

**Medicare Amendment to the HNE Provider Manual**  
*(Effective January 1, 2009)*

**Table of Contents**

<b>XIV. HNE Medicare Advantage-Prescription Drug (MA-PD) Members – eff. 1/1/2009 ....</b>	<b>4</b>
<b>A. Definitions .....</b>	<b>4</b>
<b>B. Safeguard privacy and maintain records accurately and timely [42 CFR § 422.118].....</b>	<b>6</b>
<b>C. The HNE MA-PD plan does not include permanent "out of area" members who may receive benefits in continuation area [42 CFR § 422.54(b)] .....</b>	<b>6</b>
<b>D. Prohibition against discrimination based on health status [42 CFR § 422.110(a)].....</b>	<b>7</b>
<b>E. Services of noncontracting providers and suppliers [42 CFR § 422.100(b)] .....</b>	<b>7</b>
<b>F. Pay for ambulance, emergency, urgently needed, and post stabilization services [42 CFR § 422.113] .....</b>	<b>7</b>
1. Ambulance services: .....	7
2. Emergency and urgently needed services: .....	7
3. Stabilized condition.....	8
4. Post-stabilization care services. ....	8
5. HNE post-stabilization services policy .....	9
<b>G. Mammography and influenza and pneumococcal vaccines .....</b>	<b>9</b>
1. Direct access to mammography and influenza vaccinations [42 CFR § 422.100(g)(1)].....	9
2. No copay for influenza and pneumococcal vaccines [42 CFR § 422.100(g)(2)] .....	9
<b>H. Agreements with providers to demonstrate "adequate" access [42 CFR § 422.112(a)(1)].....</b>	<b>9</b>
1. Provider network within the HNE MA-PD Service Area: .....	9
2. Provider obligation to treat: .....	10
3. PCP panel:.....	10
4. Specialty care including direct access to women's specialists for routine and preventive services and out-of-network care when services are not available in plan [42 CFR § 422.112(a)(3)] .....	10
5. Credentialed providers [42 CFR § 422.112(a)(5) and § 422.204].....	10
6. Provider antidiscrimination rules [42 CFR § 422.205] .....	11
7. Written standards for timely access to care, individual medical necessity determinations, and consideration of HNE MA-PD member input into the provider's proposed treatment plan [42 CFR § 422. 112(a)(6)].....	12
8. Services available 24 hrs/day, 7 days/week [42 CFR § 422.112(a)(7)] .....	12
9. Ensure services are provided in a culturally competent manner [42 CFR § 422.112(a)(8)] .....	12
<b>I. Adhere to CMS marketing provisions [42 CFR § 422.80(a), (b), (c)].....</b>	<b>13</b>
1. CMS review of Marketing Materials. ....	13
2. HNE may distribute the Marketing Materials 5 days following their submission to CMS if— .....	13
3. Guidelines for CMS review. ....	13
<b>J. Continuity and coordination of care.....</b>	<b>16</b>
1. Policies that specify under what circumstances services are coordinated and the methods for coordination [42 CFR § 422.112(b)(1)]; .....	16
2. Offering to provide each member with an ongoing source of primary care and providing a primary care source to each member who accepts the offer [42 CFR § 422.112(b)(2)]; .....	16
3. Programs for coordination of plan services with community and social services generally available through contracting or noncontracting providers in the area served by the MA-PD plan, including nursing home and community-based services [42 CFR § 422.112(b)(3)];.....	17

4.	Procedures to ensure that HNE and its provider network have the information required for effective and continuous patient care and quality review, including procedures to ensure that—	17
5.	Procedures to inform members of follow-up care or provide training in selfcare as necessary [42 CFR § 422.112(b)(5)]; and	17
6.	Systems to address barriers to member compliance with prescribed treatments or regimens [42 CFR § 422.112(b)(6)].	17
<b>K.</b>	<b>Information on advance directives</b>	<b>17</b>
1.	HNE provides written information to those individuals with respect to the following:	17
2.	HNE provides information specified in bullet # 1 of this section at the time of enrollment	18
3.	HNE requires HNE providers to document in a prominent part of the individual's current medical record whether or not the individual has executed an advance directive [42 CFR § 422.128(b)(1)(ii)(E)].	18
4.	HNE and HNE providers shall not condition the provision of care or otherwise discriminate against an individual based on whether or not the individual has executed an advance directive.	19
5.	HNE and HNE providers shall ensure compliance with requirements of Massachusetts law (whether statutory or recognized by the courts of the State) regarding advance directives.	19
6.	HNE and HNE providers shall provide for education of staff concerning its policies and procedures on advance directives.	19
7.	HNE and HNE providers shall provide for community education regarding advance directives	19
8.	Care that conflicts with an advance directive and matters of conscience	19
9.	HNE shall inform individuals that complaints concerning noncompliance with the advance directive requirements may be filed with the State survey and certification agency.	19
<b>L.</b>	<b>Provide services in a manner consistent with professionally recognized standards of care [42 CFR § 422.504(a)(3)(iii)]</b>	<b>19</b>
<b>M.</b>	<b>Hold harmless provision, continuation of benefits provisions, and compliance [42 CFR § 422.504(g)(2)(i); 422.504(g)(2)(ii); 422.504(g)(3)]</b>	<b>20</b>
1.	Hold harmless provisions	20
2.	Continuation of benefit provisions	20
3.	Compliance with hold harmless provisions and prevention of member billing	20
<b>N.</b>	<b>Payment and incentive arrangements specified [42 CFR § 422.208]</b>	<b>20</b>
<b>O.</b>	<b>Subject to applicable Federal laws [42 CFR § 422.504(h)]</b>	<b>21</b>
<b>P.</b>	<b>Disclose to CMS all information necessary to (1) Administer &amp; evaluate the program (2) Establish and facilitate a process for current and prospective HNE MA-PD members to exercise choice in obtaining Medicare services [42 CFR § 422.64(a); 422.504(a)(4); 422.504(f)(2)]</b>	<b>21</b>
1.	Provide information necessary to enable CMS to provide current and potential members information need to make informed decisions	21
4.	Right to inspect, evaluate, and audit	21
5.	Information necessary to administer & evaluate the program	21
6.	Information necessary to establish and facilitate a process for current and prospective HNE MA-PD members to exercise choice in obtaining Medicare services	22
7.	The number, mix, and distribution of providers from whom HNE MA-PD members may obtain services; any out-of network coverage; any point-of-service option, including the supplemental premium for that option; and how HNE meets MA-PD access to service requirements;	22
8.	Out-of-area coverage provided by the plan;	22
9.	Coverage of emergency services, including;	22
10.	Any mandatory or optional supplemental benefits and the premium for those benefits;	23

11. Prior authorization rules and other review requirements that must be met in order to ensure payment for the services. HNE must instruct HNE MA-PD members that, in cases where noncontracting providers submit a bill directly to the member, the member should not pay the bill, but submit it to the HNE for processing and determination of member liability, if any;.....	23
12. All grievance and appeals rights and procedures;.....	23
13. A description of HNE's quality assurance program; and .....	23
14. Members' disenrollment rights and responsibilities. ....	23
15. Upon request of an individual eligible to elect an MA-PD plan, HNE must provide to the individual the following information: .....	23
16. 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 [42 CFR § 422.111(e)].....	24
17. Notification to authorities .....	25
<b>Q. Submission of data, medical records and certify completeness and truthfulness [42 CFR § 422.310(d)(3)-(4), 422.310(e), 422.504(d)-(e), 422.504(i)(3)-(4), 422.504(l)(3); § 423.514; and § 423.153] .....</b>	<b>25</b>
<b>R. Compliance with credentialing, recredentialing, medical policy, utilization management, medical management, and quality improvement programs [42 CFR § 422.202(b); 422.504(a)(5)].....</b>	<b>25</b>
1. Medical Management and prohibition on billing HNE MA-PD members for Covered Services provided without prior approval and retrospective review for Medical Necessity .....	25
2. Quality Improvement Activities.....	26
S. Obligations of HNE: .....	26
1. Licensure.....	26
2. Compliance with Law .....	26
3. 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).....	26
4. Administration .....	27
5. Administrative Notification .....	27
6. Provision of the HNE MA-PD Member Contract and HNE MA-PD Provider Directory .....	27
7. Member eligibility .....	27
8. Administration and compliance with of Medical or Utilization Management and Quality Management Programs [42 CFR § 422.202(b); 422.504(a)(5)].....	28
9. Disclose to CMS quality & performance indicators for plan benefits re: disenrollment rates for HNE MA-PD members enrolled in the plan for the previous two years [42 CFR § 422.504(f)(2)(iv)(A)] .....	28
10. Disclose to CMS quality & performance indicators for the benefits under the plan regarding HNE MA-PD member satisfaction [42 CFR § 422.504(f)(2)(iv)(B)].....	28
11. Disclose to CMS quality & performance indicators for the benefits under the plan regarding health outcomes [42 CFR § 422.504(f)(2)(iv)(C)].....	28
12. Notify providers in writing for reason for denial, suspension & termination [42 CFR § 422.202(c)(1)] .....	28
13. Provide 60 days notice (terminating contract without cause) [42 CFR § 422.202(c)(4)] .....	29
14. Prohibition of use of excluded practitioners [42 CFR § 422.752(a)(8)].....	29
15. Adhere to member appeals/grievance procedures [42 CFR § 422.562(a)] .....	29
<b>T. Prompt notification of overpayments or underpayments .....</b>	<b>30</b>
<b>U. Pharmaceutical Management Procedures under the HNE MA-PD Plan.....</b>	<b>30</b>
<b>XV. Member Rights and Responsibilities.....</b>	<b>30</b>
<b>A. Contacting the HNE Medicare Advantage Plan:.....</b>	<b>30</b>
<b>B. The following Member Rights and Responsibilities statement is included in the Evidence of Coverage for HNE MA-PD Members: .....</b>	<b>31</b>

## XIV. HNE Medicare Advantage-Prescription Drug (MA-PD) Members – eff. 1/1/2009

### A. Definitions

**Account** means an entity, including the Centers for Medicare and Medicaid Services (CMS), other governmental entities, and individuals, that has entered into an agreement with HNE pursuant to which HNE provides or administers benefits for the entity's employees and their dependents, or others covered under such agreement with HNE.

**Covered Services** means the health care services that a HNE MA-PD member is entitled to receive through the HNE MA-PD plan if such services are: (1) included in the Member Contract (2) determined to be Medically Necessary by HNE or HNE's designee, (3) determined by HNE or HNE's designee to be generally accepted, and not experimental in nature; (4) initiated pursuant to a referral from a Primary Care Physician if such referral is required by HNE policies or procedures; (5) properly authorized for payment by HNE in accordance with the Member Contract or HNE policies and procedures; (6) provided by a physician or provider credentialed and/or privileged as required by HNE; and (7) if applicable, as otherwise required by Medicare laws, regulations, and instructions applicable to HNE MA-PD plan.

**Emergency Medical Condition** means a medical condition, whether physical, surgical, or mental, manifesting itself by acute symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected by a prudent layperson, who possesses an average knowledge of health and medicine, to result in placing the health of the MA-PD member or another (including an unborn child) in serious jeopardy, serious impairment to bodily function; or serious dysfunction of any body organ or part; or as determined by a provider with knowledge of the person's condition, to result in severe pain that cannot be managed without such care, or, with respect to a pregnant woman, as further defined in section 1867(e)(1)(B) of the Social Security Act, 42 U.S.C. section 1395dd(e)(1)(B).

**Emergency Services** means those Covered Services, inpatient and outpatient, that are: (1) furnished by a provider qualified to furnish Emergency Services; and (2) needed to evaluate or stabilize an Emergency Medical Condition.

**HNE MA-PD Service Area** means the geographic area approved by CMS within which an HNE MA-PD member may enroll in a Medicare Advantage Product plan offered by HNE, and covers specifically Franklin, Hampden, and Hampshire counties in Massachusetts.

**Marketing Materials** include any informational materials targeted to Medicare members that:

- Promote HNE, or any MA-PD plan offered by HNE;
- Inform Medicare members that they may enroll, or remain enrolled in, an MA-PD plan offered by HNE;
- Explain the benefits of enrollment in an MA-PD plan, or rules that apply to members;
- Explain how Medicare services are covered under an MA-PD plan, including conditions that apply to such coverage;
- Examples of Marketing Materials include, but are not limited to:

- (i) General audience materials such as general circulation brochures, newspapers, magazines, television, radio, billboards, yellow pages, or the internet.
- (ii) Marketing representative materials such as scripts or outlines for telemarketing or other presentations.
- (iii) Presentation materials such as slides and charts.
- (iv) Promotional materials such as brochures or leaflets, including materials for circulation by third parties (e.g., physicians or other providers).
- (v) Membership communication materials such as membership rules, subscriber agreements (evidence of coverage), member handbooks, and wallet card instructions to members.
- (vi) Letters to members about contractual changes; changes in providers, premiums, benefits, plan procedures, etc.
- (vii) Membership or claims processing activities (e.g., materials on rules involving non-payment of premiums, confirmation of enrollment or disenrollment, or annual notification information).

***Medically Necessary*** services means a health care service that, as determined by HNE or HNE's designee, is required to diagnose or treat a member's illness, injury, symptom, complaint, or condition and:

- is consistent with the diagnosis and treatment of the member's health condition and provided in accordance with generally accepted medical practice and HNE's medical policies and HNE's medical technology assessment guidelines;
- is supported by scientific evidence concerning the effect on health outcomes and has final approval, if applicable, from the appropriate government regulatory bodies;
- is essential to improve the member's net health outcome by providing a positive effect on overall health that is greater than its harmful effect;
- is as beneficial as any established alternatives covered under the Member Contract
- is as cost-effective as an established alternatives;
- is consistent with the level of skilled services that are furnished;
- is furnished in the least intensive type of medical care setting required by the member's health condition;
- is not furnished solely for the member's convenience or religious preference or for the convenience of the member's family or health care provider; and
- is not solely intended to promote athletic achievements or a desired lifestyle or to increase or enhance the member's environmental or personal comfort, or to improve (as opposed to restore) the member's appearance or how the member feels about his or her appearance.

HNE or its designee will determine if a health care service is Medically Necessary for the member. The fact that any provider has furnished, prescribed, ordered, recommended, or approved a treatment, or that the treatment is offered as a last resort, does not of itself make the treatment Medically Necessary. When applicable, HNE or its designee will use Medicare

guidelines to determine whether a health care service is Medically Necessary. Inclusion of a health care service on the Fee Schedule shall not be considered a determination that the service is Medically Necessary or generally acceptable in all circumstances.

All determinations made by HNE shall be based upon clinical information regarding the member that was available to the provider at the time services were rendered. HNE will at all times be in compliance with the regulations of the Massachusetts Department of Public Health and Massachusetts Division of Insurance regarding Medical Necessity.

**Member Contract** means the description of Covered Services a member is entitled to, including the application, the subscriber certificate, any amendments to the subscriber certificate, any riders, and any special agreements required by the applicable Account or government agency, in force at any time during the term of the provider agreement that the member will be furnished any Covered Service by the provider.

**Urgently Needed Services** means Covered Services that are not Emergency Services as defined this section, provided when a member is temporarily absent from the HNE MA-PD Service Area (or, under unusual and extraordinary circumstances, provided when the member is in the HNE MA-PD Service Area but HNE's provider network is temporarily unavailable or inaccessible) when the services are Medically Necessary and immediately required—

- (A) As a result of an unforeseen illness, injury, or condition; and
- (B) It was not reasonable given the circumstances to obtain the services through the HNE MA-PD plan.

**B. Safeguard privacy and maintain records accurately and timely [42 CFR § 422.118]**

HNE and HNE providers must safeguard the privacy of member records and maintain accurate medical records, providing members with timely access to their records and information. HNE requires providers to establish procedures that meet the following minimum requirements:

- Abide by all Federal and State laws regarding confidentiality and disclosure of medical records, or other health and enrollment information. HNE providers must safeguard the privacy of any information that identifies a particular member and have procedures that specify—
  - (a) For what purposes the information will be used by the provider; and
  - (b) To whom and for what purposes it will disclose the information.
- Ensure that medical information is released only in accordance with applicable Federal or State law, or pursuant to court orders or subpoenas.
- Maintain the records and information in an accurate and timely manner.
- Ensure timely access by members to the records and information that pertain to them.

HNE maintains a notice of privacy practices that meets these requirements. Providers may find the notice posted on to HNE's website. Providers may also request a hard copy by calling the HNE Provider Relations Department.

**C. The HNE MA-PD plan does not include permanent "out of area" members who may receive benefits in continuation area [42 CFR § 422.54(b)]**

HNE has not opted to allow members to reside outside of the HNE MA-PD Service Area. In general, if an HNE MA-PD member has left the HNE MA-PD Service Area for more than 6 months but has not moved from the MA-PD plan's service area or residence, HNE must disenroll the individual from the plan.

**D. Prohibition against discrimination based on health status [42 CFR § 422.110(a)]**

Except as provided in the exception listed below, HNE will not deny, limit, or condition the coverage or furnishing of benefits to individuals eligible to enroll in a MA-PD plan offered by HNE on the basis of any factor that is related to health status, including, but not limited to the following:

- Medical condition, including mental as well as physical illness.
- Claims experience.
- Receipt of health care.
- Medical history.
- Genetic information.
- Evidence of insurability, including conditions arising out of acts of domestic violence.
- Disability.

**Exception.** As an MA-PD organization, HNE may not enroll an individual who has been medically determined to have end-stage renal disease. However, an HNE MA-PD member who develops end-stage renal disease while enrolled in HNE MA-PD may not be disenrolled for that reason.

**E. Services of noncontracting providers and suppliers [42 CFR § 422.100(b)]**

HNE makes timely and reasonable payment to or on behalf of the HNE MA-PD plan member for the following services obtained from a provider or supplier that does not contract with HNE to provide services covered by the MA-PD plan:

- Ambulance services dispatched through 911 or its local equivalent as provided in Section E.
- Emergency and Urgently Needed Services as provided in Section E.
- Maintenance and post-stabilization care services as provided in Section E.
- Renal dialysis services provided while the member is temporarily outside the HNE MA-PD Service Area.
- Services for which coverage has been denied by HNE and found upon appeal to be services the member was entitled to have furnished, or paid for, by HNE.

**Reasonable payment** with respect to benefits for services furnished by a noncontracting provider means that HNE shall provide payment in an amount the provider would have received under original Medicare (including balance billing permitted under Medicare Part A and Part B).

**F. Pay for ambulance, emergency, urgently needed, and post stabilization services [42 CFR § 422.113]**

**1. Ambulance services:**

The HNE MA-PD plan is financially responsible for ambulance services, including ambulance services dispatched through 911 or its local equivalent, where other means of transportation would endanger the member's health.

**2. Emergency and urgently needed services:**

*HNE is financially responsible for emergency and urgently needed services—*

- Regardless of whether the services are obtained within or outside the HNE MA-PD plan;
- Regardless of whether there is prior authorization for the services. HNE does not require prior authorization for emergency or Urgently Needed Services and does not include instructions to seek prior authorization in any materials furnished to HNE MA-PD members or HNE providers. HNE MA-PD members are informed of their right to call 911.
- In accordance with the prudent layperson definition of Emergency Medical Condition regardless of final diagnosis;
- For which a plan provider or HNE MA-PD representative instructs a member to seek Emergency Services within or outside the plan; and
- With a limit on charges to members for emergency department services of \$50 or what it would charge the member if he or she obtained the services through the HNE MA-PD plan, whichever is less.

### 3. **Stabilized condition.**

The physician treating the HNE MA-PD member must decide when the member may be considered stabilized for transfer or discharge, and that decision is binding on HNE.

### 4. **Post-stabilization care services.**

*Post-stabilization care services* means Covered Services, related to an emergency medical condition, that are provided after a member is stabilized in order to maintain the stabilized condition, or, under the circumstances described in paragraph (c)(2)(iii) of this section, to improve or resolve the member's condition.

*HNE is financially responsible for post-stabilization care services obtained within or outside the HNE MA-PD plan that are —*

- pre-approved by a plan provider or other HNE MA-PD plan representative (consistent with 42 CFR §422.214);
- not pre-approved by a plan provider or other HNE MA-PD plan representative, but administered to maintain the member's stabilized condition within 1 hour of a request to HNE for pre-approval of further post-stabilization care services;
- not pre-approved by a plan provider or other HNE MA-PD plan representative, but administered to maintain, improve, or resolve the member's stabilized condition if—
  - (A) HNE does not respond to a request for pre-approval within 1 hour;
  - (B) HNE cannot be contacted; or
  - (C) The HNE MA-PD plan representative and the treating physician cannot reach an agreement concerning the member's care and a plan physician is not available for consultation. In this situation, HNE must give the treating physician the opportunity to consult with a plan physician and the treating physician may continue with care of the patient until a plan physician is reached or one of the criteria above is met; and

*Impose no greater cost sharing.* HNE shall limit charges to HNE MA-PD members for post-stabilization care services to an amount no greater than what HNE would charge the

member if he or she had obtained the services through the HNE MA-PD plan. For purposes of cost sharing, post-stabilization care services begin upon inpatient admission.

**End of HNE's financial responsibility.** HNE's financial responsibility for post-stabilization care services it has not pre-approved ends when—

- A plan physician with privileges at the treating hospital assumes responsibility for the member's care;
- A plan physician assumes responsibility for the member's care through transfer;
- An HNE MA-PD plan representative and the treating physician reach an agreement concerning the member's care; or
- The member is discharged.

#### **5. HNE post-stabilization services policy**

HNE does not require prior approval for post-stabilization services coordinated by in-plan emergency department staff. Instead, HNE encourages emergency department staff to interact directly with a member's primary care physician to set up any post-stabilization services required. Accordingly, HNE will not retrospectively deny any care or treatment, including laboratory and radiological testing provided as part of post-stabilization services coordinated by in plan emergency department staff so long as the treatment is consistent with generally accepted principles of professional medical practice and is a covered benefit under the member's plan.

HNE also covers emergency and Urgently Needed Services provided by out-of-plan providers consistent with "prudent layperson" standards. HNE covers reasonable and customary charges for these services. The member's PCP must coordinate follow-up care out of the HNE MA-PD Service Area. HNE does not cover care (including follow-up care) the member receives outside the HNE MA-PD Service Area once the member is medically able to return to the HNE MA-PD Service Area.

#### **G. Mammography and influenza and pneumococcal vaccines**

##### **1. Direct access to mammography and influenza vaccinations [42 CFR § 422.100(g)(1)]**

Members of the HNE MA-PD plan may directly access (through self-referral) screening mammography and influenza vaccine. Physician referral is *not* required for these services.

##### **2. No copay for influenza and pneumococcal vaccines [42 CFR § 422.100(g)(2)]**

HNE does not impose cost-sharing for influenza vaccine and pneumococcal vaccine on HNE MA-PD plan members.

#### **H. Agreements with providers to demonstrate "adequate" access [42 CFR § 422.112(a)(1)]**

##### **1. Provider network within the HNE MA-PD Service Area:**

HNE maintains and monitors a network of appropriate providers that is supported by written agreements and is sufficient to provide adequate access to Covered Services to meet the needs of the population served. These providers are typically used in the network as primary care providers (PCPs), specialists, hospitals, skilled nursing facilities, home health agencies, ambulatory clinics, and other providers.

**2. Provider obligation to treat:**

Each HNE MA-PD plan physician agrees to accept any HNE MA-PD member referred to him/her or otherwise seeking Covered Services unless that member has not been seen previously by the Physician or the Physician's practice is closed to all new patients covered by all payers. Each physician must notify HNE at least ninety (90) days prior to closing such practice to new members. HNE physicians shall provide or manage the health care services and benefit programs for HNE MA-PD members.

**3. PCP panel:**

HNE has established a panel of PCPs from which the member may select a PCP. In most cases, the member's PCP will provide or arrange for the health services the member needs. Members may change PCPs whenever they wish. Members may contact HNE Member Services or go online to HNE Direct to select a PCP. PCPs may also view their panel of patients online through HNE Direct.

**4. Specialty care including direct access to women's specialists for routine and preventive services and out-of-network care when services are not available in plan [42 CFR § 422.112(a)(3)]**

HNE arranges for necessary specialty care, and in particular gives women members the option of direct access to a women's health specialist within the network for women's routine and preventive health care services provided as basic benefits. The term "basic benefits" means all Medicare-covered benefits (except hospice services). HNE also arranges for specialty care outside of the HNE MA-PD plan provider network when network providers are unavailable or inadequate to meet a member's medical needs. Prior approval is required for out-of-network care when services are not available in plan.

**5. Credentialed providers [42 CFR § 422.112(a)(5) and § 422.204]**

HNE demonstrates to CMS that its providers in the HNE MA-PD plan are credentialed appropriately. HNE has established written policies and procedures for the selection and evaluation of providers. These policies must conform with the credentialing and recredentialing requirements set forth below and with the antidiscrimination provisions set forth in the next section.

HNE follows a documented process with respect to providers and suppliers who have signed contracts or participation agreements that—

- For providers (other than physicians and other health care professionals) requires determination, and redetermination at specified intervals, that each provider is—
  - (i) Licensed to operate in the State, and in compliance with any other applicable State or Federal requirements; and
  - (ii) Reviewed and approved by an accrediting body, or meets HNE's standards;
- For physicians and other health care professionals, including members of physician groups, covers—
  - (i) Initial credentialing that includes written application, verification of licensure or certification from primary sources, disciplinary status, eligibility for payment under Medicare, and site visits as appropriate. The application must be signed and dated and include an attestation by the applicant of the correctness and

completeness of the application and other information submitted in support of the application;

- (ii) Recredentialing at least every 3 years that updates information obtained during initial credentialing, considers performance indicators such as those collected through quality improvement programs, utilization management systems, handling of grievances and appeals, member satisfaction surveys, and other plan activities, and that includes an attestation of the correctness and completeness of the new information; and
- (iii) A process for consulting with contracting health care professionals with respect to criteria for credentialing and recredentialing.

- Specifies that basic benefits must be provided through, or payments must be made to, providers and suppliers that meet applicable requirements of title XVIII and part A of title XI of the Act. In the case of providers meeting the definition of “provider of services” in section 1861(u) of the Act, basic benefits may only be provided through these providers if they have a provider agreement with CMS permitting them to provide services under original Medicare.
- Ensures compliance with the requirements at 42 CFR § 422.752(a)(8) that prohibit employment or contracts with individuals (or with an entity that employs or contracts with such an individual) excluded from participation under Medicare and with the requirements at 42 CFR § 422.220 regarding physicians and practitioners who opt out of Medicare.
- Termination of the provider agreement if the provider is excluded from participation in Medicare under Section 1128 or 1128A of the Social Security Act or from participation in any other Federal health care program as defined in Section 1128B(f) of the Social Security Act. (HNE may revoke its delegation for the provision of health care services including, if applicable, the delegated responsibility to meet CMS reporting requirements, and thereby terminate provider agreement if CMS or HNE determines that providers have not performed satisfactorily.)

**6. Provider antidiscrimination rules [42 CFR § 422.205]**

Consistent with the requirements of this section, HNE’s policies and procedures concerning provider selection and credentialing, and with the requirement under 42 CFR § 422.100(c) that all Covered Services be available to MA-PD plan members, HNE may select the practitioners that participate in the HNE MA-PD plan provider networks. In selecting these practitioners, HNE may not discriminate, in terms of participation, reimbursement, or indemnification, against any health care professional who is acting within the scope of his or her license or certification under State law, solely on the basis of the license or certification. If HNE declines to include a given provider or group of providers in its network, it must furnish written notice to the effected provider(s) of the reason for the decision.

The antidiscrimination rules in this section do not preclude any of the following by HNE:

- Refusal to grant participation to health care professionals in excess of the number necessary to meet the needs of the plan's members.

- Use of different reimbursement amounts for different specialties or for different practitioners in the same specialty.
- Implementation of measures designed to maintain quality and control costs consistent with its responsibilities.

**7. Written standards for timely access to care, individual medical necessity determinations, and consideration of HNE MA-PD member input into the provider's proposed treatment plan [42 CFR § 422.112(a)(6)]**

HNE has established written standards for the following:

- Timeliness of access to care and member services that meet or exceed standards established by CMS. Timely access to care and member services within a plan's provider network is continuously monitored to ensure compliance with these standards, and HNE takes corrective action as necessary.
- Policies and procedures (coverage rules, practice guidelines, payment policies, and utilization management) that allow for individual medical necessity determinations.
- Provider consideration of member input into the provider's proposed treatment plan.

**8. Services available 24 hrs/day, 7 days/week [42 CFR § 422.112(a)(7)]**

HNE ensures that the hours of operation of its MA-PD plan providers are convenient to the population served under the plan and do not discriminate against Medicare members; and plan services are available 24 hours a day, 7 days a week, when Medically Necessary.

PCPs should be on call (or arrange for coverage) 24 hours a day, 7 days a week. The PCP or the covering physician should call the member back as soon as possible if the member reached an answering service.

The below hospitals are currently contracted with HNE to provide services to HNE MA-PD members:

- Baystate Franklin Medical Center, 164 High Street, Greenfield, MA 01301
- Baystate Mary Lane Hospital, 85 South Street, Ware, MA 01082
- Baystate Medical Center, 759 Chestnut Street, Springfield, MA 01199
- Cooley Dickinson Hospital, 30 Locust Street, Northampton, MA 01060
- Holyoke Medical Center, 575 Beech Street, Holyoke, MA 01040
- Noble Hospital, 115 West Silver Street, Westfield, MA 01086

**9. Ensure services are provided in a culturally competent manner [42 CFR § 422.112(a)(8)]**

HNE ensures that services are provided in a culturally competent manner to all HNE MA-PD plan members, including those with limited English proficiency or reading skills, and diverse cultural and ethnic backgrounds.

**I. Adhere to CMS marketing provisions [42 CFR § 422.2260- 2276]**

**1. Definitions [42 CFR § 422.2260].**

Marketing materials. Marketing materials include any informational materials targeted to Medicare beneficiaries which:

- (1) Promote the MA organization, or any MA plan offered by the MA organization.
- (2) Inform Medicare beneficiaries that they may enroll, or remain enrolled in, an MA plan offered by the MA organization.
- (3) Explain the benefits of enrollment in an MA plan, or rules that apply to enrollees.
- (4) Explain how Medicare services are covered under an MA plan, including conditions that apply to such coverage.
- (5) May include, but are not limited to, the following:
  - (i) General audience materials such as general circulation brochures, newspapers, magazines, television, radio, billboards, yellow pages, or the Internet.
  - (ii) Marketing representative materials such as scripts or outlines for telemarketing or other presentations.
  - (iii) Presentation materials such as slides and charts.
  - (iv) Promotional materials such as brochures or leaflets, including materials for circulation by third parties (for example, physicians or other providers).
  - (v) Membership communication materials such as membership rules, subscriber agreements, member handbooks and wallet card instructions to enrollees.
  - (vi) Letters to members about contractual changes; changes in providers, premiums, benefits, plan procedures etc.
  - (vii) Membership or claims processing activities (for example, materials on rules involving non-payment of premiums, confirmation of enrollment or disenrollment, or annual notification information).

**2. Review and distribution of marketing materials [42 CFR § 422.2262].**

- (a) CMS review of marketing materials. (1) Except as provided in paragraph (b) of this section, an MA organization may not distribute any marketing materials (as defined in Section I.1), or election forms, or make such materials or forms available to individuals eligible to elect an MA organization unless—
  - (i) At least 45 days (or 10 days if using marketing materials that use, without modification, proposed model language as specified by CMS) before the date of distribution the MA organization has submitted the material or form to CMS for review; and
  - (ii) CMS does not disapprove the distribution of new material or form.
- (b) File and use. The MA organization may distribute certain types of marketing materials, designated by CMS, 5 days following their submission to CMS if the MA organization certifies that in the case of these designated marketing materials, it followed all applicable marketing guidelines and, when applicable, used model language specified by CMS without modification.

**3. Guidelines for CMS review [42 CFR § 422.2264].**

In reviewing marketing material or election forms, CMS determines that the Marketing Materials:

- Provide, in a format (and, where appropriate, print size), and using standard terminology that may be specified by CMS, the following information to Medicare beneficiaries interested in enrolling:

- (i) Adequate written description of rules (including any limitations on the providers from whom services can be obtained), procedures, basic benefits and services, and fees and other charges.
  - (ii) Adequate written description of any supplemental benefits and services.
  - (iii) Adequate written explanation of the grievance and appeals process, including differences between the two, and when it is appropriate to use each.
  - (iv) Any other information necessary to enable beneficiaries to make an informed decision about enrollment.
- Notify the general public of its enrollment period in an appropriate manner, through appropriate media, throughout its service area and if applicable, continuation areas.
  - Include in the written materials notice that HNE, as a MA-PD organization, is authorized by law to refuse to renew its contract with CMS, that CMS also may refuse to renew the contract, and that termination or non-renewal may result in termination of the member's enrollment in the plan.
  - Ensure that materials are not materially inaccurate or misleading or otherwise make material misrepresentations.
  - For markets with a significant non-English speaking population, provide materials in the language of these individuals.

**4. Deemed approval [42 CFR § 422.2266].**

If CMS has not disapproved the distribution of marketing materials or forms submitted by an MA organization with respect to an MA plan in an area, CMS is deemed not to have disapproved the distribution in all other areas covered by the MA plan and organization except with regard to any portion of the material or form that is specific to the particular area.

**5. Standards for MA organization marketing [42 CFR § 422.2268].**

1. In conducting marketing activities, HNE may not—
  - (a) Provide cash or other monetary rebates as an inducement for enrollment or otherwise.
  - (b) Offer gifts to potential enrollees, unless the gifts are of nominal (as defined in the CMS Marketing Guidelines) value, are offered to all potential enrollees without regard to whether or not the beneficiary enrolls, and are not in the form of cash or other monetary rebates.
  - (c) Engage in any discriminatory activity such as, for example, attempts to recruit Medicare beneficiaries from higher income areas without making comparable efforts to enroll Medicare beneficiaries from lower income areas.
  - (d) Solicit door-to-door for Medicare beneficiaries or through other unsolicited means of direct contact, including calling a beneficiary without the beneficiary initiating the contact.
  - (e) Engage in activities that could mislead or confuse Medicare beneficiaries, or misrepresent HNE. HNE not claim it is recommended or endorsed by CMS or Medicare or that CMS or Medicare recommends that the beneficiary enroll in the MA plan. It may, however, explain that HNE is approved for participation in Medicare.

- (f) Market non-health care related products to prospective enrollees during any MA or Part D sales activity or presentation. This is considered cross-selling and is prohibited.
- (g) Market any health care related product during a marketing appointment beyond the scope agreed upon by the beneficiary, and documented by the plan, prior to the appointment.
- (h) Market additional health related lines of plan business not identified prior to an in-home appointment without a separate appointment that may not be scheduled until 48 hours after the initial appointment.
- (i) Distribute marketing materials for which, before expiration of the 45-day period, HNE receives from CMS written notice of disapproval because it is inaccurate or misleading, or misrepresents HNE, its marketing representatives, or CMS.
- (j) Use providers or provider groups to distribute printed information comparing the benefits of different health plans unless the providers, provider groups, or pharmacies accept and display materials from all health plans with which the providers, provider groups, or pharmacies contract. The use of publicly available comparison information is permitted if approved by CMS in accordance with the Medicare marketing guidance.
- (k) Conduct sales presentations or distribute and accept MA plan enrollment forms in provider offices or other areas where health care is delivered to individuals, except in the case where such activities are conducted in common areas in health care settings.
- (l) Conduct sales presentations or distribute and accept plan applications at educational events.
- (m) Employ MA plan names that suggest that a plan is not available to all Medicare beneficiaries. This prohibition shall not apply to MA plan names in effect on July 31, 2000.
- (n) Display the names and/or logos of co-branded network providers on the HNE's member identification card, unless the provider names, and/or logos are related to the member selection of specific provider organizations (for example, physicians, hospitals). Other marketing materials that include names and/or logos of provider co-branding partners must clearly indicate that other providers are available in the network.
- (o) Engage in any other marketing activity prohibited by CMS in its marketing guidance.
- (p) Provide meals for potential enrollees, which is prohibited, regardless of value.
- (q) Use a plan name that does not include the plan type. The plan type should be included at the end of the plan name.

**6. Licensing of marketing representatives and confirmation of marketing resources [42 CFR § 422.2272].**

- 1. In its marketing, HNE must:
  - (a) Demonstrate to CMS' satisfaction that marketing resources are allocated to marketing to the disabled Medicare population as well as beneficiaries age 65 and over.
  - (b) Establish and maintain a system for confirming that enrolled beneficiaries have, in fact, enrolled in the MA plan, and understand the rules applicable under the plan.
  - (c) Employ as marketing representatives only individuals who are licensed by the State to conduct marketing activities (as defined in the Medicare Marketing Guidelines) in that State, and whom HNE has informed that State it has appointed, consistent with the appointment process provided for under State law.

- (d) Report to the State in which the HNE appoints an agent or broker, the termination of any such agent or broker, including the reasons for such termination if State law requires that the reasons for the termination be reported.

**7. Broker and agent requirements [42 CFR § 422.2274].**

- (a) Agents and brokers must be compensated according to CMS requirements. Please note: HNE currently uses only agents who are employees of HNE.
- (b) HNE must ensure agents selling Medicare products are trained annually on Medicare rules and regulations specific to the plan products they intend to sell.
- (c) HNE must ensure agents selling Medicare products are tested annually, as specified in CMS guidance.
- (d) Upon CMS' request, HNE must provide to CMS, in a form consistent with current CMS guidance, the information necessary for it to conduct oversight of marketing activities.
- (e) HNE must comply with State requests for information about the performance of a licensed agent or broker as part of a state investigation into the individual's conduct. CMS will establish and maintain a memorandum of understanding (MOU) to share compliance and oversight information with States that agree to the MOU.

**8. Employer group retiree marketing [42 CFR § 422.2276].**

HNE may develop marketing materials designed for members of an employer group who are eligible for employer-sponsored benefits through the MA organization, and furnish these materials only to the group members. These materials are not subject to CMS prior review and approval.

**J. Continuity and coordination of care.**

HNE ensures the continuity of care and integration of services through arrangements with contracted providers that include—

**1. Policies that specify under what circumstances services are coordinated and the methods for coordination [42 CFR § 422.112(b)(1)];**

Under these policies, HNE shall honor all open authorizations for care; place outbound calls to affected Medicare members scheduled for services and undergoing treatment plans to coordinate continuation of care; maintain “network crossover reports,” so Medicare members can be quickly reassigned to other plan-contracted providers or groups within the HNE MA-PD Service Area; and provide an opportunity for members undergoing a treatment plan to continue to see providers that are no longer in the network due to the group insolvency.

**2. Offering to provide each member with an ongoing source of primary care and providing a primary care source to each member who accepts the offer [42 CFR § 422.112(b)(2)];**

Each PCP shall assist the HNE MA-PD plan in coordinating care provided to HNE MA-PD members while outside of the HNE MA-PD Service Area, when such assistance is requested by the member or by a practitioner providing Emergency Services or Urgently Needed Services and such care is covered in accordance with the terms of the Member Contract or otherwise required by Medicare rules and regulations. A physician’s obligation to provide care to a member for a particular condition or related conditions may cease if the member refuses to follow a course of treatment prescribed by the physician. Prior to taking any action, the provider will refer the matter to HNE for review and resolution. HNE will

notify the provider of the outcome of the review and will inform the provider of required action.

**3. Programs for coordination of plan services with community and social services generally available through contracting or noncontracting providers in the area served by the MA-PD plan, including nursing home and community-based services [42 CFR § 422.112(b)(3)];**

The HNE case management program includes coordination of plan services with community and social services.

**4. Procedures to ensure that HNE and its provider network have the information required for effective and continuous patient care and quality review, including procedures to ensure that—**

- Under the HNE Case Management Program, HNE makes a “best-effort” attempt to conduct an initial assessment of each member's health care needs, including following up on unsuccessful attempts to contact a member, within ninety (90) days of the effective date of enrollment;
- Each provider, supplier, and practitioner furnishing services to members maintains an member health record in accordance with HNE standards, taking into account professional standards; and
- There is appropriate and confidential exchange of information among provider network components.

[42 CFR § 422.112(b)(4)]

**5. Procedures to inform members of follow-up care or provide training in selfcare as necessary [42 CFR § 422.112(b)(5)]; and**

HNE maintains procedures to ensure that members are informed of specific health care needs that require follow-up and receive, as appropriate, training in self-care and other measures they may take to promote their own health. Procedures for informing members of follow-up care and training in selfcare are incorporated into HNE case management, complex case management, and disease management programs.

**6. Systems to address barriers to member compliance with prescribed treatments or regimens [42 CFR § 422.112(b)(6)].**

HNE addresses barriers to member compliance through HNE quality management, case management, complex case management, and disease management programs.

**K. Information on advance directives**

HNE maintains written policies and procedures concerning advance directives with respect to all adult individuals receiving medical care by or through the HNE MA-PD plan.

**1. HNE provides written information to those individuals with respect to the following:**

- Rights under the Massachusetts laws to make decisions concerning their medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate advance directives. The information must reflect changes in Massachusetts law as soon as possible, but no later than ninety (90) days after the effective date of the law.
- HNE’s written policies respecting the implementation of those rights, including a clear and precise statement of limitation if HNE cannot implement an advance directive as a matter of conscience. At a minimum, this statement must do the following:

- (A) Clarify any differences between institution-wide conscientious objections and those that may be raised by individual physicians.
- (B) Identify the state legal authority permitting such objection.
- (C) Describe the range of medical conditions or procedures affected by the conscience objection.

**2. HNE provides information specified in bullet # 1 of this section at the time of enrollment**

If a member is incapacitated at the time of initial enrollment and is unable to receive information (due to the incapacitating condition or a mental disorder) or articulate whether or not he or she has executed an advance directive, HNE may give advance directive information to the member's family or surrogate in the same manner that it issues other materials about policies and procedures to the family of the incapacitated member or to a surrogate or other concerned persons in accordance with Massachusetts law. HNE is not relieved of its obligation to provide this information to the member once he or she is no longer incapacitated or unable to receive such information. Follow-up procedures must be in place to ensure that the information is given to the individual directly at the appropriate time.

**3. HNE requires HNE providers to document in a prominent part of the individual's current medical record whether or not the individual has executed an advance directive [42 CFR § 422.128(b)(1)(ii)(E)].**

HNE instructs HNE MA-PD members where to obtain advance directive forms (such as living a will or power of attorney). Members are also instructed to give a copy of the form to their treating physician(s). If a member knows ahead of time that they are going to be hospitalized, and they have signed an advance directive, it is also recommended that members take a copy of the form with them to the hospital.

If an HNE provider receives an advance directive form from an HNE MA-PD member, HNE providers must document in prominent part of the individual's current medical record whether or not the individual has executed an advance directive.

Providers shall comply with requirements of the Patient Self-Determination Act, whether or not applicable by law, and HNE's policies and procedures on advance directives, including making members aware of their right to document an advance directive or health care proxy in the member's medical record.

In addition, Hospitals must, in accordance with written policies and procedures, for all adult individuals:

- Inform them, in writing, of Massachusetts laws regarding advance directives;
- Inform them, in writing, of its policies regarding the implementation of advance directives (including a clear and concise explanation of a conscientious objection, to the extent that Massachusetts law permits for a hospital or any agent of a hospital that, as a matter of conscience, cannot implement an advance directive);
- Educate staff and the community on issues concerning advance directives.

4. **HNE and HNE providers shall not condition the provision of care or otherwise discriminate against an individual based on whether or not the individual has executed an advance directive.**

HNE and HNE Providers, including hospitals, shall not condition the provision of care or otherwise discriminate against an individual based on whether or not the individual has executed an advanced directive.

5. **HNE and HNE providers shall ensure compliance with requirements of Massachusetts law (whether statutory or recognized by the courts of the State) regarding advance directives.**

HNE and HNE Providers, including hospitals, ensure compliance with requirements of Massachusetts law (whether statutory or recognized by the courts of the State) regarding advance directives.

6. **HNE and HNE providers shall provide for education of staff concerning its policies and procedures on advance directives.**

HNE and HNE Providers, including hospitals, shall provide for education of staff concerning its policies and procedures on advance directives.

7. **HNE and HNE providers shall provide for community education regarding advance directives**

HNE shall provide for community education regarding advance directives that may include material required in bullet # 1 of this section, either directly or in concert with other providers or entities. Separate community education materials may be developed and used, at HNE's discretion. The same written materials are not required for all settings, but the material should define what constitutes an advance directive, emphasizing that an advance directive is designed to enhance an incapacitated individual's control over medical treatment, and describe applicable Massachusetts law concerning advance directives. HNE shall document its community education efforts as appropriate.

8. **Care that conflicts with an advance directive and matters of conscience**

HNE providers are not required to —

- provide care that conflicts with an advance directive; and
- implement an advance directive if, as a matter of conscience, a provider cannot implement an advance directive. The provider and each physician agree to promptly notify HNE if the provider or physician has conscientious objections to implementing any member's advance directives or health care proxy.

9. **HNE shall inform individuals that complaints concerning noncompliance with the advance directive requirements may be filed with the State survey and certification agency.**

- L. **Provide services in a manner consistent with professionally recognized standards of care [42 CFR § 422.504(a)(3)(iii)]**

Covered services shall be provided in accordance with generally accepted standards of sound patient care and, to the extent consistent with these standards, in accordance with the terms and conditions of HNE's written agreement with the provider, the member contract, applicable laws of the Commonwealth and federal laws and regulations, and HNE's objective to provide members with comprehensive, quality, and cost-effective inpatient, ambulatory, and Emergency Services in the optimal setting. To the extent permitted under their license, physicians shall be responsible for providing proper care and treatment to all of their patients. Physicians shall use their own independent judgment as to the proper course of care or treatment of their patients without regard to any agreement, provision, or understanding with HNE, whether expressed or

by implication. No HNE agreement, provision, understanding, rule, or policy, whether expressed or by implication, shall be construed to conflict with any applicable standard of proper medical care, treatment, or course of conduct by any provider or member of the provider's staff. Providers shall provide the same quality of care to HNE MA-PD members as is provided to their other patients.

**M. Hold harmless provision, continuation of benefits provisions, and compliance [42 CFR § 422.504(g)(2)(i); 422.504(g)(2)(ii); 422.504(g)(3)]**

**1. Hold harmless provisions**

As stated in the HNE provider agreement, the provider must in no event bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against an HNE MA-PD member that are the legal obligation of HNE. This provision will apply, but not be limited to insolvency of HNE, contract breach, and provider billing. This provision does not prohibit the collection of supplemental charges or co-payments on HNE's behalf made in accordance with the terms of the HNE MA-PD member's member contract.

**2. Continuation of benefit provisions**

In the event of HNE's insolvency or other cessation of operations, HNE providers will continue to provide services to HNE MA-PD members through the period for which the premium has been paid to HNE, and services to HNE MA-PD members confined in an inpatient hospital on the date of insolvency or other cessation of operations will continue until their discharge.

**3. Compliance with hold harmless provisions and prevention of member billing**

To ensure compliance with hold harmless provisions and to help prevent member billing, HNE may implement any or all of the following procedures:

- Initiate internal audits of hold-harmless provisions in downstream provider contracts;
- Provide written notification to all HNE MA-PD members assigned to or receiving care through insolvent provider groups instructing them not to pay bills (except applicable copayments and or deductibles) for provider group obligations and to forward any bills to HNE;
- Provide written notification to an insolvent group's downstream contractors informing them that billing HNE MA-PD members for an insolvent group's obligations is prohibited; or
- Develop and implement specific policies and procedures to prevent non-contracting providers from billing HNE MA-PD members for insolvent provider group obligations.

**N. Payment and incentive arrangements specified [42 CFR § 422.208]**

If HNE or any of its subcontracting arrangements utilize a physician incentive plan in their payment arrangements with individual physicians or physician groups, such plan must meet the following requirements: (1) HNE must makes no specific payment, directly or indirectly, to a physician or physician group as an inducement to reduce or limit Medically Necessary services furnished to any particular HNE MA-PD member (indirect payments may include offerings of monetary value, such as stock options or waivers of debt, measured in the present or future); and (2) If the physician incentive plan places a physician or physician group at substantial financial risk, as determined under paragraph (d) of 42 CFR § 422.208, for services that the physician or physician group does not furnish itself, HNE must assure that all physicians and

physician groups at substantial financial risk have either aggregate or per-patient stop-loss protection in accordance with paragraph (f) of 42 CFR § 422.208. In addition, for any physician incentive plan, HNE shall provide to CMS assurance satisfactory to the Secretary that the requirements of 42 CFR § 422.208 are met as well as provide the following information to any HNE MA-PD member who requests it: (1) whether the MA-PD organization uses a physician incentive plan that affects the use of referral services; (2) the type of incentive arrangement; and (3) whether stop-loss protection is provided. HNE shall provide written notice of its rules of participation, including terms of payment and credentialing and other rules directly related to participation decision. HNE shall provide written notice of material changes in such rules before the rules are put into effect. HNE shall provide written notice of adverse participation decisions and a process for appeal. HNE shall also include, and require any provider first tier and downstream entities to include, a provision setting forth the terms of payment and any incentive arrangements in the written agreements with providers of health care services for the HNE MA-PD benefit plan.

**O. Subject to applicable Federal laws [42 CFR § 422.504(h)]**

HNE and HNE providers are subject to and shall comply with applicable Federal laws, including laws and regulations designed to prevent or ameliorate fraud, waste, and abuse, including, but not limited to, applicable provisions of Federal criminal law, the False Claims Act (31 U.S.C. 3729 et. seq.), and the anti-kickback statute (section 1128B(b)) of the Act); and including HIPAA administrative simplification rules at 45 CFR parts 160, 162, and 164.

**P. Disclose to CMS all information necessary to (1) Administer & evaluate the program (2) Establish and facilitate a process for current and prospective HNE MA-PD members to exercise choice in obtaining Medicare services [42 CFR § 422.64(a); 422.504(a)(4); 422.504(f)(2)]**

**1. Provide information necessary to enable CMS to provide current and potential members information need to make informed decisions**

HNE must provide, on an annual basis, and in a format and using standard terminology that may be specified by CMS, the information necessary to enable CMS to provide to current and potential beneficiaries the information they need to make informed decisions with respect to the available choices for Medicare coverage.

**4. Right to inspect, evaluate, and audit**

The Department of Health and Human Services (DHHS), the Comptroller General, or their designees have the right to inspect, evaluate, and audit any pertinent contracts, books, documents, papers, and records of the related entity(s), contractor(s), or subcontractor(s), first-tier and downstream entities involving transactions related to the MA-PD contract as specified below.

DHHS', the Comptroller General's, or their designee's right to inspect, evaluate, and audit any pertinent information for any particular contract period will exist through 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later.

**5. Information necessary to administer & evaluate the program**

All information that is necessary for CMS to administer and evaluate the program and to simultaneously establish and facilitate a process for current and prospective beneficiaries to exercise choice in obtaining Medicare services. This information includes, but is not limited to:

- The benefits covered under an MA-PD plan;

- The MA-PD monthly basic beneficiary premium and MA-PD monthly supplemental beneficiary premium, if any, for the plan or in the case of an MSA plan, the MA-PD monthly MSA premium;
- The service area and continuation area, if any, of each plan and the enrollment capacity of each plan; and
- The plan quality and performance indicators for the benefits under the plan including:
  - Disenrollment rates for HNE MA-PD members electing to receive benefits through the plan for the previous 2 years;
  - Information on HNE MA-PD member satisfaction;
  - Information on health outcomes;
  - The recent record regarding compliance of the plan with requirements of this part, as determined by CMS; and
  - Other information determined by CMS to be necessary to assist HNE MA-PD members in making an informed choice among MA-PD plans and traditional Medicare;
- Information about HNE MA-PD member appeals and their disposition;
- Information regarding all formal actions, reviews, findings, or other similar actions by States, other regulatory bodies, or any other certifying or accrediting organization; and
- Any other information deemed necessary by CMS for the administration or evaluation of the Medicare program.

**6. Information necessary to establish and facilitate a process for current and prospective HNE MA-PD members to exercise choice in obtaining Medicare services**

HNE must disclose to existing HNE MA-PD members and to each new member electing the HNE MA-PD plan in clear, accurate, and standardized form; and at the time of enrollment and at least annually thereafter, information relating to the HNE MA-PD plan, including:

- The HNE MA-PD Service Area and any enrollment continuation area;
- The benefits offered under the plan, including applicable conditions and limitations, premiums, cost sharing (such as copayments, deductibles, and coinsurance), and any other conditions associated with receipt or use of benefits; and for purposes of comparison;
- The benefits offered under original Medicare;
- For an MA-PD Medical Savings Account (MSA) plan, the benefits under other types of MA-PD plans; and
- The availability of the Medicare hospice option and any approved hospices in the service area, including those HNE owns, controls, or has a financial interest in.

**7. The number, mix, and distribution of providers from whom HNE MA-PD members may obtain services; any out-of-network coverage; any point-of-service option, including the supplemental premium for that option; and how HNE meets MA-PD access to service requirements;**

**8. Out-of-area coverage provided by the plan;**

**9. Coverage of emergency services, including:**

- Explanation of what constitutes an emergency, referencing the definitions of emergency services and emergency medical condition at 42 CFR 422.113;

- The appropriate use of emergency services, stating that prior authorization cannot be required;
  - The process and procedures for obtaining emergency services, including use of the 911 telephone system or its local equivalent;
  - The locations where emergency care can be obtained and other locations at which contracting physicians and hospitals provide emergency services and post-stabilization care included in the MA-PD plan;
- 10. Any mandatory or optional supplemental benefits and the premium for those benefits;**
- 11. Prior authorization rules and other review requirements that must be met in order to ensure payment for the services. HNE must instruct HNE MA-PD members that, in cases where noncontracting providers submit a bill directly to the member, the member should not pay the bill, but submit it to the HNE for processing and determination of member liability, if any;**
- 12. All grievance and appeals rights and procedures;**
- 13. A description of HNE's quality assurance program; and**
- 14. Members' disenrollment rights and responsibilities.**
- 15. Upon request of an individual eligible to elect an MA-PD plan, HNE must provide to the individual the following information:**
- Benefits under original Medicare, including covered services, member cost sharing, such as deductibles, coinsurance, copayment amounts and any member liability for balance billing;
  - Information and instructions on how to exercise election options;
  - A general description of procedural rights (including grievance and appeals procedures) under original Medicare and the HNE MA-PD program and the right to be protected against discrimination based on factors related to health status;
  - The fact that HNE may terminate or refuse to renew its contract, or reduce the service area included in its contract, and the effect that any of those actions may have on individuals enrolled in that HNE's MA-PD plan;
  - Benefits, including covered services beyond those provided under original Medicare, any beneficiary cost sharing, and any maximum limitations on out-of-pocket expenses, the extent to which an HNE MA-PD member may obtain benefits through out-of-network health care providers, the types of providers that participate in the plan's network and the extent to which an HNE MA-PD member may select among those providers, and the coverage of Emergency and Urgently Needed Services.
  - The HNE MA-PD monthly basic beneficiary premium and the HNE MA-PD monthly supplemental beneficiary premium (if any);
  - The HNE MA-PD Service Area;
  - Quality and performance indicators for benefits under a plan to the extent they are available as follows (and how they compare with indicators under original Medicare)
  - Disenrollment rates for Medicare enrollees for the 2 previous years, excluding disenrollment due to death or moving outside the plan's service area, calculated according to CMS guidelines;
  - Medicare enrollee satisfaction;
  - Health outcomes;

- Plan-level appeal data;
- The recent record of plan compliance with the requirements of this part, as determined by the Secretary; and
- Other performance indicators.
- Whether the plan offers mandatory supplemental benefits or offers optional supplemental benefits and the premiums and other terms and conditions for those benefits;
- The procedures the organization uses to control utilization of services and expenditures;
- The number of disputes, and the disposition in the aggregate, in a manner and form described by the Secretary. Such disputes shall be categorized as:
- Grievances according to Subpart M of 42 CFR 422 and Chapter 13 of the Medicare Managed Care Manual;
- Appeals according to Subpart M of 42 CFR 422 and Chapter 13 of the Medicare Managed Care Manual.
- A summary description of the method of compensation for physicians;
- Financial condition of HNE, including the most recently audited information regarding, at least, a description of the financial condition of HNE. Other HNE financial information that must be disclosed:
  - The cost of its operations;
  - The patterns of utilization of its services;
  - The availability, accessibility, and acceptability of its services;
  - To the extent practical, developments in the health status of its enrollees;
  - Information demonstrating that the MA-PD organization has a fiscally sound operation; and
  - Other matters that CMS may require.

**16. 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 [42 CFR § 422.111(e)]**

HNE providers shall conspicuously post or provide HNE MA-PD members and referral sources with notice of termination. The notice must be in a form acceptable to HNE, stating that the relevant provider is no longer an HNE MA-PD plan provider. The notice shall specify the product in which the provider is no longer participating. Notices must be mailed or posted prior to the effective date of termination, and notification must continue through the applicable notice or other such notice period required by law or accrediting body.

Upon HNE issuance or receipt of a termination notice, a PCP's HNE MA-PD plan panel(s) will be closed to new HNE MA-PD members. HNE will expedite the reassignment of plan panel members to other PCPs.

In accordance with applicable Medicare laws, rules, and instructions, HNE shall make a good faith effort to provide written notice of a termination of a contracted provider at least 30 calendar days before the termination effective date to all enrollees who are patients seen on a regular basis by the provider whose contract is terminating, irrespective of whether the termination was for cause or without cause. When a contract termination involves a primary care professional, all HNE MA-PD members who are patients of that primary care professional must be notified.

## **17. Notification to authorities**

In the event that HNE terminates a provider contract because the HNE provider fails to meet quality of care or other reportable standards established by HNE or other entity to which HNE is accountable, HNE shall, in accordance with applicable state and federal laws, rules, regulations, or instructions, give written notice of that termination to applicable licensing and disciplinary entities and other appropriate authorities.

### **Q. Submission of data, medical records and certify completeness and truthfulness [42 CFR § 422.310(d)(3)-(4), 422.310(e), 422.504(d)-(e), 422.504(i)(3)-(4), 422.504(l)(3); § 423.514; and § 423.153]**

HNE providers agrees, and must require subcontractors, to agree: to provide to HNE all information necessary for HNE to meet its data reporting and submission obligations to CMS, including, but not limited to, all data necessary to characterize the context and purposes of each health care services encounter on behalf of a Medicare Member and data necessary for HNE to meet its reporting obligations under 42 CFR § 422.516, § 422.257, § 423.514 and § 423.153 (under Part C), and to comply with the requirements in 42 CFR Sec. 422.310 (under Part D) for submitting data to CMS, and with the requirements in all applicable Medicare laws and regulations and CMS instructions for providing data and statistics indicating: (1) the cost of MA-PD Plan operations; (2) the patterns of utilization of MA-PD Plan services; (3) the availability, accessibility, and acceptability of MA-PD Plan services; (4) information demonstrating the MA-PD Plan has a fiscally sound operation; and (5) other matters as required by CMS. HNE providers and any subcontractors agree to certify and assure the accuracy, completeness, and truthfulness of data provided to HNE that HNE is obligated to submit to CMS.

### **R. Compliance with credentialing, recredentialing, medical policy, utilization management, medical management, and quality improvement programs [42 CFR § 422.202(b); 422.504(a)(5)]**

Providers shall participate in and comply with HNE's credentialing, recredentialing, medical policy, utilization management, medical management, and quality improvement programs and standards, including, but not limited to, HNE peer review policies, procedures, and guidelines. At HNE's request, providers shall comply with any independent quality review entity and improvement organization's (IRE/QIO) activities pertaining to the provision of services to HNE MA-PD members.

#### **1. Medical Management and prohibition on billing HNE MA-PD members for Covered Services provided without prior approval and retrospective review for Medical Necessity**

Covered Services provided by HNE providers without prior approval when such authorization is required will be considered non-Covered Services and will be the exclusive responsibility and liability of the HNE provider. HNE providers shall not bill either HNE or the HNE MA-PD member for such services. HNE providers may request review of HNE decision pursuant to the appeal procedures outlined in this manual and in accordance with applicable law. Any disallowance of a claim made in good faith by HNE after an appeal is considered shall be conclusive and binding upon the provider.

If, through HNE's medical management activity, HNE determines that any portion of service provided by HNE providers to an HNE MA-PD member is not Medically Necessary, HNE may, at its discretion, deny, or reduce payment for these services. Prior approval for a service does not preclude subsequent retrospective review to confirm documentation supports the information on which approval of Medical Necessity was based. Providers may appeal a denial or reduction of payment through the HNE Provider Appeal procedure outlined in this manual. Any disallowance of a claim made in good faith by HNE after an appeal is considered shall be conclusive and binding upon the provider.

HNE shall provide HNE providers with timely notification of its decisions regarding authorization of services or referrals in accordance with applicable law. Under any circumstances, HNE providers agree that it will not bill the HNE MA-PD member for such services.

## **2. Quality Improvement Activities**

HNE providers shall actively participate in all of HNE's applicable quality improvement activities. HNE providers shall work with HNE to provide data necessary to comply with Healthplan Employer Data & Information Set (HEDIS) measures and will coordinate with HNE on data collection and improvement efforts related to quality improvement programs designed and implemented by HNE or its designee(s). At HNE's request, providers shall comply with any IRE/QIO activities pertaining to the provision of services to HNE MA-PD members. In connection with these programs, HNE providers shall permit HNE or its designee to inspect HNE provider facilities and to conduct on-site reviews of the facilities and medical records for HNE MA-PD members Covered Services, with prior notice, during normal business hours at a mutually agreed upon time. Providers shall allow HNE to inspect and copy HNE MA-PD member medical records for Covered Services and shall comply with HNE requests to provide copies of records for Covered Services. All information, records, and documents required shall be provided within a reasonable period of time and without cost to HNE, subject to applicable law. Providers shall identify the lead physician accountable for the provider's quality improvement program and for coordinating with HNE on data collection and improvement efforts.

HNE also encourages HNE providers to participate in CMS and DHHS quality improvement initiatives.

## **S. Obligations of HNE:**

### **1. Licensure.**

HNE shall maintain its license under the laws of the Commonwealth of Massachusetts. HNE shall notify HNE providers immediately in the event that its license is suspended or revoked, unless such revocation is due to HNE's receipt of a successor license.

### **2. Compliance with Law.**

HNE is committed to fair and proper contracting procedures and compliance with all state and federal laws and regulations, including Medicare laws and regulations, the Social Security Act, the Civil Rights Act of 1964, the Age Discrimination Act of 1975, the American with Disabilities Act, and all other laws and regulations applicable to recipients of federal funds. In support of this commitment HNE has established a Compliance Program. (Refer to Section XIV for more details on HNE's Compliance Program.)

### **3. 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)**

HNE is also committed to compliance with other laws, specifically Federal laws and regulations Federal laws and regulations designed to prevent or ameliorate fraud, waste, and abuse including, but not limited to:

- Applicable provisions of Federal criminal law;
- The False Claims Act (31 U.S.C. 3729 et seq.);

- The Anti-kickback statute (Section 1128B(b) of the Act); and
- HIPAA administrative simplification rules at 45 CFR Part 160, 162, and 164.

As MA-PD organization receiving Federal payments under a MA-PD contract, HNE and related entities, contractors, and subcontractors paid by HNE to fulfill its obligations under its MA-PD contract are subject to certain laws that are applicable to individuals and entities receiving Federal funds.

As a MA-PD organization offering a Part D prescription drug benefit, HNE must also follow additional requirements relating to fraud, waste, and abuse specific to the prescription drug benefit [42 CFR 423.504(b)(4)(vi)(H)]. In support of this commitment HNE has established a Compliance Program, including a Fraud, Waste, and Abuse Prevention Program. (Refer to Section XIV for more details on HNE's Compliance Program.)

#### **4. Administration**

Unless expressly delegated to the provider by HNE or expressly retained by the applicable Account, HNE shall conduct all administrative services customarily performed by a health maintenance organization or a licensed insurer or third-party administrator, as applicable, including, but not limited to: marketing and sales; eligibility and enrollment; premium billing; member services; appeals and grievances; credentialing; claims adjudication, processing, and payment; quality assurance and management; and medical or utilization management. In those cases where functions have been delegated, HNE will conduct oversight in accordance with HNE policy and applicable law.

#### **5. Administrative Notification**

HNE maintains and provides the provider with this HNE Provider Manual. From time to time, the HNE Provider Manual may be revised by HNE. HNE will provide the provider sixty (60) days prior written notice of such changes, including changes related to claims submission or medical or utilization management policies. With respect to changes required to ensure compliance with state or federal law or regulation, HNE will make reasonable effort to provide sixty (60) days prior written notice. HNE shall develop and distribute such other policies, procedures, and rules as may be necessary for the efficient administration of the HNE MA-PD plan, and the provider shall be required to comply with all such policies, procedures, and rules.

#### **6. Provision of the HNE MA-PD Member Contract and HNE MA-PD Provider Directory**

Copies of the HNE MA-PD Member Contract and the HNE MA-PD Provider Directory available to HNE MA-PD members and potential members will be made available to HNE providers upon the provider's request. HNE will provide providers with timely notification of any substantial changes in Covered Services included in Member Contracts, except for Account-specific benefit changes.

#### **7. Member eligibility**

HNE shall maintain an HNE MA-PD member eligibility data system, via HNE Direct, which includes provisions for access by HNE providers. Providers may also contact HNE to verify member eligibility over the telephone.

**8. Administration and compliance with of Medical or Utilization Management and Quality Management Programs [42 CFR § 422.202(b); 422.504(a)(5)]**

HNE may develop and administer and HNE providers shall comply with programs for medical or utilization management and quality management, medical records requirements, claims auditing, risk management, and HNE MA-PD member and provider education. HNE shall make efforts to conduct activities related to these programs in a manner that does not interfere unreasonably with HNE providers' operations. HNE shall ensure that medical management decisions are based solely on appropriateness of care and service. In addition, HNE acknowledges that it does not compensate individuals conducting utilization review for denial of coverage or service, and does not provide any financial incentives to individuals making utilization management decisions that encourage denial of coverage or service. HNE shall consult with HNE MA-PD plan providers as HNE develops and implements medical policy and quality improvement programs and medical management procedures. The HNE provider contract does not contain any incentive plan that includes specific payment made to a health care professional as an inducement to reduce, delay, or limit specific Covered Services that are Medically Necessary and appropriate. HNE acknowledges that provider contract payment provisions do not compensate providers for providing Covered Services that are not Medically Necessary and appropriate, nor do they compensate HNE for denying Covered Services that are Medically Necessary and appropriate.

**9. Disclose to CMS quality & performance indicators for plan benefits re: disenrollment rates for HNE MA-PD members enrolled in the plan for the previous two years [42 CFR § 422.504(f)(2)(iv)(A)]**

HNE shall disclose to CMS quality and performance indicators for plan benefits including disenrollment rates for HNE MA-PD members enrolled in the plan for the previous two years according to the requirements of CMS rules and regulations.

**10. Disclose to CMS quality & performance indicators for the benefits under the plan regarding HNE MA-PD member satisfaction [42 CFR § 422.504(f)(2)(iv)(B)]**

HNE may administer one or more HNE MA-PD member satisfaction survey(s). If requested by HNE, providers shall assist HNE in surveying members by distributing survey materials, as made available by HNE, to members at the time of each appointment, or as otherwise agreed to by HNE and HNE providers. HNE shall disclose the results of the survey(s) to CMS according to the requirements of CMS rules and regulations.

**11. Disclose to CMS quality & performance indicators for the benefits under the plan regarding health outcomes [42 CFR § 422.504(f)(2)(iv)(C)]**

HNE shall disclose the results of the quality and performance indicators for the benefits under the plan regarding health outcomes to CMS according to the requirements of CMS rules and regulations.

**12. Notify providers in writing for reason for denial, suspension & termination [42 CFR § 422.202(c)(1)]**

If HNE suspends or terminates an agreement under which the physician provides services to HNE MA-PD plan members, HNE shall give the affected provider written notice of the following: (1) The reasons for the action, including, if relevant, the standards and profiling data used to evaluate the physician and the numbers and mix of physicians needed by HNE; and (2) the affected physician's right to appeal the action and the process and timing for requesting a hearing.

**13. Provide 60 days notice (terminating contract without cause) [42 CFR § 422.202(c)(4)]**

HNE or an HNE provider may terminate a Medicare Advantage contract without cause so long as the party terminating the contract provides at least sixty (60) days written notice to each other of the termination without cause.

**14. Prohibition of use of excluded practitioners [42 CFR § 422.752(a)(8)]**

HNE is prohibited from employing or contracting with an individual or entity who is excluded from participation in Medicare under section 1128 or 1128A of the Social Security Act (or with an entity that employs or contracts with such an excluded individual or entity) for the provision of any of the following: (1) Health care; (2) Utilization review; (3) Medical social work; and (4) Administrative services.

HNE represents that it does not employ or contract with any individual or [First Tier, Downstream, or Related] entity that has been excluded from Medicare under Section 1128 or 1128A of the Social Security Act for the provision of any Covered Services or any utilization review services, medical social work services, or administrative services.

**15. Adhere to member appeals/grievance procedures [42 CFR § 422.562(a)]**

HNE shall establish and maintain: (1) A grievance procedure as described in 42 CFR § 422.564 for addressing issues that do not involve organization determinations; (2) A procedure for making timely organization determinations; (3) Appeal procedures that meet the requirements of this subpart for issues that involve organization determinations.

HNE must ensure that all HNE MA-PD members receive written information about the (1) Grievance and appeal procedures that are available to them through the MA-PD organization; and (2) Complaint process available to the enrollee under the QIO process as set forth under section 1154(a)(14) of the Act.

If HNE delegates any of its responsibilities with respect to appeals and grievances to another entity or individual through which the organization provides health care services, HNE is ultimately responsible for ensuring that the entity or individual satisfies the relevant requirements.

***High Level Description of the HNE grievance process for HNE MA-PD members:***

A grievance is any complaint or dispute (other than one that involves an organization determination) expressing dissatisfaction with any aspect of the operations, activities, or behavior of a Medicare health plan, or its providers, regardless of whether remedial action is requested. The member must file the grievance either orally or in writing no later than 60 days after the triggering event or incident precipitating the grievance. HNE receives and documents oral grievances filed by or on behalf of HNE members. HNE will respond to all concerned parties about the results of the investigation as expeditiously as the member's case requires based on the member's health status, but no later than 30 days after the grievance is received. HNE may extend this time frame by up to 14 days if member requests or agrees to an extension. Member grievances that are handled over the telephone by Member Services and can be resolved at the time the call is received will be appropriately documented and forwarded to the Complaints and Appeals Department (CAD) for tracking and trending. If the grievance cannot be handled at the time of the call, or if it is received in writing, it will be routed directly to the CAD who will handle investigation, resolution and outcome notification in accordance with all applicable regulatory procedures and time frames and will be documented to assist with tracking and trending. HNE will notify the member in writing of the decision and appropriate next steps.

***High Level Description of the HNE appeal process for HNE MA-PD members:***

If HNE denies a member's request for an item or service in whole or in part (issues an adverse organization determination), the member may appeal the decision to the plan by requesting a reconsideration. The member or the member's representative may request a standard or expedited reconsideration. A member's physician may request an expedited reconsideration on the member's behalf. If a physician requests the expedited reconsideration, HNE will expedite the request. If the member's physician is also the member's representative, he, or she may also request a standard reconsideration.

HNE will document all written requests for reconsideration. Expedited requests can be made either orally or in writing. Standard requests must be made in writing. Reconsideration requests must be filed with HNE within 60 calendar days from the date of the notice of the organization determination. Reconsiderations will be documented by the Complaints and Appeals Department (CAD) for appropriate handling, investigation, resolution, outcome notification, and tracking and trending.

HNE will make its decision and notify the member of its decision as quickly as the member's health requires, but no later than 72 hours for expedited requests or 30 calendar days for standard requests, or 60 calendar days for payment requests. The CAD will process and respond in accordance with all applicable regulatory procedures and time frames. HNE will notify the member in writing of an approval decision and process payment appropriately. If the decision is unfavorable to the member, in whole or in part, HNE will automatically submit the case file and its decision for automatic review by the Part C Independent Review Entity (IRE). HNE will notify the member of HNE's decision to affirm the adverse determination and that HNE has forwarded the case to the IRE, including the member's right to submit additional evidence pertinent to the case to the IRE. HNE will cooperate and provide any requested information from the IRE or any entities involved in subsequent levels of review.

**T. Prompt notification of overpayments or underpayments**

HNE providers shall promptly notify HNE of any overpayments or underpayments. HNE providers shall allow HNE to seek prompt refund for any duplicate, excess, or otherwise erroneous payments, or to deduct the amount overpaid from future payments.

**U. Pharmaceutical Management Procedures under the HNE MA-PD Plan**

HNE's Pharmaceutical Management Procedures under the HNE MA-PD Plan are included in the HNE MA-PD Formulary, and shall be posted online to HNE's website. A written copy shall also be made available upon request.

## **XV. Member Rights and Responsibilities**

**A. Contacting the HNE Medicare Advantage Plan:**

You may call Member Services at 1-413-787-0010 or 1-877-443-3314. TTY/TDD users may call 1-800-439-2370. A representative is available 8:00 a.m. to 8:00 p.m., seven days a week. Members and physicians may also use these numbers for questions about Part C processes or the status of Part C claim, request, or appeal and Part C and D grievances.

If members would like to come to our office and meet with an HNE Medicare Advantage Sales or Member Services Representative, HNE's office hours are 8:00 a.m. to 5:00 p.m., Monday through Friday.

For questions related to HNE Medicare Advantage Plan Part D Prescription Drug coverage, call 1-800-546-5677, 24 hours a day, seven days a week. TTY/TDD users should call 1-866-706-4757. Members and physicians may also use these numbers for questions about Part D processes or the status of Part D claim, request, or appeal.

Mail correspondence to:

HNE Medicare Advantage Plan  
Name of Department\*  
One Monarch Place, Suite 1500  
Springfield, MA 01144-1500

\* For example, departments that you might write to include:

- Clinical Services
- Complaints and Appeals
- Member Services
- Sales
- Enrollment

**B. The following is a list of Member Rights and Responsibilities (the complete statement with further explanation is included in the Evidence of Coverage documents for members posted to HNE.com, click on “HNE Medicare Advantage”):**

**SECTION 1 Our plan must honor your rights as a member of the plan**

Section 1.1 We must provide information in a way that works for you (in languages other than English that are spoken in the plan service area, in Braille, in large print, or other alternate formats, etc.)

Section 1.2 We must treat you with fairness and respect at all times

Section 1.3 We must ensure that you get timely access to your covered services and drugs

Section 1.4 We must protect the privacy of your personal health information

Section 1.5 We must give you information about the plan, its network of providers, and your covered services

Section 1.6 We must support your right to make decisions about your care

- You have the right to know your treatment options and participate in decisions about your health care
  - To know about all of your choices.
  - To know about the risks.
  - The right to say “no.”
  - To receive an explanation if you are denied coverage for care.
- You have the right to give instructions about what is to be done if you are not able to make medical decisions for yourself

Section 1.7 You have the right to make complaints and to ask us to reconsider decisions we have made

Section 1.8 What can you do if you think you are being treated unfairly or your rights are not being respected?

Section 1.9 How to get more information about your rights

**SECTION 2 You have some responsibilities as a member of the plan**

Section 2.1 What are your responsibilities?

- Get familiar with your covered services and the rules you must follow to get these covered services.

- If you have any other health insurance coverage or prescription drug coverage besides our plan, you are required to tell us.
- Tell your doctor and other health care providers that you are enrolled in our plan.
- Help your doctors and other providers help you by giving them information, asking questions, and following through on your care.
- Be considerate. We expect all our members to respect the rights of other patients. We also expect you to act in a way that helps the smooth running of your doctor's office, hospitals, and other offices.
- Pay what you owe.
- Tell us if you move.
- Call member services for help if you have questions or concerns.