Provider Manual

August 2024

SimpraAdvantage
Alabama's Healthplan

Table of Contents

Plan Overview

The Provider Manual is customarily updated annually but may be updated more frequently as policies or regulatory requirements change. Providers can access the most current Provider Manual at Simpra.com. The information contained in this Manual is current as of January 2024.

The Provider Manual contains policies, procedures, and regulatory/contractual requirements to support you in providing comprehensive care to our members and understanding our programs and processes. References to providers refers to contracted (in-network) providers unless otherwise indicated.

Introduction

Simpra Advantage ("health plan" or "Plan") is a Medicare Advantage PPO Plan.

There are different types of Medicare health plans. Simpra Advantage is a Medicare Advantage Special Needs Plan (SNP), which means its benefits are designed for people with special health care needs.

Simpra Advantage offers three Plans:

- Simpra Advantage (PPO I-SNP) and Simpra Advantage Premier (PPO I-SNP) are PPO Institutional Special Needs Plans (I-SNP) designed to improve the care of residents in nursing and other long-term care (i.e., assisted living) facilities in Alabama.
- Simpra Advantage (D-SNP) is a PPO Dual-Eligible Special Needs Plan (D-SNP) designed for those who have both Medicare and Medicaid and reside in any county of Alabama.

Some important things to remember about Medicare SNP members:

- A SNP member is covered by Medicare and has chosen to get their Medicare health care and prescription drug coverage through our Plan.
- A SNP member has Medicare rights and protections.
- A SNP member gets supplemental benefits from the Plan. Supplemental benefits are not covered under Part A, Part B, or Part D.
- A SNP member's benefits, provider choices, and drug formularies (list of covered
- drugs) are tailored to best meet their specific needs.
- A SNP member typically requires a deeper level of care coordination.
- SNPs focus more on specific lifestyle care management needs with specialized expertise tailored to members' needs.

Our Model of Care

The Plan's Model of Care (MOC) provides patient-centered, primary care-driven care experience. Focusing on the prevention of avoidable hospitalizations and reduction of acute exacerbations, the MOC is designed to improve the quality of life for members while providing access to the same services covered by Original Medicare. Supplemental benefits offer additional services and support for the Plan's special population.

Medicare requires initial and annual training for network providers, as well as out-of- network providers that are seen by members on a routine basis. Our Provider Network Management and Clinical Education teams will work together to coordinate this required training with you. Providers may attend online interactive training sessions, in person training sessions, or review and attest to review of the MOC. The SNP MOC training presentation is located here: Model of Care Training

Goals of the Simpra Advantage Model of Care

- Improve access to medical, mental health, and social services
- Improve access to affordable care
- Improve coordination of care through an identified point of contact
- Improve transitions of care across health care settings and providers
- Improve access to preventive health services
- Help assure appropriate utilization of services
- Improve member health outcomes

Participating providers should know:

1. All members may choose a primary care physician (PCP), or one will be designated. The staffing model, which could include care provided by a Nurse Practitioner (NP) or Physician Assistant (PA) is described in the Model of Care Training.

2. The Plan has received permission from CMS to waive the 3-day hospitalization stay required before providing skilled nursing services. This is important because it allows skilled nursing facilities (SNF), with approval from the member's PCP, to treat the member in the nursing home when appropriate, and reserves acute hospital stays for Members requiring more intensive services.

3. The Plan strives to reduce unnecessary paperwork whenever possible. Providers are encouraged to be familiar with the claims, notification, prior authorization, and referral processes outlined in this Manual.

Working with the Plan

Key Contacts

Plan's Member Services Department

- 1-844-637-4770 (TTY users call 833-312-0044)

Plan's Provider Services Department

- 1-844-637-4770 (TTY users call 833-312-0044)

Member Identification & Eligibility

All participating providers are responsible for verifying a member's eligibility during each visit or before the appointment.

Simpra Advantage has the most current eligibility information. You can verify member eligibility through the following ways:

- Member ID Card: Note that changes do occur, and the card alone does not guarantee member eligibility.
- Provider Web Portal: The Simpra Advantage web portal allows providers to verify eligibility online 24/7, Provider Portal.
- Provider Services Department: 1-844-637-4770 (TTY users call 833-312-0044).

Please note, membership data is subject to change. The Centers for Medicare and Medicaid Services (CMS) may retroactively terminate members for various reasons and recoup payments it made to the Plan.

When this occurs, the Simpra Advantage claims recovery unit will request a refund from the provider for any services furnished when the member was ineligible. The provider must then contact CMS Eligibility to determine the member's actual benefit coverage for the date of service in question. Typically, the beneficiary is disenrolled to Medicare fee-for-service. If the Medicare timely filing period has passed, Federal law gives providers an extra six months after the Plan's recoupment to file a claim.

Benefits and Services

All Simpra Advantage members receive benefits and services as defined in their Evidence of Coverage (EOC). Benefits and services are subject to change on January 1st of each year.

Providers may contact the Provider Services line for information on covered services and verification of applicable member copayments and/or cost sharing owed by the member to the provider for the provision of services.

All participating providers are obligated to bill and collect applicable member copayments and/or cost sharing as defined under the Simpra Advantage policy or CMS regulations.

Participating providers of Simpra Advantage are prohibited from balance-billing members copayments and/or cost sharing when members are determined qualified and eligible for benefits under the state Medicaid program. For more information refer to MLN Article SE1128 or visit: http://www.cms.gov/MLNMattersArticles/Downloads/SE1128.pdf.

Inflation Reduction Act of 2022

The Inflation Reduction Act (IRA) was signed into law on August 16, 2022. The IRA eliminates the member's deductible and imposes a statutory maximum beneficiary cost sharing of $35 per month's supply for Part D covered insulins. In addition, effective January 1, 2023, the IRA eliminates the deductible and imposes a statutory maximum beneficiary cost sharing of $0 for adult vaccines as recommended by the Advisory Committee on Immunization Practices (ACIP).

Also beginning January 1, 2023, in accordance with the IRA of 2022, Part D Vaccines must be provided to all Simpra Advantage enrollees at $0 cost sharing. Additionally, effective January 1, 2023, all Simpra members' monthly out-of-pocket costs for Part D covered insulin products will be capped at $35 per month's supply.

Beginning on July 1, 2023, a similar monthly $35 cap will be implemented for insulin furnished through Durable Medical Equipment (DME) under Part B. Plans must also cover Part B insulin at or below the original Medicare coinsurance cap of $35 for a one-month's supply of insulin without applying a service category or plan level deductible.

Beginning on January 1, 2024, the 5% coinsurance requirement for Part D enrollees will be eliminated.

Emergent and Urgent Services

Simpra Advantage follows the Medicare definitions of emergency services, and urgently needed services:

- Emergency Services: Covered inpatient and outpatient services that are furnished by an emergency department when a member has an injury, a sudden illness, or an illness that quickly gets much worse.

- Urgently Needed Services: Covered services that are urgently needed to treat a sudden illness or injury that isn't a medical emergency.

The Simpra Advantage provider network includes multiple hospitals, emergency rooms, and providers that are able to treat the emergent conditions of Simpra Advantage members twenty-four (24) hours a day, seven (7) days a week. Emergent services should be obtained from the closest facility that can provide the service.

All emergency and urgently needed services may occur without prior authorization or referrals. For emergent issues occurring onsite in the member's nursing home or in the service area, the Plan Provider is generally responsible for providing, directing, or facilitating a member's emergent care. This includes emergent services provided onsite in the nursing facility ("treatment in place"). The Plan Provider or his/her designee must be available 24 hours a day, 7 days a week to assist members needing emergent services.

Emergent issues requiring services or expertise not available onsite in the member's nursing home are addressed by transferring the member to an acute care hospital or emergency room able to provide the needed care. The Plan Provider is generally responsible for coordinating the transition of the member to the hospital or emergency room, including communicating with the hospital or emergency room about the member. Members may have a copayment responsibility for an outpatient emergency visit unless it results in an admission.

While most members remain in the service area, Simpra Advantage members may receive emergency services and urgently needed services from any provider regardless of whether services are obtained within or outside a Simpra Advantage authorized service area or network. In unusual circumstances, when the member is in the service area and the network is temporarily unavailable or inaccessible, prior approval is needed and will be approved only for continuity of care.

The Simpra Advantage network includes contracts with ambulance transport services when an ambulance is required for member safety. In cases where ambulance services are dispatched through 911 or a local equivalent, the Plan follows Medicare rules on coverage for ambulance services as outlined in 42 CFR 410.40. Due to the emergency medical condition, members are only liable for the applicable cost sharing.

Excluded Services

In addition to any exclusions or limitations described in the members' Evidence of Coverage (EOC), the following items and services are not covered under the Original Medicare Plan or by Simpra Advantage:

- Services that are not reasonable and necessary, according to the standards of the Original Medicare Plan.
- Experimental or investigational medical and surgical procedures, equipment, and medications, unless covered by the Original Medicare Plan or unless, for certain services, the procedures are covered.
- Orthopedic shoes unless they are part of a leg brace and included in the cost of the brace (exception: orthopedic or therapeutic shoes are covered for people with diabetic foot disease).
- Supportive devices for the feet (exception: orthopedic or therapeutic shoes are covered for people with diabetic foot disease).
- Hearing aids and routine hearing examinations unless otherwise specified in the EOC.

- Routine eye examinations, radial keratotomy, LASIK surgery, vision therapy, and other low vision aids and services, and eyeglasses (which are only covered after cataract surgery) unless otherwise specified in the EOC.

- Self-administered prescription medication for treatment of sexual dysfunction, including erectile dysfunction, impotence, and anorgasmy or hyporgasmy unless otherwise included in the member's Part D benefit. See the formulary for details.

- Reversal of sterilization measures and non-prescription contraceptive supplies.

- Naturopathic services.

Services provided to veterans in Veterans Affairs (VA) facilities. However, in the case of emergencies received at a VA hospital, if the VA cost sharing is more than the cost sharing required under the Plan, the Plan will reimburse veterans for the difference. Members are still responsible for the Plan cost sharing amount.

Continuity of Care

Simpra Advantage's policy is to provide for continuity and coordination of care with medical practitioners treating the same patient, and coordination between medical and behavioral health services. As such, participating providers must notify the Plan when they are terming or wish to term the Simpra Advantage Plan network. This will ensure Simpra is able to provide impacted members at least 30 calendar days advance notice of a provider termination where possible. When advance notice to Simpra is not possible, please notify the Plan as soon as possible.

When a practitioner leaves the Simpra Advantage network and a member is in an active course of treatment, our Utilization Management (UM) staff will attempt to minimize any disruption in care by potentially offering continuity of care services with the current provider for a reasonable period of time.

In addition, members undergoing active treatment for a chronic or acute medical condition will have access to the existing provider for a minimum of 90 calendar days.

If the Plan terminates a participating provider, Simpra Advantage will work to transition a member into care with a Participating Physician or other provider within Simpra Advantage's network. Simpra Advantage is not responsible for the health care services provided by the terminated provider following the date of termination under such circumstances.

Simpra Advantage also recognizes that new members join our health plan and may have already begun treatment with a provider who is not in the Simpra Advantage network. Under these circumstances, Simpra Advantage will work to coordinate care with the provider by identifying the course of treatment already ordered and offering the member a transition period of a minimum 90 calendar days or until the current course of treatment is complete.

Simpra Advantage will honor plans of care (including prescriptions, DME, medical supplies, prosthetic and orthotic appliances, specialist referrals, and any other on-going services initiated prior to a new member's enrollment for a minimum of 90 calendar days or until the PCP evaluates the member and establishes a new plan of care.

For additional information about continuity of care or to request authorization for such services, please contact our Prior Authorization Department at:

- **1-844-637-4770 (TTY users call 833-312-0044)**

Notification of Emergent Inpatient, Observation, SNF Part A, Skill in Place, Part B Therapy Admissions

For timely care coordination, Simpra Advantage requires notification as soon as reasonably possible within two (2) business day for the following services:

- ER and Urgent-Direct Admissions
- Observation Status
- Admissions following outpatient procedures or Observation status
- Skilled Nursing Facility (SNF) Part A
- Part B Therapy in a SNF
- Skill in Place

For notification of admission, providers should call:

- 1-844-637-4770 (TTY users call 833-312-0044)
- Fax: 251-725-5099
- Provider Portal

Emergent admission notification must be received within two business days of admission. For observation stays, Simpra Advantage expects hospitals (including critical access hospitals) to furnish the Medicare Outpatient Observation Notice (MOON) as required by law. This obligation exists even though Simpra Advantage waives the three-day stay requirement.

Prior Authorization

Requests for prior authorization of services should be made before or at the time of scheduling the service. PCPs and Specialists are responsible for requesting prior authorization for the services they order. Facilities may also request prior authorizations for scheduled admissions, elective admissions, procedures, and outpatient services ordered by the PCP. Simpra's Prior Authorization form is available on www.Simpra.com in the Provider section, under Provider Documents.

Simpra recommends calling at least 7 days in advance of an elective admission, procedure, or service. Prior authorization requests are prioritized by the level of medical necessity. For prior authorizations, providers should enter a request via the provider portal, phone, or fax:

- 1-844-637-4770 (TTY users call 833-312-0044)
- Fax: 251-725-5099

Services Requiring Prior Authorization

Providers should refer to the provider section of the Plan's website at Simpra.com, for a listing of services typically requiring referral or authorization.

Documentation for Prior Authorizations

The Utilization Management (UM) Department documents and evaluates requests utilizing CMS guidelines as well as nationally accepted criteria, processes the authorization determination, and notifies the provider and member of the determination. Examples of information required for a determination include, but are not limited to:

- Member name and identification number
- Location of service (e.g., hospital or outpatient surgical center setting)
- Servicing/Attending physician name
- Date(s) of service
- Number of visits, or units, or the quantity of service being requested
- Diagnosis description and ICD-10 code(s)
- Service/Procedure/Surgery description and CPT or HCPCS code
- Clinical information supporting the need for the service
- Initial Coverage Decisions and Time Frames

Review Type	Notification
Standard/Non-urgent pre-service medical services	Within 14 calendar days of the request
Standard/Non-urgent pre-service Part B drug services	Within 72 hours of the request
Expedited/Urgent pre-service medical services	Within 72 hours of the request
Expedited/Urgent pre-service Part B drug services	Within 24 hours of the request
Post-service/Payment	Within 30 calendar days of the request

- Expedited Review: When you as a provider believe waiting for a decision under the routine time frame could place the member's life, health, or ability to regain maximum function in serious jeopardy, you may request an expedited request. Expedited medical service requests will be determined within 72 hours or as soon as the member's health requires. Expedited requests for Part B drug services will be determined within 24 hours.

- Routine/Standard Review: If all required information is submitted at the time of the request, CMS generally mandates a health plan determination within 14 calendar days, however, Simpra Advantage prioritizes all service requests for completion as quickly as the member's health condition warrants but within 14 calendar days.

Once the UM Department receives the request for authorization, Simpra Advantage will review the request using nationally recognized industry standards, as well as Medicare local and national coverage determination criteria. If the request for authorization is approved, Simpra Advantage will assign an authorization number and enter the information in the Plan's medical management system.

The authorization number is only used for reference, it does not signify approval. Claims for services requiring prior authorization must be submitted with the assigned authorization numbers. This authorization number can be used to reference the admission, service, or procedure.

Concurrent Review

Concurrent Review is the process of initial assessment and continual reassessment of the medical necessity and appropriateness of inpatient care during an acute care hospital, rehabilitation, SNF, or other inpatient admission, and any services that are continued after the initial service has been approved to ensure:

- Covered services are provided at the appropriate level of care; and

- Services are administered according to the individual facility/vendor contract.

Utilizing CMS guidelines and InterQual (IQ) to review criteria, Simpra Advantage's UM department and the Plan's Medical Directors will conduct a medical necessity review. Simpra Advantage is responsible for final authorization.

Simpra Advantage requires updated clinical information for concurrent review no later than two (2) business days before the last covered day. If clinical information is not received within two (2) business days of admission or prior to the last covered day, an administrative denial may be issued. To prevent delays in care, it is important to send updated clinical notes to Simpra UM at least two (2) business days prior to the last covered day. Therapy notes should be current (no older than fourteen (14) calendar days old) with clear goals and documentation of the member's progress towards meeting the goals. Please fax concurrent service requests and clinical to UM at:

- **Fax: 251-725-5099**

Specific to the ISNP: UM Review is not required for readmission to the referring NF (the member's primary nursing facility); however, if the member is transitioning to an alternate facility, requests for review should be faxed to:

- **Fax: 251-725-5099**

A Simpra Advantage Medical Director reviews all acute, rehab, long-term acute care (LTAC) and SNF stays that do not meet medical necessity criteria and issues a determination. If the Simpra Advantage Medical Director deems the inpatient or SNF confinement does not meet medical necessity criteria, the Medical Director will issue an adverse determination (a denial). The UM nurse or designee will notify the provider(s), (e.g., facility, attending/ordering provider) verbally and in writing and will notify the member in accordance with Medicare guidelines.

The criteria used for the determination are available to the practitioner/facility upon request. To request a free copy of the criteria on which a decision is made, please contact:

- **1-844-637-4770 (TTY users call 833-312-0044)**

For members receiving hospital care and for those who transfer to a non-referring SNF or Acute Inpatient Rehabilitation Care, Simpra Advantage will approve the request or issue a denial if the request is not medically necessary. Simpra Advantage will issue a denial if a member who is already receiving care in an Acute Inpatient Rehabilitation Facility has been determined to no longer require further treatment at that level of care. This document will include information on the members' or their authorized representatives' right to file an expedited appeal, as well as instructions on how to do so if a member or member's physician does not believe the denial is appropriate.

Simpra Advantage also collaborates with the facility to issue written Notice of Medicare Non-Coverage (NOMNC) determinations by CMS guidelines. The facility is responsible for delivering the notice to the member or their authorized representative/power of attorney (POA) and for having the member, authorized representative or POA sign the notice within two calendar days prior to the last covered day. The facility is expected to fax a copy of the signed NOMNC back to the UM Department at the number provided in the NOMNC. The NOMNC includes information on a member's rights to file a fast-track appeal.

Rendering of Adverse Determinations (Denials)

In some instances, the UM staff is authorized to render an administrative denial decision to participating providers based only on contractual terms, non-covered or exhausted benefits, or eligibility. Late authorization requests, or not providing clinical information that demonstrates medical necessity, as requested, will result in an administrative adverse determination. Such administrative denials will not allow the provider to appeal.

Only a Simpra Advantage Medical Director, or delegated physician, may render an adverse determination (denial) based on medical necessity, but he/she may also decide based on administrative guidelines.

When making a decision based on medical necessity, the Plan requests necessary information, including pertinent clinical information from the treating provider, to allow the Medical Director to

make appropriate determinations. The Medical Director may suggest an alternative Covered Service to the requesting provider. If the Medical Director makes a determination to deny or limit an admission, procedure, service or extension of stay, Simpra Advantage notifies the facility or provider's office of the denial of service.

Notices are issued to the provider, the member, or the member's authorized representative documenting the original denied request and the alternative approved service, along with the process for appeal, according to CMS guidelines. Simpra Advantage employees are not compensated for denial of services. The PCPs or Attending Physician may contact the Medical Director by telephone to discuss decisions only before an adverse determination is rendered.

After the adverse determination is rendered, the decision may not be changed unless an appeal is initiated.

Notification of Adverse Determinations (Denials)

Written notifications are sent to the member and/or the requesting provider, as applicable, and contain the reason for each denial, including the specific utilization review criteria with pertinent subset/information or benefits provision used in the determination of the denial, and are delivered as follows:

Review Type	Notification
Standard non-urgent pre-service decisions	within 14 calendar days of the request
Standard non-urgent Part B drug decisions	within 72 hours of the request
Urgent medical service decisions	*within 72 hours of the request
Urgent Part B drug decisions	*within 24 hours of the request
Routine concurrent decisions	within 3 business days of the request
Urgent concurrent decisions	*within 24 hours of the request

**Denotes initial verbal notification of the denial decision is provided with electronic or written notification given no later than three (3) calendar days after the verbal notification.*

Simpra Advantage complies with CMS requirements for written notifications to members, including rights to file appeals and grievances.

Billing and Claims

Claims Submission

While Simpra Advantage prefers electronic submission of claims, both electronic and paper claims are accepted. If interested in submitting claims electronically, contact the Simpra Advantage Provider Services Department at: 1-844-637-4770 (TTY users call 833-312-0044).

Simpra Advantage also offers the ability to submit claims through the eHealthsuite Provider Portal. Instructions on how to gain access to the portal can be found on the Plan website at the Provider Resources page.

Forward all completed paper claims forms to the address noted below:

Simpra Advantage Claims

PO Box 23607

Tampa, FL 33623-3607

Timely Filing

As a Simpra Advantage participating provider, you have agreed to submit all claims within the time frame outlined in your provider agreement with Simpra Advantage.

Claim Format Standards

Standard CMS required data elements must be present for a claim to be considered a clean claim and can be found in the CMS Claims Processing Manuals. The link to the CMS Claims Processing Manual is: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS018912

Simpra Advantage can only pay claims which are submitted accurately. The provider is always responsible for accurate claims submission. While Simpra Advantage will make its best effort to inform the provider of claims errors, ultimately claim accuracy rests solely with the provider.

Physicians in the same group practice who are in the same specialty must bill and receive payment as though they were a single physician. If more than one service is provided on the same day to the same patient by the same physician or more than one physician in the same specialty in the same group, they must bill and receive payment as though they were a single physician.

For example, only one evaluation and management service may be reported unless the evaluation and management services are for unrelated diagnoses. Instead of billing separately, the physicians should select a level of service representative of the combined visits and submit the appropriate code for that level.

Physicians in the same group practice and who are in different specialties may bill and receive payment without regard to their membership in the same group.

Claim Payment

Simpra Advantage pays clean claims according to contractual requirements. A clean claim is a claim for a Covered Service that has no defect or impropriety. A defect or impropriety includes, without limitation, a lack of pertinent data fields completed, or substantiating documentation required by Simpra Advantage, or a particular circumstance requiring special handling or treatment, which prevents timely payment from being made on the claim.

Pricing

Original Medicare typically has market adjusted prices by code (i.e., CPT or HCPCS) for the services Original Medicare covers. However, there are occasions where Simpra Advantage offers a covered benefit for which Medicare has no pricing. To expedite claims processing and payment in these situations, Simpra Advantage will work to arrive at a fair market price by researching other external, publicly available pricing sources, such as other carriers', fiscal intermediaries', or state-published schedules for Medicaid. Simpra Advantage requests you make every effort to submit claims with standard coding. As described in this Manual and/or your Agreement, you retain your right to submit a Request for Reconsideration if you feel the reimbursement is incorrect.

Simpra Advantage will apply correct coding edits, Multiple Procedure Payment Reductions (MPPRs) as outlined by CMS in the Relative Value Unit (RVU) table. Simpra Advantage will also follow guidelines put forth by the American Medical Association (AMA) CPT and CMS HCPC coding guidelines. Bundling, multiple procedure reductions, or payment modifiers may impact contracted allowances. All editing applied by Simpra Advantage is subject to the appeals/payment dispute and clinical review policies and procedures outlined in this manual.

New or Unlisted Codes

From time to time, providers may submit codes that are not recognized by the claims system. This can happen when new codes are added by CMS for new and newly approved services or procedures, or if existing codes are changed. Providers should not bill with terminated or deleted CPT or HCPC codes.

Simpra Advantage follows Original Medicare coverage guidelines for new services and procedures. If Original Medicare approves a new service, procedure, or code, Simpra Advantage will load the new code as it is made available.

In the event a provider submits a code, and the Simpra Advantage claims system does not recognize it as a payable code or does not have a contracted allowance, the following process applies:

- Simpra Advantage maintains the right to review and/or deny any claim with CPT/HCPC codes that are not recognized by the system. Supporting documentation may be requested to substantiate services, determine allowance basis, and to make a coverage determination. Examples include, but are not limited to, new CPT/HCPC codes, not otherwise classified (NOC) codes, and codes designated as Carrier Defined by CMS;

- The provider may dispute the denial as outlined in their contract, attaching the Medicare coverage guidelines or proof of payment for the service/code (EOB) from Original Medicare; and

- Simpra Advantage will pay for any services that include proof of payment by Original Medicare within the past six (6) months at the provider's contract rate or, if not addressed, 100% of the current Medicare rates less all applicable copayments, deductibles, and cost sharing for which the provider furnishes proof.

Providers may submit documentation of payment for new services/codes with original claims to prevent the need for an initial denial and subsequent appeal and re-adjudication process.

All codes/services submitted for payment but not recognized by the claims system will be subject to verification of medical necessity. Providers should always call for prior authorization of any procedure/service/or code for which they have concerns about coverage.

HEDIS Coding Tips

CPT Category II codes, when added to a claim, help identify additional information about the member's care. This method of reporting simplifies and improves accuracy of reporting select quality measures for HEDIS®, CMS Star Ratings reporting and incentive programs.

Category II codes are for informational purposes only and this communication is not intended to suggest or guide reimbursement. Reach out to Provider Services if you would like additional information.

Claims Encounter Data

Providers who are paid under capitation must submit claims within the same timely filing limit required in their provider agreement with Simpra Advantage for non-capitated claims to capture encounter data as required per your Simpra Advantage Provider Agreement.

Explanation of Payment (EOP)/Remittance Advice (RA)

The EOP/RA statement is sent to the provider after Simpra Advantage has determined coverage and payment. The statement provides a detailed description of how the claim was processed.

Non-Payment/Claim Denial

Any denials of coverage or non-payment for services by Simpra Advantage are addressed on the Explanation of Payment (EOP) or Remittance Advice (RA). An adjustment/denial code will be listed for each billed line if applicable. An explanation of all applicable adjustment codes per claim is listed below that claim on the EOP/RA. Per your contract, the member may not be billed for services denied by Simpra Advantage unless the member received the denial **before** the service was provided and the member indicated they wanted to receive the services regardless of coverage. The member may not be billed for a covered service when the provider has not followed Simpra Advantage's procedures. In some instances, providing the needed information may reverse the denial (i.e., referral form with a copy of the EOP/RA, authorization number, etc.). When no benefits are available

for the member or the services are not covered, the EOP/RA will alert you to this.

Obtaining a pre-services review will reduce denials.

Processing of Hospice Claims

When a Medicare Advantage (MA) member has been certified as hospice, the financial responsibility for that member shifts from Simpra Advantage to Original Medicare. Original Medicare retains payment responsibility for all hospice and non-hospice related claims for traditional Medicare benefits beginning on the date of the hospice election.

The only services Simpra Advantage is financially responsible for during this time include any supplemental benefits Simpra Advantage offers in addition to Original Medicare benefits.

Members can revoke hospice elections at any time. If so revoked and once notified by CMS, the Plan will resume coverage for the member the first of the following month. These rules apply for both professional and facility charges.

Simpra Advantage may be notified of a hospice election by CMS after claims have been paid for dates of service during the hospice election period. In this instance, the Plan will notify the provider that a refund is due to the Plan.

The provider must remit the refund to Simpra Advantage and submit a claim for these services to Original Medicare, consistent with CMS policies.

Subrogation

Subrogation is the coordination of benefits between a health insurer and a third-party insurer (i.e., property and casualty insurer, an automobile insurer, or worker's compensation carrier), not two health insurers.

Claims involving Subrogation or Third-Party Recovery (TPR) will be processed internally by Simpra Advantage Claims Department. Members who may be covered by third-party liability insurance should only be charged the required copayment. The bill can be submitted to the liability insurer. The provider should submit the claim to Simpra Advantage with any information regarding the third-party carrier. All claims are processed per the usual Claims procedures.

For claims related questions, please contact your Simpra Advantage Provider Services Department at: **1-844-637-4770 (TTY users call 833-312-0044)**.

Appeals and Payment Disputes

Provider Claims Payment Dispute

If your claim was paid and you dispute the payment amount, please follow the Payment Dispute process below. Payment dispute procedures are separate and distinct from our Medicare Advantage appeal procedures.

A formal written Payment Dispute request is required when the provider disagrees with a paid

amount on a claim. This does not include a medical necessity or administrative denial. All Payment Disputes must be:

- Submitted in writing within 60 calendar days from the date of original payment
- Include a cover letter with:
    - Claim Identifiable information
    - Specific rationale on why the payment made is not appropriate or needs adjustment
- Include necessary attachments:
    - Copy of the original remittance advice (RA)
    - All applicable documentation supporting additional payment
      (Note: Medical records typically are not needed for payment disputes.
      Only documentation supporting why the provider believes a claim was paid incorrectly such as previous Medicare Payment, physician fee schedule, rate letters, etc.)

Providing the above information enables the Payment Dispute Unit to review the request properly and promptly. Requests that do not follow all the above requirements may be delayed. Simpra Advantage will not request additional information and expects the provider to submit the necessary information to substantiate their request for additional payment.

Mail provider claims payment disputes to:

Simpra Advantage Medicare Payment Dispute

PO Box 23607

Tampa, FL 33623-3607

Participating Provider Administrative Plea/Appeals Responsibility

A provider may submit a formal request to review a previous decision where an adverse determination was made stating the participating provider failed to follow administrative rules, assigning liability to the provider (see original decision letter) where the services were rendered.

All requests must be submitted in writing within 60 calendar days of the decision letter date and include a cover letter with:

- Member Identifiable information;
- Date(s) of service in question;
- The specific rationale as to why the payment made is not appropriate or needs adjustment; and
- Include necessary attachments:

- Copy of the original decision
- Only the portion of the medical records that substantiate the claim

Mail requests for review to:

Simpra Advantage Appeals & Grievances

PO Box 20648

Tampa, FL 33622-0648

In the event Simpra Advantage waives the administrative requirement and the request requires a medical review, submit all the necessary information to substantiate the request for payment. Simpra Advantage will not request additional records to support the provider's argument.

Providing the above information enables the Plan to review requests properly and promptly within 60 calendar days. In the event Simpra Advantage waives the administrative requirement, the request will be transferred to the appropriate area for review under that process and applicable time frames. Requests that do not follow the above requirements may be delayed.

Member Grievances and Appeals

Simpra Advantage Members have the right to file a complaint if they have concerns or problems related to their care or coverage. Members or an appropriately appointed/ authorized representative may file appeals or grievances regarding care or coverage determinations. To obtain information relative to appeals, grievances, or concerns and/or coverage determinations, members should be directed to contact our Member Services Department.

Appeals

Members of Simpra Advantage have the right to appeal any decision about payment failure to arrange or continue to arrange for what the member believes are covered services (including non-Medicare covered benefits). These include, but are not limited to:

- Payment for emergency services, post stabilization care, or urgently needed services;
- A denied claim for any other health services furnished by a non-participating provider or supplier they believe should have been provided, arranged for, or reimbursed by Simpra Advantage;
- Services they have not received, but believe are the responsibility of Simpra Advantage to pay; and/or
- A reduction in, or termination of, service that a member feels is medically necessary.

Also, a member may appeal any decision to discharge from the hospital. In this case, a notice will be given to the member with information about how to appeal. The member will remain in the hospital while the decision is reviewed. The member will not be held liable for charges incurred during this

period regardless of the outcome of the review. Please refer to the applicable Simpra Advantage Evidence of Coverage (EOC) for additional information.

A treating physician may request a reconsideration on the Member's behalf. The appeal must be submitted within 60 days of the original decision. You must receive a notice of denial, or remittance advice before you can submit an appeal.

An appeal is a reconsideration of a previous decision not to approve or pay for a service, including a level of care decision (includes not just outright denials, but also "partial" ones). Appeals receive an independent review made by someone not involved in the initial decision. Requesting an appeal does not guarantee the request will be approved, or the claim paid.

The appeal decision may still be to uphold the original decision.

A request for a standard appeal must be submitted to the address/fax listed below within 60 calendar days from the original decision. Appeal requests should include a copy of the denial, and any medical records supporting why the service is needed.

A request for an expedited appeal (pre-service requests only) may be filed verbally or in writing. To make a verbal request, please call: 1-844-637-4770 (TTY users call 833-312-0044).

An enrollee or physician may request an expedited appeal where they believe deciding within the standard time frame could seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.

Providers contracted with Simpra Advantage may not use the member appeal process to file an appeal for post-service payment disputes. Contracted providers should use the process outlined in the "Billing and Claims" section of this manual or in their provider agreement if they believe a claim was denied for payment in error or if there are additional circumstances the Plan should consider.

Part C Appeals Phone

- **1-844-637-4770 (TTY users call 833-312-0044)**

Member Grievances

Members of Simpra Advantage have the right to file a grievance about problems they observe or have experienced with the Plan. Situations for which a grievance may be filed include, but are not limited to:

- Issues such as waiting times, physician behavior or demeanor, and adequacy of facilities and other similar member concerns;
- Involuntary disenrollment situations; and/or
- Complaints concerning the quality of services a member receives.

Grievances may be received by the Plan Provider, Contracted Facilities, Plan Customer Service Representatives, and through Simpra's Member Services. All grievances are logged, categorized, and

worked to resolution per CMS guidelines for Medicare Advantage plans.

Complaints or grievances should be reported to Member Services. Providers must cooperate with Simpra Advantage to investigate grievances related to the provider or provider's services.

Members are also entitled to a report that describes the number of quality-of-care grievances and appeals and their dispositions processed during the most recent calendar year. Members may contact the Simpra Advantage Member Services Department for a copy of this report.

Provider Information

Provider Credentialing

Simpra Advantage does not discriminate in terms of participation, reimbursement, or based on the population of beneficiaries serviced, against any health care professional who is acting within the scope of his or her license or certification under state law. All Provider and Facility applicants to Simpra Advantage must meet basic eligibility requirements and complete the credentialing process prior to becoming a participating provider.

No provider can be assigned an effective date with Simpra Advantage, be included in the Plan Provider Directory, or have Simpra Advantage members assigned to them without having successfully completed the credentialing process.

Note: If you are not yet a contracted provider with Simpra Advantage and would like to join our network, please contact Provider Services at **1-844-637-4770 (TTY users call 833-312- 0044)**. A provider must be contracted with Simpra Advantage prior to being credentialed.

Credentialing and Recredentialing Process

All credentialing activities are administered through the Plan's Credentialing Committee, which reports its activities to the Simpra Board of Directors. The Credentialing Committee is comprised of network primary care and specialty providers, in addition to the physician chairperson.

Once a provider has applied for initial credentialing consideration, Simpra Advantage will conduct primary source verification of the applicant's licensure, education and/or board certification, privileges, lack of sanctions or other disciplinary action, and malpractice history by querying the National Practitioner Data Bank (NPDB).

The credentialing process can take up to 90 calendar days to complete. Once credentialing has been completed, and the applicant is approved, the provider will be notified in writing of the outcome. All providers are required to re-credential at least every three years (36 months) to maintain an active participating status with Simpra Advantage. Information obtained during the initial credentialing process will be updated and re-verified, as required. Providers will be notified of the need to submit recredentialing information at least four months in advance of their three-year anniversary date. Three separate attempts will be made to obtain the required information via mail, fax, email, or telephonic request. Providers who fail to return recredentialing information before their

recredentialing due date, or in the event any of the recredentialing criteria has not been met, the Credentialing Committee may impose adverse action, including termination of your participation with Simpra Advantage.

Written notification, via certified mail, will be sent by the Chief Medical Officer within thirty calendar days of any adverse action stating the reasons for termination, the consequences thereof and your appeal rights pursuant to the Credentialing Committee's appeal process for providers (policy available upon request).

To begin the credentialing process, providers must submit a completed CAQH Universal Credentialing Application form. If you have any questions or need assistance, please reach out to networksupport@simpra.com.

Provider Rights

Providers have the right to review information obtained from any outside source to evaluate their credentialing application except references, recommendations, or other peer-review protected information, also known as primary source recommendation. The provider may submit a written request to review his/her file information at least thirty calendar days in advance. The Plan will establish a time for the provider to view the information at the Plan's offices.

Providers have the right to correct erroneous information when information obtained during the credentialing process varies substantially from what was submitted by the provider. In instances where there is a substantial discrepancy in the information, Simpra Advantage will notify the provider in writing of the discrepancy within thirty (30) calendar days of receipt of the information. The provider must submit a written response and any supporting documentation to the Credentialing Department to either correct or dispute the alleged variation in their application information within 30 calendar days of notification.

Providers have the right to be informed of the status of their application and may request the status of the application either telephonically or in writing. Simpra Advantage will respond within ten (10) calendar days and may provide information on any of the following: application receipt date, any outstanding information or verifications needed to complete the credentialing process, anticipated committee review date, and approval status.

Facility/ Provider Selection Criteria

When assessing providers, Simpra Advantage utilizes the following criteria:

- Must be in good standing with all state and federal regulatory bodies
- Has been reviewed and approved by an accrediting body, if applicable
- If not accredited, can provide a copy of a recent CMS site survey or evidence of successfully passing a recent CMS site survey with no deficiencies noted.
- Maintains current professional and general liability insurance, as applicable
- Has not been excluded, suspended and/ or disqualified from participating in any Medicare,

Medicaid, or any other government health-related program

- Must have coverage related to the organization's location and services
- For "providers of services" under section 1861(u) of the Social Security Act, must have a provider agreement with CMS permitting them to provide services under Original Medicare; is not on the precluded provider list.

Note that the accreditation requirement does not apply to all organizational types. If it is required, the Plan will request it during the application process.

Facility/ Provider Application Requirements

To begin the facility credentialing process, the following must be submitted:

- A completed Ancillary/Facility Credentialing Application with a signed and dated attestation
- If responded "Yes" to any disclosure question in the application, an appropriate explanation with sufficient details/information is required
- Copies of all applicable state and federal licenses (i.e., facility license, DEA, pharmacy license, etc.)
- Proof of current professional and general liability insurance, as applicable
- Proof of Medicare participation
- Copy of DEA Registration
- If accredited, proof of current accreditation
- If not accredited, a copy of any state or CMS site survey that has occurred within the last three years including evidence the organization successfully remediated any deficiencies identified during the survey.

Credentialing Committee/Peer Review Process

All initial applicants and recredentialed providers are subject to a peer review process before approval or reapproval as a participating provider. The Plan Medical Director may approve providers who meet all of the acceptance criteria. Providers who do not meet established thresholds are presented to the Credentialing Committee for consideration. The Credentialing Committee is comprised of primary care and specialty providers and has the authority to approve or deny an appointment status to a provider. All providers must be credentialed and approved before being assigned a participating effective date.

Non-Discrimination in the Decision-Making Process

Simpra Advantage's Credentialing Program is compliant with all CMS and state regulations, as

applicable. Through the universal application of specific assessment criteria, Simpra Advantage ensures fair and impartial decision-making in the credentialing process.

No provider is denied participation based solely on race, ethnicity, national origin, religion, sex, age, mental or physical disability or medical condition, sexual orientation, type of population served or for specializing in certain types of procedures.

Provider Notification

All initial applicants who complete the credentialing process are notified in writing of their Plan effective date with Simpra Advantage. Providers are advised not to see Simpra Advantage members until the notification of successful credentialing is received. Applicants who are denied by the Credentialing Committee are notified in writing within sixty (60) calendar days of the decision. Notification will provide the reasons for the denial/term and any appeal rights to which the provider may be entitled.

Appeals Process & Notification of Authorities

In the event a provider's participation is limited, suspended, or terminated, the provider is notified in writing within 60 calendar days of the decision. Notification includes a) the reason(s) for the action, b) the appeals process or options available to the provider, and c) the time limits for submitting an appeal. A panel of peers reviews the appeals. When termination or suspension is the result of quality deficiencies, the appropriate state, and federal authorities, including the National Practitioner Data Bank (NPDB) are notified of the action.

Confidentiality of Credentialing Information

All information obtained during the credentialing and recredentialing process is considered confidential and will be handled and stored securely in accordance with federal and state laws and regulations. Confidential practitioner credentialing and recredentialing information is not disclosed to any person or entity except with the written permission of the provider or as otherwise permitted or required by law.

Ongoing Monitoring

Simpra Advantage conducts routine, ongoing monitoring of the preclusion list, license sanctions, Office of Inspector General (OIG) exclusions, Medicare/Medicaid sanctions and the CMS Opt-Out list between credentialing cycles on a monthly basis. Any provider whose license has been revoked or has been precluded, excluded, suspended, and disqualified from participating in any Medicare, Medicaid, or any other government health-related program, or who has opted out of Medicare will be automatically terminated from Simpra Advantage.

Site Evaluations

Site evaluations may be required when it is deemed necessary as a result of a customer complaint or quality of care issue, or otherwise mandated by state or federal regulations. Office site evaluations will review the following:

- Physical appearance and accessibility;

- Customer safety and risk management;
- Medical record management and security of information;
- Appointment availability;
- Cleanliness and adequacy of equipment; and
- Policies and Procedures.

Providers who fail to pass the area of the site visit specific to the complaint or who do not meet the site evaluation standards will be required to submit a corrective action plan and make corrections to meet the requirements. Follow-up reviews may be conducted to ensure compliance.

Provider Directory

To be included in the Simpra Advantage Provider Directory or any member communications, providers must be fully credentialed and approved, and must be credentialed under a specialty or capability required for Online Provider Directory display by CMS. Directory specialty designations must be commensurate with the education, training, board certification and specialty(ies) verified and approved via the credentialing process. Any requests for changes or updates to the specialty information in the directory may only be approved by the Credentialing and Recredentialing Process of the Plan.

Plan Notification Requirements for Providers

The following list of changes must be reported to Simpra Advantage at least thirty (30) calendar days in advance (or longer as stated in the provider agreement) by emailing networksupport@simpra.com:

- Provider Termination (inclusive of, but not limited to, retirement, moving out of service area, no longer accepting Medicare, group termination)
- Practice address
- Billing address
- Fax or telephone number
- Hospital affiliations
- Practice name
- Provider joining or leaving the practice (including retirement or death)
- Provider taking a leave of absence
- Practice mergers and/or acquisitions

- Adding or closing a practice location
- Tax Identification Number (please include W-9 form)
- NPI number changes and additions
- Changes in practice office hours, practice limitations, or gender limitations
- Panel status changes (closed or open panel)
- Office Hour updates

By providing this information promptly, you will ensure your practice is listed correctly in the Simpra Advantage Provider Directory.

Closing Patient Panels

When a participating PCP elects to stop accepting new patients, the provider's patient panel is considered closed. If a participating PCP closes his or her patient panel, the decision to stop accepting new patients must apply to all patients regardless of insurance coverage. Providers may not discriminate against Simpra Advantage members by closing their patient panels for Simpra Advantage members only. Providers who decide they will no longer accept any new patients must notify Simpra Advantage at least 30 calendar days prior to the change effective date.

Access and Availability Standards for Providers

Simpra Advantage has established written standards to ensure timeliness of access to care that meets or exceed the standards established by CMS, to ensure all standards are communicated to providers, to continuously monitor compliance with the standards, and to take corrective action as needed. Simpra Advantage also requires all providers to offer standard hours of operation that (1) do not discriminate against Medicare enrollees, and (2) are convenient for Simpra Advantage members, the facilities where members reside, and facility staff who aid in member care.

Provider Responsibility

- Simpra Advantage members have access to care 24 hours a day, 7 days a week as medically necessary. Simpra Advantage policies are in place to help ensure members have timely access to routine, preventive care, network providers, women's health services, and after-hours care. Plan Providers are required to provide routine, preventive care, and monitoring visits for their assigned members at the member's nursing facility residence every 60 days for all members and every 30 days for members identified as moderate or high risk.
- Assigned providers must make routine visits for non-urgent new onset symptoms or conditions or condition exacerbations within one week (7 calendar days) at the member's nursing facility residence.
- Immediate urgent and emergent care at the member's nursing facility residence, in a physician's office, or telephonically in coordination with the Nurse Practitioner.

- 24 hours a day, 7 days a week telephonic access for medically necessary member care, with approved and contracted physician coverage during time off (call coverage), with emergency care calls, both weekdays or after-hours, responded to immediately; urgent care calls, weekdays, and after-hours, responded to within 30 minutes; and routine care calls returned by the end of the day.

- Specialists are required to be available for a consult or new member patient appointment within 21 calendar days of the initial request and to be immediately available to PCPs for an urgent or emergent consult regarding a member.

- Telephone Access (applicable to all contracted providers regarding calls from members, members' caregivers, Simpra Advantage PCP, Simpra Advantage Medical Director and Utilization Management staff, and nursing home facility staff):

    - Emergency care calls, both weekdays and after-hours calls, are to be addressed immediately. Urgent care calls, both weekdays and after-hours calls, are returned within 30 minutes.

    - Routine care calls, both weekdays and after-hours calls, will be returned promptly. All calls are answered promptly by the provider, provider staff and/or a reliable paging service or answering service.

Non-Discrimination and Cultural Competency

Participating providers must provide services to all Plan customers, consistent with the benefits covered in their policy, without regard to race, ethnicity, national origin, religion, sex, age, mental or physical disability or medical condition, sexual orientation, claims experience, medical history, evidence of insurability (including conditions arising out of acts of domestic violence), genetic information, source of payment, or any other bases deemed unlawful under federal, state, or local law.

It is the responsibility of contracted providers to provide covered services in a culturally competent manner to Plan customers and ensure those with limited English proficiency or reading skills, diverse cultural and ethnic backgrounds, and physical or mental disabilities receive the health care to which they are entitled.

Dual Eligibles and Cost Sharing

Enrollees eligible for both Medicare and Medicaid will not be held liable for Medicare Part A and B cost-sharing when the state is responsible for paying such amounts. Providers will be informed of Medicare and Medicaid benefits and rules for enrollees eligible for Medicare and Medicaid. Providers may not impose cost sharing that exceeds the cost sharing amount that would be permitted with respect to the individual under title XIX if the individual were not enrolled in such a plan. Providers will: (1) accept the MA plan payment as payment in full, or (2) bill the appropriate state source. [42 C.F.R. §§ 422.504(i)(3)(i) and 422.504(g)(1)(i).

Patient Hold Harmless

Participating Providers are prohibited from balance billing Simpra Advantage members including, but not limited to, situations involving non-payment by Simpra Advantage, insolvency of Simpra Advantage, or Simpra Advantage's breach of its Agreement. Provider shall not bill, charge, collect a deposit from, seek compensation or reimbursement from, or have any recourse against customers or persons, other than Simpra Advantage, acting on behalf of customers for Covered Services provided pursuant to the Participating Provider's Agreement.

The provider is not, however, prohibited from collecting copayments, coinsurances, or deductibles for covered services in accordance with the terms of the applicable customer's Benefit Plan, or for collecting payment when rendering non-covered services if the provider complies with the requirements of the non-covered services section of the Provider Manual.

Non-Covered Services

Providers may only collect fees from Simpra Advantage members for non-covered services when the service is clearly listed as a non-covered service in the members EOC, or the member has been provided with a standardized written Organization Determination (OD) denial notice from the Plan prior to the item or service being rendered to the member. In circumstances where there is a question whether the Plan will cover an item or service, providers should inform members that they have the right to request an OD prior to obtaining the service from the provider. If coverage is denied, the Plan provides the member with a standardized written OD denial notice which states the specific reasons for the denial and informs the member of his or her appeal rights.

Providers may not hold the member financially responsible or issue any form or notice that advises the customer they will be responsible for the costs associated with non-covered services unless the customer has already received the appropriate pre-service OD denial notice from Simpra Advantage or the service or item is explicitly stated as a non-covered service in the EOC.

Network Access Monitoring and Compliance

Using valid methodology, Simpra Advantage will collect and perform regular analyses of provider data to measure performance against the Plan's written standards. Examples of measurement tools include:

- Access and Availability Survey: Utilizes the third next available appointment methodology to survey selected high-volume and high-impact specialists like cardiology, endocrinology, neurology, ophthalmology, pulmonology, and urology for availability and appointment timeliness requirements as set forth in the Provider Agreement and the Provider Manual.

- After-hours Care Telephone Survey: Annual survey to measure provider after-hours availability and responsiveness to routine and urgent calls.

- Member Satisfaction Survey: Annual survey includes questions related to accessibility and availability of network services.

In addition to regularly scheduled performance measurement, complaints related to access to care

(provider or after hours) are collected through the Simpra Advantage Provider Services Department line or submissions to the plan's Quality Improvement Committee. Access complaints are analyzed quarterly and reported through the Quality Improvement Committee with immediate action taken to rectify situations where access may cause harm to a member.

Performance consistently falling outside of written standards, with failure to make progress in corrective actions, may result in the recommendation to close primary care panels; contracting with additional practitioners or providers if needed; and adverse credentialing or contracting decisions in cases of persistent failure to make progress towards meeting standards.

Member Medical Records

Simpra Advantage participating providers are required to maintain patient medical records current and in accordance with HIPAA privacy regulations. Member information must be kept confidential and stored in a secure location where only authorized personnel can access.

Patients have the right to approve or refuse the disclosure of their medical records when required by law. Providers must maintain a clinical record system that supports the capacity to properly process, store, retrieve and distribute medical records.

The following must be included in patient medical records:

- Identifying information of the member
- Identification of all providers participating in the member's care and information regarding services furnished by the providers
- Significant illnesses and medical and psychological conditions
- Presenting complaints, diagnose and treatment plans
- Prescribed medications, including dosages and dates of initial or refill prescriptions
- Information on allergies and adverse reactions
- Past medical history, physical exams, courses of treatment and possible risk factors
- Patient immunization records
- Indicate member's preference for a Power of Attorney
- Include a copy of member's advance directive if one is available
- Health education and wellness promotion services accessed by members

Unless otherwise stated in the provider agreement, Simpra Advantage has the right to request and access Simpra Advantage patient medical records for the purposes of claim payment, quality of care, coordinating treatment plans, utilization management reviews or as part of a CMS, state, or federal audit.

Provider Marketing Guidelines

CMS has advised Medicare Advantage plans to prohibit providers from steering or attempting to steer an undecided potential enrollee toward a specific plan or limiting the number of plans offered either by the Plan or another sponsor based on the financial interest of the provider or agent. Providers should remain neutral to the extent they assist beneficiaries with enrollment decisions. Please consult the CMS Marketing Guidelines or other CMS published materials for the full list of acceptable marketing activities.

Activities that may and may not be performed by a Provider are listed in the sections below. The following table provides some important terms to know when considering what activities are appropriate:

Term	Definition
Permission to Contact (PTC)	Documentation that indicates that a beneficiary or their responsible party has requested additional information about the health plan.
Scope of Appointment (SOA)	Documentation of a sales appointment with a beneficiary or their responsible party. The document is signed before any benefits discussion, specifies that no other product type outside of those in the beneficiary's original request is discussed, and states that there is no obligation to enroll in the Plan.
Enrollment Application	Form that must be signed by the beneficiary (or their Power of Attorney) to enroll the beneficiary in the health plan.

Permitted Provider Activities

- Suggest looking into Plan membership as a matter of course in treatment.
- Refer patients to the Plan marketing materials available in common areas.
- Display and distribute Simpra Advantage marketing materials in common areas. The office must display or offer to display materials for all participating Medicare Advantage plans if requested by the Plan.
- Collect a Permission to Contact (PTC) form if a patient/resident or their authorized representative voices interest in learning more about a Simpra Advantage plan.
- Pass a Permission to Contact (PTC) form to a Simpra Advantage sales representative.

- Mail or provide a letter to patients notifying them of their affiliation with Simpra Advantage. Announcements may not include marketing content.

- Provide objective information while treating the patient about specific Plan attributes and formularies, based on a patient's medications and healthcare needs.

- Answer questions or discuss the merits of a plan or plans, including cost-sharing and benefit information (these discussions may occur in areas where care is delivered).

- Refer patients to other sources of information, such as the State Health Insurance Assistance Programs (SHIPs), Simpra Advantage marketing representatives, state Medicaid, or 1-800-Medicare to assist the patient in learning about the Plan and making a healthcare enrollment decision.

- Provide beneficiaries with communication materials (not marketing materials) furnished by Simpra Advantage in a treatment setting.

- Provide information and assistance in applying for the Low-Income Subsidy (LIS).

- Display promotional items with the Simpra Advantage logo.

- Allow Simpra Advantage to have a room/space in provider offices separate from where patients receive healthcare services, to provide Medicare beneficiaries with access to a Simpra Advantage sales representative.

Prohibited Provider Activities

- Offer anything of value to induce enrollees to select them as their provider.

- Distribute marketing materials or applications in areas where healthcare is provided.

- Make phone calls or direct urge or attempt to steer a patient towards any specific plan or a limited set of plans based on financial or other interests of the provider Mail marketing materials on behalf of the Plan.

- Collect/accept Scope of Appointment (SOA) forms or enrollment applications on behalf of the Plan.

- Offer inducements to persuade patients/beneficiaries to enroll in a particular plan or organization.

- Health screen potential enrollees as a marketing activity or when distributing Plan information to patients.

- Accept compensation directly or indirectly from the Plan for any marketing or beneficiary enrollment activity.

- Call members who are disenrolling from Simpra Advantage to encourage re-enrollment in the plan.

- Call patients to invite them to the sales and marketing activities of a health plan.
- Advertise using Simpra Advantage's name without Simpra Advantage's prior consent and CMS approval, depending upon the content of the advertisement.

Emergency/Disaster Situations

In the event of an Emergency or Disaster declaration by the President, the Governor, or an announcement of a public health emergency by the Secretary of Health and Human Services, members should have access to providers, services, and medications. When a declaration notice is received, the notice is posted to the Plan website indicating the impacted state, counties, effective date, and declaration expiration date.

To ensure customers have access to the services needed, as of the declaration effective date, the Plan will:

- Waive requirements for gatekeeper referrals where applicable;
- Temporarily reduce plan-approved out-of-network cost sharing to in-network cost sharing amounts;
- Waive the 30-day notification requirement to enrollees if all the changes (such as reduction of cost sharing and waiving authorization) benefit the enrollee;
- Allow Part A and Part B and supplemental Part C plan benefits to be furnished at specified noncontracted facilities (note that Part A and Part B benefits must, per 42 CFR §422.204(b)(3), be furnished at Medicare-certified facilities);
- Ensure customers have adequate access to covered Part D drugs dispensed at out-of-network pharmacies when those customers cannot reasonably be expected to obtain covered Part D drugs at a network pharmacy, and when such access is not routine;
- As necessary, lift the "refill-too-soon" edits; and
- Allow affected customers to obtain the maximum extended day supply, if requested and available at time of refill.

Member Assignment to New PCP

PCPs receive regular updates of member assignments and related services and benefits. Simpra's PCPs have a limited right to request a member be assigned to a new PCP. A provider may request to have a member moved to the care of another provider due to the following:

- Fraudulent use of services or benefits.
- The member is disruptive, unruly, threatening, or uncooperative to the extent his/her membership seriously impairs the provider's ability to provide services to the member, and a physical or behavior health condition does not cause the behavior noted above.

- Threats of physical harm to a provider and/or his/her office staff.
- Non-payment of required patient share responsibility for services rendered to members who are not Dual Eligibles (Medicare and Medicaid).
- Receipt of prescription medications or health services in a quantity or manner which is not medically beneficial or not medically necessary.
- Repeated refusal to comply with office procedures essential to the functioning of the provider's practice or to accessing benefits under the managed care plan.
- The provider should make reasonable efforts to address the member's behavior that has an adverse impact on the patient/physician relationship through education and counseling and, if medically indicated, referral to appropriate specialists.
- Simpra Advantage will document all actions taken by the provider and Simpra Advantage to cure the situation, including member education and counseling. A Simpra Advantage PCP cannot request a disenrollment based on an adverse change in a member's health status or utilization of services medically necessary for treatment of a member's condition.
- A member also may request a change in PCP at any time. The PCP change requested by the member will be effective the first of the month following the receipt of the request unless circumstances require an immediate change.

Quality of Care Concerns

Simpra Advantage is committed to ensuring members receive quality care according to recognized standards of care. Quality of Care concerns may include specific Clinical Quality Indicators and Quality of Care Complaints. Quality Indicators are defined as an adverse outcome occurring in any care setting indicative of potential inappropriate or incomplete medical care. Quality of Care Complaints are those concerns reported by members, families, staff, or providers indicating a potential problem in the provision of quality care and services.

The purpose of identifying these concerns is to identify opportunities to improve clinical care and service. Clinical Quality Indicators may include the following examples:

- Unplanned readmission to the hospital (within 30 calendar days)
- Inpatient hospitalization following outpatient surgery
- Post-operative complications (including an unplanned return to the Operating Room)
- Falls with injury or harm
- Unplanned removal, injury, or repair of organ or structure during the procedure (excludes incidental appendectomy)
- Avoidable incidences resulting in injury to the member

- Mortality review (in cases where death was not an expected outcome)
- Quality of care complaints are categorized as:
    - Availability of services
    - Clinical quality concerns
    - Provider/staff concerns

All reported potential Quality of Care concerns are reviewed and tracked. Simpra Advantage often requests records from providers and facilities as part of the process. The Quality Improvement Committee reviews trends related to Quality of Care concerns and may recommend actions to prevent future instances. Any action taken based on severity or trend is documented in the Simpra Advantage provider record and reviewed by the Credentialing Committee at the time of recredentialing.

Quality Improvement Program

The Simpra Advantage Quality Improvement (QI) Program mission is to provide an effective, system-wide, measurable approach to continuous monitoring, evaluating, and improving access, quality of care and services for enrolled members and to work with providers to ensure a quality health care experience for enrolled members using a cost-effective and efficient method.

The QI Program ensures we have the necessary infrastructure to coordinate care, promote quality, performance, and efficiency on an ongoing basis. We take a proactive approach to assure quality care and improve the way we engage with members, providers, and other stakeholders to realize our mission and commitment to member care.

The QI Program is designed to systematically evaluate and monitor the quality, appropriateness, and outcome of care/services delivered to Simpra Advantage members. The QI Program is designed to provide mechanisms for continuous improvement and problem resolution.

Our QI Program includes all elements of the CMS Health Plan Management System (HPMS) template and is written to ensure compliance with Medicare Managed Care Manual, Chapter 5 and 16b.

Quality improvement activities include the following:

- Monitoring/review of provider accessibility and availability
- Monitoring/review of member satisfaction/grievances
- Monitoring/review of member safety
- Monitoring/review of continuity and coordination of care
- Clinical measurement and improvement monitoring of the SNP Model of Care (MOC) and all QI activity

- Documentation, analysis, re-measurement, and improvement monitoring of member health outcomes utilizing our care management platform
- Chronic Care Improvement Program (CCIP)
- Collection and reporting of Healthcare Effectiveness Data and Information Set (HEDIS)
    - Measures of member and provider satisfaction including participation and analysis of the Health Outcomes Survey (HOS) and Consumer Assessment of Health Plan Survey (CAHPS), if required.
- Provider credentialing and recredentialing
- Provider peer review oversight
- Clinical practice guidelines
- Monitoring and analysis of utilization measures
- Monitoring and analysis of adverse outcomes/sentinel events
- Collection and reporting of Part C Reporting Elements
- Collection and reporting of Part D Medication Management data

Providers play an active role in making sure members receive quality care. Providers and Facilities are expected to cooperate with quality improvement activities implemented by Simpra Advantage. These initiatives may take place at the individual provider level or a facility level and may include provider incentives or other contracting initiatives. Provider incentives are developed and reviewed annually based on key performance metrics. These incentives are designed to promote collaboration to improve member health and patient outcomes. For more information on this year's Quality Incentive Program please contact your Provider Relations representative.

Providers are required to deliver services, establish internal structures to monitor performance and report on quality improvement initiatives, as requested. Quality improvement initiatives may include medical record requests for the annual HEDIS measure reporting, documentation audits, surveys on access, satisfaction, and investigation of reported quality of care issues.

Each year, Simpra Advantage will monitor and evaluate our QI Program performance and implement improvement activities through the following documents:

- Quality Improvement Program Description (QIPD) defines the quality infrastructure that supports Simpra Advantage strategies. The QIPD establishes QI program governance, scope, goals, objectives, structure, and responsibilities.
- Quality Improvement Work Plan tracks and monitors ongoing progress of QI activities throughout the year.

- Quality Improvement Annual Evaluation assesses outcomes of clinical and administrative programs, processes, patient safety and service delivery. This Annual document evaluates the status of QI Program goals and objectives.

Providers and members may request a copy of the Quality Improvement Program or Annual Evaluation at any time.

Clinical Practice Guidelines

The following clinical practice guidelines are intended to support our health care team and serve as resources to ensure our providers have the most up-to-date, evidence-based information recommended by nationally recognized organizations.

These are resources you may find beneficial in the care of our members. Some of these sources may require a subscription.

AMDA:

The Society for Post-Acute and Long-Term Care Medicine - the standard care process in the post-acute and long-term care (PA/LTC) setting.

https://paltc.org/products/full-set-clinical-practice-guidelines-and-7-pocket-guides

COPD:

Global Strategy for the Diagnosis, Management and Prevention of COPD.

Clinicians - Global Initiative for Chronic Obstructive Lung Disease - GOLD (goldcopd.org)

Diabetes:

Standards of Medical Care in Diabetes—2022 Abridged for Primary Care Providers | Clinical Diabetes | American Diabetes Association (diabetesjournals.org)

Heart Failure:

2022 AHA/ACC/HFSA Guideline for the Management of Heart Failure

https://www.ahajournals.org/doi/epub/10.1161/CIR.0000000000001063

Hypertension:

ACC and American Heart Association (AHA) guidelines for the detection, prevention, management, and treatment of high blood pressure.

2020 International Society of Hypertension Global Hypertension Practice Guidelines (ahajournals.org)

Dementia:

Alzheimer's Association Dementia Care Practice Recommendations

Clinical Practice Guidelines for the Management of Behavioral and Psychological Symptoms of Dementia: A Systematic Review With AGREE II (nih.gov)

Centers for Medicare & Medicaid Services:

National Partnership to Improve Dementia Care in Nursing Homes | CMS

Osteoporosis:

2020 Clinical Practice Guidelines for Postmenopausal Osteoporosis

American Association of Clinical Endocrinologists/American College of Endocrinology Clinical Practice Guidelines for the Diagnosis and Treatment of Postmenopausal Osteoporosis—2020 Update (sciencedirectassets.com)

Guidelines are provided for informational purposes only and are not meant to direct individual treatment decisions. All patient care and related decisions are the sole responsibility of providers. These guidelines do not dictate or control a provider's clinical judgement regarding the appropriate treatment of a patient in any given case.

Medical Necessity

"Medically Necessary" or "Medical Necessity" means health care services or supplies that a physician, exercising prudent judgement, would provide and/or order for a patient. The services must be:

- in accordance with generally accepted standards of medical practice;
- clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease; and
- not primarily for the convenience of the patient, physician, or other health care provider, and
- not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury, or disease

Simpra Advantage utilizes the following Medical Necessity criteria to guide utilization management decisions. This may include, but is not limited to, decisions involving inpatient reviews, prior authorizations, level of care, and retrospective reviews.

- CMS Medicare Coverage Database (Search page)
- InterQual

- HPG-01 Skill in Place:

Simpra Advantage Plan Utilization Management department authorizes Skill in Place (Part A) services for enrollees who meet Centers for Medicare and Medicaid Services (CMS) criteria for skilled services as specified in chapter eight of the Medicare Benefit Policy Manual (8.30 – Skilled Nursing Facility Level of Care – Genera). Skill in Place is a unique service provided to enrollees living in skilled nursing facilities who are not post-acute, (recently discharged from an inpatient hospitalization) but require skilled services to prevent an acute hospitalization or visit to an emergency department. The Skill in Place guideline was created as a tool to assist skilled nursing facilities in their decision to start a Simpra Enrollee on Skill in Place services.

- HPG-02 Home Health:

Simpra Advantage Plan Utilization Management department authorizes home health services for enrollees who meet Centers for Medicare and Medicaid Services (CMS) criteria for skilled services in their home (Medicare Benefit Policy Manual, Chapter 7- Home Health Services, Section 20- Conditions to be Met for Coverage of Home Health Services, Section 30- Conditions Patient Must Meet to Qualify for Coverage of Home Health Services). The Home Health guideline was created as a tool for contracted home health agencies to refer to when starting care for Simpra members. Simpra does not require prior authorization for home health agencies to initiate care for Simpra members and the Home Health guideline walks the home health agency through when and how to submit their request for authorization of services to care for our members.

Simpra Advantage Medical Necessity criteria does not supersede state or Federal law or regulation.

Utilization Reporting and Monitoring

Under- and over-utilization may indicate inadequate coordination of care or inappropriate utilization of services and may be harmful to the patient. Utilizing data from provider and practitioner sites, individual product lines, the utilization management documentation system, and claims management system, Simpra Advantage monitors for under- and over-utilization, analyzes data to identify the causes, and takes action to correct any issues identified. Simpra Advantage then implements appropriate interventions whenever potential problems are identified and will further monitor the effect of these interventions.

Simpra Advantage also carefully ensures that its quality-based incentives are aligned to encourage appropriate decisions on the delivery of care to members. Simpra Advantage unequivocally promises members, providers, and employees that it does not employ incentives to encourage barriers to care and service.

Member Rights

Advance Medical Directives

The Federal Patient Self-Determination Act ensures the patient's right to participate in healthcare decision-making, including decisions about withholding resuscitative services or declining/withdrawing life sustaining treatment. Simpra Advantage requires all participating providers to have a process in place under the intent of the Patient Self Determination Act. All providers contracted with Simpra Advantage may be informed by the member that the member has executed, changed, or revoked an advance directive. Participating providers may not condition the provision of care or otherwise discriminate against an individual based on whether the individual has executed an advance directive.

At the time a service is provided, the provider should ask the member to provide a copy of the advance directive to be included in his/her medical record. If the PCPs and/or treating provider cannot as a matter of conscience fulfill the member's written advance directive, he or she must timely advise the member and Simpra Advantage.

Simpra Advantage and the PCPs and/or treating provider will arrange for a transfer of care. To ensure providers maintain the required processes for advance directives, Simpra Advantage conducts periodic member medical record reviews.

Additional Rights

The right to be treated with dignity and respect

Members are afforded appropriate privacy and treated with respect, consideration, and dignity. Simpra Advantage and its contracted providers must obey applicable laws that prohibit discrimination on the basis of a person's race, ethnicity, national origin, religion, sex, age, mental or physical disability or medical condition, sexual orientation. Providers may not discriminate against enrollees based on their payment status or refuse to serve enrollees because they receive assistance with Medicare cost sharing from a state Medicaid program. If members need help with communication, such as a language interpreter, they should be directed to call the Member Services at **844-637-4770 (TTY users call 833-312-0044)**. Member Services can also help members file complaints about access to facilities (such as wheelchair access). Members can also call the Office for Civil Rights at **1-800-368-1019** or **TTY/TDD 1-800-537-7697**, or the Office for Civil Rights in their area for assistance.

The right to see participating providers, get covered services and get prescriptions filled promptly

Members will get most or all their healthcare from participating providers—the doctors and other health providers who are part of Simpra Advantage. Members have the right to choose a participating provider. Simpra Advantage will work with members to ensure they find

physicians who are accepting new patients. Members have the right to go to a women's health specialist (such as a gynecologist) without a referral. Members have the right to timely access to their providers and to see specialists when needed. Members also have the right to access their

prescription benefit promptly. Timely access means members can get appointments and services within a reasonable amount of time. The Evidence of Coverage (EOC) explains how members access participating providers to get the care and services they need. It also explains their rights to get care for a medical emergency and urgently needed care.

The right to know about treatment choices and to participate in decisions about their healthcare

Members have the right to get full information from their providers when they receive medical care, and the right to participate fully in treatment planning and decisions about their healthcare. Simpra Advantage's providers must explain things in a way that members can understand. Members have the right to know about all the treatment choices that are recommended for their condition, including all appropriate and medically necessary treatment options, no matter what their cost or whether Simpra Advantage covers them. This includes the right to know about the different Medication Management Treatment (MTM) Programs that Simpra Advantage offers and those in which members may participate. Members have the right to be told about any risks involved in their care.

Members have the right to receive a detailed explanation from Simpra Advantage if they believe a Plan Provider has denied care that they believe they are entitled to receive or care they believe they should continue to receive. In these cases, members must request an initial decision. Initial decisions are discussed in members' EOC.

Members have the right to refuse treatment. This includes the right to leave a hospital or other medical facility, even if their doctors advise them not to leave. This also may include the right to stop taking their medication. The provider should counsel members on the risks and benefits of their decision. However, if members refuse treatment, they accept responsibility for what happens because of refusing treatment.

The right to make complaints

Members have the right to file a complaint if they have concerns or problems related to their care or coverage. Members or an appointed/authorized representative may file appeals or grievances regarding care or coverage determinations. If members make a complaint or file an appeal determination, Simpra Advantage will treat them fairly and not discriminate against them because they made a complaint or filed an appeal or coverage determination. Members should be directed to call the Member Services Department to obtain information relative to appeals, grievances, or concerns, and/or coverage determinations.

Right to receive complete and accurate health information

Members or legally authorized designees should receive complete and accurate information concerning about the member's health evaluation, diagnosis, treatment, and prognosis and have the right to participate in health care decisions unless such information is contraindicated for medical reasons.

In addition to the above, members have the right to:

- Maintain confidentiality of their health information
- Refuse to participate in research, if applicable
- Interpretive services, as necessary
- Access to information regarding advance directives, as required by state or federal laws and regulations
- Access to provider credentials upon request
- Change providers, including PCPs and expedite the request to change
- Receive information about a provider's malpractice insurance upon request
- Request a second opinion related to health care treatment and services

Safety and Sanitary Environments

Simpra Advantage participating providers must ensure the servicing site and equipment used is adequate to provide needed services to Plan customers. In general, the servicing site must:

- Meet Americans with Disabilities Act (ADA) site standards
- Meet building safety standards such as, but not limited to, exit signs, fire extinguishers visible, sprinklers, etc.
- Have emergency and disaster policies are in place
- Have adequate space to facilitate treatment and prevent cross contamination
- Have designated treatment or exam rooms that provide adequate patient privacy
- Be free of obstructions to allow adequate flow of delivered services
- Ensure medical equipment needed for treatment is cleaned, serviced routinely, and functioning properly
- Have secure locations, lockboxes, or storage areas to protect syringes, needles, or any medical equipment from unauthorized use
- Implement infection prevention programs and appropriate hand hygiene that include provisions to report untoward events in accordance with nationally recognized standards, such as the Centers for Disease Control and Prevention (CDC)

- Implement programs to reduce and avoid medication errors and prevent falls and physical injuries
- Implement safety protocols to properly manage potential threats and hazards

Compliance Program

Overview

The purpose of the Simpra Advantage Compliance Program is to articulate our commitment to compliance with all pertinent regulatory requirements. It also serves to encourage Associated Care Ventures employees, Simpra Advantage network providers and other contractors, and other interested parties to develop a better understanding of the laws and regulations that govern Simpra Advantage's operations.

Simpra Advantage is committed to full compliance with federal and state regulatory requirements applicable to our Medicare Advantage and Medicare Part D lines of business. Non-compliance with regulatory standards undermines Simpra Advantage's business reputation and credibility with the federal and state governments, subcontractors, pharmacies, providers, and most importantly, its members.

Simpra Advantage's Compliance Department serves as the hub for all internal and external compliance concerns, compliance reporting and training, and oversees processes regarding compliance and Fraud, Waste and Abuse (FWA) training by our first-tier, downstream or related entities (FDRs). Medicare program requirements apply to FDRs; therefore, Simpra Advantage monitors and audits its first-tier entities to ensure compliance with all applicable federal and state laws. Onsite audits may be conducted when deemed necessary, often as a result of a risk assessment, the tracking and trending of member complaints related to access, service or care provided or FDR performance below acceptable service level metrics.

The Compliance Program is designed to prevent violations of federal and state laws governing Simpra Advantage's lines of business, including but not limited to, healthcare FWA laws. In the event such violations occur, the Compliance Program will promote early and accurate detection, prompt resolution, and when necessary, disclosure to the appropriate governmental authorities.

If you have compliance concerns or questions, call the Simpra Advantage Compliance Hotline toll-free at **1-833-416-5035** or visit the website, SimpraAdvantage.ethicspoint.com.

You may request a copy of Simpra Advantage Compliance Program document by contacting Simpra Advantage Provider Services via email at: compliance@simpra.com or call: **1-844-637-4770 (TTY: 833-312-0044).**

Fraud, Waste, and Abuse

The CMS requires Medicare Advantage Organizations (MAOs), such as Simpra Advantage, to implement and maintain an effective compliance program that includes measures to prevent, detect and correct Medicare Part C and Part D program non-compliance and FWA. Simpra Advantage has policies and procedures in place to identify suspected FWA, as well as other processes to identify and properly recover overpayments. These procedures allow the Plan to report potential fraud or misconduct related to the Medicare program to the appropriate government authority as specified at 42 U.S.C. § 1395w-104 and 42 C.F.R. § 423.504(b)(4)(vi)(H), and Simpra Advantage has policies and procedures in place for cooperating with CMS and law enforcement entities.

Associated Care Ventures/ Simpra Advantage (ACV/Simpra) monitors all aspects of its business and its business relationships with third parties, including healthcare providers and members to detect fraudulent and abusive practices. All employees, contractors, and other parties are required to report compliance concerns and suspected or actual misconduct to the Simpra Advantage Chief Compliance Officer.

Simpra Advantage conducts a periodic analysis of all levels of Current Procedural Terminology (CPT), ICD-9/ICD-10, and HCPCS codes billed by our providers. The analysis allows Simpra Advantage to comply with its regulatory requirements for the prevention of FWA, and to supply our providers with useful information to meet their own compliance needs. Simpra Advantage will review your coding and may review medical records of providers who continue to show significant variance from their peers.

Simpra Advantage endeavors to ensure compliance and enhance the quality of claims data, a benefit to both Simpra Advantage's medical management efforts and our provider community.

To meet your FWA obligations, please review and revise your coding policies and procedures for compliance and adherence to CMS guidelines necessary to ensure they are consistent with official coding standards.

Reporting Compliance Matters

There are many specific regulations that Simpra Advantage must follow. If you have any compliance matters you would like to report you may report then to the Simpra Advantage's Chief Compliance Officer, or Compliance Department in the following ways:

1. By Email at: compliance@simpra.com
2. By phone at: **1-833-416-5035 (TTY 711)**
3. By Mail to: ATTN: Chief Compliance Officer, Associated Care Ventures/Simpra Advantage, 3008 7th Avenue South, Birmingham, Alabama 35233
4. If you prefer, you may report anonymously three different ways:

a. Call our toll-free Compliance Hotline at **1-833-416-5035 (TTY 711)**, a confidential resource for employees, contractors, agents, members, or other parties to voice concerns about issues potentially affecting Simpra Advantage's ability to meet legal or contractual requirements and to report suspected or actual misconduct.

b. Click on our online form at: Report Compliance or Fraud Matters

All such communications will be kept as confidential as possible, but there may be times when the reporting individual's identity may become known or need to be disclosed to meet requirements of governmental review actions. Anyone that reports compliance concerns in good faith can do so without fear of retaliation.

Standards of Conduct

The Simpra Advantage Standards of Conduct states the overarching principles and values by which Simpra Advantage operates and defines the underlying framework for our Compliance Program. The Standards of Conduct describes our expectations that:

- All ACV employees, and FDRs conduct themselves in an ethical manner
- Potential/Actual acts of non-compliance and FWA are reported via appropriate means
- Reported issues will be addressed and corrected