Network Provider Manual

HORIZON P·A·C·E

ALL INCLUSIVE CARE FOR THE ELDERLY

VERSION 2

Table of Contents

I. WELCOME TO HORIZON PACE

Thank you for participating in our PACE Provider Network. This Provider Manual is meant to assist you in working with our Participants within the framework of Horizon PACE policies and procedures. Familiarizing yourself with and adhering to the procedures outlined in this manual will help ensure a mutually beneficial, productive relationship in caring for our Participants.

Mission

Comprehensive Care for Seniors at Home

For more than 25 years, Kentuckians have trusted Horizon with their most precious treasure – their loved ones. We have served more than 30,000 families through our adult day health care, personal care, home health, and case management services. We have now expanded our services with Horizon PACE (Program of All-Inclusive Care for the Elderly). An innovative alternative to nursing homes, PACE is a nationally praised model that provides quality healthcare services and functions as a health plan for seniors – many of whom are Medicare and Medicaid eligible. Our PACE program covers an 11 County service area with PACE Centers in Bowling Green, Richmond, and Monticello.

In implementing our mission, we follow six principles:

1. We treat people with dignity and respect.
2. We believe that people are capable of making progress at any age.
3. We strive to make our service accessible to all members of the community.
4. We provide services consistent with the highest standards of care.
5. We believe that successful response to our clients' needs require staff with high levels of knowledge, skill and integrity.
6. We ensure continuation of services by being responsible fiscal managers.

Purpose of Manual

This Manual serves as a guide to the policies and procedures governing the administration of the Horizon PACE program and is an extension of and supplements the Provider Agreement between Horizon PACE and healthcare Providers who include, without limitation: physicians, hospitals and ancillary Providers (collectively, Providers).

In accordance with the Provider Agreement, participating Providers must abide by all applicable provisions contained in this Manual. Revisions to this Manual reflect changes made to Horizon PACE's Policies and Procedures. Revisions shall become binding 30 days after notice is provided by mail or electronic means, or such other period of time as necessary for Horizon PACE to comply with any statutory, regulatory, contractual and/or accreditation requirements. As Policies and Procedures change, updates will be issued by Horizon PACE in the form of Provider Bulletins and will be incorporated into subsequent versions of this Manual.

Overview of PACE

PACE, or Program of All-Inclusive Care for the Elderly, is an innovative model that provides a range of integrated preventative, acute care, and long-term care services to manage the often complex medical, functional, and social needs of the frail elderly.

PACE was created as a way to provide clients, family, caregivers and professional health care Providers the flexibility to meet a person's health care needs while continuing to live safely in the community.

The purpose of a PACE program is to provide pre-paid, capitated, comprehensive health care services that are designed to:

- Enhance the quality of life and autonomy for frail, older adults;
- Maximize dignity of and respect for older adults;
- Enable frail, older adults to live in their homes and in the community as long as medically and socially feasible; and
- Preserve and support the older adult's family unit.

PACE provides Participants all the care and services covered by Medicare and Medicaid, as authorized by the interdisciplinary team (IDT), as well as additional medically necessary care and services not covered by Medicare and Medicaid. There are no limitations or condition as to amount, duration or scope of services and there are no deductibles, copayments, coinsurance, or other cost sharing that would otherwise apply under Medicare or Medicaid. The IDT assesses the Participant's needs and develops a comprehensive care plan that meets the needs of its Participants across all care settings on a 24 hour basis, each day of the year. Social and medical services are provided primarily in an adult day health care center, but are supplemented by in-home and referral services as needed.

The PACE model of care is built around an interdisciplinary team which includes a primary care physician, nurse, social worker, physical therapist, occupational therapist, recreational therapist, dietician, center director, transportation coordinator, personal care worker and home care coordinator. Each Participant is assessed twice a year by the team. Based on the assessments, Participant problems are identified, and the team builds an integrated care plan to resolve them.

Benefits include, but are not limited to:

- Primary Care (Physician, Nurse Practitioner, Physician Assistant, or Community PCP)
- Nursing
- Prescription Medications
- Dentistry
- Podiatry
- Optometry
- Audiology
- All Medical Specialty Services (cardiology, pulmonology, nephrology, oncology, ophthalmology, etc.)
- Labs, X-ray
- Dialysis
- Hospital Care
- Emergency and Urgent Care
- Short-term Rehab and Long-term Care
- Rehabilitation Therapies
    - Physical Therapy
    - Occupational Therapy
    - Speech Therapy

- Engagement Programs
  - Socialization
  - Music, cultural events, and games
  - Stimulating cognitive activities
  - Group exercise activities
- Nutritional Support
  - Nutrition counseling
  - Meals
- Transportation
  - To and from the Horizon PACE Center
  - To and from scheduled medical appointments
- Social Services
  - Connections to community resources
  - Counseling and psychological services
  - Guidance and support for Participants and caregivers
- In-Home Services
  - Skilled Home Health (nursing, wound care, medication administration, etc.)
  - Safety Assessment and Equipment
  - Personal care (bathing, dressing, grooming etc.)
  - Chore services (meal preparation, light housekeeping, laundry, etc.)
- End of Life Care

Eligibility

To be eligible to enroll as a Horizon PACE Participant, an individual must be:

- 55 years of age or older
- Eligible for nursing facility level of care as determined by the Department of Medicaid Services pursuant to 907 KAR 1:022
- Eligible for Medicaid services; pay the Medicaid portion of the capitation payment if eligible for Medicare but not Medicaid; pay the full capitation payment if not eligible for Medicaid or Medicare
- Able to live safely in the community with the services provided by the PACE program
- A resident of the Horizon PACE service area (see Service Area on next page)

Service Area

Horizon PACE currently serves an 11-county market from three PACE Centers. These PACE centers are located in Bowling Green, Monticello, and Richmond and encompass the zip codes listed below.

HORIZON PACE - Bowling Green

CITY	ZIP
AUBURN	42206
WOODBURN	42170
ROCKFIELD	42274
BOWLING GREEN	42104
ALVATON	42122
BOWLING GREEN	42103
BOWLING GREEN	42101
AUSTIN	42123
LUCAS	42156
OAKLAND	42159
SMITHS GROVE	42171
PARK CITY	42160
FOUNTAIN RUN	42133
ETOILE	42131
GLASGOW	42141
EIGHTY EIGHT	42130
CAVE CITY	42127
KNOB LICK	42154
SUMMER SHADE	42166

HORIZON PACE - MONTICELLO

CITY	ZIP
FERGUSON	42533
SOMERSET	42501
CRAB ORCHARD	40419
BRODHEAD	40409
WILLIAMSBURG	40769
STEARNS	42647
REVELO	42638
STRUNK	42649
PINE KNOT	42635
MONTICELLO	42633
NANCY	42544
SCIENCE HILL	42553
BRONSTON	42518
MARSHES SIDING	42631
WHITLEY CITY	42653
BURNSIDE	42519
PARKERS LAKE	42634
BURKESVILLE	42717
ALBANY	42602
ALPHA	42603
RUSSELL SPRINGS	42642

HORIZON PACE - RICHMOND

CITY	ZIP
RICHMOND	40475
ORLANDO	40460
WACO	40385
PAINT LICK	40461
SOMERSET	42503
BEREA	40404
EUBANK	42567
BEREA	40403
CRAB ORCHARD	40419
EAST BERNSTADT	40729
BRODHEAD	40409
SANDGAP	40481
CORBIN	40701
MC KEE	40447
LONDON	40750
WANETA	40488
GRAY	40734
ANNVILLE	40402
KEAVY	40737
GRAY HAWK	40434
LONDON	40743
IRVINE	40336
LONDON	40744
MANCHESTER	40962
LILY	40740
STANTON	40380
LONDON	40741
TYNER	40486
MOUNT VERNON	40456
RAVENNA	40472
LIVINGSTON	40445

II. BECOMING A HORIZON PACE NETWORK PROVIDER

At Horizon Pace, it is our mission to provide the highest quality care for our Participants – your patients. We look forward to developing a partnership which will enable us to best serve the needs of our Participants and allow them to live fulfilling lives as independently as possible.

Baseline Criteria

Baseline criteria for practitioners to qualify for Horizon Provider network participation:

- License to Practice – Practitioners must have a current, valid, unrestricted license to practice.
- Drug Enforcement Administration Certificate – Practitioners must have a current valid DEA certificate (as applicable to practitioner specialty), and if applicable to the state where services are performed, hold a current Controlled Dangerous Substance (CDS) or Controlled Substance Registration (CSR) certificate (applicable for M.D., D.O., D.P.M., D.D.S., D.M.D.).
- Work History – Practitioners must provide a minimum of five years' relevant work history as a health professional.
- Board Certification – Providers must maintain board certification in the specialty being practiced as a Provider, or must have verifiable educational training from an accredited training program in the specialty requested.
- Hospital Admitting Privileges – Specialist practitioners shall have hospital admitting privileges at a Horizon network hospital (as applicable to specialty). Primary care Providers may have hospital admitting privileges or may enter into a formal agreement with another Horizon network participating Provider who has admitting privileges at a Horizon network hospital, for the admission of Participants.
- Ability to Participate in Medicaid and Medicare – Providers must have the ability to participate in Medicaid and Medicare. Any individual or entity excluded from participation in any government program is not eligible for participation in the Horizon PACE network. Existing Providers who are restricted from participation in any government program are subject to immediate termination in accordance with Horizon PACE policy and procedure and the Agreement.
- Providers Who Opt Out of Medicare – A Provider who opts out of Medicare is not eligible to become a Horizon PACE network Provider. An existing Provider who opts out of Medicare is not eligible to remain as a network Provider for Horizon PACE.
- Liability Insurance – Horizon Pace Providers (all disciplines) are required to carry and continue to maintain professional liability insurance, unless otherwise agreed by Horizon in writing. Providers must furnish copies of any current professional liability insurance certificate to Horizon PACE, concurrent with expiration.

Credentialing

Credentialing is the process by which Horizon PACE or its credentialing delegate evaluates the credentials and qualifications of practitioners. Allied Health Professionals (AHPs), both dependent and independent, are also credentialed by Horizon PACE. AHPs include, but are not limited to the following: nurse practitioners, physician assistants, social workers, physical therapists, occupational therapists, audiologists, and behavioral health Providers.

This review includes (as applicable to practitioner type):

- Background
- Education
- Postgraduate training
- Certification(s)
- Experience
- Work history and demonstrated ability
- Malpractice claims history
- Malpractice insurance
- Patient admitting capabilities (as applicable)
- Licensure, regulatory compliance and health status which may affect a practitioner's ability to provide healthcare
- Medicare and Medicaid participation status
- Accreditation status, as applicable to non-individuals

Re-Credentialing

In accordance with regulatory, accreditation, and Horizon PACE policy and procedure, re-credentialing is required at least once every 36 months.

Right to Correct Erroneous Information

The practitioner may review documentation submitted by him or her in support of the credentialing/re-credentialing application, together with any discrepant information received from professional liability insurance carriers, state licensing agencies, and certification boards, subject to any Horizon PACE restrictions. Horizon PACE or its designee, will review the corrected information and explanation at the time of considering the practitioner's credentials for Provider network participation or re-credentialing.

Confidentiality

Information acquired through the credentialing process is considered confidential and Horizon PACE staff and credentialing delegates who have access to the files are responsible for ensuring the information remains confidential, except as otherwise provided by law. Horizon PACE may deny or restrict participation, terminate participation, or take other action in accordance with the Provider's written agreement with Horizon PACE and our credentialing policies and procedures.

Monitoring

Office of Inspector General Medicare/Medicaid Sanctions Report

On a monthly basis, Horizon PACE or its designee accesses the listings from the Office of Inspector General (OIG) List of Excluded Individuals and Entities (LEIE) report of exclusions and reinstatements, for the most current available information. This information is cross-checked against Horizon PACE's network of Providers. If participating Providers are identified as being currently excluded, such Providers are subject to immediate termination, in accordance with Horizon Pace policies and procedures and the Agreement.

Sanction Reports Pertaining to Licensure, Hospital Privileges or Other Professional Credentials

On a monthly basis, Horizon PACE, or its designee, contacts state licensure agencies to obtain the most current available information on sanctioned Providers. This information is cross-checked against the network of Horizon PACE Providers. If a network Provider is identified as being currently under sanction, appropriate action is taken in accordance with Horizon PACE policy and procedure. If the sanction imposed is revocation of license, the Provider is subject to immediate termination.

Notifications of termination are given in accordance with contract and Horizon PACE policies and procedures.

If a sanction imposes a reprimand or probation, written communication is made to the Provider requesting a full explanation, which is then reviewed by Horizon PACE to determine whether the Provider should continue participation or whether termination should be initiated.

III. NETWORK PROVIDER RESPONSIBILITIES

- Providers must act in the best interests of PACE program Participants, including the protection of Participants' rights.
- Providers must abide by all laws, rules, and regulations governing PACE.
- Providers must abide by all laws, rules, and regulations relating to patient privacy and access to records.
- Providers must adhere to all contract provisions.
- Providers must report any known or suspected instances of unethical or illegal behavior and must not retaliate against any staff member who in good faith reports any such concerns.
- Providers must have written policies and procedures that guide staff members in complying with regulatory and contractual requirements.
- Providers and their staff must attend annual compliance training which includes training on fraud, waste, and abuse.
- Providers must check the government sanction and exclusion databases (http://exclusions.oig.hhs.gov; www.sam.gov) on a monthly basis to ensure that they, their employees, and their subcontractors are not excluded from participating in government programs. Providers must maintain documentation of this monthly monitoring activity. Horizon PACE may ask for this documentation. Providers shall immediately notify Horizon PACE if any person is included on the exclusion list.

- Providers must obtain prior authorization prior to rendering any services to Horizon PACE program Participants, a service authorization is needed to specify the authorized services in accordance with the Participant's service plan. If an authorization has not been received, the Provider is expected to contact the Participant's IDT to obtain prior authorization.

- Providers must provide written notice to Horizon PACE regarding any change in the type, scope, or location of delivery of services at least ninety (90) days prior to the effective date of such change.

- Providers must send written notice to Horizon PACE within five (5) days of any legal, governmental, or other action initiated against Provider.

- Providers must notify Horizon PACE of any changes in address, telephone number, or other contact information, such as email address or administrator name.

- Providers must demonstrate sensitivity to cultural diversity and must honor Participants' beliefs. Providers are expected to foster staff attitudes and interpersonal communication styles that respect Participants' cultural backgrounds.

- Providers must maintain documentation of all services provided and provide copies of this documentation upon request.

IV. RECORDS

Record Keeping, Record Submission, and Records Inspection

All network Providers must maintain and upon request furnish to Horizon PACE all information requested by Horizon PACE related to the quality and quantity of services provided through their contract. This includes written documentation of care and services provided, including dates of services, time records, invoices, contracts, vouchers, or other official documentation evidencing in proper detail the nature and propriety of the services provided. Network Providers must submit progress notes to Horizon PACE within 72 hours of care delivery and must submit progress notes on the same day if the Provider is recommending any changes to a patient's treatment regimen.

Providers shall maintain books and records, including Participant medical records, pertaining to services provided in a form consistent with and in compliance with provisions of all applicable state and federal laws.

Confidentiality of Participant Information and Release of Records

Medical records must be maintained in a manner designed to protect the confidentiality of such information and in accordance with applicable state and federal laws, rules and regulations. All consultations or discussions involving the Participant or her or his case must be conducted discreetly and professionally in accordance with all applicable state and federal laws, including the privacy and security rules and regulations of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), as may be amended. All Provider practice personnel must be trained on HIPAA Privacy and Security regulations. The practice must ensure there is a procedure or process in place for maintaining confidentiality of Participants' medical records and other Protected Health Information (PHI) as defined under HIPAA; and the practice is following those procedures and/or obtaining appropriate authorization from Participants to release information or records where required by applicable state and federal law. Procedures must

include protection against unauthorized/inadvertent disclosure of all confidential medical information, including PHI.

Every Provider is required to provide Participants with information regarding their privacy practices and to the extent required by law, with their Notice of Privacy Practices (NPP).

Examples of confidential information include, but are not limited to, the following:

- Medical records
- Communication between a Participant and a physician regarding the Participant's medical care and treatment
- All personal and/or PHI as defined under the federal HIPAA privacy regulations, and/or other state or federal laws
- Any communication with other clinical persons involved in the Participant's health, medical and behavioral care (i.e., diagnosis, treatment and any identifying information such as name, address, Social Security Number (SSN), etc.)
- Participant transfer to a facility for treatment
- Any communicable disease, such as AIDS or HIV testing, that is protected under federal or state law

The NPP informs the Participant of their rights under HIPAA and how the Provider and/or Horizon PACE may use or disclose the Participant's PHI. HIPAA regulations require each covered entity to provide a NPP to each new patient or Participant.

Disclosure of Information

Protected health information may only be used and disclosed as the Privacy Rule permits or as the individual who is the subject of the information (or the individual's personal representative) authorizes in writing.

Access to Records

Providers must comply with the Privacy Rule as well as the Information Blocking Rule in providing Participants with access to their records.

V. QUALITY IMPROVEMENT

Horizon PACE strives to deliver outstanding services so Participants can achieve their goals and desired outcomes. Delivering quality care is a strategic objective and is driven each year by the annual Quality Improvement (QI) Plan.

Horizon PACE uses objective measures to demonstrate improved performance with regard to the following:

(1) Utilization of PACE services, such as decreased inpatient hospitalizations and emergency room visits.

(2) Caregiver and Participant satisfaction.

(3) Outcome measures that are derived from data collected during assessments, including data on the following:

  (i) Physiological well-being.

  (ii) Functional status.

  (iii) Cognitive ability.

  (iv) Social/behavioral functioning.

  (v) Quality of life of Participants.

(4) Effectiveness and safety of staff-provided and contracted services, including the following:

  (i) Competency of clinical staff.

  (ii) Promptness of service delivery.

  (iii) Achievement of treatment goals and measurable outcomes.

(5) Nonclinical areas, such as grievances and appeals, transportation services, meals, life safety, and environmental issues.

Horizon PACE encourages its network Providers to communicate feedback as to how we can continue our strong tradition of delivering quality care.

VI. UTILZATION MANAGEMENT AND PRIOR AUTHORIZATION

Horizon PACE maintains a "Right Care, Right Place, Right Time" Program to evaluate medical necessity and manage the quality and cost of health care services delivered to Participants. All services are evaluated either prospectively, concurrently, or retrospectively to determine medical necessity based on standard criteria.

Utilization Management

The utilization management program is designed to ensure that:

- Services are medically necessary, consistent with the assigned Participant's diagnoses, and are delivered at appropriate levels of care.
- Services are provided by Horizon PACE contracted Providers and that the utilization review staff is notified immediately to discuss the use of non-contracted Providers based on services that are not available through contracted Providers.
- Hospital admissions and length of stay are justified.
- Services are not over-utilized or under-utilized.
- Continuity and coordination of care is monitored.
- Guidelines, standards, and criteria set by governmental and other regulatory agencies are followed. Horizon PACE utilizes standard criteria, such as InterQual Criteria, National Coverage Decisions, the Medicare Benefit Policy Manual, Local Coverage Determinations and current literature to assess all requests for determination of medical necessity. All criteria are reviewed by the Quality Improvement Committee on an annual basis.
- New technology is evaluated based on Medicare and Medicaid reviews and review of studies that determine its application and effectiveness.

Prior Authorization

Prior authorization allows for efficient use of covered services by Participants to receive the most appropriate level of care in the most appropriate setting. PACE is somewhat unique in that all services must be prior authorized by the Interdisciplinary Team.

Prior authorization may be obtained by submitting an authorization request through the Horizon PACECare system. Once received the request will be reviewed by the IDT and then approval or denial of the item or service will be communicated to the Provider. Any denial is appealable by the Participant or the Participant's authorized representative (see Service Determination Process).

Participant Scheduling

Horizon PACE is responsible for scheduling appointments and arranging transportation to and from all Provider encounters for Horizon PACE Participants. Please refrain from scheduling appointments directly with Participants or their family members. Please contact Horizon PACE to schedule an appointment or other service.

Urgent and Emergency Care

Horizon PACE provides coverage for the treatment of an emergency medical condition, which is defined by CMS as a condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following:

- Serious jeopardy to the health of the Participant.
- Serious impairment to bodily functions.
- Serious dysfunction of any bodily organ or part.

Emergency care is appropriate when services are needed immediately because of an injury or sudden illness and the time required to reach Horizon PACE or one of the network Providers, would cause risk of permanent damage to the Participant's health. Emergency services include inpatient and outpatient services that meet the following requirements:

- Are furnished by a qualified emergency services Provider, other than the PACE organization or one of its contract Providers, either in or out of the PACE organization's service area.
- Are needed to evaluate or stabilize an emergency medical condition.

Prior authorization is not required for emergency care. In the event of an emergency, Horizon PACE instructs its Participants to seek immediate care, or call 911 for assistance. Horizon PACE will not deny payment if a Horizon PACE contracted health care Provider instructs a Participant to seek emergency services. Providers must notify Horizon PACE within 24 hours of providing emergency care.

Horizon PACE provides coverage for urgently needed out-of-network and post-stabilization care services when either of the following conditions are met:

- The services are preapproved by Horizon PACE.
- The services are not preapproved by Horizon PACE because Horizon PACE did not respond to a request for approval within 1 hour after being contacted or cannot be contacted for approval.

Post-stabilization care means services provided subsequent to an emergency that a treating physician views as medically necessary after an emergency medical condition has been stabilized. They are not emergency services, which PACE organizations are obligated to cover. Rather, they are non-emergency services that the PACE organization should approve before they are provided outside the service area.

Urgent care means the care provided to a PACE Participant who is out of the PACE service area, and who believes their illness or injury is too severe to postpone treatment until they return to the service area, but their life or function is not in severe jeopardy.

VII. CLAIMS AND PAYMENT

Identification Cards

Every Horizon PACE Participant receives an identification card that will detail the Participant's name and identification number. This card identifies them as a Horizon PACE Participant and should be presented to physicians and other Providers when seeking healthcare services. If a Horizon PACE Participant is requesting service and is unable to present an identification card, please contact the Horizon PACE Provider Services at the following numbers:

1-(877) 249-8545 – Monticello

1-(877) 676-8581 – Bowling Green

1-(877) 676-8583 – Richmond

Regardless of whether a Participant has an identification card, Providers should verify Participant eligibility at the time of service to ensure she/he is enrolled in Horizon PACE. Failure to do so may affect claims payment.

Eligibility for Payment

Specific payment terms are defined within the individual Provider contracts with Horizon PACE; however, the payment for services provided may also be affected by the following:

- The Participant's eligibility at the time of service
- Whether services provided are covered services
- Whether services provided are medically necessary
- Whether services were without the prior authorization of the IDT
- The amount of the Provider's billed charges
- Adjustments of payments based on coding edits described below

Claim Submission

Providers are responsible for submitting a clean claim for each Participant served to receive payment. A clean claim is free from errors and contains all the following:

Participant Information:

- Participant full name
- Participant ID number
- Date of birth

Service Information:

- Authorization number (each claim form must contain ONLY ONE authorization number)
- Date(s) of service (date range or individual days)
- Service/HCPCS/Revenue code/Modifier (if applicable)
- Diagnosis code (if applicable)
- Number of units (number of days in service period or units of provided service)
- Unit rate/billed amount

Provider Information:

- Provider name
- Provider address
- Provider Tax Identification Number (TIN)
- National Provider Identifier (NPI)

All Providers are required to bill encounters within ninety (90) days from the date of service as prescribed in the Provider Agreement.

Electronic Claims

All encounters, when possible, should be submitted electronically through the Availity Clearinghouse. The Horizon PACE Payer ID is: R4569. If electronic submission is not possible, Horizon PACE will accept paper CMS 1500 and UB-04 forms.

Claims Processing

Horizon PACE will process all clean claims within thirty (30) calendar days of receipt. A Clean Claim means one which can be processed without obtaining additional information from the Provider of the service or from a third party. It does not include a claim from a Provider who is known to be under investigation for fraud or abuse, a claim under review for medical necessity or a claim for which there is no authorization, or the claim does not match the services authorized via the authorization.

Payment for services rendered is subject to verification that:

- The Participant was enrolled in Horizon PACE at the time the service was provided;
- The service was delivered to the patient (cancelled services are not eligible for payment); and
- The Provider was compliant with Horizon PACE prior authorization policies at the time of service.

Claims that are not clean may be denied. In the event of a denial of payment for services rendered to Participants, a Provider shall not bill, charge, seek payment or have any recourse against the Participant, Medicare, or Medicaid for such services. Medicare and Medicaid will not be responsible for claims for the Participant while they are enrolled as a Participant of Horizon PACE. All claims for services provided to Horizon PACE Participants must be submitted to Horizon PACE.

Coding Edits

Horizon PACE will process Provider claims that are accurate and complete in accordance with Horizon PACE's normal claims processing procedures and applicable state and/or federal laws, rules and regulations with respect to the timeliness of claims processing. Such claims processing procedures and edits may include, without limitation, automated systems applications which identify, analyze, and compare the amounts claimed for payment with the diagnosis codes and which analyze the relationships among the billing codes used to represent the services provided to Participants.

These automated systems may result in an adjustment of the payment to the Provider for the services or in a request, prior to payment, for the submission of medical records that relate to the claim. Providers may request reconsideration of any adjustments produced by these automated systems by submitting a timely request for reconsideration to Horizon PACE (please see the Provider Claims Reconsideration section of this Manual for more information). A reduction in payment as a result of claims policies and/or processing procedures is not an indication that the service provided is a non-covered service.

Pass-Through Billing

Horizon PACE prohibits pass-through billing. Pass-through billing occurs when the ordering Provider requests and bills for a service, but the service is not performed by the ordering Provider or those under their direct employ. Provider agrees that services related to pass-through billing will not be eligible for reimbursement from Horizon PACE and Provider shall not bill, charge, seek payment or have any recourse against Horizon PACE or Participants for any amounts related to the provision of pass-through billing.

Claim Payment Dispute Process

Providers must submit any payment dispute to Horizon PACE in writing within 60 days of receipt of the Explanation of Payment (EOP). When submitting the dispute, the Provider must include the following information:

- Date(s) of service
- Member name
- Member ID number and/or date of birth
- Provider name
- Provider Tax ID/TIN
- Total billed charges
- A statement explaining the reason for the dispute
- Supporting documentation when necessary (e.g., proof of timely filing, authorization, medical records)

Horizon PACE will issue a payment dispute determination decision within 45 days.

Any Provider not satisfied with the payment dispute determination decision must pursue the dispute resolution procedures within the Provider Agreement.

VIII. COMPLIANCE

Horizon PACE operates a comprehensive compliance program and has procedures in place to self-report any potential fraud or misconduct related to PACE to CMS and DMS.

Horizon PACE requires all Providers to comply with all federal and state laws and regulations designed to prevent fraud, waste and abuse, including but not limited to, applicable provisions of the United States Criminal Code, the False Claims Act (FCA), the Anti-Kickback Statute (AKS), and the Physician Self-Referral Law (Stark Law). Additionally, Providers must comply with the Health Insurance Portability and Accountability Act (HIPAA) as amended, the 21st Century Cures Act, and all applicable state and federal laws, including, but not limited to, Title VI of The Civil Rights Act of 1964, the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, and the Americans with Disabilities Act.

The following are some examples of fraudulent, abusive, and unacceptable practices that are prohibited by Horizon PACE:

- Submission of false information for the purpose of obtaining greater compensation than to which the Provider is legally entitled (i.e., upcoding or unbundling of charges).
- Billing for services not rendered or billing in advance of care.
- Knowingly demanding or collecting any compensation in addition to claims submitted for covered services.
- Ordering or furnishing inappropriate, improper, unnecessary, or excessive care services or supplies.
- Failing to maintain or furnish, for audit and investigative purposes, sufficient documentation on the extent of care and services rendered to Participants.
- Offering or accepting inducements to influence Participants to join the plan or to use or avoid using a particular service.
- Submitting bills or accepting payment for care, services or supplies rendered by a Provider who has been disqualified from participation in the Medicare or Medicaid programs.

Providers who suspect fraud, waste, and abuse on the part of another Provider or a Participant are encouraged to contact the Horizon PACE Compliance Hotline at:

1-833-753-6195
or
horizonpace@compliancehotline.com

These reports may be made anonymously. All contacts will be treated confidentially.

Fraud, Waste, and Abuse Training

All Medicare Part D prescription drug Providers are required to conduct annual training on fraud, waste, and abuse. To the extent that Horizon PACE operates as a Medicare Part D provider, Horizon PACE may require some of their participating provider network organizations to provide Part D Fraud, Waste, and Abuse training to their staff both initially and annually.

IX. PARTICIPANT RIGHTS

PACE program Participants have certain rights and protections. As a Provider, you have the responsibility to respect every Participant's rights. See Appendix C for a list of Participant Rights.

X. SERVICE DETERMINATION

A service determination request is a (1) a request to initiate a service; (2) a request to modify an existing service, including to increase, reduce, eliminate, or otherwise change a service; or (3) a request to continue coverage of a service that the PACE organization is recommending be discontinued or reduced. Requests to initiate, modify, or continue a service do not constitute a service determination request if the request is made prior to completing the development of the initial plan of care.

A Participant, a Participants' designated representative, or a Participant's caregiver may make a service determination request.

Unless a member of the interdisciplinary team is able to approve the service determination request in full at the time the request is made, Horizon PACE must bring a service determination request to the interdisciplinary team as expeditiously as the Participant's condition requires, but no later than 3 calendar days from the time the request is made. The full interdisciplinary team must review and discuss each service determination request and decide to approve, deny, or partially deny the request based on that review. If the interdisciplinary team expects to deny or partially deny a service determination request, the appropriate members of the interdisciplinary team, as identified by the interdisciplinary team, must conduct an in-person reassessment before the interdisciplinary team makes a final decision.

If the interdisciplinary team makes a determination to approve a service determination request, it must provide the Participant or the designated representative either oral or written notice of the determination. Notice of any decision to approve a service determination request must explain the conditions of the approval in understandable language, including when the Participant may expect to receive the approved service. If the interdisciplinary team decides to deny or partially deny a service, it must provide the Participant or the designated representative both oral and written notice of the determination. Notice of any denial must:

(i) State the specific reason(s) for the denial, including why the service is not necessary to maintain or improve the Participant's overall health status, taking into account the Participant's medical, physical, emotional, and social needs, and the results of the reassessment(s) in understandable language

(ii) Inform the Participant or designated representative of his or her right to appeal the decision

(iii) Describe the standard and expedited appeals processes

(iv) For a Medicaid Participant, inform the Participant of both of the following:

(A) his or her right to continue receiving disputed services during the appeals process until issuance of the final determination and;

(B) the conditions for continuing to receive disputed services.

XI. PARTICIPANT GRIEVANCES

A grievance is a complaint, either written or oral, expressing dissatisfaction with service delivery or the quality of care furnished.

All Horizon PACE staff members may receive grievances and must document the grievance on the Grievance Form. The Quality Improvement Director will acknowledge receipt of the grievance within five (5) days and thereafter will assign the appropriate Horizon PACE staff member to investigate and resolve the grievance. Resolution of the grievance will be communicated in writing within thirty (30) days.

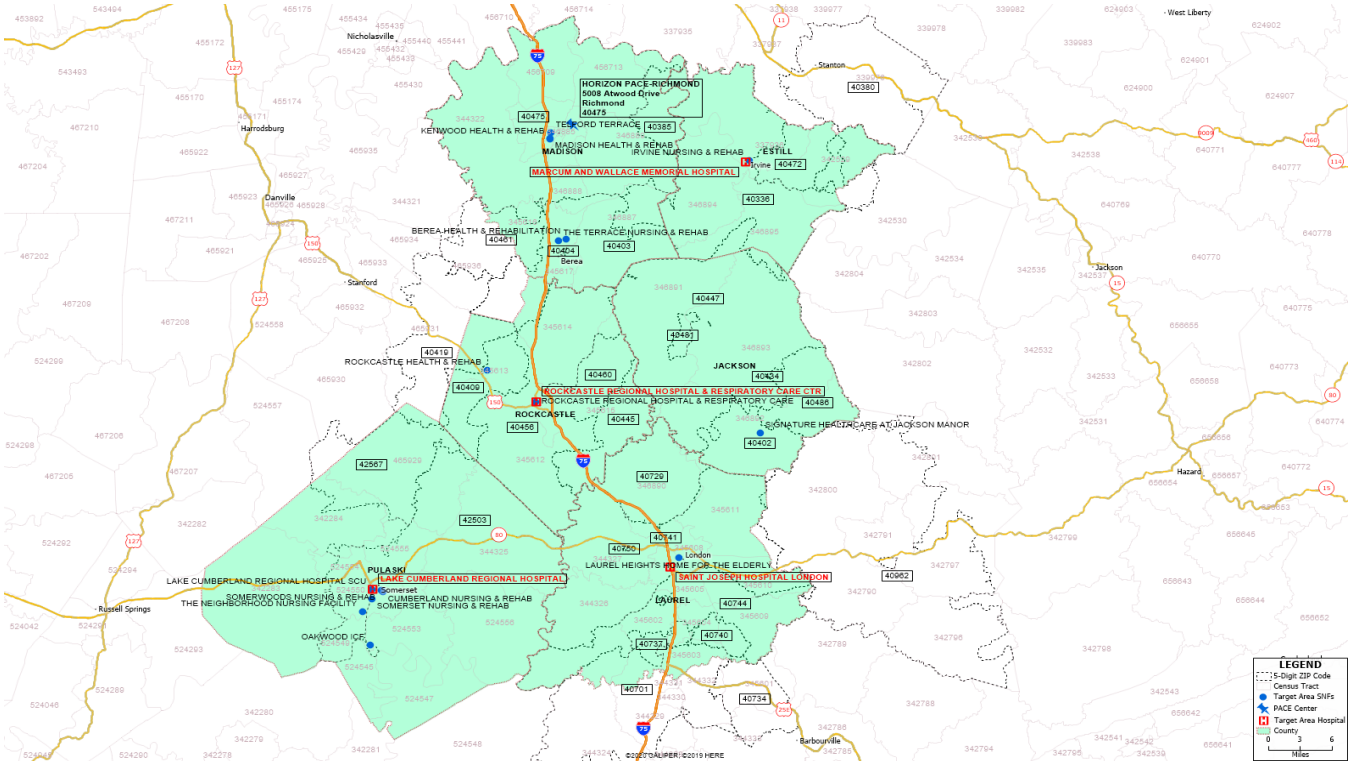
Horizon PACE must continue to furnish all required services to the Participant during the grievance process.

XII. PARTICIPANT APPEALS

An appeal is a Participant action taken with respect to the PACE organization's non-coverage of, or nonpayment for, a service including denials, reductions, or termination of services. A request to initiate, modify or continue a service must first be processed as a service determination request before the PACE organization can process an appeal.

Appeal Process

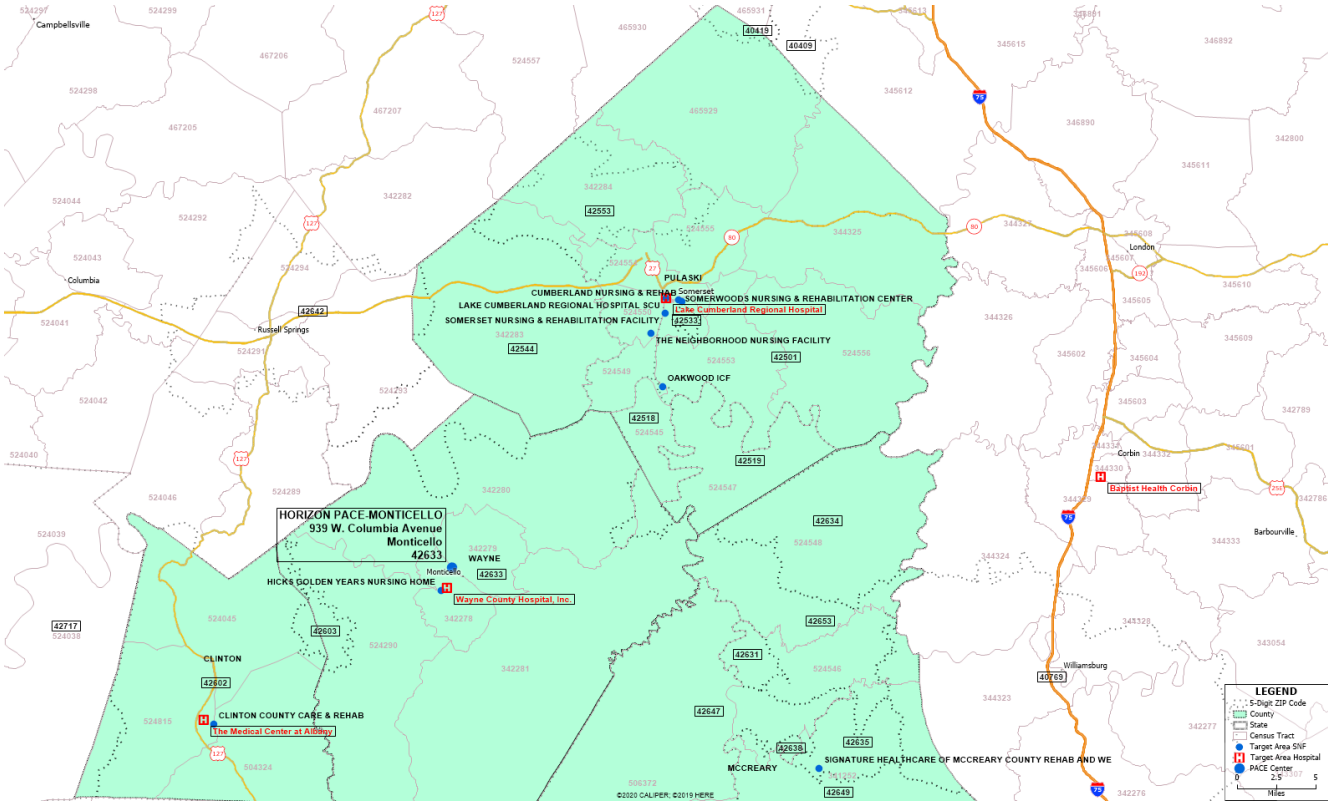
- A Participant or a Participant's designated representative may submit an appeal either verbally or in writing.
- The QI Director will provide written acknowledgment of the appeal within five (5) calendar days.
- A review of the appeal will be conducted by an independent third party reviewer or committee.
- An appeal decision will be made as expeditiously as the Participant's health condition requires, but no more than thirty (30) days after receipt of the appeal. Written notification of the decision will be provided as follows:
    - If the decision is in favor of the Participant, the disputed service will be provided as expeditiously as the health condition of the Participant requires.
    - If the decision is adverse to the Participant, the Participant will be advised of additional appeal rights through Medicare and/or Medicaid.



HORIZON PACE - Richmond

CITY	ZIP
RICHMOND	40475
ORLANDO	40460
WACO	40385
PAINT LICK	40461
SOMERSET	42503
BEREA	40404
EUBANK	42567
BEREA	40403
CRAB ORCHARD	40419
EAST BERNSTADT	40729
BRODHEAD	40409
SANDGAP	40481
CORBIN	40701
MC KEE	40447
LONDON	40750
WANETA	40488

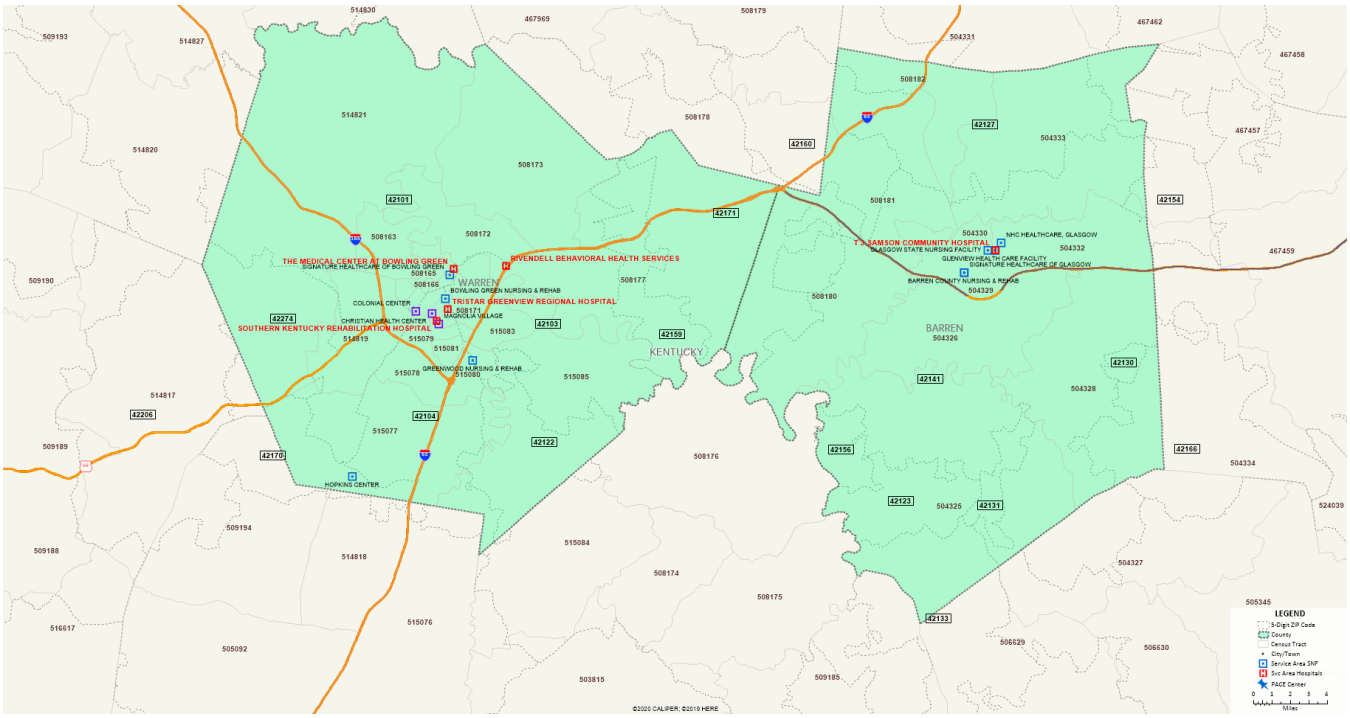
CITY	ZIP
GRAY	40734
ANNVILLE	40402
KEAVY	40737
GRAY HAWK	40434
LONDON	40743
IRVINE	40336
LONDON	40744
MANCHESTER	40962
LILY	40740
STANTON	40380
LONDON	40741
TYNER	40486
MOUNT VERNON	40456
RAVENNA	40472
LIVINGSTON	40445



HORIZON PACE - Monticello

CITY	ZIP
FERGUSON	42533
SOMERSET	42501
CRAB ORCHARD	40419
BRODHEAD	40409
WILLIAMSBURG	40769
STEARNS	42647
REVELO	42638
STRUNK	42649
PINE KNOT	42635
MONTICELLO	42633
NANCY	42544

CITY	ZIP
SCIENCE HILL	42553
BRONSTON	42518
MARSHES SIDING	42631
WHITLEY CITY	42653
BURNSIDE	42519
PARKERS LAKE	42634
BURKESVILLE	42717
ALBANY	42602
ALPHA	42603
RUSSELL SPRINGS	42642



HORIZON PACE - Bowling Green

CITY	ZIP
AUBURN	42206
WOODBURN	42170
ROCKFIELD	42274
BOWLING GREEN	42104
ALVATON	42122
BOWLING GREEN	42103
BOWLING GREEN	42101
AUSTIN	42123
LUCAS	42156
OAKLAND	42159

CITY	ZIP
SMITHS GROVE	42171
PARK CITY	42160
FOUNTAIN RUN	42133
ETOILE	42131
GLASGOW	42141
EIGHTY EIGHT	42130
CAVE CITY	42127
KNOB LICK	42154
SUMMER SHADE	42166

Appendix B – Contact Information

Contact information will be provided upon completion of the three-way contract between CMS, Medicaid, and Horizon PACE.

Appendix C – Participant Rights

(a) Respect and nondiscrimination. Each Participant has the right to considerate, respectful care from all PACE employees and contractors at all times and under all circumstances. Each Participant has the right not to be discriminated against in the delivery of required PACE services based on race, ethnicity, national origin, religion, sex, age, sexual orientation, mental or physical disability, or source of payment. Specifically, each Participant has the right to the following:

(1) To receive comprehensive health care in a safe and clean environment and in an accessible manner.

(2) To be treated with dignity and respect, be afforded privacy and confidentiality in all aspects of care, and be provided humane care.

(3) Not to be required to perform services for the PACE organization.

(4) To have reasonable access to a telephone.

(5) To be free from harm, including physical or mental abuse, neglect, corporal punishment, involuntary seclusion, excessive medication, and any physical or chemical restraint imposed for purposes of discipline or convenience and not required to treat the Participant's medical symptoms.

(6) To be encouraged and assisted to exercise rights as a Participant, including the Medicare and Medicaid appeals processes as well as civil and other legal rights.

(7) To be encouraged and assisted to recommend changes in policies and services to PACE staff.

(b) Information disclosure. Each PACE Participant has the right to receive accurate, easily understood information and to receive assistance in making informed health care decisions. Specifically, each Participant has the following rights:

(1) To be fully informed in writing of the services available from the PACE organization, including identification of all services that are delivered through contracts, rather than furnished directly by the PACE organization at the following times:

(i) Prior to and upon enrollment in the PACE organization.

(ii) At the time a Participant's needs necessitate the disclosure and delivery of such information in order to allow the Participant to make an informed choice.

(2) To have the enrollment agreement, described in 42 CFR § 460.154, fully explained in a manner understood by the Participant.

(3) To examine, or upon reasonable request, to be helped to examine the results of the most recent review of the PACE organization conducted by CMS or the State administering agency and any plan of correction in effect.

(4) To contact 1-800-MEDICARE for information and assistance, including to make a complaint related to the quality of care or the delivery of a service.

(c) Choice of Providers. Each Participant has the right to a choice of health care Providers, within the PACE organization's network, that is sufficient to ensure access to appropriate high-quality health care. Specifically, each Participant has the right to the following:

(1) To choose his or her primary care physician and specialists from within the PACE network.

(2) To request that a qualified specialist for women's health services furnish routine or preventive women's health services.

(3) To have reasonable and timely access to specialists as indicated by the Participant's health condition and consistent with current clinical practice guidelines.

(4) To receive necessary care in all care settings, up to and including placement in a long-term care facility when the PACE organization can no longer provide the services necessary to maintain the Participant safely in the community.

(5) To disenroll from the program at any time and have such disenrollment be effective the first day of the month following the date the PACE organization receives the Participant's notice of voluntary disenrollment as set forth in 42 CFR § 460.162(a).

(d) Access to emergency services. Each Participant has the right to access emergency health care services when and where the need arises without prior authorization by the PACE interdisciplinary team.

(e) Participation in treatment decisions. Each Participant has the right to participate fully in all decisions related to his or her treatment. A Participant who is unable to participate fully in treatment decisions has the right to designate a representative. Specifically, each Participant has the following rights:

(1) To have all treatment options explained in a culturally competent manner and to make health care decisions, including the right to refuse treatment, and be informed of the consequences of the decisions.

(2) To have the PACE organization explain advance directives and to establish them, if the Participant so desires, in accordance with 42 CFR §§ 489.100 and 489.102.

(3) To be fully informed of his or her health and functional status by the interdisciplinary team.

(4) To participate in the development and implementation of the plan of care.

(5) To request a reassessment by the interdisciplinary team.

(6) To be given reasonable advance notice, in writing, of any transfer to another treatment setting and the justification for the transfer (that is, due to medical reasons or for the Participant's welfare, or that of other Participants). The PACE organization must document the justification in the Participant's medical record.

(f) Confidentiality of health information. Each Participant has the right to communicate with health care Providers in confidence and to have the confidentiality of his or her individually identifiable health care information protected. Each Participant also has the right to review and copy his or her own medical records and request amendments to those records. Specifically, each Participant has the following rights:

(1) To be assured of confidential treatment of all information contained in the health record, including information contained in an automated data bank.

(2) To be assured that his or her written consent will be obtained for the release of information to persons not otherwise authorized under law to receive it.

(3) To provide written consent that limits the degree of information and the persons to whom information may be given.

(g) Complaints and appeals. Each Participant has the right to a fair and efficient process for resolving differences with the PACE organization, including a rigorous system for internal review by the organization and an independent system of external review. Specifically, each Participant has the following rights:

(1) To be encouraged and assisted to voice complaints to PACE staff and outside representatives of his or her choice, free of any restraint, interference, coercion, discrimination, or reprisal by the PACE staff.

(2) To appeal any treatment decision of the PACE organization, its employees, or contractors through the process described in 42 CFR § 460.122.

HORIZON
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