Health Plan

PROVIDER MANUAL

MedCare Partners Health Plan PCP-D Provider Manual
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Introduction

Using this Guide

The MedCare Partners Health Plan (MCPHP) Provider Manual contains essential information on the administrative components of MCPHP's operations including:

- Claims Billing and Submission, Provider Disputes, Coordination of Benefits
- Prior Authorization and Referral Information
- Health Care Access and Coordination

Definitions

"Emergency medical condition" means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in any of the following:

(1) Placing the patient's health in serious jeopardy.
(2) Serious impairment to bodily functions.
(3) Serious dysfunction of any bodily organ or part.
(4) "Active labor" means a labor at a time at which either of the following would occur: (a) There is inadequate time to effect safe transfer to another hospital prior to delivery; or (b) A transfer may pose a threat to the health and safety of the patient or the unborn child.

"Health Plan" means any full-service health care service plan licensed under the Knox-Keene Act that has entered into a plan-to-plan agreement with MCPHP for the provision and/or arrangement of covered services to members of the health plan.

"In Network" refers to MCPHP's entire network of providers that have entered into an agreement with MCPHP to provide covered services to members enrolled in specific health plan products.

"Out of Area" refers to the geography outside MCPHP's service area of any specific health plan product.

"Out-of-area coverage" means coverage while an enrollee is anywhere outside the service area of MCPHP and includes coverage for urgently needed services to prevent serious deterioration of an enrollee's health resulting from unforeseen illness or injury for which treatment cannot be delayed until the enrollee returns to MCPHP's service area.

"State" refers to the state of California.

About MedCare Partners Health Plan

MedCare Partners Health Plan (MCPHP) aims to create a community-based, California supported healthcare delivery system that emphasizes optimizing access to medical care for the underserved ethnic population by using a culture and language specific user interface throughout the entire care continuum.

MCPHP and all partner providers, both professional and ancillary, commit to bringing innovative and progressive practice standards to ethnic populations, starting with the Vietnamese demographic.

MCPHP products and services is built around a Medicare senior health plan product. MCPHP operates with a Restricted Knox Keene license under the auspices of the Department of Managed Health Care. The company has a unique plan-to-plan agreement with Brand New Day, a large, multi-state full Knox Keene partner and is working to obtain additional agreements with other national health plan companies. With these agreements, MCPHP can provide a model of care specifically for the Vietnamese/Asian population which addresses all language concerns as well as cultural philosophies and sensitivities that have previously created barriers to efficient and complete care between a senior patient and the care network. MCPHP is working with individual providers, IPAs, and medical groups to create a robust network for the population along with hospitals and ancillary services who have the desire to provide and participate in the MCPHP model to provide the utmost comfort and care to our population.

Participating Health Plans

Role of the Health Plan with a Knox-Keene License

Under the Knox-Keene Health Care Service Plan Act of 1975 (Knox-Keene Act), the California Department of Managed Health Care ("DMHC") requires licensure for any entity that assumes global financial risk for professional health services and/or hospital and other institutional health care services. MCPHP operates under a Restricted Knox-Keene license. This type of license allows MCPHP to assume global risk by accepting both institutional and professional risk-based capitation payments as subcontractors to unrestricted, full-service plans.

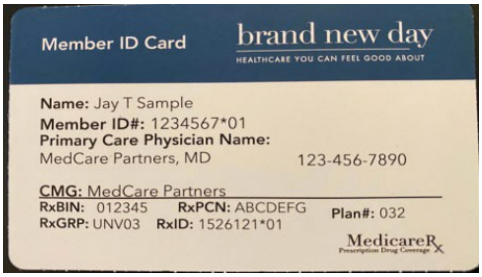
Checking Member Eligibility

Providers are responsible for verifying members' eligibility for all medical services they provide. Please check the Members health plan ID card at each visit and keep a copy of both sides of the health plan ID card for your records. Additionally, it is important that you verify eligibility and benefits before or at the point of service for each office visit.

Providers may verify member eligibility by contacting the Health Plan directly by calling the number located on the back of the members ID card or utilizing the Health Plans portal.

Health Plan Identification (ID) Cards

MCPHP members receive health plan ID cards containing information needed for providers to submit claims. Information may vary in appearance or location on the card for different payers or other unique requirements. However, all cards display the following information:



Brand New Day Health Plan Partner

Brand New Day offers comprehensive benefit programs designed to address our members' unique healthcare needs. Programs for individuals with Medicare only, Medicare and Medi-Cal, and or individuals with ongoing medical conditions such as Diabetes, Cardiovascular Disease, Dementia, or Mental Illness, or those who live in long-term care facilities. Patients who wish to enroll should be advised to call MCPHP at **(833) 569-2538.** To verify eligibility please call Brand New Day at **(866) 255-4795**.

Participating Physicians

MCPHP has contracted with participating physicians in Riverside, Santa Clara, Orange and San Diego Counties. Select Primary Care Physicians (PCP) access MCPHP's network through PCP Direct contracting. Contact MCPHP directly at **(833) 569-2528**. The PCP Direct contracting is managed by NeueHealth **(888) 293-6383**, which includes Utilization Management, Claims Processing, and Credentialing, etc.

Selection and Role of the Primary Care Physician

All MCPHP members are required to select a primary care physician (PCP) at the time of enrollment. If a member does not choose a PCP, the MCPHP participating health plan will assign a PCP for the member. To change the designated primary care physician, members are required to contact their health plan.

MCPHP members may choose a PCP based on proximity to either their home or work address. Members are required to visit their primary care physician for non-urgent or non-emergency care.

The PCP is responsible for providing and coordinating medical care for their patients, including referrals to specialists, hospitals, and other healthcare providers anywhere in the MCPHP Network.

Specialty Care

MCPHP provides a comprehensive network of physician specialists. These specialties include but are not limited to:

- Allergy and Immunology
- Cardiology
- Cardiothoracic Surgery
- Colorectal Surgery
- Critical Care Medicine
- Dermatology
- Ear, Nose and Throat
- Endocrinology
- Gastroenterology
- General Surgery
- Hematology/Onc
- Infectious Disease
- Nephrology
- Neurology
- Neurosurgery
- Gynecology
- Ophthalmology
- Orthopedic Surgery
- Pain Management
- Plastic surgery
- Podiatry
- Pulmonary Disease
- Radiation Oncology
- Rheumatology
- Urology
- Vascular Surgery

MCPHP PCPs refer members for specialty services when clinically appropriate, choosing a participating MCPHP specialist. Referrals for some specialty care require prior authorizations. Additional details are covered in the next section.

Lab Services

MCPHP Physicians should refer members to the Quest Diagnostics laboratory.

Behavioral Health Access, Triage and Referral

MCPHP provides behavioral health specialty services for its members through a contracted vendor. The Holman Group conducts behavioral health intake, referrals, and utilization management. For behavioral health access, triage and referral contact The Holman group at **800-837-4292.**

MCPHP Hospitals are:

Fountain Valley Regional Medical Center
17100 Euclid St, Fountain Valley, CA 92708
(714)-966-7200
https://www.fountainvalleyhospital.com/home

Good Samaritan Medical Center
1225 Wilshire Blvd, Los Angeles, CA 90017
(213)-977-2121
https://www.pihhealth.org/

Los Alamitos Medical Center
3751 Katella Ave, Los Alamitos, CA 90720
(562)-598-1311
https://www.losalamitosmedctr.com/

Lakewood Regional Medical Center
3700 East South Street Lakewood, CA 90712
(562) 531-2550
https://www.lakewoodregional.com/

Orange Coast Memorial Medical Center
18111 Brookhurst St, Fountain Valley, CA 92708
(714) 378-7000
https://www.memorialcare.org/

Placentia Linda Hospital
1301 N Rose Dr, Placentia, CA 92870
(714) 993-2000
https://www.placentialinda.com/

Regional Medical Center – San Jose
225 N Jackson Ave, San Jose, CA 95116
(408) 259-5000
https://regionalmedicalsanjose.com/

Riverside Community Hospital
4445 Magnolia Ave, Riverside, CA 92501
(951) 788-3000
https://riversidecommunityhospital.com/

Repatriation from Non-Contracted Hospital

If a MCPHP member is admitted to a non-contracted facility, that member may be considered for repatriation to a MCPHP facility. Such a transfer may take place only when these circumstances apply:

- The member has been medically stabilized;
- The transferring and receiving health care providers determine that no material clinical deterioration of the member is likely to occur during or upon transfer;
- The transferring and receiving health care providers believe that further inpatient health care treatment is medically necessary; and
- The member cannot safely be discharged home.

If a MCPHP member cannot obtain non-emergent/non-urgent medically necessary inpatient services at a MCPHP facility, the member's physician may refer the member to a non-contracted facility. Utilization Management staff may approve services at a non-contracted facility that can offer such care. Prior authorization and medical review are required for non-emergent/non-urgent inpatient services at non-contracted facilities. Refer to the Utilization Management section below.

Emergency Services

Emergency services and care means medical screening, examination, and evaluation by a physician and surgeon, or, to the extent permitted by applicable law, by other appropriate licensed persons under the supervision of a physician and surgeon, to determine if an emergency medical condition or active labor exists and, if it does, the care, treatment, and surgery, if within the scope of that person's license, necessary to relieve or eliminate the emergency medical condition, within the capability of the facility. Emergency services and care also means an additional screening, examination, and evaluation by a physician, or other personnel to the extent permitted by applicable law and within the scope of their licensure and clinical privileges, to determine if a psychiatric emergency medical condition exists, and the care and treatment necessary to relieve or eliminate the psychiatric emergency medical condition, within the capability of the facility.

All Emergency Services are covered without prior authorization and do not require medical record review. These requests cannot be denied for failure to obtain a prior approval when approval would be impossible, e.g., the member is unconscious and in need of immediate care, or where a prior approval process could reasonably be expected to result in any of the following: 1) placing the member's health in serious jeopardy, 2) serious impairment to bodily functions, or 3) serious dysfunction of any bodily organ or part at the time medical treatment is required.

In the MCPHP service area, MCPHP shall pay for all medically necessary facility services provided to a member who is admitted through the emergency room until the member's condition is stabilized. All requests for authorizations of medically necessary health care services after stabilization and all responses to such authorization requests will be fully documented in the Utilization Management tracking system. Treating physicians will document provision of all medically necessary health care services in their usual medical record.

When MCPHP's Utilization Management department denies requests for authorization of post stabilization medical care at outside facilities and elects to transfer a member to another health care provider, the following applies:

- A physician or other appropriate practitioner reviews presenting symptoms and discharge diagnoses for emergency services. MCPHP may not restrict emergency medical conditions based on lists of diagnoses or symptoms. Behavioral health care practitioners are available to review psychiatric emergency conditions. MCPHP shall inform the treating provider of the decision to transfer the member to another health care provider.
- MCPHP shall effectuate the transfer of the member as soon as possible.

The emergency screening fee (Medical Screening Exam) will be paid in a timely fashion by the responsible party for all ER claims when clinical data that would support a higher level of payment is not available. MCPHP has processes to review and address claims payment and provider disputes about emergency room claims that have been denied.

Non-contracted providers are paid for the treatment of the emergency medical condition, including medical necessary services rendered to a member, until the member's condition has stabilized sufficiently to permit discharge or referral and transfer to a contracted facility.

Ambulance services are covered when the member reasonably believed the condition was an emergency.

Out of Area Emergency Services

Emergency and urgent services are covered when a member is temporarily out of the service area and requires immediate medically necessary healthcare because 1) the illness, injury, or condition was

unforeseen; and 2) it was not reasonable for the member to obtain the services through MCPHP providers given the circumstances. Members are responsible for payment of copays and/or coinsurance per their specific benefit plan but can never be balance-billed for emergency services. Under unusual and extraordinary circumstances, services may be considered urgently needed when they are provided within the service area by a non-MCPHP provider when a MCPHP provider is unavailable or inaccessible.

Ancillary Providers and Services

MCPHP has a network of ancillary providers. MCPHP members may access contracted ancillary providers with a physician referral. Prior authorization is not required for many services including the following ancillary services but please check MCPHP's website for a list of all services that require prior authorization.

- Urgent Care Centers
- Routine Laboratory Tests (In Network)
- Diagnostic Imaging: plain x-rays and non-contrast ultrasound
- Emergency services
- Basic Prenatal Care
- Family planning services
- Sexually Transmitted Disease Services
- Preventive Services
- HIV testing
- Involuntary Psychiatric Inpatient Admission
- Self-referral for Behavioral Health

Provider Obligations and Plan Oversight

If a MCPHP member contacts a provider seeking to become a new patient and that provider is not accepting new patients, the provider will direct the patient to the health plan. Any provider not accepting new patients will contact MCPHP.

Provider agreements will include a stipulation that if a contracted provider is no longer accepting new patients, or if the provider was previously not accepting new patients, but is currently accepting new patients, the provider is required to notify MCPHP within five (5) business days.

Claims Submission Information

Filing a Claim

MCPHP is delegated to pay claims for Medicare Advantage Products indicated in this Provider Manual. MCPHP has contracted with NeueHealth, its Value Service Organization ("VSO"), to perform the claims processing on their behalf.

- Providers are encouraged to file claims electronically whenever possible. Submitted claims should provide all required information; those submitted with missing data may result in a delay in processing or denial.
- MCPHP Website – www.medcarepartners.com provides general information.
- NeueHealth Website https://eznetedi.neuehealth.com/EZ-NET60/ click New User Registration. This portal provides access to query and view status on claims, authorization inquiry and submission, eligibility, contracted providers, and other important information.

Electronic Claims Submission

MCPHP, through NeueHealth, contracts with the vendors listed below for submission of electronic claims. Additional clearinghouses/vendors may also submit using these channels. The benefits of electronic claim submission include:

- Reduction or elimination of costs associated with printing and mailing paper claims
- Improvement of data integrity using clearinghouse edits
- Faster receipt of claims by MCPHP, resulting in reduced processing time and quicker payment
- Confirmation of receipt of claims by the clearinghouse
- Availability of reports when electronic claims are rejected
- The ability to track electronic claims, resulting in greater accountability

Clearinghouse	Phone Number	Payer ID
Office Ally	1-866-575-4120	NEUEH
Availity	1-800-282-4548	NEUEH

Electronic Data Interchange (EDI) questions

For questions regarding electronic claim submission, please call NeueHealth at **888-293-6383** or the claims clearinghouses at the numbers listed above. NeueHealth Provider Services Department is open Monday – Friday 8:30-5:00 pm PST.

Paper Claims Submission and NeueHealth Contact Information

- Paper Claim Submissions P.O. Box 8350, La Verne, CA 91750
- Appeals & Provider Dispute P.O. Box 8350, La Verne, CA 91750
- NeueHealth Phone 1-888-293-6383
- NeueHealth Fax 1-888-320-3851

Electronic Funds Transfer (EFT)

MCPHP provides EFT for its providers for claims. Providers may contact NeueHealth at **1-888-293-6383**. NeueHealth uses Zelis services. To register go to https://www.zelispayments.com/ or you may contact Zelis at **855-496-1571.**

Claims Questions

Contact the NeueHealth 1-888-293-6383, Monday-Friday 8:30-5:00 PST. Or visit the provider portal 24 hours/day, 7 days/week at https://eznetedi.neuehealth.com/EZ-NET60/

Clean Claim Guidelines

A "clean claim" is a claim that can be processed without obtaining additional information from the provider of service or from a third party but does not include claims under investigation for fraud or abuse or claims under review for medical necessity.

Reasons for claim denial include, but are not limited to, the following:

- Duplicate submission
- Member is not eligible for date(s) of service(s) ("DOS")
- Incomplete data
- Non-covered services

Timely Filing Guidelines for Medicare Advantage

- Contracted Providers: Billing Limitation – within 90 calendar days (3 months) from the Date of Service. Refer to each provider's contract for variations in the claim filing limit.
- Non-Contracted: Billing Limitation – within 365 calendar days (1 year) from the Date of Service.

Corrected Claims

Providers must correct and resubmit claims to MCPHP within the 12-month clean claim time frame. When resubmitting a denied claim, the provider must submit a new claim containing all previously submitted lines. The original claim reference number from the remittance advice ("RA") must be included on the claim so that MCPHP can identify the resubmitted claim. If the claim reference number is missing, the claim may be entered as a new claim and denied for being submitted beyond the initial

submission time frame. Corrected claims must be appropriately marked as such and submitted to theappropriate claims electronic processor or mailing address.

Balance Billing

Balance billing is the practice of a participating provider billing a member for the difference between the contracted amount and billed charges for covered services. When participating providers contract with MCPHP, they agree to accept MCPHP' contracted rate as payment in full. Billing members for any covered services above and beyond the contracted rate is a breach of contract. Participating providers may only seek reimbursement from MCPHP members for appropriate cost-share amounts, including copayments, coinsurance, and/or deductibles.

Member Financial Responsibility

MCPHP members are responsible for co-pays or coinsurance as determined by their individual benefit plan.

MCPHP providers agree to accept payment per their contract as payment in full. Balance billing for thedifference between the contracting amount and billed charges for covered services is prohibited and isconsidered a breach of contract, as well as a violation of state and federal statutes. In some instances, balance billing of members can result in civil penalties.

- Providers may bill a MCPHP member when the member knowingly receives non- covered services. The provider must notify the member in advance of the charges and have the membersign a statement agreeing to pay for the services and must file the signed statement in the member's medical record.
- MCPHP members may not be reported to a collection agency for any covered servicesrendered by a MCPHP provider.
- MCPHP members may not be charged for services that are denied or limited due to the provider's failure to comply with billing requirements, such as timely filing, lack of authorization,or lack of clean claim status.

Coordination of Benefits

Coordination of benefits ("COB") is required before submitting claims for members who are covered byone or more health insurers other than their primary health plan. MCPHP follows the applicable regulations regarding coordination of benefits between both commercial and government insurance products.

Participating providers are required to administer COB according to the applicable regulations. The participating provider should ask the member about coverage through another health plan and enterthat other health insurance information on the clai

Providing COB Information

For MCPHP to document member records and process claims appropriately, include the following information on all COB claims submitted to MCPHP:

- Name of the other carrier
- Subscriber ID number with the other carrier including contact information, primary subscriber, or preferable a COB form from the provider.

If a MCPHP member has other group health insurance coverage, follow these steps:

- File the claim with the primary carrier, as determined by the applicable regulations.
- After the primary carrier has paid, attach a copy of the *Explanation of Payment (EOP)* or Explanation of Benefits (*EOB)* to a copy of the claim and submit both to MCPHP within six months from the date of service. COB claims can also be submitted electronically with the details from the other payer ERA appropriately submitted in the 837 transaction COB loops.
- If the primary carrier has not made payment or issued a denial, submit the claim to MCPHP prior to the timely filing limit of six months from the date of service. If denied based on timeliness, the claims are treated as non-reimbursable, and the member cannot be billed.

COB Payment Calculations

MCPHP coordinates benefits and pays balances, up to the member's liability, for covered services. However, in cases where MCPHP is not the primary payer, the dollar value of the balance payment cannot exceed the dollar value of the amount that would have been paid had MCPHP been the primary payer.

In some cases, members who have coverage through two carriers are not responsible for cost-shares or copayments. Therefore, it is advisable to wait until payment is received from both carriers before collecting from the member.

Overpayments

MCPHP makes every attempt to identify a claim overpayment and indicate the correct processing of the claim on the provider's Remittance Advice (RA). An automatic system offset, where applicable, might occur in accordance with the reprocessing of the claim for the overpayment, or on immediate subsequent check runs.

If a provider independently identifies an overpayment from MCPHP (such as a credit balance),the following steps are required to be taken by the provider:

Send the overpayment refund and applicable details to: MCPHP c/o NeueHealth P.O. Box 8350, La

Verne, CA 91750

Include a copy of the RA that accompanied the overpayment to expedite MCPHP's adjustment of the provider's account. It takes longer for MCPHP to process the overpayment refund without the RA. If the RA is not available, the following information must be provided:

- Member name and MCPHP member ID number
- Date of service
- Payment amount
- Vendor name and number
- Provider tax ID number
- Reason for the overpayment refund

If a provider is contacted by a third-party overpayment recovery vendor acting on behalf of MCPHP, the provider should follow the overpayment refund instructions provided by the vendor.

If a provider believes he or she has received a MCPHP check in error and has not cashed the check, he or she should return the check to the address above with the applicable RA and a cover letter indicating why the check is being returned.

Additional Information

If you have additional questions, please contact NeueHealth at **888-293-6383**, Monday – Friday 8:30 a.m. – 5:00 p.m. Pacific Time with questions regarding third-party recovery, coordination of benefits or overpayments.

Provider Disputes

Provider Disputes due to Claims Decisions

A provider dispute due to claims decision is a written notice from the provider to MCPHP (sent to MCPHP's claims administrator NeueHealth) that:

- Challenges, appeals or requests reconsideration of a claim (including a bundled group of similar claims) that has been denied, adjusted or contested;
- Challenges a request for reimbursement for an overpayment of a claim; and/or seeks resolution of billing or other contractual dispute;

Providers should exhaust all claims processing procedures and follow the guidelines below before filing a claim dispute with MCPHP:

- If the provider has not received a Claims Remittance Advice (RA) identifying the status of the claim, they should call NeueHealth to inquire whether the claim has been received and processed.
- Providers should allow 45 calendar days following claim submission before inquiring about a claim. However, providers should inquire well before six months from the date of service because of the time frame for initial claim submission and for filing a claim dispute (*see* "Provider Dispute Time Frame Medicare Advantage" below).
- If a claim is pending in the NeueHealth claims system, a claim dispute will not be investigated until the claim is paid or denied. A delay in processing a claim may be cause for a claim dispute on a pended claim provided all claim dispute deadlines are met (must be filed with 12 months of the last payment).

Past Due Payments

If the provider dispute involves a claim and the outcome is determined to be in favor of the provider, MCPHP will pay any outstanding money due, including any required interest or penalties, within 15 business days of the date of the decision. When applicable, accrual of the interest commences on the day following the date by which the claim should have been processed.

Claims Payment Turnaround Time Medicare Advantage

Claims payment turnaround time is 60 calendar days.

Provider Dispute Time Frame Medicare Advantage

Disputes are accepted if they are submitted no later than 12 months from the date of payment. If the provider's contractual agreement provides for a dispute-filing deadline that is greater or less than 365 calendar days, the contract dispute filing deadline applies.

Non-contracted providers: Appeals are accepted within 60 calendar days if no payment is made on first claim submission by provider. Provider Dispute Resolution will occur within 120 calendar days of dispute submission if provider is disputing the payment or the non-payment.

Provider Disputes due to Utilization Management (UM) Decisions

Providers should follow the same process as above. Members may appeal denials based on the process described on the CMS website.

Submitting Provider Disputes

Providers should submit provider disputes on a Provider Dispute Resolution Request form. If the dispute is for multiple and substantially similar claims, a Provider Dispute Resolution Request spreadsheet should be submitted along with the form. Providers may download an electronic copy of the Provider Dispute Resolution Request form by visiting https://eznetedi.neuehealth.com/EZ-NET60/. The provider dispute form must include the provider's name, NPI ID number, contact information including telephone number, and the number assigned to the original claim. Additional information required includes:

- If the dispute is regarding a claim or a request for reimbursement of an over or underpayment of a claim, the dispute must include a clear identification of the disputed item, the date of service, and a clear explanation as to why the provider believes the payment amount, request for additional information, request for reimbursement of an overpayment, or other action is incorrect.
- If the claim is regarding a UM decision, the dispute must include a copy of all correspondence including letters from the member's physician(s) and a copy of the pertinent member medical records.
- If the dispute is about another issue, a clear explanation of the issue and the basis of the provider's position.
- If the provider dispute does not include the required submission elements as outlined above, the dispute is returned to the provider along with a written statement requesting the

missing information necessary to resolve the dispute. The provider must resubmit an amended dispute along with the required missing information.

- MCPHP does not discriminate or retaliate against a provider due to a provider's use of the provider dispute process. A provider claim dispute is processed without charge to the provider; however, MCPHP has no obligation to reimburse any costs that the provider has incurred during the claim dispute process.
- Providers can send provider disputes to: MCPHP c/o NeueHealth P.O. Box 8350, La Verne, CA 91750

Provider Disputes-All Other Disputes

All other types of provider disputes between MCPHP and Providers for which the agreement between MCPHP and Provider does not specify specific procedures or timelines should be resolved, to the extent possible, by informal meetings or discussions between appropriate representatives of the parties. Providers may submit disputes to MCPHP by mailing a detailed description of the dispute and any supporting documentation to 17542 E. 17th Street, Suite 410, Tustin, CA 92780. The parties will meet and confer within 30 calendar days of receipt to resolve the dispute. If the parties are unable to resolve the dispute within 60 days of the first meeting to discuss the dispute, then either party may provide written notification of their intent to proceed with arbitration or other dispute resolution process provided for in their Agreement with MCPHP. (Timeframes apply unless otherwise described in a provider's contract or as required by law or regulation).

Member Grievances and Appeals

MCPHP is not delegated by our Health Plans to review, process or manage member grievances or appeals. Health Plans shall be responsible for resolving all Member Grievances (complaints) or Appeals of benefit or claims decisions.

For Brand New Day Members

Members should contact Brand New Day in one of these ways:

Appeals and Grievance Department Contact Information	
Phone:	1-866-255-4795; TTY 711
Fax:	1-657-400-1217
Hours of Operation:	Monday – Friday, 8 a.m. - 8 p.m. from April 1 - September 30 7 days a week, 8 a.m. – 8 p.m. from October 1 - March 31
Email:	complaints@universalcare.com
Address:	Brand New Day Attn: Appeals and Grievance Department P.O. Box 93122 Long Beach, CA 90809

Resolution Time Frame

Member Appeals and Grievances are handled by each health plan's grievance and appeals department within DMHC regulated timeframes following receipt of the grievance/appeal and a written determination will be provided.

Utilization Management

Financial Prohibition

All utilization decisions regarding coverage and/or services must be based upon appropriateness of care and services and the existence of coverage. Financial rewards or incentives must not influence any utilization decisions. To assure that the risks of underutilization are considered, no rewards or incentives can be issued that will discourage appropriate care and services to the Members. In addition, MCPHP does not reward Practitioners, Providers, or employees for issuing denials of coverage or service. Compensation plans for individuals who provide utilization review services do not contain incentives, direct or indirect for these individuals to make inappropriate review decisions. All denials must be strictly based on insufficient medical appropriateness or not a covered benefit.

Prior Authorization

Utilization management authorization decisions are conducted by MCPHP. For clinical trials, out of area services and transplants the health plan makes and communicates all authorization decisions.

Referrals for the following services require prior authorization. The list below is not all inclusive and may vary depending on individual member's benefit plans.

- Admissions - Non-emergent inpatient admissions
- Bariatric-related services
- Cardiology procedures - Elective interventional cardiology procedures, including cardiac catheterization and procedures requiring contrast
- CAR-T
- Chemotherapy / Infusion Therapy
- Clinical trials
- Dialysis
- Durable medical equipment, including prosthetics
- Experimental/investigational services and new technologies
- Gender reassignment surgery including drugs and consults
- GI Procedures
- Home health and home infusion services
- Injectables in office
- Out of network/ out of area referrals
- Outpatient surgery

- Pain management procedures
- PET Scans
- Radiation Therapy
- Radiology interventional procedures - Elective interventional radiology procedures requiring contrast administration
- Rehabilitation therapies such as physical, occupational, and speech therapy
- Self-Injectables
- Skilled Nursing Facilities
- Transplant-related services

If a MCPHP member cannot obtain non-emergent/non-urgent medically necessary inpatient services at a MCPHP facility listed above, the member's physician may refer the member to a non-contracted facility. Utilization Management staff may approve services at a non- contracted facility that can offer such care. Prior authorization and medical review are required for non-emergent/non-urgent inpatient services at non-contracted facilities.

MCPHP conducts the following types of review per their respective policies and procedures, and in coordination with the member's health benefit plan, including but not limited to:

- Prospective Review
- Medically Urgent Services Review
- Concurrent Review of patients admitted to acute care hospitals, rehab facilities and skilled nursing facilities
- Discharge Planning
- Ancillary Services Management

UM Contact

Authorization submission should be made on the NeueHealth portal at https://eznetedi.neuehealth.com/EZ-NET60/. You may also contact NeueHealth **888-293-6383**.

Denial Notification

Verbal and written notice of denials and communications must meet health plan requirements.

Emergencies

Emergency services are covered both in-network and out-of-network and do not require prior authorization.

Notification of Admission

All elective acute care hospital and skilled nursing facility ("SNF") admissions require authorization.

Notification of emergency admissions should be made to NeueHealth within 24 hours or the next business day of presentation.

Quality Management

The MCPHP Quality Management (QM) Program is directed by providers and the intent is ensure the quality of care provided is being reviewed, that problems are being identified, that effective action is taken to improve care where deficiencies are identified, and that follow up is planned where indicated. The QM Program structure is designed for continuous quality improvement efforts to promote a culture of improving quality of care and services. The QM activities yield data from multiple sources which, after analysis, is integrated and utilized for planning and guiding administrative and managerial decision-making for Quality Management.

The QM Program is designed to improve aspects of care delivered to Members in the health care settings. The goal of the QM Program is to continuously improve the quality of care and service delivered to Members; to include, but not limited to the following:

- Develop, implement, and coordinate activities that are designed to improve the process by which care and service are delivered.
- Monitoring that the provision and utilization of services meets professionally recognized standards of practice.
- Maintain compliance with accreditation and regulatory standards and provisions
- Alignment and Integration of Quality Initiatives with NeueHealth Population Health Management; to include, Behavioral Health Integration
- Annually structure a specific Quality Initiative to ensure the capacity to service diverse members. Objectives includes, but not limited to reducing health disparities, improving cultural competence, or improving network adequacy for underserved populations.
- Annually structure a specific Quality Initiative to ensure the capacity to service members with complex health needs. Objectives may include addressing the needs of members with physical disabilities, developmental disabilities, chronic conditions, and sever mental illness.
- Develop and Implement integrated Quality Improvement Projects
- Facilitate Provider integration with the Quality Initiatives
- Implementation of an internal surveillance structure to identify and correct quality concerns
- Measure performance using industry standard quality measures and develop a system of transparency to display measures; to include, Member and Provider Satisfaction
- Annually review the effectiveness of the QM Program and make needed programmatic changes for future program design

Population Health Management

MedCare Partner's Population Health Management (PHM) program structure and functionality support a commitment to providing quality healthcare that is accessible, easy, and affordable. The PHM program is centered on using evidence-based practice to coordinate care and provide services and benefits to make health insurance easy-to-understand and easy-to-use.

PHM Purpose

The purpose of the PHM program is to improve the health outcomes of a population. MCPHP deploys integrated, fully aligned population-based health programs focused on consumers, powered by technology, and aligned with Care Partners.

PHM Coordination

NeueHealth population health management teams perform triage functions to ensure coordination of programs and services that are deployed by Physicians, Health Plan sponsors, or community based or external management programs. The population health management teams will determine Member eligibility for other external programs and the services offered to Members (i.e., LTSS, CCS, Disease Management, Behavioral Health, Community Social Service). The Model of Care goals developed by Health Plan Sponsors are integrated into the NeueHealth policies and procedures.

PHM Scope

The PHM program encompasses a comprehensive model designed to objectively and systematically assess Members' needs across the continuum of care. The model entails the following core programs:

- Case Management Program: The Case Management Program is designed to stratify Members based on the population characteristics and provide an intensive case management approach to the high cost, high needs subpopulation.
- Health and Wellness Program: The Health and Wellness Program is designed to address health maintenance for the low-risk population and to maintain this subpopulation at their current level of functioning in partnership with the primary care physician.
- Transition of Care Program: The Transition of Care Program is designed to provide case management interventions to those Members at risk for adverse outcomes due to transitions across care settings.

PHM Objectives

The PHM strategy is designed to meet the Member's needs, preferences, and values across the continuum of care. The strategic objectives of the PHM Program include:

- Keeping Members healthy.
- Managing Members with emerging risk.
- Patient safety or outcomes across settings.

- Managing multiple chronic illnesses

Access to Care

The California Department of Managed Health Care requires Knox-Keene licensed entities to adhere to the following standards for timely access to care. All MCPHP participating providers must meet these standards for appointment and telephone wait times.

DMHC Regulated Appointment Wait Times

MCPHP members have the right to appointments within the following time frames:

Type of Appointment	Wait time
Urgent	
• for services that do not require prior approval	48 hours
• for services that require prior approval	96 hours
Non-Urgent	
• Primary care	10 business days
• Specialist	15 business days
• Behavioral health care provider (non-physician)	10 business days
• Other services to diagnose or treat a health condition	15 business days

Nurse Advice Line

Brand New Day provides access to an advice nurse line, accessible 24 hours a day, 365 days a year via the telephone number on members' health plan identification cards. Contact the Nurse Advice Line by dialing **866-255-4795**.

General Administrative Requirements

Provider Responsibilities

Participating providers are responsible for:

- Providing health care services within the scope of the provider's practice and qualifications, that are consistent with generally accepted standards of practice;
- Accepting MCPHP members as patients on the same basis that the provider accepts other

patients (nondiscrimination);

- Providing timely communication and feedback regarding member healthcare needs to affiliated physicians;
- Obtaining current insurance information from the member;
- Adhering to standards of care and MCPHP policies to perform utilization management and quality improvement activities, including prior authorization of necessary services and referrals;
- Informing the member that services may not be covered when referring to physicians outside the network unless prior authorization has been issued;
- Cooperating with MCPHP and its participating providers to provide or arrange for continuity of care to members according to state regulations undergoing an active course of treatment in the event of provider termination;
- Operating and providing contracting services in compliance with all applicable local, state and federal laws, rules, regulations, and institutional and professional standards of care, including federal 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 (31 U.S.C. 3729 et. seq.), the anti-kickback statute (42 U.S.C. § 1320a-7b.), and Health Insurance Portability and Accountability Act (HIPAA) administrative simplification rules at 45 CFR parts 160, 162 and 164.

Provider Rights to Advocate on Behalf of the Member

MCPHP validates that its providers, acting within the lawful scope of their practices, are not prohibited or otherwise restricted from advising or advocating, on behalf of members who are the providers' patients, for the following:

- The member's health status, medical care or treatment options, including any alternative treatment that may be self-administered;
- Any information the member needs to decide among all relevant treatment options;
- The risks, benefits and consequences of treatment or non-treatment; and
- The member's right to participate in decisions regarding his or her behavioral health care, including the right to refuse treatment and to express preferences about future treatmentdecisions

Nondiscrimination

MCPHP and its participating providers must not discriminate against any provider that serves high-risk populations or specializes in conditions that require costly treatment.

Credentialing and Re-credentialing

Credentialing and re-credentialing of physicians and licensed individual practitioners is delegated to NeueHealth. MCPHP's Chief Medical Officer chairs the MCPHP's Credentialing Committee which oversees credentialing activities.

Credentialing Adverse Action

If a practitioner's credentials are suspended or terminated the practitioner will be provided written notification to include the reason for the action and a summary of the appeal rights process. The appeals process allows practitioners to request a hearing and submit supporting documentation within (30) calendar days after the notification was submitted to the practitioner.

Practitioners have the right to be represented by an attorney or another person of their choice. MCPHP may not have an attorney present if the practitioner does not have attorney representation.

When a timely request for appeal is received a peer panel of individuals will be appointed to review the appeal. The hearing panel members will be peers of the affected practitioner. A peer is an appropriately trained and licensed practitioner in a practice like that of the affected practitioner. Panel members do not have to possess identical specialty training.

When the hearing concludes the panel will submit a written notification to the practitioner to include the appeal decision and the specific reasons for the decision.

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