LONGEVITY HEALTH

PROVIDER MANUAL

EFFECTIVE JANUARY 1, 2025

Our Statement of Purpose:
To improve the health and quality of life of nursing home residents by caring for their unique medical, social and emotional needs.

LONGEVITY HEALTH

Table of Contents

Plan Overview

The Longevity Health Plan Provider Manual is customarily updated annually but may be updated more frequently as policies or regulatory requirements change. Providers can access the most current Provider Manual at www.LongevityHealthPlan.com. The information contained in this manual is currently effective January 1, 2025.

The provider manual contains policies, procedures, regulatory/contractual requirements to support you, our providers, in providing comprehensive care to our members and understanding our programs and processes.

Any reference to *providers* refers to contracted (i.e., in-network) providers unless otherwise indicated.

Introduction

Longevity Health Plan ("Longevity," "health plan" or "Plan") is a Medicare Advantage HMO Plan in all markets except for New Jersey, where it operates as a PPO plan. There are different types of Medicare health plans. Longevity Health Plan is a Medicare Advantage Special Needs Plan (SNP), which means its benefits are designed for people with special health care needs.

Longevity Health Plan is an Institutional Special Needs Plan (ISNP) designed to improve care for long-term residents of nursing facilities in Colorado, Florida, Illinois, Massachusetts, Michigan, New Jersey, New York, and North Carolina.

Important things to remember about Medicare SNP members:

- A SNP member is still covered by Medicare and has chosen to get their Medicare healthcare and prescription drug coverage through our plan.
- A SNP member still has Medicare rights and protections.
- A SNP member gets supplemental benefits from the plan. Supplemental benefits arenot covered under Part A, Part B or Part D.
- A SNP member's benefits, provider choices and drug formularies (list of covered drugs)are tailored to best meet their specific needs.
- A SNP member typically requires a deeper level of care coordination.
- SNPs focus more on specific lifestyle care management needs with specialized expertise.

  tailored to members' needs.

Our Model of Care

Longevity's Model of Care provides residents living in nursing facilities with a patient-centered, primary care-driven care experience. Focusing on the prevention of avoidable hospitalizations and reduction of acute exacerbations, our Model of Care is designed to improve the quality of life for members while providing access to the same services covered by Original Medicare. Supplemental benefits provide additional services and support for Longevity's special member population.

The Model of Care includes four sections:

- MOC 1: Description of the SNP Population
- MOC 2: Care Coordination
  - SNP Staff Structure
  - Health Risk Assessment (HRA)
  - Face-to-Face Encounter
  - The Individualized Care Plan (ICP)
  - The Interdisciplinary Care Team (ICT)
  - Care Transition Protocol
- MOC 3: Provider Network
- MOC 4: Quality Measurement and Performance Improvement

MOC 1: Description of the SNP Population

Members of LHP are:

- Likely to be 65 years or older, female, widowed, or single.
- Often have multiple chronic conditions such as heart disease, diabetes, COPD, depression.
- Likely prescribed one or more high-risk medications per month.
- May be confined to bed or wheelchair and require assistance with activities of daily living.
- Often have moderate to severe cognitive impairment, overall low health literacy, and potential socioeconomic issues creating barriers to care.

Characteristics of the most vulnerable Members may include:

- Hospital admission within the last 30 days or four or more hospital admissions or emergency room visits in the last 12 months.
- The presence of multiple chronic conditions and complex comorbidities, unhealed pressure ulcers, or abnormal weight loss.
- Complex medication regimen with multiple high-risk medications.
- Recently experienced a fall in the facility.
- Recently experienced a major change in health or mental status.
- Receiving Part A skilled services in the nursing facility.
- Significant functional impairment.
- Likely to feel down and depressed.
- Near the end of life.
- Experiencing high social risk, such as an unsteady living situation, food insecurity, or a lack of reliable transportation.

MOC 2: Care Coordination

LHP SNP Staff Structure

Example of employed and contracted staff members	Roles and responsibilities
APP – Advanced Practice Registered Nurse or Physician Assistant	Provides primary care in collaboration with the primary care physician. Participates in/oversees care coordination activities such as completing HRAs, risk stratification, Member visits, ICPs, ICTs, and managing transitions of care. Identifies members of the ICT and leads the ICT meeting as needed. Oversees members of the clinical care team including RNs, social workers, behavioral health support specialists, and medical assistants.
Plan Model of Care RN (RN Field Coordinator)	Conducts care coordination activities in collaboration with the APP including completing HRAs, risk stratification, Member visits, ICPs, ICTs, and sharing health status information across settings and managing transitions of care.
Plan Social Worker	Collaborates with the clinical care team to address Members' social needs. In collaboration with the APP/RN participates in care coordination activities such as completing HRAs, ICPs, ICTs, and managing transitions of care.
Licensed Practical Nurse	Supports care management staff in completing care coordination activities based on guidelines outlined in State Nurse Practice Acts. LPNs work under the direction of a Nurse Practitioner or an RN and provide restorative and supportive care, health counseling, and teaching.
RN Care Coordinator	Provides telephonic care coordination and care management for Members during transitions of care. Focus is on sharing information across settings.
PCP	Oversees delivery of medical care and implementation of the model of care for Plan Members. Participates in ICT meetings.

Health Risk Assessment (HRA)

The HRA is used to initiate the development of the individualized care plan (ICP), collect information about the health status of LHP Members, help to stratify Members by risk level, and monitor changes in health status on an annual basis.

All new Members receive an HRA within 90 days of enrollment and annually thereafter (some organizations may have shorter timeframes). Outcomes of the post-HRA visit such as medication changes, therapy referrals, and diagnostic tests will be included in the facility's electronic medical record and incorporated into the Member's ICP.

Face-to-Face Encounter

An annual face-to-face encounter is required by Medicare for all SNP members. The goal of the face-to-face encounter is to improve health outcomes, identify needs and risks, reduce gaps, and increase collaboration between the Member's ICT and the care management team.

Individualized Care Plan (ICP)

Needs identified in the HRA are addressed in the ICP. The ICP focuses on Member self-management goals and preferences. All Members have an ICP that is updated with significant changes in health status and is available to the Member and the Care Team

Individualized care team (ICT)

The ICT revolves around the Member and is focused on the Member's goals and preferences. The exact composition of the ICT varies and is dependent on each Member's unique needs. ICT participants are selected based on their functional roles, knowledge, and/or established relationship with the Member. The ICT reviews progress towards goals and updates the ICP as needed.

Care Transitions

The Model of Care utilizes care transition protocols to safely transition Members between levels of care and across care settings using evidence-based clinical practices. Care transition protocols ensure that every Member has a centralized point of contact for care transitions and facilitate information-sharing with external providers/facilities to ensure coordinated care across settings.

MOC 3: Provider Network

LHP Members have access to a comprehensive contracted network of providers, facilities, ancillary services, specialist physicians, and acute care facilities with the specialized clinical expertise to care for I-

SNP Members.

Primary care services and supportive ancillary services such as therapy, diagnostic radiology, and labs are provided within the facility as appropriate. LHP clinicians also coordinate services outside of the facility including specialist visits and diagnostic testing not available on campus.

Both contracted providers and out-of-network providers seen by Members on a routine basis must receive initial and annual training on the Model of Care.

MOC 4: Quality Measurement and Performance Improvement

The purpose of the Quality Improvement Program (QI Program) is to take a proactive approach to improve quality of care for LHP Members. The QI Program supports and promotes this vision through continuous improvement and monitoring of medical care, patient safety, and behavioral health services.

The QI Program is assessed annually to evaluate the overall effectiveness of the program. Enhancements are made to the QI Program based on the annual evaluation. The QI Program provides the overall structure, framework, and governance to improve quality of care for Members. The QI Program includes both performance (process) measures and Member outcome measures.

Key quality initiatives focus on:

- Fall prevention.
- Medication adherence and deprescribing based on clinical guidelines.
- Hospitalization for potentially preventable complications and preventing unnecessary hospital readmissions.
- Improving Member satisfaction.

Working with the Plan

Key Contacts

Provider Services Department

877-344-4090

Member Identification & Eligibility

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

Longevity Health Plan maintains the most current eligibility information. You can verify member eligibility the following ways:

- **Via Member ID Card:** Note that changes do occur, and the card alone does not guarantee member eligibility.
- **Via Provider Web Portal:** Longevity Health Plan web portal allows providers to verify eligibility online 24/7 at https://lhpprovider.prod.healthaxis.net/login
- **Call the Call Center at the number listed above.**

Please note membership data is subject to change.

The Centers for Medicare and Medicaid Services (CMS) may retroactively terminate members for various reasons and recoup payments made to the plan. When this occurs, the Longevity claims recovery unit will request a refund from the provider for any services furnished during the time that the member was ineligible. The provider must then contact CMS Eligibility to determine the member's actual benefit coverage for the date of service in question. Typically, the beneficiary is disenrolled from the ISNP to Medicare fee-for-service. If the Medicare timely filing period has passed, Federal law gives providers an additional six months after the plan's recoupment to file a claim.

Benefits and Services

All Longevity Health Plan members receive benefits and services as defined in their Evidence of Coverage (EOC). Benefits and Services are subject to change on January 1 of each year.

Providers may contact their state-specific Provider Services number (see page 4) for information on covered services and verification of applicable member copayments and/or cost-sharing owed by the member to the provider for the provision of services.

All participating providers are obligated to bill and collect applicable member copayments and/or cost-sharing as defined under the Longevity Health Plan policy or CMS regulations. Participating providers of Longevity Health Plan are, however, prohibited from balance billing members for copayments and/or cost-sharing when members are determined qualified and eligible for benefits under the state Medicaid program. For more information refer to MLN Article SE1128, or at this link: http://www.cms.gov/MLNMattersArticles/Downloads/SE1128.pdf.

Emergent and Urgent Services

Longevity Health Plan follows the Medicare definitions of "emergency medical condition," "emergency services," and "urgently needed services" as defined in the Medicare Managed Care Manual Chapter 4

Section 20.2:

Emergency medical condition: "A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

- Serious jeopardy to the health of the individual or, in the case of a pregnant woman, the health of the woman or her unborn child;
- Serious impairment to bodily functions; or
- Serious dysfunction of any bodily organ or part."

Emergency services: "Covered inpatient and outpatient services that are furnished by a provider qualified to furnish emergency services; and needed to evaluate or treat an emergency medical condition."

Urgently needed services: "Covered services that are not emergency services as defined above but:

- Are medically necessary and immediately required as a result of an unforeseen illness, injury or condition;
- Are provided when the member is temporarily absent from the plan's service area or under unusual and extraordinary circumstances when the member is in the service area, and the network is temporarily unavailable or inaccessible; and
- It was not reasonable given the circumstances to wait to obtain the services through

the Plan network."

Longevity's network includes multiple hospitals, emergency rooms and providers able to treat the emergent conditions of our members 24 hours a day, seven (7) days a week. Emergent services should be obtained from the closest facility that can provide the service. Emergency and urgently needed services do not require prior authorization or referrals. For emergent issues occurring onsite in the member's nursing home or in the service area, the PCP and/or the assigned facility APP is generally responsible for providing, directing or facilitating a member's emergent care. This includes emergent services provided onsite in the nursing facility ("treatment in place"). The PCP or their designee must be available 24 hours a day, seven (7) days a week to assist members needing emergent services.

Emergent issues requiring services or expertise not available onsite in the member's nursing home are addressed by transferring the member to an acute care hospital or emergency room able to provide the needed care. The PCP, in coordination with the Longevity's Clinical Team, is responsible for coordinating the transition of the member to the hospital or emergency room. This includes communicating with the

hospital or emergency room about the member. Members may have a copayment responsibility for outpatient emergency visits unless it results in an admission.

While most members remain in the Longevity service area, our members may receive emergency services and urgently needed services from any provider regardless of whether services are provided within or outside our authorized service area or network. In unusual circumstances, when the member is in the service area and the network is temporarily unavailable or inaccessible, prior approval may be required to see an out-of-network provider and an out-of-network or out-of-area visit will be approved only for continuity of care.

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

Excluded Services

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

- Services that are not reasonable and necessary, according to the standards of the Original Medicare Plan.
- Experimental or investigational medical and surgical procedures, equipment, and medications, unless covered by the Original Medicare Plan or unless, for certain services, the procedures are covered.
- Orthopedic shoes unless they are part of a leg brace and included in the cost of the brace (exception: orthopedic or therapeutic shoes are covered for people with diabetic foot disease).
- Supportive devices for the feet (except orthopedic or therapeutic shoes for people with diabetic foot disease).
- Hearing aids and routine hearing examinations unless otherwise specified in the EOC.
- Routine eye examinations, radial keratotomy, LASIK surgery, vision therapy and other low vision aids and services, and eyeglasses (which are only covered after cataract surgery), unless otherwise specified in the EOC.
- Self-administered prescription medication for the treatment of sexual dysfunction, including erectile dysfunction, impotence and anorgasmia or hyporgasmy unless otherwise included in the member's

Part D benefit. Please see the formulary for details.

- Reversal of sterilization measures and non-prescription contraceptive supplies.
- Naturopathic services.
- Services provided to veterans in Veterans Affairs (VA) facilities. However, in the case of emergencies received at a VA hospital, if the VA cost sharing is more than the cost sharing required under the Plan, the Plan will reimburse veterans for the difference. Members are still responsible for the Plan cost sharing amount.

Continuity of Care

Longevity Health Plan's policy is to provide for continuity and coordination of care with medical practitioners treating the same patient, and coordination between medical and behavioral health services. When a practitioner leaves Longevity Health Plan's network and a member is in an active course of treatment, our Utilization Management staff will attempt to minimize any disruption in care by potentially offering continuity of care services (continuity of care) with the current provider for a reasonable period of time.

In addition, members undergoing active treatment for a chronic or acute medical condition will have access to the existing provider through the current period of active treatment or a maximum of 90 calendar days, whichever is shorter.

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

We also recognize that new members joining our health plan may have already begun treatment with a provider who is not in the Longevity network. Under these circumstances, Longevity will work to coordinate care with the provider by identifying the course of treatment already ordered and offering the member a transition period of up to 90 calendar days to complete the current course of treatment.

Longevity Health Plan will honor plans of care (including prescriptions, DME, medical supplies, prosthetic and orthotic appliances, specialist referrals and any other on-going services) initiated prior to a new member's enrollment for a period of up to 90 calendar days or until the Primary Care Physician evaluates the member and establishes a new plan of care. For additional information about continuity of care or to request authorization for such services, please contact our Prior Authorization Department at 877-344-4090.

Seeing Specialists/Other Providers or Testing

Longevity Health Plan uses a gatekeeper model, meaning prior to seeing a specialist/other provider or having testing completed the request should be reviewed in advance by the member's PCP and/or assigned facility APP to help in care coordination.

A member's PCP may send a member to in-network specialists. Whenever possible, in-network specialists are encouraged to treat members in the nursing facility for the member's safety and comfort. All specialist physician services must be approved by the member's PCP and/or the assigned facility APP. Whether the request originates with the PCP or from other specialists, services should be provided by Longevity Health Plan participating physicians/facilities.

The following paragraph applies only to HMO ISNP plans.

Services provided by "out-of-network" physicians or facilities require prior authorization from Longevity's Utilization Management team. Out-of-network services may be allowed in certain circumstances where in-network providers are not available or if a continuity of care concern exists (see section above on Continuity of Care).

Notification of Inpatient and Observation Admissions

Longevity Health Plan requires providers to notify us of emergent inpatient and observation admissions as follows:

- Admissions following outpatient procedures or observation status—notification.
- Observation Status—notification

For notification of admission, providers should call 877-344-4090.

Emergent admission notification must be received within one business day of admission. For observation stays, Longevity Health Plan expects hospitals (including critical access hospitals) tofurnish the Medicare Outpatient Observation Notice (MOON) as required by law. This obligation exists even though Longevity waives the three-day stay requirement.

Prior Authorization

Requests for prior authorization of services should be made before or at the time of scheduling the service. PCPs and Specialists are responsible for requesting prior authorization for the services they order. Facilities may also request prior authorization for scheduled admissions, elective admissions, procedures, and outpatient services ordered by the PCP.

Longevity recommends calling at least 15 days prior to an elective admission, procedure, or service. Requests for prior authorization will be prioritized according to the level of medical necessity. For prior authorization, providers should fax 1-855-969-5876 or call toll-free for all markets (855-969-5876).

Services Requiring Prior Authorization

Providers should refer to the list of services typically requiring referral or authorization in the provider section of Longevity's website: www.LongevityHealthPlan.com.

Documentation for Prior Authorizations

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

- Member name and identification number
- Location of service (e.g., hospital or outpatient surgical center setting)
- PCP
- Servicing/attending physician name.
- Date of service
- Diagnosis
- Service/Procedure/Surgery description and CPT or HCPCS code
- Clinical information supporting the need for the service.

Decisions and Timeframes

Expedited: When providers believe waiting for a decision under the routine time frame could place the member's life, health, or ability to regain maximum function in serious jeopardy, you may request an expedited determination. Expedited requests will be determined within 72 hours or as quickly as the member's health requires.

Routine: If all required information is submitted at the time of the request, CMS generally mandates a health plan determination be made within 14 calendar days.

Once the Utilization Management Department receives the request for authorization, Longevity will review the request using nationally recognized industry standards or local coverage determination criteria. If the

request for authorization is approved, we will assign an authorization number and enter the information in the Longevity medical management system.

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

Concurrent Review

Concurrent Review is the process of initial assessment and continual reassessment of the medical necessity and appropriateness of inpatient care during an acute care hospital, rehabilitation, SNF or other inpatient admission; and of any services that continue to be provided after the initial service has been approved. The purpose of concurrent review is to ensure:

- Covered services are provided at the appropriate level of care; and
- Services are administered according to the individual facility/vendor contract.

Utilizing CMS guidelines and InterQual Guidelines to review criteria, Longevity's Utilization Management department and Longevity's Medical Directors will conduct a medical necessity review. Longevity Health Plan is responsible for final authorization.

Longevity's preferred method for concurrent review is the submission of clinical documentation to our Utilization Management nursing staff within one (1) Business Day of notification or on the last authorized day. If clinical information is not received within 24 hours of an admission or on the last covered day, an administrative denial may be issued, or the medical necessity determination will be made on the existing clinical criteria. If it is not feasible for the facility to contact Longevity via phone, the facility may fax the member's clinical information within one business day of notification to:

- Fax: 1-855-969-5876

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

- Fax: 1-855-969-5876

A Longevity Health Plan Medical Director reviews all acute, rehab, long-term acute care (LTAC) and SNF stays that do not meet medical necessity criteria and issues a determination. If the Longevity Medical Director deems the inpatient or SNF stay not medically necessity, the Medical Director will issue an adverse determination (a denial). The Utilization Management nurse or designee will notify the provider(s), e.g.

facility, attending/ordering provider verbally and in writing and will notify the member as required by law. The criteria used for the determination is available to the practitioner/facility upon request. To request a copy of the criteria, please 877-344-4090.

For members receiving hospital care and for those who transfer to a non-referring SNF or Acute Inpatient Rehabilitation Care, Longevity will approve the request or issue a denial if the request is not medically necessary, or if there is a contracted facility that can provide the care.

We will also issue a denial if a member who is already receiving care in an Acute Inpatient Rehabilitation Facility no longer requires further treatment at that level of care. The denial will include information on the member's or their authorized representative's right to file an expedited appeal, as well as instructions on how to do so if the member or member's physician does not believe the denial is appropriate.

Longevity Health Plan also issues written Notice of Medicare Non-Coverage (NOMNC) determinations by CMS guidelines. The facility is responsible for delivering the notice to the member or their authorized representative/power of attorney (POA) and for having the member, authorized representative or POA sign the notice within the written time frame listed in the Adverse Determination section of the provider manual. The facility is expected to fax a copy of the signed NOMNC back to Utilization Management Department at the number provided. The NOMNC includes information on members' rights to file a fast-track appeal.

Capitated Nursing Facilities must continue to follow their standard NOMNC process for capitated services. Longevity will not generate NOMNCs for this provider type.

Rendering of Adverse Determinations (Denials)

In some instances, the Utilization Management staff is authorized to render an administrative denial decision to participating providers based only on contractual terms, benefits, or eligibility. Late authorization or not providing clinical information as requested will result in an administrative adverse determination.

Only a Longevity Medical Director or delegated physician may render an adverse determination (denial) based on medical necessity, but he/she may also decide based on administrative guidelines. When rendering a decision based on medical necessity, Longevity requests necessary information, including pertinent clinical information from the treating provider, to allow the Medical Director to make appropriate determinations. The Medical Director may suggest an alternative Covered Service to the requesting provider. If the Medical Director decides to deny or limit an admission, procedure, service or extension of stay, Longevity notifies the facility or provider's office of the denial of service.

Notices are issued to the provider, the member or the member's authorized representative documenting

the original denied request and the alternative approved service, along with the process for appeal, in accordance with CMS guidelines.

Longevity Health Plan employees are not compensated for denial of services.

The PCP or Attending Physician may contact the Medical Director by telephone to discuss decisions only before an adverse determination is rendered. After the adverse determination is rendered, the decision may not be changed unless an appeal is initiated.

Notification of Adverse Determinations (Denials)

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

- For non-urgent pre-service decisions: within 14 calendar days of the request
- For urgent pre-service decisions: *within 72 hours of the request

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

Longevity Health Plan complies with CMS requirements for written notifications to members, including rights to file appeals and grievance.

Overview

The focus of Longevity Health Plan's Claims Department is to process claims in an accurate and timely manner. Longevity has established toll-free telephone numbers for Providers to access a representative in the Customer Service Department for any claim inquiries.

Claims Submission

While Longevity Health Plan prefers electronic submission of claims, both electronic and paperclaims are accepted. If interested in submitting claims electronically, contact your local Longevity Health Plan Provider Services Department at 877-344-4090.

Longevity Health Plan also offers the ability to review claims through the Provider Portal. Instructions on how to gain access to the portal can be found on Longevity's website: https://lhpprovider.prod.healthaxis.net/login

Forward all completed paper claims forms to the following address:

Longevity Health Plan

PO Box 21063

Eagan, MN 55121

Electronic Funds Transfer (EFT) and Electronic Remittance Advice (ERA) Process

Longevity (in partnership with VPay) has implemented an enhanced online Provider registration process for electronic funds transfer (EFT) and electronic remittance advice (ERA) services.

Once a Provider has registered, this service offers Providers several options for viewing and receiving remittance details. ERAs can be imported directly into practice management or patient accounting systems, eliminating the need to rekey remittance data. Multiple practices and accounts are supported. Providers can reuse enrollment information to connect with multiple payers. Different payers can be assigned to different bank accounts.

Explanation of Payment (EOPs) can be viewed and/or downloaded and printed from VPay's website once registration is completed.

Providers can register using VPay's Provider registration process. VPay can be reached by email support@vpay.usa.com or call 1-888-920-0623.

Timely Claims Submission

Unless otherwise stated in the Executed Contract Agreement, participating Providers must submit Clean Claims (initial, corrected and voided) to Longevity within 90 calendar days from the date of discharge (for inpatient services) or the date of service (for all other services).

The start date for determining the timely filing period is the "from" date reported on a CMS-1500 or 837 P for professional claims or the "through" date used on the UB-04 or 837-I for institutional claims.

Unless prohibited by federal law or the Center for Medicare and Medicaid Services (CMS), Longevity may deny payment of any claim that fails to meet Longevity's submission requirements for Clean Claims or failure to timely submit a Clean Claim to Longevity. A Provider whose claim is denied as described in this paragraph must not bill or accept payment from the Member for the services in question due to CMS Balance Billing regulations.

The following items are acceptable as proof a clean claim was submitted timely:

- A clearinghouse electronic acknowledgement indicating claim was electronically accepted by Longevity.
- A Provider's electronic submission sheet that contains all the following identifiers:
    - Patient name
    - Provider name
    - Date of service to match Explanation of Benefits (EOB)/claim(s) in question.
    - Prior submission bill dates
    - Longevity's product name or line of business

The following items are examples of what is not acceptable as evidence of timely submission:

- Strategic National Implementation Process (SNIP) Rejection Letter
- A copy of the Provider's billing screen

Claim Format Standards

Standard CMS required data elements must be present for a claim to be considered a clean claim and can be found in the CMS Claims Processing Manuals. The CMS Claims Processing Manuals can be found at this link: cms.gov/manuals/downloads/clm104c12.pdf .

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

Physicians in the same group practice who are in the same specialty must bill and receive payment as though they were a single physician. If more than one service is provided on the same day to the same patient by the same physician or more than one physician in the same specialty in the same group, they must bill and receive payment as though they were a single physician. For example, only one evaluation and management service may be reported unless the evaluation and management services are for unrelated diagnoses. Instead of billing separately, the physicians should select a level of service representative of the combined visits and submit the appropriate code for that level.

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

Tax ID and National Provider Identifier Requirements

Longevity requires the payer-issued Tax Identification Number (Tax ID/TIN) and National Provider Identifier (NPI) on all claim submissions, except for atypical Providers (Providers that do not provide healthcare services, and instead provide services such as home and vehicle modifications, taxi services and respite care). Atypical Providers must pre-register with Longevity before submitting claims to avoid NPI rejections.

Longevity will reject claims without the Tax ID and NPI, and such claims will not qualify as Clean Claims. More information on NPI requirements, including the Health Insurance Portability and Accountability Act of 1996's (HIPAA) NPI Final Rule Administrative Simplification, is available at cms.gov/Regulations-and-Guidance/HIPPA-Administrative-Simplification/NationalProvidentStand.

Taxonomy

To increase appropriate adjudication, Providers are encouraged to submit claims with the correct taxonomy code consistent with Provider's specialty and services being rendered. This taxonomy code must be registered on the National Plan and Provider Enumeration System (NPPES) and be included in the CMS taxonomy crosswalk. Longevity may reject the claim or pay it at the lower reimbursement rate if the taxonomy code is incorrect, invalid, or omitted. In such cases, Providers must not bill or accept payment from the Member for the amount denied or reduced by Longevity.

Claims Submission Requirements

Providers using electronic submission shall submit Clean Claims to Longevity or its designee, as applicable, using the HIPAA-compliant 837 electronic format or a CMS 1500/UB-04 (or their successors), as applicable. Claims shall include the Provider's NPI, Tax ID, and the valid taxonomy code that most accurately describes the services reported on the claim. The Provider acknowledges and agrees that no reimbursement or compensation is due for a Covered Service, and no claim is complete for a Covered Service, unless performance of that Covered Service is fully and accurately documented in the Member's medical record prior to the initial submission of any claim. The Provider also acknowledges and agrees that at no time shall Members be responsible for any payments to the Provider except for Member expenses or Non-Covered Services, including cases in which payment is denied or reduced because of the Provider's failure to follow the requirements set forth in this Manual and CMS billing and payment rules and regulations.

Electronic Claims Submissions

Longevity accepts electronic claims submission through Electronic Data Interchange (EDI) as its preferred method of claims submission. All files submitted to Longevity must be in the ANSI ASC X12N format, version 5010A, or its successor.

Since most clearinghouses can exchange data with one another, Providers should work with their existing clearinghouse, or the clearinghouse's Longevity uses, to establish EDI with Longevity.

275 Claim Attachment Transactions via EDI

Effective September 1, 2020, Providers may submit unsolicited attachments (related to pre-adjudicated claims). In addition, the Plan may solicit claims attachments via 275 transactions through the clearinghouse to the billers that use the clearinghouse. At this time, electronic attachments (275 transactions) are not intended to be used for appeals, disputes, or grievances.

What are Acceptable Electronic Data Interchange Healthcare Claim Attachment 275 Transactions?

Electronic attachments (275 transactions) are supplemental documents providing additional patient medical information to the payer that cannot be accommodated within the ANSI ASC X12, 837 claim format. Common attachments are certificates of medical necessity (CMNs), discharge summaries and operative reports to support a healthcare claim adjudication. The 275 transaction is not intended to initiate Provider or Member appeals, grievances, or payment disputes.

HIPAA Electronic Transactions and Code Sets

HIPAA Electronic Transactions and Code Sets is a federal mandate that requires healthcare payers such as Longevity, as well as Providers engaging in one or more of the identified transactions, to be able to send and receive all standard electronic transactions using the HIPAA-designated content and format.

To promote consistency and efficiency for all claims and encounter submissions to Longevity, it is Longevity's policy that these requirements apply to all paper and DDE transactions. All Providers must submit HIPAA-compliant diagnoses codes ICD-10-CM. Please refer to the CMS website for more information about ICD-10 codes at cms.gov, and the ICD-10 Lookup Tool at cms.gov/medicare-coverage-database/staticpages/icd-10-

code-lookup.aspx for specific codes.

Paper Claims Submissions

Providers are encouraged to submit claims to Longevity electronically.

If permitted under the Provider Agreement and until the Provider can submit electronically, paper claims (UB-04 and CMS-1500, or their successors) must contain the required elements and formatting described below:

- All paper claims must be submitted on original (red ink on white paper) claim forms.
- Any missing, illegible, incomplete, or invalid information in any field will cause the claim to be rejected or processed incorrectly.

Per CMS guidelines, the following process should be used for Clean Claims submission.

- The information must be aligned within the data fields and must be:
  - On an original red-ink-on-white paper claim form.
  - Typed. Do not print, handwrite, or stamp any extraneous data on the form.
  - In black ink.
  - In large, dark font such as, PICA or ARIAL, and 10-, 11-or 12-point type.
  - In capital letters.
  - The typed information must not have:
    - Broken characters.
    - Script, italics, or stylized font
    - Red ink
    - Mini font
    - Dot matrix font

For additional information published by CMS see:

CMS UB-04 Fact Sheet: cms.gov

CMS-1500 Fact Sheet: cms.gov

Claim Payment

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

Pricing

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

Longevity will apply correct coding edits, MPPRs as outlined by CMS in the RVU table. We will also follow guidelines put forth by the AMA CPT and CMS HCPC coding guidelines. Bundling, multiple procedure reductions or payment modifiers may impact contracted allowances. All editing applied by Longevity is subject to the appeals/payment dispute and clinical review policies and procedures outlined in this manual.

New or Unlisted Codes

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

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

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

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

Defined by CMS;

- The provider may dispute the denial as outlined in their contract, attaching the Medicare coverage guidelines or proof of payment for the service/code (EOB) from Original Medicare; and
- Longevity Health Plan will pay for any services that include proof of payment by Original Medicare within the past six (6) months at the provider's contract rate or, if not addressed, 100% of the current Medicare rates less all applicable copayments, deductibles, and cost-sharing for which the provider furnishes proof.
- Providers may submit documentation of payment for new services/codes with original claims to prevent the need for an initial denial and subsequent appeal and re- adjudication process.
- All codes/services submitted for payment but not recognized by the claims system will be subject to verification of medical necessity. **Providers should always call for prior authorization of any procedure/service/or code if they have questions or concerns about coverage.**

HEDIS Coding Tips

CPT Category II codes, when added to a claim, help identify additional information about themember's care. This method of reporting simplifies and improves accuracy of reporting selectquality measures for HEDIS®, CMS Star Ratings reporting and incentive programs. Category II codes are for informational purposes only and this communication is not intended to suggest or guide reimbursement. Contact Provider Services if you would like additional information.

Claims Encounter Data

Providers who are paid under capitation must submit encounter claims within the timely filing limit required in their agreement with Longevity Health Plan.

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

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

Non-Payment/Claim Denial

Any denials of coverage or non-payment for services by Longevity Health Plan are addressed on the Explanation of Payment (EOP) or Remittance Advice (RA). An adjustment/denial code will be listed for each billed line, if applicable. Explanations of all applicable adjustment codes per claim are listed below that claim on the EOP/RA. Per your contract, the member may not be billed for services denied by

Longevity Health Plan unless the member received the prior request denial **before** the service was provided and the member indicated they wanted to receive the services regardless of coverage. The member may not be billed for a covered service when the provider has not followed Longevity Health Plan's procedures. In some instances, providing the needed information may reverse the denial (e.g., referral form with a copy of the EOP/RA, authorizationnumber, etc.). When no benefits are available for the member or the services are not covered, the EOP/RA will alert you to this.

Obtaining pre-services review will reduce denials.

Processing of Hospice Claims

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

The only services Longevity Health Plan is financially responsible for during hospice election are the supplemental benefits Longevity Health Plan offers in addition to Original Medicare benefits.

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

Longevity Health Plan may be notified of a hospice election by CMS after claims have been paid for dates of service during the hospice election period. In this instance, Longevity will notify the provider that a refund is due to the Plan. The provider must remit the refund to Longevity and submit a claim for these services to Original Medicare, consistent with CMS policies.

Subrogation

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

Claims involving Subrogation or Third-Party Recovery (TPR) will be processed internally by the Longevity Health Plan Claims Department.

Members who may be covered by third-party liability insurance should only be charged the required copayment. The bill can be submitted to the liability insurer. The provider should submit the claim to Longevity Health Plan with any information regarding the third-party carrier. All claims are processed per the usual claims' procedures.

For claims related questions, please contact your local Longevity Health Plan Call Center at 877-344-4090 and a Call Center representative will gladly assist.

Participating Provider Claims Payment Dispute

If your claim was paid and you dispute the payment amount, please follow the process below. A formal payment dispute request is required from a Provider to contest a paid amount or a formal request to review a previous decision where a determination was made that the provider failed to follow administrative rules, assigning liability to the provider.

All Payment Disputes must be:

- Submitted in writing within 65 days from the original payment.
    - If payment dispute is filed past the 65-day timeframe, please include good cause reasoning for the late filing or the dispute will not be reviewed.
- Include a cover letter with:
    - Claim Identifiable information, including but not limited to both member and provider identifying information (must include date of service)
    - The specific rationale as to why the payment made was not appropriate or requires adjustment.
    - The specific rationale as to why the administrative rules were not followed, requiring an exception to be made or extenuating circumstance warranting a re-review of the request for provision of payment.
- Include necessary attachments:
    - Copy of the original Remittance Advice (RA)
    - All applicable medical records or other attachments that support additional payment.

Providing the above information enables the Payment Dispute Unit to review the request properly and promptly. Incomplete requests may delay resolution. Longevity will not request additional information and expects the provider to submit the information necessary to substantiate their request for additional payment.

The claims payment dispute must be in writing and mailed or faxed to:

Longevity Health Plan Appeals Department

PO Box 21063

Eagan, MN 55121

Fax: 1-855-969-5853

Providers will be notified of the final decision of payment disputes via denial letter or an updated Remittance Advise if additional payment is granted.

Member Grievances and Appeals

Appeals

Longevity members have the right to appeal any decision about Longevity's failure to provide or pay for what they believe are covered services.

Examples include, but are not limited to:

- Reimbursement for emergent or urgently needed care outside the service area but within the United States and its territories;
- A denied claim for any other health services furnished by a non-participating provider or supplier they believe should have been provided, arranged for or reimbursed by Longevity Health Plan;
- Services they have not received, but believe are the responsibility of Longevity Health Plan to pay for; and/or
- A reduction in or termination of a service a member feels is medically necessary.

Also, a member may appeal any decision by Longevity to discharge from the hospital. In this case, a notice will be given to the member with information about how to appeal. The member will remain in the hospital while the decision is reviewed. The member will not be held liable for charges incurred during this period regardless of the outcome of the review. Please refer to the Longevity Health Plan Evidence of Coverage (EOC) for additional information.

Providers and other entities with an interest in the outcome of a pre-service determination may file an appeal. This includes the member's treating physician (acting on behalf of the member), the staff of the physician's office (acting on said physician's behalf) or any other provider or entity (other than the MA plan).

An appeal is a reconsideration of a previous decision not to approve or pay for a service, including a level of care decision (including "partial" denials in addition to outright denials.

Appeals will receive an independent review by someone not involved in the initial decision. Requesting an appeal does not guarantee the request will be approved or the claim paid. The appeal decision outcome

may be to uphold the original decision.

A request for a standard appeal must be submitted to the address/fax listed below within 65 days from the original decision. Appeal requests should include a copy of the denial and any medical records supporting why the service is needed.

A member or physician may request an expedited appeal if they believe relying on standard timeframe(s) may jeopardize the life or health of the member or the member's ability to regain maximum function. A request for an expedited appeal (pre-service requests only) may be filed orally or in writing. To request an expedited appeal orally, please call your state-specific telephone number (see page 6) or fax to 1-855-969-5853.

Providers contracted with Longevity Health Plan may not use the member appeal process to file an appeal for post-service payment disputes. Contracted providers should use the Payment Dispute process outlined above, or the process outlined in their provider agreement if they believe a claim was denied for payment in error or if there are additional circumstances Longevity should consider.

Part C Appeals Phone and Fax Number

Call 877-344-4090or fax to 1-855-969-5853.

Member Grievances

Members of Longevity Health Plan have the right to file a complaint, also called a grievance, about problems they observe or experience with the health plan. Situations for which a grievance may be filed include but are not limited to:

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

Grievances should be reported to Member Services. Grievances are logged, categorized, and worked to resolution per CMS guidelines for Medicare Advantage plans.

Providers must cooperate with Longevity Health Plan investigations regarding grievances related to the provider and/or provider's services.

Provider Information

Provider Credentialing

Longevity Health Plan does not discriminate (in terms of participation, reimbursement or the population of members served) against any health care professional who is acting within the scope of his or her license or certification under state and federal law, based on race, color, religion, national origin, sex (including gender identity), sexual orientation, age, or disability. All practitioners and organizational applicants to Longevity Health Plan must meet basic eligibility requirements and complete the credentialing process prior to becoming a participating provider.

No provider can be assigned a health plan effective date, be included in a provider directory, or have members assigned without completing the credentialing process.

Application Process

If you are not yet a contracted provider, please contact the Call Center to submit a request for participation in Longevity's provider network or submit the request to networksupport@longevityhealthplan.com.

To initiate the credentialing process, providers must submit a completed and signed credentialing application and signed contract to Longevity Health Plan. The application can be a State Mandated Credentialing application, a CAQH Universal Credentialing Application form or CAQH ID, or a completed application with a signed and dated Attestation and Consent and Release form that is less than 180 days old.

Credentialing and Recredentialing Process

Once a Provider has applied for initial consideration, Longevity's verification organization or its designee will conduct primary source verification of the applicant's licensure, education and/or board certification, privileges, lack of sanctions or other disciplinary action and malpractice history by querying the National Practitioner Data Bank.

The credentialing process can take up to 90 days to complete. Once credentialing has been completed and the applicant is approved, the provider will be notified in writing of theireffective date.

All practitioners are required to recredential at least every three years to maintain an active participating status with Longevity Health Plan. Information obtained during the initial credentialing process will be updated and re-verified as required. Practitioners will be notified of the need to submit re-credentialing information at least four months in advance of their three-year anniversary date. Three separate attempts

will be made to obtain the required information via mail, fax, email and/or telephonic request. Practitioners who fail to return recredentialing information before their re-credentialing due date will be notified in writing oftheir termination from the network.

Provider Rights

Providers have the right to review information obtained from any outside source to evaluate their credentialing application except references, recommendations, or other peer-review protected information, also known as primary source recommendation. The provider may submit a written request to review his/her file information at least 30 days in advance. Longevity will establish a time for the provider to view the information at the Plan's offices.

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

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

Facility/Organizational Provider Selection Criteria

When assessing organizational providers, Longevity uses the following criteria:

- Must be in good standing with all state and federal regulatory bodies.
- Has been reviewed and approved by an accrediting body.
- If not accredited, can provide appropriate evidence of successfully passing a recent state or Medicare site review, or meets other Longevity criteria.
- Maintains current professional and general liability insurance as applicable.
- Has not been excluded, suspended and/ or disqualified from participating in any Medicare, Medicaid, or any other government health-related program.

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

Facility/Organizational Provider Application Requirements

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

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

Credentialing Committee/Peer Review Process

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

Non-Discrimination in the Decision-Making Process

Longevity Health Plan's Credentialing Program complies with all CMS and State regulations as applicable. Through the universal application of specific assessment criteria, Longevity ensures fair and impartial decision-making in the credentialing process. No provider 's participation is based solely on race, gender,

age, religion, ethnic origin, sexual orientation, type of population served or for specializing in certain types of procedures.

Provider Notification

All initial applicants who complete the credentialing process are notified in writing of their plan effective date. Providers are advised not to see Longevity Health Plan members until the notification of successful credentialing is received. Applicants who are denied by the Credentialing Committee are notified in writing within 60 days of the decision outcome detailing the reasons for the denial/term and any appeal rights to which the provider may be entitled.

Appeals Process & Notification of Authorities

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

Confidentiality of Credentialing Information

All information obtained during the credentialing and re-credentialing process is considered confidential and is handled and stored confidentially and securely as required by law and regulatory agencies. Confidential practitioner credentialing and re-credentialing information is not disclosed to any person or entity except with the written permission of the practitioner or asotherwise permitted or required by law.

Ongoing Monitoring

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

Provider Directory

To be included in Provider Directories or any other member information, providers must be fully

credentialed and approved and must be credentialed under a specialty or capability required for Online Provider Directory display by CMS. Directory specialty designations must be commensurate with the education, training, board certification and specialty(s) verified and approved via the credentialing process. Requests for changes or updates to the specialty information in the directory may only be approved by the Credentialing and Recredentialing Process of the Plan.

Plan Notification Requirements for Providers

The following changes must be reported to Longevity Health Plan via email to your assigned Provider Relations Representative and networksupport@longevityhealthplan.com within the timeframe outlined in the Provider Agreement:

- Practice address
- Billing address
- Fax or telephone number
- Hospital affiliations
- Practice name
- Provider joining or leaving the practice (including retirement or death), including change effective date.
- Provider taking a leave of absence.
- Practice mergers and/or acquisitions
- Adding or closing a practice location
- Tax Identification Number (please include W-9 form)
- Individual and/or group NPI number changes and additions
- Changes in practice office hours, practice limitations, or gender limitations
- Open or closed provider panel status changes
- Office Hour updates

Providers should send updates promptly or prior to the effective date of the change but at a minimum are required to send updates at least monthly but no longer than every 90 days. By providing this information promptly, you will ensure your practice is listed correctly in the Provider Directory.

Closing Patient Panels

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

Access and Availability Standards for Providers

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

Provider Responsibility

Longevity Health Plan members have access to care 24 hours a day, seven (7) days a week as medically necessary. Longevity has additional policies in place to make sure members have timely access to regular and routine care services, urgent care services, preventative care, network providers, women's health services or after-hours care.

PCPs are required to:

- Provide routine, preventive care, and monitoring visits for their assigned members on-site at the member's nursing facility residence every 60 days for all assigned members and more frequently (every 30 days) for members identified as a moderate or high risk. Routine care calls returned by the end of the day.
- Provide routine visits for non-urgent new onset symptoms or conditions or condition exacerbations within one week (7 days) on-site at member's nursing facility residence.
- Provide within 48 hours urgent and emergent care on-site at member's nursing facility residence or in the physician's office or telephonically in coordination with the Longevity Nurse Practitioner.
- Provide 24 hours a day, 7 days a week telephonic access for medically necessary member care, with approved and contracted physician coverage during time off (call coverage), with emergency/urgent

care calls, both weekdays and after-hours.

Specialists are required to:

- Be available for a consult or new patient appointment within 21 days of the initial request and to be immediately available to PCPs for an urgent or emergent consult regarding a member.
- Provide telephone Access (applicable to all contracted providers regarding calls from members, members' caregivers, Longevity Health Plan PCP, Longevity Health Plan Medical Director and Utilization Management staff, and nursing home facility staff):
- Immediately address emergency care calls, both weekdays and after-hours, and urgent care calls, both weekdays and after-hours calls, returned within 1 hour.
- Return routine care calls, both weekdays and after-hours calls within 1 hour. All calls must be answered promptly by the provider, provider staff and/or a reliable paging service or answering service.

Behavioral Health providers are required to:

- Provide non-life-threatening emergency care within 6 hours.
- Provide urgent care within 48 hours.
- Provide a consult or new patient appointment within 10 days of the initial request.
- Provide follow-up routine care within 21 days.

Dual Eligibles and Cost Sharing

Enrollees eligible for both Medicare and Medicaid, cannot be held liable for Medicare Part A and B cost sharing when the State is responsible for paying such amounts. Providers will be informed of Medicare and Medicaid benefits and rules for enrollees eligible for Medicare and Medicaid. Provider may not impose cost-sharing that exceeds the amount of cost-sharing that would be permitted with respect to the individual under Title XIX if the individual were not enrolled in such a plan.

Providers must:

- Accept the MA plan payment as payment in full, or
- Bill the appropriate State source. [42 C.F.R. §§ 422.504(i)(3)(i) and 422.504(g)(1)(i)]

Patient Hold Harmless

Participating Providers are prohibited from balance billing Longevity Health Plan members. This

prohibition includes, but is not limited to, situations involving non-payment by Longevity, insolvency of Longevity Health Plan or Longevity's breach of its Agreement. Providers shall not bill, charge, collect a deposit from, seek compensation or reimbursement from, or have any recourse against members or persons, other than Longevity Health Plan, acting on behalf of members for Covered Services provided pursuant to the Participating Provider's Agreement. The provider is not, however, prohibited from collecting copayments, coinsurances, or deductibles for covered services in accordance with the terms of the applicable member's Benefit Plan, or for collecting payment when rendering non-covered services if the provider complies with the requirements of the non-covered services section of this Provider Manual.

Non-Covered Services

Providers may only collect fees from members for non-covered services when the member has been provided with a standardized written Organization Determination (OD) denial notice from Longevity Health Plan prior to the item or service being rendered to the member, or if the member's EOC clearly states the item or service is a non-covered service.

In circumstances where there is a question whether the plan will cover an item or service,members have the right to request an OD prior to obtaining the service from the provider. If coverage is denied, Longevity Health Plan provides the member with a standardized written OD denial notice which states the specific reasons for the denial and informs the member of his or her appeal rights. In the absence of the appropriate Longevity OD denial notice or a clear exclusion in the EOC, the member must be held harmless (i.e., cannot be held financially liable for the charges).

When a provider knows or believes that a service or item is not covered under the member's benefit, and the EOC does not explicitly state the item or service as non-covered, the provider must advise the member to request a pre-service OD from Longevity Health Plan or the provider can request the OD on the member's behalf before the provider proceeds with rendering the services, providing the item, or referring the member to another provider for the non- covered item or service.

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

Network Access Monitoring and Compliance

Using valid methodology, Longevity Health Plan will collect and perform regular analyses of provider data to measure performance against our written standards. Examples of measurement metrics include:

- Patient Access and Availability (especially across key specialties such as infectious disease, cardiology, pulmonology)
- Appropriate after-hours availability and responsiveness to both routine and urgent calls
- Member satisfaction
- Periodic surveys of ISNP Skilled Nursing Facilities conducted by Longevity Health Plan

In addition to regularly scheduled performance measurement, Longevity will review monthly utilization reports to track utilization trends and identify significant changes in utilization that may indicate an issue. Complaints related to access to care (provider or after hours) are collected through the Longevity Customer Service line or submissions to the Quality Improvement Committee. Access complaints are analyzed quarterly and reported through the Quality Improvement Committee with immediate action taken to rectify situations where access may cause harm to a member.

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

Provider Marketing Guidelines

CMS has advised Medicare Advantage plans to prohibit providers from steering or attempting to steer an undecided potential enrollee toward a specific plan or limiting to several plans offered either by the plan sponsor or another sponsor based on the financial interest of the provider or agent. Providers should remain neutral parties to the extent they assist beneficiaries with enrollment decisions.

Below are general guidelines to assist you in determining what marketing and patient outreach activities are permissible under CMS guidelines. Please consult the CMS Marketing Guidelines or other CMS published materials for the full list of acceptable and unacceptable provider behaviors.

Providers Can:

- Suggest looking into plan membership as a matter of course in treatment.
- Collect a Permission to Contact if a resident/responsible party voices interest in learning more about the plan.
- Pass a Permission to Contact to a sales agent.
- Mail or provide a letter to patients notifying them of their affiliation with Longevity Health Plan.

- Provide objective information to patients on specific plan attributes and formularies, based on a patient's medications and health care needs while treating the patient.
- Answer questions or discuss the merits of a plan or plans, including cost sharing and benefit information (these discussions may occur in areas where care is delivered).
- Refer patients to other sources of information, such as the State Health Insurance Assistance Programs (SHIPs), Longevity Health Plan marketing representatives, State Medicaid, or 1-800-Medicare to assist the patient in learning about the plan and making an enrollment decision.
- Provide beneficiaries with communication materials furnished by Longevity Health Plan in a treatment setting.
- Refer patients to the plan marketing materials available in common areas. Display and distribute Longevity marketing materials in common areas. The office must display or offer to display materials for all participating Medicare Advantage plans if requested by the plan.
- Provide information and assistance in applying for the Low-Income Subsidy.
- Allow Longevity Health Plan to have a room/space in provider offices separate from where patients receive health care services to provide Medicare beneficiaries with access to a Longevity sales representative.

Providers Cannot:

- Offer anything of monetary value to induce enrollees to select them as their provider.
- Distribute marketing materials/applications in an exam room.
- Urge or steer toward any specific plan or a limited set of plans based on the providers.

own interest.

- Collect/accept enrollment applications or scope of appointment forms on behalf of the plan.
- Offer inducements to persuade beneficiaries to enroll in a particular plan or organization.
- Health Screen potential enrollees when distributing information to patients, health screening is prohibited.
- Expect compensation directly or indirectly from the plan for beneficiary enrollment activity.
- Call members who are disenrolling from the health plan to encourage re-enrollment in a health plan.

- Call patients to invite patients to the sales and marketing activities of a health plan.
- Advertise using Longevity Health Plan's name without Longevity's prior consent and potentially CMS approval depending upon the content of the advertisement.

Member Assignment to New PCP

PCPs can receive regular updates of member assignments and related services and benefits by calling Client Services. Longevity Health Plan's PCPs have a limited right to request a member be assigned to a new PCP. A provider may request to have a member moved to the care of another provider due to the following behaviors:

- Fraudulent use of services or benefits. The member is disruptive, unruly, threatening, or uncooperative to the extent his/her membership seriously impairs the provider's ability to provide services to the member, and a physical or behavior health condition does not cause the behavior mentioned above.
- Threats of physical harm to a provider and/or his/her office staff.
- Non-payment of required patient share responsibility for services rendered to members who are not Dual Eligibles (Medicare and Medicaid).
- Receipt of prescription medications or health services in a quantity or manner which is not medically beneficial or not medically necessary.
- Repeated refusal to comply with office procedures essential to the functioning of the provider's practice or to accessing benefits under the managed care plan.

The provider should make reasonable efforts to address member behavior that has an adverse impact on the patient/physician relationship through education and counseling, and if medically indicated, referral to appropriate specialists.

A member also may request a change in PCP for any reason. A PCP change requested by a member will be effective the first (1st) day of the month following receipt of the request unless circumstances require an immediate change.

Quality of Care Concerns

Longevity Health Plan is committed to ensuring members receive quality care according to recognized standards of care. Quality of Care concerns may include specific Clinical Quality Indicators and Quality of Care Complaints. Quality Indicators are defined as an adverse outcome occurring in any care setting indicative of potential inappropriate or incomplete medical care. Quality of Care Complaints are those

concerns reported by members, families or providers indicating a potential problem in the provision of quality care and services.

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

- Unplanned readmission to the hospital (within 30 days).
- Inpatient hospitalization following outpatient surgery.
- Post-operative complications (including an unplanned return to the Operating Room).
- Unplanned removal, injury or repair of organ or structure during the procedure (excludes incidental appendectomy).
- Avoidable incidences resulting in injury to the member.
- Mortality review (in cases where death was not an expected outcome).

Quality complaints are categorized as:

- Access to care
- Availability of services
- Clinical quality concerns
- Provider/staff concerns

Longevity reviews and tracks all reported Quality of Care concerns are reviewed and tracked and we often request records from providers and facilities as part of the process. The Quality Improvement Committee reviews trends related to Quality-of-Care concerns and may recommended actions to prevent future instances. Any action taken based on severity or trend is documented in the health plan provider record and reviewed by the Credentialing Committee at the time of re- credentialing.

Quality Improvement Program

The purpose of the Quality Improvement Program (QI Program) at Longevity Health Plan is to take a proactive approach to assure quality care and continually improve the way we provide care and engage with members, partners, and other stakeholders. In the implementation of the QI Program, Longevity will be an agent of change, promoting innovations throughout our organization, sites of care, and in the utilization of resources, including technology, to deliver health care services to meet the needs of our target population. The QI Program is designed to monitor and evaluate the quality, appropriateness and outcomes of

care/services delivered to Longevity members and to provide mechanisms for continuous improvement and problem resolution objectively and systematically.

Quality improvement activities include the following:

- Monitoring/review of provider accessibility and availability.
- Monitoring/review of member satisfaction/grievances.
- Monitoring/review of member safety.
- Monitoring/review of continuity and coordination of care.
- Clinical measurement and improvement monitoring of the SNP Model of Care and all QI activities.
- Documentation, analysis, re-measurement, and improvement monitoring of member health outcomes utilizing the Align360 care management platform.
- Chronic Care Improvement Program (CCIP).
- Collection and reporting of Healthcare Effectiveness Data and Information Set (HEDIS).
- Participation and analysis of the Health Outcomes Survey (HOS) and Consumer Assessment of Health Plan (CAHPS) Survey, if required.
- Credentialing and re-credentialing.
- Provider peer review oversight.
- Clinical practice guidelines.
- Monitoring and analysis of under and over-utilization.
- Monitoring and analysis of adverse outcomes/sentinel events.
- Collection and reporting of Part C Reporting Elements.
- Collection and reporting of Part D Medication Management data.

The PCP plays an active role in making sure members receive the best care. Each year, Longevity Health Plan will evaluate past performance and implement improvement activity. Providers and members may request a copy of the Quality Improvement Program or Annual Evaluation at any time.

Clinical Practice Guidelines

The following clinical practice guidelines are intended to support our health care team and serve as resources

to ensure our providers have the most up-to-date, evidence-based information recommended by nationally recognized organizations. AMDA – The Society for Post-Acute and Long-Term Care Medicine - This is the standard care process in the post-acute and long-term care (PA/LTC) setting. The most up to date clinical practice guideline can be found on the plan website at www.longevityhealthplan.com.

- **COPD:** Global Strategy for the Diagnosis, Management and Prevention of COPD.
- **Diabetes:** Standards of Medical Care in Diabetes - 2021 with a particular focus on chapter 12: Older Adults.
- **Heart Failure:** 2017 focused update of the 2013 Guidelines for the Management of Heart Failure.
- **Hypertension:** ACC and American Heart Association (AHA) guidelines for the detection, prevention, management and treatment of high blood pressure.
- **Dementia:** Alzheimer's Association Dementia Care Practice Recommendations and American Psychiatric Association – Practice Guidelines on the use of Antipsychotics to Treat Agitation or Psychosis in Patients with Dementia.
- **Osteoporosis:** 2020 Clinical Practice Guidelines for Postmenopausal Osteoporosis.
- **Depression:** American Psychiatric Association (APA) (2019). APA Guideline For the Treatment of Depression. Clinical Practice Guideline for the Treatment of Depression Across Three Age Cohorts.
- **Preventive:** World Health Organization, Preventing and managing COVID-19 across long- term care services: Policy brief, 24 July 2020 and Centers for Disease Control and Prevention (2020). Prevention and Control of Seasonal Influenza with Vaccines: Recommendations of the Advisory Committee on Immunization Practices — United States, 2020–21 Influenza Season.

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

Utilization Reporting and Monitoring

Under- and over-utilization may indicate inadequate coordination of care or inappropriate utilization of services. Both under- and over-utilization may be harmful to the patient. Utilizing data from provider and practitioner sites, individual product lines, and the system as a whole. Longevity Health Plan monitors for under- and over-utilization, analyzes data to identify the causes, and takes action to correct any issues identified. We then implement appropriate interventions whenever potential problems are identified and

will further monitor the effect of these interventions. Longevity also carefully ensures that incentives are aligned to encourage appropriate decisions on the delivery of care to members. Longevity unequivocally promises members, providers, and employees that it does not employ incentives to encourage barriers to care and service.

Member Rights

Advance Medical Directives

The Federal Patient Self-Determination Act ensures the patient's right to participate in health care decision-making, including decisions about withholding resuscitative services or declining/withdrawing life sustaining treatment. Through guidelines established by the CMS, HEDIS requirements, and our policies and procedures, Longevity requires all participating providers to have a process in place under the intent of the Patient Self-Determination Act. All providers contracted directly or indirectly with Longevity may be informed by the member that the member has executed, changed, or revoked an advance directive. At the time a service is provided, the provider should ask the member to provide a copy of the advance directive to be included in his/her medical record. If the PCP and/or treating provider cannot, as a matter of conscience, fulfill the member's written advance directive, the PCP must advise the member and Longevity Health Plan at which time Longevity and the PCP and/or treating provider will arrange for a transfer of care. Participating providers may not ration the provision of care or otherwise discriminate against an individual based on whether the individual has executed an advance directive. However, nothing in the Patient Self-Determination Act precludes the right under state law of a provider to refuse to comply with an advance directive as a matter of conscience. To ensure providers maintain the required processes to advance directives, Longevity conducts periodic patient medical record reviews to confirm the required documentation exists.

Additional Rights

Treatment with Dignity and Respect.

Members are afforded appropriate privacy and treated with respect, consideration, and dignity. Members have the right to be treated with dignity, respect, and fairness at all times. Longevity Health Plan and its contracted providers must obey the laws against discrimination to protect members from unfair treatment. These laws say Longevity and its contracted providers cannot discriminate against members because of a person's race, disability, religion, gender, sexual orientation, health, ethnicity, creed, age, or national origin. Providers may not discriminate against enrollees based on their payment status or refuse to serve enrollees because they receive assistance with Medicare cost-sharing from a

State Medicaid program. If members need help with communication, such as a language interpreter, they should be directed to call the Member Services Department. The Member Services Department can also help members in filing complaints about access to facilities (such as wheelchair access).

Members can also call the Office for Civil Rights at 1-800-368-1019 or TTY/TDD 1-800-537-7697,or the Office for Civil Rights in their area for assistance.

See Participating Providers, Receive Covered Services, and Have Prescriptions FilledPromptly.

Members will get most or all their health care from participating providers—the doctors and other health providers who are part of Longevity Health Plan. Members have the right to choose a participating provider. Longevity will work with members to ensure they find physicians who are accepting new patients. Members have the right to go to a women's health specialist (such as a gynecologist) without a referral. Members have the right to timely access to their providers and to see specialists when care from a specialist is needed. Members also have the right to access their prescription benefit promptly. Timely access means members can obtain appointments and services within a reasonable amount of time. The Evidence of Coverage (EOC) explains how members access participating providers to get the care and services they need. It also explains their rights to receive care for a medical emergency and urgently needed care.

Know About Treatment Choices and to Participate in Decisions About Their Health Care.

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

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

Members have the right to refuse treatment, including the right to leave a hospital or other medical facility

even if their doctors advise them not to leave, and the right to stop taking their medication. If members refuse treatment, they accept responsibility for what happens as a result of refusing treatment.

Make Complaints.

Members have the right to file a complaint if they have concerns or problems related to their care or coverage. Members or an appointed/authorized representative may file appeals or grievances regarding care or coverage determinations. If members make a complaint or file an appeal determination, Longevity Health Plan must treat them fairly and not discriminate against them because they made a complaint or filed an appeal or coverage determination.

Members should be directed to call the Member Services Department to obtain information relative to appeals, grievances, or concerns and/or coverage determinations.

Receive Complete and Accurate Health Information.

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

Corporate Compliance Program

Overview

The purpose of Longevity Health Plan's Corporate Compliance Program is to articulate Longevity's commitment to compliance with all pertinent regulatory requirements. It also serves to encourage our employees, providers and other contractors, and other interested parties to develop a better understanding of the laws and regulations that govern Longevity Health Plan's operations. Further, Longevity's Corporate Compliance Program also ensures all practices and programs are compliant with applicable laws and regulations.

Longevity Health Plan and its subsidiaries are committed to full compliance with federal and state regulatory requirements applicable to our Medicare Advantage and Medicare Part D lines of business. Non-compliance with regulatory standards undermines Longevity's business reputation and credibility with the federal and state governments, subcontractors, pharmacies, providers, and most importantly, its members. Longevity and its employees are also committed to meeting all contractual obligations outlined in our contracts with the CMS. These contracts allow Longevity to offer Medicare Advantage and Medicare Part D products and services to Medicare beneficiaries.

The Corporate Compliance Program is designed to prevent violations of federal and state laws governing

Longevity Health Plan's lines of business, including but not limited to, health care fraud, waste, and abuse laws. In the event such violations occur, the Corporate Compliance Program will promote early and accurate detection, prompt resolution and, when necessary, disclosure to the appropriate governmental authorities.

Longevity Health Plan has in place policies and procedures for coordinating and cooperating with the MEDIC (Medicare Drug Integrity Contractor), CMS, State Regulatory Agencies, Congressional Offices, and law enforcement. We also have policies ensuring we will cooperate with any audits conducted by CMS, the MEDIC or law enforcement or their designees.

If you have compliance concerns or questions, call the Longevity Health Plan Compliance Hotline toll-free at 1-855-969-5859.

Fraud, Waste and Abuse

Longevity Health Plan has policies and procedures to identify fraud, waste, and abuse, as well as other processes to identify overpayments within its network and to properly recover such overpayments. These procedures allow Longevity to report potential fraud or misconduct related to the Medicare program to the appropriate government authority as specified at 42 U.S.C. § 1395w-104 and 42 C.F.R. § 423.504(b)(4)(vi)(H). Longevity Health Plan has policies and procedures in place for cooperating with CMS and law enforcement entities.

The evaluation and detection of fraudulent and abusive practices by Longevity Health Plan encompasses all aspects of Longevity Health Plan business and its business relationship with third parties, including health care providers and members. All employees, contractors and other parties are required to report compliance concerns and suspected or actual misconduct without fear of retaliation for reports made in good faith. The Compliance Officer may be contacted in the following manner:

- Anonymously by calling the toll-free Compliance Hotline at 1-855-969-5859
- By email to compliance@longevityhealthplan.com
- By mail to Corporate Compliance Officer, Longevity Health Plan, 11780 U.S. Highway One, Suite #N107, Palm Beach Gardens, FL 33408

The Compliance Hotline is a completely confidential resource for employees, contractors, agents, members, or other parties to voice concerns about any issue potentially affecting Longevity Health Plan's ability to meet legal or contractual requirements and/or to report misconduct that could give rise to legal liability if not corrected.

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

Also, as part of an ongoing effort to improve the delivery and affordability of health care for our members, Longevity Health Plan conducts periodic analyses of all levels of Current Procedural Terminology (CPT), ICD-9/ICD-10 and HCPCS codes billed by our providers. The analysis allows Longevity Health Plan to comply with its regulatory requirements for the prevention of fraud, waste, and abuse (FWA), and to supply our providers with useful information to meet their own compliance needs in this area. Longevity Health Plan will review coding and may review medical records of providers who continue to show significant variance from their peers.

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

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

You may request a copy of the Longevity Health Plan Compliance Program document by contacting Longevity Health Plan Provider Services via email at compliance@longevityhealthplan.com or by calling your state-specific provider services telephone number.