VANTAGE HEALTH PLAN

PARTICIPATING PROVIDER MANUAL

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Thank you for the continued care of our Members. This updated Provider Manual provides essential information for our Healthcare Providers. If you have any questions about this Manual or your participation in Vantage Health Plan, Inc. (Vantage), please call Toll–Free 888-823-1910 and choose the Provider Services Department.

Annette Napier
Director of Provider Relations
www.VantageHealthPlan.com

Vantage Health Plan

Participating Provider Manual

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COMMERCIAL

MEDICARE

Disclaimer: Included with this Provider Manual is discussion of matters which may be of a legal nature. That material is provided for general information purposes only. Any legal questions or issues should be directed to the Provider's legal advisor. Vantage does not provide legal advice.

Section 1.0 – Introduction

Please note, the term "Provider" or "Participating Provider" as used throughout this Provider Manual, also referred to hereinafter as "Manual", is inclusive of Practitioners, individual and group affiliated, as well as facilities and ancillary service suppliers, as appropriate, who are contracted with Vantage.

1.1 Provider Welcome

Welcome to Vantage, a Louisiana-based health maintenance organization. It is the goal of Vantage to offer high quality healthcare in a cost-effective manner by truly managing all aspects of care rendered to members of Vantage (Members).

Vantage was established in 1994 by local physicians in Northeast Louisiana. Our complete health maintenance program emphasizes prevention and early detection of medical problems through an organized network of physicians, hospitals, skilled nursing facilities, ancillary providers, pharmacies, and other healthcare providers.

Vantage is pleased to welcome you as a Participating Provider. This Manual explains the policies and procedures of the Vantage network. We hope it provides you and your office staff with helpful information as you effectively service Vantage's Members. The information is intended to address most situations your office will encounter. You may use it as a guide to answer questions about Member benefits, claims submission, and many other issues.

To aid in attaining the goal of ensuring high quality, cost-effective healthcare, Vantage uses a strong and proven Utilization Review/Quality Management Program. Approval by Vantage's Medical Management staff is required for inpatient admissions and certain outpatient services (listed in this manual) to be eligible for payment. Utilization Review Services provide for inpatient pre-admission certification, concurrent review for continued stay, retrospective review for emergency department utilization, and prior authorization for certain outpatient services.

Occasionally, Vantage will distribute communication documents on administrative issues and general information of interest regarding Vantage's Medicare Advantage Plans to you and your office staff. It is very important that you and/or your office staff read the newsletters and other special mailings and retain them with this Provider Manual so you can incorporate any changes into your practice.

If you have any questions about this manual or your participation in Vantage Health Plan, Inc., please call (318) 361-0900 and press "3" for the Provider Relations Department.

1.2 Corporate Mission Statement

Vantage Health Plan, Inc. strives to be a healthcare innovator by pro-actively seeking opportunities to improve the quality of healthcare while balancing the cost of that care.

We are committed to service. We believe our employees, Members, and Providers deserve and expect honesty, integrity, quality, and excellence in an insurance company. We believe outstanding customer service is achieved by continually working to improve oneself and the healthcare product provided.

We are committed to strength. We're strong to keep you strong. We believe in providing our Members with wellness and preventive services to promote health. We strive not only to offer quality healthcare, but a higher quality of life as a result of that healthcare.

We are committed to satisfaction. We believe communication must be clear to all for proper expectations to be met. Only with the understanding of one's coverage can proper expectations be made and satisfaction

obtained. It is the goal and desire of every employee to provide excellent customer service thereby achieving Member and Provider satisfaction.

We are committed to solutions. We believe that for every challenge there is a win-win solution. We believe that a strong Provider network and a variety of products are needed to meet the needs of our community and to provide quality healthcare.

We are committed to success! We believe that companies don't succeed, people do! You make Vantage Health Plan, Inc. possible. Therefore, it is our mission to help you succeed by providing exceptional service, rock-solid strength, customer satisfaction, and innovative solutions for your healthcare coverage needs.

1.3 Contacting Vantage

Vantage staff can be reached for routine questions or inquiries at the telephone numbers listed below. There is a Vantage staff member on call Monday through Friday from 8:00 a.m. to 8:00 p.m. to meet your needs. If you have an Emergency after 8:00 p.m. or on weekends and need to speak with a Vantage staff member, you should call the main number and leave a message with the answering service.

Department:	*Contact for:*	*Phone/Fax Number:*
Provider Relations	▪ Provider Networking ▪ Credentialing ▪ Provider In-service ▪ EFT (Electronic Funds Transfers for deposits) ▪ Vantage Web Portal (online claim status) ▪ Claims Payments	**318-361-0900 Phone Option "3" 318-807-1116 Fax 888-823-1910 Toll-Free**
Medical Management	▪ Prior Authorization Case Management ▪ Healthcare Coordination Practice Guidelines ▪ Discharge Planning	**318-361-0900 Phone Option "2" 318-361-2170 Fax 888-823-1910 Toll-Free**
Member Service	▪ Eligibility verification ▪ Covered Benefits ▪ Claim status ▪ Appeals & Grievances	**318-361-0900 Phone Option "1" 318-807-1113 Fax 888-823-1910 Toll-Free**
Marketing	▪ Marketing Information	**318-361-0900 Option "4" 318-361-2178 Fax 888-823-1910 Toll-Free**
Pharmacy	▪ Pharmacy Information	**318-998-0405 Phone 318-361-2170 Fax 888-316-4354 Toll-Free**
Main Office	▪ Receptionist	**318-361-0900 Phone 318-361-2159 Fax 888-823-1910 Toll-Free**
TTY	**This number requires special telephone equipment.**	**318-361-2131 Phone 866-524-5144 Toll-Free**
www.VantageHealthPlan.com	**www.VantageMedicare.com**	

1.4 Claims Submission

New and corrected paper claims are to be submitted and mailed to the following address:

Vantage Health Plan, Inc.
130 DeSiard Street, Suite 300
Monroe, LA 71201

1.5 Programs Available to Vantage Members

1.5.1 Behavioral Health Case Management Program

The Behavioral Health Case Management is a program designed for members who have chronic psychiatric conditions. Inclusion into the Behavioral Health Case Management Program is limited to any member with a behavioral health related diagnosis that has necessitated inpatient hospitalization or extensive outpatient treatment. This includes both mental illness and substance use disorders. Behavioral Health Case Management focuses on chronic psychiatric conditions that require monitoring and education to help members manage their conditions. This may include members with high hospital utilization, inappropriate emergency room use, post-hospital discharge issues, and noncompliance with medications. Behavioral Health Case Management helps members that require long-term case management services by providing support, education, coordination of services, and assistance locating resources.

The case managers track these member's health status and needs over time and periodically provide them with health information. Behavioral Health Case Managers teach members and families about self-management and preventive care. They will also work with the member, their physician(s), and their behavioral healthcare provider to coordinate the best possible care.

1.5.2 Social Services Case Management Program

The Social Services Case Management Program is a program designed for members who are in need of resource acquisition related to healthcare needs. These resource needs may be inhibiting members from reaching maximum health by preventing them from keeping appointments, paying for medications, or understanding their insurance benefits. These areas of need may include transportation assistance, Medicaid application assistance, financial assistance, food stamp qualification, housing, medication cost, and non-compliance. Social service case management helps members by providing community resource education and coordination of services. The Social Service Case Manager works closely with the other Vantage case management programs to ensure the member's additional needs are met.

1.5.3 General Case Management Program

The General Case Management is a program designed for members who may have less complicated chronic conditions but have a risk for developing other conditions or complications and have a need for care coordination. General Case Management focuses on conditions that require monitoring and education to help members manage their health by providing support, basic education, coordination of services, and assistance locating resources. Enrollment into the General Case Management Program is not limited to any particular diagnosis. Members who do not meet criteria for Complex Case Management, but require assistance to access medical care, coordination of services, health education, and assistance locating resources, may benefit from General Case Management. This may include members with frequent hospitalizations, inappropriate emergency room use, post-hospital discharge issues, or uncontrolled, unmanaged health issues.

Members are case managed telephonically by a Registered Nurse (RN) case manager; therefore, they do not have to leave home. The case managers track member's health status and needs over time and periodically provide them with health information. General Case Management nurses teach members about self-management and preventive care. They will also work with the member and the member's physician(s) to coordinate the best possible care. The goal of this program is to assist members to achieve an optimal quality of life.

1.5.3.1 Resources that we can assist you with if needed:

- Resource Social Services by Registered Social Worker
- Clinical Social Services by Licensed Clinical Social Worker
- Behavioral Health Case Management
- Medication Therapy Management
- Vantage Medication Adherence Program (VMAP)
- Tobacco Cessation Program by Certified Educators
- Diabetes Education
- Nutritional Services
- Weight Loss Programs
- Heart Failure, Diabetes, and COPD Disease Management

1.5.3.2 Referral identification sources include, but are not limited to:

- Provider Referrals
- Care and Disease Management Program Referrals
- Discharge Planning or Transitional Care
- Member Self-Referral
- Family Referrals
- Utilization Management Referrals

1.5.3.3 Referral Process:

Each referral is reviewed for enrollment in General Case Management based on available information and telephonic member assessment. Participation in this program is voluntary and at no cost for all eligible Vantage members. If you would like to refer a member or if you would like additional information regarding eligibility into the General Case Management Program, please call (318) 998-0406, option 1, or toll-free (888) 823-1910, option 1, then option 5.

1.5.4 Complex Case Management Program

Vantage's Complex Case Management Program identifies members with complex healthcare needs based upon their chronic condition. The goal of Complex Case Management is to help members regain optimum health and/or improved functional capability, educate members regarding their chronic condition, teach members about self-management and preventive care, reinforce the Primary Care Provider's (PCP) prescribed treatment plan, and provide information on resources that are available to our members.

The program is a telephonic case management program and involves a comprehensive assessment of the member's condition, determination of available benefits and resources, development and implementation of a plan of care, and coordination of services. After a member has been identified for Complex Case Management, a Registered Nurse (RN) case manager will contact the member to perform an initial assessment and develop a plan of care. The case manager works closely with the member and the member's physician(s) to coordinate care.

1.5.4.1 Enrollment criteria for Complex Case Management includes one or more of the following diagnoses and at least one inpatient admission in the last 12 months:

- COPD
- CHF
- Hypertension
- Atrial Fibrillation
- Coronary Artery Disease

1.5.4.2 Resources that we can assist you with if needed:

- Resource Social Services by Registered Social Worker
- Clinical Social Services by Licensed Clinical Social Worker
- Medication Therapy Management
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Each referral is reviewed for enrollment in Complex Case Management based on available information and telephonic member assessment. Participation in this program is voluntary and at no cost for all eligible Vantage members. If you would like to refer a member or if you would like additional information regarding the Complex Case Management Program, please call (318) 998-0406, option 1, or toll-free at (888) 823-1910, option 5, then option 1.

1.5.5 Disease Management Programs (DMPs)

Vantage's Disease Management Programs (DMPs) are educational programs for Members with chronic (long-term) condition(s). The purpose of the DMPs is to help Members better self-manage their condition(s). Once enrolled in one of the DMPs, a clinical pharmacist will contact the Member to discuss their chronic condition(s). The pharmacist will also send educational and health reminder mailings, perform a complete medication review, and offer daily self-care tips to help better manage their condition(s) and set healthcare goals.

1.5.5.1 Vantage Health Plan offers the following DMPs:

- Diabetes
- Heart Failure
- Chronic Obstructive Pulmonary Disease (COPD)

1.5.5.2 Why our Members should participate in a Vantage Health Plan DMP?

- It's available at no cost to Members
- It's educational and supportive
- It builds on information they already have
- It will not conflict with Provider intentions
- It's done over the phone and through the mail. The Members don't have to leave their home.

If you know a Member who could benefit from one of our DMPs, please call one of our Clinical Disease Management Pharmacists at 1-888-316-7907 and they will be happy to assist you.

1.5.6 Dual Eligible Special Needs Plan Case Management Program

The purpose of Vantage Health Plan's Dual Eligible Special Needs Plan (SNP) Case Management Program is to ensure that SNP beneficiary's healthcare needs and preferences for health services are met over time. Case Management will help to maximize the use of effective, efficient, and high-quality care that will lead to improved health outcomes. The SNP Case Management Program includes the delivery of services and benefits to members who are potentially medically complex, have multiple chronic conditions, and are disabled or facing psychosocial or socioeconomic difficulties. All Vantage SNP enrollees are enrolled in SNP Case Management with an active or passive status.

The SNP Case Management Program includes a face-to-face Health Risk Assessment that is conducted by a Nurse Practitioner, a comprehensive initial assessment of the member's condition and history by the case manager, determination of available benefits and resources, and the development and implementation of an individualized care plan. Vantage's care management plans consist of performance goals, monitoring of the member's adherence and progress, and follow-up planning for ongoing support. Care management plans are focused on the delivery of appropriate healthcare services for members with complex, acute, and chronic care needs. The program provides an opportunity for early intervention with new and existing members so that services can be provided timely and in a satisfactory manner for the members and the members' physicians. The program helps to manage the member's condition and comorbidities, assesses, and identifies issues that directly and indirectly affect the member's ability to access care, and monitors the member's adherence to treatment plans as prescribed. In close collaboration with the member, the member's family and healthcare providers, and the Interdisciplinary Care Team, Vantage's SNP Case Management Program supports and reinforces the individualized care plan, provides education, and coordinates available services.

1.5.7.1 Resources that we can assist you with if needed:

- Resource Social Services by Registered Social Worker
- Clinical Social Services by Licensed Clinical Social Worker
- Behavioral Health Case Management
- Medication Therapy Management
- Vantage Medication Adherence Program (VMAP)
- Transportation for Medical Appointments
- Tobacco Cessation Program by Certified Educators
- Diabetes Education
- Nutritional Services
- Weight Loss Programs
- Heart Failure, Diabetes, and COPD Disease Management

Section 2.0 – Administrative Procedures

2.1 Marketing

Participating Providers may not develop or use any materials that market Vantage Medicare Advantage Plans without the prior written approval of Vantage. Federal laws require CMS-contracted Medicare Advantage Plans to obtain authorization from the Centers for Medicare and Medicaid Services (CMS) prior to distributing marketing materials, documents, or other information to Medicare beneficiaries.

2.2 Change in Provider Information

Providers are required to notify both the Vantage Provider Relations Department and CMS through the CMS-contracted intermediary in writing of any changes in information regarding their practice. Such changes include:

- Address changes, including changes for satellite offices
- Phone Number
- Fax Number
- Hours of Operation
- Additions / deletions to a group
- Name changes
- Tax ID number changes
- National Provider Identification (NPI) Number changes

*IMPORTANT! Providers are also required to notify Vantage in writing 90 days prior to their termination date if they choose to leave Vantage.

Should a single Provider or an entire medical group decide that it wishes to terminate its contract, Vantage requires a list of Members receiving ongoing healthcare from the Provider so that notification can be sent to Members prior to the date of the Provider's termination. It is critical that each Vantage Member receive timely and appropriate Provider access. The Vantage Provider Relations Department will work with terminated Providers during the 90-day termination transition period to ensure access for each Vantage Member remains uninterrupted.

2.3 Member Rights

Vantage Members are informed of their rights and responsibilities through the Certificate of Coverage (COC) Booklet for Commercial Members or Evidence of Coverage (EOC) for Medicare Advantage Members. Vantage Providers are also required by federal and state law to respect and honor Members' rights.

Vantage Members have the following rights and responsibilities:

- A right to receive information about Vantage, its services, its Healthcare Providers, and their rights and responsibilities as a Member.
- A right to participate with Healthcare Providers in making decisions about their healthcare.
- A right to receive timely access to covered services and prescription drugs.
- A right to privacy and the protection of personal health information, in accordance with state and federal law.
- A right to candid discussion of appropriate or Medically Necessary treatment options for one's conditions, regardless of cost or benefit coverage.
- A right to voice grievances or file appeals about Vantage, coverage decisions, its Healthcare Providers, or the care provided.
- A responsibility to understand one's health problems and participate in developing mutually agreed upon treatment goals to the degree possible.
- A right to make recommendations regarding Vantage's Member rights and responsibilities policy.

- A right to be treated with fairness, respect & recognition of one's dignity & right to privacy.
- A responsibility to supply information (to the extent possible) that Vantage and its Healthcare Providers need in order to provide care.
- A responsibility to follow treatment Plans and instructions for care that is agreed to with one's Health Care Provider.
- A right to receive communication assistance for verbal and printed communications, including assistance for the visually impaired and hearing impaired and translation services for languages other than English.

Vantage has the responsibility:

- To not discriminate against Members based on race, color, religion, national origin, age, disability, sex, gender identity, sexual orientation, or any other legally protected characteristic, or any other basis prohibited by law.
- To keep personal health information private and secure, as required by law.
- To give out and use personal health information only for the following purposes:
  - Treatment;
  - Payment; and
  - Healthcare operations (such as information used to measure how well their care is improving).
- To contact Members if their personal health information is needed for any reason besides treatment, payment, and healthcare operations.
- To honor Members' decisions to approve or deny the use of their information.
- To provide information and/or a written explanation as to coverage determinations, therapy programs, or other treatment options.
- To provide information about Vantage and how Vantage compares to other Plans.
- To provide translation services or other communication formats to convey information to Members.

2.4 Member Responsibilities

When Members receive healthcare benefits through Vantage, certain conditions, coverages, limitations and exclusions may apply to their benefits. Employers, by offering Vantage, have agreed to provide to their eligible employees a health benefit plan designed to encourage the use of Vantage Participating Providers for their healthcare needs. Members are made aware that Vantage offers Provider coverage at affordable rates because of its specific system of controls and responsibilities.

Each Vantage Member is informed in their COC or EOC, as applicable, of the following Member Responsibilities:

- When enrolling in Vantage HMO, each Member must select a Primary Care Provider to provide and/or coordinate his/her healthcare. A list of participating Primary Care Providers is enclosed with each COC or EOC Booklet. If a Member does not select a Primary Care Provider, one will be assigned.
- Identify themselves as Vantage Members when seeking medical care by presenting their Vantage Member ID Card, which indicates their participation in Vantage.
- Pay any required cost-share at the time services are received.
- Pay for all non-covered services.
- Comply with all UR/QM requirements and other elements of Vantage Medical Management.

Make sure that the Provider (physician and facility) from whom services are to be received is a Vantage Participating Provider, except when prior authorized by Vantage or in cases of medical emergency.

Section 3.0 - Provider Roles and Responsibilities

3.1 Confidentiality

In accordance with state and federal laws, Vantage has established confidentiality policies and practices for its own operation and to outline expectations of its Provider network. To obtain a copy of Vantage Notice of Privacy Practices, please visit the Vantage Corporate website at *www.VantageHealthPlan.com* or the Vantage Medicare Advantage website at *www.VantageMedicare.com* and click on the Privacy Policy located at the bottom of the page.

All Providers are required to comply with Vantage policies on the confidential handling of Member information and must abide by all state and federal laws regarding confidentiality and disclosure of medical records or other protected health and enrollment information. Providers are authorized to share Member's protected health information with Vantage for the purposes of treatment, payment, and operations as authorized by the Member's signature on the Medicare application.

Vantage and all network Providers are required to obtain special consent (authorization) from Members for any uses or disclosures of protected health information beyond uses for treatment, payment, and operations. Members have the right to specifically approve or deny the release of personal health information for uses other than treatment, payment, and operations. Examples of uses and disclosures that require special consent or authorization include data requested for workers' compensation claims, release of information that could result in the Member being contacted by another organization for marketing purposes, and data used in research studies. In cases where consent is required from Members who are unable to give it or who lack the capacity to give it, Vantage and all network Providers will accept special consent or authorization from persons designated by the Member. Designated persons, such as parents/guardians for minors or an agent pursuant to a power of attorney, may authorize the release of personal health information and may obtain access to information about the Member.

Member information transferred from Vantage to another organization as permitted by routine or special consent will be protected and secured according to Vantage's privacy policies and procedures.

Vantage may use Member information for quality studies, health outcomes measurements, and other aspects of health plan operations and will de-identify the information as required by state and federal privacy laws.

Vantage Members have the right to appeal any plan decision that involves issues of information confidentiality and privacy. Vantage Members are permitted to access, copy, and inspect their medical records upon request. One copy of a Member's complete medical record will be made available upon request at no charge and in accordance with state administrative regulations.

3.2 Reporting and Compliance Obligations

Cooperation in Meeting Centers for Medicare & Medicaid Services (CMS) Requirements

Vantage must provide information necessary to CMS for CMS to administer and evaluate the Vantage Medicare Advantage and Health Insurance Marketplace programs and establish and facilitate processes for current and prospective Members to exercise a choice in obtaining services. Such information includes plan quality and performance indicators, such as dis-enrollment rates, Member satisfaction, and information on health outcomes. Participating Providers must cooperate with Vantage in its data reporting obligations by providing Vantage with any information needed to meet its obligations to CMS.

Certification of Diagnostic Data

Vantage Medicare Advantage & Health Insurance Marketplace programs are specifically required to submit

to CMS data necessary to characterize the context and purposes of each encounter between a Member and a supplier, physician, or other Provider (encounter data). Participating Providers that furnish diagnostic data to assist Vantage in meeting its reporting obligations to CMS must certify (based on best knowledge, information, and belief) the accuracy, completeness, and truthfulness of the data.

3.3 The Role of the Medical Home Primary Care Provider (MH-PCP)

PCP means a Family Practitioner, General Practitioner, Pediatrician, or Internal Medicine physician who meets state requirements and is trained to give basic medical care. The MH-PCP is to function within his/her scope of licensure or certification, has admitting privileges at a hospital, and agrees to provide primary healthcare services to Members 24 hours a day, seven days a week.

The MH-PCP serves as the Member's initial and most important contact for receiving medically necessary covered services. The MH-PCP provides or coordinates care for each Member. This includes:

- Maintaining continuity of care for all Members by serving as PCP.
- Exercising primary responsibility for arranging and coordinating the delivery of medically-necessary healthcare services to Members.
- Maintaining a current medical record for each Member, including documentation of all medical services (MH-PCP and specialty) provided to the Member.
- Providing periodic physical examinations.
- Providing routine injections and immunizations.
- Providing or arranging 24 hours a day, 7 days a week access to medical care.
- Assisting Members to obtain needed specialty care and other medically necessary services.
- Arranging and/or providing necessary inpatient medical care at participating hospitals.
- Providing health education and information.
- Discussing Advance Medical "Directives" with all Members as appropriate, and documenting in medical records (in a prominent place) if a Member has executed a Directive. In Louisiana, the Directive may be referred to as a "Declaration."
- Maintaining records of periodic preventive services and providing appropriate timely reminders to Members when services are due.

All Member education materials encourage Members to seek their MH-PCP's advice before accessing medical care from any other source, except for emergency services.

3.4 The Role of Specialists

Specialty Care Providers (Specialist(s)) deliver services beyond the scope of primary care to Members. For Members who have a MH-PCP, the Specialist is encouraged to coordinate care through the Member's MH-PCP. Necessary prior authorization for hospital admissions or specified diagnostic testing procedures must be obtained. Refer to Section 5.0, "Prior-Authorization," for a complete listing of procedures requiring prior authorization from the Vantage Utilization Management Department.

It is important for the Specialist to communicate regularly with the MH-PCP regarding any specialty treatment. Specialists are encouraged to report the results of their services to the Member's MH-PCP. The Specialist should copy all test results in a written report to the MH-PCP.

3.5 Responsibilities of All Providers

3.5.1 Professional Manner

The Provider must provide services in a manner consistent with professionally recognized standards of care and in a culturally competent manner.

3.5.2 Provider and Member Communications

Providers must provide appropriate and adequate medical care to all Vantage Members. No action of Vantage or any entity on Vantage's behalf in any way relieves or lessens the Provider's responsibility and duty to provide appropriate and adequate medical care to all Members under the Provider's care. Vantage agrees that, regardless of the coverage limitations, the Provider may freely communicate with Members regarding available treatment options and nothing in this Provider Manual shall be construed to limit or prohibit open clinical dialogue between the Provider and the Member.

3.5.3 Advance Directives (Declarations)

Living will, living will directive, advance directive, and declaration (collectively referred to hereafter as "Declaration") are all terms used to describe a document that provides directions regarding healthcare to be provided to the person executing the document. In Louisiana, a Declaration is governed by Louisiana Revised Statute 40:1299.58.1, et seq.

A Member who is 18 years of age or older and who is of sound mind may make a Declaration which:

- Directs the withholding or withdrawal of life-prolonging treatment
- Directs the withholding or withdrawal of artificially provided nutrition or hydration
- Designates one or more adults as an agent or successor agent to make healthcare decisions on his or her behalf

A Declaration may be revoked at any time by the declarant.

Healthcare Agents - If a healthcare agent is appointed in a Declaration, the agent is required to consider the recommendations of the attending physician and to honor the requests made by the declarant in the Declaration.

Provider's Responsibilities - Providers should:

- On the first visit, as well as during routine office visits when appropriate, discuss the Member's wishes regarding a Declaration for care and treatment.
- Document in the Member's medical record the discussion and whether a Declaration has been executed.
- If asked, provide the Member with information about a Declaration.
- Upon receipt of a Declaration from the Member, file the Declaration in the Member's medical record.
- Not discriminate against any Vantage Member because he or she has or has not executed a Declaration.
- Communicate to the Member if the Provider has any conscientious objections to a Declaration.
- Outside of Louisiana- If a Provider is not based in Louisiana, reference should be made to the applicable law(s) governing Declarations in his/her jurisdiction.
- Retain all member medical records for ten (10) years.

3.5.4 Sanctions under Federal Health Programs and State Law

Participating Providers must ensure that no management staff or other persons who have been convicted of criminal offenses related to their involvement in Medicaid, Medicare, or other Federal Healthcare Programs are employed or subcontracted by the Participating Provider.

As more fully stated in your contract, Participating Providers must disclose to Vantage whether the Provider

or any staff member or subcontractor has had any prior violation, fine, suspension, termination, or other administrative action taken against them under Medicare or Medicaid laws; under any federal or state laws and regulations regarding the provision of medical services, by any insurer. Participating Providers must notify Vantage immediately if any such sanction is imposed on the Provider, a staff member, or subcontractor.

3.5.5 Suspected Child or Adult and Elder Abuse or Neglect

Cases of suspected child or adult and elder abuse or neglect might be uncovered during an examination. If suspected cases are discovered, a report should be made immediately, by telephone or otherwise, to a representative of the local Department for Social Services office, local law enforcement agency, or the Louisiana State Police, as appropriate.

Adult abuse is defined by Louisiana Revised Statute 15:1503 as the infliction of physical or mental injury on an adult by other parties, including but not limited to such means as sexual abuse, abandonment, isolation, exploitation, or extortion of funds or other things of value. The statute describes an adult as any individual 18 years of age or older or an emancipated minor who, due to a physical, mental, or developmental disability or the infirmities of aging, is unable to manage his/her own resources, carry out the activities of daily living, or protect himself from abuse, neglect, or exploitation.

To facilitate reporting of suspected child abuse and neglect cases, mandated reporters of child abuse and/or neglect may use the Louisiana Office of Community Services form (OCS Form CPI-2). These forms may be obtained from the local Louisiana Department for Social Services office. If a provider is not based in Louisiana, a comparable form available in his/her jurisdiction may be utilized for reporting purposes.

3.6 Provider Complaints & Grievances

Vantage recognizes its responsibility to provide Participating Providers with adequate access to Vantage personnel and committees of their peers to make inquiries, to express concern, and to obtain information regarding the method to file a complaint and/or grievance. Vantage has established an administrative grievance procedure to provide a full and fair review of grievances. This procedure is intended to provide prompt consideration of Provider grievances at the appropriate decision making levels of Vantage.

3.6.1 Step 1 – Initial Complaint and Immediate Follow-up

The Provider Relations Department will assist the Provider in trying to resolve the matter on an informal basis. If this is not successful, the Provider may file a written complaint or formal grievance.

- Vantage defines inquiries as any questions pertaining to benefits, Provider network, eligibility, billing correspondence, status of a claim, and/or proper use of Vantage.
- Vantage defines complaint as a specific incident related to the health plan or network and the occurrence that resulted in any degree of dissatisfaction to the Provider.
- Vantage defines grievance as a request for review of any situation which has not been resolved to the Provider's satisfaction or acceptance. This request must be in writing and sent to a Medical Director who initiates the formal grievance procedure.

1. Calls or initial inquiries will be directed to the appropriate Department. If the complaint involves medical care services, the Medical Management Department will assist in investigating and responding to such complaints.
2. The Medical Management Department will collect and document all pertinent information from the Provider.
3. The Medical Management Department will try to address the complaint satisfactorily on an informal basis. If this is an inquiry, a copy of the contact report detailing the circumstances, description of the findings, and the resolutions will be placed in the Provider's file.

3.6.2 Step 2 – Formal Grievance Procedure

1. If Step 1 has been followed and the complaint is unresolved or the resolution is unacceptable to the Provider, a formal grievance may be filed. The grievance should be filed as soon as possible after the date that the cause for complaint occurred but must be received within one (1) year of such date. The grievance should explain why the Provider is not satisfied with the initial response and what action the Provider requests to resolve the complaint. It should be mailed or hand delivered to:

Vantage Health Plan, Inc.
Provider Relations Department
130 DeSiard Street, Suite 300
Monroe, LA 71201

2. The grievance will be presented to a Medical Director, who will evaluate and respond to all grievances filed by Providers. For any grievance involving medical care issues, a Medical Director may request that a subcommittee of the UR/QM Committee be assembled to evaluate the findings and advise on how to respond to the grievance.
3. If desired or determined necessary, the Vantage Medical Director and/or other appropriate Vantage representatives will be available to meet with the Provider during the grievance process.
4. The Provider will be notified in writing of a Medical Director's decision within thirty (30) days. If processing the Provider's grievance involves the collection of information from outside the Vantage service area, Vantage will have an additional thirty (30) days to render a decision.

3.6.3 Step 3 – Appeal of Grievance Determination

1. Should the Provider decline to accept the determination of the committee, he or she may submit within thirty (30) days after receipt of the response an appeal to the Vantage Board of Directors.
2. The appeal will be presented to the Board of Directors within thirty days from the date Vantage receives such a request.

The Provider will be notified in writing regarding the decision of the Vantage Board of Directors within forty-five (45) days from the date the Provider files a written appeal. The decision of the Vantage Board of Directors will be considered a final decision.

Section 4.0 – Provider Performance Standards

4.1 Appointment Scheduling Standards

Providers must adhere to the following appointment scheduling standards to ensure timely access to quality medical care as required by CMS. Compliance with these standards will be audited by periodic on-site review of Provider offices and chart sampling.

Appointments with PCP's and Specialists must:

- Be scheduled within 30 days for routine care and preventive care visits
- Be scheduled within 7 days for non-urgent care, but in need of attention

Other appointment standards are as follows:

- Appointments for urgent care services must be scheduled within 24 hours.
- Appointments for emergency care must be immediately provided.
- Appointments for routine behavioral health visits are to be provided within 10 days of request.
- Pregnant women in their first trimester are to be provided preventive care visits within 14 days of request.
- Pregnant women in their second trimester are to be provided preventive care visits within 7 days of request.
- Pregnant women in their third trimester are to be provided preventive care visits within 3 days of request.

4.2 After-Hours Telephone Coverage

MH-PCP's are required to provide coverage for Vantage Members 24 hours a day, 7 days a week. When an MH-PCP is unavailable to provide services, the MH-PCP must ensure that he or she has coverage from another Participating Provider. Hospital emergency rooms or urgent care centers are not substitutes for coverage from another Participating Provider. Participating Providers can consult their Provider Directory, or contact Vantage Provider Relations with questions regarding which Providers participate in the Vantage network. After hours, telephones may be:

- Answered by an answering service that can contact the MH-PCP or another designated medical Provider who can return the call within a maximum of 30 minutes.
- Answered by a recording directing the Member to call another number to reach the MH-PCP or another Provider whom the MH-PCP has designated to return the call within a maximum of 30 minutes.
- Transfer to another location where someone will answer the telephone and be able to contact the MH-PCP or another designated Provider who will return the call within a maximum of 30 minutes.

Unacceptable after-hours telephone coverage in an MH-PCP's office includes:

- No answer after office hours.
- Telephones answered after hours by a recording that tells Members to leave a message.
- Telephones answered after hours by a recording that directs Members to go to the emergency room for non-emergency services.

4.3 Provider Office Standards

- The Provider shall not differentiate or discriminate in the treatment of any Member because of the Member's race, color, national origin, ancestry, religion, health status, sex, age, or any other legally protected characteristic, or source of payment.
- The office waiting times should not exceed 60 minutes.
- Appointments for Members should be scheduled at the rate of 6 or less per hour per Provider.
- Health assessments/general physicals should be scheduled within 30 days.
- Providers should have a "no show" follow-up policy. For example, the PCP or Specialist might send two notices of missed appointments to the Member, followed by a telephone call to the Member. Any actions for missed appointments should be documented in the Member's medical record.
- Member medical records must be maintained in an area that is not accessible to persons not employed by the practice. When releasing a Member's medical record to another practice or Provider, Providers are required to first obtain written consent from the Member.
- Providers must complete appropriate consent forms, as required by state and federal regulations and laws.

4.4 Medical Record-Keeping and Continuity and Coordination of Care Standards

Vantage has adopted the following medical record-keeping standards, which cover confidentiality, organization, documentation, access, and availability of records. These standards are based on the National Committee for Quality Assurance (NCQA) guidelines and may be revised as needed to conform to new NCQA recommendations. Compliance with these standards will be audited by periodic on-site review of Providers' offices and chart samplings. Providers must achieve an average score of 80% or higher on the medical records review. Vantage will assist Providers scoring less than 80% through corrective action plans and re-evaluation. Each medical encounter whether direct or indirect must be comprehensively documented in the Member's medical chart. Each medical record chart must have documented, at a minimum:

- Member name
- Member identification number
- Member age
- Member sex

- Member date of birth
- Date of service
- Allergies and any adverse reaction
- Chief complaint/purpose of visit
- Subjective findings
- Objective findings, including diagnostic test results
- Diagnosis/assessment/ impression
- Plan including services, treatments, procedures, and/or medications ordered; recommendation and rationale
- Name of Participating Provider including signature and initials
- Instructions to Member
- Evidence of follow-up with indication that test results were reviewed by PCP and any abnormal findings discussed with Member/legal guardian
- Health risk assessment and preventative measures

Confidentiality of Records

Participating Providers must comply with all state and federal laws concerning confidentiality of health and other information related to Members. Participating Providers must have policies and procedures regarding the use and disclosure of health information that comply with applicable laws. Medical records must be maintained in a secure area that is only accessible to Provider office staff.

Organization of Records

- There must be only one medical record per patient.
- The medical record must be bound or have the pages fastened to prevent loss of medical information.
- Each and every page in the record must contain the Member's name and/or ID number.
- The medical record must be organized in chronological order with the most recent information appearing first. The record should include separate sections for progress notes, lab results, x-ray and other imaging studies, hospital records (ER report and discharge summaries), home health nursing reports, physical therapy reports, etc.
- All charts must contain flow sheets for health maintenance.

Documentation

- The record must be legible.
- Personal data should include the social security number (SSN), date of birth, address, employer, home and work telephone numbers, marital status, emergency contact information, and guardianship/custodial arrangements. If a Member objects to providing his/her SSN, the last 4 digits may be accepted provided the Member's insurer does not use the SSN as his/her identification number for billing purposes.
- Medication allergies and adverse reactions must be prominently noted in the record.
- There must be a completed immunization record in the medical record.
- All charts must contain a problem and medication list. Significant illnesses and medical conditions must be indicated on the problem list.
- Medical history (for Members seen three or more times) must be easily identified and include medical, surgical, and obstetric histories. For children and adolescents (18 years of age and younger), medical history must include prenatal care, birth, operations, and childhood illnesses.
- All entries in the medical record must be signed or initialed and dated.
- Encounter forms or notes must have a notation, when indicated, regarding follow-up care, calls, or visits. The specific time of return must be noted in weeks, months, or as needed (PRN). Encounter data must be certified for completeness and truthfulness.
- For Members 12 years of age and older seen three or more times, documentation should reflect assessment of and counseling for tobacco, alcohol, substance abuse, and risk of sexually transmitted

diseases.
- If a consultation is requested, there must be a note from the consultant in the record.
- Consultation, lab, and x-ray reports filed in the chart must be initialed by the Provider to indicate review. Consultation and abnormal lab and imaging study results should have a specific notation in the record of follow-up plans.
- There must be evidence that preventive screenings and services are offered in accordance with Vantage Clinical Practice Guidelines. Use of risk assessments, disease maintenance, and preventive health materials are encouraged.
- Copies of consent forms, when applicable, should be maintained in the record.
- The medical record must also contain an indication of the Member's Declaration as appropriate.
- Vantage recommends that data on a Member's race, ethnicity, and spoken and written language are collected in health records, integrated into the Provider's management information systems, and periodically updated.

Access and Availability of Records
- Providers must permit Vantage, upon request, access to a Member's medical record to inspect, review, and copy within five (5) working days of receipt of request.
- Providers must permit appropriate state and/or federal regulatory agencies access to books, records, and other papers as stated in this Provider Manual.
- Members must have the right to all information contained in the medical record unless access is restricted for medical reasons. In accordance with state administrative regulations, Providers must furnish Members with a copy of their medical record and any costs assessed shall be in conformity with Louisiana Revised Statute 40:1299.96.
- When releasing records to an entity other than Vantage, Providers are first required to obtain written consent from the Member.

Continuity and Coordination of Care

While there are some indicators of continuity and coordination of care included within the documentation standards, Vantage will also assess medical records for evidence of continuity and coordination of care using the following criteria:
- The record must be legible to someone other than the writer. Any record determined illegible by one reviewer must be evaluated by a second reviewer.
- At each office visit, the history and the physical performed must be documented and reflect appropriate subjective and objective information for presenting complaints.
- The working diagnosis must be consistent with the clinical findings.
- The plan of action and treatment must be consistent with the diagnosis.
- Lab and other studies must be ordered as appropriate.
- Unresolved problems from previous office visits must be addressed in subsequent visits.
- There must be a review for the under and over-utilization of consultations.
- Age, gender, or disease-appropriate direct access services must be documented in the medical record. For example: mammography, influenza vaccinations, immunizations, diabetic retinal eye exams, women's specialists for routine and preventive services, family planning, and cancer screening services.
- There must be no evidence that the Member has been placed at inappropriate risk by a diagnostic or therapeutic problem.

In addition, Participating Providers must document in a prominent part of the Member's current medical record whether or not the Member has executed a Declaration.

4.5 Provider Obligations

When evaluating the performance of a Participating Provider, Vantage will review at a minimum the following areas:

- **Quality of Care** - measured by clinical data related to the appropriateness of a Member's care and Member outcomes.
- **Efficiency of Care** - measured by clinical and financial data related to a Member's healthcare costs.
- **Member Satisfaction** - measured by the Members' reports regarding accessibility, quality of healthcare, member-Participating Provider relations, and the comfort of the practice setting.
- **Administrative Requirements** - measured by the Participating Provider's methods and systems for keeping records and transmitting information.
- **Participation in Clinical Standards** - measured by the Participating Provider's involvement with panels used to monitor quality of care standards.

4.6 Provider Compliance to Standards of Care

Vantage Participating Providers must comply with all applicable laws and licensing requirements. In addition, Participating Providers must furnish covered services in a manner consistent with standards related to medical and surgical practices that are generally accepted in the medical and professional community at the time of treatment. Participating Providers must also comply with Vantage's standards, which include but are not limited to:

- Guidelines established by the federal Centers for Disease Control and Prevention (CDC)
- All federal, state, and local laws regarding the conduct of their profession

Participating Providers must also comply with Vantage policies and procedures regarding the following:

- Participation on committees and clinical task forces to improve the quality and cost of care
- Prior authorization requirements and time frames
- Participating Provider credentialing requirements
- Participating Provider "on-site" standards
- Appropriate release of inpatient and outpatient utilization and outcome information
- Accessibility of Member medical record information to fulfill the business and clinical needs of Vantage
- Cooperate with efforts to assure appropriate levels of care
- Maintaining a collegial and professional relationship with Vantage personnel and fellow Participating Providers
- Providing equal access and treatment to all Members

Section 5.0 Prior Authorization

5.1 Review Process

Vantage follows approved processes for reviewing and authorizing requested services. Authorizations and/or adverse determinations are based on Medical Necessity and will reflect the appropriate application of Vantage's approved practice guidelines and criteria. A Medical Director will review all authorization requests not meeting clinical criteria for final determination and either approve or issue an adverse determination. In such a role, the Medical Director shall have an unrestricted and current license in the State of Louisiana. Information collected is limited to the necessary information needed to authorize the requested service and is collected from the most appropriate source. The treating physician is consulted as appropriate. Information collected may include the following:

- Requested procedure including diagnosis code(s), procedure code(s), requesting Provider, referred to Provider, place of service, estimated length of stay, etc.
- Office and hospital records
- A history of the presenting problem
- Clinical exam records and notes

- Diagnostic testing results
- Treatment plans and progress notes
- Patient psychosocial history
- Information on consultations with the treating Practitioner
- Evaluations from other healthcare Practitioners and Providers
- Photographs
- Operative and pathological reports
- Rehabilitation evaluations
- A printed copy of criteria related to the request
- Information regarding benefits for services or procedures
- Information regarding the local delivery system or community network support
- Patient characteristics and information, including Member ID, demographic information, home environment, when applicable, co-morbidities, disabilities, socioeconomic barriers as applicable, etc.
- Medications inclusive of the pharmacy profile
- Additional benefits or secondary insurance

All authorization requests which require Medical Necessity review are submitted to Utilization Review RN's who apply approved practice guidelines and criteria. Requests not meeting guidelines or criteria are forwarded to a Medical Directors for review and determination. Only reviewing physicians have the authority to issue adverse determinations for any services based on Medical Necessity. Approved requests will include an authorization number for the specific services authorized. Both Member and Provider are notified of the determination. If an adverse determination is made, the notification will include services denied, denial reason, criteria used in making the decision as well as its availability upon request, the Medical Director who reviewed the request, alternate care options if applicable, and Member appeal rights information.

The scope of the program includes, but is not limited to the following types of reviews:
- Prospective review for inpatient and outpatient services
- Concurrent review and tracking of acute hospital, SNF, acute inpatient Rehab, LTAC admissions, and readmissions
- Specialty network and out-of-network referral management
- Retrospective review
- Discharge planning
- Home Health, including personal care services such as cooking, grooming, transportation, cleaning, and assistance with other ADL related activities
- Durable Medical Equipment (DME)
- Behavioral Health
- Referrals to Case Management

5.2 Prior Authorization Requirements

The Medical Management Department hours of operation are Monday through Friday, 8:00 a.m. to 5:00 p.m. CST, except designated holidays. For urgent or emergent issues outside of these hours, please follow the prompts given after dialing the contact number. The Medical Management Department can be reached by phone at (888) 823-1910 or by fax at (318) 361-2170. The Provider's office should contact Vantage's Medical Management Department to report the type of procedure(s) requested and the facility at which the Member will access the services. The Provider must provide the clinical information to support the Medical Necessity criteria of the service. Requests for prior authorization of elective services should be received by Vantage at least fourteen (14) days prior to the date the requested service will be performed. Prior authorization of the services that require authorization must be requested in advance of the procedure being performed. Requests for authorization of urgent and emergent services must be submitted to Vantage within one (1) business day of the procedure being performed. If Providers wish to confirm a particular authorization, they

may contact Medical Management at (888) 823-1910. The Provider should have the Member's Vantage identification number available and the prior authorization number (if available) at the time of the call.

Some services will require network Providers to request prior authorization from Vantage. The following list of services and procedures will require authorization from Vantage prior to the services being scheduled.

- All inpatient services
- Observation stays
- Specialist Office Visits (if greater than 4 in a calendar year)
- Referrals to referral centers (such as MDACC)
- Treatment provided by a non-Participating Provider (physician or hospital)
- Inpatient and outpatient Mental Health/Substance Abuse
- Outpatient services, including: Major Diagnostic Testing (MRI, CT Scan, Bone Scan, Angiogram, Arteriogram, PFT, Echocardiogram, CV, Stress Test, PET Scan, Home Infusion Therapy, EEG, EMG/NCS, Cardiac Event Monitor, HIDA Scan, Holter Monitor, Sleep Study, Nuclear Cardiac Stress Test)
- Home health, hospice care, infusion therapy, and private duty nurses
- Outpatient surgeries (ASU)
- Outpatient endoscopies and heart caths (ASU)
- DME and prosthetics
- Drugs (Specialty, Injectables excluding Insulin)
- Outpatient Therapy (Physical Therapy, Speech Therapy, Occupational Therapy)
- Cardiac rehabilitation
- Podiatry procedures
- Allergy testing and injections
- Radiation/Chemo therapy
- Audiology exams
- New technologies and procedures, including procedures without a current CPT code
- Unspecified procedure codes-CPT codes ending in xxx99
- Helicobacter pylori, breath test
- Corneal topography
- Ambulance transfers
- Skilled Nursing Facilities
- Rehabilitation Facilities
- Accidental Dental
- Anesthesia and Hospitalization for Dental procedures
- Low protein foods
- Hearing impaired interpreter
- Hearing aids
- Autism spectrum disorders (based on the Member Plan)
- Insulin pump
- Cochlear implant
- Breast reduction
- Pain management
- Subsequent bone density tests (other than screening)

The above list is illustrative and subject to change. Updates are faxed to Participating Providers as needed.

PLEASE NOTE: All services and supplies are subject to review for Medical Necessity with audits performed retrospectively. Benefit inclusions/exclusions must be considered in determining eligibility for coverage for individual cases. To determine if a service or supply, such as a cosmetic procedure, is considered a benefit

exclusion, please contact the Medical Management Department.

Coverage for a cosmetic procedure is not normally a covered benefit. Coverage is based on Medical Necessity. For example, a request for breast reduction must be reviewed and Medical Necessity met prior to being a covered benefit.

This applies to high-cost medications billed to Vantage, excluding chemotherapy medications. This does not apply to the pharmacy benefit.

Section 6.0 - Quality Improvement

6.1 Quality Improvement Program

All Providers are required to participate in the Vantage Quality Improvement (QI) Program. The Vantage QI program is central to achieving our mission of improving the health and quality of life of our Members. The goal of the QI Program is to link together the knowledge, structure, and processes throughout Vantage, as well as to assess and improve the quality of care and service for Members. Vantage utilizes quality improvement tools to assess and improve key processes and outcomes throughout the organization.

The objectives of the Vantage QI Program are:

- To continually monitor key clinical and service indicators.
- To analyze aggregate data on specific occurrences.
- To manage disease and health programs.
- To conduct outreach and health education activities.
- To develop programs for populations with special needs.
- To conduct intervention studies in clinical and service areas that were selected based on review of data.
- To perform appropriate oversight of delegated activities.
- To conduct Member and Provider satisfaction surveys.
- To coordinate activities related to structure and process with cross-functional areas to improve care and service.
- To foster an environment that assists to help Providers with improving the safety of their practices.
- To conduct oversight of risk management.
- To evaluate the effectiveness of the QI program.

6.2 Quality Review of Key Clinical and Service Indicators

One of Vantage's QI Program objectives is to perform a quality review of key clinical and service indicators to assess and improve Member and Provider satisfaction. These clinical and service indicators include review of:

- Hospital medical records
- Provider office medical records
- Inpatient utilization data
- Ambulatory care utilization data
- Diagnostic utilization
- Outcome studies analysis
- HEDIS data
- Quality Indicator studies
- Clinical guideline performance studies
- Claims data
- Member satisfaction surveys
- Provider satisfaction surveys
- Member complaints, grievances, and appeals
- Preventive medicine monitors

- Health risk assessment and screening monitors
- Member disenrollment data
- Peer case reviews
- Medicare studies
- Focused reviews
- Pharmacy utilization data

Vantage looks to its Providers to participate in quality improvement committees, special ad hoc work groups, and its medical records review activities to improve the health and quality of life for our Members.

The medical records of Vantage Members (Commercial, Marketplace, and Medicare Advantage) must be made available to Vantage for support of any of the above activities upon request.

6.3 Provider Credentialing

6.3.1 How Credentialing Works

Credentialing of those Providers who are requesting participation in Vantage is conducted by the Credentialing Committee. Vantage's Board of Directors has adopted the credentialing/re-credentialing standards of NCQA for its Providers. The objectives of credentialing are as follows:

- To ensure Participating Providers are qualified by training and experienced to deliver care in their declared field of medicine.
- To ensure Participating Providers are available and accessible to Members.
- To verify information regarding the applicant's license, training, and other information contained within their application.
- To allow peer review of the applicant's experience, physical and psychological health status, and reputation in the medical community.
- To re-credential all Participating Providers every three years.

6.3.2 Acceptance of New Physicians

6.3.2.1 The following criteria must be satisfactorily completed before an application can be presented to the Credentialing Committee for review.

1. Physicians must complete the Vantage application form, including execution of a release granting Vantage access to records of any medical society, medical board, College of medicine, hospital or other institutions, organizations or entities that do or may maintain records concerning the physician.
2. Physicians must sign and return the Participating Physician Agreement, thereby agreeing to abide by all applicable terms and conditions as a Vantage Provider.
3. Physicians must be licensed to practice medicine in the state in which they are treating Vantage Members.
4. Physicians shall be board eligible or board certified in the specialty noted on the application form. A. non-board certified or eligible physicians must be able to document sufficient training at a level that would be required for boards in the stated specialty; obtain a recommendation from their place of training that confirms qualifications in the stated specialty; show proof of continuing education hours as required by the American Medical Association; provide additional information upon request. Approval is at the discretion of the Vantage Credentialing Committee.
5. Physicians must have medical staff privileges at a hospital participating in Vantage's network or arrange for inpatient coverage that is acceptable to Vantage, excluding those physicians who practice solely at urgent treatment facilities.
6. Physicians must provide evidence of current liability and malpractice insurance in amounts acceptable to the Vantage Credentialing Committee.
7. Physicians must specify a Participating Physician, if at all possible, to take call.
8. Physicians must provide sufficient information concerning any malpractice actions, hospital privileges

that have been denied, rescinded, limited and/or suspended, hospital investigations or reviews, and/or felony convictions.

9. Any physician, who after being enrolled as a Vantage Participating Provider, subsequently resigns or is terminated from such panel, must be approved by the Vantage Board of Directors before he can be reinstated in the Vantage network.
10. Vantage Provider Relations Department shall provide the Credentialing Committee any pertinent information obtained from education, hospitals and medical society files, or applicant's background record of complaints, etc.
11. Physicians must notify Vantage of any investigation or actions from the Office of Inspector General or the Centers for Medicare and Medicaid Service (CMS) related to Medicare fraud and abuse or exclusion.
12. Physicians must have an established appointment system.
13. Physicians must have a method to distinguish among emergency, urgent, and routine cases:
    a. Emergencies are seen immediately
    b. Urgent cases are seen within twenty-four (24) hours.
    c. Routine, symptomatic cases are seen within 7 days.
14. Physicians should have a protocol whereby patients with appointments receive a professional evaluation within 30 minutes of scheduled appointment time. If a delay is unavoidable, patient is informed and provided an alternative.
15. Physicians must maintain current federal license if prescribing controlled substances or dispensing medications.
16. Physicians must meet Vantage Facility Review Criteria for acceptable facility review.

6.3.3 Review by Credentialing Committee

6.3.3.1 The application of a Provider to become a Vantage Participating Provider may be rejected or deferred for any of the following reasons:

1. The Provider has engaged in conduct that is in violation of state law or standards of ethical conduct governing the practice of medicine for which the Provider was, or could have been, disciplined, or otherwise censured, or the Provider is under investigation with respect to such conduct.
2. The Provider's application has been rejected by Vantage within the previous twelve (12) months or the physician has resigned or been terminated by Vantage within the previous twelve (12) months.
3. The Provider has committed a felony, misdemeanor, or other act involving moral turpitude, dishonesty, fraud, deceit or misrepresentation, or the physician is under investigation with respect to such conduct.
4. The Provider's general area of practice or specialty, in the opinion of the Vantage Credentialing Committee involves experimental or unproved modalities of treatment or therapy not widely accepted in the local medical community or involves a service not covered by Vantage under its Master Group Contracts.
5. The Provider has had restrictions placed on his/her practice by a hospital, medical review board, licensing board, or other similar body or government agency.
6. The Provider predominantly utilizes laboratory or x-ray facilities, which are not contracted with Vantage and/or practices in an area where the services of other Vantage Specialists and ancillary service Providers are not reasonably accessible to Vantage Members.
7. The Provider has failed to fully disclose/provide all information contained on the "application for membership" form and/or failed to complete the "authorization for release" form, which allows Vantage to request additional information.
8. Vantage had received unfavorable references or non-verification of training.
9. Any other circumstance in which the Credentialing or UR/QM Committee believes that acceptance of the applicant would not be in the best interest of Vantage.

6.3.4 Termination of Participating Providers

6.3.4.1 The Vantage Board of Directors or its designee may consider termination of a Participating Provider under any of the following circumstances:

1. The Provider has engaged in conduct that is in violation of state law or standards of ethical conduct governing the practice of medicine for which the Provider was, or could have been, disciplined or otherwise censured, or the Provider is under investigation with respect to such conduct.
2. The Provider has ceased to have medical staff privileges at a hospital participating in Vantage's network, regardless of whether cessation resulted from action taken by the Provider, hospital, or Vantage in terminating its relationship with the hospital, unless the Provider makes application to another participating hospital and is accepted.
3. The Provider's malpractice coverage status has become unsatisfactory to Vantage.
4. The Provider has committed a felony, misdemeanor, or other act involving moral turpitude, dishonesty, fraud, deceit or misrepresentation, or the Provider is under investigation with respect to any such conduct.
5. The Provider has submitted a false or intentionally erroneous claim to Vantage or to an entity having a contract with Vantage.
6. The Provider has had restrictions placed on his/her practice by a hospital, medical review board, licensing board or other similar body, or government agency.
7. The Provider has ceased use of a participating hospital for his/her regular practice and does not routinely make rounds at participating facilities.
8. Arbitrary refusal to treat a Vantage Member.
9. The Provider has failed, on three or more occasions, to observe Vantage's requirements regarding pre-admission authorization, referrals to non-Participating Providers, laboratories and x-ray facilities or other pertinent Vantage policy, procedure or protocol; or has breached any other material term of the participation agreement with Vantage.
10. Any other circumstance under which the Credentialing Committee believes that continued participation by the Provider would not be in the best interest of Vantage.
11. At any time that a state or federal agency revokes, suspends, terminates, or sanctions a Provider's network participation, Vantage is prohibited by law from employing or contracting with that individual or entity. Further, Vantage will not employ/contract with anyone who is excluded from participating in Medicare or with an entity that employs or contracts with such an excluded individual or entity for the provision of any healthcare, utilization review, medical social work or administrative services. In addition, Vantage will not contract with an individual or entity that has been sanctioned under any state or federal healthcare program.

6.4 Provider Sanctioning Policy

In the event Vantage identifies healthcare services rendered to a Vantage Member by a Participating Provider which are outside the recognized treatment patterns of the medical community and quality management and/or credentialing standards, the Provider may be subject to sanctions. The National Provider Data Bank (NPDB) may be notified of all negative outcomes if formal sanctioning proceedings are implemented and if the outcome is to last 30 days or more.

In addition to the above, Vantage's Medical Director may exclude a Provider under any of the following conditions, recommendations or as required by law:

- Medical Director has received recommendations to take such actions as a result of an investigation conducted by the Office of the Inspector General or other appropriate state and/or federal agency.
- The Provider fails to cooperate with an investigation of alleged fraud and abuse.
- The Provider has been listed on the Medicare/Medicaid Sanctions Report.
- Possible sanctions for deviation from accepted quality management and/or credentialing standards and program integrity violations include:
- Termination of Participating Provider status.

Section 7.0 - Claims

7.1 Participating Providers

Non-Facility

Participating Providers should submit claims to Vantage as soon as possible after a service is rendered, using the standard CMS-1500 Claim Form, UB-04, or electronically as discussed below. Services billed beyond 90 days from date of service are not eligible for reimbursement.

To expedite claims payment, identify the following items on your claims:

- Member name
- Member's date of birth and sex
- Member's Vantage ID number
- Group policy number if available
- Indication of: 1) job-related injury or illness, or 2) accident-related illness or injury, including pertinent details
- ICD-10 Diagnosis Codes
- CPT-4 Procedure Codes
- Date of services
- Charge for each service
- Provider's Tax Identification Number
- Name/address of Participating Provider
- Signature of Participating Provider providing services
- Place of Service Code
- CMG code (Rehab) – Hospital
- HIPPS code (Home Health) – Hospital
- CBSA code (Home Health) – Hospital
- ORG (Inpatient & LTAC & Psych) – Hospital
- (NPI) Provider Number – Physician and Hospital
- RUG code (SNF) – Hospital
- Discharge status – Hospital
- Conditions codes – Hospital
- Revenue code – Hospital

Vantage will process electronic claims consistent with the requirements for standard transactions set forth at 45 CFR Part 162. Any electronic claims submitted to Vantage should comply with those requirements.

Hospitals

Hospitals should submit claims to the Vantage claims address as soon as possible after service is rendered, using the standard UB-92 Form, UB-04 Form. Services billed beyond 90 days from date of service are not eligible for reimbursement.

To expedite claims payment, identify the following items on your claims:

- Member name
- Member's date of birth and sex
- Member's Vantage ID number
- Group policy number if available
- Indication of: 1) job-related injury or illness, or 2) accident-related illness or injury, including pertinent details
- ICD-10 Diagnosis Codes

- CPT-4 Procedure Codes
- Date of services
- Charge for each service
- Provider's Tax Identification Number
- Name/address of Participating Provider
- Signature of Participating Provider providing services
- Place of Service Code
- CMG code (Rehab) – Hospital
- HIPPS code (Home Health) – Hospital
- CBSA code (Home Health) – Hospital
- ORG (Inpatient & LTAC & Psych) – Hospital
- (NPI) Provider Number – Physician and Hospital
- RUG code (SNF) – Hospital
- Discharge status – Hospital
- Conditions codes – Hospital
- Revenue code – Hospital

7.2 Coordination of Benefits

If a Vantage-administered plan is a secondary payer, Physician agrees to bill the primary payer before billing the self-insured or Vantage. Billings to a Vantage-administered plan as a secondary payer must be accompanied by a summary of payments made by the primary payer. When the payments made by the primary payer are less than the negotiated rate set forth in the Provider's contract with Vantage, then the payments made by Vantage as a secondary payer shall be based on rates in accordance with this Agreement. Vantage shall pay a lesser of (1) the Member's responsibility as set forth in the primary payer's summary of payments or (2) Vantage's negotiated rates less the payment made by the primary payer. The combined amounts received by the Provider shall not exceed 100% of the negotiated rates specified herein. When payment by the primary payer is more than the negotiated rate, Vantage shall make no additional payments. At no time will the secondary payment be more than the Member's cost share, as determined by the primary payer. Services that are not covered by the primary payer will not be covered by Vantage unless an authorization was obtained from Vantage prior to the services being rendered.

7.3 Claim Payment Disputes

Vantage has established a Provider payment dispute process to resolve any underpayment, overpayment or no payment rendered on a claim *in which a member is not held financially liable. For information on the member appeal process including how to submit an appeal on behalf of a member, please see section 13.0.*

Vantage encourages Providers to contact our Provider Relations Department to discuss questions or concerns regarding Vantage's processing of a claim. If Vantage is not able to successfully resolve a Provider's concerns over the phone, Providers may follow the below procedures for filing a payment dispute. Requests for a payment dispute should be submitted in a formal letter and sent to:

Vantage Health Plan, Inc.
Attn: Appeals
130 DeSiard Street, Suite 300
Monroe, Louisiana 71201

Letters may also be faxed to (318) 361-2170/Attention: Appeals.

Please include the following:
1. The Member's name
2. The Member's ID
3. The claim number in dispute
4. The Provider's name
5. The authorization number (if applicable)
6. Your expected resolution to the dispute.
7. Any additional information you may feel is pertinent to our review of the claim.

Please do not submit a new claim with your appeal unless you would like to change, add or correct the original claim.

First Level of Review: Within sixty (60) calendar days of Vantage's receipt of the Provider's appeal, Vantage will review the matter and provide a decision based upon a thorough review of the Member's internal claims history, any information provided with the letter, and the terms of the Provider's contract.

Vantage places payment disputes into two categories: Filing Limit Issues and Non-Filing Limit issues. Each Provider contract should outline the timeframe for submitting your first level claim payment dispute. If a contract does not specify this information, please contact our Provider Relations Department to assist in determining the timeframe for submitting a first level review. Claim payment disputes received after the timeframe for filing an appeal will be dismissed for untimely filing.

Second Level of Review: If your appeal is regarding a denial you received for untimely filing of your claim OR if your appeal is received past the filing limit allowed for submitting an appeal, you will not be afforded a second level of review. For Non-Filing Limit issues, Vantage does provide a second level review. This will be conducted by a medical director who has not participated in the initial review. To request a second level of review, please follow the above instructions on submitting a payment dispute. The time frame for filing a second level of review is 90 calendar days from the first level appeal decision notification.

7.4 Electronic Data Interchange

7.4.1 Procedures for Electronic Submission

Electronic Data Interchange (EDI) allows faster, more efficient and cost-effective claim submission for Providers. EDI, performed in accordance with nationally recognized standards, supports the healthcare industry's efforts to reduce administrative costs.

The benefits of billing electronically include:
- Reduction of overhead and administrative costs. EDI eliminates the need for paper claim submission. It has also been proven to reduce claim rework (adjustments).
- Receipt of reports as proof-of-claim receipt. This makes it easier to track the status of claims.
- Faster transaction time for claims submitted electronically. An EDI claim averages about 24 to 48 hours from the time it is sent to the time it is received. This enables Providers to easily track their claims.
- Validation of data elements on the claim form. By the time a claim is successfully received electronically, information needed for processing is present. This reduces the chance of data entry errors that occur when completing paper claim forms.
- Quicker claim completion. Claims that do not need additional investigation are generally processed quicker.

All the same requirements for paper claim filing apply to electronic claim filing.

Listed below is a description of the procedures for electronic submission for hospital and medical claims. Included are a high level description of claims and report process flows, information on unique electronic billing requirements, and various electronic submission exclusions.

7.4.2 Hardware and Software Requirements

Many different products can be used to bill electronically. As long as you have the capability to send EDI claims to Emdeon® (formerly WebMD), whether through direct submission or through another clearinghouse/ vendor, you can submit claims electronically to Vantage.

7.4.3 Contracting with Emdeon and Other Electronic Vendors

If you are interested in submitting claims to Vantage electronically but do not currently have EDI capabilities, you can contact the Emdeon Sales Department at 877-469-3263 option 3. You may also choose to contract with another EDI clearinghouse or vendor who already has Emdeon capabilities.

7.4.4 Contracting the EDI Technical Support Group

Certification Requirements

After the registration process is completed and you have received all of your certification material, proceed as follows:

- Read over the instructions carefully, with special attention to the information on exclusions, limitations, and especially, the rejection notification reports.
- Contact your system vendor and/or Emdeon to inform them you wish to initiate electronic submissions to Vantage.

Be prepared to inform the vendor of Vantage's electronic payer identification number. **(72128)**

7.4.5 Specific Data Record Requirements

Claims transmitted electronically must contain all the same data elements identified within this Section. Emdeon or any other EDI clearinghouse or vendor may require additional data record requirements.

7.4.6 Electronic Claim Flow Description

To send claims electronically to Vantage, all EDI claims must first be forwarded to Emdeon. This can be completed via a direct submission or through another EDI clearinghouse or vendor.

Once Emdeon receives the transmitted claims, they are validated against Emdeon's proprietary specifications and Vantage's specific requirements. Claims not meeting the requirements are immediately rejected and returned to the sender via an Emdeon error report. The name of this report can vary based on the Provider's/ Practitioner's contract with its intermediate EDI vendor or Emdeon. Accepted claims are passed to Vantage and Emdeon returns an acceptance report to the sender immediately.

Providers are responsible for verification of EDI claim receipts. Acknowledgments for accepted or rejected claims received from Emdeon or other contracted vendors must be reviewed and validated against transmittal records daily.

Claims containing valid Provider identification numbers are also validated against Member eligibility records before acceptance by Vantage. If a patient cannot be identified as a Vantage Member, a denial letter will be forwarded directly to the Provider. This letter is sent to the payment address documented in Vantage's Provider file. Claims passing eligibility requirements are then passed to the claim processing queues. Claims are not considered as received under timely filing guidelines if rejected or missing or invalid Member data.

Since Emdeon returns acceptance reports directly to the sender, submitted claims not accepted by Emdeon are not transmitted to Vantage.

- If you would like assistance in resolving submission issues reflected on either the Acceptance or R059 Plan Acceptance (Claim Status) reports, contact the Emdeon Helpdesk at 800-845-6592.

7.4.7 Invalid Electronic Claim Record Rejections / Denials

All claim records sent to Vantage must first pass Emdeon proprietary edits and specific edits prior to acceptance. Claim records that do not pass these edits are invalid and will be rejected without being recognized as received by Vantage. In these cases, the claim must be corrected and resubmitted within the required electronic filing deadline of 25 calendar days from the date of service. It is important that you review the rejection notices (the functional acknowledgments to each transaction set) received from Emdeon in order to identify and resubmit these claims accurately.

Rejected electronic claims may be resubmitted electronically once the error has been corrected.

7.5 Balance Billing

You may not balance bill a Member for a non-covered service unless:

1. You have informed the Member in advance that the service is not covered.
2. The Member has agreed in writing to pay for the services if they are not covered.
3. The service is not a covered benefit.
4. The benefit limit is exceeded.

Common Rejections

Invalid Claim Records - Common Rejections from Emdeon
▪ Claims with missing or invalid batch level records
▪ Claim records with missing or invalid required fields
▪ Claim records with invalid (unlisted, discontinued, etc.) codes (CTP-4, HCPCS, ICD-10, etc.)
▪ Claims without NPI numbers
▪ Claims without Member numbers

7.5.2 Electronic Billing Inquiries

Please direct inquiries as follows:

Action	Contact
If you have specific EDI technical questions,	Contact EDI Technical Support At: 877-234-4275
If you have general EDI questions or questions on where to enter required data,	Contact EDI Technical Support At: 877-234-4275
If you have questions about you claims transmissions or status reports,	Contact your System Vendor, call the Emdeon Corporations Help Desk at 800-845-6592, or access Emdeon's web site, *www.emdeon.com*
If you have questions about your claim status (receipt of completion dates),	Contact Provider Claim Services at: 800-578-0775
If you have questions about claims that are required on the Remittance Advice,	Contact Provider Claim Services at: 800-578-0775
If you need to know a Provider ID number,	Contact Provider Claim Services at: 800-578-0775
If you would like to update Provider, payee, UPIN, Tax ID number, or payment address information, for questions about changing or verifying Provider's information,	Notify your Provider representative in writing at: **Vantage Health Plan, Inc.** **Provider Services** **130 DeSiard St., Suite 300** **Monroe, LA 71201** **or by Fax: 318-807-1116** **or by Telephone: 318-361-0900 option "3"**

Section 8.0 Beneficiary Protections

8.1 Services of Non-Contracting Providers

Vantage may, subject to its sole discretion, make payment to or on behalf of a Member for services obtained from a Provider or supplier which does not contract with Vantage.

These services may include emergency and urgently needed services. An emergency medical service is a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, that would lead a prudent layperson, acting reasonably and possessing an average knowledge of health and medicine, to believe that the absence of immediate medical attention could reasonably be expected to result in the serious jeopardy of one's health or the health of an unborn child, serious impairment of bodily function, or serious dysfunction of any bodily organ or part.

8.2 Basic Benefits

1. **Direct access to women's in-network health covered services**
   Vantage does not require referral forms or prior authorization for OB/GYN visits, screening mammograms, or influenza vaccinations. No copayments are required for influenza and pneumococcal vaccines.
2. **Health assessment**
   Primary Care Providers (PCPs) will conduct a health assessment of new enrollees who make an appointment within ninety days of the effective date of enrollment.
3. **24 hour service**
   Physicians agree to maintain necessary and appropriate arrangements with other physicians of the same

specialty to assure the availability of covered services to his/her patients on a 24 hours per day, seven days per week basis, including arrangements to assure coverage after hours or when physician is otherwise absent.

4. **Cultural consideration**
   Vantage will ensure that services are provided in a culturally competent manner to all enrollees, including those with limited English proficiency or reading skills and diverse cultural and ethnic backgrounds. The Louisiana Translation Service is available at (888) 294-3032. TTY services are available by calling 711.
5. **Benefit standards**
   Vantage will assure that covered benefits are consistent with professionally recognized standards of healthcare.
6. **Declarations (Advance Directives)**
   Providers will provide written information to Members with respect to their rights under the law of Louisiana 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. Declarations, which are discussed in detail in Section 3.5.3, must be documented in Members records.
7. **Member choice**
   Vantage will disclose all information necessary to administer and evaluate the program, and establish and facilitate a process for current and prospective Members to exercise choice in obtaining services. Vantage will provide on an annual basis and in a format and using standard terminology information necessary to enable potential Members the information they need to make informed decisions with respect to available choices for coverage.
8. **Changes to Provider Network**
   Vantage will 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 Members who are patients seen on a regular basis by the Provider whose contract is terminated, irrespective of whether the termination was for cause or without cause. When a contract termination involves a primary care professional, all reasonable efforts will be made to notify Members who are patients of that primary care professional.
9. **Member Satisfaction**
   Vantage will mail surveys to Members to determine Member satisfaction.

9.0 - Prior Authorization

Required By Primary Care Providers & Specialists

Participating providers must obtain pre-authorizations in order for certain benefits to be eligible for payment. Please call Vantage Medical Management at (318) 361-0900 Option "2" or (888) 823-1910 to receive authorization. You may submit a faxed request to (318) 361-2170 listing the procedure to be performed and the clinical data indicating medical necessity for the procedure. The Medical Management Department will review the request and notify your office and/or the requesting provider of the decision.

The following services require pre-authorization before the services are scheduled:

- All inpatient services
- Observation stays
- Specialist Office Visits (if greater than 4 per calendar year.)
- Referrals to referral centers (such as MDACC)
- Treatment provided by a non-participating provider (physician or hospital)
- Inpatient and outpatient Mental Health/Substance Abuse
- Outpatient services
- Major diagnostic testing (MRI, CT Scan, Bone Scan, Angiogram, Arteriogram, PFT, Echocardiogram, CV Stress Test, PET Scan, Home Infusion Therapy, EEG, EMG/NCS, Cardiac Event Monitor, HIDA Scan, Holter Monitor, Sleep Study, Nuclear Cardiac Stress Test)
- Home health, hospice care, infusion therapy, and private duty nurses
- Outpatient surgeries (ASU)
- Outpatient endoscopies and heart caths (ASU)
- DME and prosthetics
- Drugs (Specialty, Injectables excluding Insulin)
- Outpatient Therapy (Physical Therapy, Speech Therapy, Occupational Therapy)
- Cardiac rehabilitation
- Podiatry procedures
- Allergy testing and injections
- Radiation/Chemo therapy
- Audiology exams
- New technologies and procedures, including procedures without a current CPT code
- Unspecified procedure codes-CPT codes ending in xxx99
- Helicobacter pylori, breath test
- Corneal topography
- Ambulance transfers
- Skilled Nursing Facilities
- Rehabilitation Facilities
- Accidental Dental
- Anesthesia and Hospitalization for Dental procedures
- Low protein foods
- Hearing impaired interpreter
- Hearing aids
- Autism spectrum disorders (based on the Member Plan)
- Insulin pump
- Cochlear implant
- Breast reduction
- Pain management
- Subsequent bone density tests (other than screening)

The above list is illustrative and subject to change. Updates are faxed to Participating Providers as needed.

Section 9.1 - Sample Forms

Authorization Fax Form

130 DeSiard Street, Ste.300 Monroe, LA 71201 Ph. 318-361-0900 Fax 318-361-2170

PRIOR AUTHORIZATION FORM

Date: _____
To: Medical Management Department
Fax Number: 318-361-2170

Provider's Name: _____

Fax #: _____

Pt. Name: _____
Insured ID:
☐ Medicare
☐ Commercial
☐ Marketplace

Phone Number: _____

Contact: _____

Pt. DOB: _____ Age: _____

PCP: _____

Date of Service: _____

Prior Authorization #: _____

Ordering MD: _____

[ ] Outpatient [ ] Inpatient

Provider's NPI: _____

Place of Service: _____

Facility NPI: _____

Diagnosis: _____

ICD-10 Code: _____

_____

_____

Procedure to be performed: _____

CPT codes to be billed: _____

HCPC codes to be billed: _____

Attachments are to be included at all times, when available:

[ ] Diagnostic Procedures: Clinical Notes or Diagnostic Reports for procedure /surgery
[ ] Admission: Clinical for planned admissions
[ ] DME: Physician's Order, CMN, Sleep Study, Compliance Report, Clinical Notes
[ ] DME: Date of Service when equipment was issued to patient:
[ ] Therapy: Physician's Order, Evaluation, or Clinical notes

For EXPEDITED REVIEW [72 HOURS] REQUEST ONLY:

BY SIGNING BELOW, I AM REQUESTING AN EXPEDITED REVIEW AND CERTIFYING THAT APPLYING THE STANDARD REVIEW TIME FRAME MAY SERIOUSLY JEOPARDIZE THE LIFE OR HEALTH OF THE MEMBER OR THE MEMBER'S ABILITY TO REGAIN MAXIMUM FUNCTION

SIGNATURE OF PROVIDER: _____

Request for Authorization of Behavioral Health Services

Provider Name: _____

Provider Phone: _____ Provider Fax: _____

Member Name: _____ Member Date of Birth: _____

Vantage Member ID: _____

Type of service requested:

- ☐ Inpatient
- ☐ PHP
- ☐ IOP
- ☐ Outpatient Therapy
- ☐ Psychological Testing
- ☐ Medication Management
- ☐ Substance Abuse Detoxification
- ☐ ABA Therapy

Number of service days/units requested: _____

Frequency of scheduled service for all Outpatient services (IOP/PHP): _____

_____

Ex: 8 counseling sessions @ 1/wk; 6 IOP days @ 3 days/wk; etc.)

Admit Date/Time: _____

Reason for Admission: _____

Diagnoses: _____

If previous services authorized, what was the date of the last authorized session? _____

Anticipated length of service/projected discharge date: _____

CPT code(s) to be billed: _____

PLEASE PROVIDE THE FOLLOWING WITH THIS REQUEST:

- All available evaluations conducted since the previous request. This includes, but is not limited to the following: nursing, psychiatric, psychosocial, and medical evaluations.
- Clinical progress notes completed since the previous review (do not resubmit documentation submitted w/previous requests).
- Page 2 of this request must be completed and submitted in addition to the documentation identified above for concurrent reviews.

NOTE: Requests must be submitted by 12 P.M. to allow adequate time for processing and review. Requests received after 12 P.M. Mon – Fri, may not receive a response until the next business day.

What interventions have already been provided to assist the member with development of knowledge, skills, and community supports to maintain and continue ongoing progress following discharge?

How do you plan to use the additional requested services to help the member develop skills and natural/ community based supports to maintain progress upon discharge from treatment?

Other information supporting need for continued services: (Attach supporting documentation)
NOTE: Documentation supporting ASAM level of care MUST be included with requests for Substance Abuse Treatment.

Request for Authorization and supporting documentation should be faxed to (318) 812-7208.
Behavioral Health Phone Number: (318) 998-3904.

Vantage Health Plan, Inc.

130 DeSiard Street, Suite 300

Monroe, Louisiana 71201

HOME HEALTH CERTIFICATION

(Commercial/Exchange) **Fax 1-318-812-7331**

PATIENT INFORMATION

Home Health Agency: _____

Name of Contact: _____ Phone no. _____

Date Submitted: _____ Initial SOC: _____

Patient's Name: _____

ID No. _____ Patient's DOB: _____

Primary Care MD: _____ Ordering MD: _____

Primary Dx: _____ 1st Secondary Dx: _____

Date of last MD visit related to Primary Dx: _____ ****REQUIRED!****

Certification period/date requesting: _____ Initial ☐ Recert ☐

Skilled Service and frequency requested: _____

_____

_____

_____

****Additional therapy visits requested after the initial authorization approval will require re-assessment documentation of progress toward goals before further visits are approved. *****

GIVE A DESCRIPTION OF THE PATIENT'S HOMEBOUND STATUS ALONG WITH THE NEED FOR THE REQUESTED SKILLED SERVICES RELATED TO THE PRIMARY DIAGNOSIS: **REQUIRED**

_____

_____

_____

_____

_____

_____

_____

_____

Home Health Nurse Signature: _____

HOME HEALTH CERTIFICATION

(MEDICARE ONLY) FAX: 1-318-812-7331

PATIENT INFORMATION

Home Health Agency: _____

Name of Contact: _____ Phone no. _____

Date Submitted: _____ Initial SOC: _____

Patient's Name: _____

ID No. _____ Patient's DOB: _____

Primary Care MD: _____ Ordering MD: _____

Primary Dx: _____ 1st Secondary Dx: _____

Date of last MD visit related to Primary Dx: _____ ****REQUIRED!****

Certification period/date requesting: _____ Initial ☐ Recert ☐

HHRG Score (REQUIRED): _____

Skilled Service and frequency requested: _____

_____

Pursuant to Federal Guidelines for reimbursement, the number of therapy visits greater than thirteen (13) will require re-assessment and documentation before further visits are approved.

GIVE A DESCRIPTION OF THE PATIENT'S HOMEBOUND STATUS ALONG WITH THE NEED FOR THE REQUESTED SKILLED SERVICES RELATED TO THE PRIMARY DIAGNOSIS: **REQUIRED!**

_____

_____

_____

_____

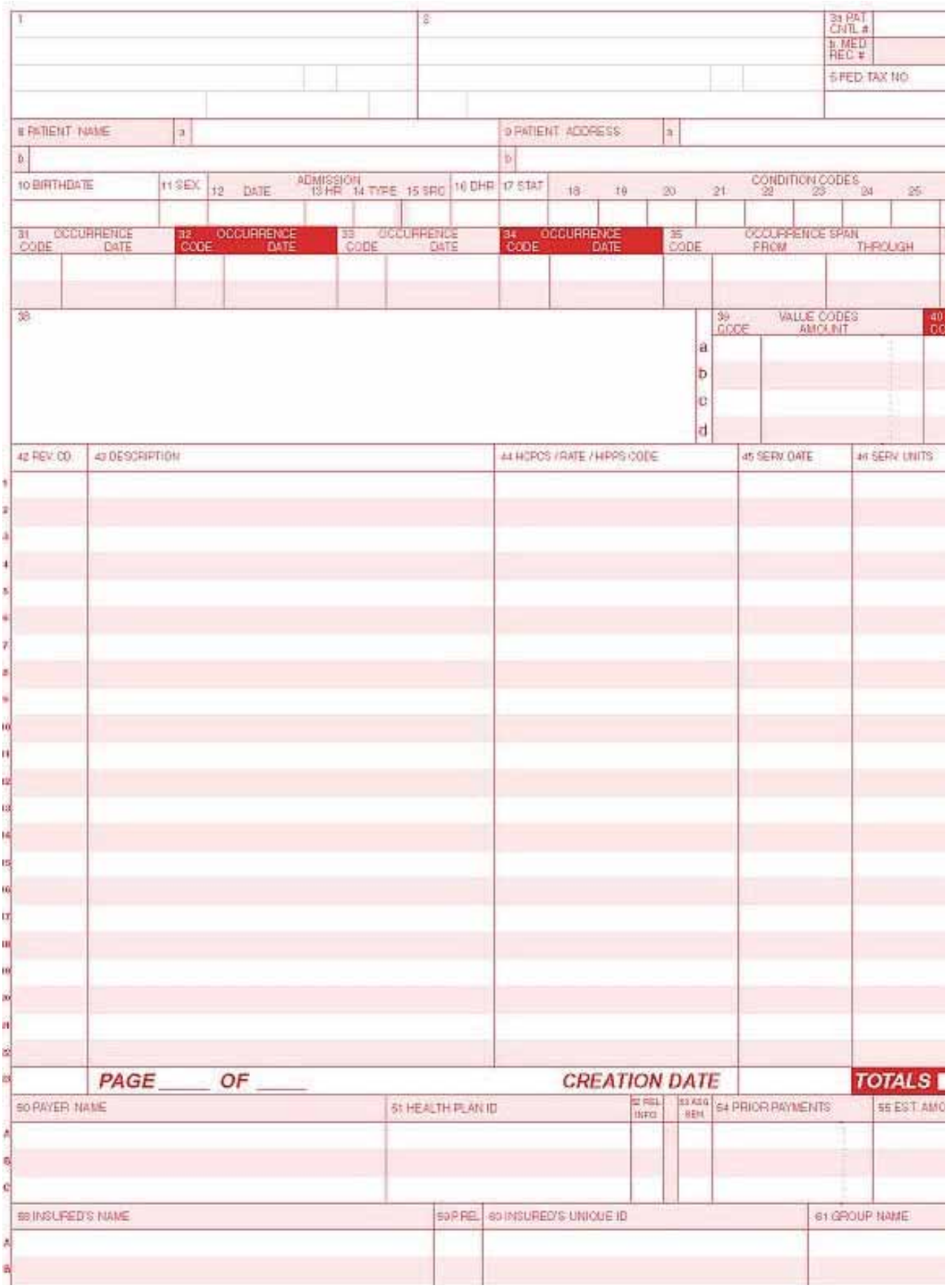
_____

_____

_____

Home Health Nurse Signature: _____

9.2 Sample UB-04 Form



9.3 Sample CMS 1500 Form

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

PICA

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

1. MEDICARE (Medicare#) MEDICAID (Medicaid#) TRICARE (ID#/DoD#) CHAMPVA (Member ID#) GROUP HEALTH PLAN (ID#) FECA BLK LUNG (ID#) OTHER (ID#)		1a. INSURED'S I.D. NUMBER (For Program in Item 1)
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE MM DD YY SEX M F	4. INSURED'S NAME (Last Name, First Name, Middle Initial)
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other	7. INSURED'S ADDRESS (No., Street)
CITY / STATE	8. RESERVED FOR NUCC USE	CITY / STATE
ZIP CODE / TELEPHONE (Include Area Code)		ZIP CODE / TELEPHONE (Include Area Code)
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA NUMBER
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous) YES NO	a. INSURED'S DATE OF BIRTH MM DD YY SEX M F
b. RESERVED FOR NUCC USE	b. AUTO ACCIDENT? YES NO PLACE (State)	b. OTHER CLAIM ID (Designated by NUCC)
c. RESERVED FOR NUCC USE	c. OTHER ACCIDENT? YES NO	c. INSURANCE PLAN NAME OR PROGRAM NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. CLAIM CODES (Designated by NUCC)	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes*, complete items 9, 9a, and 9d.
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM. 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED DATE		13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.	15. OTHER DATE QUAL. MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM MM DD YY TO
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. 17b. NPI	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM MM DD YY TO
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		20. OUTSIDE LAB? YES NO $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. A. B. C. D. E. F. G. H. I. J. K. L.		22. RESUBMISSION CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1								NPI	
2								NPI	
3								NPI	
4								NPI	
5								NPI	
6								NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO	28. TOTAL CHARGE $
29. AMOUNT PAID $	30. Rsvd for NUCC Use		
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) SIGNED DATE	32. SERVICE FACILITY LOCATION INFORMATION a. b.		33. BILLING PROVIDER INFO & PH # ( ) a. b.

NUCC Instruction Manual available at: www.nucc.org **PLEASE PRINT OR TYPE** APPROVED OMB-0938-1197 FORM 1500 (02-12)

9.4 Medicare Part D Coverage Determination Request Form

Plan Name _____
Phone # _____
Fax # _____

Medicare Part D Coverage Determination Request Form

This form cannot be used to request:

- Medicare non-covered drugs, including barbiturates, benzodiazepines, fertility drugs, drugs prescribed for weight loss, weight gain or hair growth, over-the-counter drugs, or prescription vitamins (except prenatal vitamins and fluoride preparations).
- Biotech or other specialty drugs for which drug-specific forms are required. [See <Part D plan website.>] OR [See links to plan websites at http://www.cms.hhs.gov/PrescriptionDrugCovGenIn/04_Formulary.asp]

Patient Information		Prescriber Information		
Patient Name:		Prescriber Name:		
Member ID#:		NPI# (if available):		
Address:		Address:		
City:	State:	City:		State:
Home Phone:	Zip:	Office Phone #:	Office Fax #:	Zip:
Sex (circle): M F	DOB:	Contact Person:		

Diagnosis and Medical Information		
Medication:	Strength and Route of Administration:	Frequency:
☐ New Prescription OR Date Therapy Initiated:	Expected Length of Therapy:	Qty:
Height/Weight:	Drug Allergies:	Diagnosis:
Prescriber's Signature:		Date:

Rationale for Exception Request or Prior Authorization
FORM CANNOT BE PROCESSED WITHOUT REQUIRED EXPLANATION

- ☐ Alternate drug(s) contraindicated or previously tried, but with adverse outcome (eg, toxicity, allergy, or therapeutic failure)
  - ☞ Specify below: (1) Drug(s) contraindicated or tried; (2) adverse outcome for each; (3) if therapeutic failure, length of therapy on each drug(s);
- ☐ Complex patient with one or more chronic conditions (including, for example, psychiatric condition, diabetes) is stable on current drug(s); high risk of significant adverse clinical outcome with medication change
  - ☞ Specify below: Anticipated significant adverse clinical outcome
- ☐ Medical need for different dosage form and/or higher dosage
  - ☞ Specify below: (1) Dosage form(s) and/or dosage(s) tried; (2) explain medical reason
- ☐ Request for formulary tier exception
  - ☞ Specify below: (1) Formulary or preferred drugs contraindicated or tried and failed, or tried and not as effective as requested drug; (2) if therapeutic failure, length of therapy on each drug and adverse outcome; (3) if not as effective, length of therapy on each drug and outcome
- ☐ Other:_____ ☞ Explain below

REQUIRED EXPLANATION:_____
_____

Request for Expedited Review

- ☐ REQUEST FOR EXPEDITED REVIEW [24 HOURS]
  - ☞ BY CHECKING THIS BOX AND SIGNING ABOVE, I CERTIFY THAT APPLYING THE 72 HOUR STANDARD REVIEW TIME FRAME MAY SERIOUSLY JEOPARDIZE THE LIFE OR HEALTH OF THE MEMBER OR THE MEMBER'S ABILITY TO REGAIN MAXIMUM FUNCTION

Information on this form is protected health information and subject to all privacy and security regulations under HIPAA.

COMMERCIAL

Section 10.0 – Commercial Product Overview

This manual contains information about Vantage's Commercial products. If you have any questions about Vantage products, please call Provider Relations at (318) 361-0900 option "3".

10.1 HMO

The Vantage HMO plan is a health plan sold to large employer groups. Members must select a MH-PCP at enrollment who is a Participating Provider in the Vantage network. The designated MH-PCP coordinates the Member's care and services.

10.1.1 Medical Home Primary Care Provider

- Vantage HMO Members have a copayment amount that covers their entire MH-PCP office visit. The copayment amount is listed on the Member's ID card.
- Emergency treatment should never be delayed and does not require authorization in or out-of-network.
- A service by a non-participating Provider MUST have pre-authorization from the Vantage Medical Management Department. Authorizations can be obtained by calling (318) 361-0900 option "2".

10.1.2 Specialist Physician Responsibilities

- If more than four (4) visits are needed by a Specialist within twelve (12) months, his/her office may call Medical Management at (318) 361-0900 for additional visits.
- Most Commercial Members have coverage for a routine eye exam per twelve-month benefit period. The Specialist co-pay shown on the Member's ID card applies; however, the routine eye exam is not subject to the HMO Plan deductible, if any.
- NO COPAY for an annual diabetic eye exam performed by a participating ophthalmologist or optometrist.
- A service by a non-participating Provider MUST have prior authorization from the Vantage Medical Management Department (318 361-0900,) option 2.
- The participating Specialist may refer the Member to another participating Specialist.

10.1.3 Major Diagnostic Testing

- Major diagnostic services are covered at 100% of the Vantage allowable less applicable major diagnostic copayment whether the test is performed in the Provider's office or in an outpatient setting.
- Pre-authorization is required for major diagnostic testing to be covered. Major diagnostic tests include bone scan, cardiac stress test, CAT scan, echocardiogram, EEG, event monitor, HIDA scan, holter monitor, MRI, nerve conduction study, nuclear cardiac stress test, nuclear medicine test, PET scan, pulmonary function test, sleep study. (This list is illustrative and subject to change.)

10.2 Freedom

The Freedom Plan is a Point of Service (POS) product that does have a deductible and out-of-network benefits. The Freedom Plan is sold to large employer groups.

10.2.1 Freedom Plan Highlights

- Vantage Freedom Members have a copayment amount that covers the entire office visit as well as separate copayments for inpatient, outpatient, ER visits, and major diagnostic testing.
- **Deductibles do not apply to: office visits, most labs, screening mammograms, annual prostate exams, annual pap smears, initial bone density tests, and one routine eye exam per benefit period.**
- Deductibles do apply to all other services.
- Deductible amount is noted on the Member ID card and may be per Member or a family amount.

10.2.2 Out-of-Network Benefit

- All out-of-network benefits are subject to a deductible.
- Out-of-network coinsurance is a percentage of the Vantage allowable and is noted on the Cost Share schedule.
- Deductible amount is noted on the Member ID card and may be per Member or a family amount.
- Supplementary benefits are not covered out-of-network.

You may call Vantage Member Services Department to check the status of the Member's deductible at (318) 361-0900, option 1.

10.3 High Deductible Plans

The High Deductible Plan is a Health Savings Account (HSA) qualified plan that is offered to large employer groups. The deductible and out-of-pocket maximum amounts for these plans are higher than Vantage's other products and the High Deductible Plans do not use copays.

Health Savings Account (HSA) Qualified Plans:

- Deductible included in out-of-pocket maximums
- Some medical and all drug costs accumulate to higher IRS Max
- Medical and drug expenses accumulate together toward the deductible

10.4 Metal Tier Plans (Health Insurance Marketplace)

The Metal Tier plans are a line of plans which became available effective January 1, 2014. These plans were created in response to the passing of the Affordable Care Act (ACA) on March 23, 2010 and are ACA-compliant. These plans are designed to provide comprehensive healthcare coverage with a focus on preventive care and wellness. These plans include dental and vision coverage. The plans are offered to individuals and small employer groups (under 50 employees), and are available for purchase through the Centers for Medicare and Medicaid (CMS) and the website *www.healthcare.gov*, or directly through Vantage. All Metal Tier Plans include out-of-network coverage.

1. **Platinum Plan**
   - No in-network medical deductible.
   - Lowest office visit and facility copays
   - Drug coverage included in the out-of-pocket maximum

2. **Gold and Silver Plans**
   - Gold: $750 in-network medical deductible
   - Silver: $2,400 in-network medical deductible
   - Medical deductible applies toward the out-of-pocket maximum
   - Drug coverage included in the out-of-pocket maximum

3. **Bronze Plan**
   - High Deductible Plan with office visit co-pays.
   - In-Network Medical abd drug costs apply to the deductible, excluding office visits and wellness
   - Not HSA qualified

4. **Savings Plan**
   - HSA-qualified plan
   - In-Network medical & drug costs apply to the deductible

10.5 Cost Share Reduction Plans

The Cost Share Reduction (CSR) plans are available to those Members who purchase coverage through CMS and are eligible for a subsidy to assist with the cost of healthcare. This subsidy decreases out-of-pocket maximums and reduces deductibles and cost shares. There are three (3) CSR plans available:

- Silver 73 Select: Standard Silver Plan with lower out-of-pocket maximums
- Silver 87 Basic: Lower deductible and reduced cost shares for the Member
- Silver 94 Value: Lowest deductible and lowest cost shares for the Member

Section 11.0 Commercial Inpatient/Outpatient Services

11.1 Acute Inpatient Admissions

All inpatient admissions require prior authorization from Vantage's Medical Management Department. The authorization process for admissions is typically carried out by hospital personnel through their Case Managers. Vantage's In Patient Case Management Nurses are the direct point of contact for conducting this process.

Vantage's Inpatient Case Management Nurses, in coordination with admitting physicians and hospital-based physicians (hospitalists), will be in charge of coordinating and conducting continued stay reviews, providing appropriate referrals for extended care facilities, and coordinating all services required for adequate discharge. The Inpatient Case Management Nurses will be of assistance in coordinating all services identified as necessary in the discharge planning process, as well as coordinating the required follow-up by the corresponding PCP.

For continuity of care, PCP's or the admitting hospital facilities should notify Vantage if they are admitting a Vantage Member to a hospital or any other inpatient facility, including but not limited to Skilled Nursing facilities, Rehabilitation facilities, and LTAC facilities.

To notify Vantage of an admission, the PCP or the admitting hospital should call Vantage and provide the following information:

- Notifying PCP or hospital
- Case Manager/contact name and phone/fax number
- Member's name, sex, and Vantage Member ID number
- Name of admitting PCP
- Admitting facility
- Primary diagnosis
- Reason for admission

11.2 Outpatient Services

Participating Providers must obtain prior authorizations for certain benefits to be eligible for payment. The UM Department hours of operation are Monday through Friday, 8:00 a.m. to 5:00 p.m. CST, (except designated holidays). The UM Department can be reached at (888) 823-1910. For additional prior authorization information and an illustrative list please refer to Section 5.0 in this manual.

11.3 Review Notifications

Vantage will meet all regulatory standards for the amount of time allowed to process authorization requests. Vantage will make utilization decisions in a timely manner and accommodate the urgency of individual situations. This policy applies to all decisions whether they are made on the basis of benefits or Medical Necessity unless otherwise noted.

Provider and Member Notification

Providers and Members are notified in writing of all authorization determinations according to required time frames for all standard and expedited requests (see below). Providers are notified via phone and mail for all determinations and by fax, if requested, or in the case of inpatient services. Members receive notification via mail for all determinations.

		Notification Time-frame	
Type of Request	**Decision Time frames & Delay Notice Requirements**	**Notification of Decision (Notification May Be Oral and/ or Electronic / Written)**	**Written/Electronic Notification**
Urgent Pre-Service - All necessary information received at time of initial request	Decision must be made in a timely fashion appropriate for the Member's condition **not to exceed 72 hours after receipt of the request.**	Within 72 hours of receipt of the request. Document date and time of oral notifications.	If oral notification is given within 72 hours of receipt of the request, written or electronic notification must be given no later than 3 calendar days after the initial oral notification.
Urgent Pre-Service - Extension Needed • Additional clinical information required	Additional clinical information required: Notify Member and Practitioner within 24 hours of receipt of request & provide 48 hours for submission of requested information.		
	Additional information received or incomplete: If additional information is received, complete or not, decision must be made within 48 hours of receipt of information. Note: **Decision must be made in a timely fashion appropriate for the Member's condition not to exceed 48 hours after receipt of information.**	*Additional information received or incomplete* Within 48 hours after receipt of information (for approvals and denials). Document date and time of oral notifications.	*Additional information received or incomplete* Within 48 hours after receipt of information. Note: If oral notification is given, written or electronic notification must be given no later than 3 calendar days after the initial oral notification.
	Additional information not received: If no additional information is received within the 48 hours given to the Practitioner and Member to supply the information, decision must be made with the information that is available within an additional 48 hours. Note: Decision must be made in a timely fashion appropriate for the Member's condition not to exceed 48 hours after the deadline for extension has ended.	*Additional information not received.* Member: Within 48 hours after the time-frame given to the Practitioner and Member to supply the information. Document date and time of oral notifications.	*Additional information not received* Within 48 hours after the time-frame given to the Practitioner and Member to supply the information. Note: If oral notification is given, written or electronic notification must be given no later than 3 calendar days after the initial oral notification.

Type of Request	Decision Time frames & Delay Notice Requirements	Notification Timeline	
Urgent Concurrent - (i.e., inpatient, ongoing/ambulatory services) Request involving both urgent care and the extension of a course of treatment beyond the period of time or number of treatments previously approved and the request is made at least 24 hours prior to the expiration of prescribed period of time or number of treatments. **Exceptions:** • If the request is not made at least 24 hours prior to the expiration of prescribed period of time or number of treatments, and request is urgent, default to *Urgent Pre-service* category. • If the request to extend a course of treatment beyond the period of time, or number of treatments previously approved by Vantage does not involve urgent care, default to *Non –urgent Pre-service* category.	Within 24 hours of receipt of the request.	Within 24 hours of receipt of the request.	Within 24 hours of receipt of the request. **Note:** If oral notification is given within 24 hours of request, written or electronic notification must be given no later than one (1) working day after the oral notification.
Non-urgent Pre-Service - All necessary information received at time of initial request	Decision must be made in a timely fashion appropriate for the Member's condition not to exceed 15 calendar days of receipt of request. In no less than 80% of initial determinations—within (2) working days.	Within one (1) working day of the decision.	Within five (5) working days of the decision.

Non-urgent Pre-Service - Extension Needed • Additional clinical information required • Require consultation by an Expert Reviewer	Additional clinical information required: Notify Member and Practitioner within two (2) working days of receipt of request & provide at least 45 calendar days for submission of requested information.		
	Additional information received or incomplete: **If additional information is received, complete or not, decision must be made in a timely fashion as appropriate for Member's condition not to exceed one (1) working day of receipt of information.**	Within one (1) working day of the decision.	Within one (1) working day of making the decision.
	Additional information not received If no additional information is received within the 45 calendar days given to the Practitioner and Member to supply the information, decision must be made with the information that is available in a timely fashion as appropriate for Member's condition not to exceed an additional one (1) working day.		
	Require consultation by an Expert Reviewer: Upon the expiration of the 5 business days or as soon as you become aware that you will not meet the 5 business day time-frame, whichever occurs first, notify Practitioner and Member of the type of expert reviewer required and the anticipated date on which a decision will be rendered.		

	Require consultation by an Expert Reviewer: Decision must be made in a timely fashion as appropriate for the Member's condition within 5 business days of obtaining expert review, not to exceed 15 calendar days from the date of the delay notice to the Practitioner and Member.	***Require consultation by an Expert Reviewer:*** Practitioner: Within 24 hours of the decision (for approvals and denials). Member: Within 2 business days of the decision (for approval decisions).	***Require consultation by an Expert Reviewer:*** **Within 2 business days of making the decision.**
Post-Service - All necessary information received at time of request (decision and notification is required within 30 calendar days from request)	Within 30 calendar days of receipt of request.	Within 30 calendar days of receipt of request.	Within five (5) working days of receipt of request.

Post-Service - Extension Needed • Additional clinical information required • Require consultation by an Expert Reviewer	Additional clinical information required: Notify Member and Practitioner within 30 calendar days of receipt of request & provide at least 45 calendar days for submission of requested information.		
	Additional information received or incomplete If additional information is received, complete or not, decision must be made within 15 calendar days of receipt of information.	*Additional information received or incomplete* Within 15 calendar days of receipt of information.	*Additional information received or incomplete* Within five (5) working days of receipt of information.
	Additional information not received If no additional information is received within the 45 calendar days given to the Practitioner and Member to supply the information, decision must be made with the information that is available within an additional 15 calendar days.	Additional information not received Within 15 calendar days after the time-frame given to the Practitioner and Member to supply the information.	*Additional information not received* Within five (5) working days of receipt of information.
	Require consultation by an Expert Reviewer: Upon the expiration of the 30 calendar days or as soon as you become aware that you will not meet the 30 calendar day time-frame, whichever occurs first, notify Practitioner and Member of the type of expert reviewer required and the anticipated date on which a decision will be rendered.		
	Require consultation by an Expert Reviewer: **Within 15 calendar days from the date of the delay notice.**	*Require consultation by an Expert Reviewer:* Practitioner: Within 15 calendar days from the date of the delay notice (for approvals). Member: Within 15 calendar days from the date of the delay notice (for approval decisions).	*Require consultation by an Expert Reviewer:* Within 15 calendar days from the date of the delay notice.

11.4 Preventive & Practice Guidelines

Vantage has adopted preventive and clinical practice guidelines. These guidelines, while not intended to replace clinical judgment, are statements designed to assist Practitioners in making decisions about appropriate healthcare for specific clinical circumstances. Please visit the Vantage corporate website at *[www.VantageHealthPlan.com/Physicians/PreventivePractice]* to view these guidelines.

11.5 Medical Criteria

Vantage currently uses InterQual™ to guide the pre-authorization, concurrent review, and retrospective review processes. These criteria are used and accepted nationally as clinical decision support criteria. For more information, please contact Vantage Medical Management Department. In addition, Vantage Medical Policy is developed, approved, and updated periodically with involvement from actively practicing Vantage Providers and other healthcare professionals as needed. All criteria, including Behavioral Health, are reviewed and approved by the Utilization Review Quality Management Committee annually and as needed in the interim. At least annually, the entire collection of policies is evaluated by the URQM Committee for continued relevance and effectiveness.

Utilization review criteria are based on reasonable medical evidence and are used to make decisions pertaining to the utilization of services. All services authorized by the Utilization Review staff are evaluated to determine Medical Necessity based on approved standard criteria. Screening criteria is used to determine the approval or denial of the requested treatment. Only a Medical Director may make adverse determinations for services.

The criteria used in the determination of medical appropriateness of services are clearly documented. The criteria are available upon request to all Participating Providers, to Members and the public. The materials provided are guidelines used by Vantage to authorize, modify, or deny care for persons with similar illnesses or conditions. Specific care and treatment may vary depending on individual needs and benefits covered under individual Provider contracts and/or Member benefit plans.

Incentives and/or bonuses are not used to influence clinical, utilization review decisions made by physicians or staff. UR decisions are based only on appropriateness of care and service, application of appropriate criteria and existence of coverage. Practitioners or other individuals conducting utilization review are not specifically rewarded or given financial incentives for issuing denials of coverage or making determinations resulting in under- utilization of healthcare. Employees and all decision-making Practitioners and Providers who attend the URQM Committee meetings sign a statement to this effect.
Vantage may develop recommendations or clinical guidelines for the treatment of specific diagnoses or the utilization of specific drugs. These guidelines will be communicated to Participating Providers through the Vantage Provider newsletters or other direct communication.

If you would like to propose a discussion topic to be considered for discussion by Vantage's UR/QM Committee, please contact the Medical Management Department or a Vantage Medical Director.

Section 12.0 - Commercial Utilization Review/Quality Management Committee

12.1 Overview of UR/QM Committee

Vantage's Utilization Review and Quality Management Committee (URQM) is a diversely designed committee composed of the CEO/Chief Medical Director, Managing Medical Directors, and network Providers from multiple disciplines representing the demographical needs of Vantage's Membership. The URQM Committee meets on a monthly basis and is accountable for monitoring, evaluating, and making improvements to clinical care for all benefit markets.

The responsibilities and functions for the URQM Committee include but are not limited to:

- Monthly review of utilization data, including services requested, Member demographics, diagnosis data, Provider utilization, etc.
- Monthly review of all denied services based on Medical Necessity.
- Monthly review of Pharmacy/Rx utilization data and reports including over/under utilization, Member demographics, diagnosis data, Provider utilization, etc.
- Monthly review of any newly requested review of medical technologies.
- Monthly review of stratified ER visits, inpatient utilization, readmissions, HEDIS control measures, etc.
- Annual review of policies and procedures of the Medical Management Department along with program descriptions for all programs within that department.

12.2 Adverse Determinations

Adverse determinations document and communicate the reason for denial of healthcare services to Providers and Members. Required time frames are met for Member and Provider notification. Denial letters to the Member and Provider contain information regarding the appeals process and information regarding the guideline or criteria utilized in making the determination as well as its availability for review upon request. The denial letter to the Practitioner/Provider includes the name and telephone number of the physician reviewer making the adverse determination. All adverse determinations are reviewed monthly by the UR/QM Committee. Please see Section 13.0 – Appeals & Grievances, for information regarding the process for submitting an appeal for an adverse determination.

12.3 Technology Review

Selection of Technologies for Policy Development

Issues selected for medical policy development generally come through referrals from Vantage staff, the Physician and Provider community, and Members. Priority may be given to the following:

- New diagnostic tests, therapeutic procedures, or medical devices for which other good alternatives do not exist
- Technologies that are considered life-saving
- Medical technologies that are controversial with respect to their clinical utility
- Medical technologies that have generated a high level of interest for Members and/or Providers
- New information published in the peer-reviewed scientific literature that may change the status of a technology from investigational to medically necessary

Technology Assessment Process

The technology assessment process is applied to both the development of new medical policies and updates to existing policies. In order to determine whether a medical technology may be considered medically necessary, literature searches are conducted and the published scientific evidence related to each technology is reviewed against five technology assessment criteria. In order for a technology to be considered medically necessary, all five criteria must be met. As noted above, if any one or more of the following criteria are not met, then the technology is considered investigational:

1. The technology must have final approval from the appropriate government regulatory bodies.
   - A device must have final approval from the Food and Drug Administration (FDA) for those specific indications and methods of use that Vantage is evaluating.
   - Any approval that is granted as an interim step (i.e., Treatment IND) in the FDA regulatory process is not sufficient.
2. The scientific evidence must permit conclusions concerning the effect of the technology on health outcomes.
   - The evidence should consist of well-designed and well-conducted investigations published in peer-reviewed journals. The quality of the body of studies and the consistency of the results are considered in evaluating the evidence. Scientific evidence and expert opinion provide the basis for summarizing the potential net health outcome.
   - The evidence should demonstrate that the technology can measure or alter the physiological changes related to a disease, injury, illness, or condition. In addition, there should be evidence or a convincing argument based on established medical facts that such measurement or alteration affects the health outcomes.
   - Opinions and evaluations by national medical associations, consensus panels or other technology evaluation bodies are evaluated according to the scientific quality of the supporting evidence and rationale.
3. The technology must improve the net health outcome.
   - The technology's beneficial effects on health outcomes should outweigh any harmful effects on health outcomes.
4. The technology must be as beneficial as any established alternatives.
   - The technology should improve the net health outcome as much as or more than established alternatives.
5. The improvement must be attainable outside the investigational settings.

In addition to the above criteria, the following additional criteria apply to new diagnostic technologies (e.g., imaging studies, laboratory procedures, home monitoring devices):

- Technical feasibility is demonstrated, including reproducibility and precision. For comparison among studies, a common standardized protocol for the new diagnostic technology is established.
- For accurate interpretation of study results, sensitivities, specificities, and positive and negative predictive values compared to standards are established.

The clinical utility of a diagnostic technique, i.e., how the results of the study can be used to benefit patient management, is established. The clinical utility of both positive and negative tests must be established.

External Physician Review

Vantage medical policies are submitted for review to the company Medical Directors. Upon review, the Medical Directors will engage external practicing physicians and Specialists in the Vantage membership coverage area based on the areas of technology being evaluated and/or the specific medical discipline. Additional external resources may be utilized according to the complexity of the technology being evaluated. Opinions from these external sources will be compiled along with scientific evidence and the Medical Director summaries for the final approval process.

Approval Process

All policy drafts, including analyses of the scientific evidence and summaries of the external expert opinion, are presented to the Vantage Utilization Review/Quality Management Committee for final approval. Notification of new policies will be made through Provider manuals, newsletters, and/or direct notification to Participating Providers.

Section 13.0 – Commercial and Marketplace Appeals & Grievances

Vantage recognizes its responsibility to provide Members with adequate methods to make inquiries and express concerns regarding Vantage or a Health Care Provider. Members are encouraged to contact Vantage's Member Service department for assistance with complaints or suggestions concerning the Plan.

Members have the right to file a complaint if they have concerns related to:

(a) Availability, delivery, or quality of health care services, including a complaint regarding an Adverse Determination made by Vantage's utilization review procedures;
(b) Claims payment, handling, or reimbursement for health care services; or
(c) Matters pertaining to their contract with Vantage.

Members also have the right to notices of the decisions rendered on claims and Appeals to be provided in a culturally and linguistically appropriate manner, of available internal and external Appeals processes and the availability of the Louisiana Department of Insurance to assist with the Appeals process. They have the right, upon request and free of charge, to review and have copies of all documents relevant to the claim for benefits and to submit comments and documents relating to the claim, without regard to whether that information was submitted or considered in the initial benefit determination, and to receive continued coverage pending the outcome of the Appeals process where required by applicable law of the Plan.

Vantage considers a **Grievance** to be the type of complaint a member files if they have any *concerns* related to the quality of care or services received from Vantage or a Health Care Provider.

Examples of a Grievance:

a) Unpleasant attitudes or behavior at a Health Care Provider;
b) Lengthy wait times in a Health Care Provider's facility;
c) Difficulty scheduling an appointment or contacting a Health Care Provider;
d) Complaints that a procedure or item during a course of treatment did not meet accepted standards for delivery of health care; or
e) Concerns or difficulty when contacting Vantage or communicating with a Vantage employee.

Members always have the right to file a complaint with the Louisiana Department of Insurance.

An **Appeal** is the type of complaint filed when they want Vantage to reconsider an Adverse Determination made by Vantage.

Examples of an Appeal:

(a) A determination that a request for a benefit does not meet Vantage's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness or is determined to be experimental or investigational and the requested benefit is therefore denied, reduced, or terminated or payment is not provided or made, in whole or in part, for the benefit.
(b) Vantage's denial, reduction, termination, or failure to provide or make payment, in whole or in part, for a benefit due to your eligibility to participate in our Plan.
(c) Any pre-service or post-service review where Vantage denies, reduces, or terminates or fails to provide or make payment, in whole or in part for a benefit.
(d) A Rescission of coverage determination, meaning if Vantage cancels or discontinues coverage after services have already been provided, except for circumstances when coverage is terminated due to a failure to timely pay your required premiums or contributions towards the cost of coverage.

APPEALS AND GRIEVANCES PROCEDURE

Any Member that wishes to file an Appeal or Grievance should call Vantage's Member Service department. Member Services is available Monday through Friday from 8:00 a.m. to 8:00 p.m. by calling toll-free (888) 823-1910.

The Vantage Member Services Representative will review the situation and can often resolve the complaint during the call. If the Member's complaint is resolved, a report of the communication, description of the findings, and the resolution or actions taken will be placed in the Member's file.

If the Member Services Representative is unable to resolve the complaint to the Member's satisfaction, the Member may file a formal Appeal or Grievance.

First Level Review

Members may file a formal Appeal or Grievance for further review of a complaint. A formal Appeal or Grievance must be submitted within one hundred eighty (180) days from the date of the initial decision. Written requests for review can be faxed, mailed or hand-delivered to:

Vantage Health Plan, Inc.
Attn: Appeals and Grievances
130 DeSiard Street, Suite 300
Monroe, LA 71201
Standard Fax: 318-361-2159
Expedited Fax: 318-361-2170

Please include the following:

- Member's name, address and Member identification number
- A summary of the reason for the review
- A description of the solution desired by the Member
- Signature of the Member or Authorized Representative

The letter will be forwarded to the Vantage Medical Director and will be adjudicated in a manner designed to ensure independence and impartiality without regard to the initial denial. The Medical Director will review the letter and information related to the complaint. If any evidence generated by Vantage is utilized in connection with the review to which the Member does not have access, Vantage will, if needed, make that information available to the Member and allow Members, upon request and free of charge, to review and have copies of all documents relevant to the claim for benefits and to submit comments and documents relating to the claim, without regard to whether that information was submitted or considered in the initial benefit determination, prior to a decision being rendered. The Medical Director will determine the resolution for the complaint and respond in writing to the Member within thirty (30) days from the date of receipt, or as allowed by law.

Second Level Review (Voluntary Level)

Should the Member decline to accept an adverse First Level Internal decision, the Member may request a second level voluntary review in writing. The Second Level Review is voluntary, meaning that the Member may choose to request an External Review after receipt of determination of the First Level Internal Decision. The Member must file a formal written request to the Appeals and Grievances Committee within thirty (30) days of the adverse First Level Internal review decision. This can be faxed, mailed or hand-delivered.

The Appeals and Grievances Committee will review all the information submitted by the Member and documented by the Member Services Representative and Medical Management department. The Appeals

and Grievances Committee meets on a monthly basis to review internal Appeals and Grievances. The Member will be notified in writing of the Appeals and Grievances Committee decision within five (5) calendar days of completing the review, but in no case later than **forty-five (45) days** from receipt of a second level review request.

Expedited Review

If a complaint involves an urgent care request, a Member or Authorized Representative may request a first or second level review orally or in writing. An urgent care request is one that should not be handled in the standard process because it could seriously jeopardize a Member's life or health or ability to regain maximum function. Or, would in the opinion of a Physician with knowledge of a Member's medical condition, subject the Member to severe pain that cannot be adequately managed without the health care service or treatment that is the subject of a Member's request. All requests for urgent care submitted by a Physician on a Member's behalf will be considered urgent and will be handled as soon as possible, taking into account a Member's medical situation, but in no case later than **seventy-two (72) hours** from receipt of the expedited review request.

Standard External Review

For matters involving an issue of medical necessity, appropriateness, health care setting, level of care, effectiveness or a Rescission of coverage, Members have the right for external review. This includes matters involving health care service or treatment determined to be experimental or investigational. **Within one hundred eighty (180) calendar days** from the receipt of a notice of an Adverse Determination or Final Adverse Determination, a Member or Authorized Representative may request an external review, regardless of the claim amount. Also, an external review may be requested if Vantage has not issued a decision within thirty (30) days following the filing date of an initial Grievance or Appeal with Vantage, provided the Member has not requested or agreed to a delay.

Within five (5) business days following the date of receipt of the external review request from the Member or Authorized Representative, Vantage will complete a preliminary review to determine whether the request is eligible for external review, based upon Louisiana RS 22:2436 (B). Within these five (5) days, Vantage will notify the Commissioner of Insurance, the Member and Authorized Representative, if applicable, that the request is complete and eligible for external review.

Should the request not be complete or is not eligible for external review, Vantage will provide written notification to the Member and Authorized Representative outlining the additional information needed or reasons for its ineligibility. Decisions regarding ineligibility may be appealed to the Commissioner of Insurance. The Commissioner may determine that a request is eligible for external review. If so, the Commissioner will notify Vantage and the Member or his Authorized Representative, if applicable, of this determination regarding eligibility within five (5) business days of the receipt of the request from the Member.

Once a case has been determined to be eligible for external review, Vantage will proceed with the following Independent Review Organization (IRO) process:

(1) Vantage will submit a request for assignment of an IRO by the Department of Insurance.
(2) The Commissioner will randomly assign an IRO from the list of approved IRO's compiled and maintained by the Commissioner to conduct the external review and will notify Vantage of the assigned IRO.
(3) Within one (1) business day, the Commissioner will send written notice to the Member and, if applicable, his Authorized Representative, of the request's eligibility and acceptance for external review and the identity and contact information of the assigned IRO. The Commissioner will include in the notice that the Member or Authorized Representative may submit additional information in

writing to the assigned IRO within five (5) days of receipt of the notice of assignment.

(4) Vantage must provide to the IRO within five (5) business days the documents and any information considered in making the Adverse Determination or Final Adverse Determination.

The IRO will have **forty-five (45) days** after receipt of the request for an external review to issue a written notice of its decision to the Member; the Member's Authorized Representative, if applicable; Vantage and the Commissioner. If the decision is favorable for the Member, Vantage will immediately approve the coverage or payment that was the subject of the review.

Expedited External Review

An expedited external review is available to Members in either of the following scenarios:

1. An Adverse Determination issued and the Adverse Determination (a) involves medical condition for which the time for completion of an expedited internal review of a grievance involving Adverse Determination would seriously jeopardize the life or health of the Member or would jeopardize the Member's ability to regain maximum function and (b) the Member has simultaneously filed request for expedited internal appeal of the Adverse Determination.

2. A Final Adverse Determination is issued and the Final Adverse Determination (a) involves medical condition for which the time for completion of Standard External Review of the Final Adverse Determination would seriously jeopardize the life or health of the Member or would jeopardize the Member's ability to regain maximum function OR (b) concerns an service/treatment for emergency services and Member has not been discharged from facility.

The same process will be followed as outlined in the Standard External Review process; however, the time frames outlined will be changed to immediately and as expeditiously as the Member's medical condition or circumstances requires, but in no case more than seventy-two (72) hours after the date that Vantage receives the request for an expedited external review. If the notification is provided orally and not in writing, within forty-eight (48) hours after the date of providing the notice, the IRO will provide written confirmation of the decision. If the decision is favorable to the Member, Vantage will approve the coverage that was subject of the review.

Formulary Exception Requests

Commercial and Marketplace Prescription Drug Coverage

Vantage Health Plan's "Vantage, our, we" formulary is a comprehensive listing of drugs covered by the member's plan. Below are some frequently asked questions about drug coverage, how to use the formulary and how to request drug coverage exceptions.

Can the Formulary (drug list) change?

Generally, if a member is taking a drug on our 2016 formulary that was covered at the beginning of the year, we will not discontinue or reduce coverage of the drug during the 2017 coverage year except when new adverse information about the safety or effectiveness of a drug is released. If the Food and Drug Administration (FDA) deems a drug on our formulary to be unsafe or the drug's manufacturer removes the drug from the market, we will immediately remove the drug from our formulary and our Pharmacy Benefit Manager (PBM) will provide notice to members who take the drug and their providers. In the event of a mid-year non-maintenance formulary change, the printed and web-based versions of the formulary will be updated as of the effective date of the formulary change. The updated versions of the printed formulary will be available upon request. To get updated information about the drugs covered by our plan, please contact us at (318) 361-0900 or (888) 823-1910.

How do I use the Formulary?
There are several ways to find a drug within the formulary:

Medical Condition
The drugs in the formulary are grouped into categories depending on the type of medical conditions that they are used to treat. For example, drugs used to treat a heart condition are listed under the category "Cardiovascular Agents". If you know what the drug is used for, look for the category name in the list that begins in the second section of the formulary after the alphabetical list. Then look under the category name for the drug.

Alphabetical Listing
If you are not sure what category to look under, you should look for the drug alphabetically beginning on page 1. Both brand name drugs and generic drugs are listed in alphabetical order.

Types of Drugs
Brand name drugs are capitalized (e.g., COUMADIN TAB) and generic drugs are listed in lower-case (e.g., warfarin). The information in the Special Code column tells you if our plan has any special requirements for coverage of the drug. The formulary includes a key at the bottom of each page for drugs that have a symbol in the Special Code column.

What are generic drugs and generic substitution?
Our plan covers both brand name drugs and generic drugs. A generic drug is approved by the FDA as having the same active ingredient as the brand name drug. Generally, generic drugs cost less than brand name drugs. Generic substitution is the practice of replacing a brand-name drug with the generic version. In most cases generic drugs are preferred on the formulary. Generic drugs are FDA-approved for safety and effectiveness.

The color and shape may be different from the brand-name drug, but they are made using the same strict FDA standards as brand-name drugs. If a brand-name drug is requested by the member or provider when a generic is available, the member must pay the generic drug copay plus the difference between the cost of the brand name drug and the cost of the generic drug. However, most brand name drugs with generic equivalents are non-formulary, so coverage of the brand name drug would require a formulary exception approval. The product selection fee is added to the tier 4 cost share on 5 tier formularies.

Are there any restrictions on the member's coverage?
Some covered drugs may have additional requirements or limits on coverage. These requirements and limits may include:

Prior Authorization (PA): Our plan requires the member or his/her physician to get prior authorization for certain drugs. This means that the member will need to get approval from us before he/she fills the prescription. If he/she doesn't get approval, our plan will not cover the drug.

Quantity Limits (QL): For certain drugs, our plan limits the amount of the drug that we will cover. For example, our plan provides 9 tablets per 30 days for Sumatriptan. This is based on criteria including but not limited to safety, potential of abuse, potential of overdose, FDA approved dosing guidelines, and approximation of usual doses per month. To obtain QL override, the member's physician or other prescriber's supporting statement must indicate that the request should be approved because the number of doses available under a dose restriction for the prescribing drug is ineffective or likely to be ineffective.

Step Therapy (ST): In some cases, our plan requires the member to first try certain drugs to treat his/her medical condition before we will cover another drug for that condition. For example, if Drug A and Drug B both treat the member's medical condition, our plan may not cover Drug B unless the member tries Drug A first. If Drug A does not work for the member, our plan will then cover Drug B.

Specialty Drugs (SP, MSP): A Specialty Drug is a type of prescription drug available on the formulary that is complex and expensive. Specialty Drugs are used to treat serious and/or chronic health conditions such as rheumatoid arthritis, HIV and hepatitis C. Often times these drugs require intensive monitoring and are available through a specialty pharmacy program. These drugs are designated as SP on the formulary in the Special Code column. Drugs designated as MSP (Mandatory Specialty Pharmacy Program) are only available through a specialty pharmacy program.

What if the member's drug is not on the Formulary?
If the member's drug is not included on the formulary (list of covered drugs), the member should first contact Vantage's Member Services department at (318) 361-0900 or (888) 823-1910 and ask if the drug is covered. If the member learns that our plan does not cover the drug the member can ask Member Services for a list of similar drugs that are covered by our plan. When the member receives the list, he/she may show it to the prescribing physician or other prescriber and ask for a similar drug that is covered by our plan. The member or the prescribing physician or other prescriber can also ask our plan to make an exception and cover the drug. See below for information about how to request an exception.

Formulary Exceptions Process

What does a member do before talking to me about changing his/her drugs or requesting an exception?
A member in our plan may be taking drugs that are not on our formulary, or may be taking a drug that is on our formulary but his/her ability to get it is limited. For example, he/she may need a prior authorization from us before he/she can fill the prescription. The member may talk to you to decide if he/she should switch to an appropriate drug that we cover or request a formulary exception so that we can determine if we will cover the drug he/she is taking.

How does a member request an exception to the Formulary?
A member can ask Vantage to make an exception to the restrictions or limits or for a list of other, similar drugs that may treat his/her health condition. There are several types of exceptions that a member can ask us to make.

- A member can ask our plan to make an exception and cover his/her drug. See below for information about how to request an exception.
- A member can ask us to cover a drug even if it is not on our formulary. If approved, this drug will be covered at a pre-determined cost-sharing level.
- A member can ask us to waive coverage restrictions or limits on his/her drug. For example, for certain drugs, our plan limits the amount of the drug that we will cover. If his/her drug has a quantity limit, he/she can ask us to waive the limit and cover a greater amount.

The prescribing physician or other prescriber should support the request by including an oral or written statement that provides a justification supporting the need for the non-formulary drug to treat the member's condition, including a statement that all covered formulary drugs on any tier will be or have been ineffective, would not be as effective as the non-formulary drug, or would have adverse effects.

There are several different levels of drug exceptions:

Standard Internal Review
Usually, a request for an exception will only be approved if the alternative drugs included on the plan's formulary or additional utilization restrictions would not be as effective in treating the member's condition and/or would cause the member to have adverse medical effects. The member should contact us to ask us for an initial coverage decision for a formulary or utilization restriction exception at (318) 361-0900 or (888) 823-1910.

We will make our decision and notify the member or member's designee and the prescribing physician or other prescriber of the decision within seventy-two (72) hours of receipt of the formulary exception request following Vantage's receipt of the request and information sufficient to begin review. If the member's request for an exception is approved, the medication will be covered at a predetermined cost-sharing level for one year to cover the duration of the prescription, including refills.

Expedited Internal Review
A member can request an expedited (fast) exception if he/she or and the prescribing physician or other prescriber believe that the member's health could be seriously harmed by waiting up to seventy-two (72) hours for a standard review. These circumstances exist when the member is suffering from a health condition that may seriously jeopardize his/her life, health, or ability to regain maximum function or when he/she is undergoing a current course of treatment using a non-formulary drug. If the member's request to expedite is granted, we must give the member or member's designee and the prescribing physician or other prescriber a decision no later than twenty-four (24) hours of receipt of the expedited formulary exception request and information sufficient to begin review. If approved, we will provide coverage of the non-formulary drug at a pre-determined cost-sharing level for the duration of the urgent need.

Standard External Review
If a Standard Internal Review is denied, a member can request the denial be reviewed by an Independent Review Organization ("IRO"). A Standard External Review by an IRO can be requested by the member contacting Vantage at (318) 361-0900 or (888) 823-1910.

Vantage will review internal documentation and any other supporting information to determine if the request is eligible for external review. If eligible for review, the request will be submitted to the Louisiana Department of Insurance for assignment to an IRO. Should the request not be complete or is not eligible for external review, Vantage will provide written notification to the member outlining the additional information needed or reasons for its ineligibility.

The IRO's decision regarding the member's request will be made no later than seventy-two (72) hours following Vantage's receipt of the request. The member will be notified in writing of the outcome of his/her request. If his/her coverage request is approved, the medication will be covered at a predetermined cost-sharing level for one year to cover the duration of the prescription, including refills.

For assistance filing a request for standard external review, the member may call (318) 361-0900 or (888) 823-1910.

Expedited External Review
If an Expedited Internal Review is denied, the member can request the denial be reviewed by an IRO by contacting Vantage at (318) 361-0900 or (888) 823-1910.

Vantage will immediately review internal documentation and any other supporting information to

determine if the request is eligible for expedited external review. If eligible for expedited external review, the request will be submitted to the Louisiana Department of Insurance for assignment to an IRO. Should the request not be complete or is not eligible for external review, Vantage will provide written notification to the member outlining the additional information needed or reasons for its ineligibility.

The IRO's decision regarding the member's request will be made no later than twenty-four (24) hours following Vantage's receipt of the request. The member will be notified by telephone and in writing of the outcome of his/her request. If the member's request is approved, the medication will be covered at a predetermined cost-sharing level for one year to cover the duration of the prescription, including refills.

For assistance filing a request for expedited external review, the member may call (318) 361-0900 or (888) 823-1910.

For more information
For more detailed information about our Commercial or Marketplace plan's prescription drug coverage, please call us at (318) 361-0900 or (888) 823-1910.

The formulary changes annually and as Vantage received FDA updates. Beneficiaries must use network pharmacies to access their prescription drug benefit. Benefits, formulary, pharmacy network, premium and/or copayment/coinsurance may change when the plan renews each year. This document may be available in an alternate format such as large print. Please call Member Services at (866) 704-0109 to request the alternate format.

MEDICARE

Section 14.0 – Medicare Product Overview

14.1 Vantage Medicare Advantage

Vantage is an HMO Plan with a Medicare Advantage contract. Individual Medicare beneficiaries may be eligible to enroll in a Vantage Medicare Advantage Plan if they reside in the Vantage Medicare Advantage service area and are entitled to Medicare Part A and enrolled in Part B. Individual retirees may enroll in a Vantage Medicare Advantage Plan in the parishes which Vantage is approved by CMS to market. Additional parishes may be added each Plan year.

Vantage maintains and monitors a network of Participating Providers, including Physicians, hospitals, skilled nursing facilities, ancillary Providers, and other healthcare Providers through which Members obtain covered services. Members must choose a Medical Home-Primary Care Provider (MH-PCP) to coordinate their care. To ensure continuity of care, Members should coordinate with their MH-PCP before seeking care from a Specialist, except in the case of specified services relating to wellness and preventative care benefits.

Vantage will furnish Members with a Provider Directory that lists the Participating Providers in the Vantage Medicare Advantage Network. Members will also be provided an Evidence of Coverage (EOC) booklet that will include a summary of the terms and conditions, including payment terms, Utilization Review (UR) requirements, method of payment, eligibility, and billing information.

Section 15.0 - Medicare Emergency Care/Urgent Care Services

15.1 What is a "medical emergency"?

A "medical emergency" is when the Member believes their health is in serious danger. A medical emergency includes severe pain, a bad injury, a sudden illness, or a medical condition that is quickly getting much worse.

If the Member has medical emergency:

- Get medical help as quickly as possible. Call 911 for help or go to the nearest emergency room or hospital. The Member does not need to get approval or a referral first from their doctor or other network Provider.
- As soon as possible, they should make sure their MH-PCP knows about the emergency, because you will need to be involved in following up on the emergency care. The Member or someone else should call to tell the Member's MH-PCP about the emergency care, usually within 48 hours. If they need assistance, call Vantage Health Plan, Inc. at 318-361-0900 or toll-free 1-866-704-0109 (TTY 318-361-2131 or TTY 1-866-524-5144).

The MH-PCP will talk with the doctors who are giving the emergency care to help manage and follow-up on care. When the doctors who are giving emergency care say that the Member's condition is stable and the medical emergency is over then they are still entitled to follow-up post stabilization care. The follow-up post stabilization care will be covered according to applicable guidelines. In general, if the emergency care is provided out of network, the MH-PCP will try to arrange for network Providers to take over care as soon as their medical condition and the circumstances allow.

What is covered if the Member has a medical emergency?

- The Member may get covered emergency medical care whenever they need it, anywhere in the United States. The filling of prescriptions when one cannot access a network pharmacy is discussed in Section 16.0.
- Ambulance services are covered in situations where other means of transportation In the United States would endanger the Member's health.

What if it was not a medical emergency?

Sometimes it can be hard to know if the Member has a medical emergency. For example, they might go in for emergency care – thinking that their health is in serious danger – and the doctor may say that it was not a medical emergency after all. If this happens, they are still covered for the care received to determine what was wrong, as long as they thought their health was in serious danger, as explained in "What is a 'medical emergency'?" above. If they get any extra care after the doctor says it was not a medical emergency, Vantage will pay the covered additional care as a point of service benefit.

15.2 What is "urgently needed care"?

Urgently needed care refers to a non-emergency situation when the Member is:

- Inside the United States
- Temporarily absent from Vantage's authorized service area
- In need of medical attention right away for an unforeseen illness, injury, or condition, and
- It is not reasonable given the situation for them to obtain medical care through Vantage's Participating Provider network.

Under unusual and extraordinary circumstances, care may be considered urgently needed and paid for by Vantage when the Member is in the service area, but the Provider network is temporarily unavailable or inaccessible.

15.3 What is the difference between a "medical emergency" and "urgently needed care"?

The two main differences between urgently needed care and a medical emergency are in the danger to the Member's health and location. A "medical emergency" occurs when the Member reasonably believe that their health is in serious danger, whether they are in or outside of the service area. "Urgently needed care" is when the Member needs medical help for an unforeseen illness, injury, or condition, but their health is not in

serious danger and are generally outside of the service area.

How to get urgently needed care
If, while temporarily outside Vantage's service area, the Member requires urgently needed care, then they may get this care from any Provider.

Note: If they have a pressing, non-emergency medical need while in the service area, they generally must obtain services from Vantage according to its procedures and requirements as outlined earlier in this Section.

How to submit a paper claim for emergency or urgently needed care
When the Member receives emergency or urgently needed healthcare services from a Provider who is not part of our network, they are responsible for paying their cost sharing amount and should tell the Provider to bill Vantage for the balance of the payment they are due. However, if they have received a bill from the Provider, please send that claim to Vantage Health Plan, Inc. 130 DeSiard St, Suite 300, Monroe, LA 71201, so we can pay the Provider the amount they are owed. If the Member has any questions about what to pay a Provider or where to send a paper claim, they may call Member Services.

Section 16.0 - Medicare Utilization Management

16.1 Utilization Management

Vantage monitors quality of care and utilization of services. All Participating Providers are required to obtain prior authorization from Vantage's Utilization Management Department for inpatient services and specified outpatient services listed in Section 16.3, "Prior Authorization Requirements."
The UM Department is available Monday through Friday, 8:00 a.m. to 5:00 p.m. CST, (except designated holidays). All requests for authorization of services may be received during these hours of operation by calling (888) 823-1910. Requests may be faxed to (318) 361-2170.

Vantage provides the opportunity for the Provider to discuss a decision with a Medical Director, to ask questions about a UM issue, or to seek information from the nurse reviewer about the UM process and the authorization of care by calling (888) 823-1910. After business hours or on holidays, a Provider can leave a message, and a representative will return the call the next business day.

Prior authorization or any other determination of Medical Necessity does not guarantee eligibility for payment. Eligibility of Members for payment to Physician shall be based upon the Member's actual eligibility under the applicable Benefit Plan at the time Covered Services are rendered by Physician and shall be subject to the rescission policy of Vantage.

16.2 Review Criteria/Standards for Review

Vantage may develop recommendations or clinical guidelines for the treatment of specific diagnoses, procedures, or for utilization of specific drugs not otherwise covered by national or local coverage guidelines.

Vantage is equally concerned with and monitors for over- and under- utilization of healthcare services. UM decision-making is based only on appropriateness of care and service and existence of coverage. Vantage does not specifically reward Providers or other individuals conducting utilization review for issuing denials of coverage or services.

16.3 Prior Authorization Requirements

Participating Providers must obtain prior authorizations for certain benefits to be eligible for payment. The UM Department hours of operation are Monday through Friday, 8:00 a.m. to 5:00 p.m. CST, (except designated

holidays). The UM Department can be reached at (888) 823-1910. For additional prior authorization information and an illustrative list please refer to Section 5.0 in this manual.

16.3.1 Home Health/Home Infusion Services

When medically appropriate and a Member is confined to his/her home, home healthcare may be an appropriate alternative. Prior authorization of all home health services is required.

Initial authorizations and subsequent requests for home health services may be obtained from the Case Management department. To check the status of a request that has been faxed, call (888) 823-1910 or check on the Vantage Provider Portal. A request for prior authorization must be received prior to the delivery of the service for a non-urgent request and within one (1) business day of the service being performed for an urgent or emergent service. Please fax the request with progress notes and the current plan of care to (318) 361-2170.

16.3.2 Durable Medical Equipment (DME)

Vantage Members are eligible to receive medically necessary durable medical equipment and supplies.

DME Providers must fax the request to the Vantage UM at (318) 361-2170 or call (318) 361-0900 option "2" for authorization for rental or purchase of DME items. Requests for prior authorization must be received fourteen (14) days prior to the delivery of the service for a non-urgent request and within one business day of the service being performed for an urgent or emergent service.

16.4 Inpatient Admissions

16.4.1 Prior Authorization of Elective Inpatient/Observation Hospital Services

Providers are required to obtain prior authorization for all elective inpatient/observation hospital admissions from the UM Department.

Prior authorization is mandatory for elective inpatient hospital /observation cases to qualify for payment.

Vantage may accept the hospital's or the attending physician's request for prior authorization of elective hospital admissions. However, neither party should assume that the other has obtained prior authorization.

16.4.2 Emergency Admissions

For an urgent or emergent admission or observation at an acute-care facility, the facility must provide notice within one (1) business day of the admission by calling Vantage's UM Department. For weekend admissions to a hospital or for services delivered on the weekend or after normal business hours, authorization must be obtained within one business day of the service being provided. Clinical information must be provided at the time of the notification.

To receive authorization for services, please call the Vantage UM Department at (888) 823-1910 or fax the request to (318) 361-2170.

No authorization is required for services rendered in an emergency room or urgent care center.

16.4.3 Non-Participating Hospital Transfer Policy

All Members are encouraged to receive inpatient services rendered in a Vantage participating hospital. However, Vantage recognizes that it may not be possible to comply with this requirement when a Member presents himself or herself to the closest medical facility because of a medical emergency.

16.5 Inpatient Rehabilitation Admissions

If a Member requires an inpatient rehabilitation admission to a rehabilitation hospital, the rehabilitation hospital must contact Vantage at (888) 823-1910 prior to admission. The admission will be reviewed utilizing national and local coverage decision guidelines, InterQual Level of Care Criteria® and/or applicable medical policy. All denials are reviewed by a Medical Director.

16.6 Inpatient Skilled Nursing Facility

An admission to a Skilled Nursing Facility will be reviewed by Vantage for Medical Necessity of the admission. These admissions and continued stays will be reviewed for the need for skilled nursing care or rehabilitation services that can only be provided on an inpatient basis in a skilled nursing facility under the supervision of professional or technical personnel. These will be reviewed utilizing InterQual Level of Care Criteria® and/or medical policy as appropriate. All denials are reviewed by a Medical Director.

16.7 Behavioral Health Information

16.7.1 Inpatient, Partial Hospitalization and Home Health Services

The staff will depend primarily on the InterQual Level of Care Criteria® for the management of all pre-admissions, admissions, and readmissions. Preauthorization reviews completed via telephone prior to the provision of clinical services ensure the review of intensive services by objective clinical professionals for adequacy of level of care and appropriateness of services. All denials are reviewed by a Medical Director.

Readmission requests will receive special attention since they often occur within 30 days of discharge, and frequently require a Medical Director's review.

Providers will be required to notify Vantage prior to an elective inpatient behavioral health hospitalization, detoxification and home health services in order to receive payment for the services. All of these services require prior authorization from Vantage. In order for Vantage to cover a partial hospitalization program, a Provider must document that the Member would otherwise need inpatient treatment.

16.7.2 Other Behavioral Health Services

The utilization reviews for behavioral health and substance abuse are conducted through preauthorization reviews, concurrent reviews, and/or retrospective reviews.

The primary components of the UM program will include:

- The management of the Member's care (where and when appropriate) according to the identified medically necessary need and clinical criteria. These efforts will supplement any services already provided by the Member's Provider—whether he/she is an individual Provider or a community mental health center (CMHC).
- Active and ongoing participation and involvement of the Member and his/her family (where and when appropriate) including adults where consent is given by the adult Member for involvement in the development and management of the treatment plan and overall plan of care.
- Assuring the provision of services based on access time frames as determined by community standards within the Vantage region.
- Ongoing collaboration and cooperation (where and when appropriate) among the various entities and agencies involved in the Member's care.
- Whenever possible, the provision of treatment services according to best practices methodologies. The Coordination of Care functions will incorporate the needs of Members, ranging from those with minor behavioral health illnesses, who live functional independent lives within the community to those with severe mental illnesses or severe emotional disabilities requiring ongoing individual supervision at all times. These functions will be reflected in the Behavioral Health Level of Care Criteria utilized to guide the

activities of the Vantage UM staff.

An effective system is needed to support clinically effective and rational clinical guidelines and protocols. Specifically, guidelines will provide valuable information and support to Providers to improve their clinical effectiveness in medication prescribing. All pharmacological interventions are designed to support Providers' autonomy, provide best practices, provide medication education, and minimize administrative requirements or delays for Providers and Members.

Prior Authorization
Prior authorization will define the amount of services to be authorized and an acceptable length of stay. UM, based on a review of the Member's needs and incorporation of clinical criteria, will provide prior authorizations.

16.8 Denials
A request for a service authorization may be denied for failure to meet local and national guidelines, protocols, and/or medical policies outlined in the Provider Contract or this Provider Manual.

16.8.1 Initial Decisions and Medical Necessity Denials
Initial Decisions
The "initial decision" is the first decision Vantage makes regarding coverage or payment for care.

A decision to determine if Vantage will cover medical care can be a "standard decision" that is made within the standard time-frame (typically within 14 days) or it can be an expedited decision that is made more quickly (typically within 72 hours).

A Member can ask for an expedited decision only if the Member or any Provider believes that waiting for a standard decision could seriously harm the Member's health or ability to function. If a Provider requests an expedited decision, or supports a Member in asking for one, and the Provider indicates that waiting for a standard decision could seriously harm the Member's health or ability to function, Vantage will automatically provide an expedited decision.

If Vantage does not make a decision within the time-frame and does not notify the Member regarding why the time-frame must be extended, the Member has the right to appeal, as set forth in the appeals section of this Manual.

Denials
UM/Care Coordination utilizes criteria, medical policies, protocols, and industry standard guidelines to render review decisions. Requests not meeting the guidelines, protocols, or policies are referred to a Medical Director reviewer for clinical review. A Vantage Medical Director will render all denial decisions. Whenever a denial is issued, UM provides the name, telephone number, title of the Medical Director who rendered the decision. The Vantage Medical Director is available to discuss any decision rendered with the attending Provider. To speak with a Medical Director or to the nurse reviewer, please contact UM at (888) 823-1910.

16.9 Member Appeal & Grievance
16.9.1 Grievance
What is a Grievance?
A grievance is any complaint, other than one that involves a request for an initial determination or an appeal as described in this section of this manual.

Grievances do not involve problems related to approving or paying for Part D drugs, Part C medical care or

services, problems about having to leave the hospital too soon, or problems about having Skilled Nursing Facility (SNF), Home Health Agency (HHA), or Comprehensive Outpatient Rehabilitation Facility (CORF) services ending too soon.

If we will not pay for or give the Member the Part C medical care or services or Part D drugs wanted, they believe that they are being released from the hospital or SNF too soon, or HHA or CORF services are ending too soon, the rules outlined in Section 17.0 must be followed.

What types of problems might lead to filing a grievance?

- Problems with the service received from Member Services.
- If the Member feels they are being encouraged to leave (disenroll from) Vantage.
- If the Member disagrees with our decision not to give a "fast" decision or a "fast" appeal. We discuss these fast decisions and appeals in Section 16.9.2.1.
- We do not give a decision within the required time frame.
- We do not give required notices.
- The Member believes our notices and other written materials are hard to understand.
- Waiting too long for prescriptions to be filled.
- Rude behavior by network pharmacists or other staff.
- We do not forward Member cases to the Independent Review Entity if we do not give a decision on time.
- Problems with the quality of the medical care or services received, including quality of care during a hospital stay.
- Problems with how long the Member has to wait on the phone, in the waiting room, or in the exam room.
- Problems getting appointments when needed, or waiting too long for them.
- Rude behavior by doctors, nurses, receptionists, or other staff.
- Cleanliness or condition of doctor's offices, clinics, or hospitals.

If the Member has one of these types of problems and want to make a complaint, it is called "filing a grievance."

Who may file a grievance?

The Member or someone they name may file a grievance. The person named would be the Member's "representative." Representative may be a relative, friend, lawyer, advocate, doctor, or anyone else to act for the Member. Other persons may already be authorized by a Court or in accordance with state law to act for the Member. If the Member wants someone to act for them who is not already authorized by a Court or under state law, then the Member and that person must sign and date a statement that gives the person legal permission to be the representative. To learn how to name a representative, the Member may call Member Services.

16.9.1.1 Filing a grievance with our Plan

If the Member has a complaint, they or their representative may call the phone number for Part C Grievances (for complaints about Part C medical care or services) or Part D Grievances (for complaints about Part D drugs) in Section 1.4. We will try to resolve the complaint over the phone. If asked for a written response, file a written grievance, or the complaint is related to quality of care, we will respond in writing. If we cannot resolve the complaint over the phone, we have a formal procedure to review complaints. We call this a standard grievance procedure.

A grievance may be filed by submitting the completed details in writing to Vantage Health Plan, Inc. at the following location: ATTN: Medical Director, 130 DeSiard Street, Suite 300, Monroe, LA 71201. A grievance may also be submitted orally by calling the number in Section 1.4 of this Manual. For grievances submitted in writing, a letter will be sent to the Member acknowledging receipt of the grievance. We must address the grievance as quickly as the case requires based on the Member's health status, but no later than 30 days after receiving the complaint.

The Member has the right to file an expedited grievance whenever we deny the request for an expedited decision about the request for a service, or, whenever we deny the request for an expedited decision about the appeal for a service. The Member also has the right to file an expedited grievance if they do not agree with our decision to extend the time needed to decide on the request for a service, or to consider the appeal for a service. We must decide within 24 hours if our decision to deny or delay making an expedited decision puts the Member's life or health at risk. We may extend the time frame by up to 14 days if asked for the extension, or if we justify a need for additional information and the delay is in the Member's best interest.

The grievance must be submitted within 60 days of the event or incident. We must address the Member's grievance as quickly as the case requires based on their health status, but no later than 30 days after receiving the complaint. We may extend the time frame by up to 14 days if asked for the extension, or if we justify a need for additional information and the delay is in the Member's best interest. If we deny the grievance in whole or in part, our written decision will explain why we denied it, and will tell the Member about any dispute resolution options they may have.

16.9.1.2 Fast Grievances

In certain cases, the Member has the right to ask for a "fast grievance," meaning we will answer the grievance within 24 hours. We discuss situations where the Member may request a fast grievance in Section 16.9.2.

16.9.1.3 For quality of care problems, you may also complain to the QIO

The Member may complain about the quality of care received under Medicare, including care during a hospital stay. They may complain to us using the grievance process, to the Quality Improvement Organization (QIO), or both. If the Member files with the QIO, we must help the QIO resolve the complaint. QIO is located at 5700 Lombardo Center Dr., Suite 100, Seven Hills, OH 44131, Toll Free 1-844-430-9504.

16.9.2 Complaints and Appeals about your Part D Prescription Drug(s) and/or Part C Medical Care and Service(s)

Introduction

This Section explains how the Member asks for coverage of Part D drug(s) and/or Part C medical care or service(s) or payments in different situations. This Section also explains how to make complaints when the Member thinks they are being asked to leave the hospital too soon, or think their skilled nursing facility (SNF), home health (HHA) or comprehensive outpatient rehabilitation facility (CORF) services are ending too soon. These types of requests and complaints are discussed below in Part 1, Part 2, or Part 3.

Other complaints that do not involve the types of requests or complaints discussed below in Part 1, Part 2, or Part 3 are considered grievances. The Member would file a grievance if they have any type of problem with us or one of our network Providers that does not relate to coverage for Part D drugs and/or Part C medical care or services. For more information about grievances, see Section 16.9.1.

16.9.2.1 PART 1. Requests for Part D drugs and/or medical care or services or payment

This part explains what the Member can do if they have problems getting the Part D drugs and/or Part C medical care or service requested, or payment (including the amount paid) for a Part D drug and/or Part C medical care or service already received.

If the Member has problems getting the Part D drugs and/or Part C medical care or services needed, or payment for a Part D drug and/or Part C service already received, they must request an initial determination from Vantage.

Initial Determinations
The initial determination we make is the starting point for dealing with requests the Member may have about covering a Part D drug and/or Part C medical care or services needed, or paying for a Part D drug and/or Part C medical care or service already received. Initial decisions about Part D drugs are called "coverage determinations." Initial decisions about Part C medical care or services are called "organization determinations." With this decision, we explain whether we will provide the Part D drug and/or Part C medical care or service the Member is requesting, or pay for the Part D drug and/or Part C medical care or service already received.

The following are examples of requests for initial determinations:

- The Member asks us to pay for a prescription drug they have received.
- The Member asks for a Part D drug that is not on Vantage's list of covered drugs (called a "formulary"). This is a request for a "formulary exception." See "What is an exception?" below for more information about the exceptions process.
- The Member asks for an exception to our utilization management tools - such as prior authorization, dosage limits, quantity limits, or step therapy requirements. Requesting an exception to a utilization management tool is a type of formulary exception. See "What is an exception?" below for more information about the exceptions process.
- The Member asks for a non-preferred Part D drug at the preferred cost-sharing level. This is a request for a "tiering exception." See "What is an exception?" below for more information about the exceptions process.
- The Member asks us to pay back for the cost of a drug bought at an out-of-network pharmacy. In certain circumstances, out-of-network purchases, including drugs provided in a physician's office, will be covered by Vantage.
- The Member is not getting Part C medical care or services they want, and believe that this care is covered by Vantage.
- We will not approve the medical treatment the doctor or other medical Provider wants to give the Member, and they believe that this treatment is covered by Vantage.
- The Member is being told that a medical treatment or service they have been getting will be reduced or stopped, and they believe that this could harm their health.
- The Member has received Part C medical care or services that they believe should be covered by Vantage, but we have refused to pay for this care.

What is an exception?
An exception is a type of initial determination (also called a "coverage determination") involving a Part D drug. The Member or their doctor may ask us to make an exception to our Part D coverage rules in a number of situations.

- The Member may ask us to cover a Part D drug even if it is not on our formulary. Excluded drugs cannot be covered by a Part D Plan.
- The Member may ask us to waive coverage restrictions or limits on Part D drugs. For example, for certain Part D drugs, we limit the amount of the drug that we will cover. If the Part D drug has a quantity limit, they may ask us to waive the limit and cover more.
- The Member may ask us to provide a higher level of coverage for Part D drug. If the Part D drug is contained in our third tier (Tier 4), the Member may ask us to cover it at the cost-sharing amount that applies to drugs in the second tier (Tier 3). This would lower the co-payment amount the Member must pay for Part D drug. Please note, if we grant the request to cover a Part D drug that is not on our formulary, they may not ask us to provide a higher level of coverage for the drug.

Generally, we will only approve the request for an exception if the alternative Part D drugs included on Vantage's formulary or the Part D drug in the preferred tier would not be as effective in treating the Member's condition and/or would cause them to have adverse medical effects.

You must submit a statement supporting your exception request. In order to help us make a decision more quickly, the supporting medical information from you should be sent to us with the exception request.

If we approve the exception request, our approval is valid for the remainder of the Plan year, so long as you continue to prescribe the Part D drug for the Member and it continues to be safe for treating their condition. If we deny the exception request, the Member may appeal our decision.

Note: If we approve the exception request for a Part D non-formulary drug, they cannot request an exception to the co-payment or coinsurance amount we require them to pay for the drug.

The Member may call us at the phone number shown under Important Number in Section 1.4 to ask for any of these requests.

Who may ask for an initial determination?

The Member, their prescribing physician, or someone they name may ask us for an initial determination. The person named would be the "appointed representative." The Member may name a relative, friend, advocate, doctor, or anyone else to act for them. Other persons may already be authorized under state law to act for them. If they want someone to act for them who is not already authorized under state law, then the Member and that person must sign and date a statement that gives the person legal permission to be the appointed representative. If the Member is requesting Part C medical care or services, this statement must be sent to us at the address or fax number listed under Important Numbers in Section 1.4. If the Member is requesting Part D drugs, this statement must be sent to us at the address or fax number listed under Important Numbers in Section 1.4. To learn how to name an appointed representative, the Member may call Member Services.

The Member also has the right to have a lawyer act for them. They may contact their own lawyer, or get the name of a lawyer from the local bar association or other referral service. There are also groups that will give free legal services if the Member qualifies.

Asking for a "standard" or "fast" initial determination

A decision about whether we will give the Member, or pay for, the Part D drug and/or Part C medical care or service they are requesting can be a "standard" decision that is made within the standard time frame, or it can be a "fast" decision that is made more quickly. A fast decision is also called an "expedited" decision.

Asking for a standard decision

To ask for a standard decision for a Part D drug and/or Part C medical care or service the Member, their doctor, or representative should call, fax, or write us at the numbers or address listed under Important Numbers in Section 1.4.

For delivering requests that are made outside of regular weekday business hours, fax is available 24 hours a day at 318-361-2170.

Asking for a fast decision

The Member may ask for a fast decision only if the Member or their doctor believes that waiting for a standard decision could seriously harm their health or their ability to function. (Fast decisions apply only to requests for benefits that have not yet received. The Member cannot get a fast decision if they are asking us to pay back for a benefit already received.) If the Member is requesting a Part D drug and/or Part C medical care or service that they have not yet received, the Member, their doctor, or representative may ask us to give you a fast decision by calling, faxing, or writing us at the numbers or address listed under Important Numbers in Section 1.4.

For delivering requests that are made outside of regular weekday business hours, the expedited fax is available 24 hours a day at 318-361-2170.

Be sure to ask for a "fast" or "expedited" review. If you ask for a fast decision for the Member, or support them in asking for one, and you indicate that waiting for a standard decision could seriously harm the Member's life, health or the ability to function, we will automatically give them a fast decision.

If the Member asks for a fast decision without support from a doctor, we will decide if the Member's health requires a fast decision. If we decide that the medical condition does not meet the requirements for a fast decision, we will send a letter informing them that if they get a doctor's support for a fast review, we will automatically give a fast decision. The letter will also tell them how to file a "fast grievance." The Member has the right to file a fast grievance if they disagree with our decision to deny the request for a fast review. If we deny the request for a fast initial determination, we will give them a standard decision.

What happens when you request an initial determination?

- For a standard initial determination about a Part D drug (including a request to pay back for a Part D drug that has already been received), generally, we must give our decision no later than 72 hours after we receive the request, but we will make it sooner if the request is for a Part D drug that has not been received yet and the Member's health condition requires it. However, if the request involves a request for an exception (including a formulary exception, tiering exception, or an exception from utilization management rules – such as prior authorization, dosage limits, quantity limits, or step therapy requirements, we must give our decision no later than 72 hours after we receive the physician's "supporting statement" explaining why the drug being asked for is medically necessary.

If the Member has not received an answer from us within 72 hours after we receive the request (or the physician's supporting statement if the request involves an exception), the request will automatically go to Appeal Level 2.

- If we give a fast review, we will give our decision within 24 hours after the Member or the doctor asks for a fast review. We will give the decision sooner if the Member's health condition requires us to. If the request involves a request for an exception, we will give our decision no later than 24 hours after we have received the physician's "supporting statement," which explains why the drug being asked for is medically necessary.

If we decide the Member is eligible for a fast review and they have not received an answer from us within 24 hours after receiving the request (or the physician's supporting statement if the request involves an exception), the request will automatically go to Appeal Level 2.

- For a decision about payment for Part C medical care or services already received, if we do not need more information to make a decision, we have up to 30 days to make a decision after we receive the request, although a small number of decisions may take longer. However, if we need more information in order to make a decision, we have up to 60 days from the date of the receipt of the request to make a decision. The Member will be told in writing when we make a decision.

If the Member has not received an answer from us within 60 days of the request, the Member has the right to appeal.

- For a standard decision about Part C medical care or services that have not yet received, we have 14 days to make a decision after we receive the request. However, we can take up to 14 more days

if the Member asks for additional time, or if we need more information (such as medical records) that may benefit the Member. If we take additional days, we will notify the Member in writing. If they believe that we should not take additional days, they can make a specific type of complaint called a "fast grievance".

If the Member has not received an answer from us within 14 days of the request (or by the end of any extended time period), they have the right to appeal.

- If the Member receives a "fast" decision, we will give our decision about the requested medical care or services within 72 hours after we receive the request. However, we can take up to 14 more days if we find that some information is missing that may benefit the Member, or if they need more time to prepare for this review. If we take additional days, we will notify them in writing. If the Member believes that we should not take any extra days, they can file a fast grievance. We will call the Member as soon as we make the decision.

If we do not tell the Member about our decision within 72 hours (or by the end of any extended time period), they have the right to appeal. If we deny the request for a fast decision, they may file a "fast grievance." For more information about fast grievances, see Section 16.9.1.2.

What happens if we decide completely in your favor?

- We must cover the Part D drug requested as quickly as a Member's health requires, but no later than 72 hours after we receive the request. If the request involves a request for an exception, we must cover the Part D drug requested no later than 72 hours after we receive the physician's "supporting statement." If the Member is asking us to pay back for a Part D drug that they already paid for and received, we must send payment to them no later than 30 calendar days after we receive the request (or supporting statement if the request involves an exception).

- For a fast decision about a Part D drug that the Member has not yet received, we must cover the Part D drug requested no later than 24 hours after we receive the request. If the request involves a request for an exception, we must cover the Part D drug requested no later than 24 hours after we receive the physician's "supporting statement."

- For a decision about payment for Part C medical care or services already received, generally, we must send payment no later than 30 days after we receive the request, although a small number of decisions may take up to 60 days. If we need more information in order to make a decision, we have up to 60 days from the date of the receipt of the request to make payment.

- For a standard decision about Part C medical care or services that have not yet received, we must authorize or provide the requested care within 14 days of receiving the request. If we extended the time needed to make our decision, we will authorize or provide the medical care before the extended time period expires.

- For a fast decision about Part C medical care or services that have not been received, we must authorize or provide the requested care within 72 hours of receiving the request. If we extended the time needed to make our decision, we will authorize or provide the medical care before the extended time period expires.

What happens if we decide against the Member?

If we decide against the Member, we will send them a written decision explaining why we denied the request. If an initial determination does not give them all that they requested, they have the right to appeal the

decision. (See Appeal Level 1.)

16.9.2.1.1 Appeal Level 1: Appeal to the Plan

The Member may ask us to review our initial determination, even if only part of our decision is not what was requested. An appeal to Vantage about a Part D drug is also called a Plan "redetermination." An appeal to Vantage about Part C medical care or services is also called a Plan "reconsideration." When we receive the request to review the initial determination, we give the request to those at Vantage who were not involved in making the initial determination. This helps ensure that we will give your request a fresh look.

Who may file your appeal of the initial determination?

If the Member is appealing an initial decision about a Part D drug, the Member or their representative may file a standard appeal request, or the Member, their representative, or doctor may file a fast appeal request.

Please see "Who may ask for an initial determination?" for information about appointing a representative.

If the Member is appealing an initial decision about Part C medical care or services, the rules about who may file an appeal are the same as the rules about who may ask for an organization determination. Follow the instructions under "Who may ask for an initial determination?" However, Providers who do not have a contract with Vantage may also appeal a payment decision as long as the Provider signs a "waiver of payment" statement saying it will not ask the Member to pay for the Part C medical care or service under review, regardless of the outcome of the appeal.

How soon must you file your appeal?

The Member must file the appeal request within 60 calendar days from the date included on the notice of our initial determination. We may give them more time if they have a good reason for missing the deadline.

How to file your appeal

1. Asking for a standard appeal
   To ask for a standard appeal about a Part D drug and/or Part C medical care or service signed, a written appeal request must be sent to the address listed under Part D Appeals (for appeals about Part D drugs) and/or Part C Appeals (for appeals about medical care or services) in this Section. You may also fax your request to 318-361-2170.

2. Asking for a fast appeal
   If the Member is appealing a decision we made about giving a Part D drug and/or Part C medical care or service that has not been received yet, the Member and/or the doctor will need to decide if they need a fast appeal. The rules about asking for a fast appeal are the same as the rules about asking for a fast initial determination. The Member, their doctor, or representative may ask us for a fast appeal by calling, faxing, or writing us at the numbers or address listed under Part D Appeals (for appeals about Part D drugs) and/or Part C Appeals (for appeals about Part C medical care or services) in this Section.

For delivering requests that are made outside of regular weekday business hours, fax is available 24 hours a day at 318-361-2170.

The Member will need to ask for a "fast" or "expedited" review. Remember, if you provide a written or oral supporting statement explaining that the Member needs the fast appeal, we will automatically give them a fast appeal. If the Member asks for a fast decision without support from a doctor, we will decide if their health requires a fast decision. If we decide that their medical condition does not meet the requirements for a fast decision, we will send a letter informing the Member that if they get a doctor's support for a fast review, we will automatically give them a fast decision. The letter will also tell them how to file a "fast grievance." The Member has the right to file a fast grievance if they disagree with our decision to deny the request for a fast review (for more information about fast grievances, see Section 16.9.1.2). If we deny the request for a fast appeal, we will give them a standard appeal.

Getting information to support an appeal
We must gather all the information we need to make a decision about the Member's appeal. If we need the Member's assistance in gathering this information, we will contact the Member or their representative. The Member has the right to obtain and include additional information as part of the appeal. For example, they may already have documents related to the request, or may want to get their doctor's records or opinion to help support the request. The Member may need to give the doctor a written request to get information.

The Member may give us their additional information to support the appeal by calling, faxing, or writing us at the numbers or address listed under Important Numbers in Section 1.4.
The Member may also deliver additional information in person to the address listed under Important Numbers in Section 1.4. The Member also has the right to ask us for a copy of information regarding their appeal. They may call or write us at the phone number or address listed under Important Numbers in Section 1.4. We are allowed to charge a fee for copying and sending this information to you.

How soon must we decide on a Member's appeal?

- For a standard decision about a Part D drug that includes a request to pay the Member back for a Part D drug they have already paid for and received, we will give our decision within seven calendar days of receiving the appeal request. We will give the decision sooner if they have not received the drug yet and their health condition requires us to. If we do not give our decision within seven calendar days, the request will automatically go to Appeal Level 2.

- For a fast decision about a Part D drug that has not been received yet, we will give our decision within 72 hours after we receive the appeal request. We will give the decision sooner if their health condition requires us to. If we do not give our decision within 72 hours, the request will automatically go to Appeal Level 2.

- For a decision about payment for Part C medical care or services already received, after we receive the appeal request, we have 60 days to decide. If we do not decide within 60 days, the appeal automatically goes to Appeal Level 2.

- For a standard decision about Part C medical care or services the Member has not yet received, after we receive the appeal, we have 30 days to decide, but will decide sooner if the Member's health condition requires. However, if the Member asks for more time, or if we find that helpful information is missing, we can take up to 14 more days to make our decision. If we do not tell them our decision within 30 days (or by the end of the extended time period), the request will automatically go to Appeal Level 2.

- For a fast decision about Part C medical care or services not yet received, after we receive the appeal, we have 72 hours to decide, but will decide sooner if their health condition requires. However, if they ask for more time, or if we find that helpful information is missing, we can take up to 14 more days to make our decision. If we do not decide within 72 hours (or by the end of the extended time period), the request will automatically go to Appeal Level 2.

What happens if we decide completely in your favor?

- For a standard decision about a Part D drug (including a request to pay back for a Part D drug that the Member has already received), we must cover the Part D drug requested as quickly as their health requires, but no later than 7 calendar days after we receive the request. If the Member is asking us to pay them back for a Part D drug that they have already paid for and received, we must send payment to them no later than 14 calendar days after we receive the request.

- For a fast decision about a Part D drug that has not yet received, we must cover the Part D drug requested no later than 72 hours after we receive the request.

- For a decision about payment for Part C medical care or services already received, we must pay within 60 days of receiving the appeal request.

- For a standard decision about Part C medical care or services not yet received, we must authorize or provide the requested care within 30 days of receiving the appeal request. If we extended the time needed to decide the appeal, we will authorize or provide the requested care before the extended time period expires.

- For a fast decision about Part C medical care or services not yet received., we must authorize or provide the requested care within 72 hours of receiving the appeal request. If we extended the time needed to decide the appeal, we will authorize or provide the requested care before the extended time period expires.

16.9.2.1.2 Appeal Level 2: Independent Review Entity (IRE)

At the second level of appeal, the appeal is reviewed by an outside, Independent Review Entity (IRE) that has a contract with CMS. The IRE has no connection to us. The Member has the right to ask us for a copy of their case file that we sent to this entity. We are allowed to charge a fee for copying and sending this information to the Member.

How to file the appeal

If the Member is asked for Part D drugs or payment for Part D drugs and we did not rule completely in their favor at Appeal Level 1, they may file an appeal with the IRE. If they choose to appeal, the Member must send the appeal request to the IRE. The decision received from Vantage (Appeal Level 1) will tell the Member how to file this appeal, including who can file the appeal and how soon it must be filed.

If the Member is asked for Part C medical care or services, or payment for Part C medical care or services, and we did not rule completely in their favor at Appeal Level 1, the appeal is automatically sent to the IRE.

How soon must the IRE decide?

The IRE has the same amount of time to make its decision as Vantage had at Appeal Level 1.

If the IRE decides completely in the Member's favor:

The IRE will tell them in writing about its decision and the reasons for it.

- For a decision to pay back for a Part D drug already paid for and received, we must send payment within 30 calendar days from the date we receive notice reversing our decision.
- For a standard decision about a Part D drug not yet received, we must cover the Part D drug asked for within 72 hours after we receive notice reversing our decision.

- For a fast decision about a Part D drug not yet received, we must cover the Part D drug asked for within 24 hours after we receive notice reversing our decision.

- For a decision about payment for Part C medical care or services already received, we must pay within 30 days after we receive notice reversing our decision.

- For a standard decision about Part C medical care or services not yet received, we must authorize the requested Part C medical care or service within 72 hours, or provide it within 14 days after we receive notice reversing our decision.

- For a fast decision about Part C medical care or services, we must authorize or provide the requested Part C medical care or services within 72 hours after we receive notice reversing our decision.

16.9.2.1.3 Appeal Level 3: Administrative Law Judge (ALJ)

If the IRE does not rule completely in the Member's favor, the Member or their representative may ask for a review by an Administrative Law Judge (ALJ) if the dollar value of the Part D drug and/or Part C medical care or service asked for meets the minimum requirement provided in the IRE's decision. During the ALJ review, the Member may present evidence, review the record (by either receiving a copy of the file or accessing the file in person when feasible), and be represented by counsel.

How to file your appeal?

The request must be filed with an ALJ within 60 calendar days of the date the Member was notified of the decision made by the IRE (Appeal Level 2). The ALJ may give them more time if they have a good reason for missing the deadline. The decision received from the IRE will tell them how to file this appeal, including who can file it.

The ALJ will not review the appeal if the dollar value of the requested Part D drug and/or Part C medical care or service does not meet the minimum requirement specified in the IRE's decision. If the dollar value is less than the minimum requirement, the Member may not appeal any further.

How soon will the Judge make a decision?

The ALJ will hear the case, weigh all of the evidence, and make a decision as soon as possible.

If the Judge decides in the Member's favor:

See the Section "Favorable Decisions by the ALJ, MAC, or a Federal Court Judge" below for information about what Vantage must do if our decision denying what the Member asked for is reversed by an ALJ.

16.9.2.1.4 Appeal Level 4: Medicare Appeals Council (MAC)

If the ALJ does not rule completely in the Member's favor, they or their representative may ask for a review by the Medicare Appeals Council (MAC).

How to file the appeal?

The request must be filed with the MAC within 60 calendar days of the date the Member was notified of the decision made by the ALJ (Appeal Level 3). The MAC may give more time if the Member has a good reason for missing the deadline. The decision received from the ALJ will tell them how to file this appeal, including who can file it.

How soon will the Council make a decision?

The MAC will first decide whether to review the case (it does not review every case it receives). If the MAC reviews the case, it will make a decision as soon as possible. If it decides not to review the case, the Member may request a review by a Federal Court Judge (see Appeal Level 5). The MAC will issue a written notice explaining any decision it makes. The notice will tell them how to request a review by a Federal Court Judge.

If the Council decides in the Member's favor:

See the Section "Favorable Decisions by the ALJ, MAC, or a Federal Court Judge" below for information about what we must do if our decision denying what the Member asked for is reversed by the MAC.

16.9.2.1.5 Appeal Level 5: Federal Court

The Member has the right to continue the appeal by asking a Federal Court Judge to review the case if the amount involved meets the minimum requirement specified in the Medicare Appeals Council's decision, they received a decision from the Medicare Appeals Council (Appeal Level 4), and:

- The decision is not completely favorable to the Member, or
- The decision tells them that the MAC decided not to review the appeal request.

How to file the appeal?

In order to request judicial review of the case, the Member must file a civil action in a United States district court within 60 calendar days after the date they were notified of the decision made by the Medicare Appeals Council (Appeal Level 4). The letter they get from the Medicare Appeals Council will tell them how to request this review, including who can file the appeal.

The Member's appeal request will not be reviewed by a Federal Court if the dollar value of the requested Part D drug and/or Part C medical care or service does not meet the minimum requirement specified in the MAC's decision.

How soon will the Judge make a decision?

The Federal Court Judge will first decide whether to review the case. If it reviews the case, a decision will be made according to the rules established by the Federal judiciary.

If the Judge decides in the Member's favor:

See the Section "Favorable Decisions by the ALJ, MAC, or a Federal Court Judge" below for information about what we must do if our decision denying what the Member asked for is reversed by a Federal Court Judge.

If the Judge decides against the Member:

The Member may have further appeal rights in the Federal Courts. Please refer to the Judge's decision for further information about the appeal rights.

Favorable Decisions by the ALJ, MAC, or a Federal Court Judge

This Section explains what we must do if our initial decision denying what the Member asked for is reversed by the ALJ, MAC, or a Federal Court Judge.

- For a decision to pay back for a Part D drug already paid for and received, we must send payment within 30 calendar days from the date we receive notice reversing our decision.
- For a standard decision about a Part D drug that has been received, we must cover the Part D drug asked for within 72 hours after we receive notice reversing our decision.
- For a fast decision about a Part D drug that has not been received, we must cover the Part D drug asked for within 24 hours after we receive notice reversing our decision.
- For a decision about Part C medical care or services, we must pay for, authorize, or provide the medical care or service asked for within 60 days of the date we receive the decision.

16.9.2.2 PART 2. Complaints (appeals) if the Member thinks they are being discharged from the hospital too soon

When a Member is admitted to a hospital, the Member has the right to get all the hospital care covered by the Member's applicable plan that is necessary to diagnose and treat the illness or injury. The day the Member leaves the hospital (discharge date) is based on when the stay in the hospital is no longer medically necessary. This part explains what to do if the Member believes he/she is being discharged too soon.

Information the Member should receive during a hospital stay

Within two days of admission as an inpatient or during pre-admission, someone at the hospital must give the

Member a notice called the Important Message from Medicare (call Member Services or 1-800 MEDICARE (1-800-633-4227) to get a sample notice or see it online at http://www.cms.hhs.gov/BNI). This notice explains:

- The right to get all medically necessary hospital services paid for by the applicable plan (except for any applicable co-payments or coinsurance).
- The right to be involved in any decisions that the hospital, doctor, or anyone else makes about their hospital services and who will pay for them.
- The right to get services needed after they leave the hospital.
- The right to appeal a discharge decision and have the hospital services paid for by Vantage during the appeal (except for any applicable co-payments or coinsurance).

The Member (or their representative) will be asked to sign the Important Message from Medicare to show that they received and understood this notice. Signing the notice does not mean that they agree that the coverage for the services should end – only that they received and understand the notice. If the hospital gives the Important Message from Medicare more than 2 days before the discharge day, it must give the Member a copy of the signed Important Message from Medicare before they are scheduled to be discharged.

Review of the hospital discharge by the Quality Improvement Organization
The Member has the right to request a review of discharge. They may ask a Quality Improvement Organization to review whether they are being discharged too soon.

What is the "Quality Improvement Organization"?
"QIO" stands for Quality Improvement Organization. The QIO is a group of doctors and other health care experts paid by the federal government to check on and help improve the care given to Medicare patients. They are not part of Vantage or a hospital. There is one QIO in each state. QIOs have different names, depending on which state they are in. The doctors and other health experts in the QIO review certain types of complaints made by Medicare patients. These include complaints from Medicare patients who think their hospital stay is ending too soon.

Getting the QIO to review a hospital discharge
The Member must quickly contact the QIO. The Important Message from Medicare gives the name and telephone number of the QIO and tells them what they must do.

- The Member must ask the QIO for a "fast review" of the discharge. This "fast review" is also called an "immediate review."
- The Member must request a review from the QIO no later than the day they are scheduled to be discharged from the hospital. If they meet this deadline, they may stay in the hospital after their discharge date without paying for it while waiting to get the decision from the QIO.
- The QIO will look at the medical information provided to the QIO by Vantage and the hospital.
- During this process they will get a notice, called the Detailed Notice of Discharge, giving the reasons why we believe that the discharge date is medically appropriate. Call Member Services or 1-800-MEDICARE (1-800-633-4227 - TTY users should call 1-877-486-2048) to get a sample notice or see it online at http://www.cms.hhs.gov/BNI/).
- The QIO will decide, within one day after receiving the medical information it needs, whether it is medically appropriate for the Member to be discharged on the date that has been set.

What happens if the QIO decides in the Member's favor?
We will continue to cover the hospital stay (except for any applicable co-payments or coinsurance) for as long as it is medically necessary and they have not exceeded the applicable plan coverage limitations.

What happens if the QIO agrees with the discharge?
The Member will not be responsible for paying the hospital charges until noon of the day after the QIO gives

its decision. However, they could be financially liable for any inpatient hospital services provided after noon of the day after the QIO gives its decision. They may leave the hospital on or before that time and avoid any possible financial liability.

If the Member remains in the hospital, they may still ask the QIO to review its first decision if they make the request within 60 days of receiving the QIO's first denial of the request. However, they could be financially liable for any inpatient hospital services provided after noon of the day after the QIO gave its first decision.

What happens if the Member appeals the QIO decision?
QIO has 14 days to decide whether to uphold its original decision or agree that the Member should continue to receive inpatient care. If the QIO agrees that the care should continue, we must pay for or reimburse for any care received since the discharge date on the Important Message from Medicare, and provide inpatient care (except for any applicable co-payments or deductibles) for as long as it is medically necessary and they have not exceeded the applicable plan coverage limitations.

If QIO upholds its original decision, the Member may be able to appeal its decision to an Administrative Law Judge (ALJ). Please see Appeal Level 3 in Part 1 of this Section for guidance on the ALJ appeal. If the ALJ upholds the decision, they may also be able to ask for a review by the Medicare Appeals Council (MAC) or a Federal court. If any of these decision makers agree that the stay should continue, we must pay for or reimburse for any care received since the discharge date, and provide them with inpatient care (except for any applicable co-payments or coinsurance) for as long as it is medically necessary and they have not exceeded the applicable plan coverage limitations.

What if the Member does not ask the QIO for a review by the deadline?
If the Member does not ask the QIO for a fast review of the discharge by the deadline, they may ask us for a "fast appeal" of the discharge, which is discussed in Part 1 of this Section. If they ask us for a fast appeal of the discharge and the Member stays in the hospital past the discharge date, they may have to pay for the hospital care received past the discharge date. Whether they have to pay or not depends on the decision we make.

- If we decide, based on the fast appeal, that the Member needs to stay in the hospital, we will continue to cover the hospital care (except for any applicable co-payments or coinsurance) for as long as it is medically necessary and they have not exceeded the applicable plan coverage limitations.
- If we decide that the Member should not have stayed in the hospital beyond the discharge date, we will not cover any hospital care received after the discharge date.

If we uphold our original decision, we will forward our decision and case file to the Independent Review Entity (IRE) within 24 hours. Please see Appeal Level 2 in Part 1 of this Section for guidance on the IRE appeal. If the IRE upholds our decision, the Member may also be able to ask for a review by an ALJ, MAC, or a Federal court. If any of these decision makers agree that the stay should continue, we must pay for or reimburse the Member for any care received since the discharge date on the notice received from the Provider, and provide them with any services they asked for (except for any applicable co-payments or coinsurance) for as long as it is medically necessary and they have not exceeded the applicable plan coverage limitations.

16.9.2.3 PART 3. Complaints (appeals) if the Member thinks coverage for the skilled nursing facility, home health agency, or comprehensive outpatient rehabilitation facility services, is ending too soon

When the Member is a patient in a Skilled Nursing Facility (SNF), Home Health Agency (HHA), or Comprehensive Outpatient Rehabilitation Facility (CORF), they have the right to get all the SNF, HHA or CORF care covered by the applicable plan from Vantage that is necessary to diagnose and treat their illness or injury. The day we end coverage for the SNF, HHA or CORF services is based on when these services are no longer medically necessary. This part explains what to do if they believe that coverage for services is ending too soon.

Information the Member will receive during their SNF, HHA or CORF stay
You will give the Member a written notice called the Notice of Medicare Non-Coverage at least 2 days before coverage for the services ends (call Member Services or 1-800 MEDICARE (1-800-633-4227) to get a sample notice or see it online at http://www.cms.hhs.gov/BNI/). The Member (or the representative) will be asked to sign and date this notice to show that they received it. Signing the notice does not mean that they agree that coverage for the services should end – only that they have received and understood the notice.

Getting QIO's review of our decision to end coverage
The Member has the right to appeal our decision to end coverage for services. As explained in the notice they get from the Provider, they may ask the Quality Improvement Organization (the "QIO") to do an independent review of whether it is medically appropriate to end coverage for the services.

How soon does the Member have to ask for QIO's review?
The Member must quickly contact the QIO. The written notice they get from the Provider gives the name and telephone number of their QIO and tells them what they must do.

- If they get the notice 2 days before coverage ends, they must contact the QIO no later than noon of the day after they get the notice.
- If they get the notice more than 2 days before coverage ends, they must make the request no later than noon of the day before the date that Medicare coverage ends.

What will happen during the QIO's review?
The QIO will ask why the Member believes coverage for the services should continue. They do not have to prepare anything in writing, but may do so if they wish. The QIO will also look at the medical information, talk to the doctor, and review information that we have given to the QIO. During this process, the Member will get a notice called the Detailed Explanation of Non-Coverage giving the reasons why we believe coverage for services should end. Call Member Services or 1-800-MEDICARE (1-800-633-4227 - TTY users should call 1-877-486-2048) to get a sample notice or see it online at http://www.cms.hhs.gov/BNI/).

The QIO will make a decision within one full day after it receives all the information it needs.

What happens if the QIO decides in the Member's favor?
We will continue to cover SNF, HHA or CORF services (except for any applicable co-payments or deductibles) for as long as it is medically necessary and they have not exceeded the applicable plan coverage limitations.

What happens if the QIO agrees that coverage should end?
The Member will not be responsible for paying for any SNF, HHA, or CORF services provided before the termination date on the notice they get from the Provider. They may stop getting services on or before the date given on the notice and avoid any possible financial liability. If they continue receiving services, they may still ask the QIO to review its first decision if the request is made within 60 days of receiving the QIO's first denial of the request.

What happens if the Member appeals the QIO decision?
The QIO has 14 days to decide whether to uphold its original decision or agree that the Member should continue to receive SNF, HHA or CORF services. If the QIO agrees that the care should continue, we must pay for or reimburse the Member consistent with the appealed decision.

If the QIO upholds its original decision, the Member may be able to appeal its decision to an Administrative Law Judge (ALJ). Please see Appeal Level 3 in Part 1 of this Section for guidance on the ALJ appeal. If the ALJ upholds the decision, they may also be able to ask for a review by the Medicare Appeals Council (MAC) or a Federal court. If any of these decision makers agree that the services should continue, we must pay for or

reimburse the Member consistent with the appealed decision.

What if the Member does not ask the QIO for a review by the deadline?
If the Member does not ask the QIO for a fast review of the discharge by the deadline, they may ask us for a "fast appeal" of the discharge, which is discussed in Part 1 of this Section. If we uphold our original decision, we will forward our decision and case file to the Independent Review Entity (IRE) within 24 hours. Please see Appeal Level 2 in Part 1 of this Section for guidance on the IRE appeal. If the IRE upholds our decision, the Member may also be able to ask for a review by an ALJ, MAC, or a Federal court. If any of these decision makers agree that the services should continue, we must pay for or reimburse the Member consistent with the appealed decision.

QIO is sometimes referred to as KEPRO.

Method	KEPRO (Louisiana's Quality Improvement Organization)
CALL	(216) 447-9604 (844) 430-9504 Calls to this number are free.
FAX	(844) 878-7291
WRITE	5700 Lombardo Center Dr., Suite 100 Seven Hills, OH 44131
WEBSITE	*www.keproqio.com*

Section 17.0 - Medicare Outpatient Pharmacy Services

The Vantage Medicare Advantage outpatient prescription drug program is administered through Navitus, Vantage's Pharmacy Benefit Manager (PBM).

17.1 Prescribing Outpatient Medications

Any healthcare Provider licensed to prescribe medicines , and who is enrolled in (or validly opted out of) Medicare may write a prescription ("Prescriber") for a Vantage Medicare Advantage Member, provided it is within the scope of the Provider's medical licensure and within the terms of Vantage Medicare Advantage benefits.

17.2 Drugs Covered by the Outpatient Pharmacy Benefit

Vantage Medicare Advantage covers outpatient medications under two separate benefits: the Medicare Part B benefit and the Medicare Part D benefit.

Medicare Part B
Vantage Medicare Advantage covers certain outpatient medications not payable under the Medicare B benefit under the Medicare Part B benefit according to the same coverage policies and limitations as the Medicare program.

Medicare Part D
Vantage Medicare Advantage also covers outpatient medications under the Medicare Part D benefit. The

Medicare Part D benefit varies from one Part D sponsor to another. The Vantage Medicare Advantage Part D benefit is described below in Sections 17.2.1 through 17.5.

17.2.1 Formulary

As required by the Medicare program, Vantage Medicare Advantage has a formulary for outpatient medications covered under Vantage's Part D benefit. In general, Vantage Medicare Advantage will only cover drugs on our formulary. The Pharmacy and Therapeutics Committee (P & T), which is comprised of physicians and pharmacists, meets regularly to update the formulary. Working with the Vantage Medicare Advantage Pharmacy Benefit Manager (Navitus), the Pharmacy and Therapeutics Committee (P &T) reviews, at least annually, each category of drugs to identify preferred drugs based upon clinical and pharmaco-economic data. Changes to the formulary are communicated via Vantage's website. To view the Vantage Medicare Advantage formulary, visit our web site at *www.VantageMedicare.com*. To request a copy of the formulary, please contact Member Services (866)704-0109.

17.2.2 Formulary Rules

Members are required to use the generic version of all drugs on the formulary, except in cases where the generic version is medically inappropriate or not available. In some cases, only certain dosages of a drug are included on the formulary. As appropriate, Vantage may ask Members to try a specific drug to treat a condition before we approve coverage for an alternative drug for the condition.

17.3 Restrictions on coverage

Some covered drugs may have additional requirements or limits on coverage. These requirements and limits may include Prior Authorization, Quantity Limits, and/ (or) Step Therapy. The formulary will indicate which drugs may have these requirements and/ or limits on them. Please visit *www.VantageMedicare.com* for the most up-to-date formulary available.

17.3.1 Drugs Requiring Prior Authorization

Prior authorization (PA) is an essential tool that is used to ensure that drug benefits are administered as designed and that plan members receive the medication therapy that is safe, effective for their condition, and providers the greatest value. Prescribers must confirm that their patients have met the evidence based criteria in order to obtain an override to cover the specified drugs and for the claims to be paid. Requiring prior authorization in a drug benefit can effectively help avoid inappropriate drug use and promote the use of evidence-based drug therapy. Such efficient and effective use of healthcare resources can minimize overall medical costs, improve health plan member access to more affordable care and provide an improved quality of life. Drugs which may be candidates for PA include but are not limited to the following:

- Brand name drugs for which generic products are available. Generic substitution is mandatory unless prior authorized.
- Drugs that have dangerous side effects.
- Drugs that are harmful when combined with other drugs.
- Drugs you should use only for certain health conditions.
- Drugs that are often misused or abused.
- Drugs that a doctor prescribes when less expensive drugs might work better.

An Authorization request for outpatient pharmacy services may be denied for lack of Medical Necessity, or it may be denied for failure to follow administrative procedures outlined in the Provider contract or the Provider Manual. Denial notices are generated by Vantage and are sent to the Member and to the Prescriber. The denial notice will include information regarding the Member's appeal rights.

17.3.2 Quantity Limit, Step Therapy, Tier, and Formulary Exceptions Requests:

Practitioners must provide information to support an Exceptions Request, establishing that the restriction for the prescription drug has been ineffective in the treatment of the Member's disease or medical condition or is likely to be ineffective or adversely affect the drug's effectiveness or patient compliance. Data must be based on sound clinical, medical, and scientific evidence, the known relevant physical or mental characteristics of the Member, as well as on known characteristics of the drug regimen.

Quantity Limits-limitation on a drug, equal to or below the FDA-approved maximum daily dose.

Step Therapy-requires that a member must have tried and had negative results on one or two other drugs.

Tiering Exception-drug in a higher cost share tier is priced at a lower cost-sharing tier.

Formulary Exception- drug on the formulary would not be as effective and/or would have adverse side effects.

17.4 Prior-Authorization and Exceptions Request Procedure

Prior authorizations (PAs) and exceptions requests should be submitted directly to the Pharmacy Prior Authorization department . Standard requests may be submitted via fax to (318) 361-2170 or by phone at (888)-823-1910. A response will be provided within 24-72 hours. Please see Section 17.4.1 for information regarding expedited requests.

A copy of the Vantage Medicare Advantage Drug Prior Authorization Form is provided in Section 9.0. It is imperative that this form be completed in its entirety for the Prior Authorization Department to apply Vantage Medicare Advantage clinical criteria. The Prescriber or Prescriber's representative may complete the form. Additional PA forms are available by calling your Network Development representative or the Provider Services Department at (318) 361-0900. The PA form may also be downloaded from Vantage's website, *www.VantageMedicare.com.*

To check the status of a PA, you may contact the Prior Authorization Department at (888) 823-1910. Please refer to Section 17.4.1, for days and hours of operation.

Prior authorization approvals are generally valid for twelve (12) months although some PA approvals may be valid for a shorter time period, depending on the type of drug requested.

Coverage Determination Requests:

- Vantage will accept oral or written (mail, web, or faxed) coverage determination requests from a Member, a Member's representative, or a Prescriber. The request is logged into Vantage's system (Acuity®) documenting the date and time that the request was received.
- If the request was received from a Member or Member's representative, the Prescriber is contacted for information necessary to fulfill the requirements for coverage determination.
- If the request was received from a Prescriber but does not include all of the information needed, then the Prescriber is contacted for information necessary to fulfill the requirements for coverage determination.
- The request is then reviewed by a pharmacist to determine if the request meets the criteria.
- If the request meets the criteria, it is approved and entered into the prior authorization system. The pharmacy is notified and asked to resubmit the claim.
- If the request requires further review by a Medical Director, the request is then submitted for Medical Director review.
- If a Medical Director requests additional information, the additional information is obtained from the Prescriber by the pharmacy team member and resubmitted for Medical Director review.
- Determinations will be made within the appropriate time frame for both standard and expedited requests.
- Written notice of the request outcome will be provided to the Member or their designated representative and to the Prescriber.

17.4.1 Expedited Drug Prior-Authorization Requests

Expedited PA requests should be faxed to at 318-807-1042. A response will be provided within 24 hours if the PA form is complete. Providers may call the Pharmacy Prior Authorization Department at (888) 823-1910 for assistance. Expedited requests should be used only when the Prescriber believes that applying the 72 hour standard review time frame may seriously jeopardize the life or health of the Member or the Member's ability to regain maximum function.

17.4.2 Drug Prior-Authorization Decisions

The decision outcomes of a drug PA request are as follows:

- APPROVAL: If the information is complete and meets criteria, the PA is approved. The approval is faxed or called to both the Prescriber and pharmacy within 72 hours for a standard request and within 24 hours for an urgent request.
- DENIAL: If a PA request does not meet clinical criteria, the request is reviewed by a Vantage Medicare Advantage Medical Director and may be denied. The denial is communicated via phone and letter to the Prescriber and to the Member.

17.5 Part D Transition Policy

New Members in Vantage may be taking drugs that are not on our formulary or that are subject to certain restrictions, such as prior authorization or step therapy. Current Members may also be affected by changes in our formulary from one year to the next. Members should talk to their doctors to decide if they should switch to a different drug that we cover or request a formulary exception in order to get coverage for the drug. Please contact Member Services if the Member's drug is not on our formulary, is subject to certain restrictions, such as prior authorization or step therapy, or will no longer be on our formulary next year and they need help switching to a different drug that we cover or requesting a formulary exception.

During the period of time Members are talking to their doctors to determine the right course of action, we may provide a temporary supply of the non-formulary drug if those Members need a refill for the drug during the first 90 days of new membership with Vantage. If they are a current Member affected by a formulary change from one year to the next, we will provide a temporary supply of the non-formulary drug if they need a refill for the drug during the first 90 days of the new plan year.

When a Member goes to a network pharmacy and we provide a temporary supply of a drug that is not on our formulary, or that has coverage restrictions or limits (but is otherwise considered a "Part D drug"), we will cover a 30-day supply (unless the prescription is written for fewer days). After we cover the temporary 30-day supply, we generally will not pay for these drugs as part of our transition policy again. We will provide the Member with a written notice after we cover a temporary supply. This notice will explain the steps they can take to request an exception and how to work with a doctor to decide if they should switch to an appropriate drug that we cover.

If a new Member is a resident of a long-term-care facility (such as a nursing home), we will cover a temporary 31-day transition supply (unless the prescription is written for fewer days). If necessary, we will cover more than one refill of these drugs during the first 90 days a new Member is enrolled with Vantage. If the long-term-care facility resident has been enrolled with Vantage for more than 90 days and needs a drug that is not on our formulary or is subject to other restrictions, such as step therapy or dosage limits, we will cover a temporary 31-day emergency supply of that drug (unless the prescription is for fewer days) while the new Member pursues a formulary exception.

Vantage will cover a temporary 30-day supply of non-formulary drugs (unless the prescription is written for fewer days) for current Members residing in long-term-care facilities with level of care changes (e.g, from a

hospital to a long-term care facility).

Please note that our transition policy applies only to those drugs that are "Part D drugs" and bought at a network pharmacy. The transition policy cannot be used to buy a non-Part D drug or a drug out-of-network.

Notes:

Provider Compliance Training

All contracted healthcare providers of Vantage Health Plan, Inc. (Vantage) who support our Medicare Advantage plans must attest to an understanding of and adherence to Vantage's compliance program requirements as outlined in the following materials:

- Vantage's Compliance Policy
- Vantage's Code of Conduct
- Special Needs Plan training
- General Compliance and Fraud, Waste and Abuse (FWA) training (via CMS-published content)
- Vantage's First Tier, Downstream and Related Entities (FDR) Medicare Compliance Guide

Vantage recognizes that providers enrolled in the Medicare program or accredited as a durable medical equipment, prosthetics, or orthotics and supplies (DME POS) provider are deemed to have met the FWA training requirements. However, ALL providers are required to review, understand and follow Vantage's Compliance Policy, Vantage's Code of Conduct, the Special Needs Plan training and the FDR Medicare Compliance guide. All documents may be found on Vantage's website, https://www.vantagehealthplan.com/ as well as on Vantage's Provider Portal, https://portal.vantagehealthplan.com/.

Reviewing and understanding these materials and ensuring adherence to them will help you meet your contractual obligation to comply with state and federal laws. Vantage requires that all contracted providers share this information with their employees and, if applicable, any other individuals or entities which support them in meeting their contractual obligations to Vantage. Vantage reserves the right, at any time, to request evidence of compliance from your organization.

If you have any questions about any of the information contained in the following documents, please contact Vantage's Medicare Compliance Officer, Sally Knight-Rainer. She may be reached by email, sknight@vhpla.com or via phone, 318-998-3186.

Sincerely,

Joel Wiedeman

Charles Joel Wiedeman
Director of Compliance
Vantage Health Plan, Inc.

2017 Compliance Plan

Vantage Health Plan, Inc.

From the Office of the President & CEO

Introductory Statement to the Vantage Compliance Plan

The Vantage Compliance Plan has been formatted as a handbook to provide a clear mandate for all Vantage employees and first tier, downstream and related entities (FDRs) to follow regarding the company's compliance, ethical and professional standards. The Vantage Compliance Plan will enforce the highest standards of ethics and conduct.

The rules governing the healthcare industry are unusually complex. Activities that may be perfectly legal in other industries may be crimes when executed in the health care or health insurance industry. Both Vantage and its employees or its FDRs could face substantial penalties, including civil and criminal penalties, for compliance violations or violations of the law. To help our employees and FDRs deal with the complexity of the rules and regulations of our healthcare industry, we have developed this comprehensive Compliance Plan that addresses compliance issues throughout the organization.

The Vantage Compliance Plan provides general guidelines to help employees and FDRs understand how Vantage desires to conduct business. Though every possible situation cannot be covered in this document, the Compliance Plan serves to govern the conduct of all Vantage employees and FDRs. Employees or FDRs who observe another employee, FDRs or other individuals violating this Vantage's conduct requirements should follow the described process to report a violation. Vantage will not tolerate any form of retaliation against a person who reports a compliance violation in good faith.

Your knowledge of, and dedication to these standards, will allow us to serve our members in a professional, caring and compliant manner.

Thank you,

P. Gary Jones, M.D.
President & CEO

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Vantage Compliance Program Overview

The Vantage Health Plan Compliance Plan ("Plan") is designed to promote adherence to appropriate standards of business conduct throughout all aspects of Vantage's operation and to ensure conformance with applicable federal and state regulatory obligations by it and its employees (executive, management, and support staff), partners, vendors, independent agents, independent brokers and its first-tier entities, downstream entities, and related entities (FDRs). The Plan has been developed to ensure Vantage's Compliance Program is effectively operational.

The Plan is designed with direct reference to the compliance elements recommended in the U.S. Office of Inspector General's (OIG's) Compliance Program Guidance, Vol. 64, No. 219 of the Federal Register dated November 15, 1999, and in the Prescription Drug Benefit Manual, Chapter 9 –Compliance Program Guidelines, published by the Centers for Medicare and Medicaid Services (CMS).

Compliance is the establishment of activities, practices or policies in accordance with the requirements or expectations of an external authority. In managed care, it means meeting the expectations of those who regulate Vantage's business. The best approach to compliance is to take a proactive stance in meeting our regulatory obligations on a day-to-day basis. An effective compliance program must be backed up with solid, ongoing management and organizational processes to prevent, detect and correct violations of federal and state requirements.

Vantage has created this Plan to enforce its commitment to federal and state regulatory obligations. Vantage maintains high standards of business and personal ethical conduct. The Plan outlines the organization's compliance program, which promotes moral and ethical integrity. Vantage will take immediate steps to correct any violations of the Plan, including but not limited to imposing appropriate disciplinary actions and implementing corrective measures to prevent future violations. This compliance program is one of the key components of our commitment to the highest standards of corporate conduct.

This Compliance Plan is not merely a legal document; it is a process created as part of our culture. Effective compliance requires a partnership between Vantage and every employee and FDRs. As partners, both Vantage and its employees and FDRs have certain responsibilities. For example, Vantage must make every reasonable effort to provide employees and FDRs with access to information about the laws that govern the operation of Vantage as a Health Maintenance Organization providing Commercial, Qualified Health Plans ("QHP" or "Marketplace") and Medicare Advantage products. Similarly, employees and FDRs must make every effort to understand the rules. Thus, there will be periodic training programs that focus on compliance issues and changes in the law. Employees and FDRs may be required to attend all such training sessions. Employees and FDRs may also be asked to certify that they have received and read written materials describing various laws and policies including this Plan.

The integrity and support of the Plan is made at the highest level – Vantage Health Plan's Board of Directors. On at least an annual basis, the Compliance Committee reviews and updates the Plan as necessary. Any changes, including any regulatory or statutory updates, are presented to the Vantage's Board for approval.

This Compliance Plan adheres to all applicable state and federal laws, regulations and guidance. This Plan is being implemented and adhered to by Vantage. The Compliance Committee and Compliance staff ensure that appropriate processes are in place to maintain adherence with applicable regulations and guidelines, as well as to prevent fraud, waste, and abuse (FWA). Vantage shall inform the Louisiana Department of Insurance (LDOI), CMS and any other applicable regulatory entity of any significant changes to Vantage's organizational chart, which is attached to this Plan. Furthermore, Vantage will also notify and obtain approval from LDOI, CMS and any other applicable regulatory entity of any change in ownership that would materially affect Vantage, its members and/or providers.

The Compliance Department is involved in the day-to-day operations, plan and benefit administration, audit and reporting processes for Vantage's Medicare Advantage, Commercial and Marketplace products. The Compliance Department uses inter-departmental meetings, verbal and written communication, audits and project oversight to create and sustain processes to improve Vantage operations. Company-wide, the Compliance Department and the Legal Department are utilized as the resources for state and federal guidance while also assisting in the implementation and oversight of new and existing processes to meet and exceed government requirements. Audits and ongoing oversight of these processes instill a culture of compliance and adherence to regulations.

Vantage's Commercial book of business includes the Marketplace products. While some regulations and requirements differ between the Commercial and Marketplace product lines, there are many similarities between the two. For example, Vantage has incorporated much of CMS's Marketplace enrollment, eligibility, member services, marketing and accounting practices into its Commercial business practices. Vantage's Commercial Compliance Officer is responsible for the oversight of the Commercial and Marketplace product lines. The Compliance efforts for the Commercial and Marketplace product lines rely on both CMS and state rules and regulations.

The Medicare Advantage product line is the responsibility of the Medicare Compliance Officer. The Medicare Compliance Officer works closely with many departments to ensure that CMS requirements are maintained or exceeded. The Compliance efforts for the Medicare product line relies on CMS rules and regulations.

The Compliance Committee collaborates and shares ideas that apply across product lines. It is a common occurrence that a Medicare audit can easily be used for the Marketplace product or a Marketplace policy also apply to the Commercial product line. Employees are encouraged to use the Compliance Department as a resource for state and federal expectations, best business practices and general privacy, FWA and legal questions.

It may be challenging for employees and/or FDRs to determine whether an activity is legal. Vantage does not expect employees and/or FDRs to perform legal analysis. Instead, employees and/or FDRs are expected to exercise their best judgment and to express any concerns or doubts they may have to an appropriate supervisor or point of contact. Whenever employees are asked to undertake a new activity, they will be advised to consider whether it raises any potential compliance issues and whether it is appropriate to contact the applicable Vantage Compliance Officer. Vantage's General Counsel is responsible for providing legal advice to Vantage.

Mission Statement

Vantage Health Plan, Inc. ("Vantage") strives to be a health care innovator by proactively seeking opportunities to improve the quality of health care while balancing the cost of that care.

We are committed to service. We believe our employees, members, and providers deserve and expect honesty, integrity, quality, and excellence in an insurance company. We believe outstanding customer service is achieved by continually working to improve oneself and the health care products provided.

We are committed to strength. We're strong to keep you strong. We believe in providing our members with wellness and preventive services to promote health. We strive not only to offer quality health care, but a higher quality of life as a result of that health care.

We are committed to satisfaction. We believe communication must be clear to all for proper expectations to be met. Only with the understanding of one's health insurance coverage can proper expectations be made and satisfaction obtained. It is the goal and desire of every employee to provide excellent customer service thereby achieving member and provider satisfaction.

We are committed to solutions. We believe that for every challenge there is a win-win solution. We believe that a strong provider network and a variety of products are needed to meet the needs of our community and to provide quality health care.

We are committed to success! We believe that companies don't succeed, people do! You make Vantage possible. Therefore, it is our mission to help you succeed by providing exceptional service, rock-solid strength, customer satisfaction, and innovative solutions for your health care coverage needs.

Statement of Corporate Policy

1. It is the policy of Vantage to obey all federal, state and local laws including all regulations.

2. Every employee and/or FDR must make every reasonable effort to be aware of, and comply with all laws and regulations pertaining to Vantage's Commercial, Marketplace and Medicare Advantage products.

3. Every employee and/or FDR must make every reasonable effort to ensure that other employees and/or FDRs comply with the law.

4. Every employee and/or FDR has the obligation to report to the applicable Compliance Officer any activity that the employee or FDR suspects, or reasonably should suspect, violates any law, regulation or rule.

5. Every employee and/or FDR is required to cooperate with any audit performed by, or on behalf of, Vantage to review corporate compliance by Vantage.

6. No employee and/or FDR may discriminate or retaliate against another employee and/or FDR who has, in good faith, complied with the requirements of the Compliance Plan by reporting his or her concerns to a supervisor or the appropriate Compliance Officer, depending on the product line involved.

7. Currently Vantage's Compliance leadership consists of: Joel Wiedeman, Director of Compliance; Sally Knight, Medicare Compliance Officer; Jessica Self, Commercial and Marketplace Compliance Officer; and Robert Bozeman, General Counsel and Privacy Officer.

Compliance Plan Regulations

As described in the Code of Federal Regulations (CFR) 422.503(b)(4)(vi), an organization's compliance plan, at a minimum, must include the following elements:

- Written policies, procedures, and Code of Conduct that address Part C and Part D issues and which articulate Vantage's commitment to comply with all applicable federal and state standards.
- The designation of Compliance Officers and a Compliance Committee which are accountable to the Board of Directors and Executive staff.
- Effective training and education between the Compliance Officers and the organization's employees.
- Effective lines of communication between the Compliance Officers and the organization's employees.
- Enforcement of standards through well-publicized disciplinary guidelines.
- Procedures for internal monitoring and auditing.
- Provisions for ensuring prompt response to detected offenses and development of corrective action initiatives.

Another important element of Vantage's Compliance Plan is a comprehensive fraud, waste and abuse plan as listed in the Prescription Drug Benefit Manual, Chapter 9 – Compliance Program Guidelines. Vantage has created a separate document to address the requirements of the fraud, waste and abuse component. It is titled as the *Vantage Health Plan Fraud Waste and Abuse Program.* It is described in more detail below.

Vantage also complies with additional laws and regulations designed to promote adherence to appropriate standards of business conduct and to detect, correct, and prevent fraud, waste and abuse in its various operations. These include, but are not limited to:

- Social Security Act, ss. 1128, 1902, 1903, and 1932
- Code of Federal Regulations – specifically, 42 C.F.R. § 423.504(b)(4)(vi)(A), 42 C.F.R. § 423.504(b)(4)(vi)(B), 42 C.F.R. § 423.504(b)(4)(vi)(C), 42 C.F.R. § 423.504(b)(4)(vi)(D), 42 C.F.R. § 423.504(b)(4)(vi)(E)4, 42 C.F.R. § 423.504(b)(4)(vi)(F), 42 C.F.R. § 423.504(b)(4)(vi)(G), 42 C.F.R. § 423.503(b)(4)(vi)(A), 42 C.F.R. § 423.503(b)(4)(vi)(B), 42 C.F.R. § 423.503(b)(4)(vi)(C), 42 C.F.R. § 423.503(b)(4)(vi)(D), 42 C.F.R. § 423.503(b)(4)(vi)(E)4, 42 C.F.R. § 423.503(b)(4)(vi)(F), 42 C.F.R. § 423.503(b)(4)(vi)(G), 42 C.F.R. § 423.504(b)(4)(vi)(H); 45 C.F.R. Part 74; 45 CFR 164.530; 42 C.F.R. § 400, 403, 411, 417, 422, 423, 431, 433, 434, 435, 438, 441, 447, 455, 1001, and 1manual003
- Federal and State False Claims Acts
- Anti-Kickback Statute
- Prohibition on inducements to beneficiaries
- Health Insurance Portability and Accountability Act (HIPAA)

- Health Information Technology for Economic and Clinical Health (HITECH)
- Louisiana Statutes, Title 22, Chapter 2, Part III, Subpart A; Section 572.1
- Applicable state and federal civil and criminal statutes
- Prescription Drug Benefit Manual, Chapter 9
- All sub-regulatory guidance produced by CMS for Part C and Part D such as manuals, training materials, and guides
- All sub-regulatory guidance produced by CMS for insurers
- Applicable Civil Monetary Penalties and Exclusions
- Applicable provisions of the Federal Food, Drug and Cosmetic Act
- Contractual commitments with CMS and the Louisiana Department of Insurance

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Compliance Program Goals

The purpose of our Compliance Program is to promote sound business practices and prevent and detect violations of federal and state regulations and/or company policy.

The core goals of the Program include:

- Ensuring the ongoing commitment of the Board of Directors to the Compliance Program, including the Board of Directors' commitment to provide sufficient resources for the effective implementation of the program as well as the activities of the Compliance Officers and the Compliance Committee.

- Ensuring that the Board of Directors, which is the governing body for Vantage, shall be knowledgeable of the content, structure and administration of Vantage's Compliance Program and shall exercise reasonable oversight regarding the implementation and effectiveness of the Compliance Program.

- Ensuring that the Code of Conduct is acknowledged and adhered to by all employees, FDRs and the Board of Directors of Vantage.

- Development and revision of compliance policies and procedures as required by regulatory authorities, including approval by executive staff (President/CEO, Vice President, General Counsel) and/or the Board of Directors. and dissemination to employees through training.

- Maintenance of effective channels of communication within Vantage for the reporting of suspected violations of the organization's Code of Conduct, policies and procedures, contractual requirements, and/or any suspected action of fraud, waste, and abuse, without fear of reprisal for good faith reporting.

- Prompt investigation of all credible reports of suspected violations and violations reported to Vantage by regulatory agencies, including use of appropriate tracking methods and reporting requirements.

- Implementation of routine audits of Vantage's operations to assess compliance with applicable established state and federal regulatory requirements.

- Enforcement of disciplinary actions for violations of Vantage's policies and procedures and regulatory standards.

- Ensuring Vantage provides compliance training and fraud, waste and abuse (FWA) training to all its FDRs, whether directly or indirectly.

Compliance as an Element of Performance

Vantage reviews compliance as an element of performance for employees and first tier, related and downstream entities (FDRs).

Employees

Vantage requires the promotion of, and adherence to, the elements of the Compliance Plan by employees, and adherence to the Compliance Plan is a factor considered during employee performance evaluations. To assist employees with understanding their responsibilities associated with compliance, employees undergo initial and annual training in compliance policies and procedures.

Executive staff, department directors and department supervisors are required to: 1) discuss compliance policies and procedures applicable to the function of each employee; and 2) inform all relevant employees that strict compliance with policies and procedures is a condition of employment; and 3) disclose to all employees that Vantage will take disciplinary action up to and including termination for violation of policies and procedures.

Executive staff, department directors and department supervisors will be held accountable for failure to adequately instruct their subordinates or for failure to detect non-compliance with applicable policies and legal requirements where reasonable diligence on the part of the manager or supervisor should have led to the discovery of the non-compliant behavior by the employee.

Insurance Producers (Agents and/or Brokers)

Vantage employed producers are expected to make Vantage's health insurance products available to all potential members in a manner that is complete, fair, and accurate. Producers will support all prospective policyholders in making decisions about their health care coverage in a manner that best meets the prospective policyholder's needs.

As business associates of Vantage, producers who sell Commercial, Marketplace and Medicare Advantage plans are expected to comply with all the terms and conditions of the Vantage Compliance Program, Centers for Medicare and Medicaid Services (CMS) marketing regulations, HIPAA, and applicable state and federal regulations. To ensure compliance, Vantage has a sales audit process that ensures producers selling Medicare Advantage plans meet all CMS requirements, in accordance with Chapter 3 of the Medicare Managed Care Manual (Marketing Guidelines). Vantage also has a sales audit process that will ensure producers providing guidance for Healthcare Marketplace products meet all CMS requirements, including training and testing on Marketplace regulations.

Vantage's Compliance Department will perform sales audit processes on Medicare Advantage applications. The sales audit process will be accomplished via review of

enrollment applications submitted by producers; welcome calls to all new MAPD policyholders to ensure they understand the product and were treated in a fair manner during the sales process; and periodic in-person monitoring of sales calls.

As part of the Vantage producer certification process to sell Medicare Advantage products, producers will be required to undergo compliance training and pass a marketing compliance certification examination (with a minimum passing score of 85%) annually. The Medicare Compliance Officer and Director of Marketing are jointly accountable for all aspects of the Medicare producer training and certification program. For those producers who sell only Vantage Commercial products, they also undergo training. Any marketing-related violation will be reported to the appropriate Compliance Officer and depending upon the violation for disciplinary action, leading up to and including suspension and/or termination, may be imposed.

First Tier Downstream and Related Entities (FDRs)

Vantage contracts with First Tier Downstream and Related Entities (FDRs) to provide services to administer and support Vantage's operations of all product lines. FDRs must abide by Vantage's Compliance Plan and Code of Conduct. Vantage may provide training in Compliance Plan requirements, HIPAA Security and Privacy, and fraud, waste and abuse (FWA) as needed. FDRs must complete the Vantage Business Associate Agreement (BAA). Any required contracting documents must be completed by both parties prior to accessing any Vantage member information and/or acting on behalf of Vantage.

FDRs are reviewed against the Office of Inspector General (OIG) Exclusion List prior to contracting and at least annually thereafter. Any findings will be reported immediately to the Executive staff and actions will be taken immediately to mitigate any losses or member impact.

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Compliance Plan Components

As described in the regulatory guidance, Vantage's Compliance Plan is comprised of the following components:

- Written policies, procedures, and Code of Conduct that articulate the organization's commitment to comply with all applicable federal and state rules, regulations and standards.
- The designation of Commercial and Medicare Compliance Officers and a Compliance Committee who are accountable to Vantage's Board of Directors and executive staff.
- Effective training and education between the Compliance Officers and organization's employees.
- Effective lines of communication between the Compliance Officers and the organization's employees.
- Enforcement of standards through publicized disciplinary guidelines.
- Procedures for internal monitoring and auditing.
- Provisions for ensuring prompt response to potential violations and development of corrective action initiatives as needed.
- A comprehensive fraud, waste and abuse plan.

Vantage also addresses its commitment to HIPAA regulations through policies and procedures designed and implemented by Robert Bozeman, Vantage's General Counsel, who also serves as the Privacy Officer.

Component I – Policies & Procedures and Code of Conduct

The foundation and general guidance for the Compliance Plan is through written policies and procedures. The Compliance Officers will review the Compliance Department's policies and procedures on an annual basis. Additionally, new and/or revised policies and procedures will be developed as required throughout the year to remain in compliance with requirements. The written policies, procedures, and Code of Conduct will include the following components:

1. Articulation of Vantage's commitment to comply with all applicable federal and state rules, regulations and standards
2. Description of the compliance expectations as embodied in the Code of Conduct
3. Implementation of the Compliance Plan
4. Distribution of standards to employees and/or FDRs for addressing potential compliance issues
5. Communication of compliance issues to appropriate compliance personnel
6. Investigation and resolution of potential compliance issues
7. Inclusion of a policy of non-intimidation and non-retaliation for good faith participation in the Compliance Plan, including but not limited to good faith reporting of potential issues, investigating issues, conducting self-evaluations, audits and remedial actions and reporting to appropriate officials

Vantage's *Code of Conduct* describes Vantage's commitment to ethical behavior and reflects its commitment to operate in accordance with accepted standards of business conduct. The *Code of Conduct* is reviewed and endorsed annually by Vantage's Board of Directors. The *Code of Conduct* is written in an easily understood format. The *Code of Conduct* is Vantage's foundation for ensuring integrity in all activities undertaken on its behalf.

Employees must review and attest to the Code of Conduct during their initial hiring and annually thereafter. Initial attestations shall be in writing and maintained in the employee's Human Resources records. Annual attestations may be performed in Vantage's on-line tool, Policy Center. Additionally, the *Code of Conduct* is available to all employees through Policy Center for review at any time. For providers and other FDRs, the *Code of Conduct* is provided by request and on Vantage's general website (*www.VantageHealthPlan.com*).

Component II – Compliance Officer(s) and Compliance Committee

The Compliance Officers serve as the focal point for all compliance activities within Vantage and the liaison with federal and state regulators. The Medicare Compliance Officer and the Commercial Compliance Officer are both accountable to Vantage's Board of Directors. This reporting structure will allow the Compliance Officers to function independently and objectively by reviewing and evaluating compliance issues/concerns within the organization.

Vantage is required to designate a full-time employee of the organization as the Medicare Compliance Officer to oversee the Medicare Compliance Program and operational compliance of the organization. Vantage also designates a full-time employee of the organization as the Commercial Compliance Officer to oversee the Commercial Compliance Program and operational compliance of the organization.

Each Compliance Officer shall serve as the focal point for all compliance activities for the applicable product line – Commercial or Medicare Advantage. These persons have the primary responsibility of overseeing the implementation of the Compliance Plan and ensuring that all policies and procedures are accurate and timely implemented. Coordination and communication are key functions of the Compliance Officer's responsibilities.

Each Compliance Officer has the following responsibilities, as applicable to the Commercial and Medicare Advantage product lines:

- Oversee and monitor the implementation of the Compliance Plan.
- Ensure employees receive, review, and fully understand the Compliance Plan.
- Answer questions concerning compliance issues or provide a process for employees or FDRs to refer the questions to the appropriate Compliance Officer.

- Develop and facilitate educational and training programs that focus on compliance issues and ensure employees and/or FDRs are informed and comply with applicable federal and state standards and Vantage's *Code of Conduct*.

- Create policies, programs and communication materials that encourage and prompt all employees to report suspected compliance violations, fraud, waste, abuse and other potential compliance concerns. This responsibility will include communication of non-retaliation policies and protective measures for good faith reporting.

- Annually review and revise (as needed) the Compliance Plan to reflect changes in organizational needs, government policies, and procedures. Revisions and updates may also apply to the Vantage Employee Handbook as appropriate in coordination with Vantage's Human Resources department.

- Ensure regulatory and operational documents are current and available to Vantage employees.

- Objectively and independently investigate potential compliance issues. As needed, the Compliance Officer(s) shall facilitate an investigation and any subsequent corrective action(s) with employees and/or FDRs providing services to Vantage.

- Report program improvements and solutions to reduce Vantage's exposure to compliance violations and/or fraud, waste and abuse to the Compliance Committee on a quarterly basis or as needed.

- Report incidents of non-compliance including, but not limited to situations involving fraud, waste and abuse to the executive staff and/or the Vantage Board of Directors.

The Compliance Officers and their designee(s) have the authority to review all documents and other information which are relevant to compliance activities, including but not limited to: research data, member records, claims records, records concerning marketing, and FDRs. Compliance Officer responsibilities are multi-faceted, primarily concerned with assuring the organization complies with state and federal laws and regulations in accordance with contractual requirements, established policies and procedures, and the *Code of Conduct*.

Vantage's General Counsel serves as Vantage's Privacy Officer. The regulatory guidelines for designating a Privacy Officer are found at 45 CFR 164.530. The regulatory guidance identifies the roles and responsibilities of the privacy official including the following: conducting privacy training, overseeing administrative, technical and physical safeguards to protect PHI, addressing privacy-related complaints, applying appropriate disciplinary actions against employees and/or FDRs, mitigating harmful effects of the use or disclosure of PHI, protection from retaliatory actions, and revising policies and procedures as necessary to comply with changes in law.

Vantage has established a Compliance Committee which is co-chaired by the Medicare and Commercial Compliance Officers. The committee is involved in implementing, maintaining, and revising the Compliance Plan. The members of the committee include individuals with a variety of backgrounds who understand the vulnerabilities within their respective areas of expertise. The Compliance Committee annually performs a risk assessment of various operational areas to detect exposure for potential non-compliance. Furthermore, at the discretion of the Compliance Officers, ad hoc members may be present as required during the committee meetings to address specific compliance concerns or compliance activities. Standing members of the Compliance Committee include the following:

Chairs	Members
Medicare Compliance Officer Commercial Compliance Officer	Chief Executive Officer
	Executive Vice President
	Chief Financial Officer
	Chief Information Officer
	Medical Director
	Director of Medical Management
	Controller
	Director of Marketing
	Director of Member Services and Commercial Enrollment
	Director of Provider Relations Networking
	Director of Human Resources
	Director of Compliance
	General Counsel
	Board of Directors Representative

The Compliance Committee meets quarterly or more frequently as deemed necessary. All Compliance Committee activities are recorded in minutes that are maintained in files under the direct control of the Compliance Officers. The Compliance Officers shall present Compliance Committee activities to Vantage's Board of Directors and/or CEO.

The specific responsibilities and activities of the Compliance Committee are as follows:

- Developing strategies to promote compliance and the detection of any potential violations.
- Monitoring and auditing of potential regulatory environment and specific risk areas for Vantage.
- Reviewing existing policies and procedures and assisting in the development of new policies and procedures as warranted.
- Developing the *Code of Conduct* for all staff of Vantage (executive, management, and support staff) including the facilitation of organization-wide communication regarding adherence to the *Code of Conduct*, operational policies and procedures, and state and federal laws and regulations.

- Recommending and monitoring the development of internal systems and controls to reduce compliance violations.
- Assisting with the creation and implementation of monitoring and auditing efforts.
- Ensuring compliance and fraud, waste and abuse training and education are completed as required for employees and FDRs.
- Assisting in the creation of effective corrective action plans and ensure they are implemented and monitored.
- Supporting the Compliance Officers' needs for sufficient staff and resources to carry out their duties.
- Ensuring there is a system for employees, FDRs and members to report in good faith potential compliance violations and/or instances of fraud, waste or abuse confidentially or anonymously (if desired) without fear of retaliation.
- Reviewing and approving the Compliance Plan and other related compliance oversight activities (i.e. Medicare audit calendar) prior to the Board of Directors' endorsement.
- Ensuring that training and education are appropriately completed.
- Providing regular and ad hoc reports on the activities and status of compliance efforts, including issues identified, investigated, and resolved, to the Board of Directors.
- Ensuring that the Board of Directors is knowledgeable of the content and operations of Vantage's Compliance Program.
- Ensuring that the Board of Directors understand and exercise its responsibility to provide reasonable oversight regarding the implementation and effectiveness of the Compliance Program.

Component III – Training and Education

Education and ongoing training programs are the core elements to compliance success at Vantage. Training increases employees' knowledge of compliance and is designed to cover high risk areas. Vantage's training and education include the following components:

- A description of the Compliance Plan, including a review of compliance policies and procedures, the *Code of Conduct*, and Vantage's commitment to business ethics and compliance.
- An overview of the process to ask compliance questions, request compliance clarification or good faith reporting of potential non-compliance. Training emphasizes confidentiality, anonymity, and non-retaliation for compliance-related questions or reports of potential non-compliance.
- A review of the disciplinary guidelines for non-compliant or fraudulent behavior. Disciplinary actions may include counseling and verbal warning(s), written/formal warning(s), or possible termination when such behavior is serious or repeated or when knowledge of a possible violation is not reported.
- A review of policies related to contracting with the government, such as the laws addressing fraud and abuse or gifts and gratuities for governmental employees.

- A review of potential conflicts of interest and Vantage's disclosure/attestation documentation.
- An overview of HIPAA, the CMS Data Use Agreement, and the importance of maintaining the confidentiality of Protected Health Information ("PHI").
- An overview of the compliance monitoring and auditing efforts.

Component IV – Effective Lines of Communication

A key component to the Compliance Plan is the ability to implement effective lines of communication ensuring confidentiality between the Compliance Officers, members of the Compliance Committee, Vantage's employees, the Board of Directors, and Vantage's FDRs.

The Compliance Officers will implement Vantage's non-retaliation policy to encourage employees and FDRs to report, in good faith, suspected or confirmed misconduct without fear of retribution. To meet the requirement of maintaining confidentiality, allowing anonymity (if desired), and ensuring non-retaliation, Vantage has instituted several avenues for reporting compliance concerns.

Joel Wiedeman is Vantage's Director of Compliance. Mr. Wiedeman provides direction and oversight of the Compliance Program. This role is responsible for ensuring the execution of the compliance initiatives for all lines of business within Vantage Health Plan. The Director of Compliance has management oversight of the compliance officers within Vantage. The following options are made available to report suspected or confirmed fraud, waste and abuse issues or other compliance concerns as they are identified:

- Compliance Hotline: 888-607-0058
- Compliance Email: complianceissues@vhpla.com

Vantage's Medicare Compliance Officer is Mrs. Sally Knight-Rainer. Mrs. Knight-Rainer is the contact for reporting violations pertaining to the Medicare Advantage Plans, its members, and those producers who sell this line of business. The following options are made available to report suspected or confirmed fraud, waste and abuse issues or other compliance concerns as they are identified:

- Compliance Hotline: 888-607-0058
- Medicare Compliance Fax: 318-361-2184
- Medicare Compliance Email: complianceissues@vhpla.com

The Plan's Commercial Compliance Officer is Mrs. Jessica Self. Mrs. Self is the contact for reporting violations pertaining to the Commercial and Marketplace Plans, its members, and those producers who sell this line of business. The following options are made available to report suspected or confirmed fraud, waste and abuse issues or other compliance concerns as they are identified:

- Compliance Hotline: 888-607-0058

- Commercial/Marketplace Compliance Fax: 318-807-1036
- Compliance Email: complianceissues@vhpla.com

Vantage's General Counsel, Robert Bozeman, is a member of the Compliance Committee and serves as a resource for the Compliance Department. Compliance issues which involve the interpretation and/or application of federal or state law shall be directed to General Counsel for his review. General Counsel shall serve as the liaison with any federal or state law enforcement agency (civil or criminal) regarding Compliance, Privacy or other issues related to Vantage.

The Compliance Department will distribute to employees "Compliance Emails", as appropriate. These emails are an additional avenue for the Compliance Officers to communicate important changes to regulations and processes. They also provide reminders and helpful tips for employees to perform their responsibilities in a compliant and ethical manner. Compliance emails, alerts and other compliance communications are sent to the entire organization through the company-wide email distribution.

Vantage also produces Member Newsletters which are distributed to all members. Included within the Newsletters are internal and external resources for members to report noncompliance and fraudulent activity, ensuring confidentiality and non-retaliation against those who report such incidences.

The Compliance Plan strictly prohibits retaliation against those who, in good faith, report concerns or participate in the investigation of any compliance issues.

Component V – Enforcement of Disciplinary Standards & Guidelines

The Compliance Plan includes elements and methods of publicized disciplinary standards, including standards and disciplinary guidelines such as:

- Expectations for reporting and resolving compliance issues
- Identify noncompliant or unethical behavior
- Provide timely, consistent, and effective enforcement of the standards when noncompliant or unethical behavior is determined.

Any suspected compliance violation will be investigated by the applicable Compliance Officer and/or his/her designee. Each violation will be considered on a case-by-case basis and disciplinary actions will be imposed fairly and consistently. The disciplinary guidelines apply to employees and all FDR's. Vantage has disciplinary guidelines that include the following steps:

1) Counseling and Verbal Warning
2) Written/Formal Warning
3) Corrective Action Plan
4) Termination of Employment or Agreement

The Compliance Officers reserve the right to recommend disciplinary actions on employees or FDR's for committing non-compliant violations.

Following an investigation that confirms an employee has violated one or more of the elements of the *Code of Conduct* and/or Vantage's Compliance Plan, disciplinary action will be undertaken. All acts of discipline will include consultation with the Director of Human Resources. The Compliance Officers reserve the right to combine or skip levels in the disciplinary process depending upon the facts of each situation and the nature of the compliance violation. Some actions or compliance violations may subject an employee to immediate suspension or termination of employment.

In order to ensure that employees fully understand and appreciate the serious consequences of compliance violations, the disciplinary process is described in separate compliance policies. The Employee Handbook and the initial employee compliance training also discusses the disciplinary process.

Vantage follows a similar disciplinary process for its FDRs. When a compliance issue arises with an FDR, all acts of discipline will be carried out by the applicable Compliance Officer and appropriate parties. The Compliance Officers reserve the right to combine or skip levels in the disciplinary process depending upon the facts of each situation and the nature of the compliance violation. Some actions or compliance violations may subject a FDR to immediate termination of contract. The disciplinary process is described in separate compliance policies.

Component VI – Monitoring & Auditing

Internal monitoring and auditing provides a process to assess organizational performance with regulations, contractual agreements, and applicable state and federal laws, as well as internal policies and procedures and established performance standards. Vantage will establish and implement an effective work plan for monitoring and auditing each year to perform comprehensive internal audits to ensure compliance. The work plan is designed by performing risk assessments with Vantage's various departments to identify compliance risks. The work plan also includes those areas historically identified by regulatory agencies as high risk. The work plan will also include internal monitoring and audits and as appropriate, external audits, to evaluate Vantage's compliance with CMS requirements and the overall effectiveness of the Compliance Plan.

The Compliance Department may conduct departmental monitoring and auditing activities throughout the year. Each audit performed by the Compliance Department will identify the objectives, scope, methodology, findings, recommendations, corrective action plans, resolutions and follow-up, as applicable. Any deficiencies identified by the Compliance Department will be tracked and monitored. Where applicable, audit tools will model the CMS audit tools. Audit tools will be reviewed and updated according to current and revised guidelines. For areas where CMS has not developed or distributed audit tools, the Compliance Department may develop or purchase audit tools which incorporate CMS requirements.

The Compliance Officers will report and provide updates on the monitoring results to the Compliance Committee and executive personnel. Vantage maintains ultimate responsibility for fulfilling the terms and conditions as set out in its contract(s) with CMS and its licensing obligations with the LDOI. Vantage is liable for any failure to meet all such requirements.

Component VII – Ensuring Prompt Response & Development of Corrective Actions

The Compliance Plan has established and implemented procedures for promptly responding to compliance issues, investigating potential compliance self-evaluations and audits, correcting problems promptly and thoroughly to reduce recurrences, and ensuring ongoing compliance with applicable federal and state requirements. The Compliance Department inquiry/investigation shall be timely and reasonable where evidence suggests misconduct. The initiating source of the inquiry may be an employee, provider or member complaint, a result of an internal audit, or other means. The Compliance Department considers the appropriate time of initiation of the inquiry to be immediate, but no later than two (2) weeks from the date the potential misconduct is identified and/or brought to the attention of the Compliance Department. Vantage ensures a prompt response to all detected offenses. Research and investigation timeframes may also be dictated by the source of the inquiry.

The inquiry is officially initiated by recording the investigation in the Compliance Log. The inquiry includes an investigation of the matter by the applicable Compliance Officer and/or his/her designee. These research efforts include, but are not limited to, the collection of facts, review of regulatory guidance, contact with members, and/or providers, internal requests from applicable departments, and interviews with appropriate employees.

All research, inquiries, and other investigative activities are kept as confidential as possible. Factual information is assembled, interviews conducted and recorded, and written responses obtained in order to ensure that the inquiry remains objective. Upon completing the inquiry, the applicable Compliance Officer and/or his/her designee shall complete a written summary of the findings.

In the case of compliance violations, the applicable Compliance Officer shall prepare a corrective action plan (“CAP”). The CAP will be appropriate (i.e. repayment of overpayments, disciplinary actions against responsible employee) in response to the violation. The written corrective action plan will be presented to the Compliance Committee for review, modification, and approval. It is the responsibility of the applicable Compliance Officer to ensure that the CAP is launched, monitored, and the results reported back to the Compliance Committee within the timeframe established. All communication regarding the CAP will be in writing and maintained in the Compliance Department’s files. Further, Vantage may voluntarily self-report potential fraud or misconduct to CMS, LDOI or other regulatory agency as appropriate.

Component VIII –Fraud, Waste and Abuse Program

Vantage has established a comprehensive fraud and abuse plan, respectively titled the *Vantage Health Plan Fraud, Waste and Abuse Program* ("Fraud Program"). The Fraud Program is intended to detect, prevent and control fraud, waste and abuse. The Fraud Program includes procedures to voluntarily self-report potential fraud or misconduct to the appropriate regulatory agencies.

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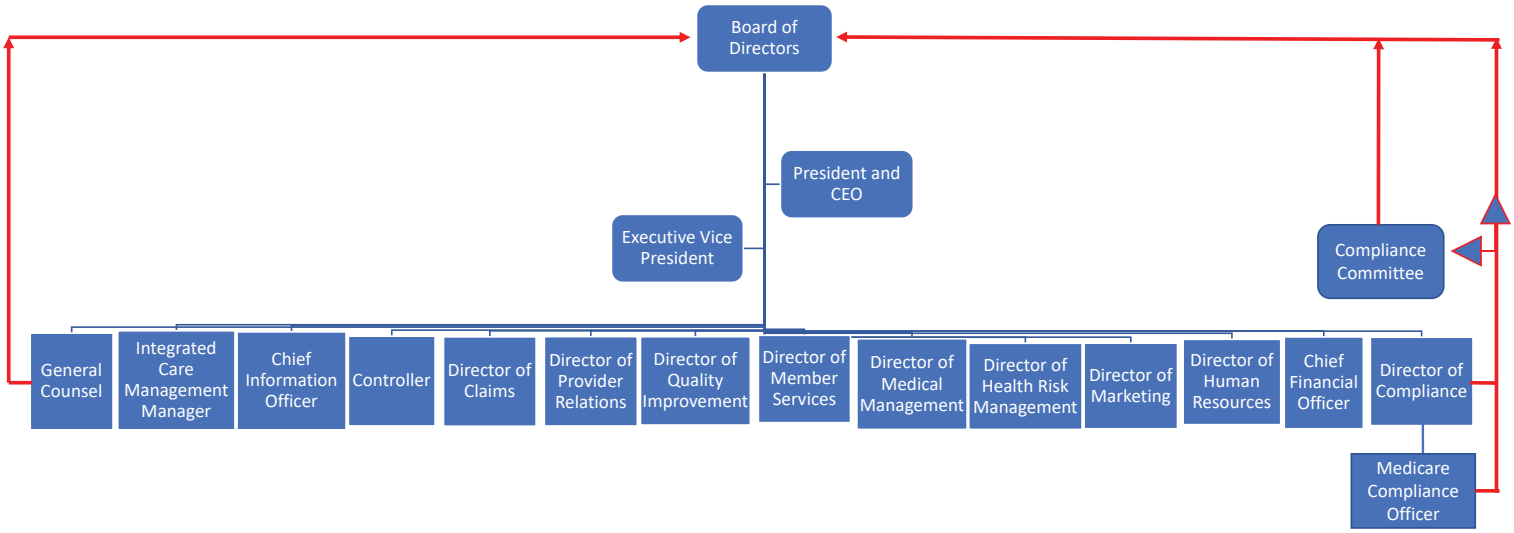
Corporate Governance and Accountability – Medicare Parts C/D



2017 Code of Conduct

Vantage Health Plan's Code of Conduct

Mission Statement:

Vantage Health Plan, Inc., "Vantage", strives to be a health care innovator by proactively seeking opportunities to improve the quality of health care while balancing the cost of that care.

We are committed to service. We believe our employees, members, and providers deserve and expect honesty, integrity, quality, and excellence in an insurance company. We believe outstanding customer service is achieved by continually working to improve oneself and the health care product provided.

We are committed to strength. We're strong to keep you strong. We believe in providing our members with wellness and preventive services to promote health. We strive not only to offer quality health care, but a higher quality of life as a result of that health care.

We are committed to satisfaction. We believe communication must be clear to all for proper expectations to be met. Only with the understanding of one's coverage can proper expectations be made and satisfaction obtained. It is the goal and desire of every employee to provide excellent customer service thereby achieving member and provider satisfaction.

We are committed to solutions. We believe that for every challenge there is a win-win solution. We believe that a strong provider network and a variety of products are needed to meet the needs of our community and to provide quality health care.

We are committed to success! We believe that companies don't succeed, people do! You make Vantage possible. Therefore, it is our mission to help you succeed by providing exceptional service, rock-solid strength, customer satisfaction, and innovative solutions for your health care coverage needs.

Build Trust and Credibility

The success of our business is dependent on the trust and confidence we earn from our customers, employees, providers and brokers. We gain credibility by adhering to our commitments, displaying honesty and integrity and reaching company goals solely through honorable conduct. It is easy to say what we must do, but the proof is in our actions. Ultimately, we will be judged on what we do.

When considering any action, it is wise to ask: will this build trust and credibility for Vantage? Will it help create a working environment in which Vantage can succeed over the long term? Is the commitment I am making one I can follow through with? The only way we will maximize trust and credibility is by answering "yes" to those questions and by working every day to build our trust and credibility.

Employment Relationship

We all deserve to work in an environment where we are treated with dignity and respect. Vantage is committed to creating such an environment because it brings out the full potential in each of us, which, in turn, contributes directly to our business success. We cannot afford to let anyone's talents go to waste.

Vantage is an equal employment/affirmative action employer and is committed to providing a workplace that is free of discrimination in all aspects of the employment relationship, including recruitment and employment, work assignment, promotion, transfer, salary administration, selection for training, corrective action and termination. The workplace will be free from abusive, offensive or harassing behavior. Any employee who feels harassed or discriminated against should report the incident to his or her manager or to Human Resources.

All employees and First Tier, Downstream and Related Entities (FDRs) are required to observe Vantage's commitment and extend to each other appropriate behavior in the workplace. All employees should be familiar with Vantage's employment policy and procedures. Any questions on these policies should be directed to your supervisor, Human Resources or the Compliance Officer.

Create a Culture of Open and Honest Communication

At Vantage everyone should feel comfortable to speak his or her mind, particularly with respect to ethics concerns. Managers have a responsibility to create an open and supportive environment where employees feel comfortable raising such questions. We all benefit tremendously when employees exercise their power to prevent mistakes or wrongdoing by asking the right questions at the right times.

Vantage will investigate all reported instances of questionable or unethical behavior. In every instance where improper behavior is found to have occurred, the company will take appropriate action. We will not tolerate retaliation against employees who raise genuine ethics concerns in good faith.

For your information, Vantage's **non-retaliation** policy is attached.

Set Tone at the Top

Management has the added responsibility for demonstrating, through their actions, the importance of this Code. In any business, ethical behavior does not simply happen; it is the product of clear and direct communication of behavioral expectations, modeled from the top and demonstrated by example. Again, ultimately, our actions are what matters.

To make our Code work, managers must be responsible for promptly addressing ethical questions or concerns raised by employees and for taking the appropriate steps to deal with such issues. Managers should not consider employees' ethics concerns as threats or challenges to their authority, but rather as another encouraged form of business communication. At Vantage, we want the ethics dialogue to become a natural part of daily work.

Compliance with the Law

Vantage's commitment to integrity begins with complying with laws, rules and regulations where we do business. All employees are bound by these laws and regulations as well as policies and procedures described in the Employee Handbook.

Each of us must have an understanding of the company policies, laws, rules and regulations that apply to our specific roles. If we are unsure of whether a contemplated action is permitted by law or Vantage policy, we should seek the advice from the resource expert. We are responsible for preventing violations of law and for speaking up if we see possible violations.

Fraud, Waste and Abuse

All employees and First Tier, Downstream and Related entities are responsible for reporting any suspected health care fraud, waste and abuse to the appropriate Compliance Officer immediately. Be prepared to give the name, phone number and office location, the item or service in question, the date of the service, and reason you believe that fraud, waste or abuse has occurred if the incident being reported is provider-related. If the incident being reported originates from a Vantage contractor or internally, please record as much information and detail as possible and report the incident to the Compliance Officer immediately. Vantage will protect your identity as much as reasonably possible. All employees shall receive fraud, waste, and abuse ("FWA") training no less than once every twelve months. New employees shall successfully complete FWA training during the first ninety (90) days of employment.

Kickbacks

The purchase or sale of goods and services must not lead to employees or their families receiving kickbacks. Kickbacks or rebates may take many forms and are not limited to direct cash payments or credits. If an employee, FDR or a policyholder of the family stands to gain personally through a transaction, it is

prohibited. Employees should consult with Legal Counsel if there is a question as to whether a proposed arrangement will result in an inappropriate kickback.

Anti-Money Laundering

Vantage will comply with laws and regulations in the USA Patriot Act designed to deter money-laundering and combat financial terrorism. Any activity aimed at concealing the origin of unlawfully gained money is strictly prohibited by Vantage. Vantage will use all reasonable efforts to prevent itself from being used by others to facilitate money laundering and the financing of terrorist activities. Further, Vantage will only conduct business with reputable providers and vendors engaged in legitimate business activities, with money derived from legitimate sources. If it suspected that Vantage has received a suspicious payment or is being used to aid money laundering, it must be immediately report to the Legal Counsel or a Supervisor.

Competition

We are dedicated to ethical, fair and vigorous competition. We will sell Vantage products and services based on their merit, superior quality, functionality and competitive pricing. We will make independent pricing and marketing decisions and will not improperly cooperate or coordinate our activities with our competitors. We will not offer or solicit improper payments or gratuities in connection with the purchase of goods or services for Vantage or the sales of its products or services, nor will we engage or assist in unlawful boycotts of particular customers.

Proprietary Information

It is important that we respect the property rights of others. We will not acquire or seek to acquire improper means of a competitor's trade secrets or other proprietary or confidential information. We will not engage in unauthorized use, copying, distribution or alteration of software or other intellectual property.

OSHA

Vantage is dedicated to maintaining a healthy environment. A safety manual has been designed to educate you on safety in the workplace. If you do not have a copy of this manual, please see our Occupational Health Nurse.

Conflict of Interest

You must avoid any situation where a conflict of interest exists or might appear to exist between your personal interests and those of Vantage. The *appearance* of a conflict of interest may be as serious as an *actual* conflict of interest. Do not let any outside financial interest influence your decisions or actions you take at Vantage. An example might include personal or family enterprises that conduct business with Vantage, its parent company, a subsidiary of Vantage or a competitor.

As a rule, Vantage will not purchase goods or services from any business in which an employee or close relative of an employee has a substantial interest. Similarly,

Vantage will not sell, give or lend any Vantage equipment, furniture, supplies or materials to any employees for their personal use. Occasional exceptions may be made when it's in the best interest of Vantage, but only when documented and approved by senior management and the Compliance Officer.

Employees should not conduct outside activities during work time. This will interfere with your regular duties and adversely affect the quality of work performed. This could also negatively affect Vantage's reputation.

There are many types of situations where potential conflicts may arise as seen list below. This is not an all-inclusive list. If you encounter a situation where a possible conflict of interest may be involved, disclose it promptly to your supervisor or to the Compliance Officer.

Here are some other ways in which conflicts of interest could arise:

1. Being employed (you or a close family member) by, or acting as a consultant to, a competitor or potential competitor, supplier or contractor, regardless of the nature of the employment, while you are employed with Vantage.

2. Serving as a board member for an outside commercial company or organization.

3. Owning or having a substantial interest in a competitor, supplier or contractor.

4. Having a personal interest, financial interest or potential gain in any Vantage transaction.

5. Accepting gifts, discounts, favors or services from a customer/potential customer, competitor or supplier, unless equally available to all Vantage employees.

Determining whether a conflict of interest exists is not always easy to do. Employees with a conflict of interest question should seek advice from management. Before engaging in any activity, transaction or relationship that might give rise to a conflict of interest, employees must seek review from their managers, the HR department or the Compliance Officer.

Gifts, Gratuities, Entertainment and Business Courtesies

Vantage is committed to competing solely on a merit of our products and services. We should avoid any actions that create a perception that favorable treatment of outside entities by Vantage was sought, received or given in exchange for personal business courtesies. Business courtesies include gifts, gratuities, meals, refreshments, entertainment or other benefits from persons or companies with whom Vantage does or may do business.

We will neither give nor accept business courtesies that constitute, or could reasonably be perceived as constituting, unfair business inducements that would violate law, regulation or polices of Vantage or customers, or would cause embarrassment or reflect negatively on Vantage's reputation.

Vantage employees or FDRs should contact their manager or the Compliance Officer if they are unsure if accepting a gift or gratuity is permitted.

Most business courtesies offered to us in the course of our employment are offered because of our positions at Vantage. We should not feel any entitlement to accept and keep a business courtesy. Although we may not use our position at Vantage to obtain business courtesies, and we must never ask for them, we may accept unsolicited business courtesies that promote successful working relationships and good will with the firms that Vantage maintains or may establish a business relationship with.

Employees who award contracts or who can influence the allocation of business, who create specifications that result in the placement of business or who participate in negotiation of contracts must be particularly careful to avoid actions that create the appearance of favoritism or that may adversely affect the company's reputation for impartiality and fair dealing. The prudent course is to refuse a courtesy from a supplier when Vantage is involved in choosing or reconfirming a supplier or under circumstances that would create an impression that offering courtesies is the way to obtain Vantage business.

We may accept occasional meals, refreshments, entertainment and similar business courtesies that are shared with the person who has offered to pay for the meal or entertainment, provided that:

- They are not inappropriately lavish or excessive.

- The courtesies are not frequent and do not reflect a pattern of frequent acceptance of courtesies from the same person or entity.

- The courtesy does not create the appearance of an attempt to influence business decisions, such as accepting courtesies or entertainment from a supplier whose contract is expiring in the near future.

- The employee accepting the business courtesy would not feel uncomfortable discussing the courtesy with his or her manager or co-worker or having the courtesies known by the public.

Employees may accept unsolicited gifts, other than money, that conform to the reasonable ethical practices of the marketplace, including:

- Flowers, fruit baskets and other modest presents that commemorate a

special occasion.

- Gifts of nominal value, such as calendars, pens, mugs, caps and t-shirts (or other novelty, advertising or promotional items).

Generally, employees may not accept compensation, honoraria or money of any amount from entities with whom Vantage does or may do business. Tangible gifts (including tickets to a sporting or entertainment event) that have a market value greater than $100 may not be accepted unless approval is obtained from management.

Employees with questions about accepting business courtesies should talk to their managers, the HR department or the Compliance Officer.

Offering Business Courtesies

Any employee who offers a business courtesy must assure that it cannot reasonably be interpreted as an attempt to gain an unfair business advantage or otherwise reflect negatively upon Vantage. An employee may never use personal funds or resources to do something that cannot be done with Vantage resources. Accounting for business courtesies must be done in accordance with approved company procedures.

Other than to our government customers, for whom special rules apply, we may provide nonmonetary gifts (i.e., company logo apparel or similar promotional items) to our customers. Further, management may approve other courtesies, including meals, refreshments or entertainment of reasonable value provided that:

- The practice does not violate any law or regulation or the standards of conduct of the recipient's organization.

- The business courtesy is consistent with industry practice, is infrequent in nature and is not lavish.

- The business courtesy is properly reflected on the books and records of Vantage.

Proper Accounting of Books and Records

We will make certain that all disclosures made in financial reports and public documents are full, fair, accurate, timely and understandable. This obligation applies to all employees, including all financial executives, with any responsibility for the preparation for such reports, including drafting, reviewing and signing or certifying the information contained therein. No business goal of any kind is ever an excuse for misrepresenting facts or falsifying records.

All corporate records must be true, accurate and complete, and company data must be promptly and accurately entered in our books in accordance with Vantage's and other applicable accounting principles.

We must not improperly influence, manipulate or mislead any unauthorized audit, nor interfere with any auditor engaged to perform an internal independent audit of Vantage books, records, processes or internal controls.

Employees should inform Executive Management and the Compliance Officer if they learn that information in any filing or public communication was untrue or misleading at the time it was made or if subsequent information would affect a similar future filing or public communication.

Record Retention

We create, retain and dispose of our company records as part of our normal course of business in compliance with all Vantage policies and guidelines, as well as all regulatory and legal requirements. Records that are subject to audit or current/threatened litigation may not be destroyed unless there is written notification of expiration of the litigation and record destruction is approved by the Compliance Officer or other authorized executive.

Per CMS guidelines, all records pertaining to Medicare Advantage members must be retained for a period of ten (10) years.

Substance vs. Form

At times, we are all faced with decisions we would rather not have to make and issues we would prefer to avoid. Sometimes, we hope that if we avoid confronting a problem, it will simply go away.

At Vantage, we must have the courage to tackle the tough decisions and make difficult choices; secure in the knowledge that Vantage is committed to doing the right thing. At times this will mean doing more than simply what the law requires. Merely because we can pursue a course of action does not mean we should do so.

Although Vantage's guiding principles cannot address every issue or provide answers to every dilemma, they can define the spirit in which we intend to do business and should guide us in our daily conduct.

Accountability

Each of us is responsible for knowing and adhering to the values and standards set forth in this Code and for raising questions if we are uncertain about company policy. If we are concerned whether the standards are being met or are aware of violations of the Code, we must contact the HR department or the Compliance Officer.

Vantage takes seriously the standards set forth in the Code, and violations are cause for disciplinary action up to and including termination of employment.

Confidentiality and Protecting Information

Most information regarding Vantage business activities is considered confidential and proprietary to Vantage. Examples of confidential and proprietary information include, but are not limited to, strategic planning documents, sales reports, customer lists, policyholder health information, broker lists, office materials or supplies (e.g., a Rolodex) and all employee information. Also included in Vantage confidential and proprietary information are Vantage trade secrets. Trade secrets include any information used by Vantage which is not generally known to the public and therefore gives Vantage an advantage over its competitors.

In addition, since Vantage is a health insurer, our employees and FDRs are entrusted with other important confidential and privileged information that may not be released without proper authorization. This includes but is not limited to medical and claims information about subscribers, beneficiaries and health service providers. Therefore, as a Vantage employee or FDR, it is your obligation and duty to maintain the confidentiality of this information while employed or affiliated with Vantage.

All employees and FDRs will comply with Health Insurance Portability and Accountability Act (HIPAA) legal requirements regarding the disclosure of Protected Health Information (PHI). The Vantage policies regarding health care information that is protected by this law will be adhered to by all Vantage employees and FDRs. The policies conform to federal and state laws and are designed to safeguard patient privacy. All employees shall receive HIPAA training no less than once every twelve months. New employees shall successfully complete HIPAA training and certification during the first ninety (90) days of employment.

If you leave the employment of Vantage, you may not take the originals or copies of any confidential and proprietary information and you may not use this information for your own gain, or that of another person or organization.

If any Vantage employee or FDR becomes aware of nonpublic information about Vantage or another related company, because of their affiliation with Vantage, federal law prohibits them from disclosing this information to anyone. As an employee or FDR of Vantage, you are prohibited from buying or selling securities based on this information. This also includes using insider trading to make investment decisions in Vantage's competitors. If you have any questions regarding or adhering to trading laws or you become aware of others who may be in violation, notify the Compliance Officer immediately.

Information Security

Vantage employees and FDRs are responsible for properly using information stored and produced by all Vantage information systems. All employees and FDRs will comply with Vantage HIPAA policies that reflect the legal requirements for protecting electronically stored and communicated Protected Health Information.

Employees are responsible for preventing unauthorized access to the systems. Sharing of passwords and other security codes is strictly prohibited. Accessing your personal electronic records for any reason, adjusting your personal policy file or claims, or those of other employees or FDRs without proper authority, is a violation of Vantage policy and an offense that will subject an offending employee or FDR to discipline, which may include termination.

Microcomputers, personal computers, Internet access, e-mail or other communication systems are intended for business-related purposes only and not for use that may be considered disruptive, offensive, harassing or harmful to others.

Vantage contracts with various software vendors to provide software for various operational needs. Each software package, unless specifically licensed for Local Area Network (LAN) or site-licensed, may only be used on a single personal computer or microcomputer. Unless expressly permitted by the software license agreement, software cannot be copied for use on more than one Vantage or personal computer or microcomputer. The Compliance Officer and the Director of IT must be consulted when there is a question about software licensing.

Payments to FDRs

Agreements with FDRs must be in writing. Such agreements must clearly and accurately set forth the services to be performed, the basis for earning the commission or fee involved and the applicable rate or fee. Any such payment must be reasonable in amount, not excessive in terms of industry practices, not exceed any applicable statutory or regulatory maximums, and be commensurate with the value of the services rendered, and approved in writing by the appropriate manager or executive.

Other Improper Payments

The use of Vantage funds or assets for any unlawful or unethical purpose is prohibited. Any improper payment made by a Vantage employee is likewise improper when made by a FDR or other third party on behalf of Vantage. This is also true for an employee or FDR who knows or has reason to know that a payment will be made. The making of any payment to a third party for any purpose other than that disclosed on the payment documentation is also prohibited.

Federal Contracts and Federal Procurement

Vantage is subject to the Federal Procurement Integrity Act when bidding on Federal contracts. This law prohibits certain business conduct for companies

seeking to obtain work from the Federal Government. During the bidding process, Vantage employees and FDRs may not:

1. Offer or discuss employment or business opportunities at Vantage with agency procurement officials; or

2. Offer or give gratuities or anything of value to any agency procurement official; or

3. Request or obtain any confidential information about the selection criteria before the contract is awarded.

In addition, other Federal provisions prohibit Federal officials from accepting anything of value, subject to reasonable exceptions such as modest items of food and refreshments. Because of these restrictions, no employee or FDR shall either offer or make a gift to a federal employee.

Political Activities and Contributions

Federal laws restrict the use of corporate funds in connection with Federal elections. Similarly, state laws restrict the use of such funds in connection with state and local elections. It is against Vantage policy (and may be illegal) for employees and FDRs to include, directly or indirectly, any political contribution on expense accounts or in any way cause Vantage to reimburse them for that expense. The political process is stringently regulated. If you have a question about acceptable political contributions, consult with the Compliance Officer.

Use of Company Resources

Company resources, including time, material, equipment and information, are provided for company business use. Nonetheless, occasional personal use is permissible as long as it does not affect job performance or cause a disruption to the workplace.

Employees and those who represent Vantage are trusted to behave responsibly and use good judgment to conserve company resources. Managers are responsible for the resources assigned to their departments and are empowered to resolve issues concerning their proper use.

Generally, we will not use company equipment such as computers, copiers and fax machines in the conduct of an outside business or in support of any religious, political or other outside daily activity, except for company-requested support to nonprofit organizations. We will not solicit contributions nor distribute non-work related materials during work hours.

In order to protect the interests of the Vantage network and our fellow employees, Vantage reserves the right to monitor or review all data and information contained on an employee's company-issued computer or electronic device, and the use of

the Internet or Vantage's intranet. We will not tolerate the use of company resources to create, access, store, print, solicit or send any materials that are harassing, threatening, abusive, sexually explicit or otherwise offensive or inappropriate. Questions about the proper use of company resources should be directed to your Director.

Media Inquiries

Vantage is a high-profile company in our community, and from time to time, employees may be approached by reporters and other members of the media. In order to ensure that we speak with one voice and provide accurate information about the company, we should direct all media inquiries to **Mike Breard.** No one may issue a press release without first consulting with **Mike Breard.**

Seeking Guidance and Reporting Violations

All employees must report any actual or suspected violation of the Compliance Plan by speaking to your supervisor or reporting the matter directly to the Compliance Officer. Steps will be taken to protect anonymity and confidentiality where warranted and appropriate. Vantage will not tolerate any form of retaliation against a person for *reporting* a compliance violation.

Corrective Action and Discipline

Individuals who violate any of Vantage's compliance program requirements, violate related corporate policies and procedures, or knowingly fails to report violations, or any supervisor, officer or FDR, who fails to oversee compliance by those he or she supervises, is subject to disciplinary action. Discipline ranges from warning to suspension or termination. Violations may also result in criminal referral and reports to law enforcement and government agencies. Any employee or FDR who harasses or threatens another employee for reporting Compliance Plan or policy and procedure violations will be terminated.

Do the Right Thing

Several key questions can help identify situations that may be unethical, inappropriate or illegal. Ask yourself:

- Does what I am doing comply with the Vantage guiding principles, Code of Conduct and company policies?

- Have I been asked to misrepresent information or deviate from normal procedure?

- Would I feel comfortable describing my decision at a staff meeting?

- Am I being loyal to my family, my company and myself?

- Is this the right thing to do?

Information and Resources:

CEO:	Dr. Gary Jones
Executive Vice President:	Mike Breard
Chief Financial Officer:	Rhonda Haygood
General Counsel:	Bob Bozeman
Human Resources Manager:	Brad Burtram
Director of Compliance:	Joel Wiedeman
Medicare Compliance Officer:	Sally Knight-Rainer
Commercial/Marketplace Compliance Officer:	Jessica Self

Vantage Health Plan, Inc.

130 DeSiard Street, Suite 300
Monroe, LA 71201

Non-Retaliation Policy

Effective: 08/01/2011	Revised by: Joel Wiedeman, Director of Compliance
	Revised Date: 04/26/2017

Policy:
A covered entity or business associate may not threaten, intimidate, coerce, harass, discriminate against, or take any other retaliatory action against any individual or other person for—

(a) Filing of a complaint under 45 CFR§160.306
(b) Testifying, assisting, or participating in an investigation, compliance review, proceeding, or hearing under this part; or
(c) Opposing any act or practice made unlawful by this subchapter, provided the individual or person has a good faith belief that the practice opposed is unlawful, and the manner of opposition is reasonable and does not involve a disclosure of protected health information in violation of subpart E of part 164 of this subchapter.

Procedure:
Vantage Health Plan, Inc. (Vantage) encourages employees, first tier, downstream and related entities (FDRs), and Business Associates to report any suspected violations of compliance, HIPAA, HITECH, or fraud, waste and abuse violations of state or federal laws and/or regulations with no fear of retaliation. To ensure protection of an individual reporting suspected violations or cooperating in an investigation, Vantage has implemented this Non-Retaliation Policy as a component of its Compliance Program.

Vantage is committed to providing a workplace and business relationship environment conducive to open discussion of its practices to ensure corporate compliance is a culture where employees. FDR's and Business Associates feel comfortable. It is Vantage's policy to comply with all applicable laws regarding unlawful discrimination or retaliation against any individual because of his/her good faith reporting of information, or his/her participation in, investigations involving suspected violations of compliance with a) Vantage's Policy and Procedures, b) Vantage's Code of Conduct, c) state or federal laws and regulations, and d) state or federal mandated policies (Compliance Violations).

Specifically, this Non-Retaliation policy prevents any employee from being subject to disciplinary or retaliatory action by Vantage or any of its employees or agents because of an individual:

- Disclosing information to a government or law enforcement agency, where the employee has reasonable cause to believe that the information discloses a violation or possible violation of federal or state law or any regulation thereunder; or

- Reporting suspected violation(s) of Vantage's Code of Conduct or any other violation of Vantage's policy and procedures or state or federal mandated policies; or

- Providing information, causing information to be provided, filing, causing to be filed, participating in an investigation or otherwise assisting in an investigation or proceeding regarding any conduct that the employee reasonably believes involves a Compliance Violation of any sort.

Vantage employees, FDR's, and Business Associates may report violations anonymously, if desired. Whether reported anonymously or not, Vantage shall keep such information confidential to the maximum extent allowed by law.

Employees, FDR's, or Business Associates who file reports or provide evidence which they know to be false or without a reasonable belief as to the truth and accuracy of such information will not be protected and may be subject to disciplinary action (corrective action), including termination of employment or relationship with Vantage.

Except to the extent required by law, Vantage does not intend this Policy to protect employees who violate the confidentiality of any applicable lawyer-client privilege or physician-patient privilege to which Vantage or its agents may be legally entitled, or to protect employees who violate their confidentiality obligations regarding Vantage's confidential and proprietary information.

Vantage has designated the Director of Compliance and Compliance Officers as being responsible for administering this Policy. In conjunction with senior management and/or Human Resources, as appropriate, the Compliance Director or Compliance Officers shall be responsible for receiving, collecting, reviewing, processing and resolving concerns and reports by employees, FDR's, Business Associates, and others on the matters described above and other similar matters. Employees are encouraged to discuss issues and concerns of compliance with their supervisor, who is in turn responsible for informing the Compliance Director or Compliance Officers of any concerns. If the employee prefers not to discuss these sensitive matters with his or her own supervisor, the employee or FDRs may directly discuss such matters with the Director of Compliance or Compliance Officers and all such discussions shall be treated as confidential. FDR's and Business Associates shall be encouraged to discuss any concerns with their point(s) of contact at Vantage or directly with the Director of Compliance or Compliance Officers.

In addition, Vantage has established the following reporting channels for compliance violations:

- Compliance Hotline: 888-607-0058

- Compliance Fax: 318-361-2184
- Compliance Email: complianceissues@vhpla.com

Vantage employees, FDRs, or Business Associates may utilize this confidential process either to raise new complaints or if he or she feels that a complaint previously raised with a supervisor or Compliance has not been appropriately handled.

If any Vantage employee, FDR, or Business Associate believes he or she has been subjected to any action that violates this Policy, he or she must file a complaint with his or her own supervisor, the Compliance Officer or Vantage's Human Resources Manager. If it is determined that an employee has experienced any improper employment action in violation of this Policy, appropriate disciplinary action (corrective action) action will be taken against the person(s) engaged in any type of a retaliation.

Employees, FDR's or Business Associates who report, in good faith, any suspected Compliance Violations may comment to the Director of Compliance, Compliance Officers or to a federal or state regulatory entity in the context of any 1) audit (internal or external), 2) on-site inspection, 3) compliance assistance effort; and/or 4) any other enforcement-related communication, may do so without fear of retaliation.

Any Vantage employee, FDR, or Business Associate who attempts to, or actually does intimidate or interfere with an individual's ability to properly report or comment on suspected Compliance Violations is subject to disciplinary action (corrective action). This may include various corrective action steps including but not limited to termination of employment or contracts/relationship, in the case of FDR's or Business Associates.

"Retaliation" means any action that is:

1. Threatened or intimidated, including the attempt to do so, as a means of preventing an individual from reporting any Compliance Violations;

2. Taken to adversely affect an employee, FDR, or Business Associate that has appropriately commented on any investigation or enforcement action (corrective action plan).

3. Taken to reciprocate or obtain revenge because of good faith reporting of suspected Compliance Violations.

This Non-Retaliation Policy prohibits the firing, demoting, harassing, or otherwise "retaliating" against individuals (applicants or employees) or in the case of FDR's or Business Associates—suspension or termination of a contract or relationship because they filed a compliance related complaint in good faith, whether the allegations are later substantiated or not. This policy forbids retaliation when it comes to any aspect of employment, including hiring, firing, pay, job assignments,

promotions, layoff, training, fringe benefits, and any other term or condition of employment. Vantage will not refuse to maintain or extend a contract/relationship with a FDR or Business Associate because of the reporting, in good faith, of a suspected Compliance Violation. The Compliance Director or Compliance Officers will collaborate with senior management of Vantage and Human Resources, where appropriate, to review and determine if this Non-Retaliation Policy has been violated in any manner and to ensure proper corrective action is carried out, if substantiated.

Definitions:

First Tier Entity – Any party that enters a written arrangement, acceptable to CMS, with Vantage to provide administrative services or health care services for a Medicare eligible individual under Part C or Part D of Medicare.

Downstream Entity – Any party that enters a written arrangement, acceptable to CMS, below the level of the arrangement between Vantage and a first-tier entity. These written arrangements continue down to the level of the ultimate provider of both health and administrative services. Examples include, but are not limited to mail order pharmacies, agents, brokers, and marketing firms.

Related Entity – Any entity that is related to Vantage by common ownership or control and:

(1) Performs some of Vantage's management functions under contract or delegation;
(2) Furnishes services to Medicare Advantage enrollees under an oral or written agreement;
(3) Leases real property or sells materials to Vantage at a cost of more than $2,500.00 during a contract period.

Business Associate – A person or entity that provides to Vantage accounting, legal, consulting, management, administrative, accreditation, financial, or related services.

HIPAA – The Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), Public Law 104-191, was enacted on August 21, 1996. This law addresses the use and disclosure of individuals' health information ("protected health information"). A major goal of this law is to assure that individuals' health information is properly protected while allowing the flow of health information needed to provide and promote high quality health care and to protect the public's health and well being.

HITECH – The Health Information Technology for Economic and Clinical Health Act ("HITECH"), which is part of the American Recovery and Reinvestment Act of 2009, broadens the scope of privacy and security protections already available under HIPAA. This law also increases the potential legal liability for non-compliance and provides for greater enforcement measures.

References:

42 CFR §422.503(b)(4)(vi)(D)
45 CFR §160.316

Exclusions:
None

Approved By: P. Gary Jones, MD, President/CEO Date: 4/26/2017

Joel Wiedeman, Director of Compliance Date: 4/26/2017

VANTAGE HEALTH PLAN

VANTAGE LOCATIONS

Monroe
130 DeSiard Street, Suite 300
Monroe, LA 71201

Shreveport
855 Pierremont Road, Suite 109
Shreveport, LA 71106

Baton Rouge
5778 Essen Lane, Suite B
Baton Rouge, LA 70810

For information on other locations:
www.VantageHealthPlan.com/locations

CONTACT

Phone Numbers:
(888) 823-1910 or TTY (866) 524-5144
(for the hearing impaired)

Website:
www.VantageHealthPlan.com