GOLD KIDNEY HEALTH PLAN®

Provider Manual

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Chapter 1: Welcome and Overview

About Gold Kidney:
Our story began by listening to patients with chronic diseases. Patients have been telling their doctors that they cannot afford the necessary treatments for their chronic conditions due to the limited availability of chronic special needs plans in the market.

Over 100 nephrologists decided to act and started the Gold Kidney Health Plan.

Our mission is to provide affordable and integrated kidney care coverage to Medicare beneficiaries.

We believe that early detection and intervention in the treatment of kidney disease and related contributing disease conditions such as diabetes, heart disease, CHF, and hypertension (high blood pressure) can improve health status and longevity when patients are given:

- Increased access to nephrology, cardiology, and endocrinology specialists
- Engagement in a collaborative care management system
- Guidance through a care model that helps people understand the best treatment and care options, such as.
    - Teaching simple diet and physical activity programs can make people feel better and enjoy a longer life.

Welcome
Welcome to the Gold Kidney Health Plan (Gold Kidney) network of providers! We look forward to collaborating with you to provide high-quality care and cost-effective health care as you treat the health care for our Members.

This administrative guide outlines your responsibilities as a provider participating in the Gold Kidney network of providers. As indicated in your provider contract with Gold Kidney, you are obliged to comply with the terms of this administrative guide. This administrative guide is updated periodically and is available on the Gold Kidney website at www.goldkidney.com.

The use of the term “provider” in this administrative guide refers to all entities contracted with Gold Kidney to provide health care or ancillary services to its plan Members. The use of the term “group” or “medical group” in this administrative guide refers to a provider that is a medical group or IPA. All capitalized terms are defined following Medicare rules unless a different definition is stated in this administrative guide or your contract with Gold Kidney.

Non-Interference
Nothing contained in this administrative guide is intended or shall be construed to interfere with the professional relationship between a Member and his/her physician(s), including. The physician’s ability to discuss treatment options with the Member or advocate for the Member in his or her Grievances relating to services. Providers likewise may not prohibit Members from completing Gold Kidney surveys and/or otherwise expressing their opinion regarding services received from providers.

Medicare Advantage

Gold Kidney is a Medicare Advantage Organization (MA Organization) subject to the requirements of the Medicare Advantage (MA) Program administered by the Centers for Medicare & Medicaid Services (CMS). Gold Kidney benefit plans also include Medicare Part D prescription drug coverage (also referred to as "MA-PD Plans"). All providers are subject to Medicare Advantage plan requirements including Part D requirements. To be a Gold Kidney provider, you must be eligible for payment by Medicare. This means that to be in the Gold Kidney network you cannot be excluded from participating in any federal health care program and that you have not opted out of the Medicare program. See *Appendix A: Select CMS Requirements* for select requirements.

Benefit Plans - Medicare

Gold Kidney products include the full benefits of Original Medicare (Part A and Part B), and some include pharmacy drug coverage (Part D). Gold Kidney offers a Medicare Advantage-only product that does not include Part D drug coverage. Products may also include additional benefits beyond Original Medicare. These additional benefits are Supplemental Benefits. Supplemental Benefits include Medicare Mandatory Supplemental Benefits and Optional Supplemental Benefits. Examples are companionship and non-emergency transportation coverage.

Benefit Plans – Chronic Special Needs Plans

Gold Kidney offers Chronic Special Needs Plans (C-SNPs), which are Medicare Advantage coordinated care plans specifically designed to provide targeted care and focus enrollment to individuals with special needs including individuals with severe or disabling chronic conditions, as specified, and defined by CMS.

Gold Kidney offers the following C-SNP plans:
Chronic Condition Special Needs Plans (C-SNP) serve Members with specific severe or disabling chronic conditions including cardiovascular disorders, chronic heart failure, diabetes mellitus, and end-stage renal disease (requiring any mode of dialysis).

Gold Kidney offers two chronic special needs plans that span the care continuum of chronic kidney disease. Each C-SNP program has a Model of Care (MOC) that outlines the targeted C-SNP population, care coordination, provider network, and quality measurement and performance ensuring that the unique needs of each Member are identified and addressed through the plan's care management practices. ***Model of Care annual training is a regulatory requirement for all providers who serve C-SNP members. The training along with the required training attestation of completion can be completed on the Gold Kidney website. www.goldkidney.com***

For a summary of C-SNP MOC requirements visit *https://snpmoc.ncqa.org.* Other references include: Chapter 5 and Chapter 16b of the Medicare Managed Care Manual and CMS Model of Care (MOC) at *https://www.cms.gov////SNP-MOC.html*

Review the applicable Summary of Benefits, Evidence of Coverage (EOC), and formulary documents available online at *https://www.goldkidney.com* for more information.

Participation in Benefits Plans
Providers are deemed to participate in all benefit plans associated with their participating networks and may not terminate participation in an individual benefit plan. Providers may contact their Provider Relations Specialist at providerrelations@goldkidney.com for more information.

Chapter 2: Key Contacts Provider Resource Guide

Gold Kidney Website - *https://www.goldkidney.com*

- Access and enroll in the Provider Portal
- Case Management programs
- Claims Overpayment and Recovery Forms
- Claims Resources
- Clinical guidelines and practice tools
- Community Connections
- Compliance Training and Resources
- EOC's and Plan Materials
- Delegation Submission and Oversight
- Initial Appeal on behalf of a Member (Part C form available)
- Member Notice/letter templates
- Multicultural Resources/Interpreter
- Services
- Option for claim payments/ERA enrollment
- Options to Submit Claims
- Part D Formulary
- The provider claims disputes and appeal forms.
- Provider Directory
- Provider Quick Reference Guide
- C-SNP Plan Codes
- Training resources
- Compliance
- HCC and Coding
- C-SNP Model of Care (MOC)

Gold Kidney Provider Portal - *https://healthsoft.goldkidney.com/ProviderPortal*

- Verify Member Eligibility and Benefits
- Claim Status
- Authorization Status
- Authorization Look – Up
- Provider Communication
- Annual Benefit Grid
- Provider Manual and Quick Reference Guide
- Gold Kidney Clinical Guidelines
- Gold Kidney Provider Newsletter
- Print member eligibility with a Confirmation Date

Network Management
*providercontracting@goldkidney.com**

- Access/availability questions
- How to become a provider
- Delegation/Delegation oversight
- Contracting questions
- Assistance with in-network specialists, Medicare-approved facilities, or other providers
- Delineation of Financial Responsibility (DOFR) for services

**Email requests for corporate changes and to add/terminate providers to credentialing@goldkidney.com*

Provider Information Line
(844) 294-6535

- Member assistance with supplemental benefits
- Hospital Authorizations
- Interpreter services (24/7)

Care Management
(844) 294-6535 and Fax (866) 515-7869
Refer a Member* Case management Questions/Support

**** Authorization requests can be faxed to (866) 515-7869***

Medical Management and Utilization Management
(844) 294-6535 and Fax (866) 515-7869

- Organization Determination/Coverage guidance
- Appeals & Grievances
- Authorizations for services ***not*** delegated to Medical Group
- Report admission.
- Hospital Authorizations
- Report an adverse event (See *Chapter 10: Network Standards*)

Claims

- Payer Portal Register at: https://www.zelis.com/provider-solutions/provider-enrollment
- Claims Status Gold Kidney Website: https://healthsoft.goldkidney.com/ProviderPortal
- Sign up for ePayments using ACH or Virtual Payment Cards, as well as electronic remittances (835, Excel, PDF), visit https://www.zelis.com/provider-solutions/provider-enrollment for more information." Or contact a Zelis Provider Enrollment Advisor today at 1-855-496-1571.

CLAIMS AND ENCOUNTER SUBMISSION
Submit claims electronically by signing up with Gold Kidney's electronic clearinghouse, Availity directly at www.Availity.com Payer ID **A6865**

Encounter Data Team

- Submit Encounters via Availity.com
- Payer ID A6865
- Encounter data portal questions.
- Audit, data reconciliation, and error resolution issues and questions
- Encounter Data Processing System (EDPS) Questions

Pharmacy Benefits

MedImpact (Pharmacy Benefits Manager (PBM))

For Coverage Determinations, 24/7:	(888) 672-7206 TTY (711)
For mail-order prescriptions:	(855) 873-8739 customerservice@birdirx.com Address: Birdi RX P.O. Box 51580 Phoenix, AZ 85076-1580
To request to add a drug to the Gold Kidney Part D Formulary:	Mail request to: Gold Kidney Health Plan P.O. Box 285 Portsmouth, NH 03802 Attn: Director, Pharmacy Benefits

Enroll in the Mail Order Program

Online at: *www.goldkidney.com/Member* or mail a completed application to:
Birdi RX
PO Box 51580
Phoenix, AZ 85076-1580

Report on Fraud, Waste, or Abuse

By Phone: (844) 974-5081 (anonymous)
By email: *FraudWaste&AbuseProg@goldkidney.com*
Online: *https://www.compliance@goldkidney.com*

Report on HIPPA Breach

By Phone: (844) 074-5081
By email (preferred): *PrivacyOffice@goldkidney.com*
By Certified Mail: Gold Kidney Health Plan, PO Box 285, Portsmouth, NH 03802

Initiate an Appeal on Behalf of a Member
By Phone: (888)672-7206
Online (Part D only): Https://Medimpact.com

Gold Kidney Resources for Members

Member Services
(844) 294 – 6535 (TYY 711)

- Provider directory
- Translation/interpreter services
- Benefits and co-payments
- Select a physician or request to transfer physicians.
- Address and phone number change
- Supplemental Benefit Information
- Resolve service issues or claims issues.
- Assistance with the Grievance or Appeal Process
- Information regarding Supplemental Benefits
- Get a Member ID card.
- Questions and information
- Case Management resource assistance
- Pharmacy benefits

Additional Resources for C-SNP Members

- Education related to Medicare and Gold Kidney benefits, and how to use them.
- Assistance with the Completion of the Initial Health Assessment
- Assistance with Hospital Care, Skilled Nursing Facility services, Rehabilitation Services
- Assistance with coordination of transportation, claims/billing issues, address, and phone number changes, and PCP/medical group changes
- Assistance with the Member Rewards program

Care Coordination Services

Gold Kidney Members receive a personal care manager when enrolled in a Chronic Special Needs Plan. The designated care teams vary by state in which the members reside. Contact the Member Services team at (844) 294-6535 for more information on how to access a member's care coordination team. See *Chapter 6 Care Management*

Medical Management Department
(844) 294-6535 Fax (866) 515-7869

- Prior Authorization
- Report Inpatient Admissions
- Transplant Care-Pre Evaluation and Transplant Services
- Inpatient mental health (in a psychiatric facility)

Transportation

Gold Kidney Health Plan's non-emergency transportation service is a supplemental benefit and not covered by Original Medicare. The primary purpose of non-emergency transportation is to aid non-emergency transportation to medically necessary services like doctors' appointments, dialysis centers, pharmacies, laboratories, and other health care providers. All transportation, including door-to-door, wheelchair, and gurney/stretcher transport, should be for health-related purposes.

To schedule transportation:
Transportation arrangements must be made no less than twenty-four (24) hours in advance (not including weekends) for a passenger vehicle and no less than forty-eight (48) hours in advance for wheelchair service (not including weekends). Rides requiring door-to-door service or gurney/stretcher vehicles require no less than seventy-two (72) hours in advance (not including weekends). Rides must be canceled in advance if transportation is no longer needed. If a ride is not canceled before the driver has been dispatched, the ride will be counted toward the annual ride limit. Each one-way trip may not exceed 50 miles.

Note: To check on an already scheduled ride or if the driver does not arrive in 10 minutes, please call ***Alivi Health at 1-888-863-0248***.

Chapter 3: Enrollment and Eligibility

To enroll in a Gold Kidney Health Plan, individuals must meet all eligibility requirements and complete the Gold Kidney application process during a valid enrollment election period.

Medicare Eligibility Requirements	C-SNP Requirements
To enroll, an individual must:	
Have Medicare Parts A & B and continue paying Part B premium,[1]. Live in the benefit plan's service area, [2] and Be a United States citizen or lawfully present in the United States, See *Chapter 1: Welcome and Overview*.	Have Cardiovascular disease, CHF, Diabetes, or ESRD-any form of Dialysis for applicable plan. Chronic conditions must be verified by the physician or plan provider within 60 days of coverage effective date.
[1] Includes those under age sixty-five (65) and qualified by Social Security as disabled. [2] Member must continuously reside within the service area for six (6) months or more.	

Open Enrollment, Lock-in, and Disenrollment

CMS requires MA Organizations to have an Annual Enrollment Period, which currently runs from October 15 to December 7 of each year. Members are also allowed to make one change during the Medicare Advantage Open enrollment period, which is January 1st through March 31st. Usually, this is the only time when MA health plans and prescription drug plans are open and accept new Members, other than those who are newly eligible or qualify for a special election period.

Members can only switch MA plans during applicable enrollment periods unless they qualify for a special election enrollment or switch to a 5-star health plan. Special election situation examples include but are not limited to, a Member moving outside the service area, turning/recently turned sixty-five (65), moving to the service area, changing Medicaid status, losing retiree health coverage, being diagnosed with a qualifying disability, etc. Other special election situations may exist, as determined by CMS, and are also found in the MA Enrollment and Disenrollment Guidance published on cms.gov.

Enrollment in a Chronic Special Needs Plan may occur year-round. If a member is newly diagnosed with a disabling chronic condition for which a special needs plan is available for people with this chronic condition, a member may join the C-SNP using a special election enrollment period.

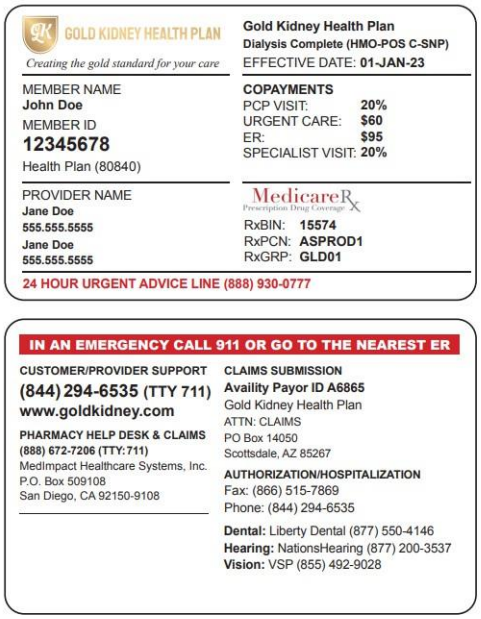
Gold Kidney must disenroll a Member when the Member does not retain Medicare Coverage Parts A and B, is deceased, no longer meets C-SNP status requirements, permanently moves out of Gold Kidney's service area, or is outside of Gold Kidney's service area for more than six (6) continuous months, Gold Kidney's contract with CMS terminated or Gold Kidney reduces its service area, is not lawfully present in the United States, and when CMS notifies Gold Kidney to disenroll a Member. Gold Kidney may pursue disenrolling a Member if the Member fails to pay applicable monthly plan premiums. Provides fraudulent information or abuses an identification card. For optional disenrollment, Gold Kidney's discretionary decision shall be final. All covered services must continue to be provided until the disenrollment effective date. Under no circumstances, however, will a Member who meets all eligibility requirements be involuntarily disenrolled due to health status.

Identifying a Patient as a Gold Kidney Member

Member identification cards are intended to identify the Member, the type of plan the Member has, and provide important/relevant information regarding copayments, etc. Cards for various products may have different looks, but the general information displayed on the identification card is like the example below:

The Applicable Claims address will appear on the Member's ID card.

Sample Member ID Card



Members are instructed to use their enrollment acceptance letter to provide their member ID and request providers call Customer Service to verify eligibility. Members may call Member Services at (844) 294-6535 for an electronic image of the member's ID card to be sent to their provider's office or to request a new or reprinted ID card.

Verifying Member Eligibility

Providers are responsible for verifying eligibility each time a Member receives care.
Possession of a Member identification card does not guarantee eligibility. Gold Kidney offers the following options to verify Eligibility and Benefits.

Electronic Eligibility and Benefits Inquiry & Response
Enrollment verification is available by accessing the Gold Kidney Provider Portal to obtain Gold Kidney Member eligibility and benefits information. To establish a connection with Gold Kidney, providers should visit: https://healthsoft.goldkidney.com/ProviderPortal
Gold Kidney's Provider Portal
Providers can self-register at **GOLD KIDNEY PROVIDER PORTAL** via the goldkidney.com website and gain immediate access to check Member eligibility status and view benefit plan information included. PCP information and print eligibility/benefit confirmation and access Plan Evidence of Coverage (EOC).
Gold Kidney's Customer Service Center
Providers can verify member eligibility/benefits and request verification. Call (844) 294-6535

Additionally, each Value-Based Contracting Medical group receives a monthly eligibility report that includes all Members assigned to that medical group.

Member Eligibility

Help us help the Member – Verification is based on the data available at the time of the request. Subsequent changes in eligibility may occur or may not yet be available, therefore, verification of eligibility **is not** a guarantee of coverage or payment.

Enrollment Area and Primary Care Physician Selection

Upon enrollment, Members are asked to select a Primary Care Physician (PCP) and medical group. Gold Kidney encourages, but cannot require, a Member to select a PCP within thirty (30) minutes or thirty (30) miles of their residence. If a Member does not select a PCP and medical group on the enrollment form, Gold Kidney will assist with the selection or assign a default PCP and medical group within thirty (30) minutes or thirty (30) miles of the Member's residence. All members are encouraged to select a PCP who is in the network to coordinate their care. All members are allowed to see any provider in or out of the Network with a referral from their PCP.

Continuation Area

A Member may elect a Gold Kidney benefit plan if he/she permanently resides in the benefit plan service area. A temporary move into a benefit plan's service area does not enable the Member to elect that benefit plan – therefore, Gold Kidney must deny.
Election and the members will not be able to enroll.

Member Requests to Change PCP

A Member may change their PCP and/or Network or Independent Practice Association (IPA) for any reason, at any time. If a Member wishes to change their PCP within their contracted network medical group or IPA, this change will be effective on the first of the following month. If the Member wishes to change their PCP to one affiliated with a different contracted medical group or IPA, the Member's request must be received on or before the twentieth (20th) of the month. The change will then be effective on the first (1st) of the following month. Change requests received after the twentieth (20th) of the month will be processed and effective for the first (1st) of the second month.

Dates of Coverage

A Member's effective date is the first day of the month, and a Member's termination date is the last day of the month. Coverage begins at 12:00:01 a.m. (MST) on the effective date and ends at 11:59:59 p.m. (MST) on the termination date. Members typically become effectively enrolled on the first (1^{st}) day of the month after completing an enrollment application. Members may be enrolled for future effective dates (ninety (90) days in advance) when they are approaching the age of sixty-five (65) and become eligible for Medicare Parts A and B in future months. We refer to these "future effective" as "Age Ins."

HMO-POS BENEFITS:

All members are encouraged to see care from in-network participating providers but to ensure members have access to the care they need; Gold Kidney plans may include a point-of-service (POS) plan benefit. The POS option allows members to see any willing Medicare Provider who accepts Medicare reimbursement rates and is willing to bill Gold Kidney for the care of that member. POS providers will get paid 100% of the Medicare allowable for the services provided to the members. All services must be medically necessary, and a Medicare-covered benefit. Selecting services such as those provided in an inpatient hospital, or surgical center, chemotherapy or radiation therapy, and a few other services identified on the Gold Kidney Prior Authorization list of services will require approval with a Prior Authorization before the out-of-network provider renders the service. See Chapter 7 Utilization Management and Chapter 4 Claims Payment.

Chapter 4: Claims

CMS Requirements
MA Organizations and their delegated entities must make correct claim determinations, which include developing the claim for additional information when necessary for:
Services obtained from a non-contracted provider.
Ambulance services are dispatched through 911.
Emergency services.
Urgently needed services.
Post-stabilization care services; and
Renal dialysis services.

MA Organizations, and their delegated entities, must also provide reasonable reimbursement for the foregoing services as well as services for which coverage has been denied but found to be services the Member was entitled to upon appeal. See 42 C.F.R. 422.100(a) and (b)(1); 422.132; 422.504(g)(1); Manual Ch. 4 – Section 10.2.

Gold Kidney will process claims for reimbursement for services rendered following all applicable regulatory requirements, including CMS requirements. These claims typically are for services provided by contracted providers under a fee-for-service arrangement or by non-contracted providers. Delegated entities that have been delegated to perform claims activities on behalf of Gold Kidney must also comply with requirements applicable to Gold Kidney including the requirements outlined in this Chapter. See *Chapter 15: Delegation Oversight*.

Claims Submission
Gold Kidney strongly encourages providers to timely submit claims electronically. Electronic claims submission is at no cost to the provider and helps effectuate the timely disposition of claims following CMS requirements. Benefits of electronic claims submission include faster disposition, improved claim control, and standardized industry format.

Electronic claims must be submitted via a clearinghouse using the HIPAA Compliant 837 Version 5010 transaction set format. Gold Kidney's clearinghouse partner is Availity. Providers can use a different clearinghouse, provided that the clearinghouse can complete transactions with Availity. If providers do not have a clearinghouse or have been unsuccessful in submitting claims to a provider's clearinghouse, please contact your clearinghouse or Availity directly at (800) 282-4548.
Providers can also contact Availity directly to establish electronic claims submissions connected with Gold Kidney. To contact Availity, call (800) 282-4548 or visit *https://availity.com/*.

Paper claims must be submitted on current CMS standard forms: UB-04 (CMS-1450), or CMS HCFA 1500. Paper claims may be submitted to:

Gold Kidney Health Plan Claims Department
P. O. Box 285
Portsmouth, NH 03802

All claims must conform to CMS clean claim requirements and claim submission guidelines, including those

outlined in the Medicare Claims Processing Manual and following prevailing Correct Coding Initiatives (CCI) Edits.

Claims submitted without all required information will be returned (paper submission) or rejected (electronic submission). Providers should promptly respond to requests for additional information and/or records to facilitate prompt payment and resolution of claims.

Providers must submit claims for services rendered within one (1) year of the date of service unless otherwise stated in a Provider's contract. Gold Kidney encourages providers to submit all claims as soon as possible.

Claim Payments
Gold Kidney's vendor partners produce provider payments, Availity, and Zelis™ Payments. Providers are encouraged to register with Zelis™ Payments as soon as practicable, to request copies of remittance advice, confirm payments of a check, electronic, or virtual card payment, or set up payment preference.

Electronic payment options:
EFT (Electronic Funds Transfer) / ACH (Automated Clearing House) – Automatic Direct Deposit
Virtual Card (vCard) – Virtual Debit Transaction
Paper Check

Providers will be able to review payments, and remittance advice documents, configure payment preferences request check tracers, and duplicate remittance advice documents following registration.

1. To enroll, contact a Zelis Provider Enrollment Advisor today at 1-855-496-1571 or visit https://www.zelis.com/provider-solutions/provider-enrollment for more information.

Overpayment and Recovery

Providers are required to report any payments made to them by Gold Kidney to which they are not entitled as well as to return any overpayment to Gold Kidney no later than sixty.
(60) days after the date on which the overpayment was identified and to notify Gold Kidney in writing of the reason for the overpayment. See *https://www.gpo.gov/////2016- 02789. pdf*.
If Gold Kidney determines that it has made an overpayment to a provider, it will claim such overpayment by sending a written notification to the provider that has received the overpayment. Providers have thirty (30) days from the receipt of the notice of the overpayment to contest or reimburse the overpayment.

Whether the provider is notified of an overpayment by Gold Kidney or discovers such overpayment independently, the provider must mail the refund check along with a copy of the notification or other supporting documentation to the following address:

Gold Kidney Health Plan
P.O. Box 285
Portsmouth, NH 03802

If Gold Kidney does not receive a payment within the required timeframe, the overpayment amount may be deducted from future claims payments.

Coordination of Benefits

Coordination of Benefits is the procedure used to process health care payments for a Member with one or more insurers providing coverage. Gold Kidney, and delegated entities for claims payment, must have procedures to identify payers that are primary to Medicare, determine the amounts payable, and coordinate benefits. (See 42 CFR 422.108 and MMCM, Chapter 4, Section 130). Before claims submission, providers must identify other payers who have primary responsibility for payment and bill that payer before billing Gold Kidney (or its delegate). When a balance is due after receipt of payment from the primary payer, a claim may be submitted to Gold Kidney (or its delegated entity) for payment consideration. The claim should include information verifying the payment amount received from the primary payer as well as a copy of the primary payer's explanation of the payment statement. Upon receipt of the claim, Gold Kidney (or its delegate) will review its liability using the coordination of benefits rules and/or the Medicare/Medicaid "crossover" rules—whichever is applicable.

Third-Party Liability

Members who experience injury or loss due to another person or entity will have all claims processed by the third-party liability insurer (TPL). Claims paid on behalf of a Member by Gold Kidney, or a Gold Kidney delegated entity will be submitted to the respective payers TPL insurer for reimbursement. Most TPL claims are initiated by a member through an insurer or attorney, who will notify Gold Kidney of the claim. Gold Kidney will refer TPL claims to the Gold Kidney TPL reinsurer for claims paid by Gold Kidney. Gold Kidney will refer any TPL claims to a Gold Kidney delegated entity where the delegated entity paid the member's claim.

Maximum Out-of-Pocket (MOOP) Limit

CMS requires MA Organizations to have a MOOP limit, which refers to the limit on how much a Medicare Advantage Member must pay out-of-pocket each year for medical services covered under Medicare Part A and Part B. Co-payments, co-insurance, and deductibles comprise Member expenses for purposes of MOOP. MOOP does not apply to the Member's Medicare Part B Premium. The MOOP limit is accumulated

based on claims paid by Gold Kidney and encounters reported to Gold Kidney by delegated providers who process claims on Gold Kidney's behalf.
All Gold Kidney benefit plans have MOOP. If a Member reaches a point where they have paid the MOOP during a calendar year (coverage period), the Member will not have to pay any out-of-pocket costs for the remainder of the year for covered Medicare Part A and Part B services. When the Member reaches this level, Gold Kidney will no longer deduct any applicable Member expenses from the provider's reimbursement.
The MOOP can vary by benefit plan and may change from year to year. Please see the applicable EOC available at *https://www.goldkidney.com* for more information.

No Balance Billing

Member balance billing (MBB) is prohibited. Gold Kidney payments to providers are considered payment in full, less any copays, coinsurance, or deductibles – which are the fiscal responsibility of the Member. Providers are prohibited from seeking additional payment from Members for any other unpaid balances.

Providers that engage in balance billing may be subject to sanctions by Gold Kidney, CMS, and other regulatory agencies.

Please note that providers may seek payment from a Member for a covered service that is NOT Medically Necessary or for a non-covered service ONLY IF the provider obtains written informed consent stating fiscal responsibility for the specific services before services are rendered.
If a copayment, coinsurance, and/or deductible amount collected from a Member at the time of service exceeds the Member cost share, the provider is required to refund the overpaid amount within fifteen (15) calendar days. Providers shall not apply overpayments to outstanding balances.

Delegated providers who process claims on Gold Kidney's behalf must have established systems and processes in place that track and accurately apply Member cost share. Delegated providers must also ensure timely billing practices for providers and downstream providers/subcontractors to prevent MBB. This process must include but is not limited to designated personnel that serve as a primary contact for MBB issues and provider notification to downstream providers regarding MBB requirements. The delegated Provider's process must comply with all requirements set forth by Gold Kidney and federal/state regulators.

To ensure compliance with MBB restrictions, Gold Kidney requires providers to investigate and resolve MBB cases within fifteen (15) calendar days of receipt, whether from Gold Kidney, a Member, or another party. Providers are also required to cooperate with Gold Kidney to resolve any MBB issues that arise.

Claims Adjudication

Definition of Clean Claim

Unless defined otherwise in a provider's contract with Gold Kidney, a "clean" claim means a claim that has no defect or impropriety (including lack of any required substantiating documentation) or circumstance requiring special treatment that prevents timely payment from being made on the claim. (See 42 U.S.C. 1395u).

Rejected v. Denied Claims

Gold Kidney may reject claims that do not meet the definition of a "clean" claim due to missing or invalid

required information. Rejected claims do not have Appeal rights. See *http://www.cms.gov/////clm104c01.pdf*. The provider must correct and resubmit the claim timely for further adjudication.

Gold Kidney will deny a claim if Gold Kidney determines that all or a portion of the claim is not payable and, in such a case, no payment is applied to the denied claim item(s). Denied claims cannot be resubmitted for payment but may be appealed (see below).

Payment

Unless otherwise stated in a provider's contract with Gold Kidney or a longer period is allowed by law, Gold Kidney shall pay any amount due within sixty (60) days of receipt of a clean claim for contracted providers.

Special Rules for Non-Contracted Provider Claims

95% of "clean" claims from non-contracted providers must be paid or denied within thirty. (30) days of receipt. (See 42 CFR 422.500; 422.520(a)(1); Manual Ch. 11 – Section 100.2 & Ch. 13 – Section 40.1). Non-contracted claims that do not meet the definition of "clean claims" must be denied within sixty (60) days of receipt. (See 42 CFR 422.520(a)(3); Manual Ch. 11 – Section 100.2 & Ch. 13 – Section 40.1). If clean claims from non- contracted providers are not paid or denied within thirty (30) days, interest must be paid following 1816 (c)(2)(B) and 1842(c)(2)(B). (See 42 CFR 422.520(a)(2); Manual Ch. 11 – Section 100.2).

Checking Claims Status

Claim status can be checked online via Gold Kidney's Provider Portal. To access, please go to https://healthsoft.goldkidney.com/ProviderPortal and follow the registration process. See *Chapter 2: Key Contacts Resource Guide* (Claims) for more information.

Provider Claims Disputes and Appeals

Payment disputes and Appeals processes for contracted providers are governed by the terms of the contract between the provider and Gold Kidney.

Special Rules for Non-Contracted Providers

Gold Kidney has established a Provider Payment Dispute Resolution (PDR) process by which non-contracted providers may dispute the amount paid for a covered service (e.g., the amount is less than or greater than the amount that would have been paid under Original Medicare, or Gold Kidney paid for a different service or more appropriate code than what was billed ("down-coding"). The PDR process for non-contracted providers cannot be used to challenge payment denials that result in zero payment being made to the non-contracted provider. These matters must be processed as Appeals. The Appeals and PDR processes are summarized below.

Appeals (Denied Claims Only) – Non Contracted Providers

The provider may request an Appeal within sixty (60) calendar days of receipt of the RA.
The request must include:
A signed Waiver of Liability (WOL) form holding the Member harmless regardless of the outcome of the appeal and supporting documentation such as a copy of the original claim and any clinical records; and
Other documentation that supports the provider's request.

NOTE: A copy of the WOL is available at: https://www.cms.gov/Medicare/Appeals-and-Grievances/MMCAG/Notices-and-Forms. If the WOL is not received timely, the request for an appeal will be

sent to MAXIMUS for dismissal and the provider will receive written notification of the dismissal directly from MAXIMUS.

Gold Kidney has sixty (60) calendar days to reconsider a denial.
Upheld denials are automatically submitted to MAXIMUS for the next level of review.
The provider will be advised regarding further appeal rights.

1st Level PDR (Payment Dispute Resolution)
Within one hundred twenty (120) calendar days of receipt of RA to the appropriate payer
1st level PDR is delegated to medical groups where the medical group is delegated for claims.
Gold Kidney, or the delegated medical group, has thirty (30) calendar days to reconsider the claims payment.

2nd Level PDR Process (Payment Dispute Resolution)
May be submitted to Gold Kidney within one hundred eighty (180) calendar days of receipt of upheld 1st level PDR via
Preferred by fax: (866)-580-0122)
By mail: Gold Kidney Health Plan, Attention: Claims-2nd Level Appeal, P.O. Box 285. Portsmouth, NH 03802
2nd level PDR is not delegated to medical groups.
Gold Kidney has sixty (60) calendar days to render a decision.

See *Chapter 10: Network Standards* for provider responsibilities concerning Appeals, Grievances, and Payment Disputes.
Guidance for Providers Delegated for Claims Activities
This section provides additional guidance for providers delegated for claims activities to ensure that claims paid on Gold Kidney's behalf are paid following CMS requirements and Gold Kidney policies.

Guidance for Providers Delegated for Claims
Check Handling Delays

The number of days allowed to mail checks after they are printed should be documented in policies and procedures. The date the claim payment check is placed in USPS mail or equivalent for delivery must be used to define the end of the measurement time when measuring timeliness.

An intentional delay before mailing checks, and beyond the routine number of days it takes to audit or Sign them is a non-compliant process unless the provider's reporting and timeliness compliance measurement has been adjusted to allow for the delay.

Claim Date Deficiencies
Each claim should be date-stamped with the date the claim is received.

Wrong Dates: If it is necessary to change a date stamp because the wrong date was stamped it should be done following the industry best practice. The industry best practice recommends that a line be drawn through the incorrect stamp, that the employee correcting initials the correction, and that the correction is

dated. The claim should then be stamped with the correct date received. Except for a situation where a date was accidentally stamped incorrectly, claims employees should not alter or change date stamps.

Double Dates: In the event of double-dated claims (e.g., a claim that has been sent to another payer, group, IPA, or health plan and date-stamped by that organization/department before arriving in the correct claims department), the earliest date stamp must be used to measure the timeliness of the claim payment or denial (also see Misdirected Claims below). All date stamps are relevant to date stamp(s) unless they can be shown to be impressed on a claim proof of loss by an entity that is not part of the delegated network.

Electronic Clearinghouses: Electronic claims that are transmitted directly to a clearinghouse by 5:00 p.m. (or by its closing time if it routinely closes between 4:00 p.m. and 5:00 p.m.) (according to the clearinghouse's time zone), must be considered as received on that day even if the delegated entity does not upload or process the data until a later date.

Misdirected Claims Deficiencies
Delegated entities must have a process for forwarding misdirected claims.
Triage and sorting processes must be established so that misdirected claims can be identified and forwarded within ten (10) calendar days of receipt to ensure that the payer has the necessary time required to adjudicate and pay the claim.

Delegated entities should instruct their physicians and downstream contracted providers regarding where to submit claims for services that are delegated risk.

Calculation of Federal Interest
Delegated entities must pay interest on clean claims that have not been paid within thirty (30) days of the earliest relevant received date stamps. Interest must be paid at the current rate beginning the 31st day from receipt of the claim up until the date that the payment is placed in the USPS mail or equivalent.

To calculate the daily federal interest rate for senior claims, divide the current approved interest rate by three hundred sixty-five (365) (three hundred sixty-six (366) for leap years). The daily interest rate is then multiplied by the total days beyond the 30th and the total amount of the claim payment that is due. Always ensure the correct interest rate when paying prompt payment interest. The rate changes semi-annually, on January 1 and July 1, and is available at *https://fiscal.treasury.gov/prompt-payment/rates.html*.

Example 1: The payment due on a clean claim for a non-contracted provider is $1,200. It is processed 53 calendar days after receipt and will take an additional 3 calendar days to verify, sign, and mail the check. The interest payment, which would be calculated based on 26 calendar delayed days (23+3 for check issuance, processing,
and mailing), is 26 x $1,200 x (the current annual interest rate)/365 days.
Example 2: The amount to be paid for a non-contracted provider is $220. Today is the 32nd day after the receipt of the claim. The checks will not be printed, signed, or mailed 6 calendar days from today. Based on the delay of 8 calendar days (2 + 6 for check processing), the interest payment is 8 x $220 x (the current annual interest rate)/365 days

CMS Approved Current Procedural Terminology (CPT) Codes with No Medicare Value
Delegates must have a process for pricing CMS-approved CPT codes with no Medicare value.

If a new code appears, delegated entities must make every effort to determine whether the procedure, drug, or supply has a pricing history and profile. If there is a pricing history, map the new code to previous customary and prevailing charges, or fee schedule amounts, to ensure continuity of pricing. If there is no pricing history or coding implosion and explosion, delegated entities must make an individual consideration determination for pricing and payment of a covered service.

MOOP/Encounter Data
Delegates must have processes that ensure accurate data, including encounter data, used to accumulate the MOOP limit. (See *Chapter 16: Encounter Data*)

Providers are expected to have systems and processes in place to track MOOP amounts and to apply benefit limitations. Providers are also required to submit claims history upon request.

1st Level PDR Process
Request for a 1st Level PDR may be made via phone or in writing but must be submitted to the delegated provider within one hundred twenty (120) calendar days from the notice of initial determination (i.e., Explanation of Benefits (EOBs), RA's, Letters). The provider must follow and include the following:
EOB or RA is used to transmit initial determination to a non-contracted provider.
Completed Payment Dispute Decision (PDD) form.
Appointment of Representative (AOR) form, if applicable.
Claims Supporting documentation.

Delegated providers must notify non-contracted providers that they may seek 2nd level review directly from Gold Kidney within one hundred eighty (180) calendar days from 1st level PDR decision notice by sending their request via:
Preferred by fax: (480) 716-7555.
By Mail: Gold Kidney Health Plan, Attention: Claims 2nd Level Appeal, PO BOX 285, Portsmouth, NH 03802
EOB or RA used to transmit a denial to a non-contracted provider must include the following information:
Non-contracted providers have the right to request a reconsideration of the denial within sixty (60) calendar days from the remittance notification date.
Non-contracted providers must include a signed WOL form holding the Member harmless regardless of the outcome of the Appeal.
Non-contracted providers should include documentation such as a copy of the original claim, remittance notification showing the denial, and any clinical records and other documentation that supports the provider's Appeal; and
Non-contracted providers can mail requests for reconsideration to:
Gold Kidney Non-Contracted Provider Appeal
PO Box 285
Portsmouth, NH 03802

All non-contracted provider Appeals must be sent to this address for reconsideration as soon as possible along with the original claim; a copy of the denial letter with Member liability if applicable; a copy of the RA or EOB and the reason for the denial, including any supporting documents.

Participating providers must seek reconsideration through the Appeals Department within **90 calendar**

days of a claim denial for lack of prior authorization, services exceeding the authorization, insufficient supporting documentation or late notification. When submitting a reconsideration, the specific code or service being reconsidered must be listed on the appeal form. Anything else related to authorization or medical necessity that is in question should be sent to the Appeals P.O. Box. Include all substantiating information like a summary of the appeal, relevant medical records and member-specific information.

Delegated Claims Denial

CMS has extremely strict requirements for the use, format, content, and delivery of the notice of denial with Member liability (e.g., claim denial that results in a Member having liability for medical service that would otherwise be the responsibility of the plan or the provider). Correspondence to Members regarding claims denials must meet CMS formal notice requirements including that they are sent in an envelope that states, on the outside, in a pre-printed format: "Important Plan Information About Your Enrollment".

If the provider is placed in retrospective review status for claim denials, the provider must submit copies of one hundred percent (100%) of claim denials with Member liability within one (1) business day after the date of the denial letter to Gold Kidney for review. Denials may be submitted by mail to:

Gold Kidney Delegation Oversight
P.O. Box 285
Portsmouth, NH 03802

Each denial should be accompanied by sufficient data to allow Gold Kidney to verify that the decision to deny the claim and hold the Member liable is correct. The denials and all supporting documentation should be faxed to Gold Kidney for review on or before the 55th day of claim aging. Gold Kidney will review the denial(s) and approve, request additional information, or overturn the decision within two (2) business days of receipt.

If Gold Kidney overturns a denial, the delegated entity must pay the claim promptly. A copy of the check and EOB representing payment must be received within the timeframe outlined in the overturned decision notification. Failure to do so may result in deductions and/or recoupments from capitation payments.

Chapter 5: Provider Payment

This section provides general information regarding provider reimbursement. Non-contracted providers and contracted providers paid on a fee-for-service basis should refer to *Chapter 4: Claims* and/or their contract with Gold Kidney for more information. Contracted capitated providers should refer to their contract with Gold Kidney for capitation rates and other specific details, including the Division of Financial Responsibility (DOFR). Capitation is paid on or about the fifteenth (15^{th}) day of each month. Capitation reports are available on the Gold Kidneys SFTP site established for the Provider. Providers may contact their Network Management Specialist at (888) 750-0080 or providercontracting@goldkidney.com for more information.

Corporate Information Changes

Providers must notify Gold Kidney of any corporate information changes to ensure that payments are made correctly. Corporate information includes but is not limited to, organization name and/or dba, organization ownership, tax identification number (TIN), and payee name and address. To notify Gold Kidney of corporate information changes, please email the following documentation to providercontracting@goldkidney.com:

A letter on provider letterhead signed by an officer.
A copy of the Provider's Articles of Incorporation, or Service Agreement.
A Fictitious Name Permit if the request is to a "dba;" and
A W-9 if the request includes a TIN change.

Physician Incentive Plans: Requirements and Limitations

CMS does not allow specific payment, directly or indirectly, to a physician or physician group as an inducement to reduce or limit Medically Necessary services. Indirect payments may include but are not limited to, offerings of monetary value (e.g., stock options, waivers of debt) measured in the present or future. Additionally, if a physician incentive plan places a physician or physician group at substantial financial risk for services that the physician or physician group does not furnish itself, Gold Kidney must ensure that all physicians and provider groups at substantial financial risk have either aggregate or per-patient stop-loss and conduct periodic surveys. Gold Kidney is required to provide all the information requested by CMS. (See 42 CFR 422.208).

Chapter 6: Care Management

Delegation of Care Management

Gold Kidney delegates certain activities to contracted providers, and contracted providers must perform these activities according to the contract and in compliance with all applicable state and federal laws, including, but not limited to, Medicare laws and regulations, and CMS guidelines. Gold Kidney, however, remains responsible for the performance of all delegated activities. (See 42 CFR 422.504(i); 42 CFR 422.202(b); and 422.504(a)(5)).

Providers should refer to their Delineation of Financially Responsibilities (DOFR) Grid for additional information, as applicable.

Gold Kidney monitors and audits all delegated activities to ensure that they are performed satisfactorily. Refer to *Chapter 4: Physician Responsibilities* and *Chapter 10: Delegation Oversight* for additional information.

This Chapter focuses on Case Management programs that Gold Kidney has implemented to maintain high-quality care.

Gold Kidney Care Management Programs

Gold Kidney integrates the person-centered care approach in developing programs and activities to ensure optimal clinical outcomes for Members. Gold Kidney offers telephonic and in-person case management programs for all Members who participate in the CSNP plans. Gold Kidney also offers Members at elevated risk for poor health outcomes identified through predictive modeling and referrals for all other plans. The goals of Gold Kidney's programs include preventing unnecessary admissions/readmissions, facilitating access to care/services, supporting providers by reinforcing adherence to treatment plans, assisting Members in navigating the health care system, facilitating goals of care discussions and completion of advanced care directives, increasing Member satisfaction, improving self-management skills by educating to evidence-based guidelines, and addressing gaps in care and care giver support.

For more information regarding these programs, including full eligibility requirements, please refer to *Chapter 2: Key Contacts Resource Guide* for contact information.

Program Description	Staffing
Complex Case Management (CCM) Program	
Telephonic case management for Members identified as high-risk for poor health outcomes and hospitalizations. Program services focus on the social determinants of health (SDOH) as well as supporting adherence to the treatment plan and preventive health care. Additional focus on Members transitioning from a care setting to home (hospital or skilled nursing facility to home), Members with advanced illness, and/or behavioral health needs.	Advanced Practitioners (Nurse Practitioners and Physician Assistants) Registered Nurses (RNs) Social Workers (MSWs, or LCSWs) Clinical Pharmacists All supported by a Board-Certified Specialist
Disease Management (DM) Program	
Telephonic disease management for Members diagnosed with: Congestive Heart Failure (CHF), Cardiovascular disease. Diabetes, and or End Stage Kidney Disease Disease management services include education and coaching following evidence-based guidelines for the management of the condition. Additional focus on social determinants of health, medication management, signs, symptoms of exacerbation and action planning, preventive care, and adherence to the treatment plan.	Advanced Practitioners (Nurse Practitioners and Physician Assistants) Registered Nurses (RNs) Social Workers (MSWs, or LCSWs) Clinical Pharmacists All supported by a Board-Certified Specialist
Medication Therapy Management Program (MTMP)	
Based on the CMS guidelines, Members identified receive Comprehensive Medication Reviews (CMRs) and Targeted Medication Reviews (TMRs). If care management needs are identified, Members are connected to Care Management for follow-up.	Clinical Pharmacists RNs
Medication Advisor Program	

High-touch Member outreach program using motivational interviewing techniques to discover barriers and offers. Individualized solutions to Members with medication adherence issues.	Care Navigators

Care Coordination	
Primarily focused on the C-SNP) population to support the following in the Model of Care: • Health Risk Assessments (HRA) • Coordination of benefits • Identification benefits • Identification of unmet needs • care planning and care management	• RNs • Non-clinical staff

Chapter 7: Utilization Management

The role of utilization management is to ensure the consistent delivery of high-quality health care services to Gold Kidney Members. At Gold Kidney, utilization management is a collaborative and cooperative effort between Gold Kidney and its delegated entities. We work together to ensure that Members receive Medically Necessary covered services, appropriate to the Member's condition, rendered in the appropriate setting, and meet professionally recognized standards of care.

Delegation of Utilization Management

Gold Kidney may delegate utilization management functions to its contracted delegated entities. Where items or services are not delegated and remain Gold Kidney's responsibility, providers should send authorization requests to Gold Kidney's Medical Management Team. The entities that have been delegated to perform utilization management activities on behalf of Gold Kidney must comply with all requirements applicable to Gold Kidney, including but not limited to, the requirements outlined in this Chapter. See also *Chapter 10: Delegation Oversight* for more information.

Organization Determinations

An Organization Determination is any decision made by an MA Organization, or its delegated entity, regarding receipt of or payment for a managed care item or service, the amount Gold Kidney requires a Member to pay for an item or service, or a limit on the number of items or services. Organization Determinations include but are not limited to, prior authorizations, concurrent review, retrospective review, and requests for continuity of care. Should Gold Kidney receive a request for an Organization Determination where the responsibility for making the determination has been delegated, Gold Kidney will refer the request to the appropriate delegated entity.

Organization Determinations must be made by health care professionals who have appropriate clinical expertise in treating the Member's condition or disease and following currently accepted medical or health care practices, considering any extraordinary circumstances that may require deviation from National Coverage Determinations (NCDs), Local Coverage Determinations (LCDs), or other criteria. Organization Determinations are always based on Member eligibility and appropriateness of care/service. Gold Kidney does not reward providers or other individuals for approving or issuing denials of authorizations.
When an entity delegated to make organization, determinations do not have all the information it needs to decide, the delegated entity must make reasonable and diligent efforts to obtain all necessary information following CMS guidelines. See *https://www.cms.gov////ORGDetermin.html.*

Delegated entities are expected to stay apprised of new and/or changing Medicare Part A and Part B coverage policies, including those that result from CMS's NCDs and LCDs.

Members must be provided with all the basic benefits covered under the original Medicare Part A and Part B. In general, Medicare coverage and payment is contingent upon a determination that:

- Service is in the covered benefit category.
- Service is not specifically excluded from Medicare coverage by Title XVII of the Social Security Act (the "Act"); and
- The item or service is "reasonable and necessary" for the diagnosis or treatment of an illness or injury, to improve the functioning of a malformed body member, or is a covered preventive service.

See MMCM Pub. #100-16, Chapter 4 – Benefits and Beneficiary Protections, Medicare Managed Care Enrollee Grievances, Organization Determinations, and Appeals Guidance.

Prior Authorization

Gold Kidney may delegate the responsibility for prior authorizations to its delegated entities, depending on the Provider's contract with Gold Kidney. Any non-delegated prior authorization will remain with Gold Kidney.

Prior authorization is never required for Emergency Services, including behavioral health services necessary to screen and stabilize Members.
Prior authorization is always required for planned inpatient care, outpatient surgeries, chemotherapy, radiation therapy, transplants, and other excessive costs Durable Medical Equipment A list of services requiring prior authorization is available on the Gold Kidney website https://goldkidney.com.

Prior Authorization is never required for Urgent or Emergent services.
Gold Kidney along with delegated Entities must follow Medicare Guidelines including, but not limited to:

- *Medicare National Coverage Determinations (NCD)*
- *Medicare Local Coverage Decisions (LCD)*
- Local Coverage Articles (LCAs) (Active/Retired)
- Medicare Manuals
- Medicare Managed Care Manual
- Medicare Benefit Policy Manual
- Program Integrity Manual
- Medicare Claims Processing Manual

Gold Kidney has adopted the KDIGO guidelines. KDIGO guidelines focus on topics related to the prevention or management of individuals with kidney diseases.

In the absence of Medicare guidelines:
Nationally recognized evidenced-based clinical practice guidelines (e.g.,

Gold Kidney Medical Policy
Nationally recognized evidence-based criteria (e.g., InterQual® or Milliman Care Guidelines) in conjunction with the clinical judgment of a qualified health professional.

Participating providers must seek reconsideration through the Appeals Department within 90 calendar days of a claim denial for lack of prior authorization, services exceeding the authorization, insufficient supporting documentation, or late notification. When submitting a reconsideration, the specific code or service being reconsidered must be listed on the appeal form. Anything else related to authorization or medical necessity

that is in question should be sent to Gold Kidney Health Plan, P.O. Box 285, Portsmouth, NH 03802 Include all substantiating information (please do not include an image of the claim) like a summary of the appeal, relevant medical records and member-specific information.

Supplemental Benefits

Members may be entitled to additional benefits beyond Original Medicare offered by the Plan: in-home services, meals, non-emergency transportation, hearing aids, etc.).
Delegated entities may request coverage guidance from Gold Kidney by contacting Gold Kidney's Utilization Management Department at 844-294-6535.

Concurrent and Retrospective Review

Gold Kidney may delegate the responsibility for concurrent review to its delegated entities. When delegated for concurrent review, the Delegated Entity must follow *Chapter 10: Delegation Oversight* and refer to the Delegated Entities Delegation of Responsibilities (DOR) for more information. When concurrent review is not delegated, Gold Kidney performs inpatient (including continued stay review, discharge planning, and discharge review) and outpatient concurrent reviews. For inpatient stays, Gold Kidney performs concurrent review from the day of admission through discharge to assure the medical necessity of each day, that services are provided at the appropriate level of care, and that necessary discharge and/or transition of care arrangements have been made.
Gold Kidney also may delegate the responsibility for retrospective review to its delegated entities. When delegated for retrospective review, the Delegated Entity must follow *Chapter 10: Delegation Oversight* and refer to the Delegated Entities DOR for more information. When a retrospective review is not delegated, Gold Kidney conducts retrospective medical record review as may be required for health care services that were provided without formal prior authorization and medical necessity screening. Regardless of delegation, a retrospective review can be triggered by claims/encounter data where services are denied for failure to obtain prior authorization or pre-defined focused reviews such as diagnosis- related grouping (DRG) validation, short stay, readmission reviews, etc.

Notice Requirements

Delegated entities are responsible for ensuring that all Member notifications are provided in a culturally competent manner. Gold Kidney requires member-facing materials to be written at appropriate levels of readability and suitability for an older adult population, understanding that there may be exceptions.

- Language assistance, written, and/or alternative format communication must also meet the applicable regulatory requirements, including:
- CMS - eighth-grade level
- Letters in Spanish for those who have requested materials in Spanish.
- Large Font letters for those Members who have requested materials in large font.

Member notices must be complete and accurate, including adequate rationale specific to the decision, written in a manner easily understandable to Members, and not subject to interpretation. Notification of denial must include citation of criteria used, rationale, and recommendations for alternative and/or follow-up with physician/provider. Notices must not use acronyms or technical/clinical terms unless an explanation/definition is provided.

Delegated entities performing utilization management functions must use Gold Kidney- approved notices. These templates have been designed to meet CMS notice requirements and are available from the Gold Kidney Utilization Management Department.

See also 42 CFR 422.624, 422.626, 489.27, and *Parts C&D Enrollee Grievances, Organization/Coverage Determinations, and Appeal Guidance*.

Notice	When Required
To Member (or Representative) After Request for Prior Authorization	
Notice of Authorization letters (Facility and Services)	Issue when service/item/stay is authorized
Notice of Dismissal of Pre-Service Request	Issue when: Request lacks valid appointment of representative form or written equivalent or valid authorization. The service/item requested has already been received.
To Member (or Physician) After Denial of Medical Coverage See *https://www.cms.gov////MADenialNotices.html*	
Notice of Denial of Medical Coverage (NDMC)	The issue for Medicare benefits only: Pre-Service Denials – Standard or Expedited Exhaustion of Skilled Nursing Benefit Denials Psychiatric Facility Exhaustion of Benefits Denials Refusal to Transfer *Note: Not to be used for Post Service Denial of Payment*
Coverage Decision Letter	Issue this letter when the organization's determination is made to reduce, stop, suspend, or deny, in whole or in part, a request for a service/item. *Note: This letter must be used in place of the Notice of Denial of Medical Coverage*
Extension Needed for Additional Information	Issue when an extension is needed for additional information in the interest of the Member. *Note: Use when requesting additional information from NON-CONTRACTED providers, NOT to spend the decisions while waiting for medical records from contracted providers.*
Services Do Not Meet Expedited Criteria	Issued when the Member has requested an expedited initial decision, and the request does not meet Expedited Initial Organization Determination (EIOD) criteria.
Notice	When Required
To Facility	
Denial of Coverage for Inpatient Hospitalization	Issue when a reviewing physician denies an inpatient facility stay/extension of an inpatient stay
Hospital Inpatients See *https://www.cms.gov////hospitaldischargeappealnotices.html*	
Important Message from Medicare (IM)	The issue is to inform of hospital discharge appeal rights. *Note: Must be delivered in person within two (2) calendar days of admission and not more than two (2) calendar days before discharge and the patient must sign that they received and understand*

Detailed Explanation of Non-Coverage (DENC)	Issue when the Member has filed an appeal with the CMS Quality Improvement Organization (QIO) for denied covered skilled nursing services (including home health, comprehensive outpatient rehabilitation, and hospice) *Note: Must be delivered no later than the close of business of the day of the QIO notification*
Detailed Notice of Discharge (DND)	Issued by the acute hospital when the Member appeals the hospital discharge (with the QIO). Delegated entities are responsible for the oversight of their contracted facilities. *Note: Must be delivered to the inpatient before noon of the day after notification* *by QIO of the appeal. The hospital must provide all documents/information requested by QIO.*
To Hospital Observation Patients See *https://www.cms.gov////hospitaldischargeappealnotices.html*	
Medicare Outpatient Observation Notice (MOON)	Issued when Member is in an outpatient setting receiving. Observation services and is not inpatient at a hospital or critical access hospital (CAH).
To Member (or Physician) Where Group is Not Responsible for Services	
Informational Letter to Beneficiary	Issue when the Member has requested services that the group does not have responsibility for providing or authorizing
To Members Whose HH, SNF, Hospice, or CORF Services Are Ending See *https://www.cms.gov////FFS-Expedited-Determination-Notices.html*	
Notice of Medicare Non-Coverage (NOMNC)	Issued when there is a termination of: SNF HH (including psychiatric home health) CORF Hospice (delivered by Hospice Provider) *Note: Must be delivered two (2) calendar days OR the second to the last day of service if care is not being provided daily, before termination of services unless an* *exception applies and must be delivered in person. Members must sign and receive a copy.*
Optional Form to Document Alternate Delivery	Utilized to document the issuance of the NOMNC when the Member and/or Member's representative is unable or refuses to sign the NOMNC. *Note: If Member is unable to make decisions for him/herself, contact Member's representative on the day of NOMNC issuance and mail the Optional Form on* *the day of contact*
Detailed Explanation of Non-Coverage (DENC)	Issued when the Member has filed an appeal with the QIO for services denied for SNF, HH, CORF, Hospice *Note: Must be delivered no later than the close of business of the day of the QIO notification*

Reinstatement of Coverage	Issued when the skilled level of care is reinstated after receipt of NOMNC. *Note: The letter advises the Member there will be no lapse in coverage. If the Member's condition changes, this letter can be issued before the QIO decision. A new NOMNC must be issued for notification of discharge at least two (2) calendar days before the l*ast covered day.

Delegated Entities for Utilization Management: Let us Help You

Gold Kidney is available to answer questions regarding required notices and to provide on-site in- service education. Providers may contact their Utilization Management team member at (844) 294-6535 or email *utilization_management@goldkidney.com* for information.

Timeliness of Pre-Service Organization Determinations (Part C)

This section applies to Part C pre-service Organization Determinations only (i.e., determinations concerning the provision of medical services/items). Please see *Chapter 8: Pharmacy* for Part D Coverage Determinations.

A Member or his/her physician may seek pre-service Organization Determination from Gold Kidney or, where applicable, its delegated entities. The Member or his/her physician may request that an Organization Determination be expedited when he/she believes that waiting for a decision under the standard time frame could place the Member's life, health, or ability to regain maximum function in serious jeopardy. Time frames for Part C pre-service Organization Determinations are:

To Render a Decision and Notify* Member and Provider (from Receipt of Request)	
Standard	**Fourteen (14) calendar days with a possible fourteen (14) day extension**
Expedited	**Seventy-two (72) hours with extension, not to exceed fourteen (14) calendar days.**
To Provide Notice* of Denial of Request to Expedite	
Prompt oral notice and subsequent written notice **within three (3) calendar days**	
*See the Notice Requirements section of this Chapter for details regarding the form of notice required	

See *https://www.cms.gov/Medicare/Appeals-and-Grievances/MMCAG//Parts-C-and- D-Enrollee-Grievances-Organization-Coverage-Determinations-and-Appeals- Guidance.pdf*

Continuity of Care

Gold Kidney, in collaboration with the assigned delegated entity, will coordinate care and services for Members who are newly enrolled, transitioning to a new PCP and/or medical group to ensure uninterrupted care and a safe transition. Criteria for continuity of care include but are not limited to outpatient mental health/chemical dependency treatment; current acute or SNF hospitalization; chemotherapy, radiation therapy, or nuclear medicine; transplant services, a complex chronic condition requiring continued care and ongoing services; DME (e.g. oxygen, hospital bed); terminal illness requiring continued care and ongoing services; and pending authorized surgery/procedure scheduled within one hundred eighty (180) days. Continuity of care decisions are made in collaboration with the Member's new PCP and/or medical group. Confirmation of medical group authorized services must be submitted to Gold Kidney by the new medical group within forty-eight (48) hours of receipt. For fiscal responsibility concerning continuity of care, please refer to the provider's contract with Gold Kidney.

The delegated entity is responsible for the continuity of care should a provider be terminated from the Gold Kidney network due to quality of care concerns, if a provider no longer provides services in Gold Kidney's service area, or if sanctioned by Medicare and/or the medical board.

Chapter 8: Pharmacy

Gold Kidney's P&T Committee

Gold Kidney is contracted with MedImpact Health Systems, Inc as its Pharmacy Benefit Manager. Gold Kidney's Part D Formulary is reviewed and approved by Gold Kidney's delegated Pharmacy and Therapeutics (P&T) Committee that meets specific requirements concerning membership, conflict of interest, P&T member disclosure to CMS, meeting administration, formulary management, formulary exceptions, and P&T committee role.

The MedImpact P&T Committee is comprised of physicians and pharmacists from various clinical specialties and evaluates new drug therapies for placement on the Gold Kidney Part D Formulary, drug utilization criteria, pharmaceutical management policies, and procedures, as well as select medication treatment guidelines for major medical conditions.

The MedImpact P&T Committee meets at least quarterly and its decisions regarding the placement of new medications on Gold Kidney's Part D Formulary are distributed to contracted providers via the Gold Kidney website formulary updates.

See www.goldkidney.com for more information.

Gold Kidney is a Medicare Advantage Organization. Gold Kidney contracts with CMS to provide Medicare Part D prescription drug coverage for Gold Kidney Members and must comply with CMS's rules and regulations.

Gold Kidney contracts with MedImpact to administer Part D programs as its Pharmacy Benefit Manager.

Pharmacy Benefits

Providers may contact their Network Management Specialist at (888) 750-0080 to request a current Gold Kidney benefits grid. Benefits grids are also available on the Gold Kidney Provider Portal at: *https://www.goldkidney.com/providers*.

Part D Formulary

Gold Kidney's Part D Formulary is a list of covered Part D drugs reviewed and approved by the MedImpact Pharmacy and Therapeutics (P&T) Committee and CMS. Gold Kidney's Part D Formulary and the updates to the Part D Formulary are available at: Pharmacy Formulary - Gold Kidney Health Plan. Providers shall use Gold Kidney's Part D Formulary and non-Formulary medications subject to the exercise of the prescribing provider's clinical judgment. In cases where non-Formulary medications are warranted, the Provider will work with Gold Kidney by requesting non-Formulary drugs using the Gold Kidney formulary exception process described in the Coverage Determination section below.

Providers may make Formulary exception requests via MedImpact by accessing the format: *https://goldkidney.com/exception-request-form-for-physicians/*

Requests to Add Drugs to the Part D Formulary

Providers may request that drugs be added to Gold Kidney's Part D Formulary. Providers may submit written requests to: Gold Kidney Health Plan, Attn: Director, Pharmacy, Gold Kidney Health Plan, 4600 E Washington, #300, Phoenix, AZ 85034

Finding a Network Pharmacy

Gold Kidney's pharmacy network includes over sixty-three thousand (63,000) pharmacies. Providers can locate a network pharmacy, including a pharmacy with preferred cost-sharing, by using the pharmacy search tool on Gold Kidney's website at: https://www.goldkidney.com/provider-directory/ for a searchable pdf or https://www.goldkidney.com/pharmacy-formulary/ for an online search. To find a pharmacy in a specific area, search options must be entered, which include a selection of the following options: a specific zip code; pharmacies within a certain mile radius; preferred pharmacies only; and/or pharmacies open 24 hours. Once results are returned, the "Details" section will advise if the pharmacy is open 24 hours or dispenses a 100-day supply.

Specialty Pharmacies and Specialty Medications

Gold Kidney provides clinical support, therapy management, counseling, and social services for Part D specialty medications through its contracted Specialty Pharmacy, MedImpact Specialty Direct. Members may also choose to use other network pharmacies to obtain Part D specialty medications. Coverage determinations for specialty medications follow the procedure described below under "Coverage Determination Process."

Mail Order Pharmacy Program

Members are encouraged to use Gold Kidney's mail-order pharmacy program, administered by MedImpact by contacting the Birdi™ Customer Service program, which allows Members to receive up to a 100-day supply of certain medications delivered to the home. Birdi™ is our mail-order pharmacy. While Members can choose any network pharmacies to fill their prescription medications, they may pay less at Birdi™. Providers can send or mail-order prescriptions to Birdi by submitting prescriptions electronically or by fax to 1-888-783-1773.

For questions contact Birdi™ Customer Service at 1-855-873-8739 (TTY dial 711) or *customerservice@birdirx.com www.medimpact.com*
To avoid delays, all prescriptions must have three (3) forms of identification (e.g., Member name, ID number, date of birth, etc.). If the three (3) forms of identification are not listed, the processing of prescriptions will be delayed. When sending prescriptions for controlled substances, a handwritten signature must be on the prescription. For more information, *https://goldkidney.com/birdi-mail-order-form-2023/*

Coverage Determination Process

Gold Kidney delegates Part D Coverage Determinations to MedImpact. Providers may request Coverage Determinations from MedImpact 24/7 as set forth below:

Submit online: https://goldkidney.com/forms/ then select "Submit Prior Authorization Request."
Submit it by phone: 858-790-7100.

Part D Coverage and Coverage Redetermination forms can be obtained from Model Part D Coverage Determination and Redetermination forms - Gold Kidney Health Plan and mailed or faxed:

Mailed to: MedImpact.
10181 Scripps Gateway Court
San Diego, CA 92131

Faxed to: 866-515-7869.

Most standard coverage determination requests are requests for exceptions to our rules or restrictions that apply to a certain drug. These requests require that you or another prescriber submit a written statement giving the medical reasons for requesting an exception to our rules or restrictions.
In these cases, we must give you as the provider our decision no later than 72 hours after we receive your statement supporting your request.

If these standard deadlines could cause serious harm to the member's health, you can ask for a "fast" or "expedited" coverage determination. If you or another prescriber tells us the member needs a fast coverage determination, we will automatically agree to give you one. For a fast coverage determination about a Part D drug, we will give you our decision within 24 hours. This usually means 24 hours after we receive a written statement supporting your request.

Part D v. Part B: Let Us Help You

For assistance in determining whether a drug falls under Part D or Part B, call the Customer Service line, and ask for the Pharmacy Department. A Gold Kidney Clinical Pharmacist will respond, usually within twenty-four (24) hours. Please note that this service is for informational purposes only and is not a Coverage Determination. Coverage Determinations are made by MedImpact as described above.

Injectables, including intravenous and intramuscular drugs, which are typically not self-administered and furnished "incident to" a physician's or other practitioner's service are covered under Part B consistent with section 1861(s)(2)(A) or (B) of the Social Security Act. **Per the "incident to" guidelines, providers are not allowed to instruct patients to purchase a drug themselves and bring it to the providers. Office for administration.**

Prescription Drug Transition of Care Policy

As a new member to the Gold Kidney Health Plan, a member may be taking drugs that are not on our formulary drug list or taking drugs that are on our drug list but have a restriction (e.g., prior authorization, quantity limit, step therapy). The transition process allows members to receive a limited supply to give them time to collaborate with their doctor to find a drug alternative, get prior authorization, or request a formulary exception.

While the member is talking with their doctor, they may be eligible to receive a 30-day transition supply of the drug during the first 90 days they are a member of our plan. After their first 30-day transition supply, we

may not continue to pay for these drugs under the transition policy.

Who may be eligible for a transition drug supply?

- New members during the first 90 days of our plan Members residing in a long-term care facility pass the first 90 days of membership in our plan.
- Members who are negatively affected by a formulary change from one contract year to the next
- If the member is a resident of a long-term care facility, we will cover a temporary 31-day transition supply (unless they have a prescription written for fewer days).

If they need a drug that is not on our formulary or their ability to get their drugs is limited, but they are past the first 90 days of membership in our plan, we will cover a 31-day emergency supply of that drug (unless they have a prescription for fewer days) while they pursue a formulary exception.

For members that move from one level of care to another as described below, Gold Kidney will provide a temporary, one-time up to 30-day supply of a Part D eligible non-formulary medication. This one-time fill needs to be authorized through the exception process. Therefore, a doctor or pharmacist will need to let MedImpact (at 1-888-672-7206) know that the member is moving from one level of care to another.

Examples of moving (or transitioning) from one level of care to another include the following:

- Members transitioning from hospital to home (discharge medications)
- Members transitioning from a Skilled Nursing benefit (LTCF) and reverting to the Part D benefit.
- Members terminating a Hospice election and reverting to Part A and Part D benefits.
- Members discharged from a Chronic Psychiatric Hospital to home (discharge medications)

If you have any questions about our transition policy or need help asking for a formulary exception, call Gold Kidney Customer Service.

Medication Therapy Management (MTM) Program

CMS requires all Part D sponsors to implement a medication therapy management (MTM) program for Members who have multiple chronic diseases, are taking multiple medications, and are likely to incur annual costs for covered Part D drugs at a specified threshold and for Members who are at-risk beneficiaries (ARBs) under a Drug Management Program (DMP). The purpose of the MTM program is to optimize therapeutic outcomes through improved medication use by providing comprehensive medication reviews (CMRs) and targeted medication reviews (TMRs) to physicians. Members in the MTM program receive a CMR from a Clinical Pharmacist or other qualified provider and receive a Recommended To-Do List and Personal Medication List upon completing the CMR. Recommendations for drug therapy changes, if any, are sent to the Member's prescriber(s). All eligible members of the MTM program will receive information about the safe disposal of prescription drugs that are controlled substances; drug take- back programs; in-home disposal; and cost-effective means to safely dispose of medications.

MTM is a service offered by Gold Kidney Health Plan at no additional cost to members. The MTM program is required by the Centers for Medicare and Medicaid Services (CMS) and is not considered a benefit. This program helps members, and their doctors make sure that the members' medications are working. It also helps us identify and reduce medication problems.

To take part in this program, a member must meet certain criteria outlined in part by CMS. These criteria are used to identify people who have multiple chronic diseases and are at risk for medication-related problems. If a member meets these criteria, we will send them a letter inviting them to participate in the program and information about the program, including how to access the program. A member's enrollment in MTM is voluntary and does not affect Medicare coverage for drugs covered under Medicare.

To qualify for Gold Kidney Health Plan's MTM program, a member must meet one of the two following criteria:

- Be an At-Risk Beneficiary or
- Meet ALL the following criteria:
- Have at least 3 of the following conditions or diseases: End-Stage Renal Disease, Chronic Heart Failure, diabetes, dyslipidemia, asthma, or Chronic Obstructive Pulmonary Disease, AND
- Take at least 8 covered Part D medications, AND
- Are you likely to have medication costs of covered Part D medications greater than $4,935 per year.

To help reduce the risk of medication problems, the MTM program offers two types of clinical reviews of a member's medications:

Targeted medication review: at least quarterly, we will review all the prescription medications and contact the member, the member's caregiver, the member's pharmacist, and/or their doctor if we detect a potential problem.

Comprehensive medication review (CMR): at least once per year, we offer a free discussion and review of all a member's medications by a pharmacist or other health professional to help the member use their medications safely. This review, or CMR, is provided to the member confidentially via telephone by pharmacies operated by Tabula Rasa HealthCare. The CMR may also be provided in person or via telehealth at the member's provider's office, pharmacy, or long-term care facility. If a member or the member's caregiver is not able to participate in the CMR, this review may be completed directly with their provider. These services are provided on behalf of Gold Kidney Health Plan. This review requires about 30

minutes. Following the review, the member will get a written summary of this review call, which can be taken by the member for their next doctor's visit. This summary includes:

Recommended To-Do List (TDL): The list has steps the members should take to help them get the best results from their medications.

Personal Medication List (PML): The medication list will help the members keep track of their medications and how to use them the right way.

To obtain a blank copy of the Personal Medication List (PML) that can help a member and their healthcare providers keep track of the medications they are taking, click here Blank PML English or Blank PML Spanish.

If a member takes multiple medications for more than one chronic health condition, they can contact their drug plan to see if they are eligible for MTM, or for more information, please contact customer service at 844-294-6535.

If you are qualified for MTM, you can chat with us now about MTM at **medwisehc.com/patient-experience**

Opioids

The CMS finalized opioid policies for Medicare drug plans effective January 1, 2019. Providers are in the best position to identify and manage potential opioid overutilization in the Medicare Part D population. The policies include improved opioid safety alerts (pharmacy claim edits) when opioid prescriptions are dispensed at the pharmacy and drug management programs for Members determined to be at risk for misuse or abuse of opioids or other frequently abused drugs. As of January 1, 2022, all Part D sponsors are required to have a drug management program for Members who are at risk due to obtaining opioids from multiple prescribers and/or pharmacies or obtaining opioids with a history of opioid- related overdose. Providers shall cooperate with Gold Kidney and provide the necessary information concerning the use of opioids by a Member or Member as part of Gold Kidney's drug management program. Residents of long-term care facilities, those in hospice care, Members receiving palliative or end-of-life care, Members with sickle cell disease (SCD), and Members being treated for active cancer-related pain are exempt from these interventions. These policies do not impact access to medication-assisted treatment, such as buprenorphine. For more information on opioid safety alerts, drug management programs, and medication-assisted treatment, contact medimpact.com.

Part D Vaccines

Gold Kidney encourages Members to obtain Part D-covered vaccines through a retail pharmacy if the vaccine is recommended by their PCP. Pharmacies will dispense and administer the vaccine under the protocol. In such a case, the pharmacy submits the vaccine claim to MedImpact with the drug cost and administration fee. Under the Inflation Reduction Act of 2022, Section 11401 (Coverage of Adult Vaccines Recommended by the Advisory Committee on Immunization Practices Under Medicare Part D), Gold Kidney Members will have access to Part D-covered vaccines recommended by the Advisory Committee on Immunization Practices at no cost to Gold Kidney Members. Covered Part D-covered vaccines include but are not limited to, Shingrix (shingles), M-M-R II (measles), and T-DAP (whooping cough) vaccines. Providers can find a complete list of the Part D-covered vaccines Gold Kidney covers in Gold Kidney's Part D Formulary. For more information, go to MedImpact.com.

Insulin

Consistent with the Inflation Reduction Act of 2022, Section 11406 (Appropriate Cost- Sharing for Covered Insulin Products Under Medicare Part D), Gold Kidney members will not pay more than $35 for a one-month supply of each insulin product covered by Gold Kidney, no matter what cost-sharing tier it is on. Most formulary insulin products are offered for a $0 copay. Providers can find a complete list of the insulin products Gold Kidney covers in Gold Kidney's Part D Formulary.

Hospice and End Stage Renal Disease (ESRD) Part D Exclusions Medicare specifies that a drug prescribed to a Part D eligible Member cannot be considered a covered Part D drug if payment for such drug is available (or would be available) under Part A or B for that Member. Two examples of drugs covered under Part A or B are (1) drugs and biological products related to the terminal illness or related conditions for Members who have elected the Medicare hospice benefit - these drugs should be covered under the Part A payment to a hospice provider; and (2) drugs used for ESRD beneficiaries receiving renal dialysis services - these drugs are included in the Part B bundled payment to an ESRD dialysis facility. Providers must understand these requirements.

Hospice Medications

PCPs remain responsible for Members receiving Medicare-certified hospice care to ensure non-hospice care and services are provided.

Drugs and biological products paid for under the Part A per-diem payments to a Medicare hospice program are excluded from coverage under Part D. In general, hospice will provide medications related to the care plan for the terminal diagnosis and four categories of drugs that relieve common symptoms during the end of life, regardless of their terminal diagnosis. These symptoms include pain, nausea, constipation, and anxiety.

For Members enrolled in Hospice, Gold Kidney has Member-level Prior Authorization requirements on the following four categories to determine their coverage under Part A versus Part D benefit: analgesics; antinauseants (antiemetics); laxatives; and antianxiety drugs (anxiolytics) as required by Medicare.

For these drugs, hospice-affiliated providers must provide a supporting statement of whether the prescribed drug is unrelated to the Member's terminal illness or related condition for Part D coverage.

PCPs should:

- Understand CMS guidelines for the management of Members in hospice.
- Demonstrate the use of Gold Kidney guidelines for delegated responsibilities.
- Implement interventions to manage hospice Members including:
- Monitoring patient status
- Ensuring care transition support
- Ensuring non-hospice care needs are met.
- Managing medications (Hospice vs. Medical Group coordination)
- Explain care responsibilities for Members that transition into and out of hospice.
- End Stage Renal Disease (ESRD) Prospective Payment Program
- CMS applies a bundled prospective payment system (PPS) for renal dialysis services provided by an ESRD dialysis facility that includes drugs used in the treatment of ESRD.
- CMS provides a single payment to ESRD facilities that covers all the resources used in furnishing an outpatient dialysis treatment including supplies and equipment used to administer dialysis, drugs, biological, laboratory testing, training, and support services. As a result, drugs used for ESRD Members receiving renal dialysis services are excluded from Medicare Part D as these drugs are included in the Medicare Part B bundled payment to an ESRD dialysis facility.

CMS has identified four (4) categories of drugs that will always be considered renal dialysis drugs when furnished to an ESRD Member and used as specified in the table below:

Intended Use	Drug Category
Access Management	Drugs used to ensure access by removing clots from grafts, reverse anticoagulation if too much medication is given, and providing anesthetic for access placement
Anemia Management	Drugs used to stimulate red blood cell production and/or treat or prevent anemia
Bone and Mineral Metabolism	Drugs used to prevent/treat bone disease secondary to dialysis
Cellular Management	Drugs used for deficiencies of naturally occurring substances needed for cellular management

Part B vs. Part D edits will apply at the Point of Service (POS) for ESRD Members for drugs that are "always" ESRD drugs.
Sensipar® (cinacalcet) is included in the ESRD PPS and is not payable under the Part D benefit when used for the provision of renal dialysis services (Part B vs. Part D edit will apply to cinacalcet at Point of Service (POS) for ESRD Members).

Chapter 9: Physician Responsibilities

Physicians participating in the Gold Kidney network have certain responsibilities based on their roles as PCPs and/or specialist physicians. Contracted medical groups and directly contracted physicians are responsible for ensuring that their physicians comply with Gold Kidney requirements as outlined in this Provider Administrative Guide including the requirements outlined in this Chapter. This responsibility extends to clinical and non- physician staff responsible for supporting physicians; all uses of "physician" shall be understood to extend to such staff.

Participation in Benefit Plans

Providers are deemed to participate in all benefit plans associated with their participating networks and may not terminate participation in an individual benefit plan. Providers may contact their Network Management Specialist at providercontracting@goldkidney.com.

PCPs and Specialist Physicians

A PCP is a family physician/family practitioner, general practitioner, gerontologist, internist, or other specialist allowed by the Member's benefit plan, selected by the Member, to be responsible for supervising, coordinating, and providing care to the Member. To ensure quality and continuity of care, the PCP is responsible for arranging all the Member's health care needs (from providing primary care services to coordinating referrals to specialists and providers of ancillary or hospital services). PCPs are also responsible for maintaining the Member's medical records, including documentation for all services provided to the Member. Members may also choose to see a Nurse Practitioner to serve as their Primary Care Provider based on state licensure laws.

A specialist physician is a physician credentialed to provide certain specialty care outside the expertise of the

PCP.

Annual Exams

Contracted medical groups are required to ensure that PCPs perform preventive visits and yearly wellness exams to assess acute chronic conditions and preventive health care needs. Additionally, Gold Kidney strongly recommends that Members are seen as often as their condition(s) require. Gold Kidney covers an annual physical examination visit separate from the annual wellness exam as an added benefit to all members.

Note: Annual wellness visits must include a review of the Member's current opioid prescriptions and screening for potential substance use disorders, including a referral for treatment as appropriate.

Please refer to the following for more information: *https://www.uspreventiveservicestaskforce.org/ https://www.medicare.gov//preventive-visit-and-yearly-wellness-exams.html*.

Initial Health Assessment/Medicare Wellness Assessment

Gold Kidney requires PCPs to conduct an Initial Health Assessment (IHA)/Medicare Wellness Assessment (AWV) for Members within ninety (90) days of the Member's enrollment effective date. Access the form at https://goldkidney.com/annual-wellness-visit- form-2023-1-25/

Comprehensive IHA/Welcome to Medicare Assessment (AWV) and Health Exams must include but are not limited to the following:

Complete history and physical (including, but not limited to)
Present and past illness(es) with hospitalizations, operations, medications
Physical exam including a review of all organ systems.
Height, weight, body mass index (BMI), blood pressure (BP), cholesterol screening
Preventive services per the United States Preventive Services Task Force (USPSTF) A and B Guidelines for 65-year-olds (including age-appropriate assessments such as tuberculosis screening, clinical breast exam, allergy, colorectal screening, mammogram, pap smear, etc.)
Review of the beneficiary's current opioid prescriptions and screening for potential substance use disorders, including a referral for treatment as appropriate.

- Mental health and status evaluation
- Social history
- Current living situation
- Marital status
- Work history
- Education level
- Sexual history
- Use of alcohol, tobacco, and drugs
- Assessment of risk factors – using the Health Risk Assessment (HRA)
- and development of behavioral risk health education – to include assessment of:
- Nutrition
- Functional status (including activities for daily living/instrumental activities for daily living (ADL/IADLs)
- Physical Activity
- Environmental Safety

- Dental/Oral Health
- Diagnoses and plan of care

Assessment of Risk Factors

The Health Risk Assessment is to be completed by the health plan or their delegate for all Members within 90 days of enrollment and annually thereafter. Updates are required is a member experiences a transition of care.

To assist physicians in meeting IHA/AWV requirements, Gold Kidney provides an IHA/AWV Report, accessible through the Provider Portal. The IHA/AWV report is updated monthly and provides detailed member-level information identifying C-SNP Members in need of an IHA/AWV. Gold Kidney encourages accessing and communicating such information to PCPs.

Post Hospitalization Visit

Contracted medical groups are encouraged to follow post-hospitalization best practices to ensure PCPs perform post-hospitalization visits within seven (7) – to ten (10) days of discharge. The post-hospital follow-up visit presents an ideal opportunity for the PCP to prepare the Member and family caregiver for self-care activities, make sure the discharge instructions are being followed, and medications are reconciled and head off situations that could lead to readmission.

PCPs are a key part of the care team and there are additional requirements regarding transitions of care for Members belonging to a Chronic Special Needs Plan (See *Chapter 1: Welcome and Overview*).

Additional Supplemental Benefits

Gold Kidney Members may be entitled to additional benefits beyond Original Medicare, including Supplemental Benefits. Some examples of Supplemental benefits are vision, dental, and hearing coverage. PCPs should refer Members to the Gold Kidney Member Services Department at (844) 294-6535, to learn about and arrange for Supplemental Benefits. PCPs remain responsible for coordinating C-SNP Member care, and for referring C- SNP Members to Gold Kidney vendors for these benefits.
Gold Kidney also offers services to identify and assist members with links to available community resources that may be of assistance to the members. Please contact the Member Services team for more information on community-related services available to members.

Advance Directives

PCPs are required to educate and should encourage each Member to complete an advance directive and document it in the Member's medical record. Completed advance directives must be placed in a prominent place in the Member's medical record (See 42 CFR 422.128(b)(1)(ii)(E)). Gold Kidney supports and recommends resources for the completion of an Advance Directive on the member portal of its website: https://goldkidney.com.

Referrals

PCPs and specialist physicians must provide referrals for Members timely and appropriate. Providers are expected to direct Members to in-network health professionals, hospitals, laboratories, and other facilities unless appropriate specialty care is not available within Gold Kidney's network. In circumstances where

Urgent or Emergency services are needed authorization or referral is not required. Out-of-network services requiring Prior Authorization are identified on the Gold Kidney Prior Authorization list.

Referrals are shared between providers and do not need to be sent to Gold Kidney for review or approval.

Prior Authorizations are required for select services as outlined in the Gold Kidney Prior Authorization process below.

In-Network Services and Medicare-Approved Facilities: Help us Help the Member

Providers may contact their Network Management Specialist directly at (888) 750-0080 or email providercontracting@goldkidney.com for assistance determining fiscal responsibility for services, locating in-network specialists, or a Medicare-approved facility. Providers may also go through *https://www.goldkidney.com/providers* to locate participating providers.

Referrals shall **not** be required for:

- Routine women's healthcare, which includes breast exams, screening mammograms (x-rays of the breast), Pap tests, and pelvic exams if received services from a network provider (See 42 CFR 422.100(g)(1)).
- Influenza vaccine and pneumococcal vaccine received from a network provider. Co- pay may not be charged (See 42 CFR 422.100(g)(2)).
- Emergency Services from network providers or out-of-network providers.
- Urgently Needed Services from network providers or from out-of-network providers when network providers are temporarily unavailable or inaccessible.
- Kidney dialysis services that the Member gets at a Medicare-certified dialysis facility when the Member is temporarily outside the plan's service area.
- Any other services specified in the applicable EOC; and
- Behavioral Health services.

Out-of-Area Dialysis Services: Help us Help the Member

PCPs should advise Members to contact Gold Kidney Member Services before they leave their benefit plan service area so that Gold Kidney and their dialysis provider can help arrange for maintenance dialysis while the Member is away.

Behavioral Health Referrals

PCPs must screen Members for behavioral health needs using validated screening tools at each visit and, when appropriate, initiate a mental health or substance use referral to the Member's assigned medical group.

Referrals for behavioral health services must be:

- Made within-network; and/or
- To a vendor who is contracted with the medical group to provide behavioral health or substance use services for the medical group (unless otherwise specified in the agreement between the medical group and Gold Kidney).
- Validated screening tools include:

Behavioral Health Disorders	Validated Screening Tools
Depressive Disorders	PHQ2, PHQ9, GDS
Anxiety Disorders	GAD2, GAD7
Bipolar Disorders	MDQ
Psychosis	PQ-B
PTSD	PC-PTSD
Substance Use Disorders	CAGE-AID

Opioid Treatment Program Services: Medicare Part B Benefit

Section 2005 of the SUPPORT for Patients and Communities Act establishes Opioid Use Disorder treatment services furnished by Opioid Treatment Programs (OTPs) as a **Medicare Part B benefit**, including necessary medications, counseling, therapy, and testing.

Standing Referrals

PCPs may allow standing referrals where a Member requires continuing specialty care over a prolonged period (e.g., Member has a life-threatening, degenerative, or disabling condition that requires coordination of care by a specialist instead of PCP). PCPs and referred specialists coordinate care and treatment, along with the Member, and develop a treatment plan that addresses the number of approved visits or the period during which the visits are authorized and the plan for each visit.

Specialist Physician Referrals

When a PCP refers a Member to a specialist physician, in addition to consultation, the specialist may refer the Member for additional in-network testing and services that are within the guidelines of their specialty. A treatment plan must be agreed upon by the PCP, the specialist physician, and the Member. In addition, a specialist physician may substitute as a PCP for a Member with a life-threatening condition or disease or degenerative and disabling condition or disease, either of which requires specialized medical care over a prolonged period, when authorized by the medical group.

Second and Third Opinions

Second and third opinions are covered even if the service is determined not to be covered. PCPs must provide referrals to another network physician when a second or third opinion is requested and appropriate. Patient-initiated second opinions that relate to the medical need for surgery or major nonsurgical diagnostic and therapeutic procedures are covered under Medicare. If the recommendation of the first and second physicians differs regarding the need for surgery (or other major procedures), a third opinion is also covered. Second and third-opinion referrals are for consultation only and do not imply referrals for ongoing treatment. (See Medicare Benefit Policy Manual, Chapter 15.)

Chimeric Antigen Receptor (CAR) T-cell Therapy

CAR-T immunotherapy is a covered service when the CMS National Coverage Determination criteria are met. See *https://www.cms.gov/medicare-coverage-database*. Inpatient administration is included in Hospitalization responsibility. Outpatient administration is included in the Outpatient Facility and Part B covers Drug responsibility.

Transplants

Transplant evaluation and services **must** be provided in a Medicare-approved transplant center; therefore, Members may only be referred to facilities that meet minimum standards established by Medicare to ensure Member safety. All transplant care must be coordinated via the plan's transplant provider by contacting the UM Prior Authorization Department at (844) 294-6535.
See *https://www.cms.gov///MedicareApprovedFacilitie/index.html*.

When a delegate refers a Member for transplant evaluation and the Plan has a financial risk for transplant services, per the DOFR, the Plan will render a transplant evaluation authorization, which may be performed concurrently with medical management of an inpatient event. Transplant (and transplant evaluation) related professional, facility, and diagnostic services must be authorized by the plan. Transplant and evaluation

Services are coordinated using the plan's designated centers of excellence and are usually billed separately from other services. All other services not related to transplant remain the fiscal responsibility of the entity at risk for inpatient care.

Medical groups are **required** to notify Gold Kidney, obtain Prior Authorization, and review. ***All*** transplant requests for collaboration. Please refer to your DOFR for further information.

Documentation of Referrals

Referring providers are responsible for ensuring that all relevant clinical information is sent to the preferred provider. The referral, as well as denial or acceptance of the referral needs, are documented in the Member's medical record by both the referring provider and preferred provider. Specialists must provide the referring PCP with informative reports on care rendered promptly.

Members on Hospice

The PCP remains responsible for Members receiving Medicare-certified hospice care to ensure non-hospice care and services are provided. Refer to the Member's EOC at *https://www.goldkidney.com* for more information.

Member elects Hospice*	
Type of Services	**Member Coverage Choice**
Hospice	Medicare
Non-Hospice Parts A&B	In Network/Medical Group
Non-Hospice Parts A&B	Out of Network Gold Kidney
Non-Hospice Part D	Gold Kidney Part D
Supplemental	Gold Kidney

*****For more information, please refer to the Gold Kidney Medical Policy available on the Gold Kidney Provider Portal.

Hospice Medication Management

Drugs and biological products paid for under Part A payments to a Medicare hospice program are excluded from coverage under Part D. In general, hospice will provide medications related to the care plan for the terminal diagnosis and four categories of drugs that relieve common symptoms during the end of life, regardless of a terminal diagnosis. These symptoms include pain, nausea, constipation, and anxiety. For Members enrolled in Hospice, Medicare determines their coverage under Part A versus Part D benefits: analgesics; antinauseants (antiemetics); laxatives; and antianxiety drugs (anxiolytics) as required by Medicare.

For these drugs, Hospice-affiliated providers must provide a supporting statement of whether the prescribed drug is unrelated to the Member's terminal illness or related condition for Part D coverage. Refer to Hospice and End Stage Renal Disease (ESRD) Part D Exclusions (See *Chapter 11: Pharmacy*).

Out-of-Area Hospitalizations

When Gold Kidney is financially responsible for out-of-area hospitalizations, Gold Kidney will coordinate care and services in collaboration with the out-of-area providers until the Member is discharged or stable for transfer and repatriation into the contracted network. Medical Groups are required to notify Gold Kidney when they become aware of an out-of-area admission. PCPs and Medical Groups are expected to work collaboratively with Gold Kidney to safely transfer the Member into the contracted network and continue

coordinating the Member's transition of care. (See *Chapter 10: Network Standards*)

Out-of-Country Hospitalizations

Gold Kidney will assume care when the Member is discharged or stable for transfer and repatriated into the contracted network. PCPs and Medical Groups are expected to work collaboratively with Gold Kidney to safely transfer the Member into the contracted network and continue coordinating the Member's transition of care.

Continuity of Care

Continuity of care is the continuous coordinated care afforded to all Members by a practitioner involved in their care and treatment. This care is a collaborative effort between providers and Gold Kidney. Physicians are responsible for working with Gold Kidney to ensure continuity of care. (*See Chapter 7: Utilization Management*)

Clinical Trials

Gold Kidney, Members may participate in a Medicare-approved clinical trial and stay enrolled in Gold Kidney to continue to get care not related to the trial through their assigned Medical Group/PCP. Authorization is not required.

Clinical trial providers should bill Original Medicare for clinical trial-related services. These services are not carved out to Gold Kidney, though Gold Kidney may help in the determination of Medicare-approved clinical trials. For additional information, refer to the Member's applicable EOC at *https://www.goldkidney.com for information*.

Providers may also refer Members to Medicare at 1-800-MEDICARE (1-800-633- 4227) for more information.

Clinical Trials: Help us Help the Member
Members do not need Gold Kidney's permission to participate in a clinical trial. Providers should direct Members to Gold Kidney Member Services for all clinical trial information. See *Chapter 2: Key Contacts Resource Guide* (Member Services).

Chapter 10: Network Standards

Access Requirements

- Maintain and monitor a **network of appropriate providers** supported by written agreements and sufficient to provide adequate access to covered services to meet the needs of Members.
- Demonstrate that providers are appropriately **credentialed.**
- Ensure plan services are available **24 hours a day, 7 days a week,** and are provided in a **culturally competent manner.**
- Ensure appropriate **ambulance services, Emergency and Urgently Needed Services, and post-stabilization care services** coverage.
- Establish **written standards for timeliness of access to care** and Member services that meet or exceed established standards, **continuously monitor** these standards, and take **corrective action,** as necessary.
- Ensure **continuity of care** and **integration of services** See 42 CFR 422.111-114; Title 28, Section 1300.67.2.1

Ensuring access to care is a collaborative effort between Gold Kidney and Gold Kidney's provider network and is accomplished through establishing and maintaining standards that apply across Gold Kidney's provider network. All network providers are responsible for abiding by these network standards.

Credentialing

To be eligible to participate in the Gold Kidney network, all providers must be able to demonstrate that they meet Gold Kidney credentialing requirements including, but not limited to, the following:
Being in good standing with all state and federal regulatory bodies.

Approved by an accrediting body or, if not accredited, can provide appropriate evidence of successfully passing a recent state or Medicare site review, or meets other plan criteria.
Maintains current general, professional, & workers' compensation liability insurance as applicable.
Not excluded, suspended, and/ or disqualified from participating in Medicare, Medicaid, or any other government health-related program; and Enrolled in Medicare.

Delegation of Credentialing Functions

Gold Kidney typically delegates credentialing functions. Entities that have been delegated to perform credentialing functions on behalf of Gold Kidney must comply with all requirements applicable to Gold Kidney, including the requirements outlined in this section. See also Chapter 15: Delegation Oversight.

Credentialing Process and Nondiscrimination

The Gold Kidney Credentialing Committee is responsible for the development and maintenance of a comprehensive credentialing and re-credentialing process, to make credentialing and re-credentialing decisions, monitor the quality of care and services, guide for continuous quality improvement to meet NCQA, CMS, and applicable state requirements. Credentialing decisions are made on a fair and impartial basis according to predetermined criteria related to professional conduct and competence, not based on an applicant's race, gender, age, ethnic origin, sexual orientation, or type of patients or procedures in which the provider specializes.

The credentialing process consists of three parts: information gathering, information review, and decision. All providers are expected to provide full, accurate, and timely information. Failure to do so could result in delay or a determination not to credential the provider. If unfavorable information about a provider is discovered during the credentialing process (e.g., professional liability settlements, sanctions, or other adverse information, etc.), Gold Kidney or a delegated entity may decide not to credential the provider. Applications that are incomplete or that do not meet standards for review will not be accepted and are not subject to appeal.

Timeline for Re-Credentialing

All providers must complete the credentialing process before becoming a Gold Kidney participating provider and must complete the re-credentialing process every three (3) years. Any new provider will be considered an out-of-network provider until the credentialing process is complete. Health Delivery Organizations (HDOs) that have fewer than three (3) stars under the CMS 5-Star Quality Rating System will be given a provisional credential of one (1) year (with an additional two (2) years granted if improvement is shown).

American Board of Medical Specialties Board Certification

Gold Kidney requires groups to obtain Board Certification status from the American Board of Medical Specialties (ABMS) of all network and contracted physicians. For Non-Board Certified physicians, the highest education attained must be primary source verified. ABMS Board Certification demonstrates a physician's exceptional expertise in a particular specialty and/or subspecialty of medical practice and provides a trusted credential that is important to patients and relevant to physician practice. ABMS Board Certification is a peer-developed, externally validated program that reflects the critical core physician values of compassion, patient-centeredness, and passion for education. Patients, physicians, health care providers, insurers, and quality organizations look for these markers as the best measure of a physician's knowledge, experience, and skills to provide quality health care within a given specialty. (See *http://www.abms.org/board- certification/.)*

Provider Appeals

Providers will be notified in writing of any decision to limit, suspend, or terminate participation in the Gold Kidney network. Notification will include the reasons for the action, the appeals process, options available to the provider, and time limits for submitting an appeal. All appeals will be reviewed by a panel of peers. When termination or suspension is the result of quality deficiencies, if reportable, it will be reported to the appropriate licensing boards, National Practitioner Data Bank (NPDB), or other appropriate disciplinary bodies. See 42 CFR 422.202(d)(1)-(4) for applicable requirements.

Provider Changes (Additions, Terminations, Panel Closures)

Delegated entities are responsible for notifying Gold Kidney of requests for provider additions, provider terminations, address changes, and panel changes. Unless otherwise stated in the contract between the delegated entity and Gold Kidney and for all products, requests are processed per the following timelines. Notification is to be emailed to credentialing@goldkidney.com.

Provider Change

Termination of Primary Care Physician (PCP)

Notice to be received by Gold Kidney at least sixty (60) calendar days before the effective date of termination, or as soon as the provider notifies the group, for Gold Kidney to notify Members of these changes timely. In the event a PCP is terminated with less than sixty (60) calendar days' notice, then the group is to provide Gold Kidney with written notice within five (5) business days of becoming aware of the termination. Terminations will become effective on the 1st of the month following the expiration of the notice period unless Gold Kidney can process the request earlier. In the event of PCP termination, the group must also provide Gold Kidney with a replacement PCP to whom to transfer the Members. The replacement PCP must be affiliated with Gold Kidney and accepting Members.

Adding New Providers

Requests must include a complete profile for the new provider or a file containing all the required data elements. Incomplete requests will be returned with details regarding deficiencies and/or notice of action needed. Gold Kidney will notify the delegated entity if the Add request is declined and provide the reason. (Reasons for declining an Add request may include the provider is no longer practicing at locations requested, the provider's specialty is one which Gold Kidney does not load, the provider has quality management issues and is closed to new site affiliations, requested site affiliation has a corrective action pending, or that contract limitations exist (e.g. provider is located outside of Gold Kidney's market or the delegated entity contracted service area, etc..)

Panel Closures

Notice to be received by Gold Kidney at least sixty (60) calendar days in advance of any PCP who will no longer be able to accept Members. If the delegated entity is unable to meet this requirement because a PCP has failed to give the delegated entity notice of closure, the delegated entity shall provide Gold Kidney notice within five (5) business days of first learning of the closure. Unless otherwise stated in the contract between days of first learning of the closure. Unless otherwise stated in the contract between Gold Kidney and the delegated entity, in no event shall a delegated entity ever have more than twenty percent (20%) of its PCP panel closed to Members at the same time.

Notice to Gold Kidney of Adverse Actions

Delegates are required to immediately notify Gold Kidney upon discovery of any contracted providers who have an adverse action against their medical/clinical license such as an accusation, probation, or other

disciplinary action imposed by the Medical Board of California and/or any applicable licensing body. Notification is to be submitted to *credentialing@goldkidney.com*

Delegates are required to review healthcare practitioners who have an accusation of adverse action against their license declared by their state Medical Board and/or any applicable licensing body. The review should include, as appropriate, but is not limited to:

- Discussion of the accusation
- Discussion of complaints and Grievances concerning the quality of care
- Review of prescribing practices (if applicable)
- Implementing appropriate interventions if there is a concern of inferior quality that could affect Member safety (e.g., panel closure, monitoring of practitioner, termination, etc.)
- Delegates are also required to monitor healthcare practitioners who have adverse action decisions (e.g., a public letter of reprimand, probationary terms, etc.) against their license declared by the state Medical Board and/or any applicable licensing board.

Monitoring should include, as appropriate, but is not limited to:

- Grievances concerning the quality of care.
- National Practitioner Data Bank (NPDB) queries
- State Medical Board e-mail notifications.
- Other applicable licensing boards, as appropriate
- Practitioner's registration and/or completion of required courses

Member Notification (Provider Terminations)

Following state and federal requirements, Gold Kidney is required to make a good-faith effort to provide written notice of the termination of a contracted provider at least thirty.
(30) calendar days before the termination effective date to all Members who are patients seen regularly by that provider (See 42 CFR 422.111(e) and 42 CFR 438.10(f)) Medical Groups are responsible for identifying and notifying impacted Members who accessed the terminating specialist or hospital in the prior twelve (12) months.

Plan Notification (Member Events)

To ensure prompt and appropriate payment of claims, providers are required to notify Gold Kidney timely of the following Member events when Gold Kidney is financially responsible:

Event	Notification Timeframe
Admissions (Planned or Unplanned)	
Acute Inpatient (in/out of area)	Within twenty-four (24) hours of admission
Outpatient Observation Stay	Within twenty-four (24) hours of admission
Skilled Nursing Facility	Within twenty-four (24) hours of admission
Long-Term Care Facility	Within twenty-four (24) hours of admission
Authorizations	
Acute Rehabilitation Unit/Long-Term Acute Care (LTAC)	Before admission (at the time of request)
Elective inpatient procedures (planned transition)	Within one (1) business day of Admission
Transplants	

Solid Organ & Bone Marrow Transplants	Before transplant pre-evaluation
Fax notifications to Gold Kidney Medical Management at (866) 515-7869.	

Out of Area/Network Services v. Directed Care/In-Area Initiated Care Gold Kidney covers services that are delivered by providers that are in the Gold Kidney contracted network and in the plan service area (e.g., that are delivered "in-network" and "in the area"). Gold Kidney also offers point-of-service coverage at no additional cost sharing. Providers may refer to non-contracted entities willing to provide care for Gold Kidney members under their HMO-POS plans. Delegated entities are responsible for ensuring that referrals to out-of-network and/or out-of-area providers are appropriate per the terms of the Member's plan benefits and covered by Medicare.

It is also important that providers understand that not all care that is delivered outside the service area constitutes "out of area" services for purposes of determining fiscal responsibility. Delegated entities remain responsible for out-of-network services when a provider, advertently or inadvertently, refers a Member to an out-of-network provider ("directed care") or transfers a Member out of network for care that was initiated by an in- network provider ("in-network initiated care"). This includes situations where a provider directs a Member to an out-of-area provider based on a standing instruction or because care is not available in the service area. In the case of both directed care and in-area- initiated care, all subsequent services related to that episode of care, including but not limited to diagnostics, admissions to acute or non-acute facilities, and consults are considered in the area for purposes of determining fiscal responsibility.

For Transplant related care/services refer to *Chapter 4: Physician Responsibilities*.

Providing Information

All providers are expected to cooperate with Gold Kidney's requests for information for Gold Kidney to, among other regulatory requirements, meet disclosure obligations required by CMS and other regulatory agencies, all information necessary to: (1) administer and evaluate the program, and (2) establish and facilitate a process for current and prospective members to exercise choice in obtaining Medicare services. (See 42 CFR 422.64(a), 422.504(a)(4)). This information includes but is not limited to, Gold Kidney quality and performance indicators for benefits including, disenrollment rates for Medicare enrollees electing to receive benefits through Gold Kidney for the previous two (2) years, information on Medicare enrollee satisfaction, information requested to support organization determinations, and information on health outcomes. See 42 CFR 422.504(f)(2)(iv)(A)-(C). See *Chapter 16: Encounter Data* for requirements specific to encounter data.

Access and Availability

CMS has established access to service and related rules to ensure that all covered services, including supplemental services, are available and accessible to Members for the duration of the benefit year (for hospitalized Members hospitalized on the termination date or, in the event of an insolvency, through discharge) and are provided in a manner consistent with professionally recognized standards of care. See 42 CFR 422.112, 422.504(a)(3)(iii).

Provider Network

Gold Kidney contracts with a network of providers to ensure that all covered services, including supplemental services, are available and accessible. To accomplish this, Gold Kidney maintains and monitors a network of appropriate providers that are supported by written agreements and are sufficient to provide adequate access to covered services to meet the needs of the population served. These providers are used in the network as PCPs, specialists, hospitals, skilled nursing facilities, home health agencies, ambulatory clinics, and other providers. See 42 CFR 422.112(a)(1)(i).

Specialty Care

Delegated Medical Groups are responsible for providing and arranging necessary specialty care. Delegated Medical Groups are also responsible for allowing Members direct access to certain routine and preventive health services. The Medical Group arranges for specialty care outside of the provider network when network providers are unavailable or inadequate to meet a Member's medical needs. If needed, Gold Kidney can assist in arranging this care. See 42 CFR 422.112(a)(3).

Provider Directory

Gold Kidney is mandated to have accurate provider data. Gold Kidney relies on delegated entities to provide accurate real-time provider roster information. Gold Kidney is required to audit and validate provider network data and provider directories on a routine basis. Gold Kidney conducts a quarterly roster verification process which ensures that each provider network is accurately recorded in Gold Kidney's provider data system.

In addition, Gold Kidney's validation efforts may include reaching out to providers using a vendor partner. Outreach to providers may include the use of fax, email, and phone calls. Providers are required to provide timely responses to such communications. Gold Kidney' requires provider updates to be reported within five (5) business days from the time the delegated entity is aware of changes to the provider roster.

Roster information includes, but is not limited to additions, terminations, ability to accept new patients, street address, phone number, and any other changes that affect availability to Members. Any changes to provider rosters should be submitted to Gold Kidney's dedicated mailbox *credentialing@goldkidney.com*.

Finding Providers: Help us Help the Member.

Members can access Gold Kidney's online searchable provider directory at *https://www.goldkidney.com* and request a hardcopy provider directory from Gold Kidney's Member Services department or the Gold Kidney website.

Access to Care Standards and Hours of Operation

CMS requires that Gold Kidney employ written standards for timeliness of access to care and services, make these standards known to all providers, continuously monitor its provider networks' compliance with these standards, and take corrective action, as necessary. These standards must ensure that the hours of operation of Gold Kidney's network are convenient to, and do not discriminate against Members and are no less available than hours offered to other patients, and that services are available 24/7, when Medically Necessary. See 42 CFR 422.112(a)(6)(i) and 42 CFR 422.112(a)(7)(ii) and Medicare Managed Care Manual (MMCM), Chapter 4, Section 110.1.1.
To ensure network adequacy following federal and state requirements, Gold Kidney has established the following accessibility standards for all contracted providers:

Accessibility Standards	
Services	**Standard (Measured From Time of Request)**
Urgent/Emergent	
Emergency Services*/Urgent Care	Immediately 24/7
Urgent Care Appointment	Forty-eight (48) hours if no prior authorization is required (otherwise ninety-six (96) hours)
Post-stabilization services**	CMS = 1 hour
Dental	Seventy-two (72) hours
* 1 or more physicians and 1 always a nurse on duty	
** Contracted delegated entities must provide 24/7 access to providers for prior authorization of Medically Necessary stabilization care and to coordinate the transfer of stabilized Members in an emergency department. Requests from the facility for prior authorization of post-stabilization care must be responded to by the delegated entity within 1 hour, CMS = 1 hour, or the service is deemed approved. Upon stabilization, additional medical-necessity assessment should be performed to assess the appropriateness of care and ensure that care is rendered in the appropriate venue.	
Non-Urgent/Non-Emergent	
Access to PCP or designee	24/7
Ancillary services	Fifteen (15) business days
Mental health care provider (non-physician)	Ten (10) business days
Specialty Care	Fifteen (15) business days
PCP appointment	Ten (10) business days
Routine and preventive care (PCP)	Thirty (30) calendar days
Telephone Triage or Screening	Thirty (30) minutes
Other	
Interpreter services	24/7

Providers must also maintain procedures for follow-up on missed appointments to monitor waiting times in physician's offices, telephone calls (to answer and return), and time to obtain appointments; and for triaging Members' calls, providing telephone medical advice (if it is made available), and accessing telephone interpreters.
For a list of Telehealth services see *https://www.cms.gov///Telehealth/Telehealth-Codes*

Cultural Competency and Interpreter Services

Providers are responsible for ensuring that all services are provided in a culturally competent manner and are accessible to all Members including those with limited English proficiency (LEP), low literacy levels, hearing, sight, or cognitive impairment, or those with diverse cultural and ethnic backgrounds. See 42 CFR 422.112(a)(8), MMCM, Chapter 4, for more information.
To this end, providers are expected to ensure that:

- Referrals are made to culturally and linguistically appropriate community services and agencies when indicated (See *Chapter 2: Key Contacts Resource Guide*)
- Interpreter services are available 24/7 at no charge to the Member either directly or through Gold Kidney resources.
- Members are to use interpretive services instead of using family and friends, especially minors, as interpreters (Section 1557 of the Patient Protection and Affordable Care Act)
- Trained and fluent bilingual staff are used in medical interpreting.
- Visible signage is displayed to assist Members in requesting an interpreter.
- The Member's primary spoken language and any request or refusal of interpreter services are recorded in their medical record: and
- Language assistance written and/or alternative format communication must meet the appropriate regulatory requirements.
- Centers for Medicare & Medicaid Services (CMS) eighth-grade level

For additional tools and resources, please see below:
Multi-Cultural Toolkit-*https://www.goldkidney.com and-interpreter-services at (844) 294-6535*
Health Equity Tip Sheet - *https://www.scanhealthplan.com//////health-equity-tip-sheet_v5.pdf*
U.S. Department of Health and Human Services (n.d.). The Office of Minority Health. *https://minorityhealth.hhs.gov*
Office of DiseasePrevention and Health Promotion, Healthy People 2020 *https://www.healthypeople.gov/2020/topics-objectives*
Topics include, but are not limited to:
Older Adults
Access to Health Services
Disability and Health
Lesbian, Gay, Bisexual, and Transgender Health
Social Determinants of Health

Interpreter Services: Help us Help the Member

Gold Kidney provides free interpreter services to Members. To access services, call the Provider Information Line, twenty-four (24) hours a day at (844) 294-6535.
(TTY User: 711) and select the Provider Services option when prompted.

Health Education

Providers must implement and maintain an easily accessible Member health education program. (See 42 CFR 422.112(b)(5)). It is the responsibility of each delegated entity to conduct annual reviews and evaluations for all health education programs, as well as provide annual staff education on the availability of health education programs.

The program must include:

- Policies and procedures describing the health education program.
- Designation of an individual responsible for implementing and overseeing the health education program.
- Health education material must be:
- Obtained from credible and reliable sources.
- Meet appropriate levels of readability and suitability for an older adult population.
- Meet appropriate CMS plain language and written communication requirements.
- Available in threshold languages and alternative formats, based on Member population including availability of interpreter services (Interpreters, American Sign Language, and TTY/TDD).
- Inventory of health education program components including, but not limited to:
- Education interventions (e.g., classes, webinars, telephonic) based on educational strategies appropriate for Members, at least some classes are offered free of charge and are available for the following topics either directly or by referral (e.g., an affiliated hospital, contracted agency, community-based) – tobacco use and cessation, alcohol and drug use, fall or injury prevention, weight control/nutrition/physical activity, and self-care and management of health conditions including chronic kidney disease, diabetes, hypertension, and Congestive Heart Failure (CHF)

Provider Training and Education

Gold Kidney supports provider partners by consistently offering training and education on a variety of topics including clinical protocols, evidenced-based practice guidelines, and cultural awareness and sensitivity instruction for Members. Provider participation is encouraged. Medical groups are responsible for providing additional training, to ensure best practices are integrated into their organizations.

Additionally, and in compliance with CMS C-SNP requirements, Gold Kidney provides a Provider Orientation Packet (POP) to all new providers participating in Gold Kidney's Network and Gold Kidney's annual SNP Model of Care training webinars contain key information and training materials to assist in the management of C-SNP Members. Completion of the annual MOC Attestation of training is required for all providers contracted or non-contracted providing services to Gold Kidney Chronical Special Needs.

Members.

Appeals, Grievances, and Payment Disputes

Gold Kidney does not delegate Member Appeals and Grievances functions to its contracted providers. See *Chapter: 11 Member Appeals and Grievances* for more information. To meet regulatory requirements, Gold Kidney requires its providers to:

- Instruct Members to contact Gold Kidney to file all Appeals and Grievances.
- Forward all Grievances and/or Appeals to Gold Kidney on the day of receipt.
- Respond timely to requests for information and records from Gold Kidney; and
- Effectuate overturn decisions promptly and provide proof of timely effectuation. (See, e.g., 42 CFR 422.618(b)(2) and (c)).

Member Appeals and Grievances are time-sensitive procedures that require timely collaboration between health plans and their provider organizations. Untimely responses to requests for medical records or other lack of cooperation may result in a favorable Member determination against the provider organization. Failure to timely effectuate overturn decisions may also result in adjustments to reimbursement.

Marketing and No Steering Rule

Gold Kidney is responsible for any comparative/descriptive material developed and distributed on Gold Kidney's behalf by providers and, as such, Gold Kidney must ensure that providers (and subcontractors) comply with CMS marketing rules. See Medicare Communications and Marketing Guidelines (effective 02/09/2022 and subsequent updates) (MCMG); 42 CFR 422.2260 and 422.2262.

Providers may **not**:

- Mail marketing materials on behalf of Gold Kidney.
- Distribute marketing materials/applications in areas where care is being delivered, except in communal areas.
- Offer anything of value to induce Gold Kidney Members to select them as their provider.
- Offer inducements to persuade beneficiaries to enroll in a particular plan.
  - Health screen when distributing information to patients.
  - Accept compensation directly or indirectly from Gold Kidney for enrollment activities; or

Providers may:

- Provide the names of plans with which they contract and objective information on all benefits based on a particular patient's medications and health care needs.
- Make available or distribute plan marketing materials and display posters for all plan sponsors being offered.
- Refer their patients to other sources of information such as CMS's website or phone number; and
- Use Gold Kidney's logo, or engage in co-branding, with Gold Kidney's prior written consent.

Member Rights and Nondiscrimination

All new and existing Members receive communications regarding rights and responsibilities in their annual EOC. To ensure these rights, providers must:

- Always treat the Member with fairness and respect.
- Ensure that the Member gets timely access to covered services and drugs.
- Protect the privacy of the Member's PHI.
- Support the Member's right to make careful decisions.
- Allow the Member the right to make complaints and to request reconsideration of decisions made.
- Advise the Member what to do if the Member believes he/she is being treated unfairly or rights are not being respected; and
- Advise the Member how to get more information about their rights.

Providers may not deny, limit, or condition the coverage or furnishing of benefits to individuals eligible to enroll in an MA 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, or disability. (See 42 CFR 422.110(a)). Providers further may not differentiate or discriminate against any Member because of his/her enrollment in Gold Kidney or because of sex, race, color, religion, ancestry, national origin, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity, or sexual orientation. Providers must also ensure equal access to health care services for limited English proficient (LEP), limited reading skills, hearing incapacity, and speech-impaired Members through the provision of high-quality interpreter and linguistic services.

Safeguard Privacy and Maintain Records Accurately and Timely

For any medical records or other health and enrollment information maintained concerning Members, providers must establish policies that abide by all federal and state laws regarding confidentiality and disclosure of medical records, or other health and enrollment information. (See 42 CFR 422.118).

Providers must further:

- Safeguard the privacy of any information that identifies a particular Member and have procedures that specify: (1) for what purposes the information will be used within the organization; and (2) to whom and for what purposes it will disclose the information outside the organization.
- Ensure that medical information is released only following applicable federal or state law, or according to court orders or subpoenas.
- Maintain the records and information in an accurate and timely manner.
- Ensure Member timely access to records and information that pertain to them; and
- Timely reports breaches of PHI (See *Chapter: 14 Privacy and HIPPA*).

Disruptive Member Issues

Gold Kidney appreciates that there are situations in which a Member's behavior can place a strain on the provider and/or the Provider Organization. CMS does not permit the involuntary termination of Members except in extremely specific circumstances requiring that Gold Kidney find a way to meet the needs of the Member while addressing the concerns of the affected providers. **Under no circumstances should providers refuse to continue to provide and arrange care for a Member. All efforts should be made to resolve the issue at the practice level first**.

If a Member is violent or threatening violence, law enforcement, and Gold Kidney should be notified immediately. Documentation of Member behavior is essential for ensuring proper management of Member and provider issues and concerns. Refer to the Medicare Managed Care Manual. Chapter 2, Medicare Advantage Enrollment and Disenrollment, Section 50.3.2–Disruptive Behavior, https://www.cms.gov/files/document/cy2021-ma- enrollment-and-disenrollment-guidance.pdf

FDR and Compliance Program Requirements

Providers that have contracted with Gold Kidney to provide administrative services or health care services to a Medicare-eligible individual under the MA program or Part D program are considered first-tier or downstream entities of Gold Kidney (also referred to as "FDRs" for "first, tier downstream, and related entities"). CMS requires that FDRs fulfill specific Medicare compliance program requirements which are outlined below and further specified in each provider contract. (See also MMCM Chapter 21, Medicare Prescription Drug Benefit Manual (PDBM) Chapter 9, and 42 CFR 422.503, 423.504.)

<table>
<tr><th colspan="2">Compliance Program Requirements</th></tr>
<tr><td colspan="2">Written Standards</td></tr>
<tr><td colspan="2">FDRs must have written standards, which may be stated in a separate Medicare-specific stand-alone document or be within a corporate Code of Conduct, which describe at a minimum the FDRs:</td></tr>
<tr><td>• Mission and commitment to compliance with the law and the highest ethical standards.
• Procedures to avoid and address conflicts of interest.
• Procedures for fraud, waste, and abuse prevention, detection, and correction.
• The policy of non-intimidation and non-retaliation;</td><td>• Method and frequency by which provider distributes standards of conduct to employees and downstream entities (required within 90 days of hire, upon update, and annually).
• System for routine monitoring and identification of compliance risks; and
• Compliance officer and high-level oversight.</td></tr>
<tr><td colspan="2">General Compliance Training</td></tr>
<tr><td colspan="2">FDRs may utilize CMS's standardized training available on the Medicare Learning Network at http://www.cms.gov/MLNProducts, or equivalent training. FDRs may use CMS's standardized general compliance training, or equivalent training, or incorporate the CMS general compliance training materials or equivalent. Training must include:</td></tr>
</table>

• Review of compliance policies and procedures, and commitment to business ethics and compliance with all Medicare requirements. • Overview of how to ask compliance questions; training should emphasize confidentiality, anonymity, and non-retaliation. • Requirement for a contractor to report to the sponsor actual or suspected Medicare and/or Medicaid program noncompliance or potential Fraud Waste and Abuse (FWA);	• Examples of reportable noncompliance. • Review of the disciplinary guidelines for non-compliant or fraudulent behavior. • Overview of HIPAA, CMS Data Use Agreement (if applicable), and the importance of maintaining the confidentiality of PHI. • Overview of monitoring and auditing process; and • Review of the laws that govern employee conduct in the Medicare program.
Fraud, Waste, and Abuse (FWA) Training	
FDRs may use CMS's standardized FWA training, or equivalent training, or incorporate the CMS FWA training materials or equivalent. FWA training must include:	
• Obligations of FDRs to have appropriate policies and procedures to address FWA. • Processes for employees to report suspected FWA to the plan sponsor directly or to their employer who then must report it to the plan sponsor; and	• Effective ways to communicate information from the compliance officer to others including physical postings of information, e-mail distributions, internal websites, and individual/group meetings with the compliance officer.
Offshore Subcontracting (CMS issued guidance 08/15/2006 and 07/23/2007; and 2008 Call Letter.)	
FDRs that engage in offshore subcontracting (CMS issued guidance 07/23/2007, *https://www.hhs.gov/guidance/sites/default/files/hhs-guidance-documents/memooffshoremodule_08.26.08_68.pdf* and *https://www.hhs.gov/guidance/document/offshore-subcontractor-data-module-hpms) must have policies that:*	
• Ensure that PHI and other personal information remain secure. • Appropriately limit subcontractor's access to Medicare data;	• Allow for immediate termination of the subcontractor upon discovery of a significant security breach; and • Include language that requires compliance with applicable laws and regulatory guidance.
Exclusion Screening, Oversight, and Records	
FDR must have policies that:	
• Ensure that no people or entities are excluded or become excluded from participation in federal programs. See Social Security Act 1862(e)(1)(B), 42 CFR 422.752(a)(8), 423.752(a)(6), 1001.1901.	• Describe oversight of FDRs and the process to monitor and audit FDR; and • Specify retention of compliance-related records for ten (10) years, or longer if required by applicable. Law.
Completion of the Gold Kidney FDR form is required annually.	

Disclosure of Ownership and Control Interest and Management Statement

Gold Kidney Providers must fully comply with all state and federal requirements for disclosure of ownership and control, interest and management, business transactions, and information for persons convicted of crimes against federal-related healthcare programs, including Medicare and Medicaid programs. See 42 CFR

422.500, 42 CFR 422.222, and 42 CFR 455 (as applicable).

A full and accurate disclosure of (1) direct or indirect ownership in the disclosing entity and/or (2) ownership interest in an obligation of the disclosing entity, is required and must.

Be reported to Gold Kidney if it equates to an ownership interest of five percent (5%) or more in the disclosing entity or at least five percent (5%) of the value of the property or assets of the disclosing entity, respectively.

Providers may contact their Network Management Specialist directly at (888) 750-0080 or email *providercontracting@goldkidney.com* for more information.

Chapter 11: Member Appeals and Grievances

CMS requires Gold Kidney to establish and maintain meaningful procedures for the timely resolution of Member Appeals and Grievances on both a standard and expedited basis.

Gold Kidney does not delegate Member Appeals and Grievance functions to providers. Members should be directed to contact Gold Kidney Member Services at (844) 294-6535.

Help us Help the Member
Should the provider receive a Member grievance, the provider should report to Gold Kidney Member Services immediately at (844) 294-6535**.**

The following table describes the difference between Appeals and Grievances and provides a summary of the relevant timeframes:

Appeal	**Grievance**
An Appeal is a review of an adverse Organization Determination, including Part D Coverage Determinations. The first step of the Appeals process is a "Request for Reconsideration" (Redetermination for Part D)	Any complaint or dispute (other than of an Organization Determination) expressing dissatisfaction with the way a health plan or delegated entity provides health care services, regardless of whether any remedial action can be taken
Examples	
• Reconsideration of the pre-service denial • Reconsideration of determination of co-payment amount • **Part D:** Redetermination of drug denial based on medically accepted off-label use	• Problems getting an appointment. • Disrespectful or rude behavior by doctors, nurses, or other staff • **Part D:** General complaint about a drug being excluded from Part D coverage
Who May File	
Enrollees, their representatives (appointed or authorized), and certain providers, see below.	Enrollees and their representatives (appointed or authorized)
Time Frames (All timeframes are calendar days unless stated otherwise)	
To Request	

Sixty (60) days from receipt of denial (extension may be granted)	Sixty (60) days from the date of the event
To Render a Decision and Notify Member and Provider (from receipt of request)	
Standard	
Pre-Service: Thirty (30) days (fourteen (14) day extension may be allowed) **Payment:** Sixty (60) days **Part D:** Seven (7) days	Thirty (30) days (fourteen (14) day extension may be allowed)
Expedited	
Pre-Service and Part D: Seventy-two (72) hours **Payment Requests:** Cannot be expedited	Twenty-four (24) hours (where criteria are met)

Further Levels of Review	
Second Level: Independent Review Entity (IRE) **Third Level:** Administrative Law Judge (ALJ) Hearing **Fourth Level:** Medicare Appeals Council **Judicial Review:** Federal District Court	Enrollee may file a complaint with the QIO in addition to or instead of a Grievance.

The foregoing is a resource only. Different rules may apply depending on whether the Appeal and/or Grievance falls under Part C or Part D. For information regarding Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance, please see *https://www.cms.gov/////Parts-C-and-D-Enrollee-Grievances- Organization-Coverage-Determinations-and-Appeals-Guidance.pdf*.

Requesting Reconsideration/Redetermination on Behalf of a Member Part C: Normally, the right of Appeal for a denial of an Organization Determination belongs solely to the Member. However, CMS allows a physician who is providing treatment to a Member, upon providing notice to the Member, to request Reconsideration on the Member's behalf. In such a case, the physician is not required to submit proof that he/she is the Member's representative.

Part D: The Member's prescribing physician or other prescriber may request Redetermination of a Coverage Determination on behalf of the Member. Notice to the Member may be required depending upon the circumstances. See *https://www.cms.gov/////Parts-C-and-D-Enrollee-Grievances-Organization-Coverage- Determinations-and-Appeals-Guidance.pdf* for CMS guidance.

To initiate a Request for Reconsideration/Redetermination on behalf of a Member under Part C or Part D, physicians can contact Gold Kidney Member Services at (844) 294-6535. For Part D, Physicians can also initiate a request for a Redetermination/Redetermination electronically on Gold Kidney's website at: *https://www.goldkidney.com.*

Continuing Benefits While an Integrated Reconsideration Is Pending:
The Member, or a Member's representative or provider, may request that the Member continue to receive the previously authorized service or item at the previously authorized level while the integrated reconsideration is pending if:

- The request for continuation and the integrated reconsideration are both filed timely, that is, within ten (10) calendar days after the notice of the Organization's Determination
- An authorized provider ordered the service or item,
- The integrated appeal involves the termination, suspension, or reduction of previously authorized services, and
- The period covering the initial authorization has not yet expired.

Please refer to *Chapter 13: Claims*, for more information regarding provider disputes and appeals.

Chapter 12: Gold Kidney's Quality Improvement (QI) Program

CMS Requirements

*MA Organizations must have a **Quality Improvement Program** to ensure the necessary infrastructure to coordinate care, and to promote quality, performance, and efficiency on an ongoing basis.*

*MA Organizations must: Develop and implement a **chronic care improvement program** and **quality improvement projects**. Develop and maintain a **health information system**.*

*Encourage providers to **participate in CMS and HHS QI initiatives**.*

*Implement a program review process for **formal evaluation of the impact and effectiveness of the QI Program** at least annually.*

***Correct all problems** that come to its attention through internal surveillance, complaints, or other mechanisms.*

*Conduct the **Medicare CAHPS® satisfaction survey**.*

***Measure performance** and report using standard CMS measures; and*

***Develop, compile, evaluate, and report** certain measures and other information to CMS, its Members, and the public. See 42 CFR 422.152.*

Gold Kidney does not delegate Quality Management (QM); however, Gold Kidney network providers are required to meet quality standards and comply with Gold Kidney's Quality Improvement Program, which includes, but is not limited to, the following requirements:

- Routine reporting of delegate data (i.e., HEDIS, ODAG, ODR).
- Providing access to documents, medical records, data, and/or information required as part of quality of care and quality improvement activities; and
- Allowing access to office site(s) and medical record keeping and documentation
- Providers and practitioners agree to allow Gold Kidney to use performance data received for the development of quality improvement initiatives and programs, population health management, public reporting to consumers, and network design.
- Practitioners/providers consent to PLAN's use of data related to my performance for Quality Improvement activities.

The performance data collected will be used for Gold Kidney's Quality Improvement Program which is designed to evaluate and improve the quality of care and/or services in collaboration with the contracted provider network objectively and systematically. The program ensures that meaningful and relevant programs based on nationally recognized research, evidence, and best practices are implemented to improve member experience and outcomes.

Practitioners participating in Gold Kidney are expected to cooperate with the Quality Incentive Program to improve the quality of care and services in addition to member experience. Gold Kidney will request from provider information to include but not limited to the collection and evaluation of data and participation in the Gold Kidney QI program with the following documents:

1. Contract
2. Amendment
3. Claims Data
4. Clinical Documentation
5. Additional documentation outlined in the contract

The Quality Improvement Program encompasses both clinical and non-clinical care and services for all Gold Kidney Members in all Gold Kidney Health Plan contracts. The program activities apply to:

- All medical and mental health care and services, both clinical and non-clinical, are.
  Provided to Members through the health plan and contracted providers and vendors.

Gold Kidney has adopted the Aims established by the Institute for Healthcare Improvement (IHI) in connection with Gold Kidney's Quality Improvement (QI) goals. Gold Kidney's quality initiatives are in pursuit of these aims:

- Improve the patient's experience of care (including quality and satisfaction).
- Improve the health of the population; and
- Reduce the per capita cost of health care.

Gold Kidney believes that members are the architects of their care and are vital to the healthcare team. By partnering with members, their families, and providers we build a foundation for successfully achieving quality outcomes. Collaboration is integrated into all components of member enrollment, healthcare delivery, and oversight. These activities are aimed at improving safety for our members and include the following intended outcomes:

- Reduced sentinel events
- Reduced medication errors
- Reduced use of high-risk medications
- Appropriate levels of utilization
- Increased compliance with standards of care
- Services/Care are provided by a quality network of contracted facilities.

Gold Kidney is person-centered and adheres to the Institute of Medicine's definition of patient-centered care as "care that is respectful of, and responsive to, individual patient preferences, needs, and values" and ensures that the member experience is excellent. Gold Kidney evaluates the appropriate cultural and linguistic services provided through a Patient Satisfaction Survey of its Care Management programs and focuses on the following outcomes:

- Attainment of member-centered goals
- Improved member experience with the health plan and its programs

Health Outcomes

Effective Care Coordination matches populations with appropriate care and services to ensure positive health outcomes. Care Management and Care Transition programs are the primary population-based interventions Gold Kidney uses to ensure effective care coordination. Gold Kidney also conducts specific member quality interventions when there are barriers to effective care coordination. While these interventions are applied to all Gold Kidney populations, the Chronic Special Needs Plans have specific requirements that are articulated in the Gold Kidney Models of Care. These activities result in the following outcomes:

- Reduction in readmission rates year over year
- Reduced admissions for ambulatory care-sensitive diagnoses
- Timely access to needed care.
- Improved communication among providers
- Improved continuity of services
- Improved coordination between medical and behavioral health

Patient Experience

To achieve improved health outcomes, physicians and office staff should:

- Schedule all patients for an annual wellness visit to evaluate and manage chronic conditions and close care gaps.
- Manage care transitions between inpatient and outpatient settings by engaging with patients and reconciling medications post-hospitalization.
- Assess and provide treatment options for common geriatric conditions like fall risk, urinary incontinence, and maintaining physical activity.
- Assess and provide treatment for mental health.
- Collaborate with specialists and other clinicians to ensure patients receive timely access to care.
- Assist patients in navigating and coordinating their care, such as assisting with appointment scheduling with specialists and engaging patients in their treatment plans.
- Reconcile patient medications to ensure patients understand their prescriptions and reduce barriers to non-adherence.

Gold Kidney and providers/provider groups can work together to achieve these outcomes by:

- Sharing data and reports including gaps in care, encounter submissions, and performance data, and acting as needed
- Participating in Gold Kidney's provider orientation and education programs.
- Providing documentation and patient records as requested by Gold Kidney

Gold Kidney provides provider quality education programs intended for provider groups and physicians looking for guidance on how best to improve their performance against several measures that CMS uses to evaluate and reward successful implementation of best practices in healthcare.

Access and Affordability

At Gold Kidney, we focus on improving affordability by monitoring appropriate utilization, and benefit design, working to improve health thereby preventing costly hospitalizations, and implementing programs to detect and prevent fraud, waste, and abuse. These efforts are balanced by a grievance and appeals process and a quality investigation process to ensure access to care. Quality outcomes related to affordability include:

- Utilization metrics within accepted benchmarks

- Maximum out-of-pocket costs following Medicare regulations.
- Reduced ambulatory care sensitive admissions.
- Reduced readmissions
- Medication adherence

QI activities are communicated to network providers through Quality Committees, individual provider performance reporting, provider Bulletins and Newsletters, and the Gold Kidney Website. The QI Program is available upon request. For more information, please contact your Utilization Management Department.

Chapter 13: Fraud, Waste, and Abuse

Providers must abide by all applicable fraud, waste, and abuse laws including laws and regulations designed to prevent or ameliorate fraud, waste, and abuse including, but not limited to, applicable provisions of federal criminal law, the False Claims Act (FCA) (31 USC 3729 et. seq.), and the Anti-Kickback Statute (section 1128B(b)) of the Act; 42 USC 1320a-7b(b). (See 42 CFR 422.504(h)(1)).

This Chapter outlines provider obligations concerning eliminating fraud, waste, and abuse and provides education and other resources for providers.

Examples of fraud, waste, and abuse include, but are not limited to:

- Billing for procedures not performed.
- Physician kickbacks for referrals.
- Authorizing and/or billing for services not medically necessary (i.e., acute inpatient instead of observation, advanced life support ambulance services instead of basic life support ambulance services, etc.).
- Certifying terminal illness when criteria are not met.
- Obtaining benefits without medical necessity (i.e., glucose test strips, incontinence supplies, or enteral, etc.) and reselling.
- Billing for services that do not meet CPT/revenue code descriptions.
- Falsifying information in a medical record/claim.
- Improper bundling/coding of charges.
- Misrepresentation by a Member/provider to seek benefits.
- Unsupported risk adjustment data (including encounter data) submitted to CMS.
- Inaccurate Prescription Drug Event (PDE) and Direct/Indirect Remuneration (DIR).
- Incorrect Low-Income Premium Subsidy for Employer Group Waiver Plans.
- Improper Opioid Prescription/Dispensing; and/or
- Incorrect enrollment into MA plans, Part D plans, and other government programs.

Investigation Process and Overpayment Recovery

Gold Kidney reviews all reports of fraud, waste, and abuse. Allegations and investigative findings may be reported to appropriate regulatory and law enforcement agencies. In addition to reporting, Gold Kidney may take corrective action, including but not limited to, recovery of overpayments. *Chapter 13: Claims* describes the overpayment recovery process for fee-for-service claims. In the case of capitated agreements, Gold Kidney may also adjust capitation payments necessary to affect the recovery of an overpayment following 42 CFR 401.301-305 and 42 CFR 438.608(d).

Provider Responsibilities

To meet regulatory requirements, providers are required to:

Be Diligent and Immediately Report Suspected Fraud, Waste, and Abuse

- Watching suspicious activity and red flags; and
- **Immediately** report suspected fraud, waste, and abuse that affects Gold Kidney or Gold Kidney Members, or retaliation for making such a report:

  By Web: *https://www.compliance@goldkidney.com*
  By E-Mail: https://goldkidney.com/fraud-waste-and-abuse-referral-form/
  By Phone: (4 8 0)-863-1196 TTY:711

All reports will be kept confidential to the extent possible and following applicable law. Providers may also report directly to the Federal Department of Health and Human Services (HHS) or the Office of the Inspector General (OIG):

By Phone:	(800) HHS-TIPS (800) 447-8477)
By E-Mail:	*HHSTips@oig.hhs.gov*
By Mail:	Office of the Inspector General HHS TIPS Hotline, P.O. Box 23489, Washington, DC 20026

Cooperate with Gold Kidney Investigations, Resolve Issues, and Protect Your Employees from Retaliation

- Cooperate with Gold Kidney's investigation of potential fraud, waste, and abuse, including timely responding to requests for medical records and other information.
- Cooperate with any corrective action requested by Gold Kidney to resolve reports of potential fraud, waste, and abuse (including return of overpayments).
- Cooperate with referrals to law enforcement and/or regulatory agencies, and
- Do not retaliate against employees who act lawfully in furtherance of an action under the FCA, including investigation for, initiation of, testimony for, or assistance in an action filed, or to be filed under the FCA. Retaliation includes but is not limited to, discharge, demotion, suspension, threats, harassment, or any other manner of discrimination against the employee in terms and conditions of employment.

Training and Education

- Provide fraud, waste, abuse, general compliance, and specialized training as required by CMS (See *Chapter 15: Delegation Oversight*).
- Require completion of training as a condition of employment or contracting.
- Participate in other fraud, waste, abuse, and compliance training opportunities; and
- Educate other providers, Members, and vendors when opportunities arise.

Compliant Policies, Procedures, and Practices

- Establish and maintain appropriate policies, procedures, and practices – update regularly to address trends in fraud, waste, and abuse (e.g., prescription drug abuse.

And hospice enrollment fraud).

- Strive for accuracy and excellence in service, coding, and billing.
- Document Member medical records properly and accurately (e.g., do not up-code, do not bill for services not rendered/not Medically Necessary, unbundle services, do not submit duplicate billing, etc.).
- Safeguard privacy; and
- Maintain records accurately and timely.

Monitoring and Oversight

All providers delegated to perform functions on behalf of Gold Kidney are audited on a routine basis to determine compliance with CMS and other requirements related to eliminating fraud, waste, and abuse. (See *Chapter 15: Delegation Oversight* for specific information).

Fraud, Waste, and Abuse Resource Sheet
Applicable Laws
Civil False Claims Act (FCA) (31 USC 3729 et seq.)
Allows a civil action to be brought against any person or entity who, among other things: (a) Knowingly presents, or causes to be presented, a false or fraudulent claim for payment or approval to any federal employee; (b) Knowingly makes, uses, or causes to be made or used a false record or statement to get. a false or fraudulent claim paid; or (c) Conspires to defraud the government by getting a false or fraudulent claim allowed or paid.
Program Fraud Civil Remedies Act of 1986 (38 USC 3801 et seq.)
This statute amended the FCA, among other things, to extend liability to any person or entity that knowingly makes, uses, or causes to be made or used, a false record or statement to conceal, avoid, or decrease an obligation to pay or transmit money or property to the Government.
Fraud Enforcement and Recovery Act of 2009 (FERA) (31 USC 3729)
This statute amended the FCA, among other things, to provide that FCA liability may attach to whether there is intent to defraud the government (it is sufficient that the false statement is material to a false claim). Therefore, many types of innocuous overpayments could now potentially lead to FCA liability.
Patient Protection and Affordable Care Act and Health Care & Education Reconciliation Act of 2010 (PPACA) (42 USC. 18001 et seq)
PPACA, among other things, requires that: overpayments be reported and returned sixty (60) days after they are identified; items/services be prescribed by a Medicare-enrolled physician or other eligible professional; physicians have a face-to-face encounter with a patient before prescribing; and maintain and provide upon request documentation for certifications for DME or home health services. The PPACA increases civil monetary penalties (CMPs) for making false statements to federal health care programs. Or for delaying inspections, suspending payment during fraud investigations, and expanding the RAC program to include Part C & D.
The Deficit Reduction Act of 2010 (DRA) (42 USC 1396h(a))
The DRA, among other things, requires that any entity that receives or makes payments under the state Medicaid/Medi-Cal plan of at least five million ($5,000,000) per year provide certain information to its employees, contractors, and agents concerning federal and state false claims act provisions, penalties, and protections.
Anti-Kickback Statute (42 USC 1320a-7b(b))

It is a felony to knowingly and willfully offer, pay, solicit, or receive any remuneration to induce or reward. Referral of items or services paid in whole or in part by a federal health care program. Remuneration includes the transfer of anything of value, directly or indirectly, overtly, or covertly, in cash or kind.

Physician Self-Referral Prohibition Statute (42 USC 1395nn)
The "Stark Law" prohibits a physician from making a referral for certain designated health services to an entity in which the physician (or a Member of his or her family) has an ownership/investment, interest, or with which he or she has a compensation arrangement unless an exception applies.
Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act of 2018 (H.R.2028 Section 195, H.R.6, Section 6063)
Effective in 2022, the SUPPORT Act requires that plans implement drug management programs for at-risk beneficiaries (H.R. 2028 Section 195).

Penalties	
Penalties for violating fraud, waste, and abuse laws include:	
The employee subject to unlawful retaliation is entitled to all relief necessary to make the employee whole including reinstatement with the same seniority status, 2x back pay and interest, special damages, litigation costs, reasonable attorneys' fees, and, where appropriate, punitive damages.	• Violation of the FCA or the California FCA is punishable by a civil penalty of not less than five thousand five hundred dollars ($5,500) and not more than eleven thousand dollars ($11,000) per claim*, plus 3x the damages the Government sustains. • Suspension of payment • Potential criminal liability
* *Each separate bill, voucher, or other false payment demand constitutes a separate claim.*	
Penalties for violating the Anti-Kickback Statute:	Penalties for violating Stark Law:
• Criminal: fines up to twenty-five thousand dollars ($25,000) per violation and up to five (5) year prison term per violation • Civil/Administrative: FCA liability, program exclusion, potential fifty thousand dollars ($50,000) CMP per violation, and civil assessment up to 3x amount claimed	• Overpayment/refund obligation • FCA liability • CMPs and program exclusion • Potential fifteen thousand dollars ($15,000) CMP for each service • Civil assessment of up to 3x amount claimed

Chapter 14: Privacy and Health Insurance Portability and Accountability Act of 1996 (HIPAA)

HIPAA Requirements

Acquisition, access, use, or disclosure of PHI in a manner not permitted under HIPAA is presumed to be a breach unless there is a low probability that PHI has been compromised, based on a multi-factored **risk assessment** that includes: (i) the nature and extent of the PHI involved, including types of identifiers and the likelihood of re-identification; (ii) the unauthorized person who used the PHI or to whom the disclosure was made; (iii) whether the PHI was acquired or viewed; and (iv) the extent to which the risk has been mitigated.

For **breaches of PHI**, **notification** of the breach must be provided to **affected individuals**, the **HHS Secretary**, and, in certain circumstances, to other state agencies and the **media**.

Notification must be provided **without unreasonable delay** and **in no case later than sixty (60) days** following the discovery of a breach.

Pub. L. No. 104-191, 110 Stat. 1936 (1996); 45 CFR Parts 160, 162, and 164. For more guidance, see http://www.hhs.gov/hipaa/for- professionals/breach-notification/.

Gold Kidney delegates various Gold Kidney activities to certain providers that involve the use and disclosure of protected health information (PHI), making these delegated providers business associates of Gold Kidney under HIPAA. Further, Gold Kidney recognizes that providers, for the provision of medical services, are also covered entities and therefore have their legal obligations related to HIPAA.

In addition to HIPAA, Gold Kidney, and Gold Kidney providers may be subject to other legal requirements concerning the privacy of Member information. Gold Kidney is required to notify OCR of HIPAA breaches involving 500 or more Members, without unreasonable delay. By meeting the obligations in this Chapter, Gold Kidney, and its providers, ensure that all HIPAA obligations are met.

The business associate agreement (BAA) between Gold Kidney and a delegated provider details the business associate's responsibilities concerning Member PHI, including reporting PHI breaches to Gold Kidney. While timeframes are outlined in each BAA, Gold Kidney requests that providers notify Gold Kidney of Member PHI breaches **as soon as possible** to meet strict regulatory expectations.

For Gold Kidney to meet regulatory expectations, prompt reporting, cooperation, and follow-up from its business associates is critical. Therefore, in the event of a Member PHI breach, providers must do the following:

- Notify Gold Kidney as soon as possible after the discovery of any breach, but no later than the time frame outlined in the provider's BAA. Notice should be addressed to the Gold Kidney Compliance Office via email (preferred) or certified mail to:

Email: *Compliance@goldkidney.com*

Certified Mail: Gold Kidney Health Plan Attention:

Compliance Officer
P.O. Box 285
Portsmouth, NH 03802

- Promptly investigate all breaches and draft an initial incident report that includes, at a minimum:
  - An initial description of the nature and circumstances of the breach.
  - A description of the number of individuals involved.
  - A description of the types of PHIS involved.
  - The date of the incident which caused the breach.
  - The date of discovery of the potential breach.
  - A list of affected Members involved in the breach, including their Gold Kidney ID numbers.
  - Any efforts are taken to mitigate harm to the individuals/Members; and
  - Sufficient information, including the investigative report, to allow Gold Kidney to ensure that Gold Kidney's obligations under HIPAA and other regulatory and contractual requirements are met.
- Cooperate with any Gold Kidney investigation, including providing timely responses to Gold Kidney inquiries regarding the breach.
- Collaborate with Gold Kidney to determine which entity will provide any required notices.
- Work with Gold Kidney to draft any required notices or obtain Gold Kidney's approval for any notice sent on behalf of Gold Kidney before distribution; and
- Ensure providers do not include Gold Kidney's name in any notice to Members without Gold Kidney's prior written approval.

For any questions about breach events, please contact Gold Kidney's Compliance Office at 844-974-5081 or *Compliance@goldkidney.com*.

Chapter 15: Delegation Oversight

Gold Kidney delegates certain activities to contracted providers, and contracted providers must perform these activities in compliance with all applicable state and federal laws, including, but not limited to, Medicare laws and regulations, and CMS guidelines. (See 42 CFR 422.504(i) and CFR 438.230). Gold Kidney, however, remains responsible for the performance of all delegated activities. To ensure that delegated activities are performed satisfactorily, Gold Kidney monitors and audits all delegated activities.

Delegation Determinations

Before delegation, Gold Kidney evaluates and documents the entity's ability to perform the delegated activity following state and federal requirements and Gold Kidney requirements. Upon delegation, each delegated entity is provided with a Delegated Services Agreement (DSA) document that describes in more detail the delegated entity's responsibilities and reporting requirements.

Gold Kidney will send updated DSAs when there are changes in delegation requirements or delegation status. Delegated entities should refer to their contract with Gold Kidney and their most recent DSA for information related to delegated activities.

Gold Kidney maintains the sole discretion to allow the delegation of activities to contracted providers or other entities. Delegated entities may not modify the delegated activities or the obligation to perform the delegated activities (e.g., sub-delegation) without prior written consent from Gold Kidney. Gold Kidney approved modifications for delegated activities may require additional reporting and auditing requirements, to ensure Gold Kidney has full access to delegate data to execute or oversee regulatory activities, for example in the event of approved sub-delegation.

Performance of Delegated Activities

Delegated entities are responsible for the performance of all delegated activities, including reporting requirements, following all applicable laws, their contract with Gold Kidney, this Provider Administrative Guide, and the DSA. Delegated entities may utilize their policies and procedures to perform delegated activities, provided to the extent that such policies and procedures are consistent with Gold Kidney's requirements. If the delegated entity's policies and procedures are inconsistent with Gold Kidney requirements, Gold Kidney requirements apply.

Delegated entities remain responsible for the performance of all delegated functions, even functions performed by subcontractors. Delegated entities are required to evaluate subcontractors' performance of delegated activities by monitoring and audits. Please see the provider contract with Gold Kidney for subcontracting requirements.

Delegates and Credentialing System Controls

Gold Kidney delegates must utilize Credentialing System security controls to protect data from unauthorized modification, including but not limited to limiting physical access to servers, files, and the operating environment that houses credentialing information, preventing unauthorized access, changes to and release of credentialing information, and password-protecting electronic systems. Gold Kidney Credentialing Delegates must provide the following system controls:

(1) Limiting Physical Access Operating Environment:

a. Limit physical access to the operating environment that houses credentialing information, to protect the accuracy of information gathered from primary sources and NCQA-approved sources.

b. Physical access may include but is not limited to, the organization's computer servers, hardware, and physical records and files.

i. "Physical access" does not refer to the organization's building or office location.

(2) Preventing Unauthorized Access and Changes to Data

a. Prevent unauthorized access, changes to, and release of credential information.

(3) Password-protecting electronic systems.

a. Utilize password-protected electronic systems, including user requirements to:

i. Use strong passwords.

ii. Discourage staff from writing down passwords.

iii. Use IDs and passwords unique to each user.

iv. Change passwords when requested by staff or if passwords are compromised.

b. Disabling or removing passwords of employees who leave the organization and alerting appropriate staff who oversee computer security.

On an annual basis, delegates must audit system control policies and procedures to ensure compliance with NCQA system control requirements. Delegates will review and ensure their internal system control monitoring process is compliant with these system control requirements.

On an annual basis, the delegate shall monitor their credentialing system security controls by identifying all modifications to credentialing and re-credentialing information that did not meet the organization's policies and procedures for modifications, analyzing all instances of modifications that did not meet the organization's policies and procedures for modifications, acting on all findings and implementing a quarterly monitoring process until it demonstrates improvement for any non-compliant finding over three consecutive quarters. If the delegates' CR system cannot identify all non-compliant modifications the delegate shall conduct an audit of delegate files, using the following sampling methodology:

Delegate randomly selects 5% or 50 files, whichever is less, from each applicable file type universe, to review against the requirements:

- Credentialing and recredentialing. (5% or 50 files total)

- At a minimum, the sample includes at least 10 credentialing files and 10 re-credentialing files. If fewer than 10 practitioners were credentialed or credentialed since the last annual audit, the organization audits the universe of files rather than a sample.

The sample size will be based on all files in the file universe and whether modifications have been made to the file. The Audit Sample will be selected from files that have had modifications.

If the Delegate identifies any modifications that did not meet the delegation agreement or the delegate's policies and procedures, the delegate will be required to submit quarterly monitoring reports, until it demonstrates compliance over three consecutive quarters.

Delegation Status, Revocation, and Resumption

Gold Kidney will grant delegation to entities that have demonstrated the ability to perform delegated functions through pre-delegation and ongoing monitoring and audit activities. Delegated entities who fail to meet monitoring and/or auditing standards may be subject to corrective action and more frequent and/or focused audits. Delegation status to the delegated entity is subject to change, dependent on the entity's performance.

Per CMS regulations, Gold Kidney or CMS also may revoke delegated activities, or specify other remedies, in instances where CMS or Gold Kidney determines that a delegated entity has not performed satisfactorily.

Delegated Reporting

- Reporting is Semiannually/Annually
- Reporting includes but is not limited to the following:
    - Annual Role-Based Access Report
    - Annual Terminated Employee Staff Report
    - Annual Security Badge Access Report
    - Annual Password Change Reports
    - System Access Report
    - Quarterly Delegated Rosters
    - Credentialing System Controls Oversight
    - Credentialing Committee Minutes
    - Verification of Credentialing
    - Policies and Procedures

Reporting from the Delegates is presented at the Delegation Oversight Committee.

Gold Kidney Oversight Committee Structure

Delegation Oversight Committee

The multi-disciplinary Delegation Oversight Committee (DOC) is responsible for (1) establishing and maintaining a formalized, comprehensive oversight program for monitoring delegated

functions and services provided by contracted health care providers including FDRs; (2) overseeing Gold Kidney's network providers' compliance with contractual and regulatory requirements; and (3) overseeing efforts to correct identified deficiencies and/or non-compliance.

Credentialing Committee

The Gold Kidney Credentialing Committee is responsible for developing and maintaining a comprehensive credentialing and re-credentialing process, making credentialing and re-credentialing decisions, monitoring the quality of care and services, and providing guidance for continuous quality improvement to meet NCQA, CMS, and applicable state requirements. Credentialing decisions are made on a fair and impartial basis, according to predetermined criteria related to professional conduct and competence, not based on an applicant's race, gender, age, ethnic origin, sexual orientation, or type of patients or procedures in which the provider specializes.

Audits

In addition to ongoing monitoring, delegated entities are subject to annual audits, focused audits, re-audits, and exigent/ad hoc audits.

- **Annual Audits**: Annual audits are conducted on a routine, scheduled basis depending on delegation status.
- **Focused Audits or Re-Audits**: A focused audit or re-audit is usually conducted when some aspect of an annual audit reveals non-compliance or is at the discretion of the DOC.
- **Exigent/*ad hoc* Audits**: An exigent or *ad hoc* audit is conducted when Gold Kidney determines there is a reasonable need for a non-routine audit (e.g., Gold Kidney becomes aware that a provider delegated for claims payment has experienced an event or series of events that might materially affect its ability to pay claims promptly). Exigent or ad hoc audits may be conducted without notice. However, to allow delegated entities to arrange for the necessary resources and staff, the audit team will notify the delegated entity one (1) hour before arriving on site.

Providers are required to submit reports to effectuate audit activities (e.g., quarterly, and annual financial statements in connection with the financial audit/monitoring). Gold Kidney notifies Providers annually of the reporting requirements. Failure to submit required reports may result in increased oversight, corrective action, or other appropriate action.

Gold Kidney's Delegated Oversight Compliance team will work with the delegated entity to schedule an audit unless an exigent or ad hoc audit is required.

Except for unscheduled exigent/ad hoc audits, once an audit date is set, the delegated entity will receive an audit confirmation letter that includes information about the audit scope, how to prepare for the audit, and other information that may be necessary to conduct the audit. Failure to timely comply with audit requests may result in corrective action, de-delegation, or sanctions.

Audit Results and Corrective Action

The results of the audit and any requests for corrective action will be returned to the delegated entity within thirty (30) to forty-five (45) calendar days of the date of the audit. Corrective action may be required in addition to other remedies or sanctions (e.g., placing the delegated entity on financial watch status). See the Sanctions section below in this Chapter. Corrective action required by Gold Kidney is separate and distinct from corrective action that may be required by third

parties (e.g., corrective action required by state regulators). Gold Kidney will consider corrective action by third parties as corrective action for noncompliance with a contractual or regulatory requirement, however, Gold Kidney is not required to accept such action.

Unless otherwise agreed to in writing, delegated entities have thirty (30) calendar days from the receipt of the corrective action request to submit a completed corrective action plan (CAP) to Gold Kidney. CAPs must include:

- A root cause analysis that describes the symptoms and underlying causes that resulted in noncompliance and steps to prevent future noncompliance.
- The expected corrective actions the entity will take to remediate and prevent future noncompliance.
- The date(s) the corrective action is expected to be completed and timeframes for specific achievements.
- The ramifications for failure to implement the corrective action successfully; and
- The staff is responsible for the implementation of corrective action.

The following are examples of deficiencies that may warrant corrective action:

- The provider is unable or unwilling to provide the information needed to conduct the audit or otherwise fails to cooperate with audit activities.
- The provider is unable or unwilling to take action to comply with legal or contractual requirements (e.g., pay claims following CMS requirements or reserve funds for Incurred but Not Reported (IBNR) claims).
- Provider lacks written policies and procedures sufficient to meet legal or contractual obligations (e.g., a policy requiring that provider report potential fraud, waste, and abuse to Gold Kidney); and
- The provider fails to maintain documentation sufficient to meet legal or contractual obligations (e.g., incomplete documentation for CMS-required training and/or screening).

Failure to cooperate with a Gold Kidney request for corrective action may result in further corrective action, de-delegation, or sanctions.

Sanctions

If a delegated entity fails to cooperate with an audit/monitoring efforts or fails to complete a CAP, Gold Kidney may institute sanctions which may include the following, unless expressly stated otherwise in the provider's contract with Gold Kidney:

- Termination of the provider contract with Gold Kidney.
- Request a letter of credit and/or other proof that the organization has access to sufficient funds for the payment of claims for healthcare expenses; and
- Exclude the provider from the Gold Kidney network.

Depending on the nature of the deficiencies, Gold Kidney may apply sanctions without first requiring a CAP.

Audit Summaries

The following tables provide an overview of delegation oversight activities. Please email Gold Kidney's DOC for additional information at Compliance@goldkidney.com.

<table>
<tr><td colspan="2">Credentialing (Providers delegated for credentialing activities)
• Delegated entities must meet all CMS requirements regarding credentialing. (See Chapter 10: Network Standards)
• Gold Kidney uses the current HICE Audit Tool
• Credentialing Delegated Entities are to submit documents to the Credentialing Department at the email labeled: credentialing@goldkidney.com</td></tr>
<tr><td colspan="2">Frequency of Audit (excluding focused audits, re-audits, and exigent/ad hoc audits)</td></tr>
<tr><td colspan="2">• Annual audit</td></tr>
<tr><td colspan="2">Scope of Audit</td></tr>
<tr><td>• Initial credentialing file review
• Recredentialing file review
• Credentialing policies, procedures, and committee
• Adverse actions monitoring & reporting.
• Quarterly credentialing/re-credentialing reports (including rosters/adds, deletions, and changes)
• Practitioner office site quality</td><td>• Ongoing monitoring
• Notification to authorities and practitioner appeal rights
• Assessment of organizational providers
• Delegation of credentialing
• Credentialing System Controls P&Ps and Reports
• Additional information as may be required</td></tr>
<tr><td colspan="2">FDR Compliance Oversight (all delegated entities)
• Delegated entities must meet all CMS downstream requirements for first-tier, downstream, and related entities (FDRs). See the provider contract with Gold Kidney for specific downstream requirements; See also the MMCM, Chapter 21, and the PDBM, Chapter 9.
• Corrective action is required for audits that result in scores of less than 100%.</td></tr>
<tr><td colspan="2">Frequency of Audit (excluding focused audits, re-audits, and exigent/ad hoc audits)</td></tr>
<tr><td colspan="2">• Sub-set selected for annual audit based on internal risk assessment.
• Annual compliance attestation component</td></tr>
<tr><td colspan="2">Scope of Audit</td></tr>
<tr><td>• Compliance policies and procedures, including detecting fraud, waste, and abuse (FWA)
• Standards of Conduct (aka Code of Conduct)
• General compliance and FWA training
• Exclusion screening
• Compliance Issue – Resolution and Reporting</td><td>• Monitoring and auditing of FDRs
• Offshore subcontracting
• Record retention policy.
• Downstream provider contracts
• Additional information may be required.</td></tr>
<tr><td colspan="2">Frequency of Audit (excluding focused audits, re-audits, and exigent/ad hoc audits)</td></tr>
<tr><td colspan="2">• Quarterly financial review
• An audit is performed based on failure to meet financial solvency requirements.
•</td></tr>
<tr><td colspan="2">Scope of Audit</td></tr>
</table>

• Financial Audit Questionnaire • Financial statement review • IBNR claims review	• Stop loss insurance. • Claims Payable Report • Additional information may be required. •
Financial Review-Quarterly Statements and Annual Financial Reports	
Every quarter, Gold Kidney will send a reminder via email for documents for quarterly review, including unaudited financial statements. Please remit the documents to the email sender's address. Documents are due to Gold Kidney on May 15th (for January 1 – March 31), August 15th (for April 1 – June 30), Nov. 15th (for July 1 – Sept. 30), and Feb. 15th (for Oct. 1 – Dec 31).	

Any organization in a risk-sharing arrangement with Gold Kidney must maintain these ratios throughout each quarter: • Positive Tangible Net Equity • Cash Claims ratio of at least 75%. • Positive Working Capital	Gold Kidney will also review the following ratios to evaluate an organization's financial status: • Debt to Equity • Days of Cash on Hand • Medical Loss • Acid Test
Monthly Review	
If an organization is placed on financial watch, a monthly review of the financial status of the organization will be required. This monthly review may include monthly unaudited financial statements, an updated Provider Financial Questionnaire, a Claims Payable Report, and others. Financial documents.	
Claims Audit (Providers delegated for claims processing activities) • Delegated entities must meet all CMS requirements regarding claims. (See *Chapter 4: Claims*, for more information regarding these requirements).	
Frequency of Audit (excluding focused audits, re-audits, and exigent/ad hoc audits)	
• Annual audit with monthly reporting component or semi-annual, if indicated based on annual risk assessment	
Scope of Audit	
• Inventory management reports. • Reports on pending claims • Medicare Advantage claims processing policies and procedures • Training materials • Organizational structure • Information systems (IS) • HICE Operational Review Questionnaire • Claim and claim supporting areas. • Testing of contracted provider status	• Claim adjudication review, which may include: ◦ Non-contracted provider claims (including but not limited to unclean claims) ◦ The contracted provider paid claims. ◦ Unaffiliated provider denials ◦ Denied claims with Member liability* ◦ 1st-level provider dispute resolution claims ◦ Reopened claims • Misdirected claims • Attestations and supporting copies. • Excluded providers. • Direct Member Reimbursements (DMR) • Additional information may be required
* If the provider is placed in retrospective review status for claim denials, 100% of denials must be submitted weekly for review.	
Monthly Reporting of Claims Processing Timeliness	

All delegated entities must report claims processing timeliness monthly, using the current version of the HICE Monthly Medicare Advantage Claim Timeliness Report. The report is available at: http://www.iceforhealth.org/. This report should be faxed/e-mailed in time to be received by the 15th of the month following the month being reported.
Quarterly Reporting of Misdirected Claims
All delegated entities must report claims that were received but determined to be payable by another entity (e.g., Gold Kidney, another medical group, a capitated provider, etc.). The Misdirected Claims Log template (based on the HICE template) will be provided by Gold Kidney to each delegated entity and must be submitted to Gold Kidney via email or SFTP by the 15th calendar day following the end of each calendar quarter: January, April, July, and October.
Utilization Management (Providers delegated for utilization management activities) Delegated entities must meet all CMS requirements regarding utilization management. (See *Chapter 7: Utilization Management* for more information).
Frequency of Audit (excluding focused audits, re-audits, and exigent/ad hoc audits)
• Annual audit • Annual C-SNP component for providers delegated for C-SNP • Monthly, quarterly, semi-annual, and annual reporting components

Scope of Audit	
• Utilization management program description • Physician involvement • Behavioral health practitioner involvement • Annual evaluation • Consistency in applying criteria. • Communication services • Appropriate professionals • Use of Board-certified consultants • Affirmative statement about incentives • Timeliness of decisions and notifications • Policies for Appeals • Emergency Services • Delegation • Adequate and appropriate access to care • Direct access to in-network women's health specialists for routine and preventative services • Arrangements for Specialty Care • Population Health Management • ODAG mail authorization process • Ambulatory case management	• Health education and Cultural Linguistics • Services are provided with cultural competence. • Initial Health Risk Assessments • Advance Directives • Nondiscrimination • Evidence of no prohibition on health care professional advice to patients • Adherence to Medicare Marketing Guidelines • Provider access during a federal disaster or public health emergency declaration • Specialist termination notifications • Clinical practice guidelines • Continuity of care and coordination of care • Standing referrals • Continuing services by a terminated provider • U.S. Preventive Services Task Force • Quality management and improvement program Requirements • Out-of-network/out-of-area contractual agreements and denial process • Additional information may be required
Scope of UM Service Denial Audit	

• Timely Organization Determinations • Timely notification to Members • Correct letter template • Appropriate criteria for denial • Relevant clinical information for decisions • Appeal rights provided	• Accuracy of notifications • Alternate treatment options are provided to Members. • Language (8th-grade level definition of medical terminology, defined acronyms when used) • Additional information as may be required
Scope of SNP Audit (Providers delegated for SNP only)	
• Description of care management program description. • Population assessment • The care management assessment process • Individualized Care Plan (ICP)	• C-SNP MOC training requirements • C-SNP Trigger Report • C-SNP Transition of Care (TOC) • Ongoing care management • Additional information as may be required
Organization Determinations, Appeals, and Grievances (ODAG) and Organization Determinations and Reconsiderations (ODR) (all delegated entities) • *Delegated entities must submit timely, complete, and accurate ODAG and ODR data for CMS submission. Corrective action is required for audits that result in a score of less than 100%.*	
Frequency of Audit (excluding focused audits, re-audits, and exigent/ad hoc audits)	
• ODAG audits are conducted quarterly. • ODR audits are conducted annually	
Scope of Audit	
• Accurate and complete universe data	

Chapter 16: Encounter Data

CMS Requirements

MA Organizations must:

*Submit complete data that **conforms to CMS' requirements** for MAPD data equivalent to Medicare fee-for-service data, as well as other relevant national standards.*

*Submit encounter data **electronically to the appropriate CMS contractor.** Data must come from the provider, supplier, physician, or other practitioner that furnished the item or service. See 42 CFR 422.310(d).*

*Submit **medical records for the validation of encounter data**, as required by CMS. There may be penalties for submission of false data. See 42 CFR 422.310(e).*

***Certify** (based on best knowledge, information, and belief) the **accuracy, completeness, and truthfulness** of all data submitted. 42 CFR 422.504(l)(3).*

Submission of timely, accurate, and complete encounter data is a collaborative effort and is crucial to appropriate care and reimbursement. MA Organizations are required to collect and submit encounter data to CMS that conform to Medicare fee-for-service standards for all Medicare-covered services and supplemental services that MA Organization providers perform. (See *422.310(d)(3)-(4), 422.504(d)-(e), (i)(3)-(4), (l)(3)).*

Provider Responsibilities

To meet CMS and other regulatory requirements, Gold Kidney requires providers to:

Submit Complete and Accurate Encounter Data in the Proper Format

- Submit all encounters using the HIPAA Compliant 837 version 5010 transaction set format in conformance with Gold Kidney Encounter Data Requirements:
- Submit encounters directly with Gold Kidney (If authorized), or through a Gold Kidney contracted clearinghouse.
- Submit all claim details for adjudicated claims only, including all applicable billed, paid, adjusted, and denied information.
- Include all information necessary for Gold Kidney to submit data to CMS following applicable CMS requirements.
- Encounter data should reflect all procedures and applicable diagnoses that accurately reflect evaluation and treatment during a single healthcare encounter.
- Document the Member's conditions as specifically as possible (e.g., diabetic with secondary ophthalmologic and renal complications, should not be coded as "diabetes without complications" – complications should be identified in the documentation)
- All supplemental data, including chart review data and added or deleted diagnosis codes, submitted via the Alternative Submission Methodology (ASM) must be submitted in the HICE format and linked to an original 837 encounter. Unlinked

Supplemental data may not be accepted by CMS for EDPS submission. (See "Submission of Supplemental Encounter Data" below)

- Encounter data should accurately reflect the medical record stored at the provider's office.

Companion Guides:
https://www.csscoperations.com/internet/csscw3.nsf/DID/C1QB31Y8ZY

Submit Timely Encounters

- Unless a longer period is expressly allowed in the provider's contract with Gold Kidney, all encounter data should be submitted to Gold Kidney within three (3) months of the date of service (DOS). Timeliness is critical to enable Gold Kidney to comply with regulatory requirements, accurately capture data for medical programs, and impact medical and financial performance. Failure to submit data may result in corrective action and/or penalties.
- Submit all encounter data for CMS sweep periods at least four (4) weeks before CMS deadlines. Gold Kidney reserves the right to audit encounters for appropriateness of quantity and quality and take corrective actions as appropriate.
- Remediate any issue impacting CMS acceptance of the encounter data within one hundred eighty (180) days of notice, including, but not limited to, EDPS errors, 5010 errors, Gold Kidney edits, CMS rejections, etc. Additionally, all rejections must be corrected at least four.
  (4) weeks before the final sweep's submission deadline for the visit's DOS. All deadlines are subject to change at any time should CMS rules change.
- Refrain from resubmitting duplicate encounter data for CMS sweep periods. Only updated, corrected, or new encounter data will be accepted by CMS.
- Providers may reconcile encounter submissions at any time to ensure successful submission to Gold Kidney and CMS (See "Reconciliation Process" below).

Cooperate with CMS and Gold Kidney Audits

- Cooperation with all federal, state, and Gold Kidney audits is mandatory (e.g., Risk Adjustment Data Validation (RADV) audits, Recovery Audit Contractor (RAC) audits, data validation audits, etc.), to ensure accuracy, timeliness, and completeness of submitted results. Providers must additionally provide requested data within specified timeframes. Failure to provide requested support for encounter data submitted to CMS may result in corrective action and/or other impacts and penalties from federal regulators.
- Providers must also cooperate with corrective action(s) requested by Gold Kidney to resolve encounter data issues or errors.

Recommended Monthly Activities

- Perform monthly (but not less than quarterly) reconciliations using the production reports available from Gold Kidney. A few of the most important reports include:
  - Hierarchical Condition Category (HCC) Monthly: contains all HCCs associated with the diagnosis codes for EDPS received during a given DOS.
  - All Diagnosis Code (DX) Monthly: contains a list of all diagnosis codes received during a given DOS.
  - All Patient Control Number (PCN) Monthly: contains a list of all PCNs received during a given DOS.
- Perform monthly corrections for all errors in Gold Kidney Rejection Reports:
  - Rendering Entity (RPX): the national provider identifier (NPI) for the entity was incorrectly provided; correct by providing the NPI for the "individual" provider.
  - Provider Name Mismatch (PNM): the rendering NPI on the encounter is incorrect

and/or does not match with Gold Kidney provider name.

- Full Encounter Data Reports (EDS): contains CMS rejection for EDS "Full Encounter" Data (See Gold Kidney Resolution Guide for instructions on how to fix full encounter data rejections located on the Provider portal).
- Invalid DX: The diagnosis code is invalid during the DOS, or the diagnosis code does not have the required level of specificity per CMS.
- Place of Service (POS) 21-23: The professional encounter has an invalid POS or is missing the corresponding Inpatient (21) or Outpatient (22 or 23) encounter. Either submit missing Inpatient or Outpatient encounters in the 837 format or correct professional encounter POS.
- HICE Pend**:** supplemental diagnosis codes submitted via the HICE file (Alternative Submission Method (ASM)) are not rolling up to an existing 837 parent encounter or the *Member ID, From/Thru DOS, NPI, and Visit Type* on the HICE submission does not match the parent 837 encounter. Correct by submitting parent 837 or ensuring the HICE encounter matches with the five key data elements on the parent 837 encounter.
- Inconsistent Condition Data Validation (ICDV): medical conditions that are unlikely to be addressed outside of an acute setting. Correct by submitting subsequent hospital visits or medical records supporting the condition. If the code is truly invalid and should not be submitted to CMS, submit the corrected 837 using the same claim ID as the initial submission via your clearinghouse with the invalid code removed (do not submit a HICE file to delete the bad code).

Recommended Annual Activities

- Perform annual reconciliations using the production reports available from Gold Kidney. A few of the most important reports include:
  - New Member Recon: Gold Kidney provides the member list by February of each year. Submit historical HICE files for the prior year's encounter by July of the existing year.
  - EDS Analysis Monthly Report: fix the EDS rejections to mitigate the impact on the overall risk score due to CMS transition to EDPS.

Because providers are required to submit complete and accurate data to Gold Kidney to meet Gold Kidney's compliance obligation with CMS, any data in error or not reflected in Gold Kidney reporting must be resubmitted before CMS and Gold Kidney deadlines.

Encounter Data System (EDS) Edits Resources	
Reject Type	**Resource**
277 Edits	*https://www.csscoperations.com/internet/csscw3.nsf/DID/I9IQVMOVZR*
CMS Companion Guide	*https://www.csscoperations.com/internet/csscw3_files.nsf/F/CSSCAppendix_3A_MA_Companion_Guide10162020.pdf/$FILE/Appendix_3A_MA_Companion_Guide10162020.pdf*

Reconciliation Process

Reconciliation of encounter data occurs between providers and Gold Kidney and between providers and clearinghouses. Where provider organizations are working with clearinghouses for submission, each clearinghouse will supply reporting details directly to the providers on the total number of encounters received, accepted, and rejected. Encounters that are rejected at the clearinghouse are not sent to Gold Kidney. Providers are responsible for reviewing and remedying any rejections identified by the clearinghouse reporting.

Once the encounter has been accepted by the clearinghouse and sent to Gold Kidney for processing, the results of the encounters will become viewable on the Gold Kidney Encounter Data Portal (EDP), accessible at *https://www.goldkidney.com/providers*. The EDP will display the total number of encounters received, accepted, rejected, and sent to CMS, as well as show the results received from CMS (accepted and rejected). The EDP can also be used to modify or correct encounter data. Please note, that error resolution completed on the EDP will be reflected within forty-eight (48) hours.

Gold Kidney does not currently supply 999 or 277 reports to providers. All accepted and rejected encounter details must be reviewed on the EDP or via the Availity clearinghouse portal.

Reconciliation reports are available monthly on the EDP, under the HCCs and Encounters modules, or by emailing the Gold Kidney Encounter Data Team at *Encounters@goldkidney.com*.

Submission of Supplemental Encounter Data

All Providers that have submitted encounter data may send supplemental data through the clearinghouse Availity.com.

Chapter 17: Risk Management Specific to Florida Providers

Gold Kidney of Florida develops and implements an incident reporting system based upon the affirmative duty of all healthcare providers and all agents and employees of Gold Kidney of Florida to report injuries and adverse incidents to the Risk Manager. F.S. § 641.55 (1)(d).

a) Incident reports shall be on the Provider Critical/Adverse Incident Reporting Form, which includes at least the following information: (F.A.C. § 59A-12.012(3), *see* form sections.)
   i) The patient's name, address, date of birth, sex, physical findings, or diagnosis and, if hospitalized, locating information, admission time and date, and the facility's name.
   ii) A clear and concise description of the facts of the incident including time, date, exact location, and coding elements as needed for the annual report based on ICD-10-CM.
   iii) A description of any injuries sustained.
   iv) Whether or not a physician was called and, if so, a brief statement of said physician's recommendations for medical treatment, if any.
   v) A listing of all people known to be involved in the incident, including witnesses, along with locating information for each; and
   vi) the name, signature, and position of the person completing the incident report along with the date and time the report was completed.

b) The Risk Manager shall have free access to all HMO and provider medical records.

c) Gold Kidney of Florida will submit an annual report summarizing incident reports on the form provided by AHCA.

d) Gold Kidney of Florida will report adverse incidents that result in a patient's death, severe brain, or spinal damage, or receiving an unnecessary surgery to AHCA within three (3) working days, with a more detailed report following in ten (10) days.

e) The Risk Manager shall provide a summary report on incidents and risk management activities to the Board of Directors at least quarterly. Gold Kidney of Florida shall retain summary data for at least three (3) years.

f) The Risk Manager shall conduct regular and systematic reviews of all incident reports and written patient grievances to identify trends or patterns as to time, place, or persons, and upon the emergence of any trend or pattern in incident occurrence, shall develop recommendations for appropriate corrective action and risk management prevention education and training.

g) The Incident Reporting Form is attached hereto for use in critical/adverse incident reporting.

References/Citations

F.S. § 641.55(2) and F.A.C. § 59A-12.012(3).

Provider Critical/Adverse Incident Reporting Form

Following reporting requirements as mandated and regulated by the Agency for Healthcare Administration (AHCA), please submit the completed, typed form to the Gold Kidney Health Plan Risk Manager **immediately** via fax at

866-580-0122.

For assistance in completing the incident report form, contact our Risk Manager at **813-847-5561**

I. Provider/Facility Information

Provider/Facility Name	NPI	Phone	Email
Street Address	**City**	**Zip Code**	**County**
Name of Person Submitting Report	**Title**	**Phone**	**Email**

II. Patient Information

Patient Name	Age/DOB	Gold Kidney Health Plan ID Number	
Street Address	**City**	**Zip Code**	**County**

III. Incident Information

Incident Type – Please check the appropriate box
☐ Death by homicide, suicide, abuse, neglect, or exploitation
☐ Death because of a healthcare provider or is otherwise unexpected.
☐ Injury or illness because of a healthcare provider and which is otherwise unexpected
☐ Brain damage, spinal damage, permanent disfigurement, fracture/dislocation of bones/joints
☐ Any condition that is not consistent with the patient's pre-existing physical condition and results in an extended length of stay, transfer to a higher level of care, or the need for definitive and specialized. Medical attention or surgical intervention.
☐ Any condition that results in a limitation of neurological, physical, or sensory function that continues after discharge from the facility.
☐ Suspected abuse, neglect, or exploitation
☐ Sexual battery
☐ Medication errors
☐ Suicide attempts
☐ Altercations requiring medical intervention
☐ Elopement
☐ Other (see incident description)

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Incident Description
Please provide a clear and concise description of the facts of the incident including time, date, exact location, and any coding elements needed for the annual report based on ICD-10-CM.
Please describe any injuries sustained;
Please indicate whether a physician was called and, if so, a brief statement of the physician's recommendations for medical treatment, if any.
Please list all the people known to be involved in the incident, including witnesses, along with locating information for each. • You should consider adding more boxes like the one that already appears in IV Witness Information.

IV. Witness Information

Witness Name	Phone	Fax	Email
Street Address	**City**	**Zip Code**	**County**

Signature: _____ **Date:** _____

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Appendix A: Select CMS Requirements

MMCM, Chapter 11, requires that MA Organizations include certain contract provisions in their downstream provider contracts. Additionally, MA Organizations must include certain MA-related provisions in the policies and procedures that apply to providers and suppliers that constitute the MA organizations' health services delivery network. The following table summarizes some of these provisions and where they can be found in this POM:

CONTRACT REQUIREMENTS SET FORTH THROUGH POLICIES, STANDARDS, & MANUALS		
	Title 42 CFR §	**POM CHAPTER**
Safeguard privacy and maintain records accurately and timely	422.118	Chapter 10, Network Standards
Permanent "out of area" members to receive benefits in continuation area	422.54(b)	Chapter 3, Enrollment and Eligibility
Prohibition against discrimination based on health status	422.110(a)	Chapter 10, Network Standards
Pay for Emergency and Urgently Needed Services	422.100(b)(1)(ii)	Chapter 9, Physician Responsibilities Chapter 10, Network Standards
Pay for renal dialysis for those temporarily out of a service area	422.100(b)(1)(iv)	Chapter 4, Claims
Direct access to mammography and influenza vaccinations	422.100(g)(1)	Chapter 9, Physician Responsibilities
No copay for influenza and pneumococcal vaccines	422.100(g)(2)	Chapter 9, Physician Responsibilities
Agreements with providers to demonstrate "adequate" access	422.112(a)(1)(i)	Chapter 10, Network Standards
Direct access to women's specialists for routine and preventive services	422.112(a)(3)	Chapter 10, Network Standards
Services available 24 hrs./day, 7 days/week	422.112(a)(7)(ii)	Chapter 10, Network Standards
Adherent to CMS marketing provisions	422.2260, *et seq.*	Chapter 10, Network Standards
Ensure services are provided in a culturally competent manner	422.112(a)(8)	Chapter 10, Network Standards
Maintain procedures to inform Members of follow-up care or provide training in self-care as necessary	422.112(b)(5)	Chapter 10, Network Standards
Document in a prominent place in the medical record if an individual has executed an advance directive	422.128(b)(1)(ii)(E)	Chapter 9, Physician Responsibilities
Provide services in a manner consistent with professionally recognized standards of care	422.504(a)(3)(iii)	Chapter 10, Network Standards

Continuation of benefits provisions (maybe met in several ways, including contract provision)	422.504(g)(2)(i). 422.504(g)(2)(ii). 422.504(g)(3)	Chapter 10, Network Standards
Payment and incentive arrangements specified	422.208	Chapter 5, Provider Payment
Responsibility over first-tier, downstream, and related entities	422.504(i)	Chapter 6, Care Management Chapter 15, Delegation Oversight

CONTRACT REQUIREMENTS SET FORTH THROUGH POLICIES, STANDARDS, & MANUALS		
Disclose to CMS all the 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	422.64(a): 422.504(a)(4) 422.504(f)(2)	Chapter 10, Network Standards
Must make a good faith effort to notify all affected Members of the termination of a provider contract 30 days before the termination by the plan. or provider	422.111(e)	Chapter 10, Network Standards
Submission of data, medical records, and certification completeness and truthfulness	422.310(d)(3)-(4), 422.310(e), 422.504(d)-(e), 422.504(i)(3)-(4), 422.504(l)(3)	Chapter 16, Encounter Data
Comply with medical policy, QI, and MM	422.202(b). 422.504(a)(5)	Chapter 12, Gold Kidney's Quality Improvement (QI) Program
Disclose to CMS quality & performance indicators for plan benefits re: disenrollment. rates for beneficiaries enrolled in the plan for the previous two years	422.504(f)(2)(iv)(A)	Chapter 10, Network Standards
Disclose CMS quality & performance indicators for the benefits under the plan. regarding enrollee satisfaction	422.504(f)(2)(iv)(B)	Chapter 10, Network Standards
Disclose to CMS quality & performance indicators for the benefits under the plan regarding health outcomes	422.504(f)(2)(iv)(C)	Chapter 10, Network Standards
Notify providers in writing of the reason for denial, suspension & termination	422.202(d)	Chapter 10, Network Standards
Provide 60 days' notice (terminating the contract without cause)	422.202(d)(4)	Chapter 10, Network Standards

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)	422.504(h)(1)	Chapter 13, Fraud, Waste, and Abuse
Prohibition of the use of excluded practitioners	422.752(a)(8)	Chapter 1, Overview Chapter 10, Network Standards Chapter 15, Delegation Oversight
Adhere to appeals/grievance procedures	422.562(a)	Chapter 11, Member Appeals and Grievances