Working Together to Reimagine Medicare Advantage

Delegation Management Manual

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eternalHealth (eH)

Founded in 2019, eternalHealth (eH) was started in Massachusetts as a healthcare plan with a simple objective: Deliver high quality, affordable care so that we can make care accessible for all Americans. Medicare beneficiaries have every right to demand high quality, affordable care from their insurers, and we know that the healthcare industry can and should do better for their members. At eH, we are committed to delivering on that mission.

We want to be forever partners in healthcare with our members. We are committed to being a new kind of plan that does things the right way and by focusing on establishing real, sustainable relationships with our members, we hope to offer the quality care that they need.

eH prioritizes our members' care and is committed to putting their care at the forefront of every decision that we make. At our core, we believe in operating with integrity, honesty, and transparency with all our partners, whether that be our members, the health systems, doctors, or other vendors.

We understand the importance of accepting feedback when building sustainable relationships. With that in mind, we have built and will continue to build upon our product and processes to address our partners' needs and pain points.

We recognize the important role that our delegates play in providing high-quality, cost-effective care to our members. This guide is intended to help delegates and their staff understand eH standards and expectations for operations. It is important to follow the guide as delegates are accountable for complying with the requirements, including completion of training on the requirements.

Pooja Ika
Founder & CEO

Delegation Management

Delegation is the process that allows eH to authorize an entity to perform designated functions or activities on its behalf. Each contracted entity must comply with the eH requirements for all delegated functions. Delegated agreements contain scope and expected performance. eH documents performance of delegated functions on a regular cadence reflected in the contract agreement. Delegated entities must adhere to all applicable Centers for Medicare & Medicaid Services (CMS), and State regulations outlined in this guidance.

Delegated Entity compliance with standards and eH criteria are evaluated through annual audits, and as needed, to meet regulatory requirements and to identify and address any performance deficiencies. All delegated employees are required to be trained in delegation standards and requirements minimally upon hire and annually thereafter. Delegated entities are responsible for maintaining training records for a period of 10 years from the date of completion.

Guideline updates are distributed to eH delegated entities when applicable.

Definitions

First Tier Entity: A party that is acceptable to CMS and enters a written agreement (contract) with eH to provide administrative services or health care services to eH Members.

Delegated Entity: A first tier entity contracted by eH to perform CMS program requirements on behalf of eH. Examples of delegated functions include:

- Sales and marketing.
- Utilization management.
- Population Health Management (PHP).
- Quality improvement.
- Pharmacy Benefit Management.
- Applications processing.
- Enrollment, disenrollment, membership functions.
- Claims administration, processing, and coverage adjudication.
- Appeals and grievances.
- Billing services.
- Licensing and credentialing.
- Pharmacy benefit management.
- Hotline operations.
- Customer service.
- Bid preparation.
- Outbound enrollment verification.
- Provider network management.

Downstream Entity: A party that enters into a written agreement, acceptable to CMS, with persons or entities involved with Medicare Advantage and/or Part D benefits below the level of an arrangement between eH or an eH First Tier entity down to the level of the ultimate provider of both health and administrative services.

Related Entity: Any entity that is related to eH by common ownership or control:

- And performs some eH management functions under contract or delegation.
- Or furnishes services to Medicare enrollees under an oral or written agreement, or leases real property or sells materials to eH.

Refer to the "Glossary" section for additional details related to the contents of this guide.

General Monitoring Program Procedures

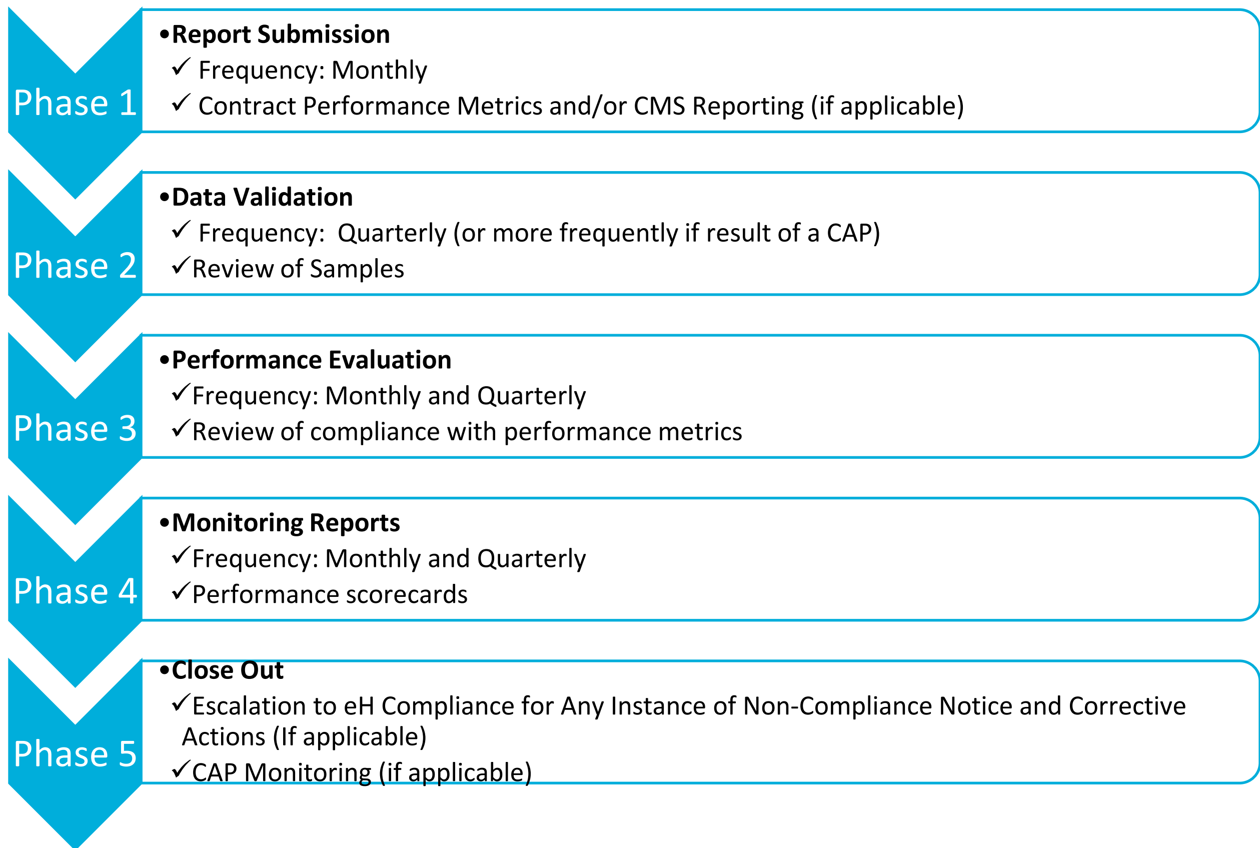
The eH monitoring program is designed to ensure that delegated entities are monitored for compliance and performance on an ongoing basis. eH utilizes data to score quantitative measures and case/ file reviews to score qualitative measures.

Measures are categorized as either "critical" or "non-critical".

- **Critical Measures:** An immediate threat to members' health and safety. Examples include:
  - Regulatory audit finding (e.g., ICAR).
  - Repeat audit findings.
  - Risk Assessment finding or referral.
  - Regulatory Agency trend.

- **Non-Critical Measures**: No immediate threat to member health or safety. Examples include:
  - Non-compliance with CMS program requirements.
  - Non-compliance with eH Policies and Procedures.
  - Non-existent or deficient policy, procedure, system, internal control, training, or staffing.

The following is the general eH monitoring process and timeline:



The eH monitoring process consists of the following 5 phases:

- Phase 1: Report Submission
- Phase 2: Data Validation Testing
- Phase 3: Case File Review
- Phase 4: Monitoring Reports
- Phase 5: Close Out

Phase 1: Report Submissions

Delegated entities are required to submit reporting as outlined within the contract. Reports are reviewed for timeliness, completeness, data formatting and logic. Unless indicated otherwise in the contract, the eH reporting specifications include:

- Report Name
- File Naming Convention
- Data Specifications (e.g., column name, field name, field length, character information and description).
- Upload/ submission instructions.

Delegated entities will have 3 documented attempts to submit accurate data before the issue is escalated to eH Compliance for review and corrective action.

Phases 2: Data Validation Testing

eH may request a live session webinar to validate that the data provided in reporting is accurate. It is the responsibility of the delegated entity to maintain and make available all information and documentation necessary to demonstrate data accuracy. Delegated entities will have 3 documented attempts to submit accurate data before the issue is escalated to eH Compliance for review and corrective action.

Phases 3: Case File Review

eH may select sample case files to review to validate accuracy of reporting. Delegated entities have 7 calendar days from the date of request to provide case file information to eH. Delegated entities will have 3 documented attempts to complete information before the issue is escalated to eH Compliance for review and corrective action.

Phase 4: Reporting

eH issues written reports to delegated entities of monitoring activity outcomes. When applicable, eH includes any requests for corrective measures related to any identified deficiencies. When applicable, responses must include a root cause (including member impact), and a remediation plan (including milestone dates and actions). Delegated entities have 14 calendar days to provide a response to the written request and oversight report. If a delegated entity misses the response timeframe, the matter is escalated to eH Compliance for review and corrective actions.

Phase 5: Closure

eH issues a written closure notification to the delegated entity. Any additional instructions are reflected in the notification.

Financial Oversight

eH is responsible for the financial oversight of delegated entities including assessments of financial conditions to determine if the entity can maintain ongoing financial solvency. The eH intent is to ensure ongoing compliance and ability to meet eH standards.

eH financial oversight may include:

- An annual financial review of the delegated entity (and/or parent organization). E.g., audited, and interim financial statements.
- An assessment of financial performance.
- A requirement for financial protection (e.g., letter of credit, performance bond or insolvency reserve).
- Submission of financial reviews to eH oversight committees.

Financial Oversight Processes

When applicable, the eH Network or Finance Department will obtain documents and forward them to the financial auditor for review, including but not limited to audited financial statements (balance sheet, income statement, statements of cash flow, IBNR lag tables, and accompanying notes for the most recent fiscal year) and Internal unaudited interim financial statements.

The financial auditor will review submitted documentation. In certain cases, audits of information are considered proprietary or subject to certain protections onsite.

The auditor completes a written report on the findings and will determine future audit frequency and recommended financial protections.

Insurance Requirements

Delegated entities must maintain insurance at the following minimum levels:

(A) Comprehensive general liability insurance corresponding to the level of risk inherent in the contract.
(B) Professional liability and/or errors and omissions insurance corresponding to the level of risk inherent in the contract.

Proof of insurance coverage is submitted to eH upon request. Delegated entities must provide eH at least 30 calendar days' notice of any cancellation or material changes to insurance policies.

Centers for Medicare and Medicaid Compliance Program Requirements

eH identifies and oversees its First Tier Entities in accordance with CMS delegation requirements. Various tools are utilized to ensure that FDRs are complaint with CMS and eH requirements including:

- Compliance Program and Offshore Operations Attestations
- Audit/ Assessment review (pre assessment and annual reviews)
- Monitoring reports and activities
- Performance review meetings

The following are Medicare Compliance Program requirements that must be followed by all FDRs that apply to any entities with downstream functions utilized for performing delegated processes on behalf of eH:

1. **Written Standards of Conduct.** First tier entities must have written standards of conduct and/or compliance program policies that explain the commitment to comply with federal and state laws, ethical behavior, and compliance program operations. The eH Code of Conduct is available for use.
2. **Training & Education.** First tier entities must ensure that its employees receive Compliance Program training including Fraud, Waste and Abuse (FWA) within 90 calendar days of hire and annually thereafter. First tier entities are required to maintain training records for a minimum period of 10 years from the date of completion. First tier entities must ensure that downstream entities receive CMS compliant training.
3. **US Department of Health & Human Services Office of the Inspector General (OIG) and General Service Administration System for Award Management (SAM) Exclusion Screening.** First tier entities must screen the OIG and SAM exclusion lists prior to hiring or contracting and monthly thereafter.
4. **Reporting Mechanisms.** First tier entities must communicate to its employees all available methods for reporting suspected or detected non-compliance, or potential fraud, waste, or abuse without retaliation. Reporting mechanisms must include an anonymous option and the option to report concerns to eH directly when applicable. First tier entities are responsible for reporting to eH Compliance (compliance@eternalhealth.com) any concerns applicable to eH delegated functions.
5. **Report Offshore Operations.** First tier entities must report its offshore operations, and the operations of any downstream entities that involves the exchange, access, or storage of eH member Protected Health Information (PHI). Pre-approval is required by eH for any offshore operations.
6. **Downstream Entity Oversight.** First tier entities are required to ensure downstream entity compliance with CMS and eH requirements through contract provisions and oversight activities including:

   a. Downstream entity contracts must contain all CMS required provisions.
   b. Comply with CMS Compliance Program requirements.
   c. Comply with applicable CMS Manuals and operational requirements.
7. **Operational Oversight.** First tier entities must conduct internal oversight activities to ensure compliance with CMS and eH program requirements.

eH Compliance Program Attestations and Audits include:

- Code of Conduct
- Compliance Program Policies & Procedures
- Compliance Program Training & Education
- Federal Health Care Program Exclusions Lists and Processes (OIG/GSA)
- Downstream Entity Oversight
- Record Retention

An authorized representative from the First Tier Entity is required to attest to organizational awareness of compliance with all applicable requirements. Entities may be asked to provide evidence of compliance.

Delegated Provider Credentialing

eH ultimately retains decision-making authority for delegated credentialing activities. Oversight of delegated credentialing is maintained through written communications and annual audits.

Entities delegated for credentialing and re-credentialing must develop and maintain a program that compliance with accreditation standards, state, and federal regulations as well as eH credentialing and re-credentialing policies and procedures.

Delegated entities must cooperate with eH annual assessments, as well as more frequent oversight based on risk and business need.

Delegated entities must obtain prior written approval from eH for all sub-delegated contracts. The Delegated entity is responsible for oversight of any sub delegated credentialing or re-credentialing activities.

Delegated entities must make available to eH, accrediting bodies, and CMS any credentialing or re-credentialing files, documentation, policies, and procedures, Quality Improvement Committee (or subcommittee) minutes, as well as any monitoring and oversight activity documentation.

eH retains the right to approve, terminate or suspend any practitioners and organizational providers.

All practitioners and organizational providers must be credentialed and approved prior to providing covered services to eH members.

Security Controls

Delegated entities must maintain written system security control policies and procedures as required by federal and state regulations, accreditation standards, and the eH contract. Ongoing monitoring and reporting of security controls are required quarterly and annually. Security controls must include:

- How primary source information is received, dated, and stored.
- Record of modifications including when, how, staff title or roles, and reason(s) for the modification(s).
- Identification of staff authorized to modify and delete information when appropriate.
- Protection of credentialing and recredentialing information and authorized modifications including limiting physical access to physical records and servers, prevention of unauthorized access, password protections, user requirements e.g., use of strong passwords, unique user IDs and changing passwords when promoted or compromised.

- Internal monitoring of credentialing and recredentialing process security controls including system controls, auditing and sampling of staff titles or roles and actions taken wen an unauthorize modification is identified (through quantitative and qualitative analysis, and quarterly monitoring and reporting activities).

SOC Compliance Requirements

SOC 2 is a standard for information security based on a "Trust Services Criteria" review intended to provide evidence that member data is handled responsibly. A SOC 2 auditor (either a CPA or firm certified by the American Institute of Certified Public Accountants), evaluates an entity's security posture to determine if policies, processes and controls comply with SOC 2 requirements.

SOC 2 reviews include a review of the following processes:

- **Information Security.** How data is protected from unauthorized access and use.
- **Logical and Physical Access Controls.** How the organization manages and restricts logical and physical access to prevent unauthorized use.
- **System Operations.** How system operations detect and mitigate process deviations.
- **Change Management.** How an organization implements a controlled change management process and prevents unauthorized changes.
- **Risk Mitigation.** How the organization identifies and mitigates risk for business disruptions and vendor services.

In addition, the following are Trust Service Criteria points of focus examples specified in the Committee of Sponsoring Organizations (COSO) framework:

- **Security.** Defenses against all forms of attack. E.g., all things that indirectly influence security like personnel and policies, a review of two-factor authentication systems and web application firewalls, etc.
- **Privacy.** Access, to member data, consent to share data, restriction of access to information, use of member data, disposal of data, etc.
- **Confidentiality.** Focus on exchange of member data.
- Processing Integrity. System security and efficiency, system activity reports and detection and correction of errors, etc.
- **Availability.** Prediction of system capacity, identify and mitigate environmental threats, and data backup, etc.

Reviews may also incorporate the following organizational cultural indicators:

- **Tone at the Top.** Board of directors and management at all levels demonstrate through directives, actions and behavior the importance of integrity and ethical values to support the functioning of the system and internal control.

- **Standards of Conduct.** The expectations of board directors and senior management concerning integrity and ethical values are defined in a code of conduct and understood at all levels of the entity and by out-sourced service providers and business partners.
- **Evaluation of Adherence to Standards of Conduct.** Processes in place to evaluate the performance of individuals and teams against expected standards of conduct.
- **Addressing Deviations and Deficiencies Timely.** Findings are identified and remediated in a timely and consistent manner.

Supporting documentation demonstrating adequate security controls and evidence of SOC 2 compliance must be submitted to eH upon request.

FDRs are expected to cooperate with any applicable eH SOC 2 audit processes and readiness assessments, including full and timely remediation of identified findings if applicable.

Practitioner information

Delegated entities are required to maintain the following information for each credentialed and re-credentialed primary care physician, specialists, or other allied health care practitioner:

- Current valid license to practice health care in applicable operating states.
- Verification of good standing clinical privileges or coverage arrangements.
- Current valid and unrestricted DEA or CDS certificate in applicable operating states.
- Current board certification(s) in the appropriate specialty.
- If not board certified, education and training.
- Five years of work history (including supporting documentation for any gaps greater than 6 months).
- Current professional liability insurance within eH approved limits.
- Review of Medicare sanction and exclusion activity.
- Review of Medicare opt-out report.
- Site visit process (including a policy that identifies a comprehensive way to conduct site visits and follow-up visits to address identified deficiencies).
- Ongoing monitoring of sanction activity including Medicare, state license sanction and limitations (30 days) and Medicare Opt-Out (quarterlY0 when applicable.
- Ongoing reviews of any member complaints, recredentialing performance data, and quality improvement activities.

Organizational Provider Information

Delegated entities are required to maintain the following information for each credentialed and re-credentialed organizational provider:

- A current valid license or certification of occupancy in applicable states.
- Professional liability insurance within eH approved limits.
- Medicare Certification Number (if applicable).
- A review of current and previous sanction activity by Medicare.
- Accreditation status by an agency (e.g., AOA, CHAP, DNV, AAAHC, AAAASF, TJC, etc.).
- Current Centers for Medicare & Medicaid Services (CMS) survey results, state survey results, or results from an onsite quality assessment in lieu of an approved accreditation.
- A copy of the Advance Directives policy (unless accredited or certified by Medicare).

Assessment/ Audit of Delegated Credentialing

Delegated entities cooperate in completing an annual assessment or audit of its credentialing program including policies, procedures, minutes, monitoring logs, files, and subdelegated activities.

Practitioner and Organizational Provider file audits will include the NCQA 8/30 rule evaluating each factor until a rate of 8/8 or denominator of 30 is achieved; or 2) the 5%/50 method, where 5% or 50 files, whichever is less are reviewed.

Credentialing Subdelegation and Offshore Contracting

If a Delegated Entity contracts with another organization to perform any part of the delegated credentialing or recredentialing processes, eH must receive the agreements and oversight processes between the Delegated Entity and the Downstream entity.

eH must be notified of any subdelegate arrangements in advance to evaluate the delegation agreement and oversight processes.

The mutually agreed upon document must meet all accreditation and regulatory requirements and must describe the following:

- Scope of services being sub-delegated.
- Decision-making responsibilities.
- Security controls.
- Reporting including cadence, content, and submission requirements.
- Sub-delegation assessment and evaluation process.
- Remedies for non-performance up to and including contract termination.

Offshore Operations

If the Delegated entity, or its subdelegates perform any services under its agreement with eH that
are not within the United States (US) or one the US Territories (American Samoa, Guam, Northern Marinas, Puerto Rico, and Virgin Islands), eH must be notified. The Delegated Entity and Subcontractor must complete and submit the eH Offshore Attestation for review.

Examples of countries that meet the definition of 'offshore' include Mexico, Canada, India, Germany, and Japan. Subcontractors that are considered offshore can be both American owned companies with certain portions of their operations performed outside the United States or foreign-owned companies with their operations performed outside the United States. Offshore subcontractors provide services that are performed by workers located in offshore countries, regardless of whether the workers are employees of American or foreign companies.

Recredentialing

Delegated practitioners are recredentialed at a minimum every 3 years, or as otherwise required or identified in regulation, CMS requirements, accreditation. Work history, education and training do not require re-verification, all other credentialing components require recredentialing.

Credentialing and Recredentialing Oversight Reports

eH requires quarterly and semiannual oversight reports from Delegated Entities including:

- Activity rosters.
- Credentialing committee meeting dates for the reporting period.
- Total number of initial credentialed (Primary care practitioners, specialty practitioners, non-physician practitioners and facilities).
- Total number of recredentialed (Primary care practitioners, specialty practitioners, non-physician practitioners and facilities).
- Total number of suspensions, terminations, and resignations for quality.
- Total number of site visits conducted.
- Improvement activities that occurred during the reporting period.

Notification of Changes

eH requires advance written notification for the following changes:

- Physical Address
- Additional Physical Addresses
- Office Site Closures
- Office Phone Numbers
- Tax Identification Number

- Billing Address

Delegated entities are required to immediately report the addition or removal of any practitioner or organizational provider.

eH requires monthly reports from Delegated Entities designed to communicate efforts to ensure directory accuracy and include the updates on changes to the following:

- Provider Name (first, last, middle)
- National Practitioner Identifier (NPI)
- Tax Identification Number (TIN)
- SSN (needed only for de-delegation)
- Date of Birth
- Gender
- Service Address
- Office / Facility Telephone Number
- Billing Address
- Billing Phone Number
- Billing E-mail Address
- Primary Specialty
- Secondary Specialty(ies)
- Board Certification Status
- Board Certification Specialty(ies)
- Board Certification Effective Date(s)
- Degree
- Medical School
- Graduation Year
- Foreign Language Spoken by Provider
- Medial/ Professional License Number
- License Expiration Date
- Hospital Affiliation
- Role of Provider (e.g., PCP, Specialist, etc.)
- Status of Accepting New Patients
- Termination Notification and Date

Prompt notification and processing of provider information is critical for the ability of eH to maintain an accurate Provider Directory.

Notification of Actions

Delegated Entities must report the following incidents in writing within five business days of awareness:

- Surrender, revocation, restriction, or suspension of a practitioner's state license, DEA registration, or state narcotics license.

- Restriction, suspension, or revocation of medical staff privileges greater than 30 calendar days.
- Reports made to the National Practitioner Data Bank or state profession medial disciplinary board, Office of Personnel Management Department List or Office of Inspector General List.
- Malpractice claims commencement, settlements, or judgments.
- Lapse, or material change in the professional liability limits as required by eH.
- Indictment, arrest, or conviction for a felony or criminal charge related to the participating provider or practitioner.
- Any adverse action taken by a peer review or similar committee.
- Any circumstances that would or could impact the ability of the Delegated Entity to carry out obligations under the delegation contract with eH, or that could materially change the representations made during the credentialing application.

Corrective Action Plan

Any material process deficiencies identified for delegated credentialing and re-credentialing functions are referred to the eH Compliance Department to take appropriate action, including when appropriate the development of a formal corrective action plan (CAP). eH Compliance coordinates with the eH Business Owner, and Delegated Entity to identify root cause and remediation of credentialing and recredentialing process deficiencies.

Delegated Provider Claims Management

Delegated Entities must comply with all claims administration requirements in accordance with Federal and State regulations, as well as the eH contract. At a minimum, claims administration requirements include the following:

- Provide upon request copies of the delegated entity claims management policies and procedures, as well as make revisions as required by regulation or contract changes.
- Cooperate with eH assessments and audits of the delegated entity's claims management program. Provide copies of policies, procedures and other requested documents within the timeframe specified in the request, not to exceed 30 calendar days from the date of the eH request.
- Permit eH designated federal and state regulatory agencies access to claim administration documents. Provide copies of policies, procedures and other requested documents within the timeframe specified in the request, not to exceed 10 calendar days from the date of the eH request.
- Submit monthly performance reports and program updates to eH.
- Retain all data, information, records, and documents related to delegated functions for a minimum of 10 years from the date of creation. Records maintenance and submission requirements survive any termination of the contract with eH.

Transmitting Data

The following are examples of Health Insurance Portability and Accountability Act (HIPAA) compliant delivery methods to respond to assessment and audit requests:

- Direct access to an eH FTP site.
- Granting direct access to the Delegated Vendor FTP site.
- Encrypted email.

Turnaround Time (TAT)

Delegated entities must establish processes to ensure compliance with proper handling and processes of claims received on behalf of eH. At minimum, Delegated Entity claims processes must include the following to demonstrate compliant TATs:

- All mail is date stamped when received by either eH, or at the Delegated Entity's office(s).
- Received dates are used to determine the TAT of a claim.
- TAT performance metrics are based on received date.
- TAT is based on the earliest receipt date regardless of any re-routing or forwarding that occurs.
- Clean claims from Non-Par (Non-Contracted) providers not paid within 30 calendar days of receipt have an interest payment applied from the date the claim should have initially paid.
    - All other claims (Par and Non-Par) must be paid or denied within 60 calendar days from the date of receipt.
- Procedures for identifying primary payors to Medicare (coordination of benefits)
- Process for making accurate determinations of emergencies, urgently needed services and covered benefits for appropriate claims processing.
- Prompt payment provisions.

Claims Reporting

Delegated Entities are required to submit reporting as outlined within the agreement with that delegated entity. Reporting may include:

- Claims Audit Reports
- Monthly Claims Inventory
- Daily/Weekly/Monthly YTD Receipts
- Daily/Weekly/Monthly YTD On Hand
- Production Reports
- Interest Paid Reports
- Denied Claims by Denial Reason
- Pended Claims Report
- Processing Turnaround Time (TAT)

Notifications of Changes

eH requires Delegated Entities to communicate in advance the following updates:

- Closure or transfer of billing offices
- Updates to Provider TIN
- Changes in sub-delegation agreements (new, termed, restricted, etc.)
- Any changes in management services (if applicable)

Claims Processing Subdelegation and Offshore Contracting

If a Delegated Entity contracts with another organization to perform any part of the delegated claims processes, eH must receive the agreements and oversight processes between the Delegated Entity and the Downstream entity.

eH must be notified of any subdelegate arrangements in advance to evaluate the delegation agreement and oversight processes.

The mutually agreed document must meet all accreditation and regulatory requirements and must describe the following:

- Scope of services being sub-delegated.
- Decision-making responsibilities.
- Reporting including cadence, content, and submission requirements.
- Sub-delegation assessment and evaluation process.
- Remedies for non-performance up to and including contract termination.

Offshore Operations

If the Delegated entity, or its subdelegates perform any services under its agreement with eH that is not within the United States (US) or one the US Territories (American Samoa, Guam, Northern Marinas, Puerto Rico, and Virgin Islands), eH must be notified. The Delegated Entity and Subcontractor must complete and submit the eH Offshore Attestation for review.

Examples of countries that meet the definition of 'offshore' include Mexico, Canada, India, Germany, and Japan. Subcontractors that are considered offshore can be both American owned companies with certain portions of their operations performed outside the United States or foreign-owned companies with their operations performed outside the United States. Offshore subcontractors provide services that are performed by workers located in offshore countries, regardless of whether the workers are employees of American or foreign companies.

Assessment/ Audit of Delegated Claims

Delegated Entities must demonstrate accurate and consistent claims management practices by participating and cooperating in operational validation assessments and audits. eH may perform desk or onsite audits depending on regulatory requirements. Audit activities may include phone interviews as well as documentation reviews.

Delegated Entities are provided with a written notice of planned assessment and audit activities 30 calendar days in advance.

eH Assessment and Audit Process

The eH assessment and audit process includes:

- Notification of the Claims Assessment and Audit. The notification includes an Operational Review Questionnaire (ORQ), a description of the universe request and submission requirements, and instructions for the submission of samples.
- The Delegated Entity returns the ORQ and universe log(s).
- Once eH receives the universe report, samples are selected for submission and review. eH sends the requested sample list to the Delegated Entity.
- The Delegated Entity submits sample file documents and eH conducts an assessment and audit of the submitted documents. Other audit options may include a live primary source audit via webinar.

Operational Review Questionnaire (ORQ)

The eH ORQ seeks to validate the Delegated Entity's overall administrative structure, staffing resources, and claim management policies and procedures. The ORQ is due prior to the start of the assessment and audit procedure includes the following:

- Claims Department staffing structure and physical locations.
- Claims volume by contract.
- Training Program (Compliance, Code of Conduct, Privacy and Claims Processing).
- Fraud, Waste, and Abuse Program (including software and audit procedures).
- Internal auditing.
- Customer Service Operations and Performance Metrics (including complaint logs)
- Claims Processing (e.g., inventory controls, date stamps, tracking and logging, pend process, misdirected claims handling, claims acknowledgement, recalculations, payment methodology, turnaround times, coordination of benefits, overpayments, medical review process and procedure, denial process, EOBs, EOBs, provider dispute resolution process etc.)
- Business Continuity Plan.

Claims Sample Files

Sample file submissions may include:

- A copy of the claim.
- A copy of the associated explanation of benefit (EOB).
- A copy of the associated Explanation of Payment (EOP) or Remittance Advice. Printed claims history reports are not acceptable.
- A copy of the cancelled check or bank statement.
- A copy of denial communication.

Audit meeting agendas may include the following topics:

- Introductions

- Overview of the purpose of the audit
- Assessment review
- System demo
- Claims sample review
- Draft preliminary report including findings.

eH creates a final reporting that includes the following information:

- Operational assessment and audit results
- Performance audit results
- Corrective Action Plans (CAP) Requirements (if applicable)
- Plans to Reassess and Re-Audit delegated functions (if applicable)

When CAPs are required to address process deficiencies, the following elements are required from the Delegated Entity:

- Root cause.
- Remediation Plan (including milestone dates and activities)
- Ongoing monitoring plan.

CAPs are monitored by eH through adequate validation testing.

Performance Audit
The performance audit includes validation of sampled claims for compliance with regulatory and contract processing requirements. Universe samples may include the following:

- Paid (Par Providers)
- Paid (Non-Par Providers)
- Member Denials
- Provider Denials
- Claims Adjustments
- Provider Payment Disputes

The typical review period is the immediate previous 3 months of activity. If a Delegated Entity is unable to provide required documents in the requested format eH will coordinate a process to obtain necessary reporting, and if applicable the development of a CAP.

Corrective Action Plan

Any material process deficiencies identified for delegated claims processing functions are referred to the eH Compliance Department to take appropriate action, including when appropriate the development of a formal corrective action plan (CAP). eH Compliance coordinates with the eH Business Owner, and Delegated Entity to identify root cause and remediation of credentialing and recredentialing process deficiencies.

Delegated Call Center Operations

Delegated Entities must comply with all call center operations requirements in accordance with Federal and State regulations, as well as the eH contract. At a minimum, call center operation requirements include the following:

- Maintenance of a toll-free number operational from 8:00AM-5:00PM Monday-Friday local time, as well as extended operations during various times of the year (e.g., Open Enrollment).
- Policies and Procedure (P&Ps) that establish processes of the management of customer service calls, including a quality control program.
- Training & Education for Call Center staff regarding operational requirements (e.g., plan product information, PCP selection, appeals and grievances, language line services, frequency asked questions, etc.).
- Capability to record and monitor live calls to ensure compliance with policies and procedures, eH contract requirements, and ability to provide coaching to call center representatives.
- Procedures to ensure data security including training, software, and monitoring. Delegated entities are required to report any privacy incidents to eH Compliance for review and must cooperate in the investigation of any potential data breaches in accordance with the signed Business Associate Agreement (BAA).

Call Center Reporting

Delegated Entities are required to submit monthly Service Level Agreement (SLA) performance reports to eH. SLA reporting will be provided as outlined within the contract. Example SLA measures include:

- Average speed of answer for member calls (30 seconds or less).
- Average speed of answer for provider calls (30 seconds or less).
- Average speed of answer for prospective member calls (30 seconds or less).
- Abandonment rate of 5% or less.
- Scoring of call monitoring reviews at 95% or higher for a passing score.

Assessment / Audit of Delegated Call Center

Delegated Entities must demonstrate accurate and consistent Call Center operations practices by participating and cooperating in operational validation assessments and audits. eH may perform desk or onsite audits depending on regulatory requirements. Audit activities may include phone interviews as well as documentation reviews. Call Center assessments and audits may include the following:

- A review of the Delegated Entity Call Center policies and procedures.
- Review of recorded and/or live calls.
- A review of Call Center representative training, and coaching.
- A review of the delegated entity's internal monitoring and auditing processes and reports.
- Permit eH designated federal and state regulatory agencies access to Call Center operations documents. Provide copies of policies, procedures and other requested documents within the timeframe specified in the request, not to exceed 10 calendar days from the date of the eH request.

Transmitting Data

The following are examples of HIPAA compliant delivery methods to respond to assessment and audit requests:

- Direct access to an eH FTP site.
- Granting direct access to the Delegated Vendor FTP site.
- Encrypted email.

Notification of Changes

Delegated Entities must notify eH immediately of any of the following activities or changes:

- Physical address change, or the addition/ closure of physical locations.
- Change in phone numbers.
- Change in ownership.
- Change in Tax Identification Number (TIN).
- Change to Call Center escalation contacts.
- Change in language assistance vendors.
- Change in subdelegates (must be prior approved by eH).
- Change in Offshore operations (must be prior approved by eH).
- Changes in management service organization (if applicable).

All notifications to eH must be made in writing.

Call Center Processing Subdelegation and Offshore Contracting

If a Delegated Entity contracts with another organization to perform any part of the Call Center functions, eH must receive the agreements and oversight processes between the Delegated Entity and the Downstream entity.

eH must be notified of any subdelegate arrangements in advance to evaluate the delegation agreement and oversight processes.

The mutually agreed document must meet all accreditation and regulatory requirements and must describe the following:

- Scope of services being sub-delegated.
- Decision-making responsibilities.
- Reporting including cadence, content, and submission requirements.
- Sub-delegation assessment and evaluation process.
- Remedies for non-performance up to and including contract termination.

Offshore Operations

If the Delegated entity, or its subdelegates perform any services under its agreement with eH that is not within the United States (US) or one the US Territories (American Samoa, Guam, Northern Marinas, Puerto Rico, and Virgin Islands), eH must be notified. The Delegated Entity and Subcontractor must complete and submit the eH Offshore Attestation for review.

Examples of countries that meet the definition of 'offshore' include Mexico, Canada, India, Germany, and Japan. Subcontractors that are considered offshore can be both American owned companies with certain portions of their operations performed outside the United States or foreign-owned companies with their operations performed outside the United States. Offshore subcontractors provide services that are performed by workers located in offshore countries, regardless of whether the workers are employees of American or foreign companies.

Assessment/ Audit of Delegated Call Center Functions

Delegated Entities are provided with a written notice of planned assessment and audit activities 30 calendar days in advance.

eH Assessment and Audit Process

The eH assessment and audit process includes:

- Notification of the Call Center Assessment and Audit. The notification includes an Operational Review Questionnaire (ORQ), a description of the universe request and submission requirements, and instructions for the submission of samples.

- The Delegated Entity returns the ORQ and universe log(s).
- Once eH receives the universe report, samples are selected for submission and review. eH sends the requested sample list to the Delegated Entity.
- The Delegated Entity submits sample file documents and eH conducts an assessment and audit of the submitted documents. Other audit options may include a live primary source audit via webinar.

Operational Review Questionnaire (ORQ)
The eH ORQ seeks to validate the Delegated Entity's overall administrative structure, staffing resources, and call center policies and procedures. The ORQ is due prior to the start of the assessment and audit procedure includes the following:

- Call Center staffing structure and physical locations.
- Call volume by contract and type (prospective members, members, and providers)
- Training Program (Compliance, Code of Conduct, Privacy and Call Center processes).
- Fraud, Waste, and Abuse Program (including software and audit procedures).
- Internal monitoring and auditing.
- Call Center operations and performance metrics.
- Call Center processes.
- Business Continuity Plan.

Call Center Sample Reviews
Sample file submissions may include:

- Call recordings.
- Call Center logs and reports.
- Call Center staff coaching notes.

Audit meeting agendas may include the following topics:

- Introductions
- Overview of the purpose of the audit
- Assessment review
- System demo
- Call Center sample review
- Draft preliminary report including findings.

eH creates a final reporting that includes the following information:

- Operational assessment and audit results
- Performance audit results
- Corrective Action Plans (CAP) Requirements (if applicable)
- Plans to Reassess and Re-Audit delegated functions (if applicable)

When CAPs are required to address process deficiencies, the following elements ae required from the Delegated Entity:

- Root cause.
- Remediation Plan (including milestone dates and activities)
- Ongoing monitoring plan.

CAPs are monitored by eH through adequate validation testing.

Performance Audit
The performance audit includes validation of sampled Call Center call recordings (or live calls) or compliance with regulatory and contract processing requirements.

The typical review period is the immediate previous 3 months of activity. If a Delegated Entity is unable to provide required documents in the requested format eH will coordinate a process to obtain necessary reporting, and if applicable the development of a CAP.

Corrective Action Plan

Any material process deficiencies identified for delegated call center functions are referred to the eH Compliance Department to take appropriate action, including when appropriate the development of a formal corrective action plan (CAP). eH Compliance coordinates with the eH Business Owner, and Delegated Entity to identify root cause and remediation of call center process deficiencies.

Delegated Enrollment & Disenrollment Processes

Delegated Entities must comply with all enrollment and disenrollment requirements in accordance with Federal and State regulations, as well as the eH contract. At a minimum including the following:

- Provide upon requests copies of the delegated entity enrollment and disenrollment policies and procedures, as well as make revisions as required by regulation or contract changes.
- Cooperate with eH assessments and audits of the delegated entity's enrollment and disenrollment policies and processes including the provision of copies of policies, procedures and other requested documents within the timeframe specified in the request, not to exceed 30 calendar days from the date of the eH request.
- Permit eH designated federal and state regulatory agencies access to enrollment and disenrollment documents. Provide copies of policies, procedures and other requested documents within the timeframe specified in the request, not to exceed 10 calendar days from the date of the eH request.
- Submit monthly performance reports and program updates to eH.
- Retain all data, information, records, and documents related to delegated functions for a minimum of 10 years from the date of creation. Records maintenance and submission requirements survive any termination of the contract with eH.

Transmitting Data

The following are examples of Health Insurance Portability and Accountability Act (HIPAA) compliant delivery methods to respond to assessment and audit requests:

- Direct access to an eH FTP site.
- Granting direct access to the Delegated Vendor FTP site.
- Encrypted email.

Turnaround Time (TAT)

Delegated entities must establish processes to ensure compliance with proper handling and processes of enrollment and disenrollment requests received on

behalf of eH. At minimum, Delegated Entity enrollment and disenrollment processes must include the following to demonstrate compliant TATs:

- All mail is date stamped when received by either eH, CMS online function, or at the Delegated Entity's office(s).
- Received dates are used to determine the TAT of an enrollment or disenrollment request.
- TAT performance metrics are based on received date.
- TAT is based on the earliest receipt date regardless of any re-routing or forwarding that occurs.

Enrollment & Disenrollment Reporting

Delegated Entities submit reporting as outlined within the contract. Reporting may include:

- Enrollment Reports
- Disenrollment Reports
- TRR Reports
- Processing Turnaround Time (TAT)
- Regulatory required reporting

Notification of Changes

Delegated Entities must notify eH immediately of any of the following activities or changes:

- Physical address change, or the addition/ closure of physical locations.
- Change in phone numbers.
- Change in ownership.
- Change in Tax Identification Number (TIN).
- Change to Call Center escalation contacts.
- Change in language assistance vendors.
- Change in subdelegates (must be prior approved by eH).
- Change in Offshore operations (must be prior approved by eH).
- Changes in management service organization (if applicable).

All notifications to eH must be made in writing.

Enrollment & Disenrollment Processing Subdelegation and Offshore Contracting

If a Delegated Entity contracts with another organization to perform any part of enrollment or disenrollment functions, eH must receive the agreements and oversight processes between the Delegated Entity and the Downstream entity.

eH must be notified of any subdelegate arrangements in advance to evaluate the delegation agreement and oversight processes.

The mutually agreed document must meet all accreditation and regulatory requirements and must describe the following:

- Scope of services being sub-delegated.
- Decision-making responsibilities.
- Reporting including cadence, content, and submission requirements.
- Sub-delegation assessment and evaluation process.
- Remedies for non-performance up to and including contract termination.

Offshore Operations

If the Delegated entity, or its subdelegates perform any services under its agreement with eH that is not within the United States (US) or one the US Territories (American Samoa, Guam, Northern Marinas, Puerto Rico, and Virgin Islands), eH must be notified. The Delegated Entity and Subcontractor must complete and submit the eH Offshore Attestation for review.

Examples of countries that meet the definition of 'offshore' include Mexico, Canada, India, Germany, and Japan. Subcontractors that are considered offshore can be both American owned companies with certain portions of their operations performed outside the United States or foreign-owned companies with their operations performed outside the United States. Offshore subcontractors provide services that are performed by workers located in offshore countries, regardless of whether the workers are employees of American or foreign companies.

Assessment/ Audit of Delegated Enrollment and Disenrollment Functions

Delegated Entities are provided with a written notice of planned assessment and audit activities 30 calendar days in advance.

eH Assessment and Audit Process

The eH assessment and audit process includes:

- Notification of the Enrollment/Disenrollment Assessment and Audit. The notification includes an Operational Review Questionnaire (ORQ), a description of the universe request and submission requirements, and instructions for the submission of samples.
- The Delegated Entity returns the ORQ and universe log(s).
- Once eH receives the universe report, samples are selected for submission and review. eH sends the requested sample list to the Delegated Entity.

- The Delegated Entity submits sample file documents and eH conducts an assessment and audit of the submitted documents. Other audit options may include a live primary source audit via webinar.

Operational Review Questionnaire (ORQ)
The eH ORQ seeks to validate the Delegated Entity's overall administrative structure, staffing resources, and call center policies and procedures. The ORQ is due prior to the start of the assessment and audit procedure includes the following:

- Enrollment and disenrollment staffing structure and physical locations.
- Application volume by contract
- Training Program (Compliance, Code of Conduct, Privacy and Enrollment and Disenrollment processes).
- Fraud, Waste, and Abuse Program (including software and audit procedures).
- Internal monitoring and auditing.
- Enrollment and Disenrollment operations and performance metrics.
- Enrollment & Disenrollment processes.
- Business Continuity Plan.

Enrollment & Disenrollment Sample Reviews
Sample file submissions may include:

- Enrollment Application
- Disenrollment Request
- Enrollment and Disenrollment response letters and notifications
- Enrollment and Disenrollment processing reports (including internal and CMS reporting)
- Enrollment and disenrollment staff coaching notes.

Audit meeting agendas may include the following topics:

- Introductions
- Overview of the purpose of the audit
- Assessment review
- System demo
- Enrollment sample review
- Disenrollment sample review
- Draft preliminary report including findings.

eH creates a final reporting that includes the following information:

- Operational assessment and audit results
- Performance audit results
- Corrective Action Plans (CAP) Requirements (if applicable)
- Plans to Reassess and Re-Audit delegated functions (if applicable)

When CAPs are required to address process deficiencies, the following elements ae required from the Delegated Entity:

- Root cause.
- Remediation Plan (including milestone dates and activities)
- Ongoing monitoring plan.

CAPs are monitored by eH through adequate validation testing.

Performance Audit
The performance audit includes validation of sampled enrollment / disenrollment processes or compliance with regulatory and contract processing requirements.

The typical review period is the immediate previous 3 months of activity. If a Delegated Entity is unable to provide required documents in the requested format eH will coordinate a process to obtain necessary reporting, and if applicable the development of a CAP.

Corrective Action Plan

Any material process deficiencies identified for delegated call center functions are referred to the eH Compliance Department to take appropriate action, including when appropriate the development of a formal corrective action plan (CAP). eH Compliance coordinates with the eH Business Owner, and Delegated Entity to identify root cause and remediation of call center process deficiencies.

Delegated Grievances

Delegated Entities must comply with all grievance filing requirements in accordance with Federal and State regulations, as well as the eH contract. At a minimum, grievance requirements include the following:

- Provide upon requests copies of the delegated entity grievance policies and procedures, as well as make revisions as required by regulation or contract changes.
- Cooperate with eH assessments and audits of the delegated entity's grievance policies and processes, including the provision of policies, procedures and other requested documents within the timeframe specified in the request, not to exceed 30 calendar days from the date of the eH request.
- Permit eH designated federal and state regulatory agencies access to grievance documents. Provide copies of policies, procedures and other requested documents within the timeframe specified in the request, not to exceed 10 calendar days from the date of the eH request.
- Submit monthly performance reports and program updates to eH.
- Retain all data, information, records, and documents related to delegated functions for a minimum of 10 years from the date of creation. Records

maintenance and submission requirements survive any termination of the contract with eH.

Transmitting Data

The following are examples of Health Insurance Portability and Accountability Act (HIPAA) compliant delivery methods to respond to assessment and audit requests:

- Direct access to an eH FTP site.
- Granting direct access to the Delegated Vendor FTP site.
- Encrypted email.

Turnaround Time (TAT)

Delegated entities must establish processes to ensure compliance with proper handling and processes of grievances received on behalf of eH. At minimum, Delegated Entity claims processes must include the following to demonstrate compliant TATs:

- All calls related to grievances are recorded and made available to eH and regulatory agencies upon request.
- Responses to Complaint Tracking Module (CTM) filings are responded to in compliance with the timeframe requested by eH based on CMS categorization of the complaint type.
- All mail is date stamped when received by either eH, or at the Delegated Entity's office(s).
- Received dates are used to determine the TAT of a grievance.
- TAT performance metrics are based on received / filed date.
- TAT is based on the earliest receipt date regardless of any re-routing or forwarding that occurs.

Grievance Reporting

Delegated Entities submit reporting as outlined within the contract r Reporting may include:

- Grievance processing and oversight reports
- Grievance reporting to applicable committees (e.g., UMQIC)
- Processing Turnaround Time (TAT)

Notification of Changes

Delegated Entities must notify eH immediately of any of the following activities or changes:

- Physical address change, or the addition/ closure of physical locations.
- Change in phone numbers.
- Change in ownership.

- Change in Tax Identification Number (TIN).
- Change to Call Center escalation contacts.
- Change in language assistance vendors.
- Change in subdelegates (must be prior approved by eH).
- Change in Offshore operations (must be prior approved by eH).
- Changes in management service organization (if applicable).

All notifications to eH must be made in writing.

Grievance Processing Subdelegation and Offshore Contracting

If a Delegated Entity contracts with another organization to perform any part of Grievance functions, eH must receive the agreements and oversight processes between the Delegated Entity and the Downstream entity.

eH must be notified of any subdelegate arrangements in advance to evaluate the delegation agreement and oversight processes.

The mutually agreed document must meet all accreditation and regulatory requirements and must describe the following:

- Scope of services being sub-delegated.
- Decision-making responsibilities.
- Reporting including cadence, content, and submission requirements.
- Sub-delegation assessment and evaluation process.
- Remedies for non-performance up to and including contract termination.

Offshore Operations

If the Delegated entity, or its subdelegates perform any services under its agreement with eH that is not within the United States (US) or one the US Territories (American Samoa, Guam, Northern Marinas, Puerto Rico, and Virgin Islands), eH must be notified. The Delegated Entity and Subcontractor must complete and submit the eH Offshore Attestation for review.

Examples of countries that meet the definition of 'offshore' include Mexico, Canada, India, Germany, and Japan. Subcontractors that are considered offshore can be both American owned companies with certain portions of their operations performed outside the United States or foreign-owned companies with their operations performed outside the United States. Offshore subcontractors provide services that are performed by workers located in offshore countries, regardless of whether the workers are employees of American or foreign companies.

Assessment/ Audit of Delegated Grievance Functions

Delegated Entities are provided with a written notice of planned assessment and audit activities 30 calendar days in advance.

eH Assessment and Audit Process

The eH assessment and audit process includes:

- Notification of the Grievance Process Assessment and Audit. The notification includes an Operational Review Questionnaire (ORQ), a description of the universe request and submission requirements, and instructions for the submission of samples.
- The Delegated Entity returns the ORQ and universe log(s).
- Once eH receives the universe report, samples are selected for submission and review. eH sends the requested sample list to the Delegated Entity.
- The Delegated Entity submits sample file documents and eH conducts an assessment and audit of the submitted documents. Other audit options may include a live primary source audit via webinar/

Operational Review Questionnaire (ORQ)

The eH ORQ seeks to validate the Delegated Entity's overall administrative structure, staffing resources, and grievance policies and procedures. The ORQ is due prior to the start of the assessment and audit procedure includes the following:

- Grievance staffing structure and physical locations.
- Grievance volume by contract.
- Training Program (Compliance, Code of Conduct, Privacy and Grievance processes).
- Fraud, Waste, and Abuse Program (including software and audit procedures).
- Internal monitoring and auditing.
- Grievance operations and performance metrics.
- Grievance processes.
- Business Continuity Plan.

Grievance Sample Reviews

Sample file submissions may include:

- Grievance call recordings.
- Written grievance filings.
- Grievance logs and reports.
- Grievance staff coaching notes.

Audit meeting agendas may include the following topics:

- Introductions
- Overview of the purpose of the audit
- Assessment review

- System demo
- Grievance sample review
- Draft preliminary report including findings.

eH creates a final reporting that includes the following information:

- Operational assessment and audit results
- Performance audit results
- Corrective Action Plans (CAP) Requirements (if applicable)
- Plans to Reassess and Re-Audit delegated functions (if applicable)

When CAPs are required to address process deficiencies, the following elements ae required from the Delegated Entity:

- Root cause.
- Remediation Plan (including milestone dates and activities)
- Ongoing monitoring plan.

CAPs are monitored by eH through adequate validation testing.

Performance Audit
The performance audit includes validation of sampled Grievance call recordings (or live calls) or compliance with regulatory and contract processing requirements.

The typical review period is the immediate previous 3 months of activity. If a Delegated Entity is unable to provide required documents in the requested format eH will coordinate a process to obtain necessary reporting, and if applicable the development of a CAP.

Corrective Action Plan

Any material process deficiencies identified for delegated call center functions are referred to the eH Compliance Department to take appropriate action, including when appropriate the development of a formal corrective action plan (CAP). eH Compliance coordinates with the eH Business Owner, and Delegated Entity to identify root cause and remediation of call center process deficiencies.

Delegated Appeals (Part C Reconsiderations)

Delegated Entities must comply with all Appeals (Part C Reconsideration) requirements in accordance with Federal and State regulations, as well as the eH contract. At a minimum, Appeals (Part C Reconsideration) administration requirements include the following:

- Provide upon requests copies of the delegated entity Appeals (Part C Reconsideration) policies and procedures, as well as make revisions as required by regulation or contract changes.
- Cooperate with eH assessments and audits of the delegated entity's Appeals (Part C Reconsideration) management program. Provide copies of policies, procedures and other requested documents within the timeframe specified in the request, not to exceed 30 calendar days from the date of the eH request.
- Permit eH designated federal and state regulatory agencies access to Appeals (Part C) administration documents. Provide copies of policies, procedures and other requested documents within the timeframe specified in the request, not to exceed 10 calendar days from the date of the eH request.
- Submit monthly performance reports and program updates to eH.
- Retain all data, information, records, and documents related to delegated functions for a minimum of 10 years from the date of creation. Records maintenance and submission requirements survive any termination of the contract with eH.

Transmitting Data

The following are examples of Health Insurance Portability and Accountability Act (HIPAA) compliant delivery methods to respond to assessment and audit requests:

- Direct access to an eH FTP site.
- Granting direct access to the Delegated Vendor FTP site.
- Encrypted email.

Turnaround Time (TAT)

Delegated entities must establish processes to ensure compliance with proper handling and processes of Appeals (Part C Reconsiderations) received on behalf of eH. At minimum, Delegated Entity Appeals (Part C Reconsideration) processes must include the following to demonstrate compliant TATs:

- All mail is date stamped when received by either eH, or at the Delegated Entity's office(s).
- Received dates are used to determine the TAT of an Appeal (Part C Reconsideration).
- TAT performance metrics are based on received date.

- TAT is based on the earliest receipt date regardless of any re-routing or forwarding that occurs.

Appeals (Part C Reconsiderations) Reporting

Delegated Entities submit reporting as outlined within the contract. Reporting may include:

- Appeals (Part C Reconsiderations) Audit Reports
- Monthly Appeals (Part C Reconsiderations) Reporting
- Daily/Weekly/Monthly Appeals (Part C Reconsiderations) Reports
- Processing Turnaround Time (TAT)

Notification of Changes

Delegated Entities must notify eH immediately of any of the following activities or changes:

- Physical address change, or the addition/ closure of physical locations.
- Change in phone numbers.
- Change in ownership.
- Change in Tax Identification Number (TIN).
- Change to Call Center escalation contacts.
- Change in language assistance vendors.
- Change in subdelegates (must be prior approved by eH).
- Change in Offshore operations (must be prior approved by eH).
- Changes in management service organization (if applicable).

All notifications to eH must be made in writing.

Appeals (Part C Reconsiderations) Subdelegation and Offshore Contracting

If a Delegated Entity contracts with another organization to perform any part of the Appeals (Part C Reconsiderations) functions, eH must receive the agreements and oversight processes between the Delegated Entity and the Downstream entity.

eH must be notified of any subdelegate arrangements in advance to evaluate the delegation agreement and oversight processes.

The mutually agreed document must meet all accreditation and regulatory requirements and must describe the following:

- Scope of services being sub-delegated.
- Decision-making responsibilities.
- Reporting including cadence, content, and submission requirements.
- Sub-delegation assessment and evaluation process.

- Remedies for non-performance up to and including contract termination.

Offshore Operations

If the Delegated entity, or its subdelegates perform any services under its agreement with eH that is not within the United States (US) or one the US Territories (American Samoa, Guam, Northern Marinas, Puerto Rico, and Virgin Islands), eH must be notified. The Delegated Entity and Subcontractor must complete and submit the eH Offshore Attestation for review.

Examples of countries that meet the definition of 'offshore' include Mexico, Canada, India, Germany, and Japan. Subcontractors that are considered offshore can be both American owned companies with certain portions of their operations performed outside the United States or foreign-owned companies with their operations performed outside the United States. Offshore subcontractors provide services that are performed by workers located in offshore countries, regardless of whether the workers are employees of American or foreign companies.

Assessment/ Audit of Delegated Appeal (Part C Reconsideration) Functions

Delegated Entities are provided with a written notice of planned assessment and audit activities 30 calendar days in advance.

eH Assessment and Audit Process

The eH assessment and audit process includes:

- Notification of the Appeals (Part C Reconsiderations) Assessment and Audit. The notification includes an Operational Review Questionnaire (ORQ), a description of the universe request and submission requirements, and instructions for the submission of samples.
- The Delegated Entity returns the ORQ and universe log(s).
- Once eH receives the universe report, samples are selected for submission and review. eH sends the requested sample list to the Delegated Entity.
- The Delegated Entity submits sample file documents and eH conducts an assessment and audit of the submitted documents. Other audit options may include a live primary source audit via webinar.

Operational Review Questionnaire (ORQ)

The eH ORQ seeks to validate the Delegated Entity's overall administrative structure, staffing resources, and Appeals (Part C Reconsiderations) policies and procedures. The ORQ is due prior to the start of the assessment and audit procedure includes the following:

- Appeals (Part C Reconsiderations) staffing structure and physical locations.
- Appeals (Part C Reconsiderations) by contract and type (members, member representatives, and providers)

- Training Program (Compliance, Code of Conduct, Privacy and Part C Reconsideration processes).
- Fraud, Waste, and Abuse Program (including software and audit procedures).
- Internal monitoring and auditing.
- Appeals (Part C Reconsiderations) operations and performance metrics.
- Appeals (Part C Reconsiderations) processes.
- Business Continuity Plan.

Appeal (Part C Reconsideration) Sample Reviews
Sample file submissions may include:

- Written Appeal (Part C Reconsideration) Request
- Reviewer Qualifications and Credentials
- Supporting Resources (medical review criteria, EOC, SB, etc.)
- Written Appeal (Part C Reconsideration) Decision Letter
- Proof of Effectuation (if applicable)
- IRE Case Submission (If applicable)
- Appeal (Part C Reconsideration) logs and reports.
- Appeal (Part C Reconsideration) staff coaching notes.

Audit meeting agendas may include the following topics:

- Introductions
- Overview of the purpose of the audit
- Assessment review
- System demo
- Appeal (Part C Reconsideration) sample review
- Draft preliminary report including findings

eH creates a final reporting that includes the following information:

- Operational assessment and audit results
- Performance audit results
- Corrective Action Plans (CAP) Requirements (if applicable)
- Plans to Reassess and Re-Audit delegated functions (if applicable)

When CAPs are required to address process deficiencies, the following elements ae required from the Delegated Entity:

- Root cause
- Remediation Plan (including milestone dates and activities)
- Ongoing monitoring plan

CAPs are monitored by eH through adequate validation testing.

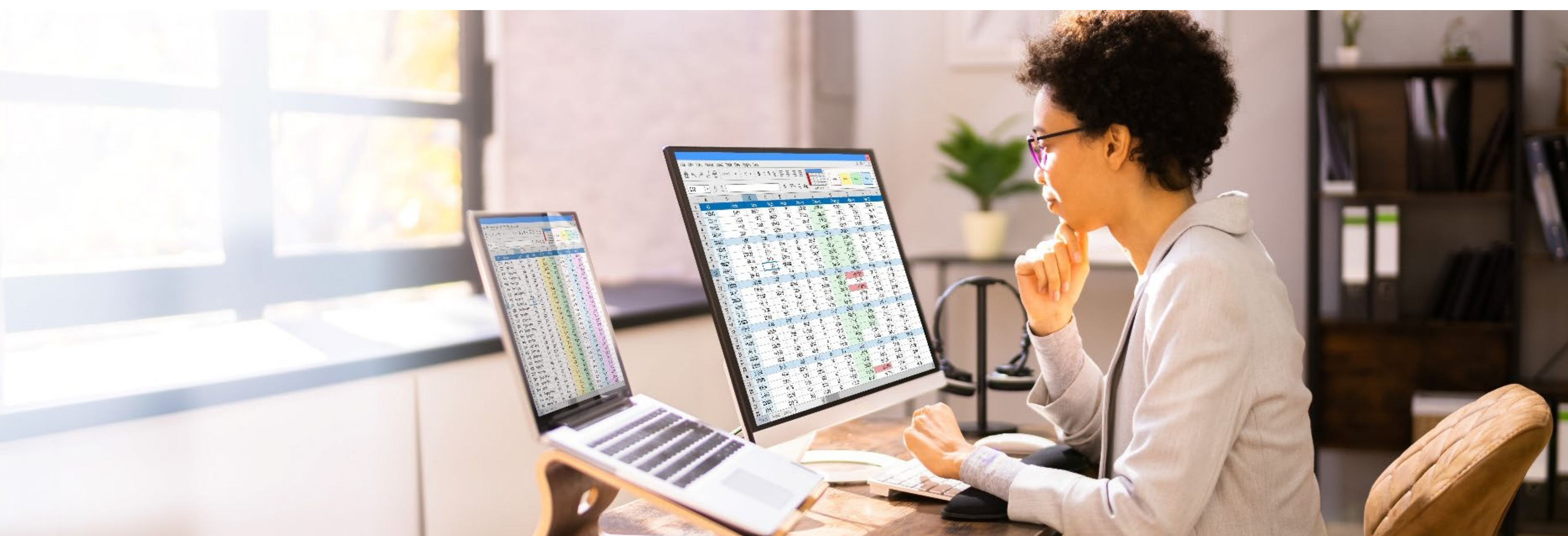
Performance Audit

The performance audit includes validation of compliance with regulatory and contract processing requirements.

The typical review period is the immediate previous 3 months of activity. If a Delegated Entity is unable to provide required documents in the requested format eH will coordinate a process to obtain necessary reporting, and if applicable the development of a CAP.

Corrective Action Plan

Any material process deficiencies identified for delegated call center functions are referred to the eH Compliance Department to take appropriate action, including when appropriate the development of a formal corrective action plan (CAP). eH Compliance coordinates with the eH Business Owner, and Delegated Entity to identify root cause and remediation of call center process deficiencies.



Delegated Billing Services

Delegated Entities must comply with all billing service requirements in accordance with Federal and State regulations, as well as the eH contract. At a minimum, billing services requirements include the following:

- Provide upon requests copies of the delegated entity billing services policies and procedures, as well as make revisions as required by regulation or contract changes.
- Cooperate with eH assessments and audits of the delegated entity's billing services program. Provide copies of policies, procedures and other requested documents within the timeframe specified in the request, not to exceed 30 calendar days from the date of the eH request.

- Permit eH designated federal and state regulatory agencies access to billing services documents. Provide copies of policies, procedures and other requested documents within the timeframe specified in the request, not to exceed 10 calendar days from the date of the eH request.
- Submit monthly performance reports and program updates to eH.
- Retain all data, information, records, and documents related to delegated functions for a minimum of 10 years from the date of creation. Records maintenance and submission requirements survive any termination of the contract with eH.

Transmitting Data

The following are examples of Health Insurance Portability and Accountability Act (HIPAA) compliant delivery methods to respond to assessment and audit requests:

- Direct access to an eH FTP site.
- Granting direct access to the Delegated Vendor FTP site.
- Encrypted email.

Turnaround Time (TAT)

Delegated entities must establish processes to ensure compliance with proper billing services processed on behalf of eH. At minimum, Delegated Entity claims processes must include the following to demonstrate compliant TATs:

- All mail is date stamped when received by either eH, or at the Delegated Entity's office(s).
- Received dates are used to determine the TAT when applicable.
- TAT performance metrics are based on received date when applicable.
- TAT is based on the earliest receipt date regardless of any re-routing or forwarding that occurs.

Billing Services Reporting

Delegated Entities submit reporting as outlined within the contract i. Reporting may include:

- Billing Services Reports
- Processing Turnaround Time (TAT)

Notification of Changes

Delegated Entities must notify eH immediately of any of the following activities or changes:

- Physical address change, or the addition/ closure of physical locations.
- Change in phone numbers.
- Change in ownership.
- Change in Tax Identification Number (TIN).

- Change to Call Center escalation contacts.
- Change in language assistance vendors.
- Change in subdelegates (must be prior approved by eH).
- Change in Offshore operations (must be prior approved by eH).
- Changes in management service organization (if applicable).

All notifications to eH must be made in writing.

Billing Services Subdelegation and Offshore Contracting

If a Delegated Entity contracts with another organization to perform any part of Billing functions, eH must receive the agreements and oversight processes between the Delegated Entity and the Downstream entity.

eH must be notified of any subdelegate arrangements in advance to evaluate the delegation agreement and oversight processes.

The mutually agreed document must meet all accreditation and regulatory requirements and must describe the following:

- Scope of services being sub-delegated.
- Decision-making responsibilities.
- Reporting including cadence, content, and submission requirements.
- Sub-delegation assessment and evaluation process.
- Remedies for non-performance up to and including contract termination.

Offshore Operations

If the Delegated entity, or its subdelegates perform any services under its agreement with eH that is not within the United States (US) or one the US Territories (American Samoa, Guam, Northern Marinas, Puerto Rico, and Virgin Islands), eH must be notified. The Delegated Entity and Subcontractor must complete and submit the eH Offshore Attestation for review.

Examples of countries that meet the definition of 'offshore' include Mexico, Canada, India, Germany, and Japan. Subcontractors that are considered offshore can be both American owned companies with certain portions of their operations performed outside the United States or foreign-owned companies with their operations performed outside the United States. Offshore subcontractors provide services that are performed by workers located in offshore countries, regardless of whether the workers are employees of American or foreign companies.

Assessment/ Audit of Delegated Billing Service Functions

Delegated Entities are provided with a written notice of planned assessment and audit activities 30 calendar days in advance.

eH Assessment and Audit Process

The eH assessment and audit process includes:

- Notification of the Billing Services Assessment and Audit. The notification includes an Operational Review Questionnaire (ORQ), a description of the universe request and submission requirements, and instructions for the submission of samples.
- The Delegated Entity returns the ORQ and universe log(s).
- Once eH receives the universe report, samples are selected for submission and review. eH sends the requested sample list to the Delegated Entity.
- The Delegated Entity submits sample file documents and eH conducts an assessment and audit of the submitted documents. Other audit options may include a live primary source audit via webinar.

Operational Review Questionnaire (ORQ)

The eH ORQ seeks to validate the Delegated Entity's overall administrative structure, staffing resources, and Billing policies and procedures. The ORQ is due prior to the start of the assessment and audit procedure includes the following:

- Billing services staffing structure and physical locations.
- Billing services by contract.
- Training Program (Compliance, Code of Conduct, Privacy and Billing processes).
- Fraud, Waste, and Abuse Program (including software and audit procedures).
- Internal monitoring and auditing.
- Billing services operations and performance metrics.
- Billing services processes.
- Business Continuity Plan.

Billing Sample Reviews

Sample file submissions may include:

- Invoices
- Copies of cancelled checks
- Banking and deposit statements/ copies
- Billing staff coaching notes

Audit meeting agendas may include the following topics:

- Introductions
- Overview of the purpose of the audit
- Assessment review
- System demo
- Billing sample review
- Draft preliminary report including findings.

eH creates a final reporting that includes the following information:

- Operational assessment and audit results
- Performance audit results
- Corrective Action Plans (CAP) Requirements (if applicable)
- Plans to Reassess and Re-Audit delegated functions (if applicable)

When CAPs are required to address process deficiencies, the following elements ae required from the Delegated Entity:

- Root cause.
- Remediation Plan (including milestone dates and activities)
- Ongoing monitoring plan.

CAPs are monitored by eH through adequate validation testing.

Performance Audit
The performance audit includes compliance with regulatory and contract processing requirements.

The typical review period is the immediate previous 3 months of activity. If a Delegated Entity is unable to provide required documents in the requested format eH will coordinate a process to obtain necessary reporting, and if applicable the development of a CAP.

Corrective Action Plan

Any material process deficiencies identified for delegated call center functions are referred to the eH Compliance Department to take appropriate action, including when appropriate the development of a formal corrective action plan (CAP). eH Compliance coordinates with the eH Business Owner, and Delegated Entity to identify root cause and remediation of call center process deficiencies.

Delegated Clinical Operations

eH may delegate clinical functions for utilization management (UM) and Population Health Management (PHM) to meet CMS, state, and other federal program requirements. eH is ultimately responsible for all decision-making authority of delegated functions. eH conducts oversight through reporting, monitoring, and auditing activities.

UM and PHM delegated entities must ensure the following:

- Development of clinical processes that comply with CMS and eH standards and requirements.
- Effective implementation of any required corrective actions for process improvements.
- Cooperate with assessment and audit activities.
- Obtain eH prior approval for any sub-delegation, or offshore operations.

Delegated Clinical Function Requirements

The following conditions are prerequisites for delegation of eH UM functions:

- An executed agreement (including a BAA).
- A financial risk arrangement that includes downside risk with the health plan (if applicable).
- UM and PHM fully operational for 12 consecutive months prior to engagement with eH.
- Delegates must have an active Utilization Review Agent (URA) license, certification, or registration (if applicable).
- A comprehensive program description
- Delegate ability to accept referrals from eH, and other delegates for UM services.
- Delegates must ensure coverage for urgent issues 7 days a week during business hours.
- Delegates must identify contacts for escalated issues.

- Capability to provide accurate UM data (e.g., HEDIS data) timely (and address any identified errors promptly).

The following conditions are prerequisites for delegation of eH PHM functions:

- The delegate program must include STAR measure gaps closures.
- Delegate ability to transfer data and records to eH.
- The delegate program must include agreed upon components (e.g., readmission avoidance, management of comorbidities, care coordination for advance illness and end of life, etc.).

Security Controls

Delegated Entities are required to maintain written system security control policies and procedures that include the following:

- UM denial information (request receipt date, a copy of the denial notification, and supporting documentation related to the qualifications of the denial based on medical necessity, etc.).
- Qualifications for staff that are able to make modifications (authorized and acceptable modifications or deletions).
- The process for making program modifications (including reason for the modification, date of the modification, staff titles and roles).
- Protection of UM information (e.g., physical access controls, password protection, user access rules, etc.)

Clinical Program Procedures

Delegated Entity policies and procedures utilized to adopt and evaluate UM review criteria information sources and processes must comply with applicable accreditation standards, CMS and eH contract requirements. Delegated Entity UM Program descriptions must be submitted to eH annually and include any revisions required by eH or regulatory bodies.

Utilization Management Committee

Delegated entities must either participate in the eH UMQIC Committee or establish a UM committee responsible for oversight of all utilization management activities. UM membership should include a senior medical director, and other licensed physicians as necessary. UM Committees must meet at minimum quarterly. Meeting minutes must be maintained for a period of 10 years from the date of creation and made available to eH upon request.

Written Utilization Management Review Decision Guidelines

Delegated Entities must maintain a set of UM review decision protocols based on medical evidence consistent with eH requirements and guidelines. Any protocol

revisions must be submitted to eH for review. Delegated Entities are responsible for educating network providers on UM decision making guidelines and criteria.

Utilization Management Recommendations and Decisions

UM decisions must be made in a timely manner in accordance with CMS and eH requirements. All UM decisions must reflect professional judgment and be in alignment with generally accepted medical standards. A qualified physician must review denials related to medical necessity. Qualified physicians must have appropriate licensure and meet any accreditation requirements. Board certified physicians may be utilized to conduct denial reviews. Denial reasons must be clearly documented with CMS approved grade level language and include appeals process information. eH retains ultimate responsibility and authority on final denial determinations, and appeal process decisions.

Utilization Management Functions

Delegated Entities may perform various utilization management (UM) functions. Except for emergencies, delegated utilization management services must be provided by contracted providers. Delegated UM functions may include:

- Processing prior authorization requests for hospital admissions for non-emergency services and elective outpatient procedures.
- Processing prior authorization requests for skilled nursing facilities or sub-acute facilities, durable medical equipment organizations, hospice, home health, diagnostic testing, or other covered outpatient services.
- Concurrent review.
- Retrospective review.
- Discharge planning.
- Care/ Case Management functions.

Utilization Management Reporting Requirements

The following are required UM reports by cadence:

- Monthly
  - Bed Days/ 1000
  - Admits/ 1000
  - Average Length of Stay
  - Number of UM cases (inpatient and outpatient)
  - Timeliness reports (average TAT for UM standard and expedited reviews)
  - ODAG reports
- Quarterly
  - Compliance Program Attestation (including system security controls attestation)
- Semi Annual

  - Bed Days/ 1000
  - Admits/ 1000
  - Average Length of Stay
  - Number of UM cases (inpatient and outpatient)
  - Timeliness reports (average TAT for UM standard and expedited reviews)
- Annual
  - UM Committee Charter
  - UM Program Description
  - UM Program Evaluation
  - UM Work Plan
  - UM Program Security Controls Analysis

Population Health Management (PHM) Functions

The eH PHM program is designed to address complex member care needs. Delegated entities are delegated to perform various PHM functions including:

- Population assessments to determine appropriate interventions.
- Communication of support and referral options (e.g., discharge planning, caregiver referrals, practitioner referrals, self-referrals, etc.).
- The provision of opt-in/opt out instructions for use of program services.
- Utilization of evidence-based clinical guidelines.
- System documentation of the staff responsible for prompting member interaction, date and time of interactions and any applicable care follow-up.

Complex Case Management

Delegated compliance care management may include the following:

- Member rights and responsibilities (e.g., right to decline or participate in case management services).
- Initial assessment includes condition-specific issues, social determinates, behavioral health status, visual and hearing needs, available community resources, cultural and linguistic needs, and life-planning activities.
- Documentation of clinical and medication history.
- Development individualized care plans including preferences, member-desired level of member involvement, goals, caregiver resources, identification of any barriers, referrals to resources, and follow up schedule. Care plans will include assessment of progress and communication cadence.

Delegated Entities are responsible for conducting a compressive annual analysis of overall PHM program effectiveness utilizing at minimum the following four measurements:

1. A clinical measure.
2. A cost measure.
3. A utilization measure.

4. A member feedback measure (including member complaints and grievance data).

Each measure must be inclusive of:

- A relevant process or outcome.
- A valid method of measurement for quantitative results.
- Clear identification of measurement specifications.
- Analyss of results including quantitative and qualitative analysis.
- An intervention plan to improve performance.
- Completion of a remeasurement.

Population Health Management (PHM) Reporting Requirements

Delegated Entities responsible for eH PHM program administration are required to submit the following reports:

- Annual PHM Program Description
- PHM Population Assessment
- Effectiveness Evaluation of the PHM Program
- Evaluation of the Member Experience
- Evaluation of the Provider Experience
- Total members enrolled in the PHM Program
- Total member opting out of the PHM Program

Medical Technology

Delegated Entity policies and procedures must include the distribution of eH issued guidelines, protocols, clinical policies and appropriate us or new medical technologies and devices. eH retains ultimate authority for decision making related to medical technology and application policies and procedures.

Quality-of-Care Concerns (QOC)

Delegated Entities must report quality of care concerns to eH within 24 hours of identification. The eH Clinical Team is responsible for investigating, reviewing, tracking, and trending all QOC issues.

Contact Person for Members

Delegated Entities must provide a mechanism and contact for members to obtain assistance, and additional information related to utilization management decisions and processes.

Surveys

eH and CMS may conduct surveys with members and network providers to determine satisfaction levels with delegated patient management activities. eH shares the results of survey activities with delegated entities for the purpose of

identifying potential process improvements. When applicable, Delegated Entities are expected to develop and implement performance improvement plans to address any gaps or issues identified through the survey process.

Clinical Operations Subdelegation and Offshore Contracting

If a Delegated Entity contracts with another organization to perform any part of the delegated clinical processes, eH must receive the agreements and oversight processes between the Delegated Entity and the Downstream entity.

eH must be notified of any subdelegate arrangements in advance to evaluate the delegation agreement and oversight processes.

The mutually agreed document must meet all accreditation and regulatory requirements and must describe the following:

- Sope of services being sub-delegated.
- Decision-making responsibilities.
- Reporting including cadence, content, and submission requirements.
- Sub-delegation assessment and evaluation process.
- Remedies for non-performance up to and including contract termination.

Offshore Operations

If the Delegated entity, or its subdelegates perform any services under its agreement with eH that
is not within the United States (US) or one the US Territories (American Samoa, Guam, Northern Marinas, Puerto Rico, and Virgin Islands), eH must be notified. The Delegated Entity and Subcontractor must complete and submit the eH Offshore Attestation for review.

Examples of countries that meet the definition of 'offshore' include Mexico, Canada, India, Germany, and Japan. Subcontractors that are considered offshore can be both American owned companies with certain portions of their operations performed outside the United States or foreign-owned companies with their operations performed outside the United States. Offshore subcontractors provide services that are performed by workers located in offshore countries, regardless of whether the workers are employees of American or foreign companies.

Assessment/ Audit of Delegated UM and PHM Functions

Delegated Entities are provided with a written notice of planned assessment and audit activities 30 calendar days in advance.

eH Assessment and Audit Process

The eH assessment and audit process includes:

- Notification of the UM and PHM Assessment and Audit. The notification includes an Operational Review Questionnaire (ORQ), a description of the universe request and submission requirements, and instructions for the submission of samples.
- The Delegated Entity returns the ORQ and universe log(s).
- Once eH receives the universe report, samples are selected for submission and review. eH sends the requested sample list to the Delegated Entity.
- The Delegated Entity submits sample file documents and eH conducts an assessment and audit of the submitted documents. Other audit options may include a live primary source audit via webinar.

Operational Review Questionnaire (ORQ)

The eH ORQ seeks to validate the Delegated Entity's overall administrative structure, staffing resources, and UM / PHM policies and procedures. The ORQ is due prior to the start of the assessment and audit procedure includes the following:

- UM and PHM staffing structure and physical locations.
- Training Program (Compliance, Code of Conduct, Privacy and UM /PHM processes).
- Internal monitoring and auditing.
- UM and PHM performance metrics.
- UM and PHM processes.
- Business Continuity Plan.

UM and PHM Sample Files

Sample file submissions may include:

- UM denial logs and reports.
- Copies of denial letters.

Audit meeting agendas may include the following topics:

- Introductions
- Overview of the purpose of the audit
- Assessment review
- System demo
- UM/PHM sample review
- Draft preliminary report including findings.

eH creates a final reporting that includes the following information:

- Operational assessment and audit results
- Performance audit results
- Corrective Action Plans (CAP) Requirements (if applicable)

- Plans to Reassess and Re-Audit delegated functions (if applicable)

When CAPs are required to address process deficiencies, the following elements ae required from the Delegated Entity:

- Root cause.
- Remediation Plan (including milestone dates and activities)
- Ongoing monitoring plan.

CAPs are monitored by eH through adequate validation testing.

The typical review period is the immediate previous 3 months of activity. If a Delegated Entity is unable to provide required documents in the requested format eH will coordinate a process to obtain necessary reporting, and if applicable the development of a CAP.

Transmitting Data

The following are examples of HIPAA compliant delivery methods to respond to assessment and audit requests:

- Direct access to an eH FTP site.
- Granting direct access to the Delegated Vendor FTP site.
- Encrypted email.

Notification of Complaints

Delegated entities must notify eH immediately of any oral or written escalated or material complaints, including attorney and media contacts, related to members and participating (contracted) providers.

Corrective Action Plan

Any material process deficiencies identified for delegated clinical operations functions are referred to the eH Compliance Department to take appropriate action, including when appropriate the development of a formal corrective action plan (CAP). eH Compliance coordinates with the eH Business Owner, and Delegated Entity to identify root cause and remediation of clinical operations process deficiencies.

Delegated Pharmacy Benefit Management

eH may delegate pharmacy benefit management functions to meet CMS, state, and other federal program requirements. eH is ultimately responsible for all decision-making authority of delegated functions. eH conducts oversight through reporting, monitoring, and auditing activities.

Delegated Pharmacy Benefit Managers (PBMs) must ensure the following:

- Development of Part D processes that comply with CMS and eH standards and requirements.
- Effective implementation of any required corrective actions for process improvements.
- Cooperate with assessment and audit activities.
- Obtain eH prior approval for any sub-delegation, or offshore operations.

Security Controls

Delegated Entities are required to maintain written system security control policies and procedures that include the following:

- Part D denial information (request receipt date, a copy of the denial notification, and supporting documentation related to the qualifications of the denial based on medical necessity, etc.).
- Qualifications for staff that are able to make modifications (authorized and acceptable modifications or deletions).
- The process for making program modifications (including reason for the modification, date of the modification, staff titles and roles).
- Protection of UM information (e.g., physical access controls, password protection, user access rules, etc.)

Part D Program Procedures

Delegated Entity policies and procedures utilized to adopt and evaluate Part D coverage review criteria information sources and processes must comply with applicable accreditation standards, CMS and eH contract requirements. Delegated

Entity UM Program descriptions must be submitted to eH annually and include any revisions required by eH or regulatory bodies.

Pharmacy & Therapeutics (P&T) Committee

Delegated entities must either lead or participate in a P&T Committee responsible for determining what drugs are included in the eH Formulary. The P&T Committee should consist of providers involved in prescribing, dispensing, and administering medications and the evaluation of medication usage. The committee also provides education and advisory services related to the use of available medications. The P&T Committees must meet at minimum quarterly. Meeting minutes must be maintained for a period of 10 years from the date of creation and made available to eH upon request. The delegated P&T committee will comply with all applicable Medicare laws, including 42 CFR 423.120, and CMS guidance and instructions, including those applicable to reviews, meetings and processes not called out above.

Written Part D Coverage Review Decision Guidelines

Delegated Entities must maintain a set of Part D coverage review decision protocols based on medical evidence consistent with eH and CMS requirements and guidelines. Any protocol revisions must be submitted to eH for review. Delegated Entities are responsible for educating network prescribers on Part D coverage decision making guidelines and criteria.

Part D Recommendations and Decisions

Part D coverage decisions must be made in a timely manner in accordance with CMS and eH requirements. All Part D Coverage decisions must reflect professional judgment and be in alignment with generally accepted medical standards. A qualified physician must review denials related to medical necessity. Qualified physicians must have appropriate licensure and meet any accreditation requirements. Board certified physicians may be utilized to conduct denial reviews. Denial reasons must be clearly documented with CMS approved grade level language and include appeals process information. eH retains ultimate responsibility and authority on final denial determinations, and appeal process decisions.

Part D Management Functions

Delegated Entities may perform various Part D program functions. Delegated Part D functions may include:

- Processing Part D coverage requests and exceptions
- Processing Part D Claims Payments
- Processing Part D Coverage Reconsiderations
- Processing Part D Grievance Filings
- Negotiating Costs and Payments with Drug Manufacturers and Pharmacies

- Operating a Part D Help Desk/ Help Line for Members, Prescribers and Pharmacies
- Create, submit, and code Prescription Drug Lists (Formularies) and the related documents
- Creating and mailing part D explanation of benefits
- Creating and mailing transition letters
- Operating a CMS compliant Medication Therapy Management program
- Maintaining an adequate pharmacy network

Part D PBM Reporting Requirements

See Appendix A for Part D Deliverables Schedule

Part D Subdelegation and Offshore Contracting

If a Delegated Entity contracts with another organization to perform any part of the delegated Part D processes, eH must receive the agreements and oversight processes between the Delegated Entity and the Downstream entity.

eH must be notified of any subdelegate arrangements in advance to evaluate the delegation agreement and oversight processes.

The mutually agreed document must meet all accreditation and regulatory requirements and must describe the following:

- Scope of services being sub-delegated.
- Decision-making responsibilities.
- Reporting including cadence, content, and submission requirements.
- Sub-delegation assessment and evaluation process.
- Remedies for non-performance up to and including contract termination.

Offshore Operations

If the Delegated entity, or its subdelegates perform any services under its agreement with eH that
is not within the United States (US) or one the US Territories (American Samoa, Guam, Northern Marinas, Puerto Rico, and Virgin Islands), eH must be notified. The Delegated Entity and Subcontractor must complete and submit the eH Offshore Attestation for review.

Examples of countries that meet the definition of 'offshore' include Mexico, Canada, India, Germany, and Japan. Subcontractors that are considered offshore can be both American owned companies with certain portions of their operations performed outside the United States or foreign-owned companies with their operations performed outside the United States. Offshore subcontractors provide services that are performed by workers located in offshore countries, regardless of whether the workers are employees of American or foreign companies.

Assessment/ Audit of Delegated Part D Functions

Delegated Entities are provided with a written notice of planned assessment and audit activities 30 calendar days in advance.

eH Assessment and Audit Process

The eH assessment and audit process includes:

- Notification of the Assessment and Audit. The notification includes an Operational Review Questionnaire (ORQ), a description of the universe request and submission requirements, and instructions for the submission of samples.
- The place, time, type, scope, and duration of the audits are agreed upon, and exclude the December-January timeframe. The auditor must execute a nondisclosure agreement.
- The scope will cover a period not to exceed 12 months unless it relates to a financial guarantee for a period exceeding 12 months. The request must be submitted within 6 months of the end of the period to be audited.
- The Delegated Entity returns the ORQ and universe log(s) and all relevant information to conduct the audit.
- Once eH receives the universe report, samples are selected for submission and review. eH sends the requested sample list to the Delegated Entity.
- The Delegated Entity submits sample file documents and eH conducts an assessment and audit of the submitted documents. Other audit options may include a live primary source audit via webinar.

Operational Review Questionnaire (ORQ)

The eH ORQ seeks to validate the Delegated Entity's overall administrative structure, staffing resources, and UM / PHM policies and procedures. The ORQ is due prior to the start of the assessment and audit procedure includes the following:

- Part D staffing structure(s) and physical locations.
- Training Program (Compliance, Code of Conduct, Privacy and Part D processes).
- Internal monitoring and auditing.
- Part D performance metrics.
- Part D processes.
- Business Continuity Plan.

Part D Sample Files

Sample file submissions may include:

- Part D denial logs and reports.
- Copies of denial letters.
- Prescription claims information, formulary files, prior authorization content
- Rebate agreements

- If issues are found, up to 300 suspected erroneous claims may be evaluated prior to final audit report creation/distribution

Audit meeting agendas may include the following topics:

- Introductions
- Overview of the purpose of the audit
- Assessment review
- System demo
- Part D sample review
- Draft preliminary report including findings.

eH creates a final reporting that includes the following information:

- Operational assessment and audit results
- Performance audit results
- Corrective Action Plans (CAP) Requirements (if applicable)
- Plans to Reassess and Re-Audit delegated functions (if applicable)

When CAPs are required to address process deficiencies, the following elements ae required from the Delegated Entity:

- Root cause.
- Remediation Plan (including milestone dates and activities)
- Ongoing monitoring plan.

CAPs are monitored by eH through adequate validation testing.

The typical review period is the immediate previous 3 months of activity. If a Delegated Entity is unable to provide required documents in the requested format eH will coordinate a process to obtain necessary reporting, and if applicable the development of a CAP.

Transmitting Data

The following are examples of HIPAA compliant delivery methods to respond to assessment and audit requests:

- Direct access to an eH FTP site.
- Granting direct access to the Delegated Vendor FTP site.
- Encrypted email.

Notification of Complaints

Delegated entities must notify eH immediately of any oral or written escalated or material complaints, including attorney and media contacts, related to members and participating (contracted) providers/ prescribers.

Corrective Action Plan

Any material process deficiencies identified for delegated clinical operations functions are referred to the eH Compliance Department to take appropriate action, including when appropriate the development of a formal corrective action plan (CAP). eH Compliance coordinates with the eH Business Owner, and Delegated Entity to identify root cause and remediation of clinical operations process deficiencies.

Field Marketing Organization (FMO)

Delegated FMOs are top-level organizations licensed to sell Medicare products in eH service areas. FMOs are required to comply with all CMS and State requirements related to sales activities. FMOs must ensure that all brokers and agents remain compliant with state licensure requirements and follow CMS and eH sales guidelines.

Assessment/ Audit of FMOs

FMOs are provided with a written notice of planned assessment and audit activities 30 calendar days in advance.

eH Assessment and Audit Process

The eH assessment and audit process includes:

- Notification of the FMO Assessment and Audit. The notification includes an Operational Review Questionnaire (ORQ), a description of the universe request and submission requirements, and instructions for the submission of samples.
- The Delegated Entity returns the ORQ and universe log(s).
- Once eH receives the universe report, samples are selected for submission and review. eH sends the requested sample list to the Delegated Entity.

- The Delegated Entity submits sample file documents and eH conducts an assessment and audit of the submitted documents.

Operational Review Questionnaire (ORQ)
The eH ORQ seeks to validate the Delegated Entity's overall administrative structure, staffing resources, and FMO policies and procedures. The ORQ is due prior to the start of the assessment and audit procedure includes the following:

- FMO staffing structure and physical locations.
- Training Program (Compliance, Code of Conduct, Privacy and Sales processes).
- Internal monitoring and auditing.
- FMO performance metrics.
- Business Continuity Plan.

FMO Sample Files
Sample file submissions may include:

- Copies of Training Certifications/ Logs
- Copies of Agent/ Broker Licensure
- Scope of Appointment Forms
- Call Recordings
- Exclusion Monitoring Reports
- Internal Monitoring and Auditing Reports
- Coaching documents

Audit meeting agendas may include the following topics:

- Introductions
- Overview of the purpose of the audit
- Assessment review
- System demo
- FMO sample review

Transmitting Data

The following are examples of HIPAA compliant delivery methods to respond to assessment and audit requests:

- Direct access to an eH FTP site.
- Granting direct access to the Delegated Vendor FTP site.
- Encrypted email.

Corrective Action Plan

Any material process deficiencies identified for delegated sales functions are referred to the eH Compliance Department to take appropriate action, including

when appropriate the development of a formal corrective action plan (CAP). eH Compliance coordinates with the eH Business Owner, and Delegated Entity to identify root cause and remediation of sales process deficiencies.

Delegated Entity Code of Conduct

eH seeks to establish and maintain business relationships that align with our core values and commitments to our members. The eH Delegated Entity Code of Conduct ("Code") is a set of ethical and legal business practices and standards that all First Tier, Downstream and Related Entities ("Delegates") are expected to abide by when acting on behalf of eH.

eH may conduct audits of Delegate facilities and business practices to monitor the commitment and compliance with the Code. Delegates must be able to demonstrate actions taken to comply with code and must fully cooperate with eH sanctioned assessments and audits. Any findings identified during assessment and audit activities must be addressed timely through appropriate corrective measures.

The full eH Code of Conduct is available on the eH website.

Promoting Compliance and Ethical Conduct

eH is committed to promoting the highest standards of business practices, ethical behavior, integrity, and regulatory compliance. eH Delegated Entities and its employees and associates acting on behalf of eH are expected to apply and promote the highest possible standards of ethical behavior, personal and professional integrity in all interactions with members and other stakeholders including regulatory agencies and the public.

Discrimination, Harassment or Abuse

eH does not engage or tolerate any discriminatory conduct against any persons based on condition, or characteristic including age, race, gender identity, sexual orientation, disability, religion, political affiliation, pregnancy, material status and anything else protected by law. eH expects all Delegated entities to comply with applicable nondiscrimination laws and regulations including the provision of fail and equal treatment in recruiting, hiring, promotion, discharge, and other terms of conditions for employment.

Health and Safety

Delegated Entities are required to fully comply with all applicable federal, state, and local health and safety regulations, laws, and standards. Delegated Entities should take proactive measures to prevent and minimize health risk exposure, including the provision of appliable and appropriate training.

Compliance and Reporting Mechanisms

Code violations, including unethical behavior and unlawful conduct related to eH delegated functions, must be reported to eH Compliance using one of the following mechanisms:

- Compliance & Ethics Hotline (Available 24/7): 1-833-823-8603
- eH Compliance e-mail: compliance@eternalhealth.com
- eH Chief Compliance Officer: (623) 910-3321

Delegated Entities are required to have a Code of Conduct that includes reporting of potential and actual violations without the fear of retaliation. If a Delegated Entity does not have a Code of Conduct, the eH Code of Conduct must be distributed to all employees.

Ethical Business Practices and Interactions

eH operates under the highest ethical business practices and standards and our business decisions are based on the best interests of the organization and not our personal interests or relationships. Delegated entities are expected to approach business interactions on behalf of eH in the same manner, including standards related to business courtesies, conflicts of interest, anti-trust, anti-corruption, government interactions and the protection of company assets, information, and intellectual property.

Business Courtesies

Business courtesies made on behalf of eH must be pre-approved by eH Compliance including gifts, entertainment, travel expenses and meals. Delegated Entities are not permitted to provide any business courtesies to any government officials.

Conflicts of Interest

Delegated Entities may not engage in any activity or relationship that may cause, or appear to cause, a conflict with the interests of eH while conducting business activities on behalf of eH. Relationships must not affect independent and sound judgement when conducting business on behalf of eH.

Anti-Trust

eH requires that all business be conducted in full compliance with applicable antitrust and fair competition laws and regulations to protect against unfair business practices and to promote a competitive economy. Delegated Entities may not engage in price fixing, discrimination or other unfair trade practices that would violate anti-trust regulations.

Anti-Corruption and Government Interactions

eH complies with all applicable US anti-corruption laws and regulations. eH Delegated Entities may not promise, offer, or authorize anything of value, including without limitations payment, gifts, travel, meals, entertainment, political contributions of any in kind exchanges with federal or state government representatives, government-owned enterprises, family members, employees or any political parties, officials, or candidate for political office on behalf of eH.

Protection of Assets, Information, and Intellectual Property
eH requires the protection of company assets, as well as confidential and property information. eH is committed to appropriately securing the privacy and security of all data and information collected, used by eH, or on behalf of eH. Delegated Entities must make every reasonable effort to protect eH assets, intellectual and confidential company information and member data. Information should only be accessed, used, and disclosed related directly to delegated functions.

Records Maintenance
Delegated Entities must maintain accurate and timely financial books, records and statements pertaining to their respective business in compliance with applicable federal, state, and local laws and regulations. Any financial records submitted to eH, or created on behalf of eH, must be accurate, complete, and meet all applicable industry and professional standards. Delegated Entities must not submit any false, misleading, or incomplete entries with respect to any transaction or expense. Records must be created, retained and disposed of in full compliance with all applicable legal and regulatory requirements.

Artificial Intelligence (AI) and Machine Learning
eH requires preapproval of any use of AI and machine learning related to delegated functions. Any use of AI implemented for predictive or clinical decision-making purposes must comply with all Federal and State regulations and principles designed to safeguard against fraud, unintended bias, discrimination, infringements on privacy and any other potential harms of the use of AI.

Subcontractors
eH must approve any proposed subcontractor agreements in advance of contract execution. All subcontractors must comply with applicable federal and state regulations, as well as CMS and eH requirements.

Failure to comply with the eH Delegated Entity Code of Conduct may result in disciplinary action, including contract termination.

Business Continuity Plan Requirements

First-Tier entities must be compliant with all CMS requirements. eH ensures First-Tier compliance through annual oversight activities. FDRs are required to develop, implement, and maintain business continuity plans that meet minimum requirements and standards for the purpose of ensuing restoration of business during and after disruptions.

Examples of disruptions include:

- Natural events (weather induced, etc.)
- Man-made disasters (workplace accidents, etc.)
- System Failures
- Emergencies
- Pandemic / Public Health emergencies

At minimum, First-Tier entity Business Continuity Plan (BCP) must include the following components:

- A documented mitigation strategy.
- Annual testing and revision.
- Annual BCP Training.
- Business Communication Plans (Including communication to and from eH related to BCP activities).
- Chain of Command
- Completion of an Annual Risk Assessment.
- Identification of Essential Functions.
- Preparations for Pandemic Public Health Emergencies.

An authorized representative for First-Tier entities must attest to awareness, readiness, and compliance with eH BCP requirements. First-Tier entities may be required to submit evidence of compliance with BCP requirements.

Health Equity and Cultural Competency

eH supports the following CMS Health Equity Priorities for Reducing Disparities in Health:

- **Priority 1**: Expand the Collection, Reporting, and Analysis of Standardized Data
- **Priority 2:** Assess causes of Disparities within CMS Programs and Address Inequities in Policies and Operations to Close Gaps
- **Priority 3:** Build Capacity of Health Care Organizations and the Workforce to Reduce Health and Health Care Disparities.
- **Priority 4:** Advance Language Access, Health Literacy, and the Provision of Culturally Tailored Services.
- **Priority 5:** Increase All Forms of Accessibility to Health Care Services and Coverage.

Delegated Entities are expected to cooperate with CMS and eH initiates to address health equity in the Medicare program, including support of the eH Cultural Competency Program.

Cultural Competency Program

The eH Cultural Competency Program consists of the following goals:

- **Goal 1:** Ensure that services are provided in a culturally competent manner to all members, regardless of physical and mental capacity, disability, sexual orientation, life choices and language, including those with limited English proficiency, including at the provider level through the evaluation of member grievance, cross-culture complaints report, and member satisfaction survey. Effectiveness is assessed against the Cultural and Linguistically Appropriate Services (CLAS) standards.
- **Goal 2**: eH and its contracted Providers, Delegated Entities, and systems effectively provide services to all members regardless of their ages, cultures, races, ethnicities, mental and physical abilities, sexual orientation, life choices and religions. The emphasis is on provider and staff education. Standards are developed and are assessed through medical record review, Performance Improvement Plans, Performance Measures, and internal and external

processes (surveys, links to pertinent websites, and the establishment of guidelines communicated to staff and providers).

- **Goal 3:** Complete an annual evaluation of the effectiveness of the Cultural Competency Plan and racks and trends any issues identified in the evaluation and implement interventions to improve the provision of services. The analysis of the results, interventions to be implemented and a description of the evaluation is described in the annual CCP submitted to eH QIC/UM Committee for review annually.
- **Goal 4:** Provide high quality, culturally sensitive services by identification, delivery, and continual monitoring of Members' needs. eH hires diverse staff and provides cultural competency training at orientation and annually after hired. Quality Improvement is continuously monitored and evaluated through services provided by network providers.
- **Goal 5:** Develop programs for improving cultural awareness, where a need is identified, through the comprehensive assessment of the Provider Network evaluation process. eH's aim is to increase the Providers' and Staffs' awareness and appreciation of customs, life choices, values and beliefs, and the ability to incorporate them into the assessment of, treatment of, and interaction with Members.

eH Delegated Entities are required to ensure that when applicable, member materials and communication are made available in preferred languages and formats. Translations are mandatory in any service area where eH meets the CMS language thresholds. eH communicates to Delegated Entities the threshold and languages when applicable.

Delegated Entities are encouraged to develop and implement a Cultural Competency Program, and Work Plan. eH makes its Cultural Competency training available to all Delegated Entities.

Privacy & Security

eH requires FDRs to adhere to federal, state, and local laws related to privacy and cybersecurity. eH may conduct cybersecurity risk assessments. If any missing or weak security controls are identified, remediation is required within a reasonable timeframe, not to exceed 6 months without an approved business justification. The eH assessment is designed to ensure that adequate security controls are in place for key areas including:

- Access management
- Asset management
- Communications security
- Cryptography
- Information security incident management
- Information security policies
- Operations security
- Personnel
- Physical and environmental security

Privacy incidents and breaches should be reported to the eH Compliance & Privacy Department. eH may request additional information related to reported incidents.

Glossary

Term	Definition
Abuse	Includes actions that may, directly or indirectly, result in: unnecessary costs to the Medicare Program, improper payment, payment for services that fail to meet professionally recognized standards of care, or services that are medically unnecessary. Abuse involves payment for items or services when there is no legal entitlement to that payment and the provider has not knowingly and/or intentionally misrepresented facts to obtain payment. Abuse cannot be differentiated categorically from fraud, because the distinction between "fraud" and "abuse" depends on specific facts and circumstances, intent and prior knowledge, and available evidence, among other factors.
Abuse (Personal)	When another person does something on purpose that causes mental or physical harm or pain.
Access	Ability to get medical care and services when needed.
Accreditation	An evaluative process in which a healthcare organization undergoes an examination of its policies, procedures, and performance by an external organization ("accrediting body") to ensure that it is meeting predetermined criteria. It usually involves both on-and off-site surveys.
Act	Refers to the Social Security Act.
Actuarial Soundness	A measure of the adequacy of Hospital Insurance and Supplemental Insurance financing as determined by the difference between trust fund assets and liabilities for specified periods.
Administrative Costs	A general term that refers to Medicare and Medicaid administrative costs, as well as CMS administrative costs. Medicare administrative costs are comprised of the Medicare-related outlays and non-CMS administrative outlays. Medicaid administrative costs refer to the Federal share of the States' expenditures for administration of the Medicaid program. CMS administrative costs or operating CMS (e.g., salaries and expenses, facilities, equipment, rent and utilities, etc.). These costs are reflected in the Program Management account.
Administrative Law Judge	A hearings officer who presides over appeal conflicts between providers of services, or beneficiaries, and Medicare contractors.
Advance Directive	A written document stating how the member wants medical decisions made on their behalf if they lose the ability to make medical decisions themselves. Examples include a Living Will and Durable Power of Attorney for health care.

Adverse Event	An unusual situation that is or may be harmful to a member. Examples include self-harm, medication errors, criminal action or other negative experience that causes harm or loss to a member.
Affiliated Provider:	A health care provider or facility that is paid for by a health plan to give services to plan members.
Age-Ins	An individual who is aging into Medicare eligibility. Such individuals typically elect to enroll in a plan during the seven-month period consisting of three months before they turn age 65, the month they turn 65, and the three months after they turn 65.
Ancillary Services	Professional services by a hospital or other inpatient health program. May include x-ray, drug, laboratory or other services.
Annual Election Period (AEP)	The Annual Election Period (AEP) for Medicare beneficiaries in the month of November each year. Enrollment will begin the following January. AEP is the only time in which all Medicare+Choice health plans will be open and accepting new members.
Appeal	As defined at 42 CFR §422.561 and §423.560, the procedures that deal with the review of adverse initial determinations made by the plan on health care services or benefits under Part C or D the enrollee believes he or she is entitled to receive, including a delay in providing, arranging for, or approving the health care services or drug coverage (when a delay would adversely affect the health of the enrollee) or on any amounts the enrollee must pay for a service or drug as defined in 42 CFR §422.566(b) and §423.566(b). These appeal procedures include a plan reconsideration or redetermination (also referred to as a level 1 appeal), a reconsideration by an independent review entity (IRE), adjudication by an Administrative Law Judge (ALJ) or attorney adjudicator, review by the Medicare Appeals Council (Council), and judicial review.
Appeal (Part C Plan)	Any of the procedures that deal with the review of adverse organization determinations on the health care services an enrollee believes he or she is entitled to receive, including delay in providing, arranging for, or approving the health care services (such that a delay would adversely affect the health of the enrollee), or on any amounts the enrollee must pay for a service as defined in 42 C.F.R. § 422.566(b). These procedures include reconsideration by the MA Plan and, if necessary, an independent review entity, hearings before Administrative Law Judges (ALJs), review by the Medicare Appeals Council (MAC), and judicial review.
Appeal (Part D Plan)	Any of the procedures that deal with the review of adverse coverage determinations made by the Part D plan sponsor on the benefits under a Part D plan the enrollee believes he or she is entitled to receive, including a delay in providing or approving the drug coverage (when a delay would adversely affect the health of the enrollee), or on any amounts the enrollee must pay for the drug coverage, as defined in 42 C.F.R. §423.566(b). These procedures

	include redeterminations by the Part D plan sponsor, reconsiderations by the independent review entity (IRE), Administrative Law Judge (ALJ) hearings, reviews by the Medicare Appeals Council (MAC), and judicial reviews.
Appeal Process	The process used when members disagree with any decision about health care services. Members can file an appeal if the plan will not pay for, or does allow, or stops a service a member thinks should be covered or provided. The health plan.
Area Agency on Aging (AAA)	State and local programs that help older people plan and care for their life-long needs. These needs include adult day care, skilled nursing care/ therapy, transportation, personal care, respite care, and meals.
Assessment	The gathering of information to rate or evaluate a member's health and needs.
Assignment	A doctor agrees to accept the Medicare-approved amount as full payment.
Audit	A formal review of compliance with a particular set of standards (e.g., policies and procedures, laws and regulations) used as base measures.
Automatic Adjudication	Automated processing of claims entered via EDI or data entry. These claims do not require a claims examiner or processer intervention.
Beneficiary	The name for a person who has health care insurance through the Medicare program.
Beneficiary and Family Centered Care Quality Improvement Organization (BFCC-QIO)	Organizations comprised of practicing doctors and other health care experts under contract to the federal government to monitor and improve the care given to Medicare enrollees. The BFCCQIOs review enrollee complaints about the quality of care provided by physicians, inpatient hospitals, hospital outpatient departments, hospital emergency rooms, skilled nursing facilities (SNFs), home health agencies (HHAs), Medicare managed care plans, Medicare Part D prescription drug plans, and ambulatory surgical centers. The BFCC-QIOs also review continued stay denials in acute inpatient hospital facilities as well as coverage terminations in SNFs, HHAs, and comprehensive outpatient rehabilitation facilities (CORFs). In some cases, the BFCC-QIO can provide informal dispute resolution between the health care provider (e.g., physician, hospital, etc.) and enrollee.
Benefit Period	The way that Medicare measures a member's use of hospital and skilled nursing facility (SNF) services. A benefit period begins the day a member goes to a hospital or SNF. The benefit period ends when a member has not received any hospital or SNF care for 60 days in a row. If a member goes into the hospital or SNF after one benefit period

	has ended, a new benefit period begins. Members must pay the inpatient hospital deductible for each benefit period. There is no limit to the number of benefit periods a member can have.
Board Certified Physician	A physician who has successfully completed a medical board examination and has been certified by a Board as a specialist in a particular area of practice. Before sitting for an examination, the physician must meet the specialty training requirements of the applicable Board. eH recognizes the American Board of Medial Specialties (ABMS) and American Osteopathic Association (AOA) Boards.
Business Associate	A person or organization that performs a function or activity on behalf of a covered entity but is not part of the covered entity's workforce. A business associate can also be a covered entity in its own right. Reference Part II 45 CFR 160.103.
Business Transaction	Any of the following kinds of transactions: 1. Sale, exchange, or lease of property; 2. Loan of money or extension of credit; or 3. Goods, services, or facilities furnished for a monetary consideration, including management services, but not including: • Salaries paid to employees for services performed in the normal course of their employment; or • Health services furnished to the MA organization's enrollees by hospitals and other providers, and by MA organization staff, medical groups, or independent practice associations, or by any combination of those entities.
Capitation	A method of payment in which a provider is paid a fixed amount for each member who is eligible for contracted services, over a set period. The capitation method may be used for PCPs, specialists, or groups of physicians (e.g., IPAs). The cost of providing an individual with a specific set of services over a set period is typically over a month or year.
Care Management (Case Management)	A process used by a doctor, nurse, or other health professional to manage your health care. Case managers make sure that members get needed services, and track use of facilities and resources.
Care Management Records	All data, information, and documentation related to a delegated entity's performance of any care management activities.
Claim	A request for payment for services and benefits received. Claims are also called bills for all Part A and Part B services billed through Fiscal Intermediaries. "Claim" is the word used for Part B physician/supplier services billed through the Carrier.
Claim Adjustment Reason Codes	A national administrative code set that identifies the reasons for any differences, or adjustments, between the original provider charge for

	a claim or service and the payer's payment for it. This code set is used in the X12 835 Claim Payment & Remittance Advice and the X12 837 Claim transactions and is maintained by the Health Care Code Maintenance Committee.
Clean Claim	A claim that has no defect, impropriety, lack of any required substantiating documentation - including the substantiating documentation needed to meet the requirements for encounter data - or particular circumstance requiring special treatment that prevents timely payment; and a claim that otherwise conforms to the clean claim requirements for equivalent claims under original Medicare.
Clean Claim (Part C)	Defined at 42 CFR §422.500(b), a claim that has no defect, impropriety, lack of any required substantiating documentation (consistent with 42 CFR §422.310(d)), or circumstance requiring special treatment that prevents timely payment and that otherwise conforms to the clean claim requirements for equivalent claims under Original Medicare. Examples: • A new claim that automatically adjudicat3es through the claims system on the first pass, and the submitted charges are either paid or denied. The claim is neither pended, nor referred for any additional information. • A claim that includes all necessary information for processing and submission (e.g., member name, member ID, control number, date of service, valid CPT/ HPCS cod, ICD code, itemized billed amount, provider name, place of service, date of service, providers address, provider TIN, etc.) • Claims pended to medical necessity review with the medical information needed to complete the review has been provided. • Claims referred for medical review and there is no need to request additional information. • Claims pended for non-participating provider ID number identification. • Claims involving coordination of benefits when primary payer information and EOB have been submitted.
CMS 1500 Form	A standard billing template developed by CMS. Physicians and suppliers use when submitting claims to Medicare and third-party payors.
CMS Required Materials	Materials that are required under 42 CFR §§ 422.2267(e) and 423.2267(e)
Co-Branding	A relationship between two or more separate legal entities, where at least one party is a plan. Co-branding is when a plan displays the name(s) or brand(s) of the co-branding entity or entities on its materials to signify a business arrangement. Co-branding

	relationships are independent of the contract that the plan has with CMS. Plans are responsible for ensuring that co-branded materials include appropriate disclaimers and other model content as specified by CMS regulations at 42 CFR §§ 422.2267(e)(36) and 423.2267(e)(37) where applicable.
Code of Federal Regulations (CFR)	The official compilation of federal rules and requirements.
Code Set	Under HIPAA, this is any set of codes used to encode data elements, such as tables of terms, medical concepts, medical diagnostic codes, or medical procedure codes and includes both the codes and their descriptions. Reference Part II 45 CFR 162.103.
Coinsurance	The percentage of charges a member pays after any plan deductibles.
Compliance Date	Under HIPAA, this is the date by which a covered entity must comply with a standard, an implementation specification, or a modification. This is usually 180 calendar days after the effective date of the associated final rule for most entities but may be longer for small health plans and for more complex changes.
Complaint	An oral or written expression of dissatisfaction by a member, or provider on behalf of a member, regarding services performed either vy a Delegated entity or participating providers.
Communication	Activities and use of materials created or administered by the plans or any downstream entity to provide information to current and prospective enrollees. All activities and materials aimed at prospective and current enrollees, including their caregivers, are "communications" within the scope of the regulations at 42 CFR Parts 417, 422, and 423. *Note: Where the term enrollee is used, whether a current or prospective enrollee, the term encompasses representatives of the enrollee who are authorized to act on the enrollee's behalf.*
Concurrent Review	A telephonic, electronic, or onsite assessment of the medical necessity and appropriateness of continued inpatient stay or level of care after the initial length of stay or assigned course of treatment has expired.
Consent and Authorization (Basic Rule)	A covered entity may use or disclose PHI only: • With the consent of the individual for treatment, payment, or health care operations • With the authorization of the individual for all other uses or disclosures • As permitted under the Privacy rule for certain public policy purposes

<table>
<tr><td></td><td></td></tr>
<tr><td>Consumer Assessment of Health Plans Study (CAHPS)</td><td>An annual nationwide survey that is used to report information on Medicare beneficiary experiences with managed care plans. Results are shared with Medicare beneficiaries and the public.</td></tr>
<tr><td>Content</td><td>Materials or activities that include or address content regarding:
The plan's benefits, benefits structure, premiums, or cost sharing,
Measuring or ranking standards (for example, Star Ratings or plan comparisons), or
Rewards and incentives as defined under 42 CFR § 422.134(a) (for MA and section 1876 cost plans only).</td></tr>
<tr><td>Continuous Quality Improvement (CQI)</td><td>A process which continually monitors program performance. When a quality problem is identified, CQI develops a revised approach to that problem and monitors implementation and success of the revised approach.</td></tr>
<tr><td>Contractor</td><td>A vendor of medical goods and/or services.</td></tr>
<tr><td>Coordination of Benefits</td><td>A program that determines which plan or insurance policy will pay first if two health plans or insurance policies cover the same benefits.</td></tr>
<tr><td>Copayment</td><td>The member’s financial responsibility for services.</td></tr>
<tr><td>Covered Benefit</td><td>A health service or item that is included in a member’s health plan, and that is paid for either partially or fully.</td></tr>
<tr><td>Covered Entity</td><td>Under HIPAA, this is a health plan, a health care clearinghouse, or a health care provider who transmits any health information in electronic form in connection with a HIPAA transaction.</td></tr>
<tr><td>Credentialing</td><td>The process for validating qualifications, certifications and licenses or practitioners for network participation in accordance with eH standards and guidelines.</td></tr>
<tr><td>Credible Coverage</td><td>Any previous health insurance coverage that can be used to shorten the pre-exiting condition waiting period.</td></tr>
<tr><td>Data Analysis</td><td>A tool for identifying coverage and payment errors, and other indicators of potential FWA and noncompliance.</td></tr>
<tr><td>Date of Receipt</td><td>The date on the return receipt of “return receipt requested” mail, unless otherwise defined.</td></tr>
<tr><td>Deductible</td><td>The amount a member must pay for health care before Medicare begins to pay either for each benefit period for Part A, or each year for Part B. Amounts can change every year.</td></tr>
</table>

Delegation	The eH process of authorizing another entity to perform certain functions on its behalf. eH does not delegate the oversight responsibility of ensuring that the delegated function is performed appropriately.
Department of Health and Human Services (DHHS)	Administers many of the “social” programs at the Federal level dealing with the health and welfare of the citizens of the United States (parent company of CMS).
Designated Code Set	A medical code set for an administrative code set that is required to be used by the adopted implantation specification for a standard transaction.
Discharge Plan	Continuing treatment plan for a member being transferred from one level of care to another.
Disclosure	Release or divulgence of information by an entity to persons or organizations outside of that entity.
Disenroll	Ending health care coverage with a health plan.
Dismissal	A decision not to review a request for a grievance, initial determination, or appeal because it is considered invalid or does not otherwise meet Medicare Advantage or Part D requirements.
DOJ	Department of Justice.
Downstream Entity	Any party that enters into an acceptable written arrangement below the level of the arrangement between a Medicare Advantage (MA) organization (and contract applicant) and a first-tier entity. These written arrangements continue down to the level of the ultimate provider of health and/or administrative services.
Effectuation	Authorization or provision of a benefit that a plan has approved, payment of a claim or compliance with a complete or partial reversal of a plan’s original adverse determination.
Eligibility (Medicare Part A)	Individuals are eligible for premium-free (no cost) Medicare Part A (Hospital Insurance) if: • Aged 65 or older and are receiving (or are eligible for) retirement benefits from Social Security or the Railroad Retirement Board or • Under 65 and have receive Railroad Retirement disability benefits for the prescribed time and meet the Social Security Act Disability requirements, or • Individual or spouse had Medicare-covered government employment or, • Under 65 and have End Stage Renal Disease (ESRD) If an individual is not eligible for premium-free Medicare Part A, coverage can be purchased by paying a monthly premium if:

	• Aged 65 or older and • Enrolled in Part B and • A resident of the United Sates and are either a citizen or an alien lawfully admitted for permanent residence who has lived in the United States continuously during the 5 years immediately before the month of enrollment application.
Eligibility (Medicare Part B)	Automatically eligible for Part B if eligible for premium-free Part A. If also no eligible for premium-free Part A but are age 65 or older AND a resident of the United States or a citizen or an alien lawfully admitted for permanent residence. Must have lived in the United States continuously during the 5 years immediately before the month during which you enroll in Part B.
Emergency Services	Medically necessary services are needed to preserve life or stabilize health, available24 hours a day, 7 days a week.
Encounter	A member's visit to their primary care provider's office documented in various records.
Enroll	To join a health plan.
Enrollee	An eligible individual who has elected a Medicare Advantage, Prescription Drug, or cost plan or health care prepayment plan (HCPP).
Enrollment Period	A certain period when you can join a Medicare health plan if it is open and accepting new Medicare members. If a health plan chooses to be open, it must allow all eligible people with Medicare to join.
Episode of Care	The health care services are given during a certain period of time, usually during a hospital stay.
EQRO Organization	Federal law and regulations require States to use an External Quality Review Organization (EQRO) to review the care provided by capitated managed care entities. EQROs may be Peer Review Organizations (PROs), another entity that meets PRO requirements, or a private accreditation body.
Evaluation	A face-to-face interview conducted by either a contagious disease or childhood disease/ mental health (CD/MH) practitioner to determine the appropriate service and level of care.
Evaluator	A contagious disease or childhood disease/ mental health (CD/MH) practitioner who conducts an initial ace-to-face interview with an individual in order to determine a treatment plan.
Expedited Appeal	A Medicare + Choice organization's second look at whether it will provide a health service. A beneficiary may receive a fast decision

	within 72 hours when life, health, or ability to regain function may be jeopardized.
Expedited Organization Determination	A fast decision from the Medicare + Choice organization about whether it will provide a health service. A beneficiary may receive a fast decision within 72 hours when life, health, or ability to regain function may be jeopardized.
Explanation of Benefits (EOB)	An explanation of how claims were processed for payment information.
External Audit	An audit of the sponsor or its FDRs conducted by outside auditors, not employed by or affiliated with, and independent of, the sponsor.
Facility	Service site for the delivery of carious levels of care.
FDR	First Tier, Downstream and Related Entities
Financial Protection	An instrument (e.g., a letter of credit or performance bond) obtained by a delegated entity to protect eH from a delegated entity's potential future insolvency or failure to pay claims to downstream providers.
First Tier Entity	Any party that enters a written arrangement with an MA organization or contract applicant to provide administrative services or health care services for a Medicare eligible individual.
Formulary	A list of certain drugs and their proper dosages. In some Medicare health plans, doctors must order or use only drugs listed on health plan's formulary.
Fraud	The intentional deception or misrepresentation that an individual knows, or should know, to be false, or does not believe to be true, and makes, knowing the deception could result in some unauthorized benefit to self or other persons.
Fraud or Abuse Complaint	A statement, oral or written, alleging that a provider of beneficiary received a Medicare benefit of monetary value, directly or indirectly, overly, or covertly, in cash or in kind, to which he or she is not entitled under current Medicare law, regulations, or policy. Potential fraud and abuse include allegations of misrepresentation and violations of Medicare requirements applicable to persons or entities that bill for covered items and services.
Freedom of Information Act (FOIA)	A provision that any person has a right, enforceable in court, of access of federal agency records, except to the extent that such records, or portions thereof, are protected from disclosure by one of nine exceptions or by one of three special law enforcement record exclusions.

Fully Accredited	Designation that all the elements within all the accreditation standards for which the accreditation organization has been approved by CMS have been surveyed and fully met or have otherwise been determined to be acceptable without significant adverse findings, recommendations, required actions or corrective actions.
Grievance	An expression of dissatisfaction with any aspect of the operations, activities or behavior of a plan or its delegated entity in the provision of health care items, services, or prescription drugs, regardless of whether remedial action is requested or can be taken. A grievance does not include, and is distinct from, a dispute of the appeal of an organization determination or coverage determination or an LEP determination.
Governing Body	A group of individuals at the highest level of governance of the sponsor, such as the Board of Directors or the Board of Trustees, who formulate policy and direct and control the sponsor in the best interest of the organization and its enrollees. As used in this chapter, governing body does not include C-level management such as the Chief Executive Officer, Chief Operations Officer, Chief Financial Officer, etc., unless persons in those management positions also serve as directors or trustees or otherwise at the highest level of governance of the sponsor.
GSA	General Services Administration
Health Care Provider	A person who is trained and licensed to give health care. Also, a place that is licensed to give health care. Doctors, nurses, and hospitals are examples of health care providers.
Health Employer Data and Information Set (HEDIS)	A set of standard performance measures that can give you information about the quality of a health plan. You can find out about the quality of care, access, cost and other measures to compare managed care plans. CMS collects HEDIS data for Medicare plans.
Health Insurance Portability and Accountability Act (HIPAA)	Title II, Subpart F of HPAA gives Health and Human Services (HHS) the authority to mandate the use of standards for the electronic exchange of health care data; to specify what medical and administrative code sets should be used withing those standards; to require the use of national identification system for health care patients, providers, payers (or plans); and employers (or sponsors); and to specify the type of measures required to protect the security and privacy of personally identifiable health care information. A regulation that guarantees patients' rights and protections against the misuse or disclosure of health records.
Health Maintenance	A type of Medicare managed care plan where a group of doctors, hospitals, and other health care providers agree to give health care to Medicare beneficiaries for a set amount of money from Medicare

Organizations (HMO)	every month. Typically, members get their care from providers in the health plan's contracted network.
Health Professionals	Physicians and other professionals, including certified nurse midwives who are engaged in the delivery of health care services and who are licensed (when required by State).
HEDIS (Healthcare Effectiveness Data and Information Set)	A set of standardized performance measures designed to ensure that purchasers and consumers have the information they need to reliably compare the performance of managed care plans. The major areas of measurement include effectiveness of care, satisfaction with the experience of care, health plan stability, cost of care, informed health care choices and health plan description information.
Hospital Affiliation	A contractual agreement between a health plan and one or more hospitals where the hospital provides the inpatient benefits offered by the health plan.
ID Number	A combination of letters and numbers on a member's insurance card assigned by eH and used to identify the member.
Independent Review Entity (IRE)	An independent entity contracted by CMS to review adverse level 1 appeal decisions made by the plan. Under Part C, an IRE can review plan dismissals.
In-Network Providers	A provider who has a contract with a health plan agreeing to provide services to members of that health plan. Members pay less when they see an in-network provider. May also be called "preferred provider" or "participating provider".
Initial Claim Determination	The first adjudication made by a carrier following a request for Medicare payment.
Initial Coverage Election Period (ICEP)	The 3 months immediately before Medicare Part A entitlement and enrollment in Part B. Individuals may choose a Medicare health plan during the Initial Coverage Election Period (ICEP). The health plan must accept the applicant unless the limit of members has been reached.
Initial Enrollment Period (IEP)	First opportunity to enroll in Medicare Part B that starts three months froe meeting all eligibility requirements for Medicare and lasts for 7 months.
Intent	Material or activities that CMS determines, as described above, are intended to: • Draw a beneficiary's attention to a plan or plans, • Influence a beneficiary's decision-making process when making a plan selection, or • Influence a beneficiary's decision to stay enrolled in a plan (retention-based marketing)

Internal Audit	An audit of the sponsor or its FDRs conducted by auditors who are employed by or affiliated with the sponsor.
Interest Payment	A calculation based on the state or CMS late-interest payment percentage for all claims processed outside of required timeframes.
Inquiry	Any verbal or written request for information to a plan or its delegated entity that does not express dissatisfaction or invoke a plan's grievance, coverage or appeals process, such as a routine question about a benefit.
IPA (Independent Practice Association)	An organization through which eH maintains and manages certain provider relationships. IPAs are groups of providers who have the same specialty. An IPA can include both PCPs and specialists. Providers within an IPA typically subcontract with a management service organization which provides administrative services such as utilization management and claims administration.
Licensed by the State as a Risk-Bearing Entity	An entity that is licensed or otherwise authorized by the State to assume risk for offering health insurance or health benefits coverage. The
Living Wills	A legal document also known as a medical directive or advance directive. It states your wishes regarding life-support or other medical treatment in certain circumstances, usually when death is imminent.
Marketing	A subset of communications and must, unless otherwise noted, adhere to all communication requirements. To be considered marketing, communications materials must meet both intent and content standards. In evaluating the intent of an activity or material, CMS will consider objective information including, but not limited to, the audience, timing, and other context of the activity or material, as well as other information communicated by the activity or material. The organization's stated intent will be reviewed but not solely relied upon.
Medical Review/ Utilization Review	Contractor reviews of Medicare claims to ensure that the service was necessary and appropriate.
Medically Necessary	Services or supplies that are proper and needed for the diagnosis or treatment of your medical condition, are provided for the diagnosis, direct care, and treatment of your medical condition, meet the standards of good medical practice in the local area, and aren't mainly for the convenience of you or your doctor.
Medicare	The federal health insurance program for people 65 years of age or older, certain younger people with disabilities, and people with ESRD (kidney failure with dialysis or a transplant).
Medicare Advantage Plan	A Medicare program that gives you more choices among health plans. Everyone who ahs Medicare Parts A and B is eligible, except

	those who have ESRD (with certain exceptions). Used to be called "Medicare + Choice.
Medicare Benefits	Health insurance available under Medicare Part A and Part B through the traditional fee-for-service payment system.
Medicare Preferred Provider Organization (PPO)	A type of Medicare Advantage Plan in which you use doctors, hospitals, and providers that belong to the network. You can use doctors, hospitals, and providers outside of the network for additional costs.
Medicare Secondary Payor	Any situation where another payer or insurer or pays your medical bills before Medicare.
Monitoring	A planned, systemic, and ongoing process to gather and organize data, and aggregate results to evaluate performance.
NBI MEDIC	National Benefit Integrity Medicare Drug Integrity Contractor (MEDIC), an organization that CMS has contracted with to perform specific program integrity functions for Parts C and D under the Medicare Integrity Program. The NBI MEDIC's primary role is to identify potential FWA in Medicare Parts C and D.
NCQA	The National Committee for Quality Assurance.
Network	A group of doctors, hospitals, pharmacies, and other health care experts hired by a health plan to take care of its members.
Non-Contracting Provider	A provider or supplier that does not contract with a MA organization to provide services covered by the MA plan.
Nonparticipating Physician	A doctor or supplier who does not accept assignment on all Medicare claims.
OIG	Office of the Inspector General within DHHS. The Inspector General is responsible for audits, evaluations, investigations, and law enforcement efforts relating to DHHS programs and operations, including the Medicare program.
Organizational Determinations	A health plan's decision on whether or pay all or part of a bill, or to give medical services, after you file an appeal. If the decision is not in the member's favor, the plan is required to give written notice including the reason for the denial and the steps in the appeals process.
Organizational Provider	An institutional provider and supplier of health care services that include but not limited to: • Freestanding surgical centers (including freestanding abortion centers) • Home care agencies • Hospitals • Nursing home

	• Skilled nursing facilities (SNFs) • Federally Qualified Healthcare Centers • Laboratories • Outpatient Diabetes Self-Management Training Providers • Portable X-Rays • Rehabilitation agencies (e.g., CORF, outpatient rehabilitation facilities, outpatient physical therapy and speech pathology providers) • Renal disease services • Rural health clinics Behavioral health can be freestanding or hospital-based organizations and include but are not limited to: • Mental health and chemical dependency hospitals • Residential treatment facilities and ambulatory settings including partial hospital programs, intensive outpatient programs, crisis stabilization centers, clinics and community mental health centers
Original Medicare Plan	A pay-per-visit health plan that lets members go to any doctor, hospital, or other health care supplier who accepts Medicare and is accepting new Medicare patients. Members must pay the deductible. Medicare pays its share of the Medicare-approved amount, and you pay your share (coinsurance). In some cases, members may be charged more than the Medicare-approved amount. Original Medicare Plan has two parts: Part A (Hospital Insurance) and Part B (Medical Insurance).
Participating Provider (Par or Contracted)	A provider contracted with eternalHealth and part of its network.
Party in Interest	1. Any director, officer, partner, or employee responsible for management or administration of an MA organization; 2. Any person who is directly or indirectly the beneficial owner of more than 5 percent of the organization's equity; or the beneficial owner of a mortgage, deed of trust, note, or other interest secured by and valuing more than 5 percent of the organization; 3. In the case of an MA organization organized as a nonprofit corporation, an incorporator or member of such corporation under applicable State corporation law; 4. Any entity in which a person described in paragraph (1), (2), or (3) of this definition: • Is an officer, director, or partner; or • Has the kind of interest described in paragraphs (1), (2), or (3) of this definition; 5. Any person that directly or indirectly controls, is controlled by, or is under common control with, the MA organization; or 6. Any spouse, child, or parent of an individual described in paragraph (1), (2), or (3) of this definition.

Pharmacy Benefit Manager (PBM)	An entity that provides pharmacy benefit management services, which may include contracting with a network of pharmacies; establishing payment levels for network pharmacies; negotiating rebate arrangements; developing and managing formularies, preferred drug lists, and prior authorization programs; performing drug utilization review; and operating disease management programs. Some sponsors perform these functions in-house and do not use an outside entity as their PBM. Many PBMs also operate mail order pharmacies or have arrangements to include prescription availability through mail order pharmacies. A PBM is often a first tier entity for the provision of Part D benefits.
Physician Incentive Plan	Any compensation arrangement at any contracting level between a Managed Care Organization (MCO) and a physician or physician group that may directly or indirectly have the effect of reducing or limiting services furnished to Medicare or Medicaid enrollees in the MCO. MCSOs must disclose physician incentive plans between the MCO itself and individual physicians and groups and, also, between groups or intermediate entities (e.g., certain IPAs, Physician-Hospital Organizations) and individual physicians and groups. Refer to 42 CFR 22.208(a).
Plan Created Materials	Materials created by plans, typically advertisements, that are not required under 42 CFR §§ 422.2267(e) and 423.2267(e).
Point of Service (POS)	A Medicare Managed Care Plan option that lets you use doctors and hospitals outside of the plan for an additional cost.
Postpayment Review	The review of a claim after a determination and payment has been made to the provider or beneficiary.
Power of Attorney	Medical power of attorney is a type of advance directive that appoints a trusted party to make decisions about medical care. Also referred to as a health care proxy, appointment of health care agent or a durable power of attorney for health care.
Preferred Provider Organization (PPO)	A M + CO coordinated care plan that (a) has a network of providers that have agreed to a contractually specified reimbursement for covered benefits with the organization offering the plan (b)provides for reimbursement of all covered benefits regardless of whether the benefits are provided with the network of providers and (c) is offered by an organization that is not licensed or organized under State law as a HMO. Refer to the Social Security Act Section 1852€(20(D), 42 USC 139w-22€(2)(D).
Preventive Services	Health care to keep an individual healthy or to prevent illness. Examples included pap tests, pelvic exams, flu shots and health screening e.g., mammogram.
Primary Care	A basic level of care usually given by doctors who work with general and family medicine, internal medicine (internists), pregnant women (obstetricians) and children (pediatricians). A nurse practitioner (NP),

	a licensed registered nurse with special training can also provide this basic level of health care.
Protected Health Information (PHI)	Any information about health status, provision of health care, or payment for health care can be linked to a specific individual. PHI is created or collected by a covered entity or a business associate of a covered entity under US law. PHI is maintained in the same record set as individually identifiable information, such as name, address, date of birth, phone number, etc. PHI is protected by the Health Insurance Portability and Accountability Act (HIPAA).
Qualified Medicare Beneficiary (QMB)	A Medicaid program for beneficiaries who need help in paying for Medicare services. The beneficiary must have Medicare Part A and limited income and resources. For those who qualify, the Medicaid program pays Medicare Part A premiums, Part B Premiums, and Medicare deductibles and coinsurance amounts for Medicare services.
Quality	How well the health plan keeps its members healthy or treats them when they are sick. Good quality health care means doing the right things at the right time, in the right way, for the right person and getting the best possible outcome.
Quality Assessment	A formal set of activities that monitor the quality of direct patient services, administrative services and/or support services. These activities include specifying and taking corrective action to remedy any deficiencies identified through the assessment process.
Quality Care Grievance	A grievance related to whether the quality of covered services provided by a plan or provider meets professionally recognized standards of health care, including whether appropriate health care services have been provided or have been provided in appropriate settings.
Quality Improvement Organization (QIO)	Groups of practicing doctors and other health care experts paid by the federal government to check and improve the care given to Medicare patients. The QIO must review your complaints about the quality of care given by inpatient hospitals, hospital outpatient departments, hospital emergency rooms, skilled nursing facilities, home health agencies, Private Fee-for-Service and ambulatory surgical centers.
Reconsideration	Under Part C, the first level in the appeals process which involves a review of an adverse organization determination by an MA plan, the evidence and findings upon which it was based, and any other evidence submitted by a party to the organization determination, the MA plan or CMS. Under Part D, the second level in the appeals process which involves a review of an adverse coverage determination by an independent review entity (IRE), the evidence and findings upon which it was based, and any other evidence the enrollee submits or the IRE obtains. As used in this guidance, the term may refer to the first level in the Part C appeals process in which

	the MA plan reviews an adverse Part C organization determination or the second level of appeal in both the Part C and Part D appeals process in which an independent review entity reviews an adverse plan decision.
Recredentialing	Process by which qualifications, certifications and licenses of practitioners are re-examined for re-approval according to eH guidelines.
Redetermination	First level in the Part D appeal process in which the plan sponsor reviews an adverse Part D coverage determination, including the findings upon which the decision was based and any other evidence submitted or obtained.
Referral	A plan may restrict certain health care services to an enrollee unless the enrollee receives a referral from a plan approved caregiver, on paper, referring them to a specific place/ person for the service. Generally, a referral is defined as an actual document obtained from a provider in order for the beneficiary to receive additional services.
Related Entity	Any entity that is related to the Medicare Advantage (MA) organization by common ownership or control and: 1. Performs some of the MA organization's management functions under contract or delegation; 2. Furnishes services to Medicare enrollees under an oral or written agreement; or 3. Leases real property or sells materials to the MA organization at a cost of more than $2,500 during a contract period.
Reopening	Remedial action taken to change a binding determination or decision even though the determination or decision may have been correct at the time it was made based on evidence of record.
Representative	Under Part C, as defined in §422.561, an individual appointed by an enrollee or other party, or authorized under state or other applicable law, to act on behalf of an enrollee or other party involved in a grievance, organization determination, or appeal. Under Part D §423.560 defines “representative” as an individual either appointed by an enrollee or authorized under state or other applicable law to act on behalf of the enrollee in filing a grievance, obtaining a coverage determination, or in dealing with any of the levels of the appeals process. For both Part C & Part D, unless otherwise provided in the applicable law, the representative will have all of the rights and responsibilities of an enrollee or other party, as applicable.
Retrospective Review	After care has been provided, a review of medical information to determine medical necessity and appropriateness of care and where it’s covered by the member’s plan.
Review of Claims	Using information on a claim or other information requested to support the services billed to make a determination.

Rights of Individuals	Individuals have the right to: • Receive notice of information practices • See and copy own records • Request corrections • Obtain an accounting of disclosures • Request restrictions and confidential communications • File complaints
Significant Business Transaction	Any business transaction or series of transactions of the kind specified in the above definition of "business transaction" that, during any fiscal year of the MA organization, have a total value that exceeds $25,000 or 5 percent of the MA organization's total operating expenses, whichever is less.
Special Election Period	A set time that a beneficiary can change health plans or return to the Original Medicare Plan, such as moving outside the service area; organization violates its contract with the member, organization does not renew its contract with CMS, or other exceptional conditions as determined by CMS.
Special Enrollment Period	A set time to sign up for Medicare Part B if Medicare Part B wasn't not taken during the Initial Enrollment Period due to individual or spouse working and being covered by a group health plan through an employer or union. Individuals can sign up anytime based on current employment status and coverage under a group plan. The last eight months of the Special Enrollment Period starts the month after the employment ends or the group health coverage ends, whichever comes first.
Specialist	A doctor who treats certain parts of the body for certain health problems, or certain age groups.
Specified Low-Income Medicare Beneficiaries (SLMB)	A Medicaid program that pays for Medicare Part B premiums for individuals who have Medicare Part A, a low monthly income, and limited resources.
Special Investigations Unit (SIU)	An internal investigation unit responsible for conducting investigations of potential FWA.
Subcontractor	A practitioner or group who has a contractual agreement with providers to provide clinical services.
Subdelegation	A delegate of a managed care organization (MCO) that gives a third entity the authority to carry out a function that has been delegated by a health plan. Any Subdelegation requires prior approval by eH. Any delegated activity performed by a subdelegate requires a pre-delegation audit and an annual audit.

TTY	A teletypewriter (TTY) is a communication device used by people who are deaf, hard of hearing, or have a severe speech impairment. A TTY consists of a keyboard, display screen, and modem. Messages travel over regular telephone lines. People who do not have a TTY can communicate with a TTY user through message relay center (MRC). A MRC has TTY operators available to send and interpret TTY messages.
UB-04 Form	A standardized billing template used by physicians.
Utilization Management	The process of monitoring and evaluation, on a prospective, concurrent and retrospective basis, the medical necessity and appropriateness of health care services that health care providers provide to members.
Utilization Review	The review of a hospital stays or other service for appropriate admission, treatment and discharge. Any day(s) or treatment denied as inappropriate will not be paid.
Vendor	Entity that provides the organization a product or service, not including any sub delegated services.
Waste	The overutilization of services, or other practices that, directly or indirectly, result in unnecessary costs to the Medicare program. Waste is generally not considered to be caused by criminally negligent actions but rather the misuse of resources.
Withdrawal	A voluntary verbal or written request to rescind or cancel a pending grievance, initial determination, or appeal request submitted by the same party.

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