SOLIS HEALTH PLANS

2020

Provider Handbook

Medicare Advantage Plan Resource Guide

H0982 01/01/20 - 12/31/20

TABLE OF CONTENTS

WELCOME TO SOLIS HEALTH PLANS!

Solis Health Plans, Inc., ('Solis') is a Health Maintenance Organization with a Medicare Advantage contract and operating currently in the State of Florida.

Effective January 1, 2021, Solis will be fully operating in the following counties:

County	SOLIS MAPD PLANS	SOLIS D-SNP PLANS	Solis C-SNP PLANS
Broward	SPF 007	SPF 012	SPF 011
Hillsborough	SPF 009	SPF 010	
Miami-Dade	SPF 001	SPF 002	
Orange	SPF 005	SPF 006	
Palm Beach	SPF 008	SPF 013	

The use of 'Provider' within this Handbook refers to entities and individuals contracted with Solis. Solis is committed to assist you and your office staff with hassle-free healthcare administration by supplying you with the information you need. Our Provider Handbook has been structured with you in mind-to make it easier for you to do business with Solis.

This Provider Handbook applies to participating Providers who are currently in network with Solis. All policies, procedures, and guidelines are explained and will provide you and your office staff with helpful information as you serve Solis Members. This information is intended to provide guidance for various situations your office may encounter while participating with Solis. It is imperative that all participating Providers and applicable office staff review this Provider Handbook and abide by all provisions contained herein. Any requirements under applicable Federal and State law, regulation or Solis policy & procedures that may be subject to change and are not expressly set forth in the content of this Handbook shall be incorporated herein by this reference and shall apply to providers and/or Solis where applicable. Such laws and regulations, if more stringent, take precedence over the content in this Handbook. Providers are responsible for complying with all laws and regulations that are applicable.

Solis will update our Provider Handbook as deemed necessary. For the most current version, please by contacting Provider Services at 833-615-9259 from 8:00am to 5:00pm or email providerrelations@solishealthplans.com.

QUICK REFERENCE GUIDE

SOLIS HEALTH PLANS

PROVIDER/DEPARTMENT	CONTACT INFORMATION
Eligibility & Benefits	SOLIS Provider Portal: www.solishealthplans.com Member Services: 833-615-9262
Member Services	Telephone: 844-447-6547
Provider Services	Telephone: 833-615-9259
Credentialing/Re-Credentialing	Registration for Credentialing Application: CAQH https://proview.caqh.org/PR/Registration Corrections to Credentialing Application: Email credentialing@solishealthplans.com Questions about Credentialing: Email credentialing@solishealthplans.com Status of Credentialing: Email credentialing@solishealthplans.com
Claims Status	SOLIS Provider Portal: www.solishealthplans.com Provider Services: 833-615-9259
Claims Address	Availity: www.availity.com (SOLIS Payor ID: SOLIS) Smart Data Solution (SDS): www.sdata.us (SOLIS Payor ID: 73581) Paper Claims: SOLIS Health Plans Attn: Claims P.O. Box 211486 Eagan, MN 55121
EFT Services (Payment Status, Technical Support, Bank Account Updates, Registration)	Telephone: 877-331-7154, Option #1 Email: providersupport@payspanhealth.com Website: http://www.payspanhealth.com
Provider Portal Help Line	Telephone: 833-615-9259
Grievance & Appeals	Fax: 833-615-9263
Authorization Intake (Utilization Management/Case Management)	Telephone: 833-615-9260
Prior Authorization Fax	Fax: 833-210-8141

SOLIS HEALTH PLANS' EXTERNAL NUMBERS

Case Management/Disease Management Fax	Fax: 833-615-9261
Behavioral Health	Telephone: 833-615-9260
Compliance	Telephone: 833-896-3761 Fax: 305-675-0532
Fraud, Waste & Abuse Hotline	Telephone: 833-896-3762
Centers for Medicare & Medicaid Services (CMS)	Telephone: 800-465-3203
Agency for Health Care Administration (AHCA) consumer complaint hotline	Telephone: 888-419-3456
DME, Home Health, Infusion Services (Coastal Care Services)	Telephone: 833-371-9571
Hearing Services (20/20)	Telephone: 833-371-9573
Dental Services (Liberty Dental)	Telephone: 833-371-9575
Vision Services (Premier Eye)	Telephone: 833-371-9570
Over-the-Counter Benefit (SunScripts)	Telephone: 833-898-7046
Wellness Benefit (Silver & Fit)	Telephone: 833-371-9576
Transportation (EPIC Non-Emergent Transportation)	Telephone: 833-371-9574
Lab Services (Quest)	Telephone: 866-697-8378
24-Hour Nurse Line	Telephone: 833-371-9569

Provider Services

HOURS OF OPERATION:

8:00 a.m. to 5:00 p.m.

Monday through Friday

SOLIS HEALTH PLANS

DEFINTIONS

Abuse - Providing information or documentation for a health care claim in a manner that improperly uses program resources for personal gain or benefit, yet without sufficient evidence to prove criminal intent

Appeal - An *appeal* includes any of the procedures that deal with the review of adverse organization determinations/coverage determinations on the health care services/prescription drug benefits a member believes he or she is entitled to receive, including delay in providing, arranging for, or approving the health care services/drug coverage (such that a delay would adversely affect the health of the member), or any amounts the member must pay.

Balance Billing - When a provider bills you for the difference between the provider's charge and the allowed amount. For example, if the provider's charge is $100 and the allowed amount is $70, the provider may bill you for the remaining $30. A preferred provider may not balance bill you for covered services.

Centers for Medicare & Medicaid Services (CMS) – Government agency responsible for overseeing the Medicare and Medicaid Programs.

Chronic Special Needs Plans (CSNP) - Health Plans that enroll individuals who are experiencing chronic and disabling health conditions; these benefit plans are available in specific counties.

Concurrent Review - Part of utilization management in which review of tests and procedures is conducted while the care is being provided (member is still in the hospital). Reviewers, usually nurses, monitor appropriateness of the care, the setting, and the progress of discharge plans **Coordination of Benefits -** A way to figure out who pays first when 2 or more health insurance plans are responsible for paying the same medical claim.

Coverage Determination - The first decision made by a plan regarding the prescription drug benefits an enrollee may be entitled to receive, including the decision not to provide or pay for a Part D drug, a decision concerning an exception request or a decision on the amount of cost- sharing for a drug.

Department of Health and Human Services (HHS) - The federal agency that oversees CMS, which administers programs for protecting the health of all Americans, including Medicare, the Marketplace, Medicaid, and the Children's Health Insurance Program (CHIP).

Downstream entity - Any party that enters into an acceptable written arrangement below the level of the arrangement between a Medicare Advantage (MA) organization, Prescription Drug Plan (PDP), or Medicare Advantage Prescription Drug Plan (MA-PD) and a First-Tier entity. These written arrangements continue down to the level of the ultimate provider of health and/or administrative services.

Dual Eligible Special Needs Plans (D-SNP) – Health Plans that enroll individuals who are entitled to both Medicare (title XVIII) and medical assistance from Florida Medicaid (title XIX).

Durable Medical Equipment (DME) - Equipment and supplies ordered by a health care provider for everyday or extended use. Coverage for DME may include: oxygen equipment, wheelchairs, crutches or blood testing strips for diabetics.

Evidence of Coverage (EOC) - The term evidence of coverage in the context of health insurance refers to any certificate or individual or group agreement or contract issued in concurrence with the certificate, agreement or contract issued to a subscriber. It contains information regarding coverage and other rights to which an enrollee is entitled

Exception - A type of coverage determination request. Through the exceptions process an enrollee can request a non-formulary drug; an exception to the plan's tiered cost-sharing structure and an exception to the application of a cost utilization management tool (e.g., step therapy requirement, dose restriction or prior authorization requirement).

Explanation of Benefit (EOB) - An explanation of benefits is a statement sent by a health insurance company to covered-individuals explaining what medical treatments and/or services were paid for on their behalf. The EOB is commonly attached to a check or statement of electronic payment.

First Tier entity - Any party that enters into a written arrangement with a MA organization, PDP, or MA-PD to provide administrative or health care services for a Medicare eligible individual.

Fraud - Intentional misuse of information in-order-to persuade another to part with something of value or to surrender a legal right. It could also be an act of planned deception or misrepresentation

Grievance - A *grievance* is any complaint or dispute, other than one involving an organization/coverage determination or late enrollment penalty determination, expressing dissatisfaction with any aspect of the operations activities or behavior, regardless of whether any remedial action can be taken. Furthermore, grievances may include complaints regarding the timeliness, appropriateness, access to, and/or setting of a provided health service, procedure, or item. Grievance issues may also include complaints that a covered health service procedure or item during a course of treatment did not meet accepted standards for delivery of health care.

Health Insurance and Portability Act (HIPAA) - Acronym that stands for the Health Insurance Portability and Accountability Act, a US law designed to provide privacy standards to protect patients' medical records and other health information provided to health plans, doctors, hospitals and other health care providers.

Health Maintenance Organization (HMO) - A type of health insurance plan that usually limits coverage to care from doctors who work for or contract with the HMO. It generally won't cover out-of-network care except in an emergency. An HMO may require you to live or work in its service area to be eligible for coverage. HMOs often provide integrated care and focus on prevention and wellness.

Medicaid - Insurance program that provides free or low-cost health coverage to some low-income people, families and children, pregnant women, the elderly, and people with disabilities. Many states have expanded their Medicaid programs to cover all people below certain income levels. Whether you qualify for Medicaid coverage depends partly on whether your state has expanded its program. Medicaid benefits, and program names, vary somewhat between states. You can apply anytime. If you qualify, your coverage can begin immediately, any time of year.

Medicare - A federal health insurance program for people 65 and older and certain younger people with disabilities. It also covers people with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a transplant, sometimes called ESRD). Medicare isn't part of the Health Insurance Marketplace. If you have Medicare coverage you don't have to make any changes. You're considered covered under the health care law.

Medicare Advantage (MA) - A type of Medicare health plan offered by a private company that contracts with Medicare to provide you with all your Part A and Part B benefits. Medicare Advantage Plans include Health Maintenance Organizations, Preferred Provider Organizations, Private Fee-for-Service Plans, Special Needs Plans, and Medicare Medical Savings Account Plans. If you're enrolled in a Medicare Advantage Plan, most Medicare services are covered through the plan and aren't paid for under Original Medicare. Most Medicare Advantage Plans offer prescription drug coverage.

Medication Therapy Management - A range of services provided to individual patients to optimize therapeutic outcomes (help patients get the most benefit from their medications) and detect and prevent costly medication problems

Offshore subcontractor - is defined as a first-tier/downstream/related entity located outside of one of the fifty U.S. states, the District of Columbia, or one of the United States Territories (American Samoa, Guam, Northern Marianas, Puerto Rico, and Virgin Islands).

Orthotics involves precision and creativity in the design and fabrication of external braces (orthoses) as part of a patient's treatment process. The orthosis acts to control weakened or deformed regions of the body of a physically challenged person.

Primary Care Provider (PCP) - A physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine), nurse practitioner, clinical nurse specialist or physician assistant, as allowed under state law, who provides, coordinates or helps a patient access a range of health care services.

Prior Authorization - Approval from a health plan that may be required before you get a service or fill a prescription in order for the service or prescription to be covered by your plan

Prosthetics involves the use of artificial limbs (prostheses) to enhance the function and lifestyle of persons with limb loss. The prosthesis must be a unique combination of appropriate materials, alignment, design, and construction to match the functional needs of the individual.

Reconsideration - A *reconsideration* is an appeal to Solis Health Plans about a medical care coverage decision. This is the member's first step in the appeals process after an adverse organization determination.
Redetermination - A *redetermination* is an appeal to Solis Health Plans about a Part D drug coverage decision. This is the member's first step in the appeals process, which involves Solis Health Plans reassessing an adverse coverage determination, the findings upon which it was based, and any other evidence submitted or obtained.
Referral - A written order from your primary care doctor for you to see a specialist or get certain medical services. In many Health Maintenance Organizations (HMOs), you need to get a referral before you can get medical care from anyone except your primary care doctor. If you don't get a referral first, the plan may not pay for the services.
Related entity - Any entity that is related to the MA, MA-PD, SNP or managed care organization by common ownership or control.
Specialist - A physician specialist focuses on a specific area of medicine or a group of patients to diagnose, manage, prevent or treat certain types of symptoms and conditions. A non-physician specialist is a provider who has more training in a specific area of health care
Specialty Care Provider -
Special Needs Plan (SNP) - A special needs plan (SNP) is a Medicare Advantage (MA) coordinated care plan (CCP) specifically designed to provide targeted care and limit enrollment to special needs individuals. A special needs individual could be any one of the following:

1. An institutionalized individual,
2. A dual eligible, or
3. An individual with a severe or disabling chronic condition, as specified by CMS.

Step Therapy - In managed medical care step therapy is an approach to prescription intended to control the costs and risks posed by prescription drugs. The practice begins medication for a medical condition with the most cost-effective drug therapy and progresses to other more costly or risky therapies only if necessary.
Waste - To use, consume, spend or expend thoughtlessly or carelessly

COMMONLY USED ACRONYMS

AHCA	Agency for Health Care Administration (AHCA)
BFCC-QIO	Florida's Beneficiary and Family-Centered Quality Improvement Organization (BFCC-QIO)
CAP	Corrective Action Plan (CAP)
CCP	Coordinated Care Plan (CCP)
CFR	Code of Federal Regulations (CFR)
CMS	Centers for Medicare & Medicaid Services (CMS)
C-SNP	Chronic Special Needs Plan
DMEPOS	Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS)
D-SNP	Dual Eligible Special Needs Plans
EFT	Electronic Funds Transfer (EFT)
EOB	Explanation of Benefit (EOB)
EOC	Evidence of Coverage (EOC)
EOP	Explanation of Payment (EOP)
ESRD	End-Stage Renal Disease (ESRD)
FDR	First Tier, Downstream, and Related Entity (FDR)
FWA	Fraud, Waste, & Abuse (FWA)
HHS	Department of Health and Human Services (HHS)
HIPAA	Health Insurance and Portability Act (HIPAA)
HMO	Health Maintenance Organization (HMO)
LTC	Long Term Care (LTC)
MA	Medicare Advantage (MA)
MLN	Medicare Learning Network (MLN)
MOON	Medicare Outpatient Observation Notice (MOON)
NCQA	National Committee for Quality Assurance (NCQA)
OIG	Office of the Inspector General (OIG)
OTC	Over-the-Counter (OTC)
PBM	Pharmacy Benefits Manager (PBM)
PCP	Primary Care Provider (PCP)
QIO	Quality Improvement Organization (QIO).
QMB	Qualified Medicaid Beneficiary (QMB)
SNP	Special Needs Plan (SNP)
UM	Utilization Management (UM)

Source: Medicare Managed Care Handbook, Chapter 11, "Medicare Advantage Application Procedures and Contract Requirements", § 100.4 – Provider and Supplier Contract Requirements. (Revised 04/25/07)

The Code of Federal Regulations (CFR) is the codification of the general and permanent rules published in the Federal Register by the executive departments and agencies of the Federal Government. It is divided into 50 titles that represent broad areas subject to Federal regulation.

Each title is divided into chapters, which usually bear the name of the issuing agency. Each chapter is further subdivided into parts that cover specific regulatory areas. Large parts may be subdivided into subparts. All parts are organized in sections, and most citations in the CFR are provided at the section level.

CONTRACT REQUIREMENTS THROUGH POLICIES, STANDARDS & MANUALS	
Safeguard privacy and maintain records accurately and timely	422.118
Permanent "out of area" members to receive benefits in continuation area	422.54(b)
Prohibition against discrimination based on health status	422.110(a)
Pay for emergency and urgently needed services	422.100(b)
Pay for renal dialysis for those temporarily out of a service area	422.100(b)(1)(iv)
Direct access to mammography and influenza vaccinations	422.100(g)(1)
No copay for influenza and pneumococcal vaccines	422.100(g)(2)
Agreements with providers to demonstrate "adequate" access	422.112(a)(1)
Direct access to women's specialists for routine and preventive services	422.112(a)(3)
Services available 24 hrs/day, 7 days/week	422.112(a)(7)
Adhere to CMS marketing provisions	422.80(a), (b), (c)
Ensure services are provided in a culturally competent manner	422.112(a)(8)
Maintain procedures to inform members of follow-up care or provide training in selfcare as necessary	422.112(b)(5)
Document in a prominent place in medial record if individual has executed advance directive	422.128(b)(1)(ii)(E)

Provide services in a manner consistent with professionally recognized standards of care	422.504(a)(3)(iii)
Continuation of benefits provisions (may be met in several ways, including contract provision)	422.504(g)(2)(i); 422.504(g)(2)(ii); 422.504(g)(3)
Payment and incentive arrangements specified	422.208
Subject to applicable Federal laws	422.504(h)
Disclose to CMS all information necessary to (1) Administer & evaluate the program (2) Establish and facilitate a process for current and prospective beneficiaries to exercise choice in obtaining Medicare services	422.64(a): 422.504(a)(4) 422.504(f)(2)
Must make good faith effort to notify all affected members of the termination of a provider contract 30 calendar days before the termination by plan or provider	422.111(e)
Submission of data, medical records and certify completeness and truthfulness	422.310(d)(3)-(4), 422.310(e), 422.504(d)- (e), 422.504(i)(3)-(4), 422.504(l)(3)
Comply with medical policy, QI and MM	422.202(b); 422.504(a)(5)
Disclose to CMS quality & performance indicators for plan benefits re: disenrollment rates for beneficiaries enrolled in the plan for the previous two years	422.504(f)(2)(iv)(A)
Disclose to CMS quality & performance indicators for the benefits under the plan regarding enrollee satisfaction	422.504(f)(2)(iv)(B)
Disclose to CMS quality & performance indicators for the benefits under the plan regarding health outcomes	422.504(f)(2)(iv)(C)
Notify providers in writing for reason for denial, suspension & termination	422.202(c)(1)
Provide 60 days notice (terminating contract without cause)	422.202(c)(4)
Comply with Federal laws and regulations to include, but not limited to: Federal criminal law, the False Claims Act (31 U.S.C. 3729 et. Seq.) and the anti-kickback statute (section 1128B(b) of the Act)	422.504(h)(1)
Prohibition of use of excluded practitioners	422.752(a)(8)
Adhere to appeals/grievance procedures	422.562(a)

ROLES AND RESPONSIBILITIES OF THE PRIMARY CARE PROVIDER (PCP)

In accordance with Solis provider agreement, the below list consists of rules and expectations set forth for all contracted primary care providers.

1. PCP must have 24 hour/day, 7 day/week coverage for members. Hours of operation should be clearly defined and communicated to members.
2. Each primary care provider shall be obligated to provide those primary care services that such primary care provider practitioner has been licensed and credentialed to provide and, other than emergency services, shall be prohibited from providing any services which the primary care provider practitioner has not been credentialed to provide.
3. PCP agrees to refer and/or admit Solis members only to participating physicians and providers (including hospitals, SNFs and other facilities) except when participating physicians and providers are not available in network or in an emergency.
4. PCP agrees to conduct assessments of the members' needs and will make appropriate and timely specialty and care management referrals. PCP will establish office procedures to facilitate the follow-up of member referrals and office visits to specialty care providers by submitting such requests to Solis. Note that referrals may not be required for certain services or benefits.
5. If a new physician is added to a group, Solis must approve and credential the physician before the physician treats enrollees. Notification of changes in the provider staff is the responsibility of the provider's office.
6. At all times hereunder, provider and each primary care provider practitioner shall render services in accordance with:
   (i) the scope of provider's and the applicable primary care provider practitioner's licensure and board certifications, as applicable;
   (ii) the prevailing standards of care of the medical profession in the community in which each primary care provider practitioner practices;
   (iii) the terms and conditions of this agreement and the provider handbook;
   (iv) the provisions of the applicable benefit plan; and,
   (v) state and federal law.
7. Provider and each primary care provider practitioner shall render services without regard to a member's race, ethnicity, religion, gender, color, national origin, age, sexual orientation, genetic information, disability, source of payment, any factor related to physical or mental health status, or on any other basis deemed unlawful under federal, state or local law.
8. PCP agrees not to bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any resources against Solis member other than for copayments, or fees from non-covered services furnished on a fee-for-service basis, non-covered services are services not covered by Medicare or services excluded in the member's Evidence of Coverage.
9. Provider and its primary care provider practitioners shall conduct their medical practice in accordance with the community standards and shall ensure that Primary care services are provided in accordance with Solis objectives of comprehensive, quality care, cost containment, and effective utilization of inpatient, ambulatory and Emergency Services.
10. Provider acknowledges and understands that no guarantees are afforded by Solis as to the number of Members who will be allowed to select or will be assigned to Provider.
11. Contracted PCPs shall provide such Covered services to members enrolled in all Medicare benefit plans, in each case, in accordance with the terms of their provider agreement with Solis.
12. PCP shall comply with Solis standards with respect to timeliness of appointments for well care, sick care, routine care, urgent care and emergency services.

13. PCP agrees to maintain malpractice insurance acceptable to Solis, which shall protect the PCP and its employees. If PCP elects not to carry malpractice insurance, appropriate documentation is to be submitted to Solis and member notification is to be posted in PCP's office or a written statement is to be provided to the members.
14. Provider agrees to maintain, at all times, a sufficient number of Practitioners to service the needs of assigned Members in accordance with the terms of their provider agreement with Solis.
15. PCP shall maintain a clean and safe professional office where services will be rendered and provide, at its sole cost, such supplies, medicines, and equipment as are necessary to render Primary care services hereunder and which are usual and customary for a medical practice in the community in which the Provider is located.
16. PCP shall formally notify Solis with any demographic changes in address, telephone, etc., via the Provider Services line: (833) 615-9259 or Provider Relations email: providerrelations@solishealthplans.com
17. Provider and Primary care provider practitioners will comply with Solis written policies and procedures set forth in the Provider Handbook.
18. PCP shall participate in and abide by Solis written grievance and appeal procedure with respect to the resolution of member complaints and grievances, as more specifically described in Solis provider handbook.
19. Provider shall report and shall cause its primary care provider practitioners to report to Solis all covered services and other services rendered to members promptly after such services are rendered.
20. Provider shall create and maintain medical records for each member receiving services from provider through its primary care provider practitioners.
21. PCP shall maintain the security and confidentiality of such Protected Health Information (PHI) as required by applicable state and federal laws, including HIPAA, and the regulations promulgated thereunder.
22. PCP shall take appropriate measures to prevent the disclosure of PHI other than as permitted by HIPAA. provider and its primary care provider practitioners shall upon becoming aware of a disclosure of PHI in violation of this agreement.
23. PCP will permit Solis or its designee(s), the representatives of accreditation organizations, and representatives of all state and federal agencies with jurisdiction over Solis (the "Regulators"), including, without limitation, AHCA, and the other government agencies to evaluate, through on-site inspection, review of records, patient records and other means, the quality, appropriateness, and timeliness of covered services performed by primary care provider practitioners.
24. PCP shall not to use or publish Solis name or logo in any advertising or marketing materials without the advance written approval of Solis.
25. Provider agrees to submit encounter data to Solis in a CMS 1500 or UB-92/04 electronic format, or its successor format. All encounter data must be submitted within thirty (30) days of the date of service
26. PCP shall provide Solis with complete and accurate encounter data by type of covered services rendered to members in the form and manner and within a timeframe specified by Solis.
27. PCP agrees to cooperate with Solis in the development and maintenance of statistical data records and procedures in support of outcomes linked to quality or safety.
28. PCP shall inform Solis immediately upon exclusion from participation in the Medicare program and acknowledges that Solis is prohibited, by federal law, from contracting with a physician excluded from participation in the Medicare program.
29. PCP shall support and participate in Solis quality assurance and management programs, all utilization review and management programs, and all peer review and quality improvement programs.

30. PCP agrees to inform Solis 60 days prior to the intention to terminate an agreement, in a timely fashion to allow Solis to make a good faith effort to contact the affected member(s) within thirty (30) days of receipt of termination notice.
31. PCP is responsible for verifying eligibility of members before rendering primary care services as appropriate.
32. The PCP must continue care in progress through the effective date of termination.
33. PCP agrees to follow CMS Marketing Guidelines found in the Medicare Managed Care Handbook – Chapter 3.
34. Provider agrees not to collect or attempt to collect copayment, coinsurance, deductibles or other cost-share amounts from any plan Medicare advantage member who has been designated as Qualified Medicare Beneficiary ("QMB") by CMS

Provider Responsibilities under Title VI of the Civil Rights Act of 1964 and the Americans with Disabilities Act (ADA) of 1990

Title VI of the Civil Rights Act of 1964

Title VI of the Civil Rights Act of 1964 prohibits against national origin discrimination which protects individuals with limited English proficiency (LEP). It applies to all entities that receive Federal financial assistance, either directly or indirectly (e.g., through a grant, cooperative agreement, contract/subcontract, Medicaid and Medicare payments, etc.). Virtually all healthcare providers must ensure that LEP patients have meaningful access to health care services at no cost to the patient. "Meaningful access" means that the LEP patient can communicate effectively.

In 2003, the U.S. Department of Health and Human Services (DHHS) issued guidance to assist healthcare providers in complying with Title VI. The DHHS points out that a thorough assessment of the language needs of the population served is to be conducted in order to develop appropriate and reasonable language assistance measures. The Guidance details four (4) factors PCPs should consider when determining the extent and types of language assistance that may be pursued:

1. The number or proportion of LEP individuals eligible to be served or likely to be encountered;
2. The frequency with which the LEP individuals come into contact with the provider;
3. The nature and importance of the program, activity or service provided by the provider to people's lives; and

The resources available to the provider and costs.

ROLES AND RESPONSIBILITIES OF THE SPECIALTY CARE PROVIDER

In accordance with Solis provider agreement, the below list consists of rules and expectations set forth for all contracted Specialists.

1. Specialist must have 24 hour/day, 7 day/week coverage for Members. Hours of operation should be clearly defined and communicated to Members.
2. Each Specialist shall be obligated to provide those services that such Specialist has been licensed and credentialed to provide and, other than Emergency Services, shall be prohibited from providing any services which the Specialist has not been credentialed to provide.
3. If a new Physician is added to a group, Solis must approve and credential the Physician before the Physician treats enrollees. Notification of changes in the provider staff is the responsibility of the provider's office.
4. At all times hereunder, Provider and each Specialist shall render services in accordance with:
   (i) the scope of Provider's and the applicable Specialist's licensure and board certifications, as applicable;
   (ii) the prevailing standards of care of the medical profession in the community in which each Specialist practices;
   (iii) the terms and conditions of this Agreement and this Provider Handbook;
   (iv) the provisions of the applicable Benefit Plan; and,
   (v) state and federal law.
5. Provider and each Specialist shall render services without regard to a Member's race, ethnicity, religion, gender, color, national origin, age, sexual orientation, genetic information, disability, source of payment, any factor related to physical or mental health status, or on any other basis deemed unlawful under federal, state or local law.
6. Specialist agrees not to bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any resources against Solis member other than for copayments, or fees from non-covered services furnished on a fee-for-service basis, non-covered services are services not covered by Medicare or services excluded in the member's Evidence of Coverage.
7. Provider and its Specialist shall conduct their medical practice in accordance with the community standards and shall ensure that services are provided in accordance with Solis objectives of comprehensive, quality care, cost containment, and effective utilization of inpatient, ambulatory, and Emergency Services.
8. Contracted Specialists shall provide such Covered services to Members enrolled in all Medicare Benefit Plans, in each case, in accordance with the terms of their provider agreement with Solis.
9. Specialist shall comply with Solis standards with respect to timeliness of appointments for Well care, Sick Care, routine care, Urgent care and Emergency Services.
10. Specialist agrees to maintain malpractice insurance acceptable to Solis, which shall protect the Provider and its employees. If the Specialist elects not to carry malpractice insurance, appropriate documentation is to be submitted to Solis and member notification is to be posted in Specialist's office or a written statement is to be provided to the members.
11. Provider agrees to maintain, at all times, a sufficient number of Practitioners to service the needs of assigned Members in accordance with the terms of their provider agreement with Solis.
12. Specialist shall maintain a clean and safe professional office where services will be rendered and provide, at its sole cost, such supplies, medicines, and equipment as are necessary to render Specialty hereunder

and which are usual and customary for a medical practice in the community in which the Provider is located.

13. Provider and Specialists will comply with Solis written policies and procedures set forth in this Provider Handbook.
14. Specialist shall participate in and abide by Solis written grievance and appeal procedure with respect to the resolution of Member complaints and grievances, as more specifically described in this Provider Handbook.
15. Provider shall report and shall cause its Specialist report to Solis all Covered services and other services rendered to Members promptly after such services are rendered.
16. Provider shall create and maintain medical records for each Member receiving services from Provider through its Specialists.
17. Specialist shall maintain the security and confidentiality of such Protected Health Information (PHI) as required by applicable state and federal laws, including HIPAA, and the regulations promulgated thereunder.
18. Specialist shall take appropriate measures to prevent the disclosure of PHI other than as permitted by HIPAA. Provider and its Specialist shall upon becoming aware of a disclosure of PHI in violation of this Agreement.
19. Specialist will permit Solis or its designee(s), the representatives of accreditation organizations, and representatives of all state and federal agencies with jurisdiction over Solis (the “Regulators”), including, without limitation, AHCA, and the other Government Agencies to evaluate, through on-site inspection, review of Records, patient records and other means, the quality, appropriateness, and timeliness of Covered services performed by Primary care provider practitioners.
20. Specialist is not to use or publish Solis name or logo in any advertising or marketing materials without the advance written approval of Solis.
21. Specialist shall provide Solis with complete and accurate encounter data by type of Covered services rendered to Members in the form and manner and within a timeframe specified by Solis, but in no event later than thirty (30) days following the date of the encounter.
22. Specialist agrees to cooperate with Solis in the development and maintenance of statistical data records and procedures in support of outcomes linked to quality or safety.
23. Specialist shall inform Solis immediately upon exclusion from participation in the Medicare program and acknowledges that Solis is prohibited, by federal law, from contracting with a physician excluded from participation in the Medicare program.
24. Specialist shall support and participate in Solis Quality Assurance and Management Programs, all Utilization Review and Management Programs, and all peer review and quality improvement programs.
25. Specialist agrees to inform Solis 60 days prior to the intention to terminate an agreement, in a timely fashion to allow Solis to make a good faith effort to contact the affected member(s) within thirty (30) days of receipt of termination notice.
26. Specialist is responsible for verifying eligibility of Members before rendering Primary care services as appropriate.
27. The Specialist must continue care in progress through the effective date of termination.
28. Specialist agrees to follow CMS Marketing Guidelines found in the Medicare Managed Care Handbook – Chapter 3.
29. Provider agrees not to collect or attempt to collect copayment, coinsurance, deductibles or other cost-share amounts from any Plan Medicare Advantage Member who has been designated as Qualified Medicare Beneficiary ("QMB") by CMS

ROLES AND RESPONSIBILITIES OF THE FACILITY

In accordance with SOLIS hospital agreement, the below list consists of rules and expectations set forth for all contracted Facilities.

1. Provider represents and warrants that Provider is licensed and authorized by the State of Florida and all other applicable governmental entities to operate its facilities and provide Hospital Services III.1
2. Provider agrees to be bound by and comply with Plan's policies, procedures and rules as promulgated from time to time, which, as now in effect and as hereafter adopted and amended, are incorporated in your Facility agreement. III.2 (a)
3. Provider agrees to cooperate with Plan in its efforts to monitor compliance with its Medicare Advantage contract and/or Medicare Advantage rules and regulations and to assist Plan in complying with corrective action plans necessary for Plan to comply with such rules and regulations III.2 (b) and (c)
4. Provider is responsible for verifying eligibility of Members before rendering services as appropriate III.3
5. Provider agrees to receive and participate in the Provider training as developed by Plan for in-service purposes in order to understand Plan's Provider Manual III.4
6. Provider shall provide Hospital Services to Members of Plan, but only when such Hospital Services are Authorized by Plan III.5 a)
7. Provider agrees to make available Hospital Services twenty-four (24) hours per day, seven (7) days per week including holidays III.5 b)
8. Provider shall cooperate with Plan's procedures for timely access to Hospital Services as required by Law III.5 b)
9. Provider agrees to comply with Americans with Disabilities Act, and when the need arises, make provisions to appropriately communicate with Member in the language or fashion used by Members III.5. c)
10. Provider shall maintain adequate personnel and facilities to fulfill the Provider's obligations under this Agreement III.5 a)
11. Provider further agrees to render Hospital Services to Members in the same manner, in accordance with the same standards of care and with the same time availability as offered his/her other patients and without regards to the degree of frequency of utilization of such Hospital Services by a Member, race, ethnicity, religion, gender, color, national origin, age, source of payment, claims experience, mental or physical disability, medical history, sexual orientation, genetic information, any factor related to physical or mental health status, or on any basis deemed unlawful under federal, state or local Law III.5 d)
12. Provider agrees to disclose to Plan, upon request and within thirty (30) days or such lesser period of time required for Plan to comply with all applicable state or federal laws, all of the terms and conditions of any payment arrangement that constitutes a "Provider incentive plan" as defined by CMS and/or any federal law or regulation III.5.e)
13. Provider agrees to cooperate with Plan's health risk assessment program. III.5 f)
14. Provider agrees not to collect or attempt to collect copayment, coinsurance, deductibles or other cost-share amounts from any Plan Medicare Advantage Member who has been designated as Qualified Medicare Beneficiary ("QMB") by CMS III.5.g)
15. Provider agrees to post a consumer assistance notice prominently displayed in the reception area and clearly noticeable by all patients III.5.h)

16. Provider agrees to maintain appropriate, accurate and complete clinical record entries, as well as to participate in the record-keeping systemestablished by Plan, as may be modified from time to time III.6 b)
17. Provider agrees to recognize and abide by all applicable state and federal Laws, regulations and guidelines, including those applicable to the Program III.6a)
18. Provider shall permit authorized representatives of Plan and anystate or federal authority or agency, including DHHS, AHCA, CMS, DFS, and the U.S. General Accounting Office or their respective designees, to inspect Provider's facilities and to review any of the records of services provided to Members, including any books, contracts, medical records, patient care documentation and other records that pertain to (i) the services performed under this Agreement, (ii) reconciliation of benefits liabilities, (iii) determination of amount payable, (iv) other relevant matters as such persons conducting the audit, evaluation or inspection deem necessary, (v) for QM use and Peer Review III.5 e)
19. Provider agrees that payment may not be made by the Plan for health care services rendered to Members which are determined by the Plan not to be Medically Necessary III.8. d)
20. Provider agrees that claims filed with an "unlisted" service or procedure code and/or with a procedure code that has no RVU assigned must include documentation of the Medicare covered or pre-authorized service provided III.8 e)
21. Provider shall cooperate in the implementation of any provisions of Plan's agreements relating to coordination of benefits and other third-party claims III.8 g)
22. Hospitals are required to issue the Medicare Outpatient Observation Notice (MOON) to Medicare enrollees, in accordance with CMS guidance 42 CFR 489.20 (y) III.8, h)
23. Provider shall immediately refund to Plan any and all sums collected by Provider from Members to which Provider was not entitled under this Agreement III.8 j) Member
24. Provider agrees to participate in and cooperate with Plan's Member Grievance procedures, as enacted by Plan from time to time, including all appeal and expedited appeal processes III.10

PROVIDER TERMINATIONS

Solis (Plan Initiated) and/or the provider (Provider Initiated) have the authority to elect a termination of a provider or entire agreement – either 'with' or 'without' cause. The Plan must abide by the terms of the provider agreement surrounding required timeframes to successfully terminate a provider/group.

Plan Initiated Termination – Termination without Cause

Once a decision has been made to terminate a provider without cause, Provider Network Management Team is to take the necessary steps to ensure Solis enrollees are not impacted.

The effective date of termination must coincide with the language included in the provider's agreement with Solis, which is sixty (60) days after the effective date of the termination without cause notice.

Provider must continue to provide Covered Services to Members until effective termination date, and member has been reassigned to another Participating Provider.

Plan Initiated Termination – Termination with Cause

There are certain instances where the Plan has the right to terminate a provider/group for cause. This termination will be immediate. The following reasons could lead to a for-cause termination, but not limited to):

- Loss or suspension of Medicare/Medicaid number
- Incarceration
- Fraudulent activity taking place by provider/group

The effective date of termination will be immediate, per the Solis provider agreement.

Provider Initiated Termination

The provider-initiated termination process will be initiated once Solis receives written termination request either via certified mail or electronic with confirmation as outlined in the provider agreement.

The termination letter will include the termination date, in accordance with the Agreement, and reference Agreement for compliance with the "Continuation of Services Upon Termination" requirements as stipulate in the contract.

Provider must continue to provide Covered Services to Members when Medically Necessary if such Member was receiving care at the time of the expiration or termination, until:

- completion of the condition for which the Member was receiving care at the time of termination
- the Member selects another Participating Provider, or
- the next open enrollment period offered by Solis, whichever is longer, but, in any event, no longer than six (6) months after termination of the Agreement

SUMMARY OF THE FLORIDA PATIENT'S BILL OF RIGHTS AND RESPONSIBILITIES

(Florida Statute 381.026)

Florida law requires that your health care provider or health care facility recognize your rights while you are receiving medical care and that you respect the health care provider's or health care facility's right to expect certain behavior on the part of patients. You may request a copy of the full text of this law from your health care provider or health care facility. A summary of your rights and responsibilities follows:

1. A patient has the right to be treated with courtesy and respect, with appreciation of his or her individual dignity, and with protection of his or her need for privacy.

2. A patient has the right to a prompt and reasonable response to questions and requests.

3. A patient has the right to know who is providing medical services and who is responsible for his or her care.

4. A patient has the right to know what patient support services are available, including whether an interpreter is available if he or she does not speak English.

5. A patient has the right to bring any person of his or her choosing to the patient-accessible areas of the health care facility or provider's office to accompany the patient while the patient is receiving inpatient or outpatient treatment or is consulting with his or her health care provider, unless doing so would risk the safety or health of the patient, other patients, or staff of the facility or office or cannot be reasonably accommodated by the facility or provider.

6. A patient has the right to know what rules and regulations apply to his or her conduct.

7. A patient has the right to be given by the health care provider information concerning diagnosis, planned course of treatment, alternatives, risks, and prognosis.

8. A patient has the right to refuse any treatment, except as otherwise provided by law.

9. A patient has the right to be given, upon request, full information and necessary counseling on the availability of known financial resources for his or her care.

10. A patient who is eligible for Medicare has the right to know, upon request and in advance of treatment, whether the health care provider or health care facility accepts the Medicare assignment rate.

11. A patient has the right to receive, upon request, prior to treatment, a reasonable estimate of charges for medical care.

12. A patient has the right to receive a copy of a reasonably clear and understandable, itemized bill and, upon request, to have the charges explained.

13. A patient has the right to impartial access to medical treatment or accommodations, regardless

of race, national origin, religion, handicap, or source of payment.

14. A patient has the right to treatment for any emergency medical condition that will deteriorate from failure to provide treatment.

15. A patient has the right to know if medical treatment is for purposes of experimental research and to give his or her consent or refusal to participate in such experimental research.

16. A patient has the right to express grievances regarding any violation of his or her rights, as stated in Florida law, through the grievance procedure of the health care provider or health care facility which served him or her and to the appropriate state licensing agency.

17. A patient is responsible for providing to the health care provider, to the best of his or her knowledge, accurate and complete information about present complaints, past illnesses, hospitalizations, medications, and other matters relating to his or her health.

18. A patient is responsible for reporting unexpected changes in his or her condition to the health care provider.

19. A patient is responsible for reporting to the health care provider whether he or she comprehends a contemplated course of action and what is expected of him or her.

20. A patient is responsible for following the treatment plan recommended by the health care provider.

21. A patient is responsible for keeping appointments and, when he or she is unable to do so for any reason, for notifying the health care provider or health care facility.

22. A patient is responsible for his or her actions if he or she refuses treatment or does not follow the health care provider's instructions.

23. A patient is responsible for assuring that the financial obligations of his or her health care are fulfilled as promptly as possible.

24. A patient is responsible for following health care facility rules and regulations affecting patient care and conduct.

History.—s. 1, ch. 91-127; s. 65, ch. 92-289; s. 656, ch. 95-148; s. 21, ch. 98-89; s. 178, ch. 98-166; s. 64, ch. 99-397; s. 7, ch. 2001-53; s. 2, ch. 2001-116; s. 3, ch. 2004-297; s. 12, ch. 2006-261; s. 3, ch. 2008-47; s. 2, ch. 2011-112; s. 1, ch. 2011-122; s. 48, ch. 2012-5; s. 11, ch. 2016-234; s. 1, ch. 2017-152

MEMBER RIGHTS AND RESPONISBILITIES

Member Rights

Regardless of how an individual obtains their Medicare benefit, every member has certain rights and protections as it relates to their health care. The following are the rights and protections for everyone with Medicare:

- Be treated with dignity and respect at all times.
- Be protected from discrimination. Every company or agency that works with Medicare must obey the law. They can't treat you differently because of your race, color, national origin, disability, age, religion, or sex.
- Have your personal and health information kept private.
- Get information in a way you understand from Medicare, health care providers, and, under certain circumstances, contractors.
- Get understandable information about Medicare to help you make health care decisions, including:
    - What's covered.
    - What Medicare pays.
    - How much you have to pay.
    - What to do if you want to file a complaint or appeal.
    - Have your questions about Medicare answered.
    - Have access to doctors, specialists, and hospitals.
    - Learn about your treatment choices in clear language that you can understand and participate in treatment decisions.
- Get health care services in a language you understand and in a culturally-sensitive way.
- Get Medicare-covered services in an emergency.
- Get a decision about health care payment, coverage of services, or prescription drug coverage.
- When a claim is filed, you will get a notice letting you know what will and won't be covered.
- If you disagree with the decision of your claim, you have the right to file an appeal.
- Request a review (appeal) of certain decisions about health care payment, coverage of services, or prescription drug coverage.
- If you disagree with a decision about your claims or services, you have the right to appeal.
- File complaints (sometimes called "grievances"), including complaints about the quality of your care.

In addition to the protections described above, every member of Solis has the following protections.

- Choose health care providers within the Solis plan, so you can get the health care you need.
- Get a treatment plan from your doctor.
- If you have a complex or serious medical condition, a treatment plan lets you directly see a specialist within the Solis plan as many times as you and your doctor think you need.
- Women have the right to go directly to a women's health care specialist without a referral within the Solis plan for routine and preventive health care services.
- Know how your doctors are paid.
- When you ask Solis health plan how it pays its doctors, Solis must tell you.
- Medicare doesn't allow Solis to pay doctors in a way that could interfere with you getting the care you need.
- Request an appeal to resolve differences with Solis.
- File a complaint (called a "grievance") about other concerns or problems with Solis.
- Get a coverage decision or coverage information from Solis before getting services.
- Request materials and/or assistance in language and formats other than written English, such as Braille, Audio or Sign language, if necessary.
- Expect that Solis will provide its Notice of Privacy Practices without his/her request.

Member Responsibilities

Members have a responsibility to:

1. Notify the Company and Health Care Providers of any changes that may affect his/her participation, health care needs or benefits. Some examples include, but are not limited to, the following:
    . Change of address or phone number;
    a. Other health insurance;
    b. Special medical condition;
    c. Change in PCP;
    d. Relocation to another county or state.
2. Ensure his/her benefits are up to date and do not expire.
3. Ensure that all information is up to date.
4. Cooperate with the Company and Health Care Providers and follow guidelines given to him/her about the Company.
5. Follow the Health Care Provider’s instructions about his/her care. This includes:

. Making appointments with the Health Care Provider

a. Canceling appointments when he/she cannot make the appointment; and

b. Contacting the Company when he/she has questions.

6. Treat Health Care Providers and staff with respect and dignity.
7. Discuss and agree upon goals for treatment with the Health Care Provider to the degree he/she is able to do so.
8. Communicate with his/her Health Care Provider to understand his/her health problems to the degree he/she is able to do so.

SOLIS Health Plans is a HMO with a Medicare contract and a contract with the Florida Medicaid Program. Enrollment in SOLIS Health Plans, Inc. depends on contract renewal. Atención: Si usted hable español, servicios de asistencia en español, de forma gratuita, están disponible para usted. Llame al **1 (844) 447-6547** (TTY 711)

PLAN ELIGIBILITIY AND ASSIGNMENT INFORMATION

Overview

Solis Health Plans' main focus is providing quality service to all members who are part of our plan. In complying with all applicable policies and procedures, Solis goal is to ensure the contracted network of providers are equipped with plan-specific information to successfully service assigned members.

Primary Care Provider (PCP) Assignment

Solis contracted PCP network will operate under the 'gatekeeper' methodology which allows the assigned PCP to coordinate healthcare needs for specialty and ancillary services. It is the intent of Solis to ensure quality and continuity of care is met and members have adequate access to the medical services they need.

Member Onboarding

Once a member is enrolled and accepted by CMS, Solis will send the member an identification card along with a unique Solis member ID number along with the member's Evidence of Coverage (EOC). The purpose of the EOC is to provide the member a comprehensive summary which details the plan in which they are enrolled.

Member ID Card

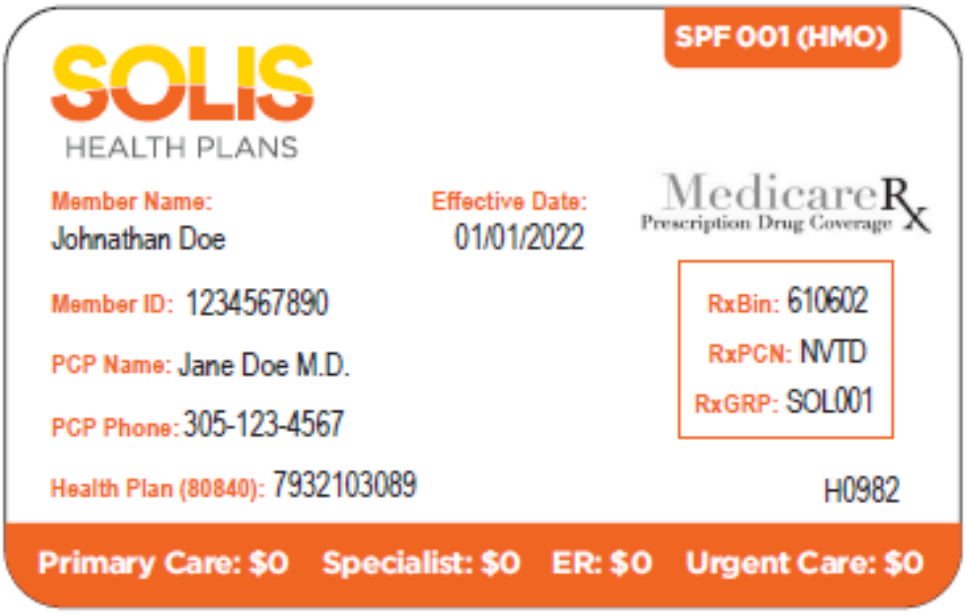
Upon enrollment, each member will receive a member ID card which indicates the following items:

- Assigned PCP and effective date
- Plan name and co-payment guidelines
- Pharmacy information
- Phone numbers to contact various departments of Solis

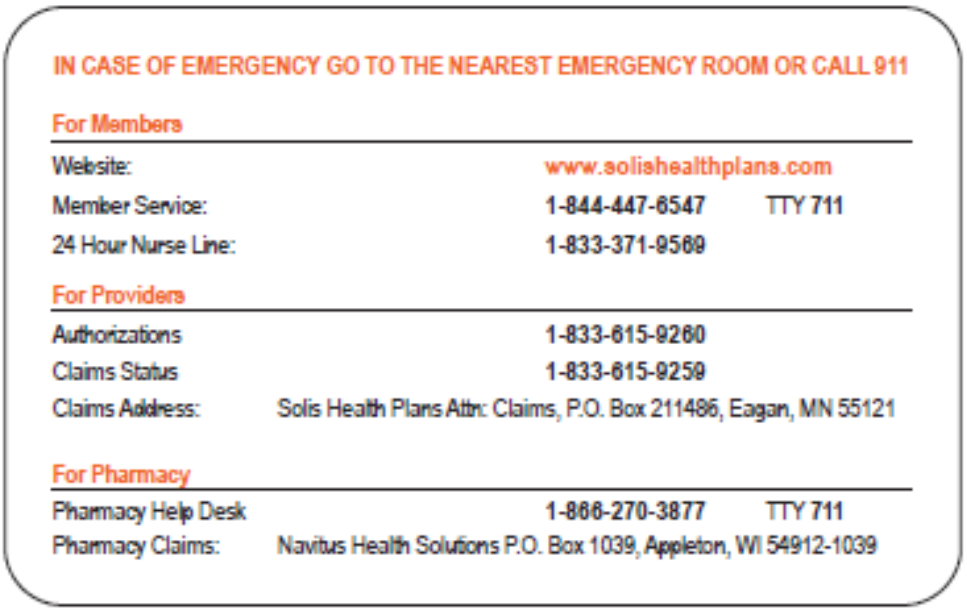
It is imperative to understand that possession of a Solis ID card does not constitute eligibility for coverage. Providers are to always verify member's eligibility prior to rendering any services via the Solis Provider Portal. New members may present a copy of their acknowledgement letter in lieu of a Solis ID card to receive service and provide proof of enrollment. Please contact Solis Eligibility & Benefits department at 833-615-9259 for additional questions surrounding member eligibility verification.

Member ID Card Example

FRONT



BACK



Appointment Scheduling

The following standards have been set forth by the Centers for Medicare & Medicaid Services (CMS) along within being included in each provider agreement:

- Urgent Services – immediately
- Non-urgent Services – within one (1) week
- Routine Services and Preventive Care – within thirty (30) days

After Hours Access

Per your signed provider agreement, Solis expects each contracted provider to have the following after-hours access capabilities:

- 24-hour answering service
- On call scheduling with access to the physician

Missed Appointments

Solis Health Plan's Member Services will work closely with the provider to assist in member outreach if a member misses a previously scheduled appointment without prior cancellation. Provider is to document missed appointments within the member's medical records. Provider may charge a fee for missing an appointment, provided such fees apply uniformly and at the same amount for all Medicare and non-Medicare patients.

Open/Closing of PCP Panel

If a provider chooses to open or close their panel, along with transferring members, provider must submit written notice to Solis at least 45 days prior to making a change. If a provider chooses to close their panel to Solis members, they must have a closed panel with all Medicare plans.

Once a provider panel is closed, notation will be made on the provider file within Solis online provider directory.

Written or email notice must be provided to a provider who wishes to accept a new member into a closed panel, along with requesting to reopen your panel to new members.

Written Requests for opening and closing a panel are to be submitted to the following address:

Solis Health Plans, Inc.
Attn: Provider Services

9250 NW 36th Street, Suite 400
Miami, FL 33178

Email Requests for opening and closing a panel are to be submitted to the following email address:

providerrelations@solishealthplans.com

Demographic Change Requests

In order for Solis Health Plans to maintain the most accurate provider directory, it is crucial that all changes in provider demographic information should be submitted to Solis in writing as soon as possible.

Changes that require notice to Solis are included, but not limited to:

- Change in practice name/legal entity
- Change in address
- Change in phone/fax number
- Adding or removing a physician to the practice (please note any new provider will need to be formally credentialed with the plan)

Please note that changes related to legal entity or tax ID may require an amendment to your provider agreement. Please contact your assigned Account Executive for additional questions and clarification or send written notice to:

Solis Health Plans, Inc.
Attn: Provider Services
9250 NW 36th Street, Suite 400
Miami, FL 33178

Medical Records

It is required that all contracted Solis Health Plans providers maintain a complete electronic or paper medical record for each member which are appropriate, accurate, and confidential. This will ensure coordination and continuity of care is executed in a timely manner. Medical records must be maintained for a minimum of ten (10) years.

Solis reserves the right to request any medical record to ensure the highest quality of care has been rendered and medical records are documented legibly and detailed. Solis will request records for the following reasons:

- Utilization review
- Risk management

- Peer review
- Customer service inquiries
- Grievance and appeals
- Validation of risk adjustment data and other Solis initiatives

Providers are also expected to establish and follow internal policy and procedures related to medical record retention.

There should be a designated person within each provider office whose responsibilities include, but are not limited to:

- Ensuring to maintain confidentiality, security, and physical safety of the records
- The timely retrieval of individual records upon request
- Having a unique identification for each member's record
- The supervision of the collection, processing, maintenance, storage, and appropriate access (i.e. – retrieval) and usage of records (i.e. – distribution)
- The maintenance of a predetermined, organized, and secured record format
- The release of information contained in records in compliance with State and Federal requirements governing the release of medical information

Documentation for each office visit should include, but not limited to:

- Reason for the visit
- Objective findings
- Medical diagnosis, including behavioral health conditions
- Necessary treatment plan
- Documentation of medical provider rendering the services, including signature and date
- All telephonic correspondence between the member/legal guardian – including the date/time any correspondence occurred
- A current immunization history
- Documentation of any members electing a member representative, power of attorney, or State-assigned guardian

GENERAL COMPLIANCE AND FRAUD, WASTE AND ABUSE REQUIREMENTS

Solis Health Plans, Inc. (Solis) has established and maintains a comprehensive Corporate Compliance Program (the "Program") in accordance with Chapter 42 of the Code of Federal Regulations, Parts 422 and 423, hereinafter collectively referred to as "Parts C & D". The program specifically addresses and meets the regulatory requirements set forth at 42 C.F.R. §§422.503(b)(4)(vi) and 423.504(b)(4)(vi) which includes measures to prevent, detect and correct Part C or D program noncompliance as well as issues related to fraud, waste and abuse (FWA).

The elements of the Solis Compliance Plan are designed to train and govern the conduct of Solis employees, directors, managers, first tier, downstream and related entities, on compliance responsibilities, and to provide a means of understanding how to raise and resolve compliance issues and concerns. The Compliance Plan includes the provision of the following key elements:

- Written **Policies and Procedures** that address specific areas of concern and outline proper procedures for complying with rules, laws, and contractual obligations, as well as a **Code of Ethics and Standards of Conduct** for guiding Solis employees, directors, management, contractors, and vendors on making ethical and compliant decisions when conducting business;
- A designated **Compliance Officer and Compliance Committee** responsible for implementation, ongoing oversight and ensuring adherence to the Compliance Program who are accountable to the **Board of Directors** who also provide oversight of the Compliance Program to ensure that compliance issues are proactively and timely identified and resolved;
- Effective **Compliance Training and Education Programs** for all Solis employees, including the chief executive and senior administrators or managers; governing body members, and first tier, downstream and related entities;
- Effective **Compliance Communication** between the Compliance Officer and Solis employees, members of the compliance committee, managers, governing body and first tier, downstream and related entities, including mechanisms such as an anonymous reporting system dedicated to Solis;
- Enforcement of standards through **Well-Publicized Disciplinary Guidelines** that encourage good faith participation in the compliance program;
- Targeted compliance **Monitoring and Auditing,** including monitoring and oversight of internal processes, evaluation of the overall effectiveness of the Compliance Program and evaluation of first tier entities compliance with CMS requirements; and
- **Protocols for Responding Promptly to Detected Offenses** and implementing corrective action initiatives.

First Tier, Downstream and Related Entity Education (FDRs)

FDRs are required to complete fraud, waste and abuse training within 90 days of administration or delivery of Parts C and D benefits, and annually thereafter. To reduce the potential burden on FDRs, CMS has developed and provided a standardized FWA training and education module. The module is available through the CMS Medicare Learning Network (MLN) at http://www.cms.gov/MLNProducts. Solis encourages FDRs to use the CMS training module and deems use of this FWA training option as compliant with Solis FWA training requirements.

FDRs who have met the FWA certification requirements through enrollment into the Medicare program or accreditation as a Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) are deemed to have met the training and educational requirements for fraud, waste, and abuse.

Solis requires FDRs provide evidence of completed FWA training. Evidence may include copies of sign-in sheets, employee attestations and electronic certifications from the employees taking and completing the training.

Reporting

Solis is required to report fraud, waste and abuse to the OIG and NBI MEDIC National Benefit Integrity (Medicare Drug Integrity Contractors). Our SIU department must conclude investigations of potential fraud, waste and abuse within a reasonable time period after the activity is discovered. If after conducting a reasonable inquiry a determination of potential fraud, waste or abuse related to the Medicare Parts C or D programs has occurred, the matter should be referred to the NBI MEDIC promptly.

Solis complies with CMS & Medicaid regulations by maintaining files for a period of 10 years on both in- network and out of-network providers who have been the subject of complaints, investigations, violations, and prosecutions.

This includes enrollee complaints, NBI MEDIC investigations, OIG and/or DOJ investigations, US Attorney prosecution, and any other civil, criminal, or administrative action for violations of Federal health care program requirements. Our SIU department also maintain files that contain documented warnings (i.e., fraud alerts) and educational contacts, the results of previous investigations, and copies of complaints resulting in investigations. Solis must comply with requests by law enforcement, CMS and CMS' designee regarding monitoring of providers within Solis network that CMS has identified as potentially abusive or fraudulent.

All Solis participating providers are expected to immediately report any known or suspected instances of non-compliance or fraud, waste and abuse to Solis. Reports may be made confidentially or anonymously.

Report suspected or known instances of <u>non-compliance</u> to the Solis Compliance Hotline at 833-896-3761.

Report suspected <u>fraud, waste and abuse</u> to the Solis Fraud Hotline at 833-896-3762.

Any individual calling the Hotline(s) may do so anonymously or may choose to identify himself or herself. Individuals are encouraged to provide their name and phone number so the Compliance department may contact them should additional information be required. Compliance makes every effort to maintain the confidentiality of individuals, within the limits of applicable laws.

Fraud and Abuse

Understand and comply with fraud and abuse laws.

Federal and state laws prohibit the submission of false statements and/or claims to Medicaid- or Medicare-funded programs. False statements and claims include, but are not limited to:

- Billing unnecessary services.
- Billing services not performed.
- Upcoding
- Unbundling

Violations of the False Statements Act occur when one knowingly makes a false statement or false record. Violations of the False Claims Act occur when one knowingly submits a false or fraudulent claim to the government for payment or approval. The False Claims Act also prohibits knowingly making or using a false record or statement to get a false or fraudulent claim paid or approved.

Knowingly and willfully offering or making, soliciting, or accepting anything of value in return for referral of a patient whose services are reimbursable by Medicaid or Medicare constitutes a violation of the Anti-Kickback Statute.

Penalties for violating the False Claims Act may include a $10,957 to $21,916 fine per false claim and/or imprisonment. Violators of the Anti-Kickback Statute may face severe penalties, including possible imprisonment of up to five years and/or fines of up to $25,000. Violations of fraud and abuse laws may result in an individual's or the company's exclusion from participation in Medicaid or Medicare programs. Those subject to the Code may not engage in any conduct that violates state or federal fraud and abuse laws.

By offering certain whistleblower provisions and protections, the federal and state False Claims Acts encourage individuals to report misconduct involving false claims to the government. The whistleblower provisions allow individuals with actual knowledge of allegedly false claims made to the government to file a lawsuit on behalf of the government and to share in any monies recovered. Whistleblowers who report false claims to the government or cooperate in investigations are also entitled to protection from retaliation.

Solis is committed to detecting, correcting, and preventing fraud, waste, and abuse. If an individual suspects fraud, waste, or abuse by providers, members, associates, FDRs or the company, he or she should contact the Chief Compliance Officer or Special Investigations Unit by calling the Fraud Hotline at 833-896-3762. Questions about what may constitute fraud, waste, and abuse should be directed to the Solis Compliance Department.

HEALTH INSURANCE AND PORTABILITY ACT (HIPAA)

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) calls for enhancements to administrative processes that standardize and simplify the administrative processes undertaken by providers, clearinghouses, health plans and employer groups.

Processes targeted for simplification include:

- Electronic transactions
- Code sets and identifiers
- Security
- Privacy

Electronic Transactions

The administrative simplification provisions mandate of HIPAA requires that all payers, providers, and clearinghouses use specified standards when exchanging data electronically. Providers and payers must be able to send and receive transactions in the designated EDI format. Providers will be able to send and receive information from health plans and payers, using the following standardized formats:

- Claims
- Claims status
- Remittance
- Eligibility
- Authorizations/referrals

Code Sets and Identifiers

Providers should use the following standardized codes to submit claims to health plans:

- ICD-10 – CM
- CPT
- HCPCS
- CDT (were HCPCS dental codes, but now ADA code, prefixed with 'D')

These common code sets enable a standard process for electronic submission of claims by providers. Solis has adopted consistent standards, code sets and identifiers for claims submitted electronically and on paper. Code sets must be implemented by the effective date to avoid claims denials.

Solis will maintain taxonomy or specialty codes currently in use and will continue to assign these codes for new providers. The codes are determined during the credentialing and contracting process. Solis only accepts active codes from nation code set sources such as ICD-10, CPT, and HCPCS, as part of our HIPAA compliance measures. As new codes are released, please convert to them by their effective date in order to prevent claims from being mailed back for recoding or resubmission. Deleted codes will not be accepted for dates of service after the date the code becomes obsolete. For additional questions, please reach out to your assigned Account Executive.

Security

Solis maintains a comprehensive security program for safeguarding protected health information in order to meet the requirements of the HIPAA security rul. HIPAA security requires a covered entity to provide administrative, technical and physical safeguards for protected health information maintained in the electronic form.

Privacy

Privacy regulations address the way in which a health plan, provider or health care clearinghouse may use and disclose individually identifiable health information, including information that is received, stored, processed or disclosed by any media, including paper, electronic, fax or voice. Regulations do allow for the sharing of information for treatment, payment and health care operations, including such plan-required functions as quality assurance, utilization review or credentialing, without patient consent. Limited sharing of information may be allowed in instance where national security may be impacted.

PARTICIPATING PROVIDER COMPLAINTS AND GRIEVANCES

Solis Health Plans 'participating providers can submit a complaint to Solis Health Plans to express dissatisfaction with the plan and/ or to request a review of a claim denial or payment amount.

If you have a concern or complaint relating to the payment of a claim and are looking for a **first level review** of an initial claim denial or are disputing a payment amount, please submit your request in writing to:

Solis Health Plans, Inc
Attn: Claims
P.O. Box 211486
Eagan, MN 55121

The written request will be reviewed by the Solis Health Plans Claims Department and must include the following information:

- Provider full name, tax identification number and complete contact information.
- An identification of the disputed item(s)/claim(s) utilizing Solis Health Plans original claim number, the date of service; and
- An explanation of the justification for why you (the provider) believes the claim denial or payment amount is incorrect. Please include any additional information you would like the Solis Health Plans to review, such as medical records and/or corrected a claim.

If you have a dissatisfaction (grievance) with any aspect of Solis Health Plans operations, you should contact your assigned Provider Services representative first to discuss the issue at hand. If you like to submit a written grievance or request a **second-level review** of a previously reviewed claim denial or payment dispute, you must document in writing the conditions and forward to your assigned Provider Services representative at:

Solis Health Plans, Inc
Attn: Provider Services
9250 NW 36th Street
Suite 400
Miami, FL 33178
Fax: 833-615-9263

The written request will be reviewed by the Solis Health Plans Provider Services Department and any other Solis Health Plans departments as needed to decide. A response will be sent to you within 60 calendar days after receipt of the written request.

MEMBER GRIEVANCES AND APPEALS (G&A)

Solis Health Plans is mandated to meet CMS requirements for working all member grievance and appeals. This information is provided to you so that you may help Solis Health Plans members with the G&A process, if they request your help. Solis Health Plans has a Grievance and Appeals Department and specialists who handle all member grievances and appeals received by Solis Health Plans

Grievance Process

A ***grievance*** is any complaint or dispute, other than one involving an organization/coverage determination or late enrollment penalty determination, expressing dissatisfaction with any aspect of the operations activities or behavior, regardless of whether any remedial action can be taken. Furthermore, grievances may include complaints regarding the timeliness, appropriateness, access to, and/or setting of a provided health service, procedure, or item. Grievance issues may also include complaints that a covered health service procedure or item during a course of treatment did not meet accepted standards for delivery of health care.

A grievance may be filed by a member or his or her authorized representative, either orally or in writing to Solis Health Plans.

- A "Grievance/Appeal Request Form" may be requested from Member Services Department by calling the Member Service toll free phone number at 844-447-6547 from 8 a.m. to 8 p.m. seven days a week. From Feb. 15 to Sept. 30, Member Services is open Monday-Friday from 8 a.m. to 8 p.m. TTY users should call 711. The written grievance request should be forwarded to the Solis Health Plans' Grievance and Appeals department at the following address or fax number:

Solis Health Plans
Attn: Grievance and Appeals Department
PO Box 524173
Miami, FL 33152
E-Fax: 833-615-9263

- If the "Grievance/Appeal Request Form" is not used, the member/authorized representative can submit his/her own *written* request to Solis Health Plans. At the least, the following information should be provided in the written request:
    - Member's name, address, phone number and identification number;
    - Summary of the occurrence;
    - Date of service/occurrence;
    - Provider name (if applicable);
    - Description of relief sought;
    - Member's signature; and
    - Date grievance was signed.

If not, the member/authorized representative can call Solis Health Plans' Member Services Department at 844-447-6547 from 8 a.m. to 8 p.m. seven days a week. From Feb. 15 to Sept. 30, Member Services is open Monday-Friday from 8 a.m. to 8 p.m. TTY users should call 711, Solis Health Plans reviews grievances and

notifies the member and/or the authorized representative of its decision as expeditiously as the member's health requires, but no later than thirty (30) calendar days from the date the grievance was received by Solis Health Plans, the grievance is received for standard grievances or twenty-four (24) hours for expedited grievance requests.

- The timeframe for a standard grievance may be extended if either the member or member's authorized representative requests an extension, or if Solis Health Plans validates the necessity for additional information and explains that the extension is in the best interest of the member.

A *quality of care* grievance can be submitted through Solis Health Plans' grievance process and/or a Quality Improvement Organization (QIO). The QIO will determine whether the quality of care (including both inpatient and outpatient services) provided by Solis Health Plans medical professionals meets the professionally recognized standards of health care, including whether appropriate health care services have been provided in appropriate settings. QIO submissions must be sent to KEPRO, Florida's Beneficiary and Family-Centered Quality Improvement Organization (BFCC-QIO) at:

KEPRO
Beneficiary and Family-Centered Care Quality Improvement Organization (BFCC-QIO) 5201 W. Kennedy Blvd., Suite 900
Tampa, FL 33609
1 (844) 455-8708; TTY – 1 (855) 843-4776
Fax: 1 (844) 834-7129

Representatives filing on behalf a member

- A ***representative*** is an individual appointed by a member, or authorized under state or other applicable law, to act on behalf of a member involved in an appeal or grievance. Unless otherwise stated, the representative will have all the rights and responsibilities of a member or party in obtaining an organization/coverage determination, filing a grievance, or in dealing with any of the levels of appeal processes.

- A member may appoint any individual (such as a relative, friend, advocate, attorney or *physician*) to act as his or her representative. However, if a member wishes to appoint a representative to act on his or her behalf, the member must submit a written representative statement to Solis Health Plans. The "Appointment of Representative Form" is preferred but a member may submit an equivalent written notice to make the appointment. A notice should include, to be equivalent
    - Includes the name, address, and telephone number of the member;
    - Includes the member's identification number;
    - Includes the name, address, and telephone number of the individual being appointed;
    - Contains a statement that the member is authorizing the representative to act on his or her behalf for the claim(s) at issue, and a statement authorizing disclosure of individually identifying information to the representative;
    - Is signed and dated by the member making the appointment; and
    - Is signed and dated by the individual being appointed as representative and is accompanied by a statement that the individual accepts the appointment.

- Unless revoked, the representation is valid for one year from the date the appointment is signed by both the member and the representative.

NOTE: A provider or physician may **not** charge a member for representation in filing a grievance, organization/coverage determination or appeal. Administrative costs incurred by a representative during the appeals process are not reasonable costs for Medicare reimbursement purposes.

Appeal Process

An ***appeal*** includes any of the procedures that deal with the review of adverse organization determinations/coverage determinations on the health care services/prescription drug benefits a member believes he or she is entitled to receive, including delay in providing, arranging for, or approving the health care services/drug coverage (such that a delay would adversely affect the health of the member), or any amounts the member must pay.

Appeal levels:

There are five (5) levels of Medicare appeals:

1. Reconsideration [Part C]/ Redetermination [Part D]
2. Independent Review Entity (IRE): MAXIMUS Federal Services, Inc.
3. Hearing by an administrative law judge/attorney adjudicator (ALJ) if the amount in controversy is at least $160 (CY 2021)
4. Medicare Appeals Council (Council)
5. Judicial review if the amount in controversy is at least $1,630 (CY 2021)

A ***reconsideration*** is an appeal to Solis Health Plans about a medical care coverage decision. This is the member's first step in the appeals process after an adverse organization determination.

A ***redetermination*** is an appeal to Solis Health Plans about a Part D drug coverage decision. This is the member's first step in the appeals process, which involves Solis Health Plans reassessing an adverse coverage determination, the findings upon which it was based, and any other evidence submitted or obtained.

Requesting a standard reconsideration/redetermination:

- A member, member's representative, or treating physician (subject to the notice requirements listed below) may request a standard reconsideration/redetermination by filing a *written* request with Solis Health Plans to the mailing address or fax referenced in the grievance section above.
    - Completion of the "Grievance/Appeal Request Form" is recommended but the requestor may submit their own form, it should contain the following information:
        - Member's name, address, telephone number, Member identification number (listed on the Member's ID card;
        - Appeal Reason;

- Requestor's signature;
- Date the appeal request was signed;
- Submission of any supporting evidence; and
- For redeterminations only:
    - If the appeal relates to a decision by Solis Health Plans to deny a drug that is not on Solis Health Plans' formulary the physician must indicate that all the drugs on any tier of Solis Health Plans' formulary would not be as effective to treat member's condition as the requested off-formulary drug or would harm the member's health.

Standard reconsideration/redeterminations requests from physicians:

- A physician who is providing treatment to a member may, upon providing notice to the member, request a standard reconsideration on the member's behalf *without* submitting a representative form.
    - If the reconsideration/redetermination comes from the member's primary care provider within Solis Health Plans' network, no member notification is required.
    - If the reconsideration/redetermination comes from either a physician within Solis Health Plans' network, or a non-contracted physician, and the member's records indicate he or she visited the physician at least once before, Solis Health Plans can presume the physician has informed the member about the request and no further verification is needed.
    - If it appears to be the first contact between the physician requesting the reconsideration/ redetermination and the member, Solis Health Plans will need to confirm that the physician notified the member about his/her reconsideration/redetermination request.

Requesting expedited reconsiderations/redeterminations:

- A member, member's representative or any physician regardless of whether they are affiliated with Solis Health Plans or not, may request that Solis Health Plans expedite a reconsideration/redetermination in situations where applying the standard procedure could seriously jeopardize the member's life, health or ability to regain maximum function.
- Due to the short timeframe, a physician *does not need* to be an authorized representative to request an expedited reconsideration on behalf of the member.
    - **NOTE**: a request for payment of a service already provided to the member is not eligible to be reviewed as an expedited reconsideration.
- To request an expedited reconsideration, the member, member's representative or physician must submit an *oral or written* request (see completion of Grievance/Request Form listed above for written requests) directly to Solis Health Plans by either calling the Member Services or mailing/ faxing the request at the contact information noted above.
    - **NOTE**: While exact words are not required, the *physician must* indicate that applying the standard time frame could seriously jeopardize the life or health of the member, or the member's ability to regain maximum function.

Timeframes:

- A reconsideration/redetermination request must be filed within sixty (60) calendar days from the date of the notice of the organization/coverage determination.
    - Solis Health Plans will only extend a time frame for filing a reconsideration/redetermination if good cause is shown. Good cause will be determined on a case by case basis.

- Solis Health Plans render a decision as expeditiously as the member's health requires but no later than:
    - Thirty (30) calendar days for a standard reconsideration (Part C);
    - Seventy-two (72) hours for an expedited reconsideration (Part C);
        - Timeframes for standard/expedited reconsiderations may be extended if either the member or member's authorized representative requests an extension, or if Solis Health Plans validate the necessity for additional information and documents that the extension is in the best interest of the member.
    - Sixty (60) calendar days for post service claims;
    - Seven (7) calendar days for standard redeterminations (Part D); and
    - Seventy-two (72) hours for an expedited redetermination (Part D).

Further appeal levels:

If the adverse organization/coverage determination is upheld by Solis Health Plans, the member or member's authorized representative can seek additional review from the succeeding appeal levels.

CLAIMS PROCESS

Overview

Solis Health Plans Claims Department Team objective is to process your claims accurately and in a timely manner. The Claims Department goal is to work closely with the Solis Provider Operations and Utilization Management Department to resolve any claims related issues.

Claims Verification Procedures

Solis wants to ensure that all providers adhere to all applicable billing data requirements to process claims timely and avoid unnecessary denials as referenced below:

- All required fields are completed on an original CMS 1500 Claim Form (02/12), CMS 1450 (UB-04) Claim Form, electronically or paper.
- Current CPT, revenue and HCPCS procedure code(s) with modifiers is appropriate.
- All diagnosis codes are to their highest number of digits available.
- Member is eligible for services under Solis during the time-period in which services were provided.
- An authorization has not been requested for services that require prior authorization by Solis.
- Coordination of Benefits (COB)
- Providers should first submit COB claim(s) to identify payers who have primary responsibility for payment of a claim before submitting a claim to Solis.
- If Solis is the secondary insurance, Solis will pay the member's responsibility after the primary insurance carrier has paid, not to exceed Solis contracted allowable rate.
- When filing a claim to Solis, you must include a copy of the Member's previous insurance's Explanation of Benefits (EOB) with the claim.
- The service provided is a covered benefit under the member's contract on the date of service and prior authorization processes were not followed.
- Third Party Liability Subrogation - Solis will pay claims for covered services when probable third-party liability has not been established or third-party benefits are not available to pay a claim. Solis will attempt to recover any third-party resources available to members and shall maintain records pertaining to third party liability collections on behalf of members for audit and review.

Clean Claims

A claim that has no defect, impropriety, lack of any required substantiating documentation, per CMS guidelines.

Denial

A claim that has passed edits and is entered into the system, however has been billed with invalid or inappropriate information causing the claim to deny. An Explanation of Payment (EOP) will be sent that includes the denial reason.

Electronic Claims Submission Rules

Provider will submit all claims electronically using the Health Insurance Portability and Accountability Act (HIPPA)- required ASC X12N 837 -Health Care Claim: Professional for professional claims and the ASC X12N837-Health Car**e** Claims: Institutional for institutional claims.

Clearinghouse	**Payor ID**	**Type of Claim**
Smart Data Solution (SDS)	73581	Paper
Availity	SOLIS	Electronic

EDI Corrections and Reversals Submission

The 837 TR3 defines what values submitters must use to signal to payors that the inbound 837P contains a reversal or correction to a claim that has previously been submitted for processing. For Professional 837 claims, 2300 CLM05-3 (Claim Frequency Code) must contain a value from the National UB Data Element Specification Type List Type of Bill Position 3. Values supported for corrections and reversals are:

- **5 = "Late Charges Only" Claim**
- **7 = Replacement of Prior Claim**
- **8 = Void/Cancel of Prior Claim**

Filing a Claim Electronically

Providers submitting claims electronically should receive an acknowledgement from Smart Data Solutions, Availity or their current clearinghouse. If f you experience any problems with your transmission, please contact your local clearinghouse representative.

Claims must be submitted to the correct payor ID number electronically or to the PO Box when all EDI methods have failed.

If you do not receive a payment or denial within sixty (60) days from submitting your claim, please contact the Solis Provider Service Representatives at 833-615-9259 to obtain a status update.

Paper Claims Submission

Claims are to be submitted to Solis Health Plans with appropriate documentation using proper claim submission forms CMS 1500 (version 02/12) and CMS 1450 (UB04). Paper submissions should be typed not hand written. Providers billing Solis directly should submit claims to:

Solis Health Plans, Inc.
Attn: Claims
P.O. Box 211486
Eagan, MN 55121

Paper Corrections and Reversals Submission

Please follow the steps below to ensure a successful resubmission of a claim:

- Enter in Box 22 Resubmission Code field the frequency code applicable: 6 (Corrected Claim) 7 (replacement of prior claim) or 8 (void/cancel of prior claim)
- Enter in Box 22 Original REF number field the document number assigned to the original/previously submitted bill located on the Explanation of Payment (EOP).
- All corrected claims, requests for reconsideration from participating providers must be received within 60 days from the date of explanation of payment or denial is issued.

Claims Status Transactions

Our claims status transactions allow you to check on the status of submitted claims for single or multiple claims over a designated period of time.

Electronic Funds Transfer (EFT)

Electronic Funds Transfer (EFT) will be available to providers soon. Providers that enroll in EFT will be able to review their EOP's online. Providers will also receive email notifications. Solis utilizes Payspan for EFT services such as payment status, technical support, bank account updates, and registration.

Please refer to the below information to register for Payspan if you don't already have an account:

Telephone: 877-331-7154, Option #1
Email: providersupport@payspanhealth.com
Website: http://www.payspanhealth.com

Timely Filing

Participating providers must submit first time claims within the timeframe referenced in your provider agreement. Claims received outside of this timeframe will be denied for untimely submission.

Claims Disputes

All claims disputes and/or requests for reconsideration from participating providers must be received within 60 days from the date of explanation of payment or denial is issued.

For Clinical Trial: CMS billing requirements for Clinical Trial/Registry/Study

For professional claims, the eight-digit clinical trial number is preceded by the two alpha characters of CT (use CT only on paper claims) must be placed in field 19 of the paper claim form CMS-1500 (e.g., CT12345678).

For electronic claims equivalent 837P in Loop 2300 REF02(REF01=P4) (do not use CT on the electronic claim, e.g., 12345678).

When submitting a clinical trial claim include ICD-10 code Z00.6 (in either the primary or secondary positions) and Modifier Q0 (numeral 0) and/or Q1, as appropriate (outpatient claims only).

Balance Billing and Member Responsibility

Provider acknowledges and agrees that no reimbursement is due for a covered service and/or if claim is complete for a covered service unless performance of that covered service is fully and accurately documented in the member's medical record prior to the initial submission of any claim. Furthermore, provider acknowledges and agrees that at no time shall members be responsible for any payment to provider except for applicable copayments, coinsurance, deductibles, and non-covered services provided to such members. Notification that a service is not a covered benefit must be provided to the member prior to the service and be consistent with Solis policy, for the member to be held financially responsible. Solis policy requires that the notification include the date and description of the service, name and signature of the member, name and signature of the provider, must be in at least 12-point Times New Roman font, and be written at a 4th grade reading level. Documentation of that pre-service notification shall be provided to Solis or its designee upon request and including timely to substantiate member appeals. In the event of a denial of payment for health services rendered to Solis members determined not to be medically necessary by the Solis, a provider shall not bill, charge, seek payment or have any recourse against member for such services, unless the member has been advised in advanced that the services are not medically necessary and has agreed in writing to be financially responsible for those services pursuant to the above-mentioned Solis policy.

Medicare Allowable for Unlisted Service or Procedure Code

Claims filed with an "unlisted" service or procedure code and/or with a procedure code that has no RVU assigned must include documentation of the service provided. The documentation must include a written description of the service and the appropriate medical reports related to the service, including the NDC number for drugs or a copy of the invoice for equipment, if applicable. Unlisted procedure codes are defined as CPT or HCPCS code descriptions that include one of the following "NOC, NEC, NOS, unlisted, not specified, miscellaneous or special report". Each claim will be reviewed manually, and Solis will assign the allowable fee based on established fees for comparable services.

Overpayment of a Claim

Overpayments include, but are not limited to, situations in which a provider has been overpaid by Solis due to an error in processing, incorrectly submitted claims, an incorrect determination that the services were covered, a determination that the covered individual was not eligible for services at the time services were rendered or another entity is primarily responsible for payment of the claim. In the event of an overpayment, Solis will notify the provider of the refund amount due in writing via mail, facsimile or email. The provider is responsible to refund Solis the overpayment amounts within 45 days of written notification, as defined in your agreement. If a refund is not issued within 45 days, Solis has the right to offset the monies due from any future payments owed to the provider.

UTILIZATION MANAGEMENT/HEALTH SERVICES

Solis Utilization Management (UM) activity is designed to actively manage and oversee the utilization of medical and behavioral health resources, while maintaining a high quality of care with desired health outcomes. The UM Program identifies, documents, and reviews all utilization issues: initiating and implementing improvement plans, as indicated, to ensure the successful delivery of medically necessary, appropriate, cost-effective, quality healthcare.

The Health Services (HS) Department will ensure that all members receive fair and non-discriminatory treatment in the delivery of healthcare services consistent with the benefits of the individual member, regardless of race, ethnicity, national origin, religion, sex, age, mental or physical disabilities, sexual orientation, genetic information, or source of payment.

Solis Health Plans' (Solis) Health Services Program will comply with all regulatory and statutory requirements and standards of all recognized accrediting bodies such as the Centers for Medicare & Medicaid Services (CMS), Agency for Healthcare Administration (AHCA), National Committee for Quality Assurance (NCQA) and FS 42 CFR §422.152. Solis goal is to manage, monitor and evaluate the utilization of healthcare services in accordance with nationally recognized criteria and standards in order to ensure provisions of appropriate and cost-effective high-quality healthcare and to achieve the highest degree of member and provider satisfaction.

Objectives

The UM Program is designed to reach its goals by achieving the following objectives:

1. Review, assess and evaluate healthcare services delivered for quality, medical necessity and appropriateness;
2. Ensure that medical review criteria used to determine medical appropriateness of care are based upon sound clinical judgment;
3. Assess member healthcare needs, stratify risk, and offer relevant case management services and resources;
4. Assess appropriateness of ancillary and clinical support services, and refer to the appropriate allied healthcare providers;
5. Ensure Plan physicians render denial decisions that are based upon lack of medical necessity;
6. Monitor and enforce compliance within the guidelines of all regulatory requirements, including minimum mandatory services as well as all services covered by the Plan;
7. Maintain active monitoring of over and underutilization patterns and coordinate action plans for improvement with other departments within Solis structure;
8. Timely identification and reporting of potential Fraud and Abuse;
9. Render UM decisions, including initial decisions and appeals, in a timely manner, based on established standards and urgency of the situation;
10. Obtain relevant clinical information in consultation with treating providers when making medical necessity decisions;
11. Monitor, identify, and access innovative technological, evidence-based, and/or best practice alternatives and solutions to meet the existing and emerging needs of member and improve efficiency of care

Standards of Care

To ensure standards of care/practice that are nationally recognized and accepted, it is the policy of Solis Health Plans to: utilize practice guidelines that are based on reliable medical evidence and/or the consensus of health care professionals in a particular field; consider the needs of the members; are adopted in consultation with providers; and are updated and reviewed periodically as appropriate to serve as the primary standard of care parameters for determining medical necessity and appropriateness. InterQual Clinical Decision Support Criteria and CMS's National and Local Coverage Determinations will be the primary resource in determining that medical necessity criteria/guidelines are met.

The criteria/guidelines and its revisions will be disseminated to all affected providers, and through disbursement of specialty specific information to the primary care providers and high-volume specialists. The criteria/guidelines will be available to members, potential members, and providers upon request by calling Solis Member Services at 844-447-6547. In cases where a determination cannot be reached using the adopted criteria, the Plan's Medical Director will review and consult with associated specialists and/or nationally recognized programs, as indicated, to reach a final decision.

Solis Health Plans Utilization and Medical Criteria Resources

The following sources are utilized by Solis Health Plans in helping to make Plan determinations. These include, but are not limited to:

- CMS's National Coverage Determinations (NCDs) and Local Coverage Determinations (LCDs)
- American College of Physicians guidelines
- Department of Health & Human Services, U.S. Preventative Services Task Force (USPSTF)
- Centers for Medicare and Medicare Services (CMS)
- National Coverage Determinations (NCDs) and Local Coverage Determinations (LCDs)
- Nationally recognized, evidence-based guidelines (See Section 8 of this Handbook)
- Solis Health Plans Medical Policy and Utilization Management Guidelines

Case Management

Solis Case Management Department works closely with other departments to ensure population health management and early identification of members with complex medical conditions and special needs.

This is accomplished using the following methods:

- Member Health Risk Assessments completed by the member either via mail, conducted telephonically or in person by the Case Management Department or by the Member Services Department telephonically
- Current and retrospective review process that identified cases using predictive modeling strategies to identify future high utilization
- Utilization reports programmed to identify certain disease processes, based on complexity and utilization patterns
- Provider participation in identifying and referring members with identified medical and behavioral conditions or special healthcare needs

- Psychosocial assessments to identify members with behavioral health conditions and substance abuse
- Identification of social determinants to manage members as a whole and refer to appropriate resources

Members with identified medical conditions and/or special healthcare needs will be referred to and managed by Solis Case Management Team. Those members who are identified with conditions that can be managed through disease management programs will be referred for the disease specific management program.

Disease Management

Solis Disease Management Team will be responsible for identifying the needs of its members in-regards-to disease specific management programs. Using identified utilization reports the specific needed areas of management will be identified, with appropriate program development and implementation for identified member populations.

The programs will be developed utilizing the following key components:

- Review of the most prevalent chronic diseases of Solis members
- Early population identification
- Evidence-based practice guidelines
- Collaborative approach/practice model
- Member-focused self-management education and coaching
- Process, quality markers and clinical outcome measurement
- Routine reporting and feedback between members, providers and health plan

Care Management Services

Solis Health Plans is committed to early identification of those members who may be at risk for health care needs/services. These members are identified through multiple resources which include but are not limited to the Health Risk Assessment and Stratification, provider referrals, member/legal guardian self-referrals, Nursing, Social Services and other ancillary provider referrals, utilization and pharmacy data and others.

The Solis Health Plans' Care Management Team will regularly monitor members with ongoing medical conditions and coordination of services for over and underutilization patterns, and care needs, such that the following functions are addressed as appropriate:

- Serve as a liaison between the member and providers
- Ensure the member is receiving routine medical care and that the member has adequate support systems at home
- Identify and coordinate transition of care needs
- Provide and refer the member/legal guardian to available community resources as appropriate
- Communicating with other members of the Interdisciplinary Care Team (ICT), including providers and/or other health plans serv7ing the member, the care plan for review and feedback and any identified special health care needs.

Those members that are identified or referred for Care Management Services will be assessed and at their risk level stratified for referral to on-going Care Management or Disease Management Programs.

Solis Health Plans' Care Management Team follows the Interdisciplinary Care Team (ICT) approach, with the Primary Care Physician (PCP) as the primary point of contact. The ICT includes providers and other professional disciplines or service representatives who are significantly involved in a member's care. Together the ICT ensure coordination of care services focused on improving member health outcomes, care planning/transition of care needs and support for the member/legal guardian, caregiver and/or the family.

Individual Care Plans are developed with the support of the ICT in identifying specific problems or needs, interventions and goals. The member/legal guardian and/or caregiver are encouraged to actively participate in the development, implementation, and on-going review of the Care Plan. Members may be referred to Solis Health Plans' Care Management Team by calling 1-833-615-9261.

REFERRAL/AUTHORIZATION REQUESTS

Solis Health Plans operates under the 'gate keeper' model, in which all primary care providers (PCP) are responsible for determining whether a referral for specialty care or ancillary services is necessary. Please contact Utilization Management at 833-615-9260 for details.

Examples of when referrals requests may be required include but are not limited to the following:

- To refer members to specialists to establish a member's treatment or diagnosis
- To provide diagnostic studies, treatments, procedures, or equipment that ranges beyond the scope of availability of the primary care services
- To provide any elective inpatient treatment

When the PCP determines that a member should be referred to a specialist or an ancillary provider, a referral must be generated by providing the '**Solis Health Plans Referral Form'** to the member. Providers who do not have internet access may request a prior authorization directly by contacting the authorization intake line at 833-615-9260. The PCP or Specialist should submit all **standard** authorization requests via fax to the Prior Authorization Department using the '**Solis Request for Service Authorization Form**.' It is imperative to include clinical documentation to support the request, including the diagnosis and procedure codes in order to deem the request as complete.

Medically necessary expedited requests will require the physician's attestation and signature that confirms the urgency for the request. The provider can also call the Prior Authorization Department Intake line at 833-615-9260 and advise that the request be 'expedited.' The Solis Health Plans associate who is taking the request will provide you with a fax number to fax the clinical information which will go directly to the nurse who will be reviewing the request.

Authorization Process

When submitting a Prior Authorization Request via fax or the Solis Electronic Portal, the Solis Health Plans Referral & Authorizations Form must be completed. The requesting provider is reminded to include:

- Member demographic information (i.e. name, sex, DOB, Solis Health Plans, Member Number)
- Provider demographic information
- Requesting provider (i.e. name, Solis Health Plans, Provider Number, phone number, fax number, contact person)
- Referred-to specialist/facility (i.e. name, Solis Health Plans, Provider Number, address, phone number, fax number, date of service, and identification if PAR (Plan participating provider/facility) or Non-PAR (not a Plan participating provider/facility)
- Diagnoses for authorization request, including ICD-10 Code(s)
- Procedure(s) for authorization request, including CPT/HCPCS Code(s)
- Number of visits requested, frequency and duration

- Pertinent medical history and treatment, laboratory and/or radiological data, physical examinations/referrals that support the medical necessity for the requested service(s) (space)

Requests that do not meet medical necessity, based upon approved criteria are reviewed by the Medical Director for a final determination. The Medical Director may conduct a peer-to-peer discussion with the requesting provider, if indicated.

Services and procedures that require prior Plan Authorization and must be provided in a Solis HEALTH PLANS participating facility* include but are not limited to:

- Inpatient and Observation Admissions, as noted above
- Admission to any rehabilitation, LTAC or skilled nursing facility
- All surgical procedures, inpatient or outpatient
- Services and items:
    - Allergy (immunotherapy), except for those services identified on the QAF
    - Ambulance transportation (non-emergency)
    - Amniocentesis
    - Cardiac and pulmonary rehabilitation programs
    - Court-ordered services
    - Chemotherapy
    - Dialysis
    - DME, including apnea monitors and bili-blankets
    - Upper endoscopies and colonoscopies at hospitals
    - Genetic testing
    - Gamma Knife, Cyberknife
    - Hearing aids
    - Home Health Services
    - Hospice care
    - Hyperbaric Oxygen Therapy (HBO)
    - Investigational and experimental procedures and treatments
    - IV Infusions
    - Laboratory services in POS 22 (outpatient surgical setting) and 24 (freestanding outpatient surgical facility
    - Lithotripsy
    - Mental Health (See Mental Health Section)
    - Nutritional counseling
    - MRI’s, MRA’s
    - Oral Surgery
    - Oxygen therapy and equipment
    - Out-of-Network Services
    - Pain Management and or Pain Injections
    - PET Scans
    - Prenatal care
    - Orthotics and Prosthetics
    - Physical, Occupational and Speech Therapy
    - Radiation therapy
    - SPECT scans

- Sclerotherapy
- Transplants and pre and post-transplant evaluations
- Wound Care and wound vacuums
- Drugs that require pre-authorization
- All services or procedures not listed on the EZ Form – No authorization Required Form

*****Unless the service is only available in a non-participating facility.

The below definitions identify the difference between a standard and expedited request per CMS guidelines.

Standard Request (Standard Organization Determination)

Per CMS guidelines, when a physician/member has made a request for a service, Solis Health Plans must notify the physician/member of its determination as expeditiously as the member's health condition requires, but no later than 14 calendar days after the date the organization receives the request for a standard organization determination.

Extensions to the 14-calendar day time frame guidelines can be made if additional clinical information is required to make a determination.

Unless medically necessary, Solis Health Plans does not authorize routine diagnostic procedures to be performed at a hospital, when a free-standing facility is available.

Solis Health Plans will **not** authorize for any experimental procedures or use of experimental medications.

Expedited Request (Expedited Organization Request):

An enrollee, or any physician (regardless of whether the physician is affiliated with the Solis Health Plans), may request that a Medicare health plan expedite an organization determination when the enrollee or his/her physician believes that waiting for a decision under the standard time frame could place the enrollee's life, health, or ability to regain maximum function in serious jeopardy.

Expedited organization determinations may not be requested for cases in which the only issue involves a claim for payment for services that the enrollee has already received. However, if a case includes both a payment denial and a pre-service denial, the enrollee has a right to request an expedited appeal for the pre-service denial.

Per CMS guidelines, the time-frame guideline for a final determination to be completed by the organization is 72 hours from the date/time the request was received by Solis. Solis has the right to extend an authorization determination an additional 14 days if more clinical documentation is required to make a decision.

It is the policy of Solis Health Plans that the Chief Medical Officer and/or Medical Director will make the final determination as to whether or not an authorization request meets Medicare guidelines and if an adverse determination (denial) should be issued.

Clinical Peer Review

Physician review will be conducted when a determination is not issued through initial clinical review. All physician clinical reviews will be conducted by a licensed Peer Clinical Reviewer (Medical Director) and will be in accordance with all Medicare requirements as well as other federal and state requirements. If a peer-to-peer conversation or review of additional information does not result in a determination, the provider, is advised of the right to initiate an appeal. All peer-to-peer consultations must be initiated within 30 days of an appeal or within 3 days of the initial adverse organizational decision.

Individuals who conduct peer clinical review are physicians who:

- Hold an active, unrestricted license;
- Unless expressly allowed by state or federal law or regulation, are located in the state of Florida;
- Are qualified, as determined by the Chief Medical Officer of Solis Health Plans, Inc., to render a clinical opinion about the medical condition, procedures, and treatment under review; and,
- Hold a current and valid Florida Medical License in the same licensure category of the ordering provider or as a Doctor of Medicine or Doctor of Osteopathic Medicine.

All requests for organizational decisions not meeting clinical criteria will be submitted for physician review by the Solis Health Services/ Utilization Management (UM) clinical staff to a Solis Health Plans Medical Director. The status will be documented in the member's record. UM staff will ensure that:

a. The appropriate clinical information including unmet criteria (LCD, NCD, InterQual, etc.) is submitted with the review request
b. For urgent requests, immediate contact with the Medical Director will be made by UM staff
c. UM staff will follow-up with the Medical Director within 24 hours to assure receipt of the case and timely response
d. The UM manager should be notified of all situations in which turnaround time is at risk of not being met

The Solis Health Plans Medical Director will evaluate each request, including clinical documentation, with the appropriate benefit language, clinical criteria and /or clinical guidelines.

a. At the Medical director's discretion, a contact may be made to the requesting physician/practitioner, attending physician or ordering provider for a peer-to-peer conversation prior to issuing the adverse organizational decision
b. A panel of licensed medical experts (physician advisors or independent review organization) will be available to the medical director for consultation
c. Licensed medical experts will be utilized representing all appropriate specialty areas for utilization management decisions in situations where specific expertise is indicated. Documentation of each discussion or peer review with a consultant (medical expert) will be made by the Medical Director and will be included in the member's UM medical platforms system.

The Medical Director will document the determination on appropriate medical platform system and return the packet to the UM nurse or other appropriate UM team member for further processing.

Once the medical director review is complete, the requesting provider will be notified of the outcome

a. If the request is approved, the authorization number is given to the provider or appropriate provider staff via fax and/or phone call.
b. If the request is not approved, the requesting provider is notified of the right to appeal or to request a peer-to-peer if one has not already occurred. The requesting provider may request a review by a different clinical peer if the original clinical peer reviewer cannot be available within one calendar day.
c. Notification of the determination will be provided to all parties as required by Federal and State requirements and documented with specific date and time information.
d. Clinical review staff, upon request, will verbally inform the member and provider of specific utilization management and operational review procedures. The staff will identify themselves by name, title, and plan and, if requested, explain utilization requirements and procedures and provide written documentation of the process.

All relevant documentation is entered into the medical platform system and all pertinent case information will be filed according to required procedures.

Participating Providers

All referral requests are to be directed to participating network provider. The only exception to the use of a non-participating provider would be when the requested services cannot be provided by one of Solis Health Plans' participating network providers. Members may request a second opinion from a non-participating provider within the same geographical service area of the organization; however, pursuant to Florida Statute 641.51 the Plan will only be responsible for sixty percent (60%) of the usual and customary charges. The member will be responsible for the remainder of the fees (40%).

HOSPITAL SERVICES

Inpatient Hospital Services

Inpatient hospital services include all items and medically necessary services which provides appropriate care during a stay in a participating hospital. These services include room and board, nursing care, medical supplies, and all diagnostic and therapeutic services. Solis Health Plans shall be responsible for Part A inpatient care to members who at the time of disenrollment are under inpatient care until the time of his/her discharge.
Solis Healthcare Plans shall not be responsible for coverage of Part A inpatient services for inpatient care already being provided at the time of enrollment of a member. The hospital would have to bill either the member insurance carrier prior to Solis Health Plans or Medicare directly.

Inpatient services include, but are not limited to:

- Acute hospital, Inpatient Rehab, long term care hospital and Skilled nursing facility stays
- Rehabilitation hospital care
- Medical supplies, drugs and biologicals, diagnostic and therapeutic services
- Use of facilities, room and board, nursing care
- Inpatient care for any diagnosis including tuberculosis and renal failure when provided by general acute care hospitals in both emergent and non-emergent conditions
- Physical therapy services when medically necessary and when provided during an enrollee's inpatient stay.

Prior Notification for Hospital Admissions

All inpatient admissions, including maternity, acute hospital, skilled nursing facilities, rehabilitation facilities and hospice require notification to the Plan.

- Elective Admissions: Notification is required at least fourteen (14) calendar days prior to the scheduled procedure or admission for prior authorization.
- Emergency Admissions: Notification required within one (1) day of an emergency of urgent admission.
- Inpatient admission after Ambulatory Surgery: required within one (1) day of the inpatient admission.

Hospital Admissions

IMPORTANT: The Plan requires authorization for all Observation status and Inpatient admissions.

Elective Admissions

When the PCP or Specialist identifies the need to schedule a hospital admission, the " Solis Prior Authorization Form" is to be submitted to the Utilization Management department at least ten (10) days prior to the scheduled admission date. This will allow for enough time for the Utilization Management department staff to verify benefits and process the pre-certification request. The Utilization Management department will conduct daily inpatient rounds and will identify members that will benefit from a care management program. Solis UM department will utilize a pro-active approach in attempting early identification and potential care management needs of the member pre and post hospitalization and implement an interventional plan of care as part of the transition of care process.

If criteria for the admission are not met, the Solis Health Plans Chief Medical Officer and/or Medical Director

will attempt to obtain additional information from the requesting physician before a final determination is made.

Note: *The hospital will notify Plan within 24 hours of the admission.*

Emergent Admissions

When the hospital emergency department, PCP or Specialist office notifies Solis Health Plans of an emergent hospital admission, the HSD staff will verify eligibility, determine benefit coverage and an authorization number will be provided.

Note: *The hospital will notify Plan within 24 hours after the admission.*

Emergency Room Notifications

Solis Health Plans does not require emergency department authorizations for emergency department visits. Members should be encouraged to contact their PCP prior to going to an emergency room, except in the case of true emergencies. If a member is seen in the emergency department and the PCP is notified, then it is the responsibility of the PCP to schedule a timely follow-up visit in his/her office.

Emergency Services

Emergency services are not subject to prior authorization requirements and are available to our members 24hrs./7 days a week, 365 days.

An emergency medical condition is a medical condition manifesting itself by acute symptoms of sufficient severity, which may include severe pain or other acute symptoms, such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect that the absence of immediate medical attention could reasonably be expected to result in any of the following:

- Serious impairment to bodily functions
- Serious dysfunction of any bodily organ or part

Solis Health Plans shall not:

- Require prior authorization for an enrollee to receive pre-hospital transport or treatment or for emergency services and care;
- Deny payment for treatment obtained when a representative of the Solis Health Plans instructs the enrollee to seek emergency services.
- Specify or imply that emergency services and care are covered by the Plan only if secured within a certain period of time;
- Use terms such as "life threatening" or "bona fide" to qualify the kind of emergency that is covered; or
- Deny payment based on a failure by the enrollee or the hospital to notify Solis Health Plans before, or within a certain period of time after, emergency services and care were given.
- Deny claims for emergency services and care received at a hospital due to lack of parental consent.

Solis Health Plans shall cover all screenings, evaluations, and examinations that are reasonably calculated to assist the provider in arriving at the determination as to whether the member has an emergency medical condition. If the provider determines that an emergency medical condition does not exist, Solis Health Plans is not required to cover services rendered subsequent to the provider's determination unless authorized by the Plan.

If the provider determines that an emergency medical condition exists, and the enrollee notifies the hospital or the hospital emergency personnel otherwise have knowledge that the patient is an enrollee of Solis Health Plans, the hospital must make a reasonable attempt to notify the enrollee's PCP, if known, or Solis Health Plans, if the Plan has previously requested in writing that it be notified directly of the existence of the emergency medical condition.

If the hospital, or any of its affiliated providers, does not know the enrollee's PCP, or has been unable to contact the PCP, the hospital must notify Solis Health Plans as soon as possible before discharging the enrollee from the emergency care area; or notify the Plan within twenty-four (24) hours or on the next business day after the enrollee’s inpatient admission.

If the hospital is unable to notify Solis Health Plans, the hospital must document its attempts to notify the Plan, or the circumstances that precluded the hospital's attempts to notify the Plan. Solis Health Plans shall not deny coverage for emergency services and care based on a hospital's failure to comply with the notification requirements of this section.

Solis Health Plans shall cover any medically necessary duration of stay in a non-contracted facility, which results from a medical emergency, until the Plan can safely transport the member to a participating facility. Solis Health Plans may transfer the member, in accordance with state and federal law, to a participating hospital that has the capability to treat the member’s emergency medical condition. The attending emergency physician, or the provider treating the member, is responsible for determining when the member is sufficiently stabilized for transfer, and that determination is binding.

Emergencies at Out-of-State Hospitals

Emergency services provided in out-of-service area and out-of-the-country hospitals are reimbursable when an emergency arises from an accident or illness, the health of the recipient would be endangered if the care or services were postponed until he returned to service area or if the health of the recipient would be endangered if he undertook travel to return to Florida.

Post-Stabilization Care Services

Post-stabilization care services will be covered without authorization, regardless of whether the enrollee obtains a service within or outside the Plan's network for the following situations:

- Post-stabilization care services that were pre-approved by Solis Health Plans

The post-stabilization care services that a treating physician viewed as medically necessary after stabilizing an emergency medical condition are non-emergency services. The Plan can choose not to cover them if they are provided by a non-participating provider, except in those three circumstances identified above.

Inpatient Case Management

A Solis Health Plans Field Case Manager will conduct regular concurrent reviews of the hospital medical record either by on-site review at the hospital or by telephonic review to determine the authorization for continued length of stay. The facility will be notified regularly of the continued authorized length of stay. In the event additional continued stay is not authorized, the member, facility, attending provider, and the PCP will be notified by Solis Health Plans.

The Solis Health Plans Field Case Manager will review the medical information on regular intervals. If the Field Case Manager is onsite at the hospital they will also be responsible to work with the attending provider, the hospital case management/discharge staff, the patient and/or family, and the PCP to discuss any discharge planning needs. The Field Case Manager will verify that the member and/or family are aware of the member's PCP's name, address and telephone number and encourage him/her to make a post-hospitalization follow-up appointment with the PCP. **The PCP is responsible for contacting the member to schedule all necessary follow up care.**

Transplants

Please send a completed Referral and Authorization form if you need to refer a member for a transplant. Solis covers major organ transplant such as: heart, lung, liver, stem cell, pancreatic, bone marrow, cornea, intestinal/multivesicular, kidney, pancreatic transplants, all pre and post-transplant care and any other as listed per CMS guidelines. Solis Health plan has partnered with OptumHealth Care Solutions, LLC for Network, and Claims pricing.

CONCURRENT REVIEW/DISCHARGE PLANNING

Overview

Solis staff will conduct initial and concurrent reviews of all inpatient admissions and observation status stays by either an on-site or telephonic Utilization Management (UM) concurrent reviewer. Every attempt will be made to complete the initial review within one working day of receipt of the notification of the admission and then regularly throughout the hospital stay.

Discharge planning will start with the initial review in identifying potential discharge needs and will be ongoing throughout the admission until the actual discharge.

SO Solis LIS staff will comply with the Health Insurance Portability and Accountability Act (HIPAA) with all member information.

- Solis UM concurrent reviewers are notified of members who are hospitalized either as a FULL admission or with OBSERVATION status, acute rehabilitation admissions and SNF admissions via the following sources:
    - Secure email notification of a new admission/observation status from the Pre-Certification staff
    - Verbal notification (in-person or phone) entering a new admission/observation into the Plan's UM system
    - Inpatient Daily Census Report (run 2Xs daily to capture admissions notified/entered during the day and to plan for the following day's priority for on-site staff)

- Solis will make every effort to educate all facilities to submit clinical information with the notification in order to establish medical necessity and provide a determination as expeditiously as possible

- When clinical information is not received with the notification, the UM concurrent reviewer will attempt to obtain clinical information to support medical necessity and the correct level of care for the admission/observation within one (1) working day of receipt of the notification of the admission/observation
    - Concurrent review will be done either on-site or telephonically

- In addition to obtaining clinical information for medical necessity and appropriate level of care, the UM concurrent reviewer will confirm:
    - Member demographics is the same as in the Plan's computer system
        - If different, follow protocol to ensure that all necessary Solis departments have the corrected information

    - That the member has no other insurance (Primary or secondary; Commercial, Medicaid, etc.)
    - That the admission is not related to an accident or work-related injury or other potential coordination of benefits (i.e. workers compensation, motor vehicle insurance, etc.)
        - NOTE: If a secondary insurance or potential coordination of benefits is identified, the concurrent reviewer is responsible for flagging the authorization, as per the Plan's process, to identify these for the current and future authorizations and claims payment review

- Initial and concurrent review (continued stay) is conducted using the clinical information and reviewing it with the approved criteria guidelines (Medicare National Coverage Determinations and McKesson InterQual Clinical Support Decision Criteria) to ensure the member initially meets criteria for the level of care and for ongoing continued stay.

- The concurrent reviewer will report daily (or as established) during the Plan's Inpatient Rounds, that will include the following:
    - Plan Medical Director
    - UM Concurrent Reviewer
    - Attending Physician, if indicated
    - UM Manager
    - Case Manager, if needed
    - Other members of the interdisciplinary team, as needed

- During inpatient rounds, the team reviews all Acute Inpatient admissions, Observation stays, Acute Inpatient Rehabilitation admissions, and Skilled Nursing Facility (SNF) admissions for needed determinations or for recommendations of changes in status or level of care needs

- Discharge planning needs are also addressed during the Inpatient Rounds

- It is the UM concurrent reviewer's responsibility to:
    - Update the authorization in the Plan's UM system daily or as appropriate, including, but not limited to:
        - Status (approved/denied)
        - Number of days/units
        - All appropriate diagnosis codes (admitting, primary, secondary, etc.)
        - Initial and continued stay comments, as dictated by Inpatient Rounds and other ad hoc consultations and reviews

    - Identifying and documenting Hospital-Acquired Conditions (HACs)

    - Referring any potential quality of care issues to the Quality/Risk Management Department

    - Identifying and coordinating all discharge needs for the member for a seamless transition of care at the time of discharge

    - Ensuring that all denial notifications are appropriately sent and received by the facility and member, as per the appropriate P&P and adverse determination notification and process

    - At the time of discharge, entering in the authorization the following:
        - The Actual Discharge Date
        - Confirming and updating all procedures and diagnosis, including the discharge diagnosis

    - Confirming and updating all approved/denied procedures and revenue codes with the final approved/denied units/days
    - Confirming and documenting if the member will be discharged to a location other than his/her residence, as noted in the Plan's system
    - Generating all discharge notifications to the facilities/PCP
    - Completing and verifying all information is correct and updating the authorization status

- Refer all discharged members to Solis Transition of Care Coordinator and/or Case Management for follow up with discharge needs

HOSPICE

To qualify for the Medicare hospice program, all recipients must:

- Be eligible for Medicare part B and certified by a physician as terminally ill with a life expectancy of six months or less if the disease runs its normal course
- Voluntarily elect hospice care for the terminal illness
- Sign and date a statement electing hospice care

Hospice is a program of care and support for people who are terminally ill. It is available as a benefit under Medicare Hospital Insurance (Part A). The focus of hospice is on care, not treatment or curing an illness. Emphasis is placed on helping people who are terminally ill live comfortably by providing comfort and relief from pain.

Some important facts about hospice are:

- A specially trained team of professionals and caregivers provide care for the "whole person", including his or her physical, emotional, social and spiritual needs.
- Services may include physical care, counseling, drugs, equipment, and supplies for terminal illness and related condition(s).
- Care is generally provided in the home
- Hospice isn't only for people with cancer.
- Family caregivers can get support.

When all the requirements are met, the Medicare hospice benefit includes:

- Physician and nursing services
- Medical equipment and supplies
- Outpatient drugs or biological for pain relief and symptom management
- Hospice aide and homemaker services
- Physical, occupational and speech-language pathology therapy services
- Short term inpatient and respite care
- Social worker services
- Grief and loss counseling for the member and his or her family

When a member/patient enrolls in hospice and they receive care from the hospital or facility, it is very important that all of the care be coordinated with their hospice physician. Once a Member is enrolled in hospice, Solis Health Plans is not financially responsible for any services related to the hospice diagnosis. The Plan will continue to assist in coordination of the member's care to the best of its ability, however, the payment process to provider's changes.

For Hospice diagnosis-related care, providers need to bill the Medicare-approved hospice organization with which the patient is enrolled. For care not related to the hospice related diagnosis, that is a Medicare covered benefit, Solis Health Plans participating providers need to bill the health plan. Non-participating providers need to bill Medicare's Fiscal Intermediary. If a Member's hospice is revoked during a month, you must continue to bill the hospice organization or the Fiscal Intermediary for CMS through the end of that month. Solis Health Plans is responsible for additional benefits not covered by Medicare, i.e. the transportation

benefit, dental and vision. Any claims received by Solis Health Plans for Medicare- covered services that are related to the hospice diagnosis or that are not additional plan benefits, will be denied by the Plan.

Note: A member who has elected hospice and requires medical treatment for a non-hospice condition can do one of the following:

1) Use plan providers and services. In such a case, the member only pays Plan allowed cost-sharing, and the provider would directly bill Solis Health Plans Healthcare Plans.
2) Use non-network providers and be treated under FFS. In such a case, if the service is not emergent/urgent care, the member would pay the total FFS allowed cost-sharing. The provider bills Medicare's Fiscal Intermediary.

When hospice services are requested by a Member, confirmed with the Centers for Medicare & Medicaid Services (CMS) and updated in the Plan's system, the Member is sent a new enrollment card reflecting a new group number beginning with RH*. This process may take time, depending on when the Hospice Form is received by CMS and when their system is updated.

It is important that your staff and/or billing company understands the process required to bill the Fiscal Intermediary for CMS for members of our Plan that are enrolled in hospice. Please communicate this information to your staff and/or billing company as appropriate.
Contact Information for the Fiscal Intermediary is as follows:

First Coast Service Options, Inc.

- Medicare Part A: Provider Contact Center- 1-(888) 664-4112
- IVR System- 1-(877) 602-8816

- Medicare Part B: Provider Contact Center- 1-(866) 454- 9007
- IVR System- 1-(877) 847-4992

Additional Resources:
Medicare Claims Processing Manual- Chapter 11: Processing Hospice Claims (Revised: 4/28/10) Section 40.2.2 – Claims from Medicare Advantage Organizations

BEHAVIORAL HEALTH

The management of Behavioral Health benefits for Solis Health Plans members is handled by the plan's integrated Behavioral Health Services Team. Behavioral Health Services include assessment and treatment of psychiatric and/or substance abuse conditions as listed on the DSM-VI. They may be acute or chronic and often referred to as "mental health" services.

Solis covers Behavioral Health services that are medically necessary and include evaluation, testing, counseling, rehabilitation and other related treatments. Services may be provided in an inpatient setting, , an intermediate levels of care or outpatient services provided by Psychiatrists (MD, DO), Psychologists (PHD, PsyD), Nurse Practitioners (ARNPs), and Licensed Clinical Social Workers (LCSW).

Covered Services:

- Outpatient services provided in an office or Community Mental Health Center

  Members will call Solis Health Plans to make appointments and obtain the names of several providers in their area. They may select an alternative behavioral health provider within the network and may receive care at doctor's offices or community agencies .
- If a member was receiving mental health or psychiatric treatment before joining Solis Health Plans, please call the Member Services Department at 844-447-6547 so that the care is not interrupted.

Inpatient Behavioral Health services will be covered for up to 190 days lifetime limit and provided in a Medicare-Certified facility. The benefit days used under the Original Medicare program will count towards the 190-day lifetime reserve days when members enroll in a Medicare Advantage Plan.

Only a licensed psychiatrist may authorize a denial for an initial or concurrent authorization of any request for behavioral health services.

Inpatient Services may be requested by:

- By calling Utilization Management 833-615-9260 and/or Case Management at 833-615-9261
-
- By fax at 833-210-8141, using the Solis Health Plans Referral Form

D-SNP
Beginning July 1, 2021, the Effective July 1, 2021, the Florida Medicaid Management Information System (FMMIS) will no longer pay for services billed to Medicaid for recipients enrolled in a Dual Eligible Special

Needs Plan (D-SNP) for the following provider types: Assistive Care, Case Management Agency, Behavioral Health, Home Health, Private ICF/DD Facility, and Skilled Nursing Facility. These providers must bill all services to a re
.

Emergency Behavioral Health Services in and Outside of the Service Area

- Members are advised to call 911 or go to the nearest emergency room if they need emergency mental health care, and to call their PCP later as soon as they can.
- Solis Health Plans will cover all emergency mental health care whether the member is in or outside the service area, at any time.
- Members may call 844-447-6547 for assistance finding behavioral care in the area where they are located
- After the initial emergency treatment, Solis Health Plans will cover the post-stabilization care services, even without authorization. Crisis intervention services are covered.

Standing Referrals for Members with Chronic and/or Disabling Conditions

Members with chronic and disabling conditions, which require ongoing specialty care, will be issued standing referrals to the appropriate specialists and/or services. The PCP needs to submit a referral for the course of treatment to be provided by a specialist and/or ancillary provider.

Solis Health Plans may request reports on the ongoing status of the member's condition from the provider.

DELEGATION OVERSIGHT

Solis Corporate Compliance, or designated delegation oversight staff, monitors services delegated to a contracted FDR in accordance with CMS, Federal and State standards and requirements.

Solis communicates service expectations and monitors FDR activities by **(I)** delineating contractual obligations, **(II)** performing pre-audits and annual audits, **(III)** monitoring contract compliance/overall performance **(IV)** maintaining ongoing communications **(V)** performing in-services, **(VI)** tracking reporting deliverables, and **(VII)** recommending corrective actions and financial penalties based on FDR's performance to the Solis Compliance, Audit & Risk Committee.

(I) Delineation of Contractual Obligation

The delegation agreement will delineate the responsibilities required by Solis of the FDR in accordance with its contract with CMS and CMS, Federal and State standards.

(II) Pre and Annual Audit

Pre-Delegation Audit: Solis has a formal review process for the oversight of FDRs performing delegated services. Prior to implementation of a new FDR, a pre-delegation desktop (and in some cases onsite) review is performed by Solis Subject Matter Experts (SMEs). The organization's policies and procedures, training materials (specifically FWA and compliance) and Code of Ethics (aka Standards of Conduct) along with other pertinent documentation are reviewed to determine compliance with Solis requirements and State and Federal regulations. If the FDR is delegated credentialing, a random sample of credentialing and re-credentialing files are reviewed to ensure compliance with the delegation agreement. Any area(s) of deficiency will be communicated to the FDR and must be addressed *prior* to final approval of delegated services.

Upon completion of the pre-delegation audit a summary of deficiencies, if any, is presented to the Compliance, Audit and Risk Committee for review and evaluation. The Committee will either approve the contract or will determine what actions, if any, should be taken by the FDR to cure the noted deficiencies. Final approval of an FDR contract is determined by the Board. Once approved, a written contract between the two entities is executed detailing the specific delegated service(s).

Annual Audit: The Compliance, Audit & Risk Committee will be responsible for monitoring the compliance of all delegated FDRs with the delegated agreement.

a) The FDR's overall performance will be reviewed at least once annually for each delegated function.
b) Audit findings reporting deficiencies will require the issuance of a corrective action plan (CAP). A re-audit may be conducted intermittently to assess compliance following implementation of a corrective action plan.
c) Audit findings by the Corporate Compliance department reporting significant deficiencies will be submitted to the Compliance, Audit and Risk Committee. Recommendations to terminate the delegated agreement will be submitted by the Compliance, Audit and Risk Committee to the Board.
d) Submission of regulatory reports by the FDR will be tracked and reported to the Compliance, Audit and Risk Committee.

(III) Monitoring Contract Compliance through Monthly and Quarterly Scorecards

Solis monitors its FDR's performance via scorecards, reports and annual on-site audits to ensure their ongoing compliance. Solis requires its FDRs submit additional performance information (e.g. network adequacy, complaints, average encounter acceptance rate, etc.) following CMS required benchmarks. Information is reviewed monthly for trends. The FDRs attest to the information provided in their score card. In instances where an SLA has been missed, the attestation reports root cause, contributing factors and an action plan for meeting compliance. The FDR scorecard's templates are reviewed monthly to ensure consistency with the most current CMS guidance.

(IV) Ongoing Communication

Monthly meetings are scheduled between FDRs and Solis to share pertinent information, to discuss operational processes, address issues, trainings and ensure continuity of services. Ad-hoc meetings are scheduled to address issues requiring immediate attention and ongoing monitoring. When necessitated, daily communication may be established with an FDR to address issues of non-compliance or heightened risks.

(V) In-servicing Subcontractors

From time to time in-service sessions with FDRs may be conducted. Topics will range in response to business requirements (i.e.: substantial change in CMS, Federal or State requirements, Solis plan benefit packages, reporting FWA, annual audit process/updates, regulatory reporting, substantial changes in health plan operations impacting the FDR, etc.). Subject matter experts (SMEs) are identified to lead in-service conversations with FDRs as may be required.

(VI) Reporting Deliverables

The dates and frequency of reports to be submitted by FDRs are closely monitored allowing sufficient time for review by the Solis SME and Corporate Compliance department prior to submission to CMS or other regulatory entities. An updated list of reports and due dates is maintained by the Corporate Compliance department and is routinely shared with FDRs.

(VII) Corrective Action Plan (CAP)

Should an FDR fail to carry out specific delegated activities, or has not met Solis performance expectations, in accordance with the terms of their agreement, or as required by CMS, Federal or State requirements, a corrective action plan (CAP) may be recommended by Corporate Compliance. CAPs are reported to the Compliance, Audit & Risk Committee and when necessary, the Board. Failure of the FDR to satisfy conditions of the CAP may result in Solis rescinding the agreement with the FDR. All CAPs will be monitored and tracked by Corporate Compliance until the deficiencies noted in the CAP have been satisfactorily remediated.

SPECIAL NEEDS PLANS (SNPs)

Solis Health Plans offers Special Needs Plans (SNPs) for members who meet specific enrollment criteria and who reside within the specified Solis Health Plans service area. These plans offer eligible members focused benefits as well as the advantages of an interdisciplinary care team approach to patient care. It is crucial that each PCP is actively engaged in the care for each member assigned to their panel.

Dual Eligible SNP (DSNP)

The below plans are the Special Needs Plans for members who are eligible for both Medicare and Medicaid; these benefit plans are available in specific counties.

- SPF 002 – Miami-Dade HMO-DSNP
- SPF 006 – Orange HMO-DSNP
- SPF 010 – Hillsborough HMO-DSNP
- SPF 012 – Broward HMO-DSNP
- SPF 013 – Palm Beach HMO-DSNP

Eligibility Requirements for Dual Eligible SNP

- Entitled to Medicare Part A
- Enrolled in Medicare Part B through age or disability
- Resident within the Plan's service area
- Receiving some level of assistance from the state Medicaid program

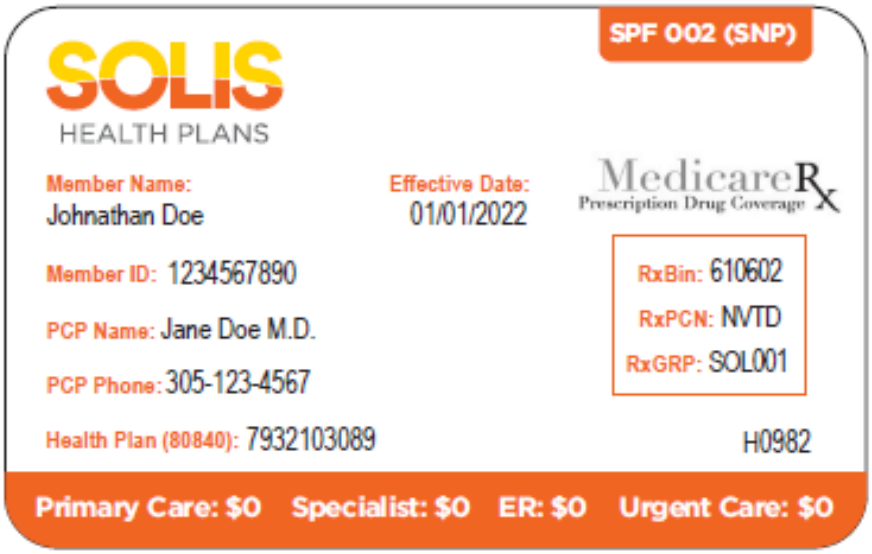
All contracted providers caring for Solis Health Plans members enrolled in a Solis Health Plans Dual Eligible SNP should be knowledgeable about the benefits covered by Florida's Medicaid program that are not covered by a Solis Health Plans Dual Eligible SNP. Federal law prohibits dually eligible members being held liable for payment of any fees that are the obligation of Solis. Any provider servicing Solis' Dual-Eligible population must comply with AHCA's Medicaid Services Coverage and Limitations Handbook. Scope of Services can be found in the link below:

https://ahca.myflorida.com/medicaid/Finance/data_analytics/actuarial/docs/Medicare_Advantage_D-SNP_Medicaid_Covered_Services

Important Note: If a member loses SNP eligibility, he or she will be disenrolled from the Plan.

Sample DSNP Member ID Card (enlarged for better visibility)

FRONT



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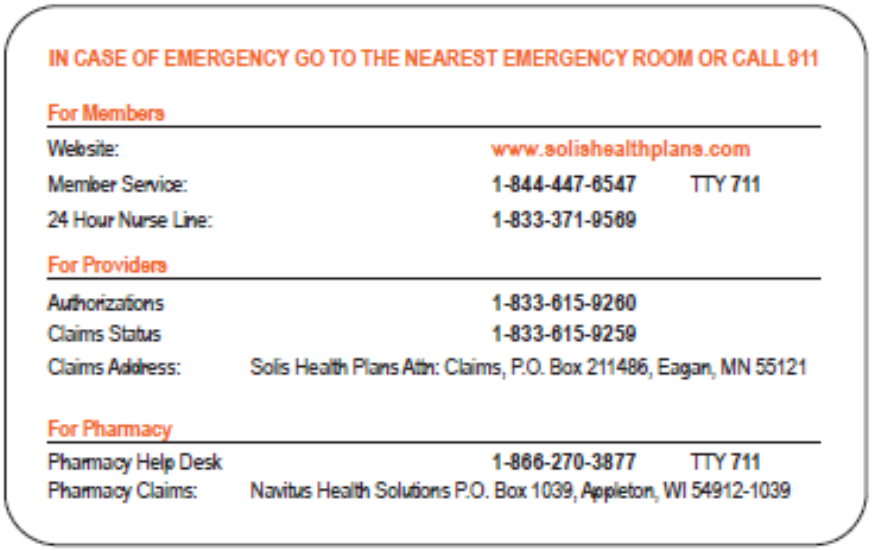


Chronic SNP (CSNP)

The below plan is the Special Needs Plan for members who are experiencing chronic and disabling mental health conditions; these benefit plans are available in specific counties.

- SPF 011 – Miami-Dade HMO-CSNP

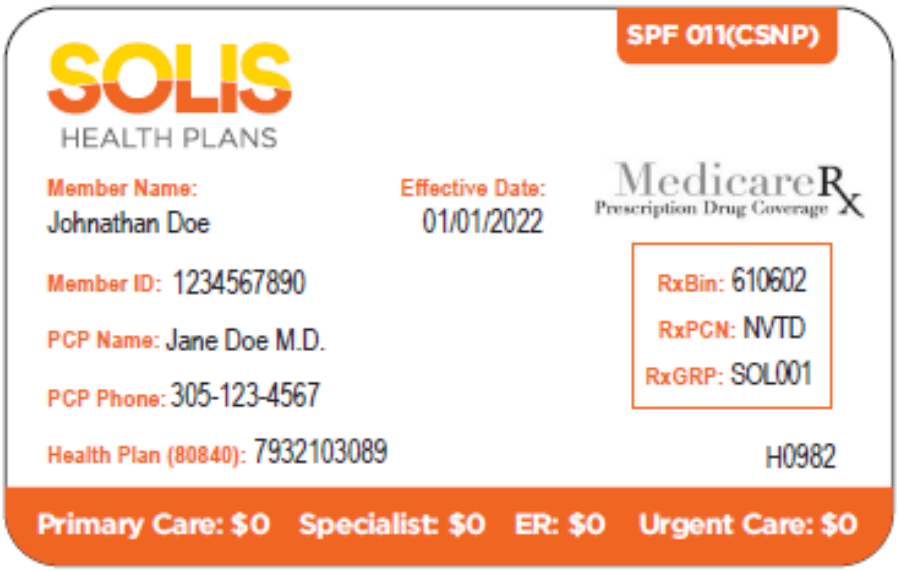
Eligibility Requirements for Chronic SNP

- Entitled to Medicare Part A
- Enrolled in Medicare Part B through age or disability
- Resident within the Plan's service area
- Are diagnosed with any of the following: Bipolar Disorders, Major Depressive Disorders, Paranoid Disorder, Schizophrenia, and Schizoaffective Disorder

Important Note: Solis will need to obtain verification of the chronic condition from your doctor within 30 days of enrollment. If Solis is unable to verify the member's chronic condition, he or she will be disenrolled from the Plan.

Sample CSNP Member ID Card (enlarged for better visibility)

FRONT



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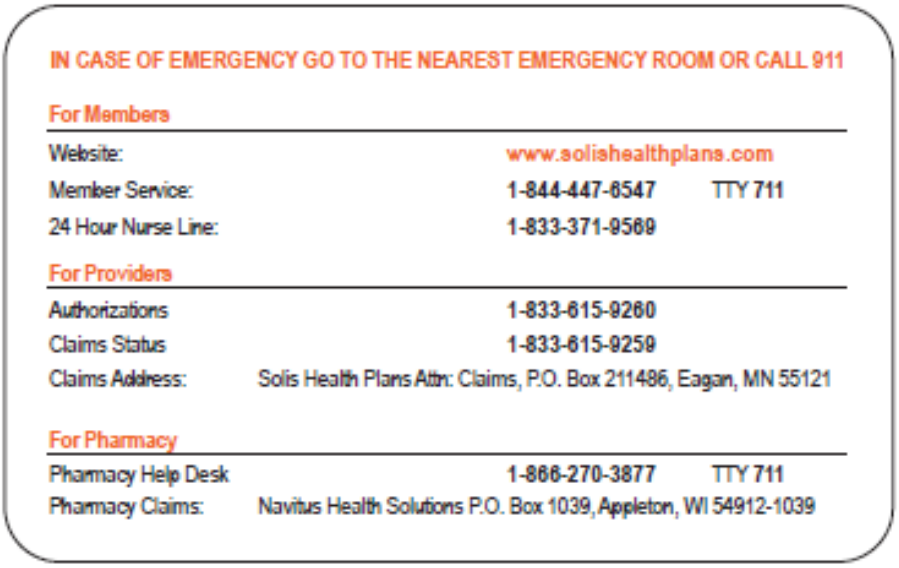

CREDENTIALING PROCESS

Objective

The purpose of credentialing providers is to exercise reasonable care in the selection and retention of competent, participating providers. Please note that the initial credentialing process can take up to sixty (60) days for completion from the date a completed application is received. The Solis credentialing department will deem an application complete when all sections are accurately completed with applicable supporting documentations included.

Solis must institute verification of certain credentialing and re-credentialing information of participating practitioners/physicians/providers as required by Federal and State regulatory agencies as well as applicable accreditation organizations. Hospital-based ancillary service providers are not credentialed or re-credentialed by Solis when those providers only provide services to Solis Members through the hospital.

The initial credentialing process must provide for verification of the following information:

- The practitioner's current valid medical license on file at all times pursuant to Section 641.495(6), Florida Statutes.
- Copy of First Coast Letter stating Provider is enrolled in Medicare.
- Proof of the practitioner's medical school graduation, completion of a residency program, and other postgraduate training is required. Evidence of Board Certification shall suffice in lieu of proof of medical school graduation, residency, and other postgraduate training.
- The practitioner's completion of training conducted in accordance with Section 456.031, Florida Statutes shall suffice as training for domestic violence screening.
- Evidence of the practitioner's specialty board certification, by the American Board of Medical Specialties or the American Osteopathic Association in the physician's practicing specialty, is required.
- Physicians who are neither board-certified nor board-eligible will be credentialed as "General Practice" if they are required for network purposes. Credentialing Staff will verify that the physician has current hospital affiliations as per application.
- Current professional liability coverage that meets or exceeds the minimum limits established by Solis. If the practitioner chooses to not care any professional liability coverage a going bare waiver must be provided in accordance with Section 458.320, Florida Statutes
- Evidence of the practitioner's professional liability claims history. In the case of an applicant with such history, evidence that the history does not demonstrate probable future sub-standard professional performance. Five (5) years of malpractice history will be reviewed. For discipline on the medical license and denial of privileges the entire history will be reviewed.
- The practitioner's ECFMG certificate, if applicable.
- History of final disciplinary actions as described in Section 456.039(1) (a) 8, Florida Statutes.
- Any sanctions imposed on the practitioner by Medicare or Medicaid.
- Medicare Opt-Out
- Proof of the practitioner's last 5-year work history and any gaps of greater than six (6) successive months.
- A statement regarding the following:
- Physical or mental health problems that may affect the practitioner's ability to provide health care;

- History of chemical dependency/substance abuse;
- History of loss of license and/or felony convictions;
- History of loss or limitation of privileges or disciplinary activity;
- Attestation to correctness/completeness of the practitioner's application;
- Attestation of total active patient load (Panel Size) for any primary care provider in accordance with Section 409.9122(12), Florida Statute.

Site Inspections

Documentation of a Site Visit for each primary care provider (i.e. – General Practice, Family Practice, Family Medicine, Internal Medicine) that includes:

- Evaluation against Solis organizational standards;
- Evaluation of the physician's medical record keeping practices at each site to ensure conformity with the Solis organizational standards;
- Determination to certain documents are posted including:
    I. Agency's statewide Consumer Call Center telephone number,
    II. a copy of the summary of Florida Patient's Bill of Rights and Responsibilities in accordance with Section 381.026, Florida Statute with a complete copy available upon request by the Member, and
    III. a Consumer Assistance Notice prominently displayed in the reception area in accordance with Section 641.511(11), Florida Statute.
- If the Practitioner's file is incomplete, the file will be returned to Provider Operations.
- After Primary source verification is completed, and additional documentation is needed, the file will be set aside as incomplete. If file remains incomplete after two requests, and 90 days, the application shall be deemed withdrawn by the applicant.

Practitioner Rights

- Practitioners have the right to review information obtained from outside sources (e.g. state licensing board, malpractice insurance) to support their credentialing application.
- The practitioner has the right to correct erroneous information in the following manner:
    I. Within 30 days of credentialing application submission
    II. Information must be submitted on a letterhead
    III. Corrections are to be submitted via email to credentialing@solishealthplans.com
- Upon request, practitioner may inquire about application status

Re-Credentialing

The re-credentialing process must be implemented at least every three (3) years, 120 days prior to expiration of credentialing, the Solis Credentialing Coordinator must initiate the re-credentialing process. Verification of the following information must occur:

- Board certified physicians with time-limited certification require re-verification of board status.
- Evidence of the practitioner's professional liability claims history since the last credentialing. If the case of settlements or adverse judgments, then 3 years of malpractice experience is reviewed.
- Any sanctions imposed on the practitioner by Medicare or Medicaid.

- A statement regarding the following:
    I. physical or mental health problems that may affect the practitioner's ability to provide health care;
    II. history of chemical dependency/substance abuse;
    III. history of loss of license and/or felony convictions;
    IV. history of loss or limitation of privileges or disciplinary activity;
    V. attestation to correctness/completeness of the practitioner's application; and
    VI. attestation of total active patient load for any primary care provider in accordance with Section 409.9122(12), Florida Statute.
- Documentation of a Site Visit for each primary care provider that includes:
    I. evaluation against Solis organizational standards;
    II. evaluation of the physician's medical record keeping practices at each site to ensure conformity with the Solis organizational standards;
    III. determination to certain documents are posted including:
        1) Agency's statewide Consumer Call Center telephone number,
        2) a copy of the summary of Florida Patient's Bill of Rights and Responsibilities in accordance with Section 381.026, Florida Statute with a complete copy available upon request by the Member, and
        3) a Consumer Assistance Notice prominently displayed in the reception area in accordance with Section 641.511(11), Florida Statute.

Practitioners are sent 3 to 4 notices starting 3 months in advanced of their re-credentialing due date. These notices may be sent by U.S. mail, facsimile, or email and include directions on how to complete re-credentialing in a timely manner. One month prior to the due date, the credentialing staff contacts the offices directly to notify them that if they do not complete their re-credentialing within the required timeframe, their contract could be terminated

- If practitioner fails to return the application, does not provide necessary information, or does not respond to requests for information, the credentialing Department will notify the Provider Operations Department for a final determination.
- If reconsideration of this termination for failure to complete application process is desired, the Provider will have 30 days from the date of the termination notice to submit all missing documentation. The termination is final if the 30-day time period has passed and no written request for appeal has been received.
- If a previous terminated Provider is re-contracted, he/she does not need to be re-credentialed if the date of the initial application is within three years and Primary source verifications are clear.

PRESCRIPTION DRUG BENEFIT (PART D)

What's covered under Solis Part D program?

Covered

All plans are required to have formularies that address all medically necessary drugs. Six drug classes of special concern have been specified in which all or substantially all drugs will be on a plan's formulary: anti-neoplastics, anti-HIV/AIDS drugs, immunosuppressant, anti-psychotics, anti- depressants and anti-convulsants.

Not Covered

By law, there are certain types of drugs that Medicare must exclude from Part D: drugs used for anorexia, weight loss or weight gain; fertility drugs; certain drugs used for the treatment of sexual or erectile dysfunction*; drugs used for cosmetic purposes or hair growth; cough and cold medicines; prescription vitamins and minerals; over-the-counter drugs; and outpatient drugs for which the manufacturer seeks to require that associated tests or monitoring services be purchased exclusively from the manufacturer as a condition of sale. For your patients that have both Medicare and Medicaid, check with your state Medicaid program as most programs are continuing to cover all or some of these excluded drugs.

*Solis covers some of the excluded erectile dysfunction drugs. Please contact the Plan for details.

Please refer to Solis website at www.solishealthplans.com for additional guidance related to Part D.

Short Decision-Making Timeframes

CMS has directed every prescription drug plan to respond to requests without delay. Plans must communicate decisions on initial coverage determinations no later than 24 hours after receiving an expedited request, or 72 hours after receiving a standard request. If a physician or other prescriber requests a coverage determination on behalf of an enrollee, the physician also will receive notice of the decision from the plan. Coverage determinations include decisions on formulary and tier exception requests. If the plan fails to meet the timeframe, the case goes to an independent review entity (IRE) under contract with CMS for a decision on the case.

Requests Made by Physicians or other Prescribers

A coverage determination can be requested by a Part D plan enrollee, by enrollee's representative or the enrollee's prescriber. A physician and/or other prescribers may request, upon providing notice to the enrollee, an expedited or a standard redetermination (first level of appeal) on behalf of the enrollee without having been appointed as the enrollee's representative. However, prescribing physicians or other prescribers cannot request a reconsideration (second level of appeal); unless they are the enrollee's appointed representative. Form CMS-1696 or an equivalent written notice can be used to appoint a representative. Form CMS-1696 is available at https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf

Physicians or other Prescribers Supporting Statements

Prescribing physicians or other prescribers have an important role in the exceptions process. Whenever an enrollee requests a formulary or tier exception, the prescribing physician or other prescriber must provide the Part D plan with an oral or written statement to support the exception request. Formulary exception requests include requests for exceptions to cost utilization management tools, such as step therapy or dose restrictions. The plan's timeframe for making a decision on an exception request does not begin until the prescribing physician's supporting statement is received by the plan. Anyone can go to the CMS coverage determination site to get contact numbers for the plans to facilitate the submission of the supporting statement.

Member Appeal Rights

If an enrollee doesn't agree with the initial coverage determination made by the plan, the enrollee has the right to appeal the coverage determination. As noted above, the prescribing physician or other prescribers can ask for an expedited or standard first level appeal (redetermination) on behalf of the enrollee. For expedited redeterminations, a Part D plan must give the enrollee (and prescribing physician involved, as appropriate) notice of its decision no later than 72 hours after receiving the request. Decisions on standard redeterminations must be communicated to the enrollee in writing no later than seven (7) calendar days after receiving the request. If a plan issues an adverse redetermination, the enrollee will receive a notice that includes information on how to request a reconsideration by the Independent Review Entity (IRE). Detailed information can be found in the members Evidence of Coverage.

Non-formulary requests

Non-formulary drug requests require members to use the drug for a medical acceptable use and, in general, to have tried and failed formulary alternatives in the same drug class. For non-formulary requests, a Part D plan enrollee, enrollee's representative or the enrollee's prescriber may access the 'Formulary Exception Request' form online at www.solishealthplans.com and follow the instructions for submittal. A prescriber's supporting statement is required for all requests before the non-formulary prescription can be approved for payment. Tier exceptions cannot be granted for non-formulary drugs.

Step Therapy

In some cases, patients are required to first try one (1) drug to treat their condition before another drug is covered for that condition. If a prerequisite drug is not found in recent past claims, a drug requiring step therapy is not covered. The physician or physician's representative, on the patient's behalf, may contact Solis to request an exception. A clinical supporting statement will be required stating that the patient has a documented intolerance, contraindication or hypersensitivity to the prerequisite drug(s), plus any additional clinical information regarding the patient's need for the step therapy drug.

Medication Therapy Management Program

Members enrolled in Solis Health Plans with Medicare prescription drug benefits may be eligible for the Medication Therapy Management (MTM) Program, in accordance with CMS guidelines. The purpose of the program is to provide medication therapy management services to targeted members. These services are

designed to ensure that covered Part D drugs are appropriately used to optimize therapeutic outcomes by improving medication use and reducing the risk of adverse drug events including adverse drug interactions.

MTM eligible members are automatically enrolled into the program after meeting qualification criteria. Once a member qualifies for MTM they are sent an introductory letter within 60 days that provides an explanation of the program, provides instructions to opt-out, and offers the opportunity to request a Comprehensive Medication Review (CMR), and this includes enrollees who are in long term care (LTC) settings. The member may request a CMR by returning an enclosed appointment form or calling the provided toll-free number. Members that request a CMR have a telephone appointment scheduled for a one-on-one consultation with a qualified MTM provider. We will also attempt to contact all qualified members via phone to offer their CMR within 60 days of qualification. Meanwhile, all members that have not opted-out of the program receive on-going Targeted Medication Reviews (TMRs) on at least a quarterly basis with each update of prescription claims. TMRs identify opportunities for interventions based on systematic drug utilization review including cost savings, adherence to national consensus treatment guidelines, adherence to prescribed medication regimens, and safety concerns. TMRs that identify drug therapy problems are categorized and triaged based on the severity of the problem. The member or prescriber is then contacted via phone, mail, or fax as appropriate for review of potential drug therapy changes. TMR-generated intervention opportunities that result in an outbound phone call to the member may allow an additional opportunity for the MTM vendor to offer the member a CMR. Members that accept the CMR on the outbound TMR call receive the CMR as outlined below. Additionally, members who are unreachable based on the primary telephonic model may receive a CMR offer and/or have the opportunity to complete a CMR with a qualified MTM provider while at their providers office, pharmacy, or LTC facility. In addition, LTC facility information may be provided to assist in outreach to LTC members. CMRs may also be completed directly with the beneficiary's prescriber over the phone, through telehealth, or face-to-face in the prescriber's office. Interventions resulting from person-to-person TMRs, non-person-to-person TMRs, and CMRs may result in prescriber contact via fax, phone, electronic health records, or mail, when appropriate.

Comprehensive Medication Reviews (CMRs) are completed as a one-on-one consultation with a qualified MTM provider. The primary method of CMR completion will be via telephone, however, CMRs may also be completed via telehealth or face-to-face. During the CMR, the members entire medication profile is reviewed (including prescriptions, OTCs, herbal supplements and samples) for appropriateness of therapy. The purpose and direction of each medication are reviewed with the recipient of the CMR and documented on the Personal Medication List (PML). Disease-specific goals of therapy and medication-related problems may be discussed, as well as any member-specific questions. After the CMR, the member is mailed the standardized post-CMR takeaway letter which includes a Medication Action Plan detailing the conversation with the MTM provider and a PML.

All members that have not opted-out of the program receive on-going Targeted Medication Reviews (TMRs) on at least a quarterly basis with each prescription claim update and each time the member should have a prescription claim for a chronic medication. At the end of each quarter, all enrolled members are reviewed to ensure that a TMR was performed that quarter. If a TMR was not performed, due to not receiving any prescription claims for the member during that quarter, the system will complete a TMR in the absence of new claims to ensure compliance. TMRs identify opportunities for interventions based on systematic drug utilization review including cost savings, adherence to national consensus treatment guidelines, adherence to prescribed medication regimens, and safety concerns. TMRs that identify drug therapy problems are categorized and triaged based on the severity of the alert. The member or physician is then contacted via phone, mail, or fax as appropriate for review of potential drug therapy changes. TMR alerts that result in an outbound phone call to the member may allow an additional opportunity for the MTM vendor to offer the member a CMR. Members that accept the CMR on the outbound TMR call receive the CMR as outlined above. Interventions resulting from

person-to-person TMRs, non-person-to-person TMRs, and CMRs may result in provider contact via fax, phone, electronic health records, or mail, when appropriate.

Solis MTM Program is administered through our Pharmacy Benefits Manager (PBM) Navitus Health Solutions by way of Sinfonia RX. If you have any questions for the pharmacist, or to schedule your pharmacist's review, please call SinfoníaRx at 1-844-866-3735, Monday through Friday, 10 a.m. to 8 p.m., Eastern. TTY/TDD users please call 1-800-367-8939.

OVER-THE-COUNTER (OTC) BENEFIT

Solis is pleased to offer an OTC benefit for each of our members. With this benefit, you are able to choose from over 120 health and wellness items.

Such items could be, but not limited to:

- Cough and Cold Medicine
- First aid items
- Vitamins
- Analgesics
- Toothbrushes, toothpaste and floss

Please encourage all Solis members to utilize this monthly benefit, as the benefit will not roll over to the next month.

For a complete list of Solis OTC items, please visit our website at https://solishealthplansstorage.blob.core.windows.net/documents/2020-2021/OTC/2021-Solis-Over-the-Counter-Catalog.pdf or contact our OTC vendor at 833-898-7046.

PARTICIPATING PROVIDER MEDICARE MARKETING GUIDELINES

Marketing, advertising, and brand regulations are the legal rules that must be followed when marketing or advertising a Solis plan or using the Solis brand. All actions must be consistent with applicable law and adhere to the terms of each provider's agreement with Solis.

The marketing and advertising of Solis is highly regulated by CMS and subject to tight restrictions. As a result, any provider cannot conduct any marketing or advertising activity related to any Solis plan without prior written approval. For specific guidance surrounding marketing and advertising regulations, please refer to Chapter 3: Medicare Marketing Guidelines which is issued by CMS and available through www.cms.gov.

CMS understands that plans may have agreements with providers in relation to plan activities. Per your provider agreement with Solis, it is crucial that all marketing activities align with Medicare guidelines and regulations. Discussions which occur between the provider and patient regarding advice on enrollment decisions much remain neutral.

Providers may distribute printed information provided by a plan sponsor to their patients comparing the benefits of all of the different plans with which they contract. Materials may not "rank order" or highlight specific plans and should include only objective information. Such materials must have the concurrence of all plans involved in the comparison and must be approved by CMS prior to distribution (e.g., these items are not subject to File & Use). The plans must determine a lead plan to coordinate submission of these materials to CMS for review

Provider Activities and Materials in the Health Care Setting

Beneficiaries often look to their health care professionals to provide them with information regarding their health care choices. To the extent that a provider can assist a beneficiary in an objective assessment of the beneficiary's needs and potential plan options that may meet those needs, providers are encouraged to do so. To this end, providers may certainly engage in discussions with beneficiaries when patients seek information or advice from their provider regarding their Medicare options. Providers are permitted to make available and/or distribute plan marketing materials for all plans with which the provider participates and display posters or other materials announcing plan contractual relationships (including PDP enrollment applications, but not MA or MAPD enrollment applications). However, providers cannot accept enrollment applications.

Providers also cannot direct, urge or attempt to persuade beneficiaries to enroll in a specific plan. In addition, providers cannot offer anything of value to induce plan enrollees to select them as their provider.

Providers may inform prospective enrollees where they may obtain information on the full range of plan options. Because providers are usually not fully aware of all Medicare plan benefits and costs, they are advised to refer their patients to other sources of information, such as the State Health Insurance Assistance Programs, plan marketing representatives, their State Medicaid Office, local Social Security Administration Office, http://www.medicare.gov, or 1-800-MEDICARE.

The "Medicare and You" Handbook or "Medicare Compare Options" (from http://www.Medicare.gov), may be distributed by providers without additional approvals. There may be other documents that provide comparative and descriptive material about plans, of a broad nature, that are written by CMS or have been previously approved by CMS. These materials may be distributed by plans and providers without further CMS approval.

This includes CMS Medicare Prescription Drug Plan Finder information via a computer terminal for access by beneficiaries. Plans should advise contracted providers of the provisions of these rules.

Plan Activities and Materials in the Health Care Setting

It is permissible for plans or plan agents to conduct sales activities in health care settings as long as the activity takes place in the common areas of the setting and patients are not misled or pressured into participating in such activities. Common areas, where marketing activities are allowed, include areas such as hospital or nursing home cafeterias, community or recreational rooms and conference rooms. If a pharmacy counter is located within a retail store, common areas would include the space outside of where patients wait for services or interact with pharmacy providers and obtain medications.

Plans are strictly prohibited from conducting sales presentations, distributing and accepting enrollment applications and soliciting Medicare beneficiaries in areas where patients primarily intend to receive health care services or are waiting to receive health care services. These restricted areas generally include, but are not limited to, waiting rooms, exam rooms, hospital patient rooms, pharmacy counter areas and dialysis center treatment areas (where patients interact with their clinical team and receive treatment).

The prohibition against conducting marketing activities in health care setting extends to activities planned in these settings outside of normal business hours.

Only upon request by the beneficiary are plan sponsors permitted to schedule appointments, only with beneficiaries residing in long-term care facilities. Providers are permitted to make available and/or distribute plan marketing materials as long as the provider and/or facilities distributes or makes available plan sponsor marketing materials for all plans with which the provider participates. CMS does not expect providers to proactively contact all participating plans; rather, if a provider agrees to make available and/or distribute plan marketing materials they should do so knowing it must accept future requests from other plan sponsors with which it participates. Providers are also permitted to display posters or other materials in common areas such as the waiting room. Additionally, plan sponsors may provide materials to long-term care facilities to provide materials in admission packets announcing all plan contractual relationships.

SNP plans may provide to long term care facility staff, for distribution to residents that meet the D-SNP criteria, an explanatory brochure for each C-SNP with which the facility contracts. The brochure may have a reply card or telephone number for the resident or responsible party to call to request a meeting or to receive additional information.

Provider Affiliation Information

Providers may announce initial and repeated affiliations for specific plans. New affiliation announcements are those providers who have entered into a new contractual relationship with Solis and can be made within the first 30 days of the new contract agreement. In the instance where such announcement to patients of a new affiliation names only one plan may occur only such announcement is conveyed through direct mail, email, or telephone. Neither Solis nor the contracted provider is obligated to notify beneficiaries that the provider is contracted with other health plans in new announcement affiliations. Continuing Affiliation announcements may be made through direct mail, email, or phone from providers to their patients and must include all plans with which the provider contracts. Any affiliation communication materials that describe plans in any way (e.g., benefits, formularies) must be approved by CMS. Materials that indicate the provider has an affiliation with certain plan sponsors and that only list plan names and/or contact information does not require CMS approval.

SNP Provider Affiliation Information

Providers may feature SNPs in a mailing announcing an ongoing affiliation. This mailing may highlight the provider's affiliation or arrangement by placing the SNP affiliations at the beginning of the announcement and include specific information about the SNP and must include all appropriate disclaimers. This includes providing information on special plan features, the population the SNP serves or specific benefits for each SNP. The announcement must list all other SNPs with which the provider is affiliated.

Comparative and Descriptive Plan Information

Providers may distribute printed information provided by a plan sponsor to their patients comparing the benefits of all of the different plans with which they contract. Materials may not "rank order" or highlight specific plans and should include only objective information. Such materials must have the concurrence of all plans involved in the comparison and must be approved by CMS prior to distribution (e.g., these items are not subject to File & Use). The plans must determine a lead plan to coordinate submission of these materials to CMS for review

Comparative and Descriptive Plan Information Provided by a Non-Benefit/Service Providing Third-Party

Providers may distribute printed information comparing the benefits of different plans (all or a subset) in a service area when the comparison is done by an objective third party (e.g., SHIPs, State agency or independent research organizations that conduct studies). For more information on non- benefit/service providing third party providers (See Section 60.1, "Provider-Initiated Activities" of the Medicare Marketing Guidelines – Chapter 3)

Provider Do's and Don'ts

Provider Do's

- **Provide the names of the plan sponsors of which you are contracted and/or participate**
- **Provide information and assistance for members applying for the Low-Income Subsidy (LIS)**
- **Make available and/or distribute plan marketing materials as long as the provider offers to distribute marketing materials to all plans in which group is contracted**
- **Offer to refer patients to other sources of information (i.e. – SHIP), plan marketing representatives, State Medicaid office, local Social Security Administration office, medicare.gov, or 1-800-MEDICARE**
- **Share information offered within www.cms.gov (i.e. – 'Medicare & You' handbook)**

Provider Don'ts

- **Conduct health screenings as a marketing activity**
- **Accept Medicare enrollment applications**
- **Mail marketing materials on behalf of plan sponsors**
- **Distribute materials in an area where patients receive health care services (i.e. – exam room) or wait to receive health care services (I.e. – waiting room)**
- **Accept compensation directly or indirectly from a plan based on benefit enrollment activities**
- **Offer anything of value to induce enrollees to select you as their provider or to enroll in a particular plan**
- **Offer scope of appointment forms**
- **Make phone calls or direct, urge or attempt to persuade beneficiaries to enroll in a specific plan based on financial or any other interests**

QUALITY IMPROVEMENT PROGRAM AND PERFORMANCE RATINGS

Solis Health Plans has thoughtfully developed a Quality Improvement (QI) Program which helps to focus efforts with the member in mind. The QI Program undergoes constant revision in order to effectively monitor, evaluate, and improve care.

The Program goals include:

- To increase the accountability for results of care and services
- To promote a healthy lifestyle for all members and reduce unhealthy behaviors
- To minimize administrative costs and burdens incurred
- To improve clinical effectiveness

Provider Portal

Solis offers a Provider Portal to its participating PCPs. The Solis Provider Portal is the system which monitors and collects data to be used for evaluation and care for their panel of members. The goal of this centralized portal is to integrate data, informatics, and health information to promote the highest quality of care delivery for every member assigned and engage all participating providers with one unified and simple platform.

Please reach out to your assigned Account Executive for additional training on the Solis Provider Portal.

CMS Star Ratings

Solis Health Plans has implemented a Quality Improvement Program which ensures Members receive the necessary care needed for their health. Provider are required to cooperate and participate with Solis' QI activities and initiatives. The Centers for Medicare & Medicaid Services (CMS) uses a five-star rating system to measure Medicare beneficiaries' experience with their health plans and the health care system. This rating system applies to all Medicare Advantage (MA) lines of business.

The scale ranges from one to five stars, where a rating of one star represents "poor" quality and five stars represents "excellent" quality. The program is a key component in financing health care benefits for MA plan enrollees. In addition, the ratings are posted on the CMS consumer website, www.medicare.gov, to give beneficiaries help in choosing among the MA plans offered in their area.

CMS Goals for the Five-star Rating System

- Implement provisions of the Affordable Care Act
- Strengthen beneficiary protections
- Strengthen CMS' ability to distinguish stronger health plans for participation in Medicare Parts C and D and to remove consistently poor performers
- Clarify program requirements

HEDIS® – Healthcare Effectiveness Data and Information Set

HEDIS® is a set of performance measures established by the National Committee for Quality Assurance (NCQA) for the managed care industry. Each year, Solis Health Plans collects data from a randomly selected sample of members for HEDIS® reporting purposes. Medicare Advantage Plans are required to report their results annually to the Center for Medicare and Medicaid (CMS), NCQA and the Agency for Health Care Administration (AHCA) use this information to monitor the performance of health plans.

Altogether, HEDIS contains 91 measures across seven (7) domains of care:

- Effectiveness of Care
- Access/Availability of Care
- Experience of Care
- Utilization and Risk Adjusted Utilization
- Relative Resource Use
- Health Plan Descriptive Information
- Measures Collected Using Electronic Clinical Data Systems.

2022 CMS STAR RATINGS

Healthcare Effectiveness Data and Information Set (HEDIS®)	
BCS	Breast cancer screening
COL	Colorectal cancer screening
OMW	Osteoporosis management in women who had a fracture
EED	Eye Exam for Patients with Diabetes
BPD	Blood Pressure Control for Patients with Diabetes
HBD	Hemoglobin A1C Control for Patients with Diabetes
CBP	Controlling high blood pressure
ART	Antirheumatic drug therapy for rheumatoid arthritis
ABA	Adult body mass index assessment
COA	Care for older adults (special needs plans only)
PCR	Plan all cause readmission rates
TRC	Transition of Care -Inpatient Admission and Discharge Notification within three (3) Days -Receipt of Discharge Information within three (3) Days -Medication Reconciliation Post Discharge

SPC	Statin therapy for patients with cardiovascular disease
SUPD	Statin Use for Patients with Diabetes
PDE	Prescription Drug Event -Medication Adherence for Hypertension (ACE/ARBS) -Medication Adherence for Cholesterol (Statin) -Medication Adherence for Diabetes

Consumer Assessment of Healthcare Providers and Systems (CAHPS®)	
	Annual flu vaccine
	Get needed care
	Get appointments and care quickly
	Customer service
	Overall rating of health care quality
	Overall rating of health plan
	Care coordination
	Get needed prescription drugs (Part D)
	Overall rating of drug plan (Part D)
	Reducing the risk of falling

Independent review entities	
	Plan making timely decisions about appeals (Part C)
	Reviewing appeals decisions (Part C)
	Appeals auto-forward (Part D)
	Appeals upheld (Part D)

CMS (Part C)	
	Complaints about the health plan
	Call center – foreign language interpreter and TTY/TDD availability
	Members choosing to leave the plan
	Health plan quality improvement

CMS (Part D)	
	Call center – foreign language interpreter and TTY/TDD availability
	Complaints about the drug plan
	Members choosing to leave the plan
	Drug plan quality improvement

Patient safety (Part D)	
	Plan provides accurate price information for Medicare's plan finder website
	Medication therapy management (MTM)-eligible members who had a pharmacist (or other health care professional) help them understand and manage their medications through a comprehensive medication review (CMR)
	Taking oral diabetes medication as Directed
	Taking blood pressure medication as Directed
	Taking cholesterol medication as Directed
	Statin Use in Persons with Diabetes (SUPD) measure calculates the percentage of patients who received at least two diabetes medication fills and also received a statin medication during the measurement period.

Special Needs Plans (SNP) Measures

CMS also collects audited data from all SNPs that have 30 or more members enrolled. CMS/NCQA are currently monitoring and evaluating at the individual SNP benefit package level.

The following is a list of HEDIS measures selected for SNP benefit packages:

- **COL** Colorectal Cancer Screening
- **COA** Care for Older Adults
- **SPR** Use of Spirometry Testing in the Assessment and Diagnosis of COPD
- **PCE** Pharmacotherapy of COPD Exacerbation
- **CBP** Controlling High Blood Pressure
- **PBH** Persistence of Beta Blocker Treatment After a Heart Attack
- **OMW** Osteoporosis Management in Older Women
- **AMM** Antidepressant Medication Management
- **FUH** Follow-Up After Hospitalization for Mental Illness
- **MPM** Annual Monitoring for Patients on Persistent Medications

- **DDE** Potentially Harmful Drug-Disease Interactions
- **DAE** Use of High-Risk Medication in the Elderly
- **BCR** Board Certification

SNP-only measures

- **Care for Older Adults –** The percentage of members 66 years and older who had each of the following:
  - Advance Care Planning
  - Medication Review
  - Functional Status Assessment
  - Pain Assessment

RISK MANAGEMENT PROGRAM

I. OBJECTIVES

A. Overall Objective

The objective of Solis Health Plans Risk Management Program is to promote effective quality patient care, while ensuring patient, visitor, employee, and physician safety by providing Solis Health Plans with the information necessary to carefully evaluate risks and exposures inherent in all the healthcare delivery system, and to allocate resources in the most efficient manner. s.641.55 (1)(a), F.S.

B. Specific Objectives

The specific objectives of the Risk Management Program include the following:

1. The development and implementation of an incident reporting system based upon the affirmative duty of all health care providers and all agents and employees of healthcare providers and health care facilities to report injuries and incidents.

2. The investigation and analysis of the frequency and causes of general categories and specific types of incidents.

3. The development of appropriate measures to minimize the risk of injuries and incidents to patients, visitors, employees, and physicians.

4. The analysis of patient grievances, which relate to patient care and quality of medical services.

5. The prevention and reduction of claims, and reduction of resources required to meet legal obligations.

6. The coordination of efforts designed to minimize risk to the patient, visitor, employee and physician.

II. RESPONSIBILITY OF THE PROGRAM

A. The Risk Management Program is the responsibility of the Governing Board of Solis Health Plans and is under the direct supervision of the Risk Manager who assures that the intent of the Risk Management Philosophy is carried out. s.641.55(2), F.S.

B. Every employee is oriented and instructed to take an active role in the prevention of injury to patients, visitors, employees and physicians and in the reporting of unusual occurrences to Risk Management. 59A-12.012(3), F.A.C.

III. PROGRAM ACTIVITIES

A. The development and implementation of an incident reporting system based upon the

affirmative duty of all health care providers and all agents and employees of Solis Health Plans, Inc. to report injuries and adverse incidents to the Risk Manager. s.641.55 (1)(d), F.S.

1. Incident reports shall be on a special form, and shall include at least the following information 59A-12.012(3), F.A.C. (see form sections)

    a. The patient's name, address, age, sex, physical findings or diagnosis and, if hospitalized; locating information, admission time and date, and the facility's name;

    b. a clear and concise description of the facts of the incident including time, date and exact location;

    c. a description of any injuries sustained;

    d. whether or not a physician was told and, if so, a brief statement of said physician's recommendations for medical treatment, if any;

    e. a listing of all persons known to be involved in the incident, specifying functional title of each, including witnesses;

    f. the name, signature and position of the person completing the incident report form along with the date and time the report was completed.


SOLIS
HEALTH PLANS