



PROVIDER RESOURCES • PLAN YEAR 2027

Provider Manual

Plan	Native Advantage (HMO)
Contract	H2851
Plan Year	2027
Audience	Participating Providers
Service Area	11 counties in northeastern Oklahoma

PROVIDER SERVICES

1-888-230-4214 (TTY 1-888-230-4215)

<https://www.nativeadvantage.com>

Native Advantage is a Health Maintenance Organization (HMO) with a Medicare Contract. Enrollment in Native Advantage depends on annual contract renewal. Native Advantage is offered by Native Advantage, Inc., a subsidiary of the Muscogee (Creek) Nation.



Table of Contents

1. Overview	3
2. Reference Guide & Helpful Links	4
Quick Reference and Contacts · Provider Portal · Availability	
3. Provider Roles and Responsibilities	8
Participation · Provider Referrals · Provider Responsibilities · Medical Records Information · Access to Care	
4. Member Eligibility and Covered Services	24
Eligibility and Benefits · Covered Services · Behavioral Health	
5. Pharmacy Benefits	27
Prescription Drugs · Pharmacies · Medication Management	
6. Utilization Management and Quality Improvement	31
Utilization Management · Prior Authorization Tools · Quality Improvement Program	
7. Initial Decisions, Appeals and Grievances	36
Initial Decisions · Appeals	
8. Care Management	40
9. Claims and Billing	43
Claims Process · Claims Submission Information	
10. Members' Rights and Responsibilities	46
Members' Rights · Members Responsibilities	
11. Plan Responsibilities	49
Plan Responsibilities to Members · Plan Responsibilities to CMS · Glossary	

Native Advantage developed this manual to make it easier for you as a participating provider to find important information that will help as you serve our members.

Native Advantage will keep you informed of changes in our policies, procedures, and benefits.

Section 1: Overview

Overview Introduction

We are proud to introduce the first tribally owned Medicare Advantage HMO plan in the United States, established by the Muscogee (Creek) Nation. Dedicated to serving the healthcare needs of our members across Oklahoma, Native Advantage, Inc. is committed to delivering high quality, accessible care that honors our cultural heritage while embracing modern innovation. We believe your expertise and services are a valuable addition to our unique plan and network.

Our Commitment to Excellence

At Native Advantage, Inc., we prioritize culturally sensitive care tailored to the needs of Native American communities and all eligible members. Our plan goes beyond standard Medicare benefits to include:

- Enhanced Accessibility: Low or no copays for in-network services.
- Wellness Focus: Programs for diabetes management, heart health, and traditional wellness practices.
- Prescription Coverage: Integrated Part D benefits with a robust formulary to
- minimize costs.

We are dedicated to being the best plan of choice by fostering strong partnerships with providers like you, ensuring members receive compassionate, effective care close to home.

Native Advantage (HMO)- The Network

Native Advantage (HMO) is a Medicare Advantage plan. HMO stands for health maintenance organization.

Native Advantage (HMO) - The Service Areas

We market our Native Advantage (HMO) plans to people eligible for Medicare Part A and B who live in the following approved service areas and counties in the state of Oklahoma:

- Creek County
- Muskogee County
- Seminole County
- Hughes County
- Okfuskee County
- Tulsa County
- Mayes County
- Okmulgee County
- Wagoner County
- McIntosh County
- Rogers County

Section 2: Reference Guide & Helpful Links

Quick Reference Guide and Contact Info

General Info for Providers

Providers can visit <https://www.nativeadvantage.com/providers> for a range of helpful information. The webpage gives you access to:

- Details on prior authorization and other requirements to ensure our members get the right care, at the right time, in the right setting.
- A link to a Quick Reference webpage that gives providers vital information in one place
- A link to provider news and updates

Providers may also call Provider Services at **1-888-230-4214** to reach a live representative Monday through Friday at 8 a.m. CST to 5 p.m. CST.

Provider Services will be closed when the following holidays fall on a routine business day (Monday – Friday).

New Years Day (January 1)

Independence Day (July 4)

Thanksgiving Day (Fourth

Memorial Day (Last Monday in
May)

Labor Day (First Monday in
September)

Thursday in November)

Christmas Day (December 25)

Provider Portal

The Portal will allow you to

- Verify eligibility.
- Review Member demographics.
- View benefit information.
- Create Referrals.
- Check Prior Authorization/Referral review status.
- Check claim status.

The Portal is available 24 hours a day, 7 days a week. You may access information about the Portal on the Providers menu at <https://www.nativeadvantage.com/providers/provider-portal>.

Availity

The Availity portal helps providers and Native Advantage securely share information easily and efficiently. As a registered Availity user, you can quickly check our members' eligibility and benefits, submit prior authorization requests, check claim status, and obtain provider claim summaries. These services are available online through the Native Advantage provider portal at

<https://www.nativeadvantage.com/providers/provider-portal>, allowing you to access the information you need without having to call Native Advantage.

Prior Authorization Forms

Prior Authorization form is available at

<https://www.nativeadvantage.com/providers/prior-authorizations>

For additional information, please refer to Section 6.

Appointment Wait Time Standards

To meet or exceed CMS's standards Native Advantage's written standards for appointment wait times for primary care and behavioral health services must meet or exceed the minimum standards as follows:

- Urgently needed services or emergency – immediately.
- Services that are not an emergency or urgently needed, but the enrollee requires medical attention—within 7 business days; and
- Routine and preventive care—within 30 business days.

APPEALS

Pre-Service Appeals Process

Native Advantage administers a pre-service appeals process for denied or partially denied benefit prior authorization requests. When submitting a pre-service appeal, always follow the directions included within the denial letter.

Submit your request and support documentation by mail or fax.

Mailing Address

Native Advantage, Inc.
PO Box 20928
Tampa, FL 33622

For expedited appeals, call

- Individual plans: 1-888-230-4214
- TTY: 1-888-230-4215
- Fax: 918-526-5824

PRESCRIPTION DRUGS

Navitus Call 1-866-270-3877 (TTY 711)

Service representatives are available 24 hours a day, 7 days a week, 365 days a year. Interpreter services are available at no cost to assist members who speak languages other than English, ensuring access to support and plan information.

Refer to Section 5 for more information.

SUPPORT

Provider Network Team are representatives that serve as the liaison between the Native Advantage plan and our provider community.

MEDICARE INFO

The Medicare coverage webpage at <http://www.cms.gov/center/coverage.asp> is where you can learn more about National Coverage Determinations and through program manuals at <http://cms.hhs.gov/manuals/> Medicare Outpatient Observation Notice (MOON)

Hospitals and critical access hospitals (CAH) are required to provide a MOON to Medicare beneficiaries (including MA/MAPD plan enrollees) informing them that they are outpatients receiving observation services and are not inpatients of a hospital or CAH. For additional CMS guidance, visit <https://www.cms.gov/medicare/forms-notices/beneficiary-notices-initiative/ffs-ma-moon>.

Dental and Vision

PCPs can also assist with referrals to dental and vision care.

For dental care- [NationsBenefits | Dental Benefit Programs](#)

For routine vision care - [VSP Vision Care | Vision Insurance](#)

To obtain a copy of the latest VSP Network Doctor list, or by contacting VSP's Member Service Department via the toll-free Customer Service telephone number at **1-855-492-9028**, or by submitting a written request to Member Service, VSP, P.O. Box 997100, Sacramento, CA 95899-7100.

Frequently Asked Questions

- **How can I verify a patient's eligibility and benefits under Native Advantage?**

You can verify a patient's eligibility and benefits through the Provider portal. You may also call Provider Services at **1-888-230-4214**.

Hours of operation:

8 a.m. - 8 p.m. 7 days per week, October – March

8 a.m. - 8 p.m. Monday – Friday, April – September

- **What is the process for submitting a claim and receiving reimbursement?**

You can submit a claim electronically through the Provider portal. You can also file a paper claim through the mail. Please refer to Section 9 for more information

- **How do I obtain or verify prior authorization?**

You can use the Provider portal to submit a prior authorization request. You may also call Provider Services, at **1-888-230-4214**, and choose the option for "Prior Authorization" or the "Utilization Management" department. Staff will assist you with prior authorizations or other related questions.

- **How do I check the status of a claim?**

You can check the Provider portal or contact Provider Services, at **1-888-230-4214**, for claim status including claim denial information.

- **How do I fix the issues with a denied claim?**

You can submit a corrected claim by mail at the claims address in the Reference Guide section or by fax at **918-526-5824**. If additional assistance is needed, contact the Provider Network Team at **1-888-230-4214**.

- **How do I monitor the status of a dispute?**

You may contact Provider Services, at **1-888-230-4214**, to check on the status of an appeal.

- **Are there specific requirements for referrals to specialists (SCP) within the network?**

Members are not required to have their PCP refer them to an SCP or other network providers. Although referrals are not required for specialist visits, certain specialist services may require prior authorization. The categories listed are high-level and are intended to provide general guidance. Visit In-network providers referrals to learn more.

- **How can I find in-network providers?**

You can find in-network providers on our website <https://www.nativeadvantage.com/find-care>

Section 3: Provider Roles and Responsibilities

Participation in Native Advantage Plan

Participation Requirements

To participate in the Native Advantage care provider:

- Must be a participating Native Advantage health care provider
- Must have privileges at a hospital contracted with Native Advantage plan.

The exception: This is not required if inpatient admissions are uncommon or not required by Native Advantage plan for the participating health care provider's specialty.

- Must have a valid National Provider Identifier (NPI) number
- Must sign Native Advantage's agreement/amendment
- Cannot have opted out of Medicare or have any sanctions or reprimands by any licensing authority or review organizations. This means:
- Participating providers cannot be named on the federal Office of the Inspector General List of Excluded Individuals-Entities, the National Practitioner Databank, or the Government Services Administration List of Parties Excluded from Federal Procurement and Non-Procurement Programs. These lists identify health care providers found guilty of fraudulent billing, misrepresentation of credentials, patient abuse or neglect, financial misconduct, or similar offenses.
- Participating providers cannot be sanctioned by the federal Office of Personnel Management or prohibited from participation in the Federal Employees Health Benefit Program.

Credentialing and Recredentialing of Participating Health Care Providers

Native Advantage will continuously credential and recredential participating providers every three years. Credential guidelines are subject to change based on industry requirements and Native Advantage's standards.

Credentialing and Recredentialing of Participating Institutional Providers

Native Advantage will continuously credential and recredential Institutional providers every three years.

Credential guidelines are subject to change based on industry requirements and Native Advantage's standards.

Appeals Process for Health Care Provider Participation Decisions

If Native Advantage decides to suspend, terminate or non-renew a provider's participation status, we will give the affected provider written notice of the reasons for that action. Those reasons may include the standards and profiling data used to evaluate the provider. Reasons may also include the number of members a provider serves and the specialty mix of providers Native Advantage plan needs.

If a reduction, suspension, or termination of a provider's participation is final and is the result of quality-of-care deficiencies, Native Advantage will notify the National Practitioner Data Bank and any other applicable licensing or disciplinary body to the extent required by law.

Notification to Members of Health Care Provider Termination

Native Advantage plan will make a good faith effort to provide written notice of a participating provider's termination to all members seen regularly by that provider within 30 days of when it becomes effective. That notice will come regardless of the reason for the termination.

Native Advantage plan will give the participating provider written notice of their right to appeal the action to a hearing panel. We will also detail the process and timing for requesting a hearing. A majority of the hearing panel members will be providers in the same medical discipline as the affected provider. A recommendation by the hearing panel is advisory and is not binding on Native Advantage plan.

If a reduction, suspension, or termination of a provider's participation is final and is the result of quality-of-care deficiencies, Native Advantage will notify the National Practitioner Data Bank and any other applicable licensing or disciplinary body to the extent required by law.

PROVIDER ROLES

Definitions of Provider Types

- **Primary Care Provider (PCP):** Each member chooses a PCP to coordinate their health care. A PCP is a patient's first point of contact when a patient has a health concern. A PCP can be a family practice physician, general practice physician, internal medicine physician, geriatric physician, pediatric physician, advanced nurse practitioner, physician assistant.
- **Specialty Care Provider (SCP):** An SCP is a health care provider who has a specialty outside of internal medicine, family practice medicine, pediatrics, geriatrics, obstetrics, and gynecology.

Role of PCP

A participating provider who has contracted Native Advantage as a PCP will agree to render a member's primary, preventive, acute and chronic health care management. The provider will also:

- Provide the same level of care to Native Advantage (HMO) patients as provided to all other patients.
- Provide urgent care and emergency care, or coverage for such care, 24 hours per day and seven days per week. A PCP will use a verifiable mechanism that can immediately direct patients to alternative after-hours care, if needed. Acceptable mechanisms may include:
 - An answering service that offers to call or page the provider or on-call provider.
 - A recorded message that directs the patient to call an answering service, with the phone number provided.
 - A recorded message that directs the patient to call or page the provider or on-call provider, with the phone number provided.
- Always available to hospital emergency room personnel for emergency care treatment and post stabilization treatment to members. Such requests must be responded to within one hour.
- Make arrangements for patient coverage when the provider is unavailable. (See Backup PCPs section.)
- Provide copies of radiology, laboratory, and other health records to SCPs to enhance continuity of care and to prevent duplication of diagnostic procedures
- Keep a central record of the member's health and health care that is complete and accurate. (See Medical Records section.)
- Follow Health Insurance Portability and Accountability Act (HIPAA) guidelines when sharing any Protected Health Information (PHI) of a member. (See Medical Records section.)
- Provide copies of medical records when requested by Native Advantage
- Enter into the member's health record all reports received from SCPs
- Arrange and get prior authorization for hospital admissions in which the provider is the admitting health care provider. The provider can also delegate this responsibility to the admitting SCP
- Assume care management as soon as possible after receiving information that a member who the provider serves as PCP has been hospitalized in the local area on an emergency basis
- Refer the member to SCPs within the Native Advantage Provider Network
- Work with Native Advantage to coordinate covered services for members and in the collection of third-party payments. Such payments might include workers' compensation and other third-

party liability. Participating providers agree to file claims information to Native Advantage even if the provider believes there is third-party liability for the claim.

IMPORTANT INFORMATION ABOUT PROVIDER REFERRALS

In-network Referrals

Members are not required to have their PCP refer them to an SCP or other network providers. Although referrals are not required for specialist visits, certain specialist services may require prior authorization. The categories listed are high-level and are intended to provide general guidance.

Members and PCPs coordinating care can check our webpage at <https://www.nativeadvantage.com/find-care> for assistance in locating an in-network SPC or other provider.

Out-of-network Referrals Required

A member may need to use a non-participating specialty provider because they cannot find an appropriate provider in-network or because of continuity-of-care concerns. In which case, the member must get a referral from the member's PCP to see a specialist outside of the Native Advantage network. In addition to the referral, the members must have prior authorization from Native Advantage to see an out-of-network specialist. Without prior authorization, claims will be denied.

Other Referral Guidance

A PCP may not make a referral to themselves, as an SCP, when treating a member who is already on their PCP list of patients.

There is one exception to this rule: Both Primary Care Providers (PCPs) and Specialty Care Providers (SCPs) may directly manage and coordinate a woman's care for obstetrical and gynecological conditions. They may also use the provider portal to refer members for OB-GYN-related specialty care and testing to other providers participating in the same network as the PCP.

If a PCP helps a member with a referral to an SCP or other specialist, the PCP should provide the SCP with the following information:

- Member's name
- Reason for consultation
- History of present illness
- Diagnostic procedures and results
- Pertinent medical history

- Current medications and treatments
- Problem list and diagnosis
- Specific information requested by SCP

After an SCP evaluates a member referred to them, the SCP should:

- Contact the referring PCP to discuss the member's condition and any recommendation for treatment or follow up care
- Send the referring PCP a consultation report that includes medical findings, test results, assessment, recommendations, treatment plan, and any other pertinent information
- Consult with the PCP if the SCP believes the member should be seen by another SCP for care coordination. The SCP should not directly refer the member to another SCP.

If a member or provider has questions about referrals, they can contact Member Services at **1-888-230-4214**.

PCPs can also assist with referrals to dental and vision care.

- For dental care - Nations' benefits **1-877-439-2665**
- For routine vision care - VSP - call **1-855-492-9028**

Role of SCP

A participating provider who performs services as an SCP is expected to perform many of the same duties and satisfy the same requirements as a PCP.

Similar duties and requirements include

- Providing the same level of care for all patients
- Providing urgent care and emergency care, with a mechanism to respond to patients after hours
- Making arrangements for patient coverage when the provider is unavailable
- Keeping patient records
- Working with Native Advantage in the collection of any third-party payments

SCPs also have other duties and responsibilities under Native Advantage plan:

- Accept referrals for members in accordance with the services and the number of visits requested by the PCP in the same Provider Network
- Report to the PCP upon completion of the consultation/treatment

- Provide copies of radiology, laboratory, and other health record information to the member's PCP, as appropriate
- Coordinate inpatient care with the PCP to avoid unnecessary visits by other doctors or providers
- Bill members only for copayments, cost share payments, and deductibles, where applicable. SCPs cannot offer to waive or accept lower copayments or cost shares or otherwise provide financial incentives to members. That includes not offering lower rates in lieu of the members' insurance coverage.
- Use their best efforts to participate with Native Advantage's Electronic Funds Transfer (EFT) and Electronic Remittance Advice (ERA) systems. Providers agree to use the systems under the terms and conditions set forth in the EFT Agreement and as described on the ERA enrollment form.
- Obtain a new authorization for services from the PCP if additional services or visits are needed beyond those first authorized by the PCP
- If authorized by the PCP, arrange for the hospital admission of the member into a participating facility. This should happen through the Native Advantage's utilization management department. SCPs must complete the steps required by Native Advantage to authorize admission.

SCP as a PCP

Any SCP who provides medical services to a member with a chronic, disabling, or life-threatening illness may apply to the Native Advantage's medical director to be a PCP for said member.

Requirements for the application include:

- The request from the SCP must include certification of medical need, along with supporting documentation, and is signed by the member and the SCP interested in serving as the PCP.
- The SCP must meet Native Advantage's requirements for PCP participation.
- The SCP must be willing to coordinate all health care needs of the member and accept reimbursement from Native Advantage.

Provider Responsibilities

Backup PCPs

During the network application process, the PCP should designate a backup provider who can see patients on behalf of the PCP when the PCP is unavailable. The covering health care provider is responsible for filing a claim for any member seen on behalf of the PCP. The PCP's staff must report any upcoming changes in covering PCPs to the Native Advantage Provider team.

24-Hour Coverage

Native Advantage requires participating PCPs and SCPs to provide coverage for members 24 hours per day, seven days per week. When a health care provider is unavailable to provide services, the provider must ensure they have arranged for coverage from a backup PCP or SCP. Hospital emergency rooms or urgent care centers are not considered substitutes for providing round-the-clock member coverage.

Participating providers may refer to the Native Advantage Provider Directory to identify in-network providers who can assist with providing 24-hour coverage. Providers may also contact the Native Advantage Member Services Department using the phone number on the back of the member's ID card for additional assistance or information.

Sub-contractors Meet All Requirements

Participating providers must ensure any entity they contract with to deliver services to members meets all requirements of their contract with Native Advantage.

Panel Closure

Any individual PCP or medical group agrees to accept members who have selected or have been assigned to the PCP or medical group unless:

- The PCP or medical group notifies Native Advantage that the entire practice is closed to new patients.

The PCP or medical group must provide Native Advantage at least 90 days prior written notice of closing their practice to new members.

Primary Care Provider Responsibilities

All Native Advantage members must choose a Primary Care Provider (PCP). The PCP is the member's first contact for their healthcare needs. The PCP provides a broad range of services and coordinates other care when necessary.

- Manage the member's total healthcare program, which includes health supervision, basic treatment, initial diagnosis, management of chronic conditions, and preventive health services.
- Provide medical care coverage for assigned patient panel 24 hours a day, 7 days a week within Native Advantage's established network of contracted providers.
- Follow up with the member within 7 days of an emergency department visit or hospitalization.
- Coordinate healthcare with Specialty Care Providers (SCPs) or healthcare facilities when such care is needed, including submitting referrals. The PCP should always refer members to Native Advantage contracted providers and contracted facilities unless the services are not available.

The most current list of contracted providers can be found using the online Provider Directory search tool at <https://www.nativeadvantage.com/find-care>.

- Provide complete information on authorized care or services to the referred SCP.

Members will usually see their PCP first for most of their health care needs. Native Advantage members may see any network SCP without a referral, but when the PCP or SCP believes they need specialized diagnostic tests or treatment (such as therapy or outpatient surgery), a referral is required.

Native Advantage requires PCPs to practice in one of the following fields:

- Family Medicine
- General Medicine
- Internal Medicine
- Pediatrics
- Geriatrics

Internal Medicine physicians must spend at least 90% of their time practicing primary care to be eligible to contract with Native Advantage as a PCP.

Advanced Practice Registered Nurses (APRNs) acting as PCPs for Native Advantage members must follow all requirements set forth for PCPs, practice in a primary care setting with an appropriately certified and contracted supervising physician and provide care within the scope of their license. The PCP designation may only be applied to the PCP's primary tax identification number (TIN).

Members Changing PCP

Members can change their PCP at any time; however, the effective date will be the first day of the following month. Native Advantage recommends against members changing their PCP if the change could have an adverse effect on the quality of their healthcare. For example:

- The Member is an organ transplant candidate.
- The Member has an unstable, acute medical condition for which they are actively receiving medical care.

Specialty Care Provider and Other Practitioner Responsibilities

An SCP provides certain specialty medical care upon referral from the PCP. SCPs must:

- Accept and treat Native Advantage members referred by their PCP.
- Comply with all Native Advantage prior authorization requirements.
- Ensure Native Advantage has authorized services when required.
- If additional Medically Necessary tests or treatments are needed beyond those initially authorized, the SCP may seek additional authorization from Native Advantage and will notify the Member's PCP.

- Actively participate in coordination of care activities which may include obtaining the Member's signed authorization to share Protected Health Information (PHI) with other providers involved in their care.
- Always refer members to Native Advantage contracted providers and facilities. Native Advantage regularly monitors the network for access and availability. If you are unable to locate services in network, please notify Provider Relations.
- Use best efforts to communicate with the Member's PCP within 5 working days.

Hospital/Facility Responsibilities

Provide covered health care services to Native Advantage members 24 hours a day, 365 days a year. Obtain necessary authorizations from Native Advantage for non-emergent hospital admissions and continued in-patient stays. Notification is required within 24 hours of admission for all inpatient hospital stays including childbirth or emergencies.

In the event of a transfer, the receiving hospital is required to provide Native Advantage notification within 24 hours of admission. Verify hospital/facility and its personnel are duly licensed, certified, contracted providers and authorized to provide covered health care services to Native Advantage Members.

Contracted providers must be routinely monitored to ensure they are not excluded, precluded, or otherwise ineligible to participate in Medicare. Provide advance written notice to Native Advantage of any significant changes in the ability to provide covered health care services to Native Advantage members. Remain in compliance with applicable State and Federal requirements, Medicare Conditions of Participation, and The Joint Commission (TJC) accreditation standards or equivalent. Provide copies of CMS or State surveys and accreditation status to Native Advantage when updated.

Provider Accessibility

All contracted providers are required to provide services, both clinical and non-clinical, that are readily available, accessible, and appropriate, when medically necessary to all enrollees, including those with limited English proficiency or reading skills and those with diverse cultural and ethnic backgrounds.

Services must be provided in a culturally competent manner and must give equitable access to all enrollees, including the following: people of ethnic, cultural, racial, or religious minorities; people with disabilities; people who identify as lesbian, gay, bisexual, or other diverse sexual orientation; people who identify as transgender, nonbinary, and other diverse gender identities, or people who were born intersex; people living in rural areas and other areas with high levels of deprivation;

people otherwise adversely affected by persistent poverty or inequality. Services include access to specialty care such as women's health services.

- Use of qualified interpreters and translators for Limited English Proficiency (LEP) patients.
- Provision of materials in accessible formats (e.g., braille, audio, CD) for individuals with disabilities. Native Advantage recommends that contracted providers use one of these methods to assist members after regular business hours:
- A professional answering service that contacts the contracted provider or the covering provider.
- A high-quality voice mail system that tells members:
- How to reach the contracted provider or the covering provider in an emergency, including phone numbers.
- What to do in an emergency or urgent situation.
- Native Advantage monitors contracted provider accessibility and appointment wait times.

Native Advantage may complete an annual access to care and availability survey for PCPs and high volume and high impact SCPs.

Contracted Provider Responsibilities

The Contracted Provider must validate their information for the Provider Directory at least quarterly to ensure all information is accurate, current, and complete. Contracted providers must notify Native Advantage in writing at least thirty (30) days in advance, when possible, of any changes, including but not limited to:

- Changes in office location(s), office hours, telephone number, fax number, email address, website, or billing address.
- Addition or closure of office location(s).
- Addition or termination of provider(s).
- Opening or closing the practice to new Native Advantage members.
- Changes to or verification of specialty status.
- Any additional information that may impact members' access to care, including accessibility, cultural or linguistic capabilities, or telehealth availability.

Quarterly Provider Directory Validation must be completed and documented for compliance and auditing purposes.

Contracted providers may be required to provide confirmation of their directory information and supporting documentation upon request by Native Advantage or applicable regulatory or auditing entities.

Failure to notify Native Advantage within 30 days of changes may result in removal from the provider directory. In addition, a roster (either provider or facility as appropriate) must be submitted to Native Advantage at least once per quarter. Rosters should be limited to locations where members are able to make an appointment to see the provider. Providers are encouraged to keep data current in the National Plan & Provider Enumeration System (NPPES). Visit NPPES help if you have questions: <https://nppes.cms.hhs.gov/webhelp/index.html>

Provider Termination from Network

Termination can be initiated for several reasons, either by the provider or by Native Advantage. A contracted provider may choose to voluntarily discontinue participation in the Native Advantage network by providing a written notice of the disaffiliation. Providers are expected to notify Native Advantage in writing as outlined in their agreement when terminating a contract. When terminating an individual provider, at least 60 calendar days' notice is required. During the termination notification period, Native Advantage will notify affected members and transfer their care to another contracted provider.

Native Advantage could initiate termination of a contracted provider for reasons that include, but are not limited to:

- Sanctions imposed upon providers by State and Federal regulatory entities.
- Provider misrepresents credentialing or contracting information.
- Provider is noncompliant with credentialing/re-credentialing requirements.
- Provider's certification or license being suspended or revoked.
- Provider opts out of Medicare.
- Safety issues.
- Native Advantage reports practitioner suspension or termination to the appropriate authorities

MEDICAL RECORDS INFORMATION

Providing Requested Medical Records

The Native Advantage plan requires providers to furnish medical records that we may request. Medical records are used for risk adjustment data that are part of CMS audits. That information is used to determine health status adjustments to CMS capitation payments.

We also use medical records for

- Advance determination of coverage
- Plan coverage
- Medical necessity
- Proper billing
- Quality / HEDIS reporting
- Fraud and abuse investigations
- Plan-initiated internal risk adjustment validation

Medical Records Review

Native Advantage, its authorized representatives, and applicable regulatory agencies reserve the right to access, inspect, and review medical records and other documentation related to services provided to members for purposes including, but not limited to, quality improvement, utilization management, credentialing, compliance monitoring, audits, investigations, and other activities required under applicable federal and state laws, regulations, and contractual obligations.

Participating Providers shall make member medical records available for review upon request and shall cooperate with onsite visits conducted by Native Advantage representatives or provide copies of requested records through secure electronic transmission, fax, or other approved methods within the required timeframe. All requests and disclosures of protected health information shall be conducted in accordance with the requirements of the Health Insurance Portability and Accountability Act (HIPAA) and other applicable privacy and security regulations.

Standards for Medical Records

Participating providers must have a system in place for keeping medical records that complies with regulatory standards. Providers must comprehensively document each medical encounter in each member's medical record. Each medical record chart must include the following:

- Names of all health care providers participating in the member's care, along with information on services furnished by these providers
- Prescribed medications, including dosages and dates of initial or refill prescriptions
- Physical examinations, needed treatments and possible risk factors for treatments
- Any evidence of member input into the proposed treatment plan
- Documentation on whether the member has executed an Advance Directive (see details immediately below)

Advance Directives

Native Advantage expects all contracted providers to offer members the opportunity to complete an Advance Directive if one is not already on file and to document in the medical record whether an Advance Directive exists. If your office does not have an Advance Directive form available, a printable copy is attached for your convenience. [Oklahoma_Advance_Directive](#)

Confidentiality of Member Information

Participating in health care providers must have policies and procedures that comply with all state and federal laws concerning confidentiality of health and other information about members. Each participating provider and their office staff must sign an employee confidentiality statement. The provider must then keep the signed statement in each employee's personnel file.

OBLIGATION TO PROVIDE ACCESS TO CARE

Patient Appointment Access Standards

Providers should meet these required standards for patients to make an appointment:

- Initial new patient visit - within 30 business days
- Preventive care - within 30 business days
- Urgently needed services or emergency - immediately
- Services that are not emergency or urgently needed, but require medical attention – within 7 business days
- Annual physical exam - within 30 business days
- In-office wait time - 30 minutes or less

These standards apply to all medical, behavioral health, and substance use disorder services, where applicable.

Native Advantage will monitor provider compliance with member access standards through office site visits and by tracking complaints and grievances reviewed by the Native Advantage Clinical Quality Improvement Committee.

Prohibition Against Discrimination

Native Advantage and all participating providers are prohibited from denying, limiting, or placing conditions on coverage or furnishing services to members based on their health status. That means coverage or services cannot be denied or limited based on:

- Medical condition, including mental or physical illness

- Claims experience
- Receipt of health care
- Medical history
- Genetic information
- Evidence of insurability, including conditions arising out of acts of domestic violence
- Disability
- Race, ethnicity, or national origin
- Religion
- Sex or sexual orientation
- Age
- Mental or physical disability
- Source of payment

Participating providers must have practice policies that show they will accept treatment for any member who needs the health care services the provider offers.

Services Provided in a Culturally Competent Manner

Native Advantage wants to ensure services are provided to all members in a culturally competent manner. That means services must be provided to members with limited English proficiency or reading skills, and to members of diverse cultural and ethnic backgrounds. Participating providers must cooperate with the Native Advantage in making sure this happens.

Native Advantage Member Services department, at **1-888-230-4214**, has the following services available for members:

- Teletypewriter services (TTY)
- Language services

Provider Performance Standards and Compliance Obligations

Evaluating Performance of Participating Health Care Providers

When evaluating the performance of a participating provider, Native Advantage will review, among other things, the following areas:

- Quality of Care: measured by clinical data related to the appropriateness of member care and to health outcomes

- Efficiency of Care: measured by clinical and financial data related to a member's health care costs
- Member Satisfaction: measured by the members' reports regarding accessibility and quality of health care, interpersonal relations with the provider and the comfort of the practice setting
- Administrative Requirements: measured by the participating provider's methods and systems for keeping records and transmitting information, hours of operation, appointment waiting times and appointment availability
- Participation in Clinical Standards: measured by the participating provider's involvement with national health panels that monitor quality of care standards

Health Care Provider Compliance to Standards of Care Participating providers must:

- Comply with all applicable laws and licensing requirements
- Furnish covered services in a manner consistent with standards related to medical and surgical practices generally accepted in the medical and professional community at the time of treatment

Participating providers must also comply with Native Advantage's standards, which include:

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

Participating providers must also comply with Native Advantage's policies and procedures regarding the following:

- Participation on committees and clinical task forces to improve the quality and lower the cost of care
- Precertification requirements
- Credentialing requirements
- Care coordination referrals that are part of the care management and disease management program
- Appropriate release of inpatient and outpatient utilization and outcomes information
- Accessibility of member medical record information to fulfill the business and clinical needs of Native Advantage.
- Providing treatment to members at the appropriate level of care
- Providing equal access and treatment to all members

Native Advantage encourages participating providers to advise their member patients about:

- The patient's health status, medical care, or treatment options (including any alternative treatments that may be self-administered). Providers should give each patient all information needed for the patient to make an informed treatment decision from all treatment options.
- The risks, benefits and consequences of treatment or non-treatment
- The rights of the individual to refuse treatment and to express preferences about future treatment decisions. Such actions shall not be considered non-supportive of Native Advantage (HMO).

LAWS REGARDING FEDERAL FUNDS

Payments that participating providers receive for furnishing services to members are, in whole or in part, from federal funds. Therefore, participating providers and any of their subcontractors must comply with laws that apply to individuals and entities receiving federal funds.

MARKETING

Participating providers may not develop, distribute, or use any marketing or promotional materials referencing Native Advantage without prior written approval from Native Advantage.

SANCTIONS UNDER FEDERAL HEALTH PROGRAMS AND STATE LAW

Participating providers must ensure they employ or subcontract with no one who has been convicted of criminal offenses related to that person's involvement in Medicaid, Medicare, or other federal health care programs.

Participating providers must disclose to Native Advantage whether the participating provider or any staff member or subcontractor has:

- Been the subject of any prior violation, fine, suspension, termination or other administrative action taken under Medicare or Medicaid laws
- Violated the rules or regulations of the state of Oklahoma, the federal government, or any public insurer.

Section 4: Member Eligibility and Covered Services

ELIGIBILITY AND BENEFITS

Member Eligibility and ID Cards

Each member will receive a Native Advantage (HMO) identification card. The card includes the member's name, member ID number, and information about the member's benefits and co-pays. Providers should check a member's eligibility and benefit information at each visit.

COVERED SERVICES

Preventive Services

Patients can lower their risk for disease, disability, and death by using preventive health care services. Members may access the following preventive health care services directly from participating providers:

- Annual Wellness Exam
- Annual Physical Exam
- Kidney Disease Education services
- Glaucoma screening
- Diabetes Self- management Training
- EKG during IPPE “Welcome to Medicare” visit
- Patients and providers can learn more about Medicare preventive services via

[The Medicare Learning Network® | CMS](#)

Emergency Care for Emergency Medical Conditions

Emergency Care services are health care services provided in a hospital or comparable facility to evaluate and stabilize recent and severe medical conditions. Those conditions - called Emergency Medical Conditions - could include severe pain and any other conditions that would lead a prudent layperson possessing an average knowledge of medicine and health to believe that failure to seek immediate medical care could result in:

- Serious jeopardy of the patient's health
- Serious impairment to bodily functions
- Serious dysfunction of any bodily organ or part

- Serious disfigurement

Native Advantage covers emergency care services needed to evaluate and stabilize an emergency medical condition. Providers should tell members with emergency medical conditions to go to the nearest emergency care provider. The member does not need prior authorization for evaluation and stabilization of an emergency medical condition.

Within one business day of admission following treatment of an emergency medical condition, participating providers must notify Native Advantage's utilization management department to get approval for post stabilization care services. Failure to timely notify Native Advantage and obtain pre-approval for post stabilization of care may result in denial of the claim for that care. Post-stabilization care that was not pre-approved and was denied cannot be billed to the member, pursuant to the participating provider agreement with Native Advantage.

Cost sharing for necessary emergency care services furnished out-of-network is the same as for such services furnished in-network.

Out-of-Area Renal Dialysis Services

A member may obtain medically necessary dialysis services from any qualified health care provider when the member is temporarily away from the member's normal service area, and the member cannot access a dialysis provider that is part of Native Advantage's network. Prior authorization is not required.

Note: Native Advantage does recommend that the members notify their case manager of any such care, so the case manager can follow up to make sure all is going well. A member may voluntarily advise Native Advantage if the member will be temporarily out of their service area. In those cases, a Native Advantage representative can help the member locate a qualified dialysis provider.

Inpatient Hospital Admissions

All inpatient hospital admissions require prior authorization from Native Advantage's utilization management department. The admitting health care provider or hospital personnel conducts the prior authorization process for admissions.

When a member arrives at any facility for an elective admission, providers should notify the utilization management department to assist in patient care coordination. Admitting health care providers must also contact the department to request prior authorization for additional days if an extension of the approved length of stay is required.

The admitting provider will give appropriate referrals for extended care. Staff from the utilization management department will help coordinate all needed services in the discharge planning process.

BEHAVIORAL HEALTH

Behavioral Health Services

Members needing to access behavioral health (mental health and substance abuse) services should contact Member Services at **1-888-230-4214** to verify benefits and prior authorization requirements.

Behavioral Health Care Managers accessed through that number will provide:

- Reviews of medical necessity for services requiring prior authorization
- Case management
- Assistance in the selection of a participating health care provider
- Crisis intervention

Behavioral health services that require prior authorization include

Inpatient Care

- Inpatient mental health
- Inpatient substance abuse
- Partial hospitalization program mental health
- Partial hospitalization program substance abuse

Native Advantage must determine whether the services are medically necessary before a prior authorization number is issued. Claims received that do not have a prior authorization number for a hospital admission or outpatient care will be denied.

Participating providers may not seek payment from the member when a claim is denied for lack of a prior authorization number. The member, a behavioral health professional, a physician or the member's authorized family member may make the call to seek prior authorization.

Native Advantage encourages behavioral health providers to admit patients to a participating Native Advantage facility unless an emergency exists that precludes safe access to a participating facility. Members can be admitted to a non-participating facility if Native Advantage has approved the admission. The member will receive in-network benefits only when services are performed at a participating facility unless Native Advantage has approved admission to a non-participating facility.

Section 5: Pharmacy Benefits

Pharmacy Benefits Manager (PBM)

Native Advantage uses Navitus as our Pharmacy Benefits Manager (PBM). Our partnership with Navitus maintains and improves the quality of care delivered to members, while helping to contain rising drug costs.

Navitus is primarily responsible for claims processing, formulary development, clinical review, and pharmacy network contracting.

Members can visit <https://www.nativeadvantage.com/navitus>

- Search for prescription drugs.
- Find a network pharmacy.
- Download forms and pharmacy information for Native Advantage
- Submit coverage determinations.

PRESCRIPTION DRUGS

Prescription Drug List

Native Advantage pharmacy benefits include a list of covered drugs (formulary) the plan has selected based on clinical recommendations of the Navitus Pharmacy and Therapeutics committee. The committee recommends drugs for the list based on safety, efficacy, uniqueness, and cost.

Native Advantage encourages physicians to prescribe drugs on the list.

Exceptions for Prescription Drugs Not on List

A member may ask for a formulary exception if a drug prescribed to them is not on the list. They can do that through coverage determination, redetermination, or appeal.

If a member or provider has any questions, they can call Navitus Member Services at **1-866-270-3877**, available 24 hours a day, 7 days a week, 365 days a year. Interpreter services are available at no cost to assist members who speak languages other than English, ensuring access to support and plan information.

Prior Authorization

Some drugs require prior approval before Native Advantage can cover them. This is so Native Advantage can best guide the correct use of these drugs. Providers can help members get approval.

Members and providers can learn more about prior authorization and access a prior authorization form through our website at <https://www.nativeadvantage.com/providers/prior-authorizations>.

Step Therapy

A member may be asked to start treatment with a drug that costs less but works just as well (for example, a generic drug) instead of starting with a drug that costs more. If the first drug does not work for the member, then the Native Advantage will cover the higher-priced drug. Members and providers can learn more about and access a form for Step Therapy at <https://www.nativeadvantage.com/Member-Resources/Member-Materials>.

Quantity Limits

There may be a limit on how much of a drug that a member is allowed, including how many pills are with each prescription. These limits are based on safety guidelines. Members and providers can learn more about quantity limits and access quantity limits exception forms available on our website <https://www.nativeadvantage.com/navitus>

PHARMACIES

Pharmacy Finder and Mail-Order Services

Native Advantage maintains a network agreement with Navitus pharmacies throughout its service area in Oklahoma. To receive covered pharmacy benefits, members must utilize participating in-network pharmacies or the designated mail-order pharmacy service, except in emergencies or other circumstances permitted under applicable regulations.

Members may access the Pharmacy Finder tool at <https://www.nativeadvantage.com/navitus> to obtain the most current listing of participating in-network Navitus pharmacies and verify pharmacy participation prior to obtaining prescription services.

Home Delivery

For certain kinds of drugs, our members can use the Native Advantage network mail-order service. Generally, the drugs provided through mail order are drugs they take on a regular basis, for a chronic or long-term medical condition. These drugs are marked as mail-order drugs in our Drug List.

Native Advantage mail-order service requires you to order at least a 30-day supply of the drug and up to a 100-day supply.

To get information about filling a member's prescriptions by mail contact Member Services (phone numbers are printed on their member ID card).

Out-of-Network Pharmacies

Members can get covered drugs from out-of-network pharmacies in emergencies or unusual circumstances, or for non-routine access to drugs covered under Medicare's Part D drug plan. (For example, members can get out-of-network access while traveling outside of Native Advantage's service area, where there is no network pharmacy.) Members can contact us to get more information on these special circumstances for out-of-network coverage and about what pharmacies may be available.

Contact Navitus Member Services at **1-866-270-3877** (TTY 711) at **1-866-270-3877**, available 24 hours a day, 7 days a week, 365 days a year.

MEDICATION MANAGEMENT

Medication Therapy Management

The Medication Therapy Management program reviews the medications members take to make sure that they are safe, they work well together, and they fit the member's lifestyle. The program is not considered a benefit, but it is offered at no additional cost to eligible members with the goal of helping members get the best results from their medicines, at the lowest possible price.

Native Advantage automatically enrolls members in the program if they have certain conditions and take a certain number of medications. The program is voluntary, and members can opt out at any time.

Prescription Drug Transition

If a member is new to one of our Native Advantage plans, they might be taking medications that Native Advantage does not cover. Members can get a limited supply of uncovered medications if they:

- Are enrolled in a prescription drug plan during the open enrollment period
- Became eligible for Medicare after the first of the year
- Switched from another plan to the Native Advantage after the first of the year
- Were affected by a level of care change (for example, admitted or discharged from a long-term facility)
- Were recently affected by formulary changes

If one of the above situations applies to a member, they can either:

- Ask their physician to change their prescription to a different medication covered by Native Advantage, or

- Send an exception request to keep using their current medications. Members can access forms and documents related to the drug transition plan at our Prescription Drug Plan Documents webpage at <https://www.nativeadvantage.com/navitus>

Medicare Contact Information

Members can contact Medicare for more information about benefits and services, including information about Medicare Advantage prescription drug coverage.

Phone: **1-800-MEDICARE (1-800-633-4227)** - 24 hours per day, 7 days per week. Members who are hearing or speech impaired can call TTY at **1-877-486-2048**.

Online: www.medicare.gov

If members would like to submit feedback directly to Medicare, they should use the Medicare Complaint Form or contact the Office of the Medicare Ombudsman.

Section 6: Utilization Management and Quality Improvement

UTILIZATION MANAGEMENT

We Follow Medicare Policies

Native Advantage must cover all services and benefits covered by Medicare.

Participating providers should refer directly to Medicare coverage policies when making coverage decisions.

Our Clinical Review Criteria

Native Advantage uses a combination of Medicare guidance, internal policies, and other guidelines in determining whether and how we pay for medical services. We use Medicare National Coverage Determinations and Local Coverage Determinations as guides. We also use Optum InterQual Care Guidelines® and other guidelines.

Native Advantage's Quality Improvement Committee reviews and approves the utilization management processes and clinical review criteria that the plans use to determine whether services are medically necessary including Medicare coverage policies - National Coverage Determinations and Local Coverage Determinations.

National Coverage Determinations (NCD)

NCDs are decisions the Centers for Medicare and Medicaid Services make on whether Medicare will pay for a certain medical treatment, service, item, or technology.

Providers and members can see details on all NCDs on the CMS website. You can also visit the CMS online manual webpage to see a range of other manuals that can help you understand Medicare coverage.

CMS continually offers online updates to program manuals. It also provides updated information through articles on the Medicare Learning Network.

Local Coverage Determinations (LCD)

CMS also provides LCDs to offer guidance to patients and providers in specific geographical areas. An LCD might add detail to an NCD, or it might explain when a service or item might be covered if there is no NCD on the topic. But an LCD should never contradict an NCD; if it does, the NCD has final authority.

Optum InterQual Care Guidelines

Native Advantage also uses Optum InterQual Care Guidelines, which are a set of widely used evidence-based guidelines for health care. For more information, please visit our website at <https://www.nativeadvantage.com/providers/clinical-guidelines>.

Other Guidance on Coverage

In coverage situations where there is no NCD, LCD or guidance on coverage in original Medicare manuals, a Medicare Advantage organization may adopt the coverage of other Medicare Advantage organizations in its service area. The Native Advantage organization may also make its own coverage determination and provide a rationale using an objective evidence-based process.

Native Advantage plan determinations on coverage must be based on:

- The medical necessity of services - including emergency, urgent care, and post-stabilization care after an emergency. Determinations on whether something is medically necessary must be based on NCDs, LCDs or internal policies. Native Advantage's medical director must review and approve those policies. Those policies must include coverage rules that are no more restrictive than Medicare's coverage rules. Before a possible treatment is scheduled, a provider, member or designated representative of a member can request a medical necessity review relating to the treatment.
- The member's medical history. That would include any conditions, diagnoses and doctor recommendations and clinical notes, along with how the member is functioning.
- When appropriate, review and analyze by Native Advantage's medical director.

Recommendations on Specific Diagnoses and Drugs

Native Advantage's may also develop recommendations or clinical guidelines for the treatment of specific diagnoses, or for the use of specific drugs.

Prior Authorization Tools and Requirements

Provider Portal

Native Advantage's Provider portal helps providers with a number of services for patients, including prior authorizations. The portal is reached from the Providers menu at <https://www.nativeadvantage.com/providers/provider-portal>.

Prior Authorization Requirements

Providers can learn more about prior authorization requirements and access related materials by visiting <https://www.nativeadvantage.com/providers/prior-authorizations>. From the homepage, select Utilization, then Providers, and then Prior Authorization Management.

Prior Authorization Checklist

Providers should include the following information when requesting prior authorization:

- Date of the first office visit with any physician for the current condition
- Date of the most recent office visit for the current condition
- Current symptoms
- Length of physician-directed treatment or observation for the current condition
- How symptoms have changed with physician-directed treatment or observation since onset of the current condition
- What conditions have been found by a medical professional on a physical exam performed for the current condition
- Any other conditions present in the medical history
- Submitter
- Ordering physician, facility, or other

In-patient Prior Authorization

The admitting health care provider or hospital or other inpatient facility should notify the Native Advantage utilization management department, at **1-888-230-4214**, if they are admitting a member to a hospital or other inpatient facility.

The Utilization Management Department reviews initial hospitalization requests to determine whether the proposed hospitalization and/or procedures meet medical necessity criteria. In some cases, the department may determine whether hospitalization or certain services are not medically necessary. Before issuing an adverse determination, a physician reviewer for Native Advantage will make a reasonable effort to contact the admitting provider to discuss the clinical findings, proposed treatment plan, and any available alternatives.

Concurrent Hospital Review

If an extension of the initially approved length of stay in a facility is required, the admitting provider or facility should contact the utilization management department to request the extension.

Discharge Planning

Clinical staff with the utilization management department will help providers and facilities with the inpatient discharge planning process. When the member is admitted to the hospital and during the hospitalization, the department's clinical staff will discuss discharge planning with the provider, the member, and the member's family.

Quality Improvement Program

Quality improvement is an essential element in delivering effective health care and services. To define and help monitor quality improvement, the Native Advantage's Quality Improvement Program measures the care and services participating providers deliver. We measure care against established goals.

We also formally evaluate the program every year to assess how effective it is. Here are some key components of the program:

Chronic Care Improvement Program

CCIP assesses interventions designed to improve the health of individuals who live with multiple or certain severe chronic conditions. The program uses evidence-based practice guidelines and collaborative practice models involving physicians and support-service providers. It also includes patient self-management techniques.

Quality Improvement Project

QIP focuses on improving performance, member care, patient safety, health care operations, and overall well-being. It does this through systematic, data-driven processes for both clinical and non clinical areas.

Quality of Care Issues

The Quality Improvement Program also analyzes trends in quality-of-care issues through the work of Quality Improvement Organizations (QIOs).

QIOs, overseen by Native Advantage, review complaints from Native Advantage patients about the quality of care they have received. QIOs determine whether the quality of services that Native Advantage provides meets recognized standards. QIOs are made up of physicians and other health care experts.

Cooperation

Participating providers are required to comply with and support all policies and procedures established under Native Advantage's for medical management, quality assurance, and performance improvement programs. Providers must also cooperate with independent quality review and

improvement organizations, including Quality Improvement Organizations (QIOs), that perform reviews and oversight on behalf of the Medicare program.

Utilization Management Program

Native Advantage's utilization management program does not prohibit participating providers from advocating on behalf of members within the utilization management process.

Patient Readmission

How often patients are readmitted to an acute care facility within 30 days of discharge from that same facility is an important quality-of-care metric. Tracking the metric encourages facilities to improve patient care.

Native Advantage will review readmissions to an acute care facility that occurs within 30 days of discharge from the same facility. We will review those readmissions consistent with the CMS Medicare Claims Processing Manual and the Medicare Quality Improvement Organization Manual.

We will perform clinical validation of acute care facility claims to determine if any readmissions are related to the patient's earlier hospital stay. Native Advantage may deny payment to the facility for related readmissions.

Certain readmissions are excluded from this policy

- Obstetrical readmissions
- Transfers of patients to receive care that was unable to be provided at the initial facility
- Skilled nursing facility and rehabilitation facility admissions
- Planned readmissions for repetitive health care treatments, including:
 - Chemotherapy
 - Staged surgical procedures
 - Procedures involving malignancies
 - Burns procedures
 - Cystic fibrosis procedures
 - Certain other treatments
 - Patient non-compliance, if documented in medical records

Section 7: Initial Decisions, Appeals and Grievances

INITIAL DECISIONS

An initial coverage determination is the first decision Native Advantage makes regarding a member's request for coverage or payment of a healthcare service. A participating provider acting on behalf of a member may request an initial coverage determination to confirm whether a service is covered under the member's Native Advantage benefit.

Examples of initial coverage determinations include

- A request for payment of medical services a member has already received.
- A request for prior authorization to determine whether a proposed service, procedure, or treatment is covered.
- A request to determine whether a specific service or treatment recommended by a participating provider is covered under the member's plan benefits.

Native Advantage generally issues payment determinations for services already received within 60 calendar days of receiving a complete request.

Pre-Service coverage determinations are processed as either

Standard Coverage Determinations: Decisions are generally made within 14 calendar days of receiving the request.

Expedited Coverage Determinations: Decisions are generally made within 72 hours when waiting for a standard determination could seriously jeopardize the member's life, health, or ability to regain maximum function. An expedited determination may be requested by the member or by a participating provider acting on the member's behalf.

If Native Advantage is unable to issue a determination within the applicable timeframe and does not notify the member of an allowable extension, the request may be treated as a denial. The member or the member's authorized representative may then exercise the right to file an appeal in accordance with Native Advantage's appeals process.

Appeals and Grievances

Members have the right to file a complaint if they have concerns about their coverage or the care they receive. Complaints are categorized as either appeals or grievances. Participating providers are required to cooperate fully with Native Advantages' appeals and grievances processes.

Appeals

An appeal is a request for Native Advantage to review and reconsiders an initial coverage or payment determination made by Native Advantage or a participating provider. Members may request an appeal if they disagree with a decision regarding the medical necessity, coverage, or payment of a service.

In certain circumstances, a participating provider may submit an appeal on the member's behalf regarding a coverage determination.

Appeals Contact Information

Providers and members with questions about the appeals process may contact Native Advantage at **1-888-230-4214** for a live representative Monday through Friday between 8 a.m. CST to 5 p.m. CST.

Additional appeals contact information is available in the Quick Reference section of this Provider Manual.

Resolving Appeals

A member has the right to appeal an adverse initial decision made by Native Advantage regarding payment for or coverage of a health care service. Generally, Native Advantage must resolve appeals involving authorization of health care services or termination of service coverage within 30 calendar days. Appeals related to payment for services are generally resolved within 60 calendar days.

If following the standard appeal timeframe could seriously jeopardize the member's life, health, or ability to regain maximum function, the member may request an expedited appeal. Expedited appeals are generally resolved within 72 hours, unless an extension is determined to be in the member's best interest. Native Advantage will automatically process an appeal on an expedited basis when requested by the member or the participating provider.

Special appeal procedures apply to hospital discharges. If a member believes coverage for a hospital stay is ending prematurely, the member may request an immediate review by a Medicare Quality Improvement Organization (QIO). To qualify for this review, the members must submit the request no later than noon on the first business day after receiving notice that coverage for the hospital stay will end. If the member misses this deadline, they may instead request an expedited appeal through Native Advantage.

Additional special appeal rights apply when coverage is ending services provided by a skilled nursing facility (SNF), home health agency (HHA), or comprehensive outpatient rehabilitation facility (CORF). These providers must give the members written notice at least 2 days before

services are scheduled to end. If the member believes coverage is ending too soon, they may request an immediate review by the QIO.

When the notice is provided exactly 2 days before coverage ends, the member must request the QIO review no later than noon of the first business day after receiving the notice. If the notice is provided more than two days before coverage ends, the member must request the review no later than noon on the day before coverage is scheduled to end. If the member does not meet the applicable QIO filing deadline, they may still request an expedited appeal through Native Advantage. Further Appeal Rights

If Native Advantage upholds a denial, in whole or in part, the appeal is automatically forwarded to an independent review entity (IRE) that is contracted by the federal government and is independent of Native Advantage. The IRE reviews the appeal and issues a decision within the following timeframes:

- **Standard pre-service (prior authorization) appeals:** Within 30 calendar days.
- **Payment appeals:** Within 60 calendar days.
- **Expedited appeals:** Within 72 hours.

If the IRE also issues an unfavorable decision and the amount in controversy meets the applicable Medicare threshold, the member may request a hearing before an Administrative Law Judge (ALJ). If the member disagrees with the ALJ's decision, they may request review by the Medicare Appeals Council (MAC). If the MAC declines to review the case or upholds the adverse decision, the member may be eligible to seek judicial review in a federal district court.

Grievances

A grievance is any complaint a member submits regarding an issue other than an organization determination or appeal. Grievances may relate to the quality of care received, appointment availability, wait times, customer service, or the condition and cleanliness of a participating provider's office or facility.

Grievance Resolution

Members who wish to file a grievance concerning Native Advantage, a participating provider, or another aspect of their care or coverage should contact the Member Services Department using the telephone number listed on the back of their member ID card.

Participating Provider Responsibilities – Organization Determinations

During each patient encounter, participating providers must inform members of their right to request a detailed written notice from Native Advantage explaining coverage decisions related to

requested services. Providers must also furnish members with the information necessary to contact Native Advantage and comply with all CMS requirements governing member notifications.

Participating Provider Responsibilities – Appeals

Participating providers are required to cooperate fully with Native Advantage and members throughout the appeals process. Providers must promptly submit all relevant medical records, clinical documentation, and other necessary information to support the review of an appeal within CMS-required timeframes. For expedited appeals, providers must supply requested information as quickly as necessary to enable timely review and determination by Native Advantage or the applicable independent review entity.

Section 8: Care Management

CARE MANAGEMENT

Native Advantage helps manage the care of members with acute or chronic conditions who can benefit from care coordination and assistance. Participating providers should work with Native Advantage's Care Management program to help.

With help from providers, the Care Management program

- Informs members of any of their specific health care needs that require follow-up and trains members in selfcare and other measures they may take to promote their health
- Identifies members with complex or serious medical conditions so care coordinators can provide timely interventions that can improve members' health
- Implements care management plans for each engaged member that:
 - Are age appropriate
 - Help with direct visits to specialty care physicians or other providers
 - Are time specific and updated periodically
 - Help coordinate health care providers who work with the member
 - Consider each member's input

The Care Management program also

- Coordinates and integrates services with community and social service programs
- Identifies and addresses barriers to members complying with prescribed treatments or regimens.

An important goal of the Care Management program is to help members improve overall health and wellness. Our care managers coordinate, monitor, and evaluate the services that can help meet members' needs. They ensure that care is provided in the right place and at the right time.

How We Inform Members About Care Management

Native Advantage informs members of available programs through the enrollment process, marketing materials, and participating providers' conversations with each member. We proactively identify members who could benefit from care management and encourage them to enroll in the Care Management program or disease management programs for certain chronic conditions. (See details below on our disease management programs.)

Coordinating Health Assessments and Programs

The Care Management program also helps to coordinate risk screenings and health assessments, and other resources and programs.

CMS requires that Medicare Advantage organizations make a good faith effort to conduct an initial health assessment of all new members within 90 days of them becoming members and annually thereafter. Examples of visits that would fulfill this obligation include:

- The original Medicare initial preventive visit, known as a "Welcome to Medicare" preventive visit
- An Annual Wellness Visit (AWV)
- A recent previous physical examination in a commercial health insurance plan (to which Native Advantage has access)

CMS also requires that Native Advantage follow up after initial unsuccessful attempts to reach a member.

Annual Health Assessment

The Native Advantage Annual Health Assessment (AHA) helps identify a member's essential clinical and care management needs. It meets the requirements of Medicare's initial preventive and annual visits. Components of the AHA include: the member's medical history, social history, family history, review of symptoms, physical exam (including noting body mass index), preventive screenings and chronic disease monitoring. These assessments can occur in a participating provider's office or in the member's home to remove barriers to completion.

Annual Wellness Visit Resources

Native Advantage recommends the CMS [Annual Wellness \(AWV\) Guide](#) as a resource to help document the members' visits to meet Medicare requirements.

The Annual Wellness Visit Guide includes a wellness visit checklist and information on:

- Medicare coverage for wellness visits
- Correct coding for wellness visits
- Guidance to help ensure all member conditions are coded correctly
- Coding for other evaluation and management services, such as lab tests
- Preventive services and screenings
- Closing care gaps by performing HEDIS measurements
- Coding tips to help minimize requests for medical records and help expedite claims processing

Second Medical or Surgical Opinion

A member may get a second opinion about a treatment recommendation or procedure if any of the following applies:

- The member disputes the reasonableness of the treatment recommendation
- The member disputes the need for the recommended procedure
- The member does not respond to treatment after a reasonable period

Disease Management Programs

Native Advantage also operates specific disease management programs for members. These programs may include:

Medical	Behavioral Health
• Diabetes • Chronic obstructive pulmonary disease • Chronic kidney disease • Congestive heart failure	• Depression • Substance abuse • Schizophrenia/psychotic disorders • Bipolar • Anxiety/panic disorders • Alzheimer's disease/dementia

Member participation in these disease management programs is voluntary. Members receive educational information through the telephone and through materials we send to them. That info can help members to self-manage their condition. The treating provider is an integral part of the disease management programs.

For additional information on these programs, members or providers can call Member Services at 1-888-230-4214.

Section 9: Claims and Billing

Claims Process

Participating providers must submit claims to Native Advantage within the timely filing limit of your agreement after the date of service. Providers should use the standard claim form or submit claims electronically as outlined below.

Services billed beyond the timely filing limit of your agreement after the date of service are not eligible for reimbursement. Participating providers may not bill or seek payment from a member for claims submitted after the timely filing deadline specified in the provider's agreement. To expedite claims payment, the following information must be submitted on your claims:

- Member's name
- Member's date of birth and sex
- Member's plan ID number, including a three-character prefix
- Member's policy number
- Indication of whether member has job-related injury or illness, or accident-related illness or injury, including details
- ICD-10 diagnosis codes
- CPT® procedure codes
- Date(s) of service(s)
- Charge for each service
- Provider's Tax Identification Number
- Provider's name and address
- Provider's signature
- Place of service code
- National Provider Identifier number

Claims Submission Information

Providers can submit claims to Native Advantage electronically or by mail.

Electronically Providers can submit claims electronically through the Availity website located on <https://www.nativeadvantage.com>. Include the Electronic Payer ID: A2191.

With electronic claims, providers should use the CMS National Standard Format or the current version of the ANSI 837 format.

Native Advantage will process electronic claims consistent with the requirements for standard transactions. Any electronic claims submitted to Native Advantage HMO should comply with those requirements.

By Mail

Providers can also submit claims to Native Advantage by mail. They should use a completed version of the applicable CMS-1500 claim form and mail it to:

Native Advantage, Inc.
c/o Medical Claims Payment Request
PO Box 20928
Tampa, FL 33622

Important claim reminders for paper forms

- Use the standard Health Care Financing Administration form - also known as the CMS-1500 form - for all paper claims submissions
- Include the name of the referring provider
- Add the prior authorization number
- If the claim is for laboratory services, make sure that you include the Clinical Laboratory Improvement Amendments (CLIA) number. The claim will be denied otherwise.

Claims containing the required information and submitted according to these guidelines will be paid within 45 days for paper claims and 30 days for electronic claims.

Duplicate Claims

Providers who submit electronic claims may get duplicate claim rejections if they submit a claim with the same information for the patient and date of service as a previously processed claim. Duplicate claim rejections should not occur if the following elements are different on the resubmitted claim:

- Patient Control Number (Loop 2300 - CLM01 Data Element)
- Clearinghouse Trace Number (Loop 2300 - REF02 where REF01 =D9)
- Line-Item Control Number (Loop 2400 - REF02 where REF01 =6R)

Providers should not submit duplicate paper claims before the 45-day payment period ends for paper claims.

Coordination of Benefits

If a member has coverage with another insurance plan that is primary to Native Advantage, providers should submit a claim to that plan first. The amount the primary plan pays for such claims will affect what Native Advantage pays on the claims. We will follow Medicare secondary payer laws and policies.

Claim Disputes

Providers may dispute a claims payment decision by requesting a claim review. If providers have questions regarding claims or claim appeals, they should contact the Native Advantage's provider member service department at **1-888-230-4214**.

Process Used to Recover Overpayments on Claims

If an overpayment occurs on a claim, Native Advantage will use a process called auto-recoupment to recover the overpayment. Providers with questions can call provider member service at **1-888-230-4214**.

If you wish to refund an overpayment on a claim, please submit the payment to the Claims Overpayments Address:

**Native Advantage, Inc.
c/o Claims Overpayments for Native Advantage
Dept 1701
Tulsa, OK 74182**

Balance Billing

Providers may not bill a member for a non-covered service unless:

- They have informed members in advance that the service is not covered, and
- The member has agreed in writing to pay for the services.

Section 10: Members' Rights and Responsibilities

MEMBERS' RIGHTS

Members have the right to timely, high-quality care and treatment with dignity and respect. Participating providers must respect the rights of all members.

Members have specific rights to

- Their choice of a qualified participating provider and contracting hospital
- Candid discussions with their providers about appropriate or medically necessary treatment options for their condition, regardless of cost or benefit coverage
- Timely access to their provider and recommendations for specialty care providers when medically necessary
- Receive emergency services when the member believes an emergency medical condition exists
- Participate in decisions regarding their health and treatment options
- Receive urgently needed services when traveling outside of Native Advantage's service area or when unusual circumstances prevent the member from obtaining care from a participating provider
- Request the aggregate number of grievances and appeals and dispositions
- Receive information when requested regarding care provider compensation
- Receive information when requested regarding the financial condition of the Native Advantage plan
- Have their right to privacy recognized
- Exercise these rights regardless of the member's race, physical or mental ability, ethnicity, gender, sexual orientation, creed, age, religion, or national origin, cultural or educational background, economic or health status, English proficiency, reading skills, or source of payment for care
- Confidential treatment of all communications and records pertaining to the member's care
- Access, copy and/or request amendment to the member's medical records consistent with the terms of the Health Insurance Portability and Accountability Act
- Extend their rights to any person who may have legal responsibility to make decisions on the member's behalf regarding the member's medical care

- Refuse treatment or leave a medical facility, even against the advice of providers (with the member accepting the responsibility and consequences of the decision)
- Complete an advanced directive, living will or other directive to the member's health care providers

Nondiscrimination

Native Advantage may not deny, limit, or place conditions on enrollment in Native Advantage based on health status. That means enrollment cannot be denied based on:

- Medical condition, including mental or physical illness
- Claims experience
- Receipt of health care
- Medical history
- Genetic information
- Evidence of insurability, including conditions arising out of acts of domestic violence
- Mental or physical disability

Native Advantage also cannot discriminate based on a range of other factors. They must comply with all provisions of:

- The Civil Rights Act
- The Age Discrimination Act
- The Rehabilitation Act of 1973
- The Americans with Disabilities Act
- The Genetic Information Nondiscrimination Act of 2008

Native Advantage must also have procedures in place that ensure members are not discriminated against in the delivery of health care services based on:

- Race
- Ethnicity
- National origin
- Religion
- Gender
- Age

- Sexual orientation
- Source of payment

Members Responsibilities

Members have the following responsibilities

- To become familiar with their coverage and the rules they must follow to get care as a member
- To give their primary care provider and other providers the information needed to care for them
- To follow the treatment plans that they and their providers agree upon
- To ask their providers any questions they might have about conditions and treatments
- To act in a way that supports the care given to other patients and to help the smooth running of their provider's office, along with hospitals and other offices
- To pay their Native Advantage copayments and coinsurance payments they may owe
- To let Native Advantage staff know if they have questions, concerns, problems, or suggestions

Surveying Member Satisfaction

Native Advantage periodically surveys members to measure satisfaction with the health care participating providers are giving and their overall satisfaction with the plan. Native Advantage reviews those survey results and shares them with providers.

Advance Directive

Members have the right to complete an advance directive statement. This statement indicates, in advance, the member's choices for medical treatment if the member becomes incapacitated or otherwise unable to make treatment decisions. Native Advantage recommends participating providers have Advance Directive forms in their offices and are available to members.

Member Complaints and Grievances

Native Advantage tracks all member complaints and grievances to identify areas of our work we can improve. Our Quality Improvement Committee also reviews these complaints and grievances.

Section 11: Plan Responsibilities

Plan Responsibilities to Members

Native Advantage Responsibilities

Maintaining an accurate and current Provider Directory is a State and Federal regulatory requirement. Invalid information can negatively impact Member access to care. Additionally, current information is critical for timely and accurate claims reimbursement.

Native Advantage is required to audit and validate the Provider Directory data quarterly at a minimum. As part of our validation efforts, Native Advantage may reach out through various methods, such as phone campaigns, letters, or fax verification. Contracted Providers are required to respond to requests within 30 days of receipt to confirm accuracy of their provider data.

Confidentiality

Native Advantage must safeguard any information that identifies a particular member. All our employees follow state and federal laws in strictly maintaining the confidentiality of the private health information of each member. We limit how we share that information internally. We also have procedures that detail the limited circumstances when information can be shared externally.

Basic Rule

Native Advantage must provide the following to members:

- **Benefits:** Native Advantage must provide or pay for medically necessary items and services in Part A (for those entitled) and Part B.
- **Access:** Members of Native Advantage must have access to all medically necessary Parts A and B services. Native Advantage is not required to provide members with the same access to providers that are provided under original Medicare.
- **Cost-Sharing:** Native Advantage may impose cost-sharing requirements for a particular item or service that is above or below original Medicare cost-sharing for that service. That can only happen when overall cost-sharing under Native Advantage is actuarially equivalent (comparable in value) to the cost-sharing under original Medicare. Also, our cost-sharing structure cannot discriminate against sicker beneficiaries.

There are exceptions where Medicare Advantage organizations are not required to cover the costs of original Medicare benefits. Here are those exceptions:

- Hospice: Original Medicare (rather than Native Advantage) will pay for hospice services for a member who has elected hospice.

Note: Medicare Advantage organizations must continue to cover inpatient services of a non-plan enrollee if the individual was a plan member at the beginning of an inpatient stay.

In addition to providing original Medicare benefits, Native Advantage also furnishes, arranges, or pays for some supplemental and prescription drug benefits.

Uniform Benefits

All Native Advantage benefits must be offered uniformly to all members in the service area of the plan. We must also offer those benefits at uniform costs for premiums and cost-sharing.

Benefits During Disasters and Catastrophic Events

Native Advantage has special requirements whenever there is a Presidential emergency declaration or a Presidential disaster declaration. They also have special requirements when a state governor declares an emergency or disaster, or when the U.S. Secretary of Health and Human Services declares a public health emergency.

Also, certain regular requirements of Medicare, Medicaid and the Children's Health Insurance Program can be waived during such emergencies. That happens only when the HHS Secretary waives these requirements through something called an "1135 waiver".

Access and Availability Rules

Native Advantage organization may specify the providers through whom members may obtain services if it ensures all services covered by original Medicare are available and accessible under Medicare's coordinated care requirements.

Cost-Sharing for In-Network Preventive Services

Native Advantage organization must cover all in-network preventive services without cost-sharing if there is no cost-sharing for those services under original Medicare.

Native Advantage organization also may not charge facility fees, professional services, or doctor's office visits if the only service provided during the visit is a preventive service that is covered with no cost-sharing under original Medicare. However, if the provider furnishes other non-preventive services during the visit, regular costsharing standards apply.

Drug Coverage

Native Advantage covers a number of prescription drugs for members who are part of the Medicare Care Advantage Pharmacy Drug Program. (See Section 5 for more info.) These drugs are generally not covered under original Medicare Part B. Covered prescription drugs include:

- Injectable drugs that Medicare considers not usually self-administered and are instead administered by a provider
- Durable medical equipment supply drugs. These are drugs that require administration by the DME (for example, a nebulizer or external or implantable pump)
- Certain vaccines, including for pneumococcal, hepatitis B (high or intermediate risk), influenza and vaccines directly related to the treatment of an injury or direct exposure to a disease or condition
- Certain oral anti-cancer drugs and anti-nausea drugs
- Hemophilia clotting factor drugs
- Drugs used in immunosuppressive therapy for a member who has received a Medicare-covered organ transplant
- Some antigens
- Intravenous immune globulin administered in the home for the treatment of primary immune deficiency
- Injectable drugs used for the treatment of osteoporosis in limited situations
- Certain drugs, including erythropoietin, administered during treatment of end stage renal disease

Clinical Trials

Medicare covers the routine costs of qualifying clinical trials that are covered under the National Coverage Determinations for clinical trials. Medicare also covers the reasonable and necessary items and services used to diagnose and treat complications arising from participating in qualifying clinical trials.

The clinical trial NCDs define what routine costs mean and clarify when items and services are reasonable and necessary. You can learn more at the [Medicare Clinical Trial Policies web page](#).

Advance Directives

At the time of initial enrollment, each Medicare Advantage organization must give its adult enrollees written information on their rights to make decisions concerning their medical care, including the right to accept or refuse medical or surgical treatment, and the right to formulate

advance directives. The Medicare Advantage organization provides information relevant to the state where the member lives.

Plan Responsibilities to CMS

Cooperation in CMS Requirements

Native Advantage must provide CMS with the information CMS needs to administer and evaluate the Medicare Advantage program and to help current and prospective members exercise their choice in obtaining Medicare services. That includes information on:

- Plan quality
- Performance indicators such as disenrollment rates
- Member satisfaction
- Health outcomes

Participating providers must provide information that Native Advantage needs in their data reporting obligations.

Certification of Diagnostic Data

CMS requires Native Advantage to submit data needed to characterize the context and purpose of each encounter between a member and a provider. Participating providers must furnish that data and must certify that the data is accurate and complete.

Glossary

Appeal

A formal action a member files when the member wants Native Advantage to reconsider and change an initial decision - by Native Advantage or by a participating provider-about what services are needed or covered. A member might also appeal what Native Advantage will pay for a service.

Benefits

The health care items or services covered by a health plan. Your health plan may sometimes be referred to as a benefits package.

Centers for Medicare and Medicaid Services

The federal agency is responsible for administering Medicare and Medicaid.

Covered Services

A service covered according to the terms in your member's health plan.

Emergency Care

Health care services provided in a hospital or comparable facility to evaluate and stabilize recent and acute medical conditions considered emergency medical conditions.

Emergency Medical Condition

A recent and severe medical condition, including but not limited to severe pain, which would lead a prudent layperson possessing an average knowledge of medicine and health to believe their condition, sickness or injury is of such nature that failure to receive immediate medical care could result in any of these:

- Serious jeopardy of the patient's health
- Serious impairment to bodily functions
- Serious dysfunction of any bodily organ or part
- Serious disfigurement
- Serious jeopardy to the health of the fetus, in the case of a pregnant patient.

Grievance

A formal action a member files regarding any type of problem with Native Advantage or a participating provider that is not appropriate as an individual appeal. For example, complaints about quality of care, waiting times for appointments or in the waiting room, and the cleanliness of the participating providers' facilities would be a grievance.

Health Insurance Portability and Accountability Act

A federal law that outlines the rules and requirements that health plans must follow to provide health care insurance coverage for individuals and groups. The law also establishes rules for how organizations must maintain the privacy of a person's health care information.

Home Health Agency

A Medicare-certified agency that provides intermittent skilled nursing care and other therapeutic services in the member's home. This happens when members are confined to their home, and a participating provider authorizes the care. Hospice

An organization or agency, certified by Medicare, that primarily provides pain relief, symptom management, and supportive services to terminally ill people and their families.

Hospital

A Medicare-certified institution licensed in the state of Oklahoma that provides inpatient, outpatient, emergency, diagnostic and therapeutic services. The term hospital does not include a convalescent nursing home or facility for the aged that furnishes primarily custodial care.

Institutional Provider

A provider that is not an individual health care professional but an institution. Examples would be a hospital, surgical center, or other medical facility.

Medically Necessary

Services or supplies that: are proper and needed for the diagnosis or treatment of a medical condition; meet the standards of good medical practice in the local community and are not for the convenience of a member or a member's health care provider.

Medicare

The federal program that provides health care coverage for eligible senior citizens and certain eligible disabled persons under age 65.

Medicare Part A

Hospital insurance benefits, including inpatient hospital care or care in a skilled nursing facility. It also covers care through a home health agency or hospice.

Medicare Part B

Supplemental medical insurance that is optional and requires a monthly premium. Part B covers physician services and services furnished by certain non-physician health care providers. Part B also covers lab testing, durable medical equipment, diagnostic tests, ambulance services, prescription drugs that cannot be self-administered, certain self-administered anti-cancer drugs, certain other health and therapy services and blood not covered under Part A.

Medicare Advantage Plan

A set of health benefits a Medicare Advantage organization offers at a uniform premium and uniform level of cost sharing to all Medicare beneficiaries in a geographic service area. A Medicare Advantage organization may offer more than one MA plan in the same area.

Member

The person to whom health care coverage has been extended by the policyholder (generally their employer). Members are also covered family members of the person. Members are sometimes called the insured or insured person.

Participating Health Care Provider or Participating Provider

Any health care provider or organization that has a written agreement with Native Advantage plans to provide services to members pursuant to the agreement's terms. A participating provider can be a health facility or other institution or person who is licensed or certified by Oklahoma and Medicare to deliver health care services.

Prior Authorization

This is a process where your provider must get approval for a specific health care treatment or service before they can be covered by Native Advantage to determine whether treatment or service is medically necessary. Not all treatments require prior authorization.

Primary Care Provider

The physician a member chooses to be their primary source for medical care. A PCP coordinates all medical care for a member, including hospital admissions and referrals to specialists.

Protected Health Information

A term created by HIPAA, this is information held by an entity covered by HIPAA that relates to a person's health, medical treatment, or payment for treatment. It also includes any information in the same set of data that could identify that person - like a name, address, birth date, or Social Security number.

Provider Network

The doctors, hospitals and other health care professionals that contract with Native Advantage to deliver medical services to its members.

Quality Improvement Organization

An independent group of practicing physicians and other health care experts that CMS pays to check and improve the care for Medicare patients. The QIO for Oklahoma is called KEPRO.

Specialty Care Provider

A health care provider who has a specialty outside of internal medicine, family practice medicine, pediatrics, geriatrics, and OB/GYN.

Provide Covered Health Care Services

Provider shall provide Medically Necessary Covered Health Care Services as applicable to their area of practice or specialty. All Covered Health Care Services shall be provided by duly licensed, certified, or otherwise authorized professional and paramedical personnel in accordance with professionally recognized standards and generally accepted medical and surgical practices prevailing in the professional community at the time of treatment.

Covering Physician

If Provider is, for any reason, unable to provide Covered Health Care Services when and as needed, Provider may engage the services of a qualified Covering Physician to provide such services in Provider's place, provided that the Covering Physician is a Contracted Provider. If Provider is a Specialist Physician, the Covering Physician must be professionally qualified and licensed in the same Specialty Service as Provider to provide such services in Provider's place.

Personnel, Equipment and Supplies

Provider will supply all necessary office personnel, equipment and supplies it deems necessary to perform Covered Health Care Services. Provider shall, at their sole cost and expense, employ such nonprofessional assistants or employees as Provider deems necessary to perform Covered Health Care Services. Native Advantage may not control, direct, or supervise Provider or Provider's employees in the performance of Covered Health Care Services.

Acceptance and Treatment of Plan Members

Provider shall provide services to Native Advantage Members in the same manner as such services are provided to Provider's other patients. Provider shall not impose any limitations on the acceptance of Members for care or treatment that is not imposed on Provider's other patients. Provider and its physicians, employees, agents and subcontractors shall (i) provide Covered Health Care Services in a culturally competent manner to Native Advantage Members, making a particular effort to ensure that those with limited English proficiency or reading skills, hearing incapacity, diverse cultural and ethnic backgrounds, and physical or mental disabilities receive the health care they need; (ii) provide Members with information concerning their treatment options in a culturally competent manner, including the option of no treatment; and (iii) ensure Members with disabilities have effective communications in making decisions regarding their treatment options.

Non-Discrimination

Provider shall not discriminate against a Member on the basis of race, ethnicity, religion, color, national origin, ancestry, physical or mental disability, medical condition, marital status, age, gender, genetic information, source of payment or protected veteran status. Further, Provider shall not deny, limit, or condition the furnishing of services to a Member on the basis of any factor that is related to the Member's health status, including but not limited to: (i) medical condition, including mental as well as physical illness; (ii) claims experience; (iii) utilization of health care; (iv) medical history; (v) genetic information; (vi) evidence of insurability, including conditions arising out of domestic violence; or (vii) disability.

Changes in Capacity

Provider should provide at least thirty (30) calendar days' prior written notice to Native Advantage of any significant changes in their capacity (e.g., to accept new patients) or ability to provide Covered Health Care Services to Native Advantage Members.

Insurance Coverage

Provider shall ensure that its professional liability insurance and general liability insurance meet the following requirements:

Professional Liability

Provider, at their sole cost and expense, shall maintain throughout the term of this Agreement, and for a period as required by State and Federal law following termination of this Agreement, professional liability insurance (i.e., medical malpractice insurance) in the minimum amount of \$1,000,000 per occurrence and \$3,000,000 annual aggregate, or as applicable by the respective State standard(s). If the policy is canceled or not renewed and coverage is provided on a claims-made basis, Provider agrees to exercise any option contained in the policy to extend the reporting period to the maximum period permitted under the policy.

General Liability

Provider, at its sole cost and expense, shall maintain throughout the term of this Agreement, general liability insurance, including but not limited to premises, personal injury, and contractual liability insurance, in a minimum amount of \$1,000,000 per

occurrence, combined single limit, bodily injury and property damage, to ensure Provider and its employees, agents, and representatives against claims for damages arising by reason of: (i) personal injuries or death incurred in connection with the performance of any Covered Health Care Services provided under this Agreement; (ii) the use of any property and facilities of the Provider; and (iii) activities performed in connection with this Agreement. All insurance required under this Agreement shall be provided by licensed insurance companies authorized to insure business in the State of Oklahoma.

Evidence of Insurance

A copy of the certificate of insurance shall be issued to Native Advantage as part of the credentialing process prior to the commencement of this Agreement, as part of Provider's recredentialing process with Native Advantage, in the event Provider's insurance changes or renews between credentialing cycles, and otherwise upon request by Native Advantage. Provider shall provide Native Advantage no less than thirty (30) calendar days prior to written notice of cancellation or material reduction in the insurance coverage specified in this Section.

Notwithstanding any other provision of this Agreement, failure to provide the certificate of insurance shall be grounds for immediate termination of this Agreement.

HIPAA Compliance

Provider attests that it is currently in compliance and will remain in compliance with HIPAA and other similar federal and state laws governing privacy and security of protected health information ("PHI").

Reporting Changes of Business Information

Provider shall make reasonable efforts to notify Native Advantage as soon as possible, in writing, of any change in Provider's business name, business address, telephone number, FAX number, Email address, tax identification number, National Provider Identification ("NPI") number(s), State license number, or other important changes.

Exclusion Screening

Provider shall not employ or contract with individuals or entities that are (i) excluded under the Office of the Inspector General's ("OIG") list of Excluded Individuals/Entities ("OIG List") at <http://oig.hhs.gov>; (ii) excluded from participation in Medicare or other Federal Health Care Program; or (iii) debarred, suspended, or proposed for debarment, declared ineligible, or voluntarily excluded by any Federal department or agency. Provider shall review the OIG List at <http://exclusions.oig.hhs.gov> and the U.S. General Services Administration's ("GSA") Excluded Parties List System ("EPLS") at <https://sam.gov> prior to the hiring of any employee, or contracting with any individual or entity, to ensure that the individual or entity is not on the Exclusion List and conduct regular follow-up Exclusion Screening checks thereafter. Upon request by Native Advantage, the Provider shall provide documentation of Exclusion Screening. Provider shall notify Native Advantage immediately upon discovering that it, or any of its employees, providers, contractors, subcontractors or agents, has furnished services as an Excluded Individual/Entity to a Native Advantage Member, immediately remove the Excluded Individual/Entity from any work related directly or indirectly to services furnished under this Agreement, and take appropriate corrective action.

Preclusion List

Effective January 1, 2019, CMS implemented the "Preclusion List," a list of providers and prescribers who are precluded from receiving payment for Medicare items and services and/or Part D drugs provided or prescribed to Medicare beneficiaries. Provider agrees not to allow employed or contracted providers and prescribers that are on the CMS Preclusion List to provide Covered Health Care Services to Native Advantage Members. Contracted Providers notified by Native Advantage or CMS that they are included on an updated CMS preclusion list, but not currently

excluded by the OIG, shall only be eligible for payment from Native Advantage for a sixty (60) day period after receiving such notice. After the expiration of such sixty (60) day notice period, Contracted Provider will no longer be eligible for payment from Native Advantage, will be prohibited from pursuing payment from a member and will be financially liable for any services, items, and drugs that are furnished, ordered, or prescribed after this 60-day period.

Native Advantage is a Health Maintenance Organization (HMO) with a Medicare Contract. Enrollment in Native Advantage depends on annual contract renewal. Native Advantage is offered by Native Advantage, Inc., a subsidiary of the Muscogee (Creek) Nation.