SHARP Health Plan

2025 Provider Operations Manual

Sharp Direct Advantage®

Effective May 2025

HELLO

As our trusted providers, we want to acknowledge and thank you for caring for our members. We greatly appreciate your hard work, dedication, and compassion.

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SECTION I

Introduction and Provider Experience

About Us

We believe better health insurance matters.

Sharp Health Plan is a nonprofit health plan that has been connecting San Diegans to better health insurance since 1992. As part of the Sharp HealthCare family, we provide direct access to The Sharp Experience® with high-quality health care coverage for San Diegans of all ages. Our benefit plans combine affordability and choice, and give members access to valuable plan enhancements, like:

- **After-Hours Nurse Advice** — When members have a health concern after regular business hours, our After-Hours Nurse Advice line connects them with a registered nurse.
- **MinuteClinic** — When members need treatment for a minor illness or injury, they can visit a MinuteClinic®. Clinics are in select CVS Pharmacy® store locations and are staffed by certified family nurse practitioners. They are open every day, including evenings and weekends.
- **Emergency Travel Services** — When members have medical emergencies while traveling 100 miles or more away from home or in another country, we connect them to doctors, hospitals, pharmacies, and other services.
- **Best Health wellness program** — Best Health® is one of a select group of health plan wellness programs in the nation to receive the National Committee for Quality Assurance's (NCQA) accreditation. With Best Health, members can access one-to-one health coaching, classes, and other no-cost wellness services.

Every year, Medicare evaluates health plans based on a 5-star rating system. Sharp Health Plan earned 4.5 out of 5 stars from Medicare for 2024, making us the best Medicare Advantage plan in California. Additionally, Sharp Health Plan was the only plan to be included in the 2024 U.S. News and World Report list of Best Insurance Companies for Medicare Advantage in California. Visit our honors, awards, and ratings to learn more about our commitment to excellence.

We continually improve the quality of our services and benefits and seek innovative solutions to today's complex health care issues. From helping members find the right health plan and the right doctor, to being a great place to work, we are here to help.

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 that 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

We believe hospitals, providers and other providers are integral to successful managed care. In order to establish high-quality service standards, we seek to work collaboratively with all our caregivers to maintain a stable provider network. As a team, we can strive to be the best integrated system of coordinated and quality care for members.

We commit to providing essential information in this manual to benefit you and your staff. 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 Account Management team at 1-858-499-8330.

Service Areas

Service Area means the geographic area in which Sharp Direct Advantage (HMO) – Individual and Employer Group Plan is licensed to provide health services, as approved by the Centers for Medicare and Medicaid Services (CMS). The Sharp Health Plan Service Area includes San Diego County, California. For more information about Sharp Health Plan's service area and Plan Medical Groups, please visit our website at Sharp Medicare Advantage or call Customer Care at 1-855-562-8853.

Sharp Direct 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 offers seven Medicare Advantage products: four are employer group waiver plans (EGWP) and three 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 Sharp Medicare Advantage.

Employer Group Waiver Plan (EGWP) Basics

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

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

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

Individual Medicare Advantage Plan Basics

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

Resource Guide

Resource	Contact Information
General Information	Sharp Direct Advantage 8520 Tech Way, Suite 200 San Diego, CA 92123 Phone: 1-858-499-8300 Toll-Free: 1-855-562-8853 TTY/TDD: 711 sharpmedicareadvantage.com
Appeals & Grievances	Providers may assist members with Appeals & Grievances by calling Customer Care. Phone: 1-855-562-8853 Fax: 1-858-636-2256 Sharp Direct Advantage Attn: Grievances & Appeals Department 8520 Tech Way, Suite 201 San Diego, CA 92123
Attestations & Rosters	For inquiries regarding roster updates or verifications. Phone: 1-858-499-8273 Email: shp.providerattestations&rosters@sharp.com
Capitation	Contact your affiliated Plan Medical Group (PMG) or Sharp Health Plan's Provider Account Management. Phone: 1-858-499-8330 Email: provider.relations@sharp.com
Claims (paid by Sharp Health Plan)	Sharp Direct Advantage Attn: Claims Department 8520 Tech Way, Ste 201 San Diego, CA 92123 Phone: 1-855-562-8853 (Provider Disputes or Reconsiderations Only) Email: shp.claimsresearch@sharp.com

Resource	Contact Information
Claims (third party liability)	Sharp Direct Advantage Attn: Claims Department 8520 Tech Way, Suite 201 San Diego, CA 92123
Claims – Behavioral Health (paid by Magellan Healthcare)	Magellan Healthcare P.O. Box 710430 San Diego, CA 92171 Phone: 1-844-483-9013
Contracts	For inquiries regarding provider contracts, contact Provider Account Management. Phone: 1-858-499-8330
Customer Care	For member or provider assistance, contact Customer Care. Provider Designated Line: 1-844-483-9014 Member Designated Line: 1-855-562-8853 Fax: 1-619-740-8571 TTY/TDD: 711 Email: customer.service@sharp.com Provider Hours: 8am to 6pm, Monday – Friday. Member Hours: 7 am to 8 pm, seven days a week
Eligibility Information	Check eligibility using your Sharp Health Plan account (provider portal). sharphealthplan.com/login
Eligibility via Interactive Voice Response (IVR)	Verify eligibility using Interactive Voice Response (IVR) system. Toll-Free: 1-844-483-9014, option 1
Fraud, Waste and Abuse	For concerns regarding fraud, waste, and abuse, contact Compliance and Regulatory Affairs. Email: shpcompliance@sharp.com

Resource	Contact Information
Find a medical provider	www.sharphealthplan.com/find-a-doctor
Find a behavioral health provider	https://member.magellanhealthcare.com/provider-search?cid=21498
Medical Policies	Review medical policies in your Sharp Health Plan account (provider portal). Web: sharphealthplan.com/login
Payment Disputes	Sharp Direct Advantage Attn: Claims Dispute Department 8520 Tech Way, Suite 201 San Diego, CA 92193-1405 Phone: 1-855-562-8853 or 1-858-499-8050 Email: shp.claimsresearch@sharp.com
Pharmacy	Information for obtaining Coverage Determinations, Exceptions and Redeterminations CVS Caremark. Phone: 1-855-344-0930
Prior Authorization – Medical Health Services	Information on Prior Authorization for Medical Health Services. Medical Health Services Fax: 1-619-740-8111 sharphealthplan.com/for-providers/utilization-management
Prior Authorization Behavioral Health Services	Information for Prior Authorization for Behavioral Health Services. Magellan Healthcare Phone: 1-844-483-9013
Provider Account Management	Provider assistance or questions regarding Sharp Health Plan. Phone: 1-858-499-8330 Fax: 1-858-303-9049 Email: provider.relations@sharp.com sharphealthplan.com/for-providers

Resource	Contact Information
Provider Directory	Report corrections to information in Sharp Health Plan's Provider Directory by contacting Provider Account Management. Phone: 1-858-499-8330 Email: provider.relations@sharp.com sharphealthplan.com/report-incorrect-provider-information
Provider Portal	Access your Sharp Health Plan account (provider portal) for member eligibility, medical policies, and benefit information. Log in or create an account: sharphealthplan.com/login

SECTION II

Member Services, Enrollment and Eligibility

Customer Care

The Customer Care Department is designed to assist both members and providers with all Sharp Health Plan's Value-Added Services and health plan benefit coordination. Customer Care can be reached toll-free at **855-562-8853** (TTY/TDD: 711).

, or by email at customer.service@sharp.com. The Customer Care Department has friendly, knowledgeable, and bilingual representatives available from 7 a.m. to 8 p.m., seven days a week, all year round. Our Customer Care Representatives assist members by answering questions regarding, but not limited to eligibility, general benefits, PCP assignment, and hospital information.

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

- Status of medical referrals and authorizations
- Premium billing questions
- Health plan options
- Community resources and support groups
- Grievances and appeals process
- ID card replacements

Provider and Member behavioral health inquiries are supported by Magellan Healthcare. Members may reach Magellan Healthcare Customer Care by calling 1-844-483-9013 (TTY/TDD: 711). The Customer Care department is available from 7am to 8pm, seven days a week, all year round. Clinical staff are available 24 hours a day, 7 days a week for crisis calls and urgent behavioral health care needs.

Member pharmacy inquiries are supported by our PBM partner CVS Caremark. Members may reach CVS Caremark by calling 1-855-222-3183 or TTY: 711.

Members associated with Teamsters may contact SAV RX's designated Customer Care phone number 1-800-228-3108 for assistance or refer to the pharmacy information located on the back of their member ID cards.

- Retail pharmacy claim inquiries
- Drug coverage inquiries
- Plan design education
- Drug coinsurance questions
- Mail service order status
- Plan benefit overrides

- Escalated member requests
- Eligibility inquiries
- Prescription billing/payment inquiries
- Prescription prior authorizations and formulary exception requests

Primary Care Physician (PCP) Assignment and Selection

All Sharp Direct Advantage Plan members must select a primary care physician (PCP) to manage their medical needs from the following practice areas:

- Medical Doctor (MD), including an internist, family practice provider, general medicine provider, and OB/GYN.
- Osteopathic provider (DO), including an internist, family practice provider, general medicine provider, and OB/GYN.
- Members select a PCP affiliated with a community clinic are assigned to the clinic, not an individual provider within the clinic.
- A Member, who is also a provider, may not select themselves as their PCP.

If a member does not select a PCP at enrollment, the Plan will assign a PCP based on the following factors:

- The member's Plan Network
- The existence of established relationships and family linkages
- The member's residence
- The member's language preference
- The member's age

Members are notified by mail of the Plan-assigned PCP and of the right to select a different PCP by contacting Sharp Health Plan Customer Care.

- Generally, a PCP assignment becomes effective on the first of the following month. For example, if the member calls to select a PCP on May 8, the assignment to that PCP becomes effective on June 1. If the member insists on assigning a PCP the first of the current month, for example today is May 8 and member is requesting PCP change for May 1, exceptions may be made.
- If a PCP change requires a Plan Medical Group (PMG) change or is starting as a new patient within a specified PMG, urgent care locations may change, member will be responsible for obtaining new PCP authorizations, new referrals to specialists, and new prescriptions for medication. In addition, the member must attest to not accessing care including medical, laboratory, or pharmacy services within the current month. If later it is deemed that the member accessed services within the same month, between two PMGs**,** the member will be held financially responsible for services rendered.

- A member identification card is sent to the member when the PCP assignment is effective and any time after that when a PCP change is made. The identification card lists the PCP, the PCP's telephone number, the Plan Medical Group, and the Plan Network.
- Sharp Health Plan encourages members to find a PCP they are comfortable with and stay with that PCP. This way, the member and doctor can establish a relationship, and the doctor will be familiar with the member's medical history. However, members can change PCPs at any time.
- PCP changes will be made based on the request from the member or the member's parent or guardian. PCP changes cannot be made by a provider or the provider's office staff without authorization from the member, but they can be made from the provider's office if the member confirms the change by telephone.

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 below. Printable EOC versions (in English and Spanish) suitable for distribution to members are also available online at 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.

General Member Enrollment Information

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

Medicare beneficiaries can enroll in a Medicare Advantage plan like Sharp 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 65th birthday.
- Initial Enrollment Period for Part D (IEP): The period when a person is first eligible for a Part D plan. A person is eligible for a Part D plan when they are entitled to Part A or enrolled in Part B and permanently reside in the service area of the plan. The IEP enrollment period is 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 will 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 when receiving services rather than the government issued red, white, and blue Medicare card.

(Samples of Sharp Health Plan's Direct Advantage Identification Cards are located on subsequent pages 22-24 within this section).

Eligibility Verification

Plan providers are responsible for verifying eligibility each time a member schedules an appointment and before medical services are provided unless it is an emergency.

Because events leading to ineligibility can occur at any time, providers are encouraged to verify eligibility on the day services are to be rendered. Specialists should always verify member eligibility on the day of the appointment. Primary care physicians must verify both eligibility and member PMG assignment on the day of the appointment.

Verification of eligibility and/or benefit coverage is NOT a guarantee of payment by Sharp Health Plan.

All members are issued a health plan identification card, which should be presented each time services are requested. The Sharp Direct Advantage Member Identification Cards include the following information:

- Member Name
- Member ID Number
- Coverage Effective Date
- Plan Medical Group Name (PMG)
- Plan Network
- Primary care physician (PCP)
- PCP Telephone/After Hours Number
- Cost-Share
- Deductible
- Copayments/Coinsurance
- Customer Care toll-free number
- TTY/TDD Number
- Medical Claims Mailing Address
- Claim and Mailing Address
- Pharmacy Claim/Billing Information

Although the Member 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/PMG and members may forget to present the most recent card when accessing services. Therefore, it is important to verify eligibility with each visit.

Providers may verify member eligibility through any of the following Sharp Health Plan methodologies:

1. Online via the Sharp Health Plan provider portal, which gives providers the ability to view member-specific eligibility information, including effective date, benefits, and copayments. To log in or create an account, visit sharphealthplan.com/login. If you are not currently set up, please contact Provider Account Management at 1-858-499-8330 or provider.relations@sharp.com.
2. To use the automated system, call the toll-free dedicated provider line at 1-844-483-9014.
    - Enter your 10-digit NPI number followed by pound (#)
    - Press 1 for provider
    - Press 1 for member eligibility
    - Enter the patient's 8- or 11-digit member ID number followed by pound (#)
    - Press 1 if correct

- Enter the patient's date of birth as a 2-digit month, 2-digit day and 4-digit year followed by pound (#)

Once authenticated, providers will hear the following details for active members:

- Member Eligibility Status
- PCP Name
- Primary Medical Group
- Plan Network
- Member Cost-Shares (Copay/Coinsurance)
    - PCP
    - Specialist
    - Urgent Care
    - Emergency Visit
    - Hospital Admission
- Member's Individual Deductible

While listening to the member details, the following navigation options are available:

- Press star (*) to repeat information
- Press pound (#) to skip to the end

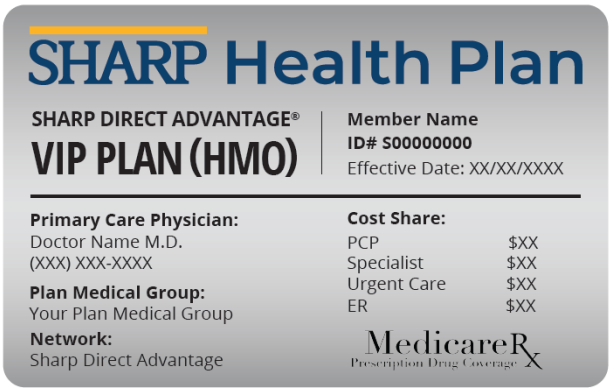
1. If a member insists, they are enrolled in Sharp Health Plan, but the provider is not able to confirm eligibility via Sharp Health Plan account (provider portal) or telephone automated (IVR) system, please call Sharp Health Plan's Customer Care Department at 1-855-562-8853(TTY/TDD: 711) for assistance from 7 a.m. to 8 p.m., seven days a week, all year round. The Customer Care Representative may be able to confirm eligibility immediately.

3. You may also contact Sharp Health Plan's Direct Advantage provider dedicated phone line at 1-844-483-9014. This phone line is available 24/7 to verify member eligibility status, PCP assignment and copay/coinsurance information.

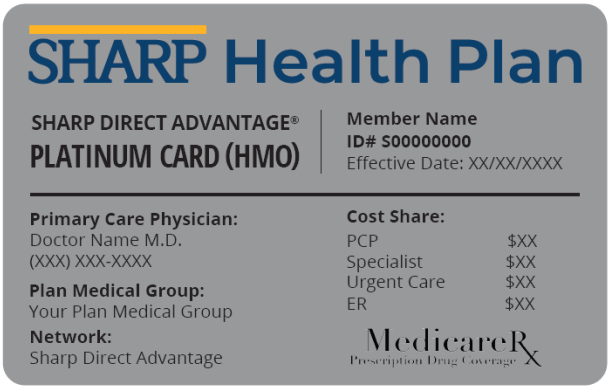
Member ID Cards

Sample Front and Back ID Card Sharp Direct Advantage Member ID Cards:

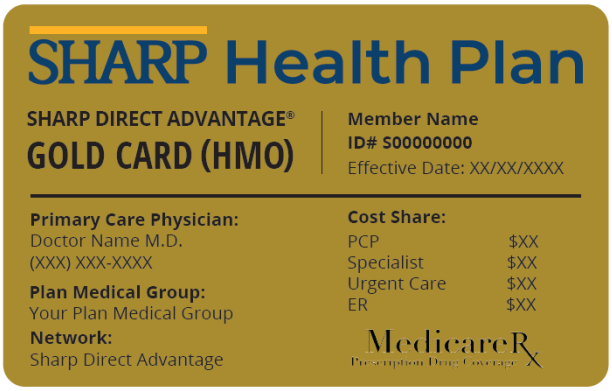
Sharp Direct Advantage VIP Plan (HMO)



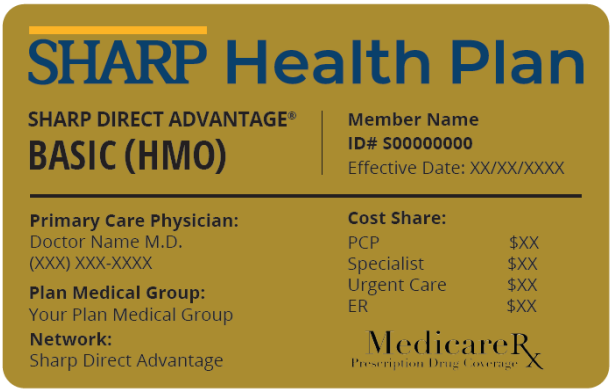
Sharp Direct Advantage Platinum Card (HMO)



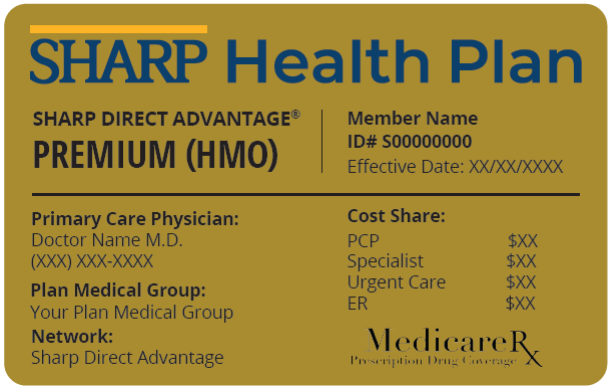
Sharp Direct Advantage Gold Card (HMO)



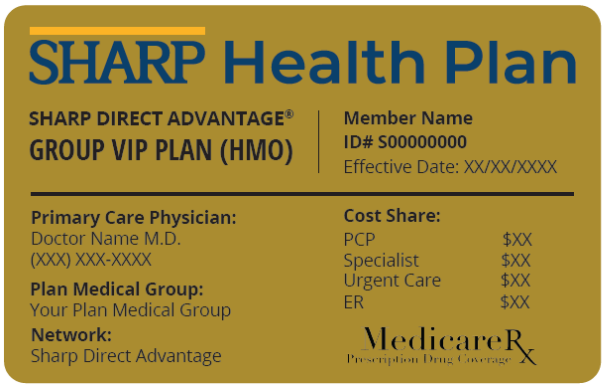
Sharp Direct Advantage Basic (HMO)



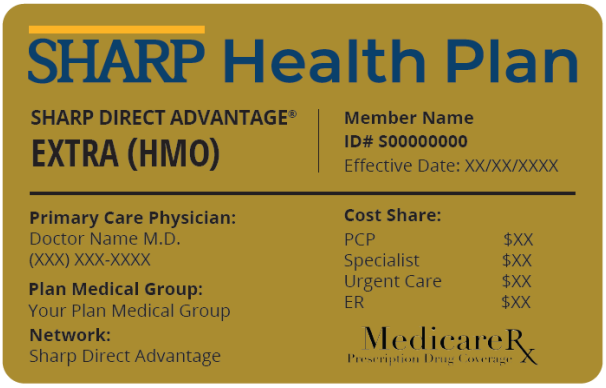
Sharp Direct Advantage Premium (HMO)

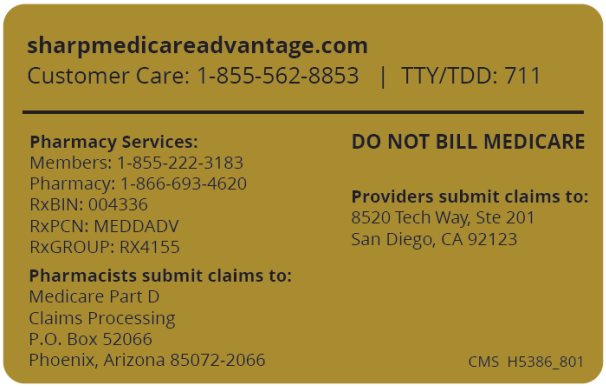


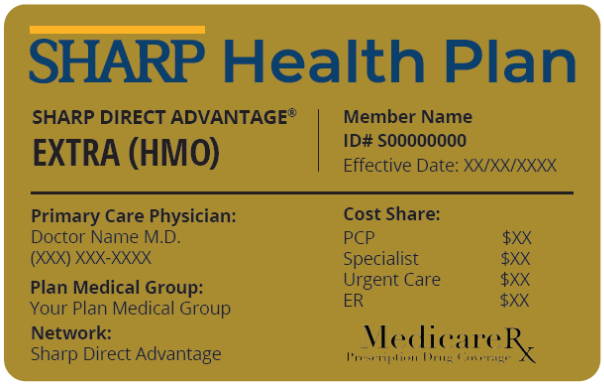
Sharp Direct Advantage Group VIP Plan (HMO)



Sharp Direct Advantage Extra (HMO)

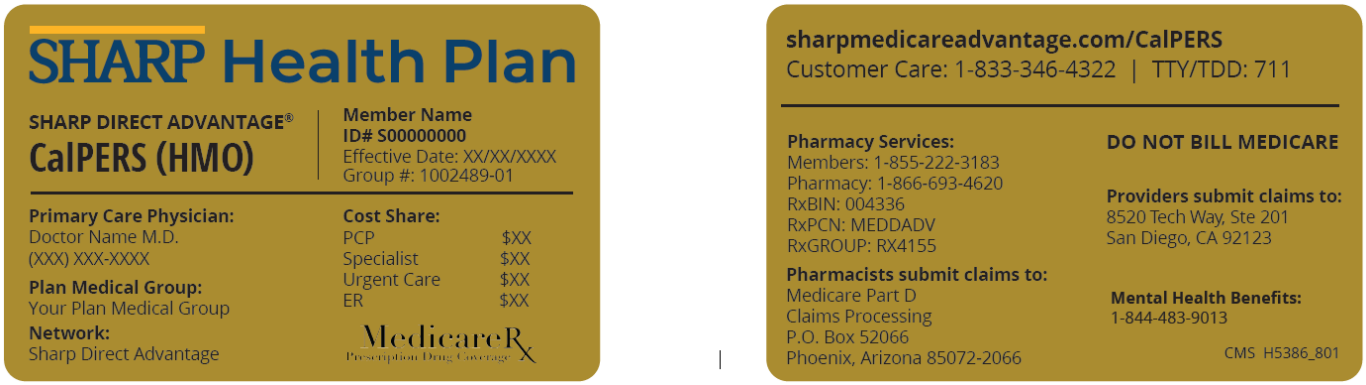






Sharp Direct Advantage (HMO) - San Diego Public Employee Benefit Association (SDPEBA)

Sharp Direct Advantage (HMO) - CalPERS



Member Grievances and Appeals

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 dedicated Medicare line at 1-855-562-8853 (TTY/TDD: 711), or by email at **customer.service@sharp.com**.

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
Attn: Grievances and Appeals Department
8520 Tech Way, Suite 201
San Diego, CA 92123-1450
Toll-free: 1-855-562-8853
Fax: 1-858-636-2256

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, 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 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–provider 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.

SECTION III

Provisions of Professional Services

Network Providers

Sharp Direct Advantage is an HMO plan. It has a defined network of provider groups, called Plan Medical Groups (PMGs), from which members choose a primary care physician (PCP), receive specialty provider care and access 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.

Plan 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.
- Provide all services in a culturally competent manner.
- 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 provider-patient communication regarding appropriate treatment alternatives or when recommending any procedure which plan provider deems medically appropriate. The provider 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 while discussing appropriate medically necessary treatment options.
- Be accessible to Sharp Direct Advantage members, including emergency access via telephone per the section, 42 CFR 422.112 Access to Care regulations below.
- The delegated plan medical group (PMG) or provider's office, as appropriate, is responsible for notifying members when telehealth services are available and responsible for explaining the process to be used to schedule a telehealth visit.
- Ensure that the member provides either verbal or written consent prior to receiving care via telehealth and that the consent is documented in the chart note.
- Members should be notified at the time of scheduling an appointment about any cost-sharing associated with a telehealth visit.

- 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 Section II: Member Services, Enrollment and Eligibility - Member Grievances and Appeals)
- 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 as defined in member handbook and page 32 of this POM. (Refer to Section II: Member Services, Enrollment, and eligibility - 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 designated amount of time to all requests for information related to potential quality of care issues and/or peer reviews and either respond personally or cosign an office or hospital staff's response or information.
- 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.
- Actively participate in the Plan's quality and utilization management initiatives.
- 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.
- Notify Sharp Health Plan within five 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 30 business days to Sharp Health Plan's annual or bi-annual request for affirmative updates, or risk deletion from the provider directory.
- Comply with this provider Manual and the terms of your agreement.

Conflicts of Interest

Plan providers are expected to conduct their affairs to avoid or minimize Conflicts of Interest by maintaining appropriate and ethical relationships with third parties, including patients and their families, other health care providers, as well as suppliers, pharmaceutical companies, device manufacturers, and subcontractors ("vendors") so that no third-party has, or appears to have, an opportunity to inappropriately influence plan providers' decisions and activities.
A plan provider must not currently have and will not have throughout the term of any agreement with Sharp Health Plan, any direct interest that may present a conflict in any manner with the performance of services required under the agreement. Plan providers should carefully consider all financial and personal interests that are or may potentially lead to a Conflict of Interest and should

be disclosed. Plan providers must conduct their affairs to avoid or minimize Conflicts of Interest and must respond appropriately when Conflicts of Interest actually or potentially arise.

A Plan provider has a continuing obligation to disclose the existence and nature of any actual or potential Conflict of Interest he or she may have. Each plan provider has an individual responsibility to disclose any potential Conflict of Interest and it is the expectation that each plan provider be in compliance with all federal and California regulations related to referrals required for the provision of certain covered services, including Federal and California anti-kickback and anti-self-referral laws, and other rules and regulations related to conflicts of interest. Questions or concerns about conflicts of interest? Please contact us at provider.relations@sharp.com or 1-858-400-8330.

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, seven 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.).
- Manage behavioral health issues within scope of a PCP. Refer members who requirements are out of scope of a PCP, assist members with obtaining Behavioral Health Care Services by calling Behavioral Health Customer Care with Magellan at 1-844-483-9013 (TTY/TDD: 711).
- Request authorization for referrals, services, procedures, and medications when required by the Plan.
- Assist with member's accessing behavior health services.

- Prior authorizations for hearing aids, both to in-network or out-of-network providers/vendors, must be submitted to 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 in a timely fashion, generally within 72 hours of receipt of results.

On-Call Providers Coverage

The PCP shall provide coverage for Sharp Direct Advantage members 24 hours a day, seven days a week and shall make coverage arrangements with another provider (preferably one who is also contracted with Sharp Health Plan and in the member's plan medical group) 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 provider in a coverage arrangement.

It is the responsibility of the PCP to ensure that the covering provider 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 provider for payment of all Covered Benefits provided to Sharp Direct Advantage members. Covering providers must not bill Sharp Direct Advantage members for covered benefits.

Role of the Specialty and Ancillary Provider

Collaboration between the PCP and specialty or ancillary providers is crucial to achieve continuity and quality 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 defined by the member's affiliated PMG or Sharp Health Plan. Depending on the member's benefit plan, if a member calls the specialist provider office directly, the specialist will determine if a referral is needed by the member's PCP.

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 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 responsible for discussing all tests and labs that he/she ordered with the member. The specialist is also responsible for sharing records with the member's PCP.

Plan Medical Group Notification of Provider Terminations

Plan medical groups (PMGs) must send telephonic and written termination notification of primary care physicians and behavioral health providers at least 45- days in advance of the actual provider termination date. This notification is required regardless of termination reasons, including but not limited to, contract dispute and breach, provider retirement, provider practice relocation, performance and disciplinary actions, sale/merger/acquisition/change of ownership or Medicare opt-out. It is a regulatory requirement to allow Sharp Health Plan members 30- day advance written notification of a provider termination other than a primary care physician or a behavioral health provider. A 60-day written notice is required between the Health Plan and providers before terminating the contract without cause. Additionally, for-cause provider contract terminations do not have a set timeframe but do require a good-faith effort in doing so as timely as possible.

Disabled Member Services

The Americans with Disabilities Act (ADA) requires public accommodations, including the professional office of a health care provider, to provide goods and services to people with disabilities on an equal basis as people without disabilities. For inquiries or assistance, please contact Sharp Health Plan Customer Care Department at 1-855-562-8853 (TTY/TDD: 711).

Emergency Services

A medical emergency is when any prudent layperson with an average knowledge of health and medicine, believes they have medical symptoms that require immediate medical attention to prevent loss of life (and loss of an unborn child if a pregnant woman), loss of a limb or function of a limb, or loss of or serious impairment to a bodily function. The medical symptoms may be an illness, injury, severe pain, or a medical condition that is quickly getting worse.

Emergency Services are those covered benefits, including emergency services and care provided inside or outside the service area that are medically required on an immediate basis for treatment of an Emergency Medical Condition.

The PMG shall take into consideration the presenting and discharge diagnosis when reviewing emergency service claims for a potential retrospective denial. The determination is based on a prudent layperson with an average knowledge of health and medicine belief, not on the treating provider's assessment. Retrospective denial of services for what appears to the reasonable layperson to be an emergency is prohibited.

Telehealth Services

California state law defines telehealth as a method of delivering health care services and public health through communication technologies that allow for the ability to diagnose, consult, treat, educate, facilitate care management, and self-management as it is relates to a patient's health care.

It is required that providers obtain either verbal or written consent from the member for the use of telehealth services prior to providing care via telehealth. Consent for telehealth services must be documented in the chart note. In addition, members should be notified at the time of scheduling an appointment about any cost-sharing associated with a telehealth visit.

MA organizations are required to maintain procedures to identify and offer digital health education to enrollees with low digital health literacy to assist with accessing any medically necessary covered telehealth benefits. Additionally, if providers that offer telehealth services are in the Provider Directory, the provider's linguistic capabilities must be identified.

Additional information regarding telehealth can be obtained from the Department of Health Care Services or from the Center of Medicare and Medicaid Services (CMS).

Provider Directory Verification and Attestation

Sharp Health Plan is committed to the accuracy of the information listed in the Plan's provider directories. Pursuant to the federal No Surprises Act under statute 42 U.S.C.A. 42 U.S.C.A. § 300gg-115(1)(2)(b), Sharp Health Plan reaches out for quarterly verification of data and provider rosters. In pursuant to (Section 1367.27 of the California Health and Safety Code) SB-137, the Plan must collect verifications annually/biannually from the providers attesting to the accuracy of the information that is provided to the plan.

Delegated Providers

Delegated provider groups must ensure that the health plan has the most up to date provider roster information, including new providers, locations, and providers no longer with the practice. In compliance with SB 137, Sharp Health Plan reaches out to you annually and requests that you attest to the provider roster information. If there are required changes, delegates must provide an updated roster within 30 business days. If there are no required changes, there will be an option to attest to no changes in that quarter. Providers must attest within 30 business days of the original request, even if there are no changes.

Failure to respond to attestation requests may result in removal from the provider directories or delay of payment/reimbursement of a claim. The Plan will notify providers ten days in advance prior to removal from the directory but will revoke the action if the plan providers respond within the ten-day notification period.

Provider-Initiated Member Dismissal

Rarely, a plan provider cares for a member who is disruptive or excessively difficult. However, in these instances, plan providers can contact Sharp Health Plan's Dedicated Provider Line at 1-844-

483-9014 to request assistance with difficult members. Plan 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. A member may not be dismissed or denied care due to diagnosis, health status/needs, or language barriers. To dismiss a plan member, plan providers must follow Sharp Health Plan's policy as outlined below.

Plan Medical Groups

Member Reassignment to Another PCP within Plan Medical Group
When a member-provider relationship is irreparably damaged, delegated plan medical groups (PMG) should make every attempt to reassign the member to another PMG provider within their network and notify the Plan of the change within five (5) business days. The notification to the Plan on member reassignment within the group must include the member reassignment letter/notification that outlines how the member can change their PCP should they want a different PCP than assigned.

Member Dismissal from Plan Medical Group
If multiple attempts to reassign the member to a different PCP. within the PMG network fail, the PMG must submit a member dismissal form to SHP in order to have the member dismissed and reassigned to another Sharp Health Plan provider.

Member dismissal will be considered under the following circumstances:

- Member demonstrates verbally abusive behavior toward the provider, 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 refuses to meet financial obligations such as copayments or coinsurance only after multiple attempts to address financial needs and assist with solutions.
- Member attempts to fraudulently obtain health care services, including allowing others to use the member's Plan identification card to receive services.

The Member Dismissal Process

The member dismissal process is as follows:

- The PMG 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.
- The PMG requests authorization to dismiss the member from the panel by faxing a completed Member Dismissal Request Form to the attention of Provider Account Management at 1-858-303-9049. A copy of the form can be found on subsequent pages of

this document. The PCP should not initiate dismissal communication with the member prior to the determination.

- The Member Dismissal Form should be completed and submitted to Sharp Health Plan for approval by the Sharp Health Plan Chief Medical Officer. The form must be completed in full and include supportive documentation detailing the situation prior to any member termination. Supporting documentation may be in the form of copies of medical records, office notes, etc., and may include:
    - Pertinent dates
    - Member's product line of business, i.e., Medicare, Exchange, Commercial. If the member is on a group benefit plan, provide the member's employer.
    - Documentation of all interactions between the member, provider(s), PMG representatives, and provider office staff in written format and/or audio files.
    - The PMG's request needs to demonstrate that the member's behavior is not due to mental illness or another medical condition. Th PMG must demonstrate evidence of interventions to manage the member through case management, social worker, and/or behavioral health referral to address potential healthcare overlying issues.
    - Documentation of previous attempts to educate member regarding noncompliance with office practices.
    - Billing statements, including amount due, letters advising members to pay their bill.

Sharp Health Plan may request additional documentation from the PMG, if necessary. Requests must be fulfilled within five business days. If requests for additional documentation are not fulfilled within this timeframe, the dismissal request will be denied.

Approval/Denial of Dismissal Requests

The process for approvals and/or denials is as follows:

- If the dismissal request is denied, the PMG will receive written notification of the decision within 30 days of Sharp Health Plan's receipt of all supporting documentation.
- If the dismissal request is approved, the PMG will receive written authorization to dismiss the member within 30 days of Sharp Health Plan's receipt of all supporting documentation.
    - After the PMG receives authorization from Sharp Health Plan to dismiss the member, the provider has five business days to provide written notification to the member and to send a copy of such notice to Sharp Health Plan.
    - The notification must include the reason for the dismissal and must not occur before authorization is received from Sharp Health Plan. Members cannot be terminated, or service refused at any point during this process.

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 business days following Sharp Health Plan's

approval to dismiss, the dismissal becomes invalid. The PMG can 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 PCP or a new PCP has been 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.

Member Dismissal Request Form

SHARP Health Plan

Member dismissal request form

Purpose

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.

Instructions

Please include all supporting details and documentation for dismissal along with this request form. Please refer to the Provider Operations Manual (POM) for additional information regarding the Member Dismissal Process. For questions please contact Provider Relations at 1-858-499-8330.

Submit

By Mail:
Sharp Health Plan
Attention: Provider Relations
8520 Tech Way, Suite 200
San Diego, CA 92123

By Fax:
Attention:
Provider Relations
1-858-408-9444

Provider information		
Provider name:	Medical Group name:	
Telephone #:	Fax #:	
Provider signature:	Date (MM/DD/YYYY):	Dismissing from entire group? ☐ Yes ☐ No
Name of person completing form:	Role / title:	
Member information		
Name:	ID number:	Date of birth (MM/DD/YYYY):
Reason for dismissal		
☐ Irreparable damage to the physician-patient relationship ☐ Financial ☐ Fraud ☐ Non-compliant ☐ Abusive or threatening ☐ Other (specify) _____		

Sharp Health Plan use 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:
If Dismissal is authorized	
Member must elect new PCP by this date:	Date Sharp Health Plan decision sent back to PCP:

01-2024

Claim Submission Requirements

Sharp Health Plan must receive claims no later than one calendar year from the claim's date of service. Claims filed after the specified timeframe will be denied with no appeal rights. For claims that include span dates of service, claims filing timeliness is determined as follows:

- For Professional claims, the "From" date is used to determine the date of service and
- For Institutional claims, the "Through" date is used to determine the date of service.

Electronic Claims Submissions

Providers have the option of submitting claims electronically through Electronic Data Interchange (EDI). The advantages of electronic claims submission include the following:

- Prompt acknowledgement of claims receipt
- Improved claims tracking and status reporting
- Reduced turnaround time for timely reimbursement
- Eliminates paper
- Improved cost effectiveness

Claims submitted electronically must be compliant with federal HIPAA transaction standards.

The provider may work with an approved clearinghouse from the list below:

Sharp Health Plan Approved Clearinghouses

Capario (Change Healthcare)
1-800-792-5246 | www.capario.com | Sharp Health Plan Payer ID: SHPPN

Office Ally
1-360-957-7000 | cms.officeally.com | Health Plan Payer ID: SHP01

Trizetto (Gateway EDI)
1-800-556-2231 | www.trizettoprovider.com | Sharp Health Plan Payer ID: SHP76

Waystar (Zirmed)
844-492-9782 | www.waystar.com | Sharp Health Plan Payer ID: SHP102

All new EDI submission requests will need to be submitted by filling out an EDI Provider Request form or the online form in your provider portal.

Claims Payment Editing System

The claims editing system in use is based on Correct Coding Initiative edits and National Correct Coding Initiative edits.

Every decision is fully supported with a variety of clinical documentation to ensure complete understanding of the system and communication to the provider community. The edits are based on the information provided on or with the claim. If the claim information is incomplete or invalid, the claim edits will be accurate but may not be the outcome the provider expected.

Edits are reviewed by auditing staff before claims are finalized. Please make sure additional documentation to justify coding is included on the claim, such as modifiers and information in box 19 of the CMS 1500 or box 84 of the UB04.

Claims Policy Administration Module

In order to process consistently based on industry-standard guidelines the Policy Administration Module allows the building of custom rules that reflect medical and payment policies. To address the complexity of benefit plan designs, the module allows for the enhancement of code auditing with additional fields and combinations for review or comparison that include:

- Frequency of procedure codes
- Claim lines for code combinations present or not present
- Claim lines for limits based on days before or after the claims date
- Claim lines for the same, different or all providers or the same specialty
- Monitoring for the frequent use of modifier codes

Industry standard guidelines that will be audited via the new Policy Administration Module include but not limited to:

- Denying the Add-On Code without the parent code billed
- Procedure allowed once in a lifetime for certain surgical procedures
- Documentation required when billing modifier 62
- Denying Co-Surgeon (mod 62) codes not payable per Medicare guidelines
- Codes not payable with team surgeon modifier 66
- Denying drug admin codes without the drug billed
- New visit frequency editing

Services of Non-Contracting Providers and Suppliers

A Medicare Advantage (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:

- Ambulance services.
- Emergency and urgently needed services.
- Maintenance and post-stabilization care services.
- Renal dialysis services provided while the member was temporarily outside the plan's service area.
- 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.

For more information on Benefits and Beneficiary Protection code 42 CFR 422.113 (Special rules for ambulance services, emergency and urgently needed services, and maintenance and post-stabilization care services), please visit the U.S. Government Publishing Office website.

Claim Addresses

Claims for services provided to members assigned to entities delegated for claims processing should be mailed directly to the entity. Claims addresses for all entities are available on the below PMG grid.

Delegated Medical Group Claim Submission Addresses and Phone Numbers

GTC – Greater Tri-Cities (IPA)	Palomar Health
PO Box 5059 Oceanside, CA 92052 Phone: 1-760-941-7309, option 3 Fax: 1-760-631-7614	PO Box 260890 Encino, CA 91426 Phone: 1-888-445-0062 or 1-818-461-5000
Sharp Community Medical Group (SCMG)	Sharp Rees-Stealy Medical Group (SRSMG)
PO Box 939037 San Diego, CA 92193 Phone: 1-858-499-2550 Fax: 1-858-499-4441	PO Box 939035 San Diego, CA 92193 Phone: 1-858-499-2410 Fax: 1-858-268-4642
Sharp Direct Advantage (Out of Area)	American Specialty Health Plan

GTC – Greater Tri-Cities (IPA)	Palomar Health
8520 Tech Way, Ste 201 San Diego, CA 92123-1450 Phone: 1-855-562-8853	PO Box 509002 San Diego, CA 92150 Phone: 1-800-972-4226
Vision Service Plan (VSP)	CVS Caremark
PO Box 997105 Sacramento, CA 95899 Phone: 1-800-877-7195	Phone: 1-855-344-0930

Encounter Data

Sharp Health Plan must receive timely Encounter Data to appropriately track member's deductibles and out-of-pocket costs, meet reporting requirements, and to monitor the value of services provided under capitation. Plan providers reimbursed under capitation must send encounter data to Sharp Health Plan for each member encounter. Encounter data must be submitted either electronically or on the applicable claim form, following standard claims submission guidelines, within 120 days of the date of service.

Encounter data completeness and quality is monitored regularly by the Plan. If problems are identified with the timeliness, quality or quantity of submissions, Sharp Health Plan will contact the capitated provider to review and correct the identified problems.

Coordination of Benefits

When a member has coverage under Sharp Direct Advantage and group coverage or Medi-Cal, the benefits of these plans will be coordinated so that the total amount paid out does not equal more than the actual cost of treatment. Coordination of benefits is vital in keeping the cost of coverage as low as possible. Please make sure to ask for all insurance coverage from the member to ensure there is no delay in payment.

Third-Party Liability

If a member is injured in an accident caused by a negligent or intentional act or omission of another person, the Plan will advance Covered Benefits at the time of need subject to an automatic lien by agreement to reimburse the Plan from any recoveries or reimbursement the member may receive from the person who caused the injury. Plan providers may not refuse to provide Covered Benefits to members who are injured by another party. Plan providers may not require members to assign any recoveries or reimbursements to the provider as a condition of receiving care. All claims for services rendered in relation to a third-party liability case should be submitted for processing. The claims will follow normal processing guidelines. Any recoveries related to third party or worker's compensation liabilities will be made by Sharp Health Plan.

Sharp Health Plan must be notified in writing of all potential and confirmed third party and worker's compensation liability cases that involve a Sharp Health Plan member.

Notification must include:

- Member name
- Member identification number
- Date of birth
- Date of injury
- Identification of third party, if known
- Provider name and address
- Date(s) of service
- ICD10 code and/or description of injury
- CPT code and/or description of service(s) rendered
- Billed charges for service(s)
- Any amount paid by other coverage (if applicable)
- Date of denial and reason(s) for any applicable denials from other payers

Send notices of potential third-party liability to:

Sharp Health Plan
Attn: Third Party Liability
8520 Tech Way, Suite 200
San Diego, CA 92123
Fax: 1-619-740-8571

SECTION IV

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 Medicare Managed Care 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 PMG's assigned Provider Services Representative for further requirements and/or information.

Disclosure to CMS and Beneficiary

In accordance with CMS guideline on Eligibility, Election and Enrollment 42 CFR 422.64 (U.S. Government Publishing Office); Sharp Health Plan shall disclose certain CMS-required information to beneficiaries, 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 concerning the available choices for Medicare coverage.

Contract Provisions

Sharp Health Plan shall disclose to CMS all information that is 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 a Medicare Advantage (MA) plan.
- The MA monthly basic beneficiary premium and MA monthly supplemental beneficiary premium, if any, for the plan.
- 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 enrollees electing to receive benefits through the plan for the previous 2 years.
    - Information on Medicare enrollee satisfaction.
    - Information on health outcomes.

    - The recent record regarding compliance of the plan; and
    - Other information determined by CMS to be necessary to assist beneficiaries in making an informed choice among MA plans and traditional Medicare.
- Information about beneficiary appeals and their disposition.
- Information regarding all formal actions, reviews, findings, or other similar actions by States, other regulatory bodies, or any other certifying or accrediting organization; and
- Any other information deemed necessary by CMS for the administration or evaluation of the Medicare program.

In meeting these requirements, provider shall cooperate with plan and assist plan in complying with these requirements when applicable.

For additional Information about the Medicare Advantage program code 42 CFR 422.504 (Contract Provisions), please visit the U.S. Government Publishing Office website.

General Requirements

Sharp Health Plan's Customer Care Department is designed to assist both members and providers with all 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 as noted on CMS guideline codes 42 CFR 422.112 (Access to Service) and 42 CFR 422.100 (General Requirements) on the U.S. Government Publishing Office website.

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
- Requests for translation of materials or alternative format materials.

Interpreter Services

Sharp Health Plan provides free interpreter services for members at scheduled appointments whose primary language is not English. Plan providers can request interpreters by calling Customer Care at 1-800-359-2002 (TTY/TDD: 711). Plan providers must make requests for face-to-face interpreting services at least five business days prior to the appointment date. Coordination of interpreter services shall not impose delays on the scheduling of the appointment. If an interpreter is

unavailable for face-to-face interpreting, Customer Care can arrange for telephone interpreting services. The provider directory should include languages spoken by the provider and within the provider office to assist in any needed language needs of the member.

Online Provider/Pharmacy Directory Requirements

In accordance with CMS codes (42 CFR 422.111 – Disclosure requirements; 422.112 – Access to service and 423.128 – Voluntary Medicare prescription drug benefits), 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). 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 Account Management at 1-858-499-8330 or shp.directory@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

Preclusion List

CMS regulation code 42 CFR 422.222 (Preclusion list) prohibits 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 have been impacted by their preclusion from the Medicare program.

Precluded providers are prohibited from pursuing payment from the beneficiary as stipulated by the terms of the contract between CMS and the Plan per code 422.504(g)(1)(iv) of the Federal Register.

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 make 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 Prescription Drug Event (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 Centers for Medicare and Medicaid Services (CMS) Precluded Provider List, all provider inquiries regarding their preclusion status must be referred to CMS Preclusion list website. 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 Coverage Determinations, Appeals, and Grievances (CDAG) and the Organization Determinations, Appeal, and Grievance (ODAG) process.

Provider Contract Termination

When Sharp Health Plan or its delegated entities become aware of a provider or prescriber listed in the 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, on a monthly basis.

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.

For more information on contract provisions code 42 CFR 422.504(g) (1) (iii) – Beneficiary financial protections, visit the U.S. Government Publishing Office website.

Anti-Discrimination Based on Payment Status

Pursuant to the Medicare Managed Care Manual, Ch. 4, Section 10.5.2 and your network provider contract, Medicare Advantage (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.

Information about the Medicare Advantage Program

Sharp Health Plan provides, on an annual basis, and in a format using standard terminology specified by CMS code 42 CFR 422.64 (Information about the MA program) , and 422.504 (Contract Provisions), 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.

CMS Marketing Provisions

In accordance with CMS guidelines, section 42 CFR 422.2268 (Standards for MA organizations communication and marketing). 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 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, providers, 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 a Sharp Direct Advantage plan.

- For at least 45 days (or ten 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 five 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, a Medicare Advantage plan offered by the Medicare Advantage organization.
- Explain the benefits of enrollment in a 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.*, providers 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, misleading, or otherwise make material misrepresentations.
- For markets with a significant non-English speaking population, provide materials in the language of these individuals.

Discrimination Against Beneficiaries Prohibited

Following CMS guidelines, section 42 CFR 422.110 (Discrimination against beneficiaries prohibited), Sharp Health Plan does not deny, limit, or condition the coverage or furnishing of benefits to individuals eligible to enroll in a Medicare Advantage plan offered by the organization based on 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, and disability.

Disclosure Requirements

Sharp Health Plan must make a good faith effort to provide written 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 physician, all members who are patients of that primary care professional must be notified by telephone and written notice at least 45 calendar days prior to the termination effective date. Medicare Advantage organizations and contracted providers are required to provide at least 60 days written notice to each other before terminating the contract without cause.

Sharp Health Plan has this policy and procedure in place. Please contact Provider Account Management at provider.relations@sharp.com or call 1-858-499-8330 if you have any questions.

Access to Services

In accordance with CMS guidelines under section 42 CFR 422.112 (Rules for coordinated care plans) a 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 physicians (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, seven 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 a member health record in accordance with standards established by the Medicare Advantage organization, considering professional standards; and
    - There is appropriate and confidential exchange of information among provider network components.

General Requirements

Subject to the conditions and limitations set forth by CMS guidelines 42 CFR 422.100 (General requirements). Sharp Health Plan must provide enrollees coverage of basic benefits affecting screening mammography, influenza vaccine, and pneumococcal vaccine.

- 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.

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/workstation.

- 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 under section 42 CFR 422.118 (Confidentiality and accuracy of enrollee records), visit the U.S. Government Publishing Office website.

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, its purpose is designed for educational purposes only and should not 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.

Medical Record Standards

Sharp Health Plan medical records standards are measurable and are based on relevant regulatory requirements and evidence-based best practices. These medical record documentation standards promote consistency in practice and support the communication of clinical information among practitioners for continuity and coordination of care. The standards are:

1. All medical record entities must be legible and should establish the stated diagnosis from the included history and physical findings.
2. The therapies noted should be current therapies.
3. Drug allergies and idiosyncratic medial problems are conspicuously noted.
4. Pathology, laboratory, and other diagnostic and screening reports are available, documented as read, and noted in the assessment if abnormal or significant.

5. The health professional responsible for each entry is identifiable and each entry is dated.
6. Consultation and progress notes are available and noted as reviewed.
7. Health care treatment recommendations are noted as having been provided to the patient.
8. Appropriate preventative care is documented.
9. Discussion about advance directives or a copy of the advance directives is in the chart.
10. Two patient identifiers are on each page of the medical record.

3. Consent, either verbal or written, for telehealth visit.
4. Medical record retention is 10 years.

Medical records shall reflect the following:

1. All services provided directly by a provider who provides health care services.
2. All ancillary services and diagnostic tests ordered by a provider.
3. All diagnostic and therapeutic services for which a member was referred by a provider, such as but not limited to:
    - Home health nursing reports
    - Specialty provider reports
    - Hospital discharge reports
    - Physical therapy reports
    - Each provider visit shall include the documentation of:
    - Medical history and physical
    - Vital signs
    - Height and weight measurements
    - Allergies and adverse reactions
    - Problem list
    - Medications
    - Clinical finding, evaluation, and plan for each visit
    - Preventive services/high-risk screening

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 would 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.

Risk Adjustment Data

Record Retention, Data and Medical Records

Pursuant to Centers for Medicare and Medicaid Services (CMS) guidelines, Medicare Advantage (MA) plans shall obtain the risk adjustment data required by CMS from the provider, supplier, provider, or other practitioner that furnished the item or service. Plan providers shall cooperate with plan when applicable and in the following:

- Plan shall include in its contracts with providers, suppliers, providers, and other practitioners, provisions that require submission of complete and accurate risk adjustment data as required by CMS. These provisions may include financial penalties for failure to submit complete data. Provider shall cooperate with plan when applicable.
- Providers and practitioners shall be required to submit a sample of medical records for the validation of risk adjustment data, as required by CMS. There may be penalties for submission of false data. Provider shall cooperate with plan when applicable.
- Provider shall maintain for ten years books, records, documents, and other evidence of accounting procedures and practices for the purpose of CMS inspection and audit. PLAN and provider shall comply with state and federal governmental auditing, inspection, and evaluation requirements, including maintenance of record, access to facilities and records, and record retention guidelines pursuant to 42 CFR 422.504(d)(e).
- Plan's contracts with providers shall contain CMS-required provisions pursuant to 42 CFR 422.504(i)(3)(4).
- When applicable, Plan and providers shall certify to the accuracy, completeness, and truthfulness of relevant data to CMS pursuant to 42 CFR 422.504(l)(3).

For more detailed information regarding these CMS sections 42 CFR 422.310(d)(3)(4) & 422.310(e) – Risk adjustment data, and 422.504(d)(e), 422.504(i)(3)(4) and 422.504(1)(3) – Contract provisions, please visit the U.S. Government Publishing Office website.

Information on Advance Directives

Pursuant to CMS guidelines under section 42 CFR 422.128 (Information on advanced 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 document in a prominent part of the individual's current medical record whether the individual has executed an advance directive. Additionally, discussions with members, caregivers, or surrogates must be included in the documentation, and may include a conversation regarding the voluntary nature of the visit, explanation of advanced directives, who was present, the time spent during the face-to-face encounter, and any changes in health care status or health care wishes if the member becomes unable to make their own decisions.

Participation Procedures

Sharp Health Plan has established a formal mechanism to consult with the providers 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 provider 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 provider and the numbers and mix of providers needed by the Medicare Advantage organization.
    - The affected provider'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 provider.
- If Sharp Health Plan suspends or terminates a contract with a provider 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.

For additional CMS detailed information on sections 42 CFR 422.202 (Participation procedures) and 422.204 (Provider section and credentialing) visit the U.S. Government Publishing Office website.

Physician Incentive Plans: Requirements and Limitations

The requirements in this section 42 CFR 422.208 (Physician incentive Plans: requirements and limitations) apply to a Medicare Advantage organization and any of its subcontracting arrangements that utilize a provider incentive plan in their payment arrangements with individual providers or provider 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 provider groups or any other organized group.

Any provider 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 provider or provider 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 provider incentive plan places a provider or provider group at substantial financial risk for services that the provider or provider group does not furnish itself, the Medicare Advantage organization must assure that all providers and provider groups at substantial financial risk have either aggregate or per-patient stop-loss and conduct periodic surveys.
- For all provider incentive plans, the Medicare Advantage organization provides all information requested to CMS.

Contract Provisions

Under CMS guidelines in section 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 a 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 provider incentive plans; and
    - For the arrangements to be specified in the contracts between the MAO, providers, first tier and downstream entities.

Continuation of Benefits

Sharp Health Plan must provide continuation of health care benefits to:

- All enrollees, for the duration of the contract period for which Centers for Medicare and Medicaid Services (CMS) payments have been made.
- For enrollees who are hospitalized on the date its contract with CMS terminates, or, in the event of an insolvency, through discharge.

In meeting with this requirement, Sharp Health Plan may use:

- Contractual arrangements.
- Insurance acceptable to CMS.
- Financial reserves acceptable to CMS; or any other arrangement acceptable to CMS.

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. (FWA). CMS strongly encourages self-reporting as an important practice in maintaining an effective compliance program. Fraud, Waste and Abuse should be reported at the plan level, and potential fraud and abuse by First Tier, Downstream, and Related Entities (FDRs).

Fraud, waste, and abuse are defined as:

- **Fraud** – Knowingly and willfully executing, or attempting to execute, a scheme or artifice to defraud Sharp Health Plan or any health care benefit program or to obtain (by means of false or fraudulent pretenses, representations, or promises) any of the money or property owned by, or under the custody or control of, Sharp Health Plan or any health care benefit program.
- **Waste** – Overutilization of services or other practices that, directly or indirectly, result in unnecessary costs to Sharp Health Plan or any health benefit program. Waste is generally not considered to be caused by criminally negligent actions but rather by the misuse of resources.
- **Abuse** – Includes actions that may, directly or indirectly, result in unnecessary costs to Sharp Health Plan or any health care benefit program. Abuse involves paying for items or services when there is no legal entitlement to that payment, and the provider has not knowingly or intentionally misrepresented facts to obtain payment. The distinction between “fraud” and “abuse” depends on specific facts and circumstances, intent and prior knowledge, and available evidence, among other factors.

(Adapted from Medicare Managed Care Manual, Chapter 21.)

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. Your support in this area helps us all. If you suspect fraud, please contact our Compliance Department at 1-858-499-8237, or email shpcompliance@sharp.com. Or send a letter 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 Centers for Medicare and Medicaid Services (CMS) requirements within 90 days of contract signature and annually thereafter. Compliance with requirements is subject to audit and/or signed attestation:

- 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 ten 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).

1. Fraud, Waste & Abuse Training
2. General Compliance Training

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.

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 (Grievance Procedures);
- 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 CVS Caremark is delegated for processing coverage determinations and redeterminations (Part D). All providers must adhere to the Sharp Health Plan Appeal and Grievance policies and procedures, available in your **Sharp Health Plan online account**.

Basis for Imposing Sanctions

For the violation listed below, The Centers for Medicare & Medicaid Services (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

    - For more information regarding CMS section 42 CFR 422.752 (Basis for imposing sanctions) visit the U.S. Government Publishing Office website.

Medicare Part D Prescriber Enrollment Requirement

The Centers for Medicare & Medicaid Services (CMS) added a new requirement for prescribers of Part D prescriptions, effective January 1, 2019. Under CMS section, 42 CFR 422.222 (Preclusion List), any provider or other eligible professional who prescribes Part D drugs to Medicare beneficiaries must not be on the CMS Preclusion List in order for the drug to be covered under the Medicare Part D program. Medicare Advantage (MA) with Part D and MA employer group plans with Part D will not pay for drugs that are prescribed by providers 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.
- Have been convicted of a felony under federal or state law within the previous ten years that CMS deems detrimental to the best interests of the Medicare program.

CMS will make the Preclusion List available to Medicare healthcare plans monthly.

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.

Part D Prescription Drug Coverage

Following CMS guidelines in section 42 CFR 423.120 (Access to covered Part D drugs), 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 covered drugs, also known as a formulary. The formulary includes a range of brand and generic drugs in a six-tiered copay structure. All covered drugs are placed on one of the six tiers. It is important for the member and provider to work together to determine which drug is most appropriate.

- Tier 1: Preferred Generic - Includes preferred generic drugs and may include some brand drugs
- Tier 2: Generic - Includes generic drugs and may include some brand drugs
- Tier 3: Preferred Brand - Includes preferred brand drugs and non-preferred generic drugs
- Tier 4: Non-Preferred Drugs - Includes non-preferred generic drugs and non-preferred brand drugs
- Tier 5: Specialty Tier - Includes very high-cost brand and generic drugs which may require special handling and/or close monitoring
- Tier 6: Selected Care – Includes select care generic drugs for treating conditions such as diabetes, high blood pressure, and high cholesterol

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 monthly to reflect additions, deletions, tier changes and utilization management changes. Sharp may immediately remove a brand name drug or original biologic product on our Drug List if we are replacing it with a newly approved generic version or interchangeable biosimilar of the same drug that will appear on the same or lower cost sharing tier and with the same or fewer restrictions.

Sharp Health Plan may make other changes once the year has started that affect drugs our members are taking. For instance, we might add a generic drug that is not new to the market to replace a brand name drug or change the cost-sharing tier or add new restrictions to the brand name drug. We also might make changes based on FDA boxed warnings or new clinical guidelines recognized by Medicare.

Sharp Health Plan will notify members at least 30 days before the effective date of the change or give the member notice of the change and a transitional fill up to 30-day supply of the drug they are taking if a refill is requested within 90 days from the negative change. Sharp Health Plan will also 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 30-day advance notice before removing the drug from the formulary. Instead, we will remove 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 1-855-562-8853 or visit sharpmedicareadvantage.com/druglist 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 outlined 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 clinical guidelines, 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 is covered per prescription or for a defined period of time.

Providers can find out if prescribed drugs are subject to these additional requirements or limits by checking the formulary. Prior authorization and step therapy criteria are available on sharpmedicareadvantage.com. If the prescribed drug does have these additional restrictions or limits, providers can ask Sharp to make an exception to the coverage rules. Please refer to the Coverage Determination/Exception Requests section.

Network Pharmacy

Sharp 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 100-day supply of their covered prescription drugs at network retail pharmacies or sent directly to them through the network mail order pharmacy, CVS Caremark® Mail Service Pharmacy. Tier 5 specialty drugs are limited up to a 30-day supply per prescription and are not available through mail order. Typically, members can expect to receive their prescription within 10-15 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 until coverage criteria is met or a prior authorization/exception request is approved. If a member is a resident of a long-term care (LTC) facility, such as a nursing home, Sharp Health Plan will cover a temporary supply of 34-day supply (unless the prescription is written for fewer days). The LTC pharmacy may provide the drug in smaller amounts at a time, up to 34-day supply, to prevent waste. 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 prior authorization), Sharp Health Plan will cover a temporary 34-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.

Pharmacy Benefits Manager (PBM)

CVS Caremark® is Sharp Health Plan's PBM. CVS Caremark Customer Care is available 24 hours a day, seven days a week. Prescriber Direct line for Coverage Determinations, Exceptions, and Redeterminations is 1-855-344-0930.

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.

- Providers can ask Sharp to cover a drug even if it is not on the formulary
- Providers can ask Sharp to waive coverage restrictions or limits on certain drugs
- Providers can ask for coverage of a drug requiring prior authorization

- 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 an Exception

1. Fil out the Coverage Determination Request form available on sharpmedicareadvantage.com
2. Include a supporting statement that the exception is medically necessary to treat the member's medical condition
3. Fax the form along with the clinical notes and supporting statements to 1-858-633-7673

A determination will be made no later than 72 hours from the date the standard request is received. For urgent requests, a determination will be made no later than 24 hours from the date the request is received. The member and the member's provider will be given notice of the coverage determination decision. If Sharp Health Plan approves the exception request, the approval is valid for the remainder of the benefit year or for a full 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.

How to Request an Appeal

Fax or mail a written request using the Redetermination Request form available on sharpmedicareadvantage.com within 60 days of the date of the denial notice. The Redetermination Request form may be sent by mail or fax:

Sharp Health Plan
c/o CVS Caremark Appeals
P.O. Box 52000 MC 109
Phoenix, AZ 85072-2000
Fax: 1-858-633-7673

For more information on CMS guidelines on sections 42 CFR 423.566 (Coverage determination) and 42 CFR 423.578 (Exception process), visit the U.S. Government Publishing Office website.

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 under section 42 CFR 423.153 (Drug utilization management, quality assurance, and medication therapy management programs). 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 events. 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 conditions, 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 oner of the following criteria:

1. Have coverage limitation(s) in place for medication(s) with a high risk for dependence and/or abuse under Sharp Health Plan's Drug Management Program (DMP), or
2. Meet all of the following criteria:
    - Have three or more of the following conditions: chronic congestive heart failure, diabetes, hypertension, dyslipidemia, HIV/AIDS, ESRD, Alzheimer's disease, respiratory disease (including asthma, COPD, and other chronic lung disorders), mental health disorders (including depression, schizophrenia, bipolar disorder, and other chronic/disabling mental health conditions) and bone disease-arthritis (including osteoporosis, osteoarthritis, and rheumatoid arthritis)
    - Received eight or more covered Part D prescriptions for chronic/maintenance drugs monthly
    - Likely to incur an annual cost threshold established by CMS each calendar year for Medicare covered prescriptions.

The MTMP cost threshold is $1,623 in previous three months.

Eligible members are automatically enrolled in the program. A welcome letter 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) with a pharmacist or other qualified provider with written summaries, and targeted medication reviews (TMR), which may result in beneficiary and prescriber directed interventions.

SHARP Health Plan

We are here for you!

1-844-483-9014 (TTY/TDD: 711).

sharpmedicareadvantage.com

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