PCOT
Physicians Contracting Organization of Texas

Committed to patient advocacy.
Quality healthcare. Independent physicians.

March 23, 2016

To All PCOT Practices

Ladies and Gentlemen:

On March 23, 2016, the PCOT's Board of Directors executed a contract with Fresenius Health Partners a network for Medicare Advantage, including Chronic Conditions Special needs plans (C-SNPs). **At this time, they are seeking to build their network to begin servicing patients in 2017.** Please see the attached summary of terms of this contract.
This contract does not include well vision care services.

The Fresenius Health Partners Medicare Advantage program could start as early as 1/1/2017 if approved by CMS.

Please indicate your practice's plans to participate in this Fresenius Health Partners MA plan contract by checking one of the boxes below for the health plan. This response should be faxed to PCOT at 903-526-2320. **The Medicare Advantage Provisions Addendum must also be signed and returned if you chose to participate in the contract.**

Sincerely,

Jennifer Roach
Executive Director

_____ Yes, our practice will accept these fees and all physicians in the practice will participate in the Fresenius Health Partners contract for Medicare Advantage

_____ No, our practice does not wish to participate in the Fresenius Health Partners contract for Medicare Advantage.

Date:_____ Practice Name:_____

Authorized Signature:_____

Tax I.D. No._____

Printed Physician Name(s)

1318 Doctors Drive Tyler, Texas 75701
903-526-3268 or 1-888-248-1907 Fax: 903-526-2320

		Physicians Contracting Organization of Texas	
		Contract Review Worksheet	
		JRR 3-7-2016	
		Background Information	
	1	Payor Name, Organizational Status	**Fresenius Health Partners**
	2	Type of Organization	Medicare Advantage ESRD (End stage renal disease)-Chronic special needs plan
	3	Type Product	Medicare Advantage, including Chronic Conditions Special needs plans (C-SNPs)
	4	Background Due Diligence, OIG Exclusion, TDI	no reports
	5	Number of covered lives, major employers	n/a-starts in 2017
	6	Hospital affiliations	ETMC (Smith county only at this time, but planning to add all ETMC locations)
	7	Laboratory affiliations	no preference
	8	Benefit plan description (Covered Services defined)	Medicare Advantage
	9	Provider procedure manual	
	10	References/ Notes	Must notify with a 60 day written notice if planning to close practice to new patients
			Must notify covered person of the cost of non-covered services prior to rendering services and obtain a signed statement
		Formulary	
		Terms	
**	11	PCOT Agency Status defined	yes
	12	Each party responsible for their own acts	yes
		Hold Harmless and Indemnification language	yes; Art 8.1
		Arbitration & mediation non binding	Non Binding
**	13	No assignment without consent (Silent PPO)	No assignment by IPA without prior written consent;
	14	No all products clauses	
	15	No marketing w/o consent	
**	16	Credentialing delegated	yes
**	17	Members can not be terminated w/o cause	Can be termed without cause by health plan or provider by giving PCOT at least 90 days written notice, Art 7.1
**	18	Adequate grievance process	yes
	19	Modifications must be mutually accepted	IPA must object within 30 days of notice of amendment
**	20	Access and confidentiality reasonable	yes
	21	Members may charge for requested medical records	no suggest amendment; amended to follow TMB Guidelines
	22	Governed by Texas Law, govered in county where care was recd	Follows Federal and State Laws
**	23	Max liability insurance required 200,000/ 600,000	1 mil/3 mil; or state minimums as required
**	24	Term: 1 year max	remain in effect until 12/31 of the following year of contract signature; Art 7.1
	25	Auto renewal	yes for one year periods; Art 7.1
**	26	Termination w/o cause not > 90 days	Can be termed without cause by health plan or provider by giving PCOT at least 90 days written notice, Art 7.1
	27	Termination Tail reasonable	
	28	HIPAA language--code sets	yes; amendment C; 4.0
		Billing/ Compensation	
	29	Claims processor (payor) identified	yes
**	30	Claims paid < 30 days (or comply with SB 418)	yes
	31	Penalty for non timely payment (Predetermined)	yes; amendment C; 13.0
	32	Payment to Non-Physician Providers	
	33	Standard filing form (HCFA 1500) acceptable; electron	yes
	34	Right to coordination of benefits payments	yes
	35	Retroactive adjustments within 90 days	Must follow CMS for Medicare
	36	Enrollee identification process specified	yes; ID card with Network ID; Art 3.4
**	37	Complete fee schedule	Medicare Advantage - PCPs-105% of current year Medicare schedule; Specialist-103% of current Medicare schedule; in office radiology-100%
		Non Specified	50% of billed charges; will review non-priced codes paid to provider for charge, cost, and frequency
		Meets PCOT Minimum Criteria	
	38	Fee schedule fixed for contract period	follow Medicare updates quarterly
	39	Fee schedule review & increase at renewal (auto esca	No
	40	New CPT Code Changes/Updates effective January 1st	follow CMS guidelines
		Miscellaneous Comments/Notes	
			Pre auth list in provider manual Must notify healthplan and PCOT in advance if submitting a request to CMS to "opt-out" of Medicare participation
			Must notify PCOT and health

PROVIDER ACCEPTANCE OF CMS REQUIRED PROVISIONS FOR MEDICARE ADVANTAGE DOWNSTREAM PROVIDER AGREEMENTS

1.1 Compliance with CMS Agreement and Federal Medicare Law. Provider shall comply with any and all requirements in the CMS Agreement which are applicable to Provider as a subcontractor of Medicare Advantage Plan as a result of this Agreement. Provider shall comply with Title XVIII of the Social Security Act and the regulations adopted thereunder by CMS for the Medicare program.

1.2 Prompt Payment. For each Clean Claim submitted by Provider, Medicare Advantage Plan shall pay the amount due to Provider within thirty (30) calendar days following receipt of a Clean Claim by Medicare Advantage Plan.

1.3 Confidentiality of Medical Records. Provider shall establish and maintain procedures and controls so that no information contained in its records or obtained from CMS or from others shall be used by or disclosed by it, its agents, officers, or employees except as provided in Section 1106 of the Social Security Act, as amended, and regulations prescribed thereunder.

1.4 Continuing Care Obligations. In the event of termination of Provider participation with Medicare Advantage Plan for any reason, Provider shall continue to provide Covered Services to Members, including any Members who become eligible during the termination notice period, until the Member is transitioned to another Medicare Advantage Plan Participating Provider.

1.5 Managed Care Program Services, Medicare Advantage Plan Accountability and Provider Cooperation. Consistent with the requirements of State and Federal Law, Medicare Advantage Plan shall be accountable for the performance of the following services for all Managed Care Medicare Advantage Plans: (i) quality management and improvement, (ii) medical management, (iii) credentialing, (iv) Member rights and responsibilities, (v) preventive health services, (vi) medical record review and (vii) payment and processing of claims (collectively, "Managed Care Program Services"). Without limiting the foregoing, Medicare Advantage Plan shall remain accountable to CMS for complying with its obligations under the CMS Agreement. Provider shall cooperate with Medicare Advantage Plan in the performance of all Managed Care Program Services.

1.6 Medical Records. Provider shall maintain all patient medical records relating to Covered Services provided to Members, in such form and containing such information as required by State and Federal Law. Medical records shall be maintained in a manner that is current, detailed, organized and permits effective patient care and quality review by Provider and Medicare Advantage Plan pursuant to State and Federal law. Medical records shall be maintained in a form and physical location which is accessible to Provider, Medicare Advantage Plan and Government Agencies. Provider shall maintain the confidentiality of all Member medical records and treatment information in accordance with State and Federal Law and have procedures in place that specify the purpose for which the information shall be used within Provider' organization and to whom and for what purposes Provider may disclose the information outside of Provider. Medical records shall be retained by Provider for at least ten (10) years following the provision of Covered Services and as required by State and Federal Law. The provisions of this Section shall survive termination of this Agreement for the period of time required by State and Federal Law.

1.7 No Billing of Members. Provider hereby agrees that in no event, shall Provider bill, charge, collect a deposit from, seek compensation, remuneration, or reimbursement from, or have any recourse against a Medicare Advantage Plan Member or person, for Covered Services provided.

This provision shall not prohibit collection of deductibles, Copayments, co-insurance and/or non-Covered Services.

1.8 Submission of Data. Provider shall cooperate with Medicare Advantage Plan in submitting to the Secretary of Health and Human Services statistical data pertaining to Provider Services provided by Provider, any other reports the Secretary may reasonably require to carry out its functions under the Medicare Advantage program.

1.9 Term. The provisions of this letter are effective as of the date signed below and shall remain in effect until terminated by Provider with ninety (90) days' written notice to Medicare Advantage Plan.

By signing below, Provider accepts of all terms in this letter and states that Provider is a Medicare Participating Provider. Provider must maintain status as a Medicare Participating Provider in order to participate with Medicare Advantage Plan:

ENTITY NAME: _____

BY: _____

NAME: _____

TITLE: _____

ADDRESS: _____

_____

DATE: _____

FRESENIUS HEALTH PARTNERS

MEDICARE ADVANTAGE ESRD- CHRONIC SPECIAL NEEDS PLAN
Frequently Asked Questions

- ***WHO IS FRESENIUS HEALTH PARTNERS (FHP)?***
  - FHP is a division of Fresenius Medical Care North America (FMCNA), which is the world's largest integrated provider of products and services for individuals undergoing dialysis treatment, a condition that affects more than 2.5 million individuals worldwide.
  - Backed by more than 30 years' experience in dialysis care and innovative research, FHP has developed a model of care specifically designed for the unique needs of patients with End-Stage Renal Disease (ESRD) and its associated comorbidities. FHP provides our members, your patients, with in-depth care coordination services and benefits focused on improvements in quality of life and clinical outcomes.
  - FHP has over 10 years' experience operating Medicare Advantage (MA) Chronic Special Needs Plans (C-SNPs) and, as a result, possesses expert teams and resources. In fact, many of the FMCNA nephrologists successfully participated in the Center for Medicare & Medicaid Services' MA ESRD Managed Care Demonstration.

- ***WHAT'S A MEDICARE ADVANTAGE SPECIAL NEEDS PLAN?***
  - These are plans offered to targeted Medicare populations with special needs like dual-eligible (Medicare and Medicaid), Institutional, and Chronic conditions, such as ESRD, also known as "C-SNPs".

- ***WHAT'S DIFFERENT ABOUT OUR HEALTH PLAN?***
  - As an MA C-SNP, FHP will structure its benefits and provider delivery system to enable enhanced care coordination, effective population management and improve quality outcomes.
  - This plan will only enroll ESRD patients, who are precluded from enrollment in a normal Medicare Advantage plan. As a result, the majority of patients will come from traditional Medicare plan.

- ***WHY SIGN UP TO PARTICIPATE IN OUR NETWORK?***
  - This will be a health plan focused on a specific vulnerable and expensive population and with a unique provider engagement and incentive model to help organize, align and engage the network...we invite you to be part of building it! The plan's effective date will be January 1, 2017.

QUICK REFERENCE GUIDE

Care Navigation Unit

• 844-209-9092

24 Hours/Day
7 Days/Week

The Care Navigation Unit should be contacted by Providers or Members for assistance

Inpatient – Hospitals

Discharge of Member from Inpatient Care
Transition of Care to another facility
Mental Health – Outpatient continuing Treatment

Daily Services for Members

Dialysis Care – Missed Appointments
Member Education – Dietary and Resources
Information for Delivery of Meals to Members

Care Coordination for Member to receive Services from an In-Network/Participating Provider or Facility

Provider Services

• 844-560-7833

Contactus@esrdplan.com

Provider Services should be contacted for assistance:

OPTION#4 = Member Eligibility
Benefits and Co-pays or Cost Sharing

OPTION #1 = "Prior Authorization"
Notification of Admission & Post Stabilization

OPTION #5 = Newtork Information
Participating Providers
Provider Manuals
Electronic Claims questions
Closing Provider Panels
Demographic Changes

www.esrdplans.com

Quality Management, Credentialing and Delegation Oversight:
844-560-7833 (Option #5)

Compliance Action Line:
800-362-6990
Compliance.ActionLine@fmc-na.com

Member/Customer Service
855-598-6774
8am-11pm ET 7/days/week

Electronic Claims Filing:
Change-HealthCare.com
(used to be EMDEON)
PAYOR ID 43197

Claims Reconsideration Process:
Mail : **Fresenius Health Plan**
PO Box 163390
Austin, TX 78716

FRESENIUS HEALTH PARTNERS

QUICK REFERENCE GUIDE

Authorization Required

844-560-7833 (option #1) / **781-419-5291** (FAX)

HOSPITAL AND SKILLED NURSING FACILITY
- All elective Admissions
- Inpatient Mental Health Care (post stabilization)

PCP and SPECIALIST OFFICE →(POS 11)
- Injectable Drugs (Part B)
- CT, MRT/MRA, PET, Cardiac Nuclear Imaging
- Wound Care

OUTPATIENT HOSPITAL →(POS 22)
- **most services** require prior authorization for this place of services – Contact Provider Services Department.

OUTPATIENT HOSPITAL – OTHER
- Blood Services
- Cardiac & Pulmonary Rehabilitation
- Chiropractic Services
- Diabetic Shoes
- DME Purchases & Rentals
- Home Delivery of Meals
- Home Health – including PT/OT and Speech
- Infusion Therapy
- Podiatry Care
- Prosthetics & Orthotics & Medical Supplies
- X-Ray, CT/MRI/MRA, PET, IMRT & Cardiac Nuclear Imaging
- Transportation (Routine- Non Emergent)

Wellness / Preventative

Annual Physical Exam & Annual Wellness Visit
-

Self-Referrals
- Bones Mass Measurements – as needed
- Breast Cancer Screening (Mammograms)
- Case Management and Care Coordination with Care Navigation Unit
- Cardiovascular Disease Risk Reduction Visits (1/Year)
- Cervical and Vaginal Cancer Screening
- Colorectal Cancer Screening
- Dental Services – Liberty Dental – (888) 352 7924
- Depression Screening – (1/Year – by PCP)
- Diabetes Self-Management Training, Services & Supplies
- Eye Exams – Davis Vision - (800) 584 3140
- Health & Wellness Education Programs done by FHP
- HIV Screening - for people whom ask for screening
- Hospice Care – Billed through Traditional Medicare
- Immunizations
  - – Hepatitis B -
  - -- Influenza & Pneumococcal (Each = 1/Year)
  - -- Other vaccines if patient is at risk and meets Medicare Part B coverage rules
- Kidney Disease Education Services
- Medical Nutrition Therapy
- Prostrate Cancer Screening Exams
- All other types of Screening and Counseling covered by Medicare Part B coverage rules