans to the extent that Member's health is endangered.
- Member demonstrates verbally abusive behavior toward the physician, ancillary or administrative office staff, or to other Plan Members.
- Member physically assaults a Plan Provider, staff member, or Plan Member, or the Member threatens any individual with any type of weapon on Plan or Provider premises, or verbalizes the intent to cause bodily harm. In such cases, appropriate charges should be brought against the Member, and a copy of the police report submitted along with the request.
- Member is disruptive to Provider or Plan operations with potential for limitations on access to care by other Members.
- Member refuses to meet financial obligations such as Copayments, Coinsurance (except for Qualified Medicare Beneficiary).

- Member attempts to fraudulently obtain health care services, including allowing others to use the Member's Plan identification card to receive services.

Providers are to first work within their Plan Medical Group (PMG) to ascertain if the member's behavior can be resolved or if the member may be reassigned to another provider within the PMG that can give appropriate care. If efforts within the PMG do not resolve the issue, the following process should be initiated.

1. The Provider should counsel the Member about the conflict or problem prior to requesting dismissal. Counseling should include written education that conveys a clear set of instructions, the compliance requirements, and the consequences, if any, for not following the instructions, placing responsibility for compliance directly on the Member.
2. If this does not resolve the issue, the Provider must contact their PMG Network Management/Provider Relations department for assistance with reassigning the Member to a new provider.
3. If multiple attempts to reassign the Member fail, the PMG must contact the Plan and submit a Member Dismissal Request Form to Sharp Health Plan for consideration by faxing the form to the attention of the Provider Relations Department at 858-408-9444. An example of the form is provided on page 16.
4. The Dismissal Form should be completed in full and include supportive documentation detailing the situation. Supporting documentation may be in the form of copies of medical records, office notes, etc., and may include:
  - a. Pertinent dates
  - b. Documentation of conversations
  - c. Billing statements, including amount due, letters advising Members to pay their bill; and/or
  - d. Documentation of previous attempts to educate Member regarding noncompliance with recommended treatment plans or office practices.
5. Sharp Health Plan may request additional documentation from the Plan Provider. Failure to provide documentation to support the dismissal request within five (5) working days of Sharp Health Plan's request will result in the

request for dismissal being denied.

6. Requests to dismiss a member from a PMG will be reviewed by the Plan's Chief Medical Officer.
7. If necessary, attempts will be made to secure an appropriate provider for the Member in another contracted PMG.
8. The provider and the PMG may not initiate dismissal communication with the Member prior to a final determination.
9. If PMG receives authorization from Sharp Health Plan to dismiss the Member, the PMG has five (5) working days to provide written notification to the Member and to send a copy of such notice to Sharp Health Plan within 10 business days.
10. The notification must include the reason for the dismissal and direct the Member to contact the Plan's Customer Care for assistance, and must not occur before authorization is received from Sharp Health Plan.
11. If denied, PMG will receive written notification of the decision within 30 days of Sharp Health Plan's receipt of all supporting documentation.

Sharp Health Plan will not contact the Member for reassignment until Sharp Health Plan has received a copy of the dismissal letter sent to the Member by the Plan Provider. If Sharp Health Plan does not receive a copy of the dismissal letter within ten (10) business days following Sharp Health Plan's approval to dismiss, the dismissal becomes invalid. The Provider is required to initiate the process again if they wish to pursue the dismissal.

The Plan Provider is required to provide treatment and access to services until the Member selects a new physician or a new physician is assigned. When a PCP dismisses a Member, all Referral Authorizations for that Member will be invalidated. The Member must contact the new PCP to obtain new referrals and Authorizations.

Members under the treatment of the delegated behavioral health provider may not be dismissed from the behavioral health medical group.

If the Plan determines that a Member's behavior is disruptive, unruly, abusive or uncooperative to the point that his/her continuing membership seriously impairs the ability to furnish services to either him/her or other members, the Plan may initiate procedures to disenroll the Medicare Advantage Member per procedures

outlined in the CMS Managed Care Manual. The Plan must first ascertain that the enrollee's behavior is not related to the use of medical services or to mental illness. The Plan may not initiate disenrollment because the beneficiary exercises his/her option to make treatment decisions with which the Plan disagrees, e.g. refuses aggressive treatment for cancer. Disenrollment of a Member from Sharp Direct Advantage may not be initiated by a PMG or its contracted providers.

## Member Dismissal Request Form

 <b>Sharp Health Plan Member Dismissal Request Form</b>	
<p>This form is to be used by a Plan Provider's office to request dismissal of a current Member assigned under a Sharp Health Plan policy. Please include all supporting details and documentation for dismissal along with this request form and send by fax, or mail, to:</p>	
<b>FAX:</b> Provider Relations (858)408-9444	<b>MAIL:</b> Sharp Health Plan Attn: Provider Relations 8520 Tech Way, Suite 200 San Diego, CA 92123
<b>PROVIDER INFORMATION</b>	
Provider Name	
Medical Group Name	
Telephone #	Fax #
Signature	
Print Name	
Print Role/Title	
Dismissing from entire group? (Y/N)	
<b>MEMBER INFORMATION</b>	
Member Name	
ID Number	
Date of Birth (MMDDYYYY)	
<b>REASON FOR DISMISSAL</b>	
<input type="checkbox"/> Irreparable damage to the physician-patient relationship <input type="checkbox"/> Financial <input type="checkbox"/> Fraud	<input type="checkbox"/> Non-compliant <input type="checkbox"/> Abusive or threatening <input type="checkbox"/> Other (specify below) _____ _____
***** For Sharp Health Plan ONLY *****	
Date dismissal request received	
Date all supporting documentation received	
Date review completed by Sharp Health Plan CMO	
Date Sharp Health Plan decision sent back to PCP	
<b>If Dismissal is authorized</b>	
Member must elect new PCP by this date	
Date forwarded to Customer Care Department	

## Sharp Health Plan Medicare Advantage Quick Reference Guide

RESOURCE	CONTACT INFORMATION
General Information	<p>Phone: 1-855-562-8853</p> <p>Website: <a href="https://www.sharpmedicareadvantage.com/">https://www.sharpmedicareadvantage.com/</a></p>
Provider Relations	<p>Phone: 1-858-499-8330</p> <p>Fax: 1-858-408-9444</p> <p>Email: <a href="mailto:provider.relations@sharp.com">provider.relations@sharp.com</a></p>
Customer Care	<p>8520 Tech Way, Ste 201 San Diego, CA 92123</p> <p>Phone: 1-855-562-8853 (toll free) 1-858-499-8050 (local)</p> <p>Fax: 1-619-740-8571</p> <p>Email: <a href="mailto:customer.service@sharp.com">customer.service@sharp.com</a></p> <p>Hours: Oct 1 – Mar 31: 8 a.m. to 8 p.m. 7 days a week Apr 1 - Sept 30: M-F 8 a.m. to 6 p.m.</p>

RESOURCE	CONTACT INFORMATION
Eligibility Verification	<p>Phone: 1-855-562-8853,</p>
<p>Claims: (Paid by Sharp Health Plan)</p>	<p>Sharp Direct Advantage 8520 Tech Way, Ste 201 San Diego, CA 92123</p> <p>Phone: 1-855-562-8853</p> <p>(Provider Disputes or Reconsiderations only)</p> <p>Fax: 1-858-636-2307</p> <p>Email: <a href="mailto:shp.claimsresearch@sharp.com">shp.claimsresearch@sharp.com</a></p>
<p>Claims: Third Party Liability</p>	<p>8520 Tech Way, Ste 201 San Diego, CA 92123-1450</p>
<p>Claims Pharmacy</p>	<p>MedImpact P.O. Box 509108 San Diego, CA 92150-9108</p>
<p>Pharmacy Help Desk</p>	<p>Phone: 1-888-672-7197</p>

RESOURCE	CONTACT INFORMATION
Capitation	<p>Phone: 1-858-499-8113</p> <p>Fax: 1-858-499-8393</p> <p>Email: <a href="mailto:provider.relations@sharp.com">provider.relations@sharp.com</a> Or Contracted Medical Group</p>
Coverage Determination- Pharmacy	<p>MedImpact Fax: 1-858-790-7100</p>
Organization Determination- Medical Services only	<p>Fax: 1-858-636-2426</p>
Appeals and Grievances	<p>Sharp Direct Advantage Attn: Appeal and Grievance Department 8520 Tech Way, Ste 201 San Diego, CA 92123</p> <p>Fax: 1-858-636-2256</p>
Medical Policies	<p>Go to: <a href="https://www.sharpmedicareadvantage.com/">https://www.sharpmedicareadvantage.com/</a>, then click "Login"</p>

RESOURCE	CONTACT INFORMATION
Payment Disputes	<p>Sharp Direct Advantage 8520 Tech Way, Ste 201 San Diego, CA 92123-1450</p> <p><b>EMPLOYER GROUP WAIVER PLAN (EGWP)</b> 1-855-820-2112 (toll free)</p> <p><b>INDIVIDUAL</b> 1-855-562-8853 (toll free) 1-858-499-8050 (local)</p> <p>Fax: 1-858-636-2307</p> <p>Email: <a href="mailto:shp.claimsresearch@sharp.com">shp.claimsresearch@sharp.com</a> or Contracted Plan Medical Group</p>
Contracts	<p>Phone: 1-855-562-8853</p> <p>Fax: 1-858-499-8244</p>
Legislative and Regulatory Affairs	<p>Email: <a href="mailto:Government.relations@sharp.com">Government.relations@sharp.com</a></p>

## Delegated Medical Groups Claim Submission Addresses

<p><b>GTC – Greater Tri-Cities (IPA)</b> PO Box 5059 Oceanside, CA 92052 Phone: 1-760-941-7309, option 3 Fax: 1-760-631-7614</p>	<p><b>Palomar Health</b> PO Box 260890 Encino, CA 91426 Phone: 1-888-445-0062 or 1-818-461-5000</p>
<p><b>Sharp Community Medical Group (SCMG)</b> PO Box 939037 San Diego, CA 92193 Phone: 1-858-499-2550 Fax: 1-858-499-4441</p>	<p><b>Sharp Rees-Stealy Medical Group (SRSMG)</b> PO Box 939035 San Diego, CA 92193 Phone: 1-858-499-2410 Fax: 1-858-268-4642</p>
<p><b>Sharp Direct Advantage (Out of Area)</b> 8520 Tech Way, Ste 201 San Diego, CA 92123-1450 Phone: 1-858-820-2112 Fax: 1-858-636-2307 (Provider disputes or reconsiderations only)</p>	<p><b>American Specialty Health Plan</b> PO Box 509002 San Diego, CA 92150 Phone: 1-800-972-4226</p>
<p><b>Vision Service Plan (VSP)</b> PO Box 997105 Sacramento, CA 95899 Phone: 1-800-877-7195</p>	<p><b>CVS Minute Clinic</b> See (SHP) Sharp Direct Advantage</p>

## Service Areas

In 2019, the following are the service areas for Sharp Direct Advantage (HMO) – Individual and Employer Group Plan

- **All of San Diego County**

## ELIGIBILITY VERIFICATION

Plan Providers are responsible for verifying each Member's eligibility prior to rendering services, unless it is an emergency. All Members are issued a Health Plan identification card, which should be presented each time services are rendered. The Sharp Direct Advantage member Identification Cards identify the following information:

- Member Name
- Member ID Number
- Plan Medical Group
- Plan Network
- Primary Care Physician (PCP)
- Telephone
- Cost Share/Copayments
- Customer Care toll-free number
- Coverage Effective Date
- Claim and Mailing Address
- Pharmacy Claim/Billing Information

Examples of Sharp Direct Advantage Identification Cards are located on subsequent pages 24 - 26.

It is the responsibility of each Provider to verify eligibility prior to providing services. Although the ID card is a primary method of identification, possession of the card does not guarantee eligibility, coverage, or benefits. Eligibility to receive services depends on verification from Sharp Health Plan. A new identification card is issued each time a Member changes PCP, but Members may forget to present the most recent card when accessing services. Therefore, it is important to verify eligibility with each visit. Eligibility may be verified using one of the following options:

1. Online via the SharpConnect provider portal which gives Provider offices the ability to view Member-specific eligibility information, including effective date, benefits and copayments. To log on or register for SharpConnect go to [www.SharpHealthPlan.com/for-providers](http://www.SharpHealthPlan.com/for-providers). Through the provider portal, Provider staff can also check the status of referrals or claims at any time with SharpConnect. If you are not currently set up for this easy-to-use and secure online resource, please contact Sharp Health Plan's Provider Relations at 858-

499-8330 or [provider.relations@sharp.com](mailto:provider.relations@sharp.com)

2. Sharp Direct Advantage provider dedicated eligibility phone line 1-855-562-8853.

If a Member insists he or she is enrolled in Sharp Direct Advantage but the Provider is not able to confirm eligibility via SharpConnect, or the Sharp Direct Advantage dedicated phone line, please call Sharp Health Plan's Customer Care Department at 858-499-8300 or toll-free at 1-800-359-2002 for assistance Monday through Friday, 8:00 a.m. to 6:00 p.m. The Customer Care Representative may be able to confirm eligibility immediately.

## Sample Sharp Direct Advantage Member ID Cards

### Sample Front and Back ID Card for Sharp Direct Advantage Gold Card (HMO)



**Sample Front and Back ID Card for  
Sharp Direct Advantage Platinum Card (HMO)**

**SHARP**  
HEALTH PLAN

**SHARP DIRECT ADVANTAGE  
PLATINUM CARD (HMO)**

**George Costanza**  
ID# 5123456789

Plan Medical Group:  
Sharp Rees-Stealy Medical Group

Network:  
Sharp Direct Advantage

**MEMBER ID CARD**

Primary Care Physician:  
Peter Minkoff M.D.  
(760) 746-3703

Cost Share:

PCP	\$10
Specialist	\$30
Urgent Care	\$30
ER	\$65

**MedicareRx**  
The Original Blue Cross of California

**sharpmedicareadvantage.com**  
Customer Care: 1-855-562-8853 | TTY: 711

---

**DO NOT BILL MEDICARE**      Effective Date: XX/XX/XXXX

Providers submit claims to:  
8520 Tech Way, Ste 201  
San Diego, CA 92123

Pharmacists submit claims to:  
MedImpact Healthcare Systems, Inc.  
PO Box 509108  
San Diego, CA 92150-9108  
888-672-7197

RxBIN	015574
RxPCN	ASPROD1
Rx Group	SHP06

CMS H5386\_802

**Sample Front and Back ID Card for  
Sharp Direct Advantage Basic (HMO)**

**SHARP**  
HEALTH PLAN

**SHARP DIRECT ADVANTAGE  
BASIC (HMO)**

**George Costanza**  
ID# 5123456789

Plan Medical Group:  
Sharp Rees-Stealy Medical Group

Network:  
Sharp Direct Advantage

**MEMBER ID CARD**

Primary Care Physician:  
Peter Minkoff M.D.  
(760) 746-3703

Cost Share:

PCP	\$10
Specialist	\$30
Urgent Care	\$30
ER	\$65

**MedicareRx**  
The Original Blue Cross of California

**sharpmedicareadvantage.com**  
Customer Care: 1-855-820-2112 | TTY: 711

---

**DO NOT BILL MEDICARE**      Effective Date: XX/XX/XXXX

Providers submit claims to:  
8520 Tech Way, Ste 201  
San Diego, CA 92123

Pharmacists submit claims to:  
MedImpact Healthcare Systems, Inc.  
PO Box 509108  
San Diego, CA 92150-9108  
888-672-7197

RxBIN	015574
RxPCN	ASPROD1
Rx Group	SHP06

CMS H5386\_802

**Sample Front and Back ID Card for  
Sharp Direct Advantage Premium (HMO)**

**SHARP**  
HEALTH PLAN

**SHARP DIRECT ADVANTAGE  
PREMIUM (HMO)**

**George Costanza**  
ID# 5123456789

Plan Medical Group:  
Sharp Rees-Stealy Medical Group

Network:  
Sharp Direct Advantage

**MEMBER ID CARD**

Primary Care Physician:  
Peter Minkoff M.D.  
(760) 746-3703

Cost Share:

PCP	\$10
Specialist	\$30
Urgent Care	\$30
ER	\$65

MedicareRx  
The Complete Prescription Program

**sharpmedicareadvantage.com**  
Customer Care: 1-855-820-2112 | TTY: 711

---

**DO NOT BILL MEDICARE**      **Effective Date:**  
XX/XX/XXXX

Providers submit claims to:  
8520 Tech Way, Ste 201  
San Diego, CA 92123

Pharmacists submit claims to:

MedImpact Healthcare Systems, Inc.	RxBIN	015574
PO Box 509108	RxPCN	ASPROD1
San Diego, CA 92150-9108	Rx Group	SHP06
888-672-7197		

CMS H5386\_802

**Sample Front and Back ID Card for  
Sharp Direct Advantage (HMO)**

**SHARP**  
HEALTH PLAN

**SHARP DIRECT ADVANTAGE  
(HMO)**

**George Costanza**  
ID# 5123456789

Plan Medical Group:  
Sharp Rees-Stealy Medical Group

Network:  
Sharp Direct Advantage

**MEMBER ID CARD**

Primary Care Physician:  
Peter Minkoff M.D.  
(760) 746-3703

Cost Share:

PCP	\$10
Specialist	\$30
Urgent Care	\$30
ER	\$65

MedicareRx  
The Complete Prescription Program

**sharpmedicareadvantage.com**  
Customer Care: 1-855-820-2112 | TTY: 711

---

**DO NOT BILL MEDICARE**      **Effective Date:**  
XX/XX/XXXX

Providers submit claims to:  
8520 Tech Way, Ste 201  
San Diego, CA 92123

Pharmacists submit claims to:

MedImpact Healthcare Systems, Inc.	RxBIN	015574
PO Box 509108	RxPCN	ASPROD1
San Diego, CA 92150-9108	Rx Group	SHP06
888-672-7197		

CMS H5386\_802

## **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 §422.100, 422.112**

#### **General Requirements**

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 to assist you. Our Customer Care Representatives assist Members by answering questions regarding, but not limited to: eligibility, general benefit information, 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.

### **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 § 422.222**

### **Preclusion list**

CMS regulations prohibit Sharp Health Plan or its delegated entities from paying claims and services rendered by a provider or prescriber listed in CMS' Precluded List. The Preclusion List consists of individuals and entities that currently been revoked from the Medicare program or have engaged in behavior for which CMS could have revoked the individual or entity, and CMS determines that the underlying conduct is detrimental to the best interests of the Medicare program. The activities may include: noncompliance, exclusion, felony, providing false or misleading information, fails on-site interview, billing abuse, improper prescribing.

Unlike the OIG and SAM exclusion file, the Preclusion List is larger and broader. The Preclusion List is to be used in addition to, rather than in lieu of, the OIG and SAM exclusion file. The Preclusion List and exclusion file overlap in the sense that excluded providers will be on the preclusion list but precluded providers who are not excluded will not be on the exclusion file.

### **The Preclusion List**

The Preclusion List will consist of providers (individuals and entities) that fall within either of the following categories:

- 1) Are currently revoked from Medicare, are under an active reenrollment bar, and CMS determines that the underlying conduct that led to the revocation is detrimental to the best interests of the Medicare program; or
- 2) Have engaged in behavior for which CMS could have revoked the individual or entity to the extent applicable if they had been enrolled in Medicare and CMS determines that the underlying conduct that would have led to the revocation is detrimental to the best interests of the Medicare program.

Prior to being added to a Preclusion List, providers will be notified by CMS of their potential inclusion on the Preclusion List and their applicable appeal rights. CMS will add a provider to the Preclusion List only if the provider's appeal is denied at the CMS level or the timeframe for the provider to request a CMS level appeal has been exhausted.

There will be one Preclusion List with subsequent updates available to Medicare plans approximately every 30 days, around the first business day of each month. SHP will share the updates with its delegated entities. SHP and its delegated entities have 30 days to review the Preclusion List for updates and must notify the impacted enrollees as soon as possible, but no later than 30 days from the posting of the updated list.

### **Initial Member Notice**

Sharp Health Plan and its delegated entities must review the Preclusion List and notify the affected members by mail (using the CMS model notice) if members have received services or prescription drugs from a precluded provider. Medicare plans are required to notify those enrollees who have received care in the last 12 months from a contracted provider or a prescription from a provider who is included on the preclusion list as soon as possible. Medicare enrollees should be allowed at least 60 days' advance notice before payment denials and claims rejections begin.

### **Initial Provider Notice**

Sharp Health Plan and its delegated entities must use reasonable efforts to notify the precluded provider of a member who was sent a notice. Sharp Health Plan and its delegated entities will notify providers included on the Preclusion List by copying the provider on the notice sent to the enrollee or by other means. This will notify providers about their patients who been impacted by their preclusion from the Medicare program.

### **Ongoing Preclusion List Screening & Member-Provider Notice**

Sharp Health Plan and its delegated entities must continue to provide written notice to affected members (using the CMS model notice) within 30 days after publication of CMS' most recent Preclusion List. The member notification must allow for a minimum of 60-day period before Sharp Health Plan and/or its delegated entities will reject a pharmacy or medical claim or service rendered by a

precluded prescriber. Sharp Health plan and its delegated entities must also continue to use reasonable efforts to notify the precluded provider of a member who was sent this notice.

### **Claim Look-Back Period**

Sharp Health Plan and its delegated entities will review the Preclusion List against its provider claims based on a 12-month look-back period to determine impacted members.

### **Claim Denial Effective Date**

Sharp Health Plan and its delegated entities will deny a precluded provider's claims or services based on the effective date of the preclusion as indicated in the Preclusion List file.

### **Pharmacy & Provider Erroneous Payment Recoupment**

If Sharp Health Plan or its delegated entities pay a Part D pharmacy claim involving a prescription written by a precluded prescriber in error, the plan must not recoup the payment from the pharmacy. However, Sharp Health Plan or its delegated entities cannot submit the PDE record to CMS.

If Sharp Health Plan or its delegated entities pay a Part C precluded provider claim in error, then the plan or its delegated entities may recoup the payment from the provider in accordance with the provider contract.

### **Member Out-of-Pocket Cost**

If a member wishes to continue to see a provider who has been included on the Preclusion List, the member may continue to do so. However, Sharp Health Plan or its delegated entities must communicate to the member that the member's out-of-pocket expense will be denied.

### **Provider Appeal Right & Inquiry**

Because Sharp Health Plan has no control over the CMS Precluded Provider List, all provider inquiries regarding their preclusion status must be referred to CMS at [providerenrollment@cms.hhs.gov](mailto:providerenrollment@cms.hhs.gov). CMS maintains the exclusion authority to preclude or include a provider, including any subsequent appeal rights.

All other provider inquiries and appeals that do not specifically pertain to the provider's preclusion status should continue to be subject to the current CDAG and ODAG process.

### Provider Contract Termination

When Sharp Health Plan or its delegated entities become aware of a provider or prescriber listed in Preclusion List, the plan or its delegated entities must remove any contracted provider from their network as soon as possible. Medicare plans and Part D plans should review the Preclusion List for this purpose as soon as possible beginning January 1, 2019, but no later than January 31, 2019 and monthly going forward.

#### **42 C.F.R. §422.504(g) (1) (iii)**

### **Cost-Share Prohibition on Qualified Medicare Beneficiaries (QMB) Members**

Medicare providers and suppliers may not bill beneficiaries enrolled in the Qualified Medicare Beneficiaries (QMB) program for any deductibles, coinsurance, and copayments. QMB is a dual eligible program that exempts individuals from Medicare cost-sharing liability. QMB 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. The prohibition on collecting Medicare cost sharing is limited to services covered under Parts A and B. Low Income Subsidy copayments still apply for Part D benefits. This prohibition is also stipulated in your network contract.

### Anti-Discrimination Based on Payment Status

Pursuant to the Medicare Managed Care Manual, Ch. 4, Section 10.5.2 and your network provider contract, MA providers cannot discriminate against enrollees based on their payment status, e.g., QMB. Specifically, MA providers may not refuse to serve enrollees because they receive assistance with Medicare cost sharing from a State Medicaid program.

## **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

## **42 CFR §422.2268**

### **CMS Marketing Provisions**

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 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 a 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:
  - 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.
  - Adequate written description of any supplemental benefits and services.
  - Adequate written explanation of the grievance and appeals process, including differences between the two, and when it is appropriate to use each.
  - Any other information necessary to enable beneficiaries to make an informed decision about enrollment.
- Notify the 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.

#### **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](mailto: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, log on to the Department of Health and Human Services website at [www.hhs.gov/ocr/privacy](http://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.

### **Amendment to Member Medical Record**

According to Health and Safety Code section 123111, an adult patient can write an "Addendum" to their medical file and request the file placed in his or her medical record. Patient shall have the right to provide to the health care provider a written addendum with respect to any item or statement in his or her record that the patient believes to be incomplete or incorrect. The addendum shall be limited to 250 words per alleged incomplete or incorrect item in the patient's record and shall clearly indicate in writing that the patient wishes the addendum be a part of his or her medical record.

The health care provider shall attach the addendum to the patient's record and shall include the addendum whenever the health care provider makes a disclosure of the allegedly incomplete or incorrect portion of the patient's record to any third party. The new information, signed and dated by the patient, shall be placed in the file and the original information should not be removed.

## **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 individual delegated the authority to sign on behalf of one of these officers who reports directly to such officer, must certify that each member for whom the organization is requesting payment is validly enrolled in a Medicare Advantage plan. The plan must be 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. Remember, support in this area helps us all. If you suspect fraud is being committed, contact Sharp Health Plan's Regulatory Affairs Department at (858)499-8237, email [government.relations@sharp.com](mailto:government.relations@sharp.com) or mail to:

Sharp Health Plan  
Fraud and Abuse Investigations  
8520 Tech Way, Ste. 201  
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.

Starting January 1, 2016, to comply with training requirements Sharp Health Plan accepts from FDRs certificates of completion of CMS' training located on the Medicare Learning Network (MLN) <https://learner.mlnlms.com/Default.aspx>. The title of the required training is Medicare Parts C and D Fraud, Waste and Abuse Training and Medicare Parts C and D General Compliance Training (February 2013).

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:

<http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/ProviderCompliance.html>

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(c) (6)**

### **Medicare Part D Prescriber Enrollment Requirement**

The Centers for Medicare & Medicaid Services (CMS) has added a new requirement for prescribers of Part D prescriptions effective January 1, 2019. Any physician or other eligible professional who prescribes Part D drugs must not be on the CMS Preclusion List in order for the drug to be coverable under the Medicare Part D program. Medicare Advantage (MA) with Part D, and MA employer group plans with Part D may no longer cover drugs that are prescribed by physicians or other eligible professionals who are listed on the CMS Preclusion List. The CMS Preclusion List contains individuals or entities who are precluded from receiving payment for Medicare Advantage items and services or Part D drugs furnished or prescribed to Medicare beneficiaries. Individuals or entities who meet one of the following criteria are on the Preclusion List:

- Are currently revoked from Medicare, are under an active reenrollment bar, and CMS has determined that the underlying conduct that led to the revocation is detrimental to the best interests of the Medicare program
- Have engaged in behavior for which CMS could have revoked the individual or entity to the extent applicable if they had been enrolled in Medicare and CMS determines that the underlying conduct that would have led to the revocation is detrimental to the best interests of the Medicare Program.

CMS will make the Preclusion List available beginning January 1, 2019. Individuals and entities on the Preclusion List will receive an email and letter from CMS/Medicare Administrative Contractors (MAC) in advance of their inclusion on the Preclusion List.

The letter will contain the reason for preclusion, the effective date of the preclusion, and the applicable rights to appeal.

Effective April 2019:

- Sharp Health Plan will reject a pharmacy claim (or deny a beneficiary request for reimbursement) for a Part D drug that is prescribed by an individual on the Preclusion List.

Sharp Health Plan will deny payment for a health care item or service furnished by an individual or entity on the Preclusion List.

## **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 generic drugs
- Tier 3: Includes preferred brand drugs
- Tier 4: Includes non-preferred generic drugs and brand drugs
- Tier 5: Includes very high cost and unique drugs

Not all drugs are included in the formulary. A Part D covered drug is available only by prescription, approved by the Food and Drug Administration (FDA) (or is a drug described under section 1927(k) (2) (A) (ii) or (iii) of the Act), used and sold in the United States, and used for a medically accepted indication (as defined in section 1927(k) (6) of the Act). In some cases, CMS prohibits coverage of certain types of drugs. The Sharp Direct Advantage Drug Formulary is updated on a monthly basis to reflect additions, deletions, tier changes and utilization manage changes. 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 as well as post a negative change notification online. 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 Direct Advantage please contact Customer Care (858)499-8300 or visit [sharpmedicareadvantage.com](http://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 Committee.
- C. **Quantity Limits:** Sharp Health Plan limits the amount of the drug that Sharp Health Plan covers per prescription or for a defined period of time.

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](http://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 Direct 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 10 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.

## Medicare Part D Transition Policy

New members may be taking drugs not listed in the Sharp Direct Advantage Formulary or the drug(s) may be subject to certain restrictions, such as prior authorization or step therapy. Members are encouraged to talk to their doctors to decide if they should switch to an appropriate drug in the plan formulary or request a Formulary Exception (a type of Coverage Determination) in order to obtain coverage for the drug. While these new members may discuss the appropriate course of action with their doctors, Sharp Health Plan may also cover the non-formulary drug or drug with a coverage restriction in certain cases during the first 90 days of new membership.

For each of the drugs not listed in the formulary or that have coverage restrictions or limits, Sharp Health Plan will cover a temporary 30-day supply (unless the prescription is written for fewer days) when the new member goes to a Network Pharmacy (and the drug is otherwise a "Part D drug"). After the first 30-day supply, Sharp Health Plan will not pay for these drugs, even if the new member has been enrolled for less than 90 days. If a member is a resident of a long-term-care facility (LTC) such as a nursing home, Sharp Health Plan will cover supplies (Part D drugs) in increments of 14-days-or-less for a temporary 31-day transition supply. Unless the prescription is written for fewer days (up to a 98-day supply during the first 90 days) if a new member is enrolled in our plan beginning on the member's effective date of coverage. A transition supply notice will be sent to the member within three business days of the first incremental transition fill. If the LTC resident has been

enrolled in our Plan for more than 90 days and needs a non-formulary drug or a drug that is subject to other restrictions (such as step therapy or dosage limits). Sharp Health Plan will cover a temporary 31-day emergency supply of that drug (unless the prescription is for fewer days) while the new member pursues a formulary exception. For members being admitted to or discharged from a LTC facility, early refill edits are not used to limit appropriate and necessary access to the formulary, and such enrollees are allowed to access a refill upon admission or discharge.

#### **42 CFR 423.153(d)**

### **Medication Therapy Management Program**

Members enrolled in Sharp Direct 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 Sharp Health Plan MTMP is for members meeting all of the following criteria:

1. Have two of the following conditions: Diabetes, Dyslipidemia, Hypertension, Chronic Heart Failure, Asthma and Chronic Obstructive Pulmonary Disease
2. Received seven or more covered Part D prescriptions for chronic/maintenance drugs monthly
3. Likely to incur an annual cost threshold established by CMS each calendar year for Medicare covered prescriptions.

The 2018 MTMP annual cost threshold is \$3,967.

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, Tier 3 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](http://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](http://sharpmedicareadvantage.com) within 60 days from the date of the denial notice. The Redetermination Request form may be sent by mail or fax:

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