Important Information for Providers about Sanford Health Plan

PO Box 91110
Sioux Falls, SD 57109-1110
Toll-free: (877) 305-5463
TTY/TDD: (877) 652-1844
Fax: (605) 328-6811
sanfordhealthplan.com

SANFORD HEALTH PLAN

Sanford Health Plan provides the following annual notices so that providers are well informed of the provisions of the Plan. If you have any questions regarding this information, please feel free to contact us at (605) 328-6868 or toll free at (877) 305-5463.

Where can I find important plan information?

Important Plan information and the Provider Manual may be found at the locations below or by calling the Plan's Provider Relations department toll-free at (800) 601-5086. The Provider Manual and the Provider News on the website contain information on Plan policies and procedures that are pertinent to participating practitioners. Below is a summary of the information you can find on our website and *my*SanfordHealthPlan web portal. Please visit these sites frequently for updates.

Sanford Health Plan's Webpage - www.sanfordhealthplan.com

Click on the Providers link to find the following:
- Preventive Health Guidelines
- Prior Authorizations: How to prior authorize and what needs prior authorizations
- Pharmacy Benefits/Formulary Information

*my*SanfordHealthPlan - www.sanfordhealthplan.com/providerlogin

Online access to member eligibility, member benefits & accumulators, claim status, explanation of payments, prior authorization information, etc. See below for more information.
- Provider Manual
- Provider News
- Provider Directory: Multiple search functions
- Code Updates
- Electronic Data Interchange
- Forms
- Clinical Resources & Tools, including Clinical Practice Guidelines and many other resources
- Health Management Programs and Quality Improvement Activities; HEDIS® Report

Create a *my*SanfordHealthPlan account

Sanford Health Plan's *my*SanfordHealthPlan portal allows practitioners the ability to verify member eligibility, check claim status, view and retrieve explanation of payments and view and submit prior authorization information online upon signing up for an account. To request a *my*SanfordHealthPlan account, follow the steps below:
1. Go to www.sanfordhealthplan.com/providerlogin
2. Click on the link "Provider Sign-Up"
3. Read the License Agreement and click on "Agree"
4. Enter all the Required Account information on the following screens
5. When all the required account information has been added, click on "Finish"
6. After clicking Finish, you will be redirected to the branded site and will then hover on the tab "complete signup" and click on "request access" and send an express request requesting on-line access to Provider Online Claim/eligibility/authorization access request.

Your information will then be submitted for review and approval. Once your account has been approved, you will receive an email from Sanford Health Plan stating whether or not your account has been approved. Once your account has been approved for access, you will be able to log on to m*y*SanfordHealthPlan through the Sanford Health Plan website using the User ID and Password you created upon setting up the account. If you have any questions or comments, please contact your Provider Relations Representative or the Provider Relations Department at (605) 328-6877 or (800) 601-5086.

2014 Quality Improvement Progress Report

Sanford Health Plan and its participating providers are committed to providing high quality healthcare to our members. The following is a list of the Plan's current quality programs which have been designed to make sure members get the right care, at the right time and the right place. For more information on the Health Plan's Quality Improvement (QI) program and outcomes, see our HEDIS® 2014 Report and the Quality Improvement Program summary, both located on the Plan's website at www.sanfordhealthplan.com/providerlogin. You may also call the Health Plan to request a copy of either of these documents at (888) 315-0884. For information on our care management programs listed below and how to enroll, call (888) 315-0884 or visit our website at www.sanfordhealthplan.com/providerlogin.

Clinical Areas of Quality Improvement

Diabetes

Last year's HEDIS® diabetes performance measures showed a number of improvements compared to the previous years' rates, showing that the program activities have again made an impact. This program has included educational materials for the semi-annual mailings. Currently the Health Management Program provides the following services to members with diabetes:
- New diabetic members are identified on a monthly basis and sent a program introduction packet;
- An online bWell Health Assessment allows the Plan to identify the member's individual needs, and to provide diabetes educational information specific to those needs.
- Semi-Annual mailings.
- Free glucometer offer.

- Selected employer group health screenings included glucose, total cholesterol and HDL, and blood pressure screenings to identify members who may have gone undiagnosed.
- Practitioners are notified of the recommended clinical practice guidelines for diabetes through the provider newsletter and on our website.
- Letters sent to participating eye care providers to remind them of the annual eye exam copay waive benefit and how to submit the claims. Also included a communication form for the eye care professionals to utilize in notifying the primary diabetes care providers of eye exam results.
- Letters were sent to members who were noncompliant with one or more of the HEDIS® diabetes indicators. Letter discusses complications and staying healthy. Members were also provided a Diabetes Care Checklist and the bWell Frequency Asked Question (FAQ) sheet to encourage them to complete a Health Assessment (HA). Education on eye exams and the eye exam benefit was also included for those members who did not submit a claim for an annual eye exam.
- The Provider Perspective newsletter contained an article on the Impact of Clinical Documentation (i.e., diabetic eye exams).
- A Provider Perspective newsletter article addressed notable HEDIS® rates, including the Comprehensive Diabetes Care HEDIS® rates. Information on where to access practice guidelines for diabetes was also included as well as information on coordinating the care of the patient.
- Sent annual health management program patient satisfaction survey and used suggestions for internal discussions..
- BPAs (Best Practice Advisories) implemented on the Sanford Clinic side of EPIC as well so that providers will be prompted when a member is out of guideline compliance.
- Population Health meetings included discussions regarding the importance of the clinics documenting this diabetic eye exam information including the eye doctor, date of exam and results

Heart Failure (HF)

The rate of ACE Inhibitor/ARB/Beta Blocker utilization was 92.86% and the rate of inpatient hospital stays for members with HF increased compared to the previous year. Currently, the HF Health Management Program provides the following services to members in the program:

- New HF members are identified on a monthly basis and sent a program introduction packet.
- An online bWell Health Assessment available for members that allows the Plan to identify the member's individual needs and to provide educational information specific to those needs.
- Semi-annual member educational materials including the educational information on symptoms, treatment and management of heart failure.
- Practitioners are notified of the recommended clinical practice guidelines for HF through the provider newsletter and on our website.
- Participated in the community/Lewis Drug hypertension initiative.
- Verisk Analytics tool utilized for monitoring care gaps and specific case manager member cohorts.
- A Provider Perspective newsletter article addressed notable HEDIS® rates, including the Controlling High Blood Pressure HEDIS® rate. Information on where to access practice guidelines for hypertension was also included as well as information on coordinating the care of the patient.
- The Member Messenger newsletter contained an article on "Your Heart and Heart Disease", as well as managing a healthy weight.
- The Member Messenger newsletter contained articles on knowing the facts about stroke, managing chronic health conditions and what is blood pressure and the risks.
- Sent annual health management program patient satisfaction survey and used suggestions for internal discussions.
- The Provider Perspective newsletter contained an article on the clinical practice guidelines adopted by the Plan and where to find them. This includes CHF guidelines. (This is a patient safety related activity.)

Hypertension

The Plan's HEDIS® rate for controlling high blood pressure decreased compared to the previous year. Members identified with hypertension for the Healthy Heart Health Management Program received the following services over the past year:

- New hypertensive members are identified on a monthly basis and sent a program introduction booklet.
- An online bWell Health Assessment available for members that allows the Plan to identify the member's individual needs and to provide educational information specific to those needs.
- Semi-annual educational mailings to members.
- Practitioners are notified of the recommended clinical practice guidelines for hypertension through the provider newsletter and on our website.
- Member Messenger newsletters including articles on heart health and on high blood pressure - why to take your medicine.
- Participated in the community/Lewis hypertension initiative.
- Verisk Analytics tool was implemented and utilized for monitoring care gaps.
- Sent annual health management program patient satisfaction survey and used suggestions for internal discussions.
- A Provider Perspective newsletter article addressed notable HEDIS® rates, including the Controlling High Blood Pressure HEDIS® rate. Information on where to access practice guidelines for hypertension was also included as well as information on coordinating the care of the patient.

Healthy Pregnancy

Sanford Health Plan provides maternity care benefits from prenatal through postpartum care. The main objective of the program is to assist a member in identifying early concerns so she and her healthcare provider can take steps to prevent or minimize any problems and ensure a healthy pregnancy. Pregnant females are encouraged to join the Healthy Pregnancy Program during their first trimester of pregnancy. Members who enrolled in 2014 enjoyed the following benefits:

- An online bWell Health Assessment available for members that allows the Plan to identify the member's individual needs and to provide educational information specific to those needs.
- The Provider Perspective newsletter contained an article on the clinical practice guidelines adopted by the Plan and where to find them. This includes healthy pregnancy guidelines. There was also information on Coordinating Care of the Patient.
- Personal phone calls from a Care Management nurse for high risk members.
- Educational materials as requested by the member.

Asthma

Our HEDIS® measure for appropriate medication utilization was 94.24% for ages 5 to 64. The Plan's activities to improve appropriate medication use include the following:

- New asthmatic members are identified on a monthly basis and sent an education information packet.

- Free peak flow meter and spacer offer.
- Practitioners are notified of the recommended clinical practice guidelines for asthma through the provider newsletter and on our website;
- Phone calls are made to members who discharged from the hospital after an asthma-related stay.

Mental Health and Substance Use Disorders

The Plan's HEDIS® measure for follow-up after inpatient hospitalizations for the treatment of mental health and substance use disorders increased last year, and the HEDIS® measure for antidepressant medication management showed an increase in the acute and continuation phase rates. The Plan's activities to improve follow-up after inpatient treatment for mental health and/or substance use disorder discharges, and compliance with antidepressant medications, included:

- Letters are sent on a monthly basis to members, who have recently been prescribed antidepressants, but have not refilled their medication. The letter educates the member about side effects, compliance, etc. Continue to incorporate depression education/resources into other health management programs.
- The Worksite Wellness Life Advocate is available to refer members to the Plan's EAP for participating employer groups.
- Practitioners are notified of the recommended clinical practice guidelines for depression through the provider newsletter and on our website.
- The Timeliness of Care Survey was completed and included an assessment of a sample of BH clinics and their compliance with the Plan's access standards for BH appointments. Clinics included in the survey were sent a follow-up letter to notify them of their compliance or noncompliance and what those standards are.
- Case Managers use a messaging system available to Sanford Behavioral Health when a Plan member is discharged from an inpatient mental health and/or substance use disorder treatment facility. Both teams work to ensure that the member gets a follow-up appointment within 7 days.
- The Member Messenger included articles on managing chronic health conditions.
- To increase awareness of available mental health and substance use disorder treatment services, Quick Reference Behavioral Health Cards were updated and made available on the website to primary care practitioners to assist in locating Sanford Health Plan participating mental health and substance use disorder practitioners in their area.
- The Plan also collaborates with mental health and substance use disorder treatment professionals to ensure the appropriateness of our activities involving mental health and substance use disorder treatment (behavioral health).

Attention Deficit/Hyperactivity Disorder (ADD/ADHD)

The ADHD activity focuses on improving the rates of appropriate follow-up for members prescribed ADHD medications:

- Newly identified members with ADHD are sent a toolkit which provides education on the symptoms, treatment and follow-up recommendations for patients taking ADHD medications.
- Practitioners are notified of the recommended clinical practice guidelines for ADHD through the provider newsletter and on our website. Tools are also available for practitioners on the website. Practitioners were also notified of the information available on the website via the provider newsletter.
- The Plan pays for the phone consultation codes that qualify for the continuation phase follow-up.
- Quick reference Behavioral Health cards were updated and made available via the Plan's website.
- ESI Express Alliance Program is in place, which will assist nurses in identifying and managing non-adherent members.

Adolescent Health

The adolescent well care visit rate increased again last year and is still significantly below the national average. Our adolescents and their parents/guardians received the following information:

- A birthday card is sent monthly to those members turning 11 and 12 as a reminder to make sure they are up-to-date on immunizations by their 13th birthday and to remind them to get an annual wellness exam.
- The Plan's website contains a KidsHealth website link to a great deal of educational information for kids and parents.
- Immunization schedule is available on the Plan's website.
- The Member Messenger newsletter had an article on Adolescent Wellness Visits and Immunizations and where to find a list of recommended immunizations.
- Notified practitioners of Clinical Practice Guidelines in the Provider Perspective newsletter.
- The Provider Perspective newsletter had an article on immunization registries and also an article on the clinical practice guidelines adopted by the Plan and where to find them. There is also information on coordinating the care of the patient.

Breast Cancer Screening

The breast cancer screening rate cannot be compared to last year because of the change in the ages included in the measure. The age is now 52-74. The rate for the mammogram screening is 78.68%. The following are activities completed to improve this rate:

- Preventive Health Guidelines are updated and printed annually in the member newsletter and are available on the Plan's website at www.sanfordhealthplan.com.
- Birthday cards are sent to women turning 40, 50 and 60 to remind them of important screening tests like mammograms and the Plan's benefits for those tests.
- With the implementation of Sanford Health's electronic medical record system, OneChart, the health maintenance screen will help to remind physicians of those patients who are due for screening tests.
- Practitioners are notified of the recommended clinical practice guidelines for breast cancer screening through the provider newsletter and on our website.
- A mass mailing was sent to all female members ages 40 and over regarding breast cancer screening and education about the importance of mammograms and the Plan's benefits for them. A small gift was also offered to those that completed their mammogram.
- Sent an additional mammogram reminder mailing to those members who are 3 months past their 40th birthday, if they haven't completed their mammogram.
- The member and provider newsletters have contained various newsletter articles regarding cancer screening tests and the Plan's benefits.
- Preventive screenings are addressed by the nurse case managers in conversations with members.
- Email reminder to age specific members regarding cancer screenings.
- Verisk Analytics tool utilized for monitoring care gaps.
- Mammogram reminder/incentive offer brochure was distributed at school in-service meetings and emailed to school business managers to share in their communication with members.

Cancer Screening
The cancer screening activity focuses on improving the rates of screening for cervical cancer and colorectal cancer. The following are activities completed to improve these rates:

- Preventive Health Guidelines are updated and printed annually in the member newsletter and are available on the Plan's website at www.sanfordhealthplan.com.
- Birthday cards are sent to women turning 21, 40, 50 and 60 and men turning 40, 50 and 60 to remind them of important screening tests (like mammogram, pap smear, colonoscopy, etc.) and the Plan's benefits for those tests.
- Practitioners are notified of the recommended clinical practice guidelines for cancer screening through the provider newsletter and on our website.
- A mass mailing was sent in June to male members ages 50 and over regarding prostate cancer screening and colorectal cancer screening and the Plan's benefits for those tests.
- The member and provider newsletters have contained various newsletter articles regarding cancer screening tests and the Plan's benefits.
- Preventive screenings are addressed by the nurse case managers in conversations with members.
- Email reminder to age specific members regarding cancer screenings.
- Verisk Analytics tool utilized for monitoring care gaps.

Tobacco Cessation
The following activities were underway to promote tobacco cessation among the Plan's membership:

- The Plan has a tobacco cessation benefit, which includes reimbursement for a specific amount of medication and telephone, group or individual counseling for a specific amount of visits.
- All Sanford Health Plan Health Management Programs and other quality improvement activities and member newsletters stress the importance of smoking cessation and the many resources available to them to help them quit as well as the Plan's tobacco cessation benefit information.
- Care Management nurses discuss tobacco use with members and also will assist in coordinating resources for tobacco cessation.
- Smoking cessation resources information is included in the Member Messenger newsletter.
- Sanford Health is implementing OneChart (electronic medical record system) across the System, which includes smoking questions to prompt the practitioner to discuss this with the patient;
- Sanford Health Plan's Wellness Educators are certified as health and wellness coaches. They can lead tobacco cessation classes upon request from clients. The educators are continuing to provide one on one counseling with members as needed.
- Tobacco Cessation web pages were added to the member and provider pages of the website and include education and resources (for adults and kids). This information has now been moved to the *my*SanfordHealthPlan portal.
- Practitioners are notified of the recommended clinical guidelines for tobacco cessation through the provider newsletter and on our website.
- The Provider Perspective newsletter provided information on smoking cessation advice rate and resources for patients on smoking cessation. This newsletter also notified practitioners that there are tobacco cessation guidelines adopted by the Plan and where to find them on the Plan's website or to call the Plan for a copy. Another article on General Health Discussions that stated providers should address tobacco cessation during office visits. Also, the newsletter contained an article on the clinical practice guidelines adopted by the Plan and where to find them. This includes tobacco cessation guidelines. There was also information on Coordinating Care of the Patient.
- The Member Messenger newsletter contained an article on kicking the habit, secondhand smoke and talking to your kids about tobacco use.

Non-Clinical Areas of Quality Improvement
CAHPS® Member Satisfaction Survey - The Plan's member satisfaction survey takes place on a yearly basis. This survey is conducted by an independent survey vendor and provides information on the experiences of our members with our Health Plan and how well we meet our members' expectations. There are 4 overall ratings of satisfaction in addition to 7 more focused composite scores which summarize survey responses in key areas. The Plan's QI Committee analyzes the results and takes actions for improvement. For more information on the Plan's CAHPS® rates, refer to our HEDIS® 2014 Report as referenced at the beginning of this article.

Member Services Phone Calls - This activity involves ongoing monitoring of the Member Services Department phone call statistics including calls answered abandoned calls and average answer speed of calls. Additional training and staff meetings are held to improve these rates and representatives are shown their individual statistics to help them improve their personal performance. Overall trends for this activity show increased performance.

Timeliness of Care - This project monitors the appointment access to the Plan's participating practitioners. Phone calls are made to a random sample of clinics to determine their compliance with the Plan's standards for access. The survey for 2014 showed a primary care practitioner compliance rate of 95% for urgent but non-emergent and routine appointments, while the behavioral health care practitioner compliance rate was 79% for the non-life-threatening behavioral health emergency appointments, 84% for the urgent behavioral health needs appointments and 80% for the routine behavioral health appointments. The overall after hours coverage rate of compliance was 100%. All clinics receive a copy of their results and a list of the Plan's access standards. Clinics who did not meet the standards were asked to develop an action plan to assist them in meeting the Plan's appointment access standards.

** HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA). HEDIS® results do not include elite1 individual plan membership data.*
CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ). CAHPS® results also do not include elite1 individual plan membership data.

Special Communication Services

In compliance with the ADA, we have all written plan materials available in alternate formats. We can read items to members over the phone and offer free oral translation in any language for members wishing to communicate with the Plan through our translation services. If you have a Sanford Health Plan member in need of translation services to communicate with us on their plan benefits or other information, plan translation services may be accessed by calling (800) 892-0675.

If you would like a listing of practitioners who speak languages other than English, please contact Provider Relations toll-free at (800) 601-5086. A listing will be sent directly to you upon your request.

Complex Case Management Referral Guide

What is the Complex Case Management Program?

Complex case management is a process that identifies high risk or high cost members. Care Managers work to assess treatment options and opportunities to coordinate care, design treatment programs to improve quality and efficacy of care, control costs and manage member care to ensure the optimum outcome. Concentrating on catastrophic or chronic cases, case management nurses are contacted to consult and manage diagnoses such as serious traumas, cancers, organ transplants, spinal cord injuries, multiple chronic illnesses (e.g., diabetes and cardiovascular problems) and/or chronic illnesses that result in high utilization.

Is there a cost for the program?

Sanford Health Plan's Complex Case Management Program is available at no cost to qualifying Health Plan members and their families.

How does the program work?

A designated case manager is responsible for managing these complex cases to ensure high quality, cost effective and appropriate utilization of health services. The case manager acts as a member advocate, seeking and coordinating creative solutions to a member's health care needs without compromising quality health outcomes for selected medical diagnoses. The case manager contacts our members by phone and/or mail and acts as a resource, educator and/or coordinator of medical care if needed.

What qualifies a Member for the program?

Complex case managers are called on to consult and manage diagnoses such as:

- Serious trauma
- Spinal cord injuries
- Cancer
- Organ transplant
- HIV
- Multiple chronic illnesses (e.g., diabetes and cardiovascular problems) and/or chronic illnesses resulting in high utilization

How do I refer a Sanford Health Plan Member for the program?

If you would like more information about this program, or if you would like to refer a Sanford Health Plan member that you feel may meet the criteria for the program, **please contact our Care Management Team at (888) 315-0884 or quality@sanfordhealth.org**.

If you are a Sanford practitioner, please feel free to use in basket messaging to contact a Health Plan case manager. If a case manager is currently following a member, they will be listed on the patient care team in One Chart. You can also send an in basket message to "SHP CRM CT Case Management" if you are unable to determine the assigned case manager.

Utilization management criteria

Every year, the Plan's Physician Quality Committee reviews the Plan's medical policies and procedures, quality programs and clinical practice guidelines. The Physician Quality Committee is charged with supporting the Plan's Board of Directors and Chief Medical Officer in meeting quality assurance goals on issues of care.

The Committee consists of physician members from various specialties, including a behavioral health practitioner, and meets at least six times a year. The Plan's Chief Medical Officer reports on the Committee's activities to the Board of Directors on a quarterly basis. The Committee is actively involved in the development of quality initiatives and health management programs. It is also responsible for approving and annually reviewing utilization management criteria. Any recommended changes in the criteria or any other program changes are approved by the Board of Directors.

All practitioners are welcome to have input into the activities of this committee. Suggestions concerning quality programs, health management programs, clinical practice guidelines and utilization management criteria are welcome and can be directed to the Chief Medical Officer by mail or by phone at (605) 328-6807 or (800) 805-7938.

Clinical Practice Guidelines

Sanford Health Plan is responsible for adopting and distributing clinical practice guidelines for acute, chronic and behavioral health care services that are relevant to our membership. The Plan's multi-specialty physician committee, the Physician Quality Committee, has reviewed and approved practice guidelines for numerous conditions for use as the Plan's primary clinical practice guidelines.

Please visit our website at www.sanfordhealthplan.com/providerlogin to find links to the adopted guidelines. If you have any questions or suggestions regarding these guidelines or to request a copy of the guidelines, please call the Plan at (605) 328-6877 or (800) 601-5086.

Preventive Health Guidelines

Sanford Health Plan recognizes that health promotion and disease prevention are the best opportunities to reduce the ever increasing portion of resources spent to treat preventable illnesses and impairments. As a Plan, we want to educate our members on how to cut health care costs, prevent premature onset of disease and disability, ant to help all members achieve healthier and more productive lives.

Preventive Health Guidelines are age-specific and describe prevention or early detection interventions and recommended frequency and conditions under which the interventions are required. Appropriate practitioners are involved in the development of preventive health guidelines (i.e., practitioners who are from specialties that would use the guidelines).

Members of Sanford Health Plan are encouraged to utilize preventive health services, health education and health promotion by publicizing preventive health services, educational classes and other articles on prevention in special mailings or in the Member Messenger Newsletters.

Current Preventive Health Guidelines are available on our website at: www.sanfordhealthplan.com for both members and practitioners (the practitioner version includes the codes that are to be used for these preventive services). A paper copy is available by calling the Plan at (605) 328-6800 or (800) 752-5863.

Physician reviewer availability

A physician reviewer is available by phone to any practitioner to discuss determinations based on medical appropriateness at (605) 328-6807 or (800) 805-7938 Monday through Friday between the hours of 8 a.m. and 5 p.m. Central Time.

Sanford Health Plan Statement on Utilization Management

Utilization Management (UM) decision making is based only on appropriateness of care and service and existence of coverage. Sanford Health Plan does not specifically reward practitioners or other individuals conducting utilization review for issuing denials of coverage or service care. Any financial incentives offered to UM decision makers do not encourage decisions that result in under-utilization and do not encourage denials of coverage or service. Decision makers sign an "Affirmative Statement Regarding Incentives" verifying the above conditions.

Prior Authorization/Certification

What Services Require Prior Authorization

1. Inpatient Hospital or other facility admissions, including for medical, surgical, neonatal intensive care nursery, mental health and/or substance use disorders;
2. Select Outpatient Services (for Minnesota Members, see Sections 3 and 4 of their Policy for specific procedures);
3. Home Health, Hospice and Home IV therapy services;
4. Select Durable Medical Equipment (DME) (for Minnesota Members, See DME requiring Certification in section 3(a) of their Policy);
5. Skilled nursing and sub-acute care;
6. Transplant Services;
7. Prosthetic Limbs;
8. Genetic Testing;
9. Select Orthotics and Prosthetics;
10. Medically-Necessary Orthodontics;
11. Select Specialty Drugs (see the Member's Summary of Pharmacy Benefits/Formulary);
12. Bariatric Surgery;
13. Insulin infusion devices;
14. Insulin pumps;
15. Continuous Glucose Monitoring Systems (CGM);
16. Referrals to Non-Participating Providers, which are recommended by Participating Providers. Certification is required for the purposes of receiving In-Network coverage only. If Certification is not obtained for referrals to Non-Participating Providers, the services will be covered at the Reduced Payment Level. Certification does not apply to services that are provided by Non-Participating Providers as a result of a lack of appropriate access to Participating Providers as described in Section 2 of the member's Policy; and
17. Bariatric surgery (for Members who have this service as a covered benefit)
18. External hearing aids for the treatment of a hearing loss that is not due to the gradual deterioration that occurs with aging and/or other lifestyle factors (for Members who have this service as a covered benefit).

Please refer to www.sanfordhealthplan.com for additional information.

New medical technologies/new applications for existing technologies and experimental/investigational procedures

In order to ensure members access to safe and effective care, Sanford Health Plan has adopted a formal mechanism to evaluate and address new developments in medical and behavioral procedures, pharmaceuticals and devices. New technology to be reviewed includes clinical interventions, procedures, pharmacological treatments and devices.

The Physician Quality Committee is responsible to recognize and evaluate new health care services, procedures and pharmacological treatments as well as their application for Plan members. A specialist representing the new technology (i.e. physician, pharmacist, etc.), if not a member of the Committee will be invited to present the technological aspects of the service/procedure/pharmacological treatment. Behavioral healthcare professionals will be involved in the decision-making process for behavioral healthcare services. Published scientific evidence and information from literature and the Internet will be reviewed to make the appropriate decisions. The technology must have final approval from appropriate government regulatory bodies. The technology must also meet all predetermined criteria established in the New Technologies policy. The Physician Quality Committee will complete the review and make coverage determinations on the new technology.

Experimental, investigational or unproven services means a drug, device, medical treatment, diagnostic procedure, technology, or procedure for which reliable evidence does not permit conclusions concerning its safety, effectiveness, or effect on health outcomes or requires approval by any governmental authority and such approval has not been granted prior to the service being rendered. Experimental and/or investigational procedures/services are not covered and are specifically excluded from coverage in the member's Benefits Policy. A participating practitioner or member may request a review of a denied experimental/investigational procedure by initiating the appeal procedure. Experimental/investigational health care is that which does not, as determined by the Chief Medical Officer on a case by case basis, meet all of the established criteria.

The Chief Medical Officer and the Physician Quality Committee will consider all requests for coverage based on the Benefits Policy guidelines. If you would like more information on either of these policies, please contact our Member Services Department at (605) 328-6800 or (800) 752-5863.

Formulary statement

The Sanford Health Plan Formulary is a list of FDA approved brand-name and generic drugs chosen by health care providers on the Physician Quality Committee. Selection criteria include clinical efficacy, safety, and cost effectiveness. Changes are made throughout the year as warranted with a complete review each year.

For a complete listing of the formulary, pharmacy locator, health news, generic substitution information, drug side effect and interaction information, personal reminders, price check, benefit information and a member's current medication usage, visit www.sanfordhealthplan.com/providerlogin.

To be covered by the Plan, drugs must be:

1. Prescribed by a licensed health care professional within the scope of his or her practice;
2. Listed in the Plan Formulary, unless certification is given by the Plan;
3. Provided by a participating pharmacy except in the event of a medical emergency. If the prescription is obtained at a non-participating pharmacy the member is responsible for the prescription drug cost in full.
4. Approved by the Federal Food and Drug Administration (FDA) for use in the United States.

Types of Formulary Programs

2-Tier Formulary:

A 2-Tier drug program uses a copayment structure that reduces a member's out-of-pocket costs when using Generic Drugs and Preferred Brand Name Drugs. When a prescription is filled, a member's copayment will be at one of these tiers: *

- Tier 1: Generic Drugs
- Tier 2: All covered Brand Name Drugs

3-Tier Formulary:

A 3-Tier drug program uses a copayment structure that reduces a member's out-of-pocket costs when using Generic Drugs and Preferred Brand Name Drugs. When a prescription is filled, a member's copayment will be at least one of these tiers: *

- Tier 1: Generic Drugs
- Tier 2: Preferred Brand Name Drugs
- Tier 3: Non-Preferred Brand Name Drugs

4-Tier Formulary

A 4-Tier drug program uses a copayment structure that reduces a member's out-of-pocket costs when using Generic Drugs and Preferred Brand Name Drugs. When a prescription is filled, a member's copayment will be at least one of these tiers: *

- Tier 1: Generic Drugs
- Tier 2: Preferred Brand Name Drugs
- Tier 3: Non-Preferred Brand Name Drugs
- Tier 4: Formulary or Specialty Name Brand Drugs exceeding a contracted value of $400

*The higher the tier, the higher the copay

A **brand name drug** is a drug manufactured and marketed under a trademark or name by a specific drug manufacturer.

A **generic drug** is a drug that (1) is approved by the Food and Drug Administration (FDA) as a therapeutic equivalent to the brand name drug, (2) contains the same active ingredient as the brand name drug, and (3) costs less than the brand name equivalent.

Injectable Drug Program

Sanford Health Plan has contracted with *CuraScript/Accredo* for specialty medications. (Please refer to the member's *Pharmacy Handbook* for a list of injectable and high cost medications that must be obtained from Accredo.) *CuraScript/Accredo* will ship a member's drug(s) and all the supplies needed for injection directly to the member's home or health care practitioner's office within 24 to 48 hours after the request is approved and medication is ordered. Administration supplies (syringes, needles etc.) are free; members are not required to pay additional co-pays for those supplies. Prior to all shipments, a Patient Admission Specialist will contact members to discuss their co-pay for the drug and arrange delivery.

CuraScript/Accredo offers toll-free customer service available 24 hours a day, 365 days a year. You can also:

- Order injectable drugs;
- Consultation with experienced, knowledgeable pharmacists;
- Ask a specially trained nurse about injectable medications.

To enroll in the *CuraScript/Accredo* program, call toll-free at *(866) 333-9721* and a customer service representative will ask the following information:

- Member's name and date of birth
- Member's phone number and address
- The name of the Member's injectable medication to be filled
- Your name, as the provider, and your phone number

CuraScript/Accredo will mail you, the practitioner, a letter explaining the program and how to send the member's prescriptions to CuraScript/*Accredo*. By participating in Specialty Care, the member is automatically enrolled in a drug therapy management program. This program entitles the member to receive the following benefits at no additional charge:

- Access to nurses and pharmacists 24 hours/day, 7 days/week for questions related to their injectable drug and the illness the drug is treating.
- Injectable drug refills reminders if the member forgets to call for a refill, and convenient refill process.
- Free delivery of the member's medication and supplies to the member's home, practitioner's office or designated location.

Step Therapy Program

A step therapy program means that a member needs to try certain medications before "stepping up" to other medications that are more expensive. This prescription drug program is designed to help keep costs down for the member and assist with a plan as medications are becoming more and more expensive. Please refer to the member's *Pharmacy Handbook* for more information on current step therapy programs.

Exception to formulary

If a Member, or you, as their Practitioner, feels that a certain drug is medically necessary for their condition, an *Exception to the Formulary Process* is available. (Please refer to the *Exception to the Formulary Process* in the Provider Handbook or online at www.sanfordhealthplan.com/providerlogin for more information.)

The Plan will use appropriate pharmacists and/or practitioners to consider exception requests and promptly grant an exception to the drug formulary, including exceptions for anti-psychotic and other mental health drugs, for a member when the health care practitioner prescribing the drug indicates to the health plan company that:

1. The formulary drug causes an adverse reaction in the patient;
2. The formulary drug is contraindicated for the patient; or
3. the prescription drug must be dispensed as written to provide maximum medical benefit to the patient.

NOTE: Members must generally try formulary medications before an exception for the formulary will be made for non-formulary medication use. To request an exception to the formulary, please call the Pharmacy Management Department at (800) 805-7938.

If you, or the member, receive an adverse determination to your request for an exception to the formulary, please follow the *Complaints and Appeals Procedure* and the *External Review Rights* in the Policy. Two types of initial appeals are available to members and practitioners to address concerns regarding requests for exceptions: an expedited appeal process and a standard appeal process. An expedited appeal process is used when the condition is of an emergent or urgent nature. This applies to requests for coverage of non-covered medications, generic substitutions, therapeutic interchanges and step-therapy protocols.

For More Detailed Pharmacy Information

Please refer to the following Member documents for specific drug coverage information by visiting www.sanfordhealthplan.com/providerlogin or by calling our Member Services Department at (800) 752-5863.

1. Summary of Benefits and Coverage – includes a description of costs the member is responsible for when obtaining prescription drugs and supplies;
2. Pharmacy Handbook - describes specific information on drug exclusions, drugs that require certification, quantity level limits on drugs, the Plan's injectable drug program, and the formulary.
3. Policy – includes a description of how and where the member may obtain prescription drugs and supplies, dispensing limitations, and excluded drugs and supplies.

Member rights & responsibilities statements

Minnesota Member Rights

In accordance with the Minnesota Department of Health and the National Committee for Quality Assurance (NCQA), you have certain rights as a Minnesota member of the Sanford Health Plan:

1. Members have the right to available and accessible services including emergency services, as defined in the Benefits Policy, 24 hours a day and seven days a week;
2. Members have the right to be informed of health problems, and to receive information regarding treatment alternatives and risks which is sufficient to assure informed choice;
3. Members have the right to refuse treatment, and the right to privacy of medical and financial records maintained by the Plan and its health care practitioners and/or providers, in accordance with existing law;
4. Members have the right to file a complaint with the Plan and the Commissioner of Health and the right to initiate a legal proceeding when experiencing a problem with the Plan or its health care practitioners and/or providers;
5. Members have the right to a grace period of 31 days for the payment of each service charge for individual coverage falling due after the first premium during which period coverage shall continue in force;
6. Medicare members have the right to voluntarily disenroll from the Plan and the right not to be requested or encouraged to disenroll except in circumstances specified in federal law;
7. Medicare members have the right to a clear description of nursing home and home care benefits covered by the Plan;
8. Members have the right to receive impartial access to treatment and/or accommodations that are available or medically indicated, regardless of race; ethnicity; national origin; gender; age; sexual orientation; medical condition, including current or past history of a mental health and substance use disorder; disability; religious beliefs; or sources of payment for care;
9. Members have the right to considerate, respectful treatment at all times and under all circumstances with recognition of their personal dignity;
10. Members have the right to be interviewed and examined in surroundings designed to assure reasonable visual and auditory privacy;
11. Members have the right to select a primary care physician (PCP) of their choice. If a member is dissatisfied for any reason with the PCP initially chosen, they have the right to choose another PCP;
12. Members have the right to expect communications and other records pertaining to their care, including the source of payment for treatment, to be treated as confidential in accordance with the guidelines established in applicable Minnesota law;
13. Members have the right to know the identity and professional status of individuals providing service to them and to know which physician or other practitioner is primarily responsible for their individual care. Members also have the right to receive information about the Plan's clinical guidelines and protocols;
14. Members have the right to a candid discussion (with the practitioner(s) responsible for coordinating their care) of appropriate or medically necessary treatment options for their conditions in a way that is understandable, regardless of cost or benefit coverage for those treatment options. Members also have the right to participate with practitioners in decision making regarding their treatment planning;
15. Members have the right to give informed consent before the start of any procedure or treatment;
16. When a member does not speak or understand the predominant language of the community, the Plan will make its best efforts to access an interpreter. The Plan has the responsibility to make reasonable efforts to access a treatment clinician who is able to communicate with the member;
17. Members have the right to receive printed materials that describe important information about the Plan in a format that is easy to understand and easy to read;
18. Members have the right to appeal any decision regarding medical necessity made by the Plan and its practitioners;
19. Members have the right to disenroll from the Plan;

20. Members have the right to receive information about the organization, its services, its practitioners and providers and members' rights and responsibilities; and
21. Members have the right to make recommendations regarding the organization's Member Rights and Responsibilities policies.

South Dakota, North Dakota and Iowa Member Rights

The Plan is committed to treating members in a manner that respects their rights. In this regard, the Plan recognizes that each member (or the member's parent, legal guardian or other representative if the member is a minor or incompetent) has the right to the following:

1. Members have the right to receive impartial access to treatment and/or accommodations that are available or medically indicated, regardless of race; ethnicity; national origin; gender; age; sexual orientation; medical condition, including current or past history of a mental health and substance use disorder; disability; religious beliefs; or sources of payment for care.
2. Members have the right to considerate, respectful treatment at all times and under all circumstances with recognition of their personal dignity.
3. Members have the right to be interviewed and examined in surroundings designed to assure reasonable visual and auditory privacy.
4. Members have the right, but are not required, to select a primary care physician (PCP) of their choice. If a member is dissatisfied for any reason with the PCP initially chosen, he or she has the right to choose another PCP.
5. Members have the right to expect communications and other records pertaining to their care, including the source of payment for treatment, to be treated as confidential in accordance with the guidelines established in applicable State law.
6. Members have the right to know the identity and professional status of individuals providing service to them and to know which physician or other practitioner is primarily responsible for their individual care. Members also have the right to receive information about our clinical guidelines and protocols.
7. Members have the right to a candid discussion (with the practitioner(s) responsible for coordinating their care) of appropriate or medically necessary treatment options for their conditions in a way that is understandable, regardless of cost or benefit coverage for those treatment options. Members also have the right to participate with practitioners in decision making regarding their treatment planning.
8. Members have the right to give informed consent before the start of any procedure or treatment.
9. When members do not speak or understand the predominant language of the community, the Plan will make its best efforts to access an interpreter. The Plan has the responsibility to make reasonable efforts to access a treatment clinician that is able to communicate with the member.
10. Members have the right to receive printed materials that describe important information about the Plan in a format that is easy to understand and easy to read.
11. Members have the right to a clear grievance and appeal process for complaints and comments and to have their issues resolved in a timely manner.
12. Members have the right to appeal any decision regarding medical necessity made by the Plan and its practitioners.
13. Members have the right to disenroll from the Plan, in accordance with Employer and/or Plan guidelines.
14. Members have the right to receive information about the organization, its services, its practitioners and providers and members' rights and responsibilities.
15. Members have the right to make recommendations regarding the organization's members' rights and responsibilities policies.

Member Responsibilities

Each member (or the member's parent, legal guardian or other representative if the member is a minor or incompetent) is responsible for cooperating with those providing health care services to the member, and shall have the following responsibilities:

1. Members have the responsibility to provide, to the best of their knowledge, accurate and complete information about present complaints, past illnesses, hospitalizations, medications, and other matters relating to their health. They have the responsibility to report unexpected changes in their condition to the responsible practitioner. Members are responsible for verbalizing whether they clearly comprehend a contemplated course of action and what is expected of them.
2. Members are responsible for carrying their Plan ID cards with them and for having member identification numbers available when telephoning or contacting the Plan.
3. Members are responsible for following all access and availability procedures.
4. Members are responsible for seeking emergency care at a participating emergency facility whenever possible. In the event an ambulance is used, direct the ambulance to the nearest participating emergency facility unless the condition is so severe that you must use the nearest emergency facility. State law requires that the ambulance transport the member to the hospital of their choice unless that transport puts the member at serious risk.
5. Members are responsible for notifying the Plan of an emergency admission as soon as reasonably possible and no later than *forty-eight (48)* hours after becoming physically or mentally able to give notice.
6. Members are responsible for keeping appointments and, when they are unable to do so for any reason, for notifying the responsible practitioner or the hospital.
7. Members are responsible for following their treatment plan, as told by the Doctor mainly responsible for their care. Members are also responsible for participating in developing mutually agreed-upon treatment goals, and to the degree possible, for understanding their health conditions, including mental health and/or substance use disorders.
8. Members are responsible for their actions if they refuse treatment or do not follow the practitioner's instructions.
9. Members are responsible for notifying the Plan within *thirty (30)* days at (800) 752-5863 if they change their name, address, or telephone number. Also, if members get married, they must inform the Plan of their change in status.
10. Members are responsible for notifying their employer of any changes of eligibility that may affect their membership or access to services. The employer is responsible for notifying the Plan.